2017 Nursing Protocols

Nursing Protocols

Annual Review Certification

2017

At least annually, the TDOC Chief Medical Officer, the TDOC Director of Nursing, the contractor's State Medical and Dental Directors, and the facility's Medical Director, shall review and approve the TDOC's Nursing Protocols. The Statewide CQI (SCQI) committee must approve any variances, as prescribed by the reviewing parties.

The signatures below certify that the nursing protocols have been reviewed and updated as appropriate.

TDOC's Chief Medical Officer Kenneth L Williams MD PhD Date 4/21/2017

TDOC's State Director of Nursing Date 4/12/17

Contractor's State Medical Director Date 4/13/17

Contractor's State Dental Director Date 18 Apr 17

Contractor's State Director of Nursing Katie P. Wingate Date 4/13/2017

Facility's Medical Director_____Date_____

(Insert copy with signatures)

TN Department of Correction

Nursing Protocols

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SECTION I

PROTOCOLS ACKNOWLEDGEMENT

INTRODUCTION

The Tennessee Department of Correction Nursing Protocols are written to instruct, guide, and educate the nursing staff on the specific steps required to evaluate an inmate's health status and provide appropriate interventions. The Nursing Protocols are directed by a physician or dentist who authorizes nurses to provide definitive treatment for minor health conditions and/or emergency care. It is the intent of the Department to ensure that the use of these Nursing Protocols enhances medical care directed by a physician or dentist and does not replace it.

It is essential that the Nursing Protocols only be used as guidelines and do not take the place of nursing assessments. A nursing assessment requires a nurse's clinical judgment and decision before a protocol intervention is implemented. If, upon the completion of a nursing assessment, a nurse does not believe he or she has the clinical experience required to determine if the protocol will provide the best intervention for the inmate, the physician or dentist should be contacted for specific orders. The provider has the clinical and medical expertise needed to determine if the inmate's symptoms match the specific Nursing Protocol in question.

Further, the Nursing Protocols should be utilized to address conditions that have the potential to develop into infectious diseases (e.g., abrasions/wounds, bites, blisters, boil-furuncles, and lacerations.) If a nursing assessment determines that an inmate has a condition that appears to be infectious, the inmate's name and TOMIS ID should be referred to the Attending Physician as well as the Infection Control Nurse (ICN) for follow up. Additionally, implementation of these Nursing Protocols will be in adherence to Standard Precautions for infection control unless a specific precaution is warranted or ordered by the physician.

All nursing staff shall be oriented in the Nursing Protocols prior to providing nursing care in accordance with the protocols. Each health facility shall maintain a current copy of the TDOC approved Nursing Protocols in their Health Services Unit Manual. In addition, a copy of the Nursing Protocols should be readily available in all clinical areas for use as a reference. At least annually, the TDOC Nursing Protocols shall be jointly reviewed by the responsible physician and the nursing staff.

TENNESSEE DEPARTMENT OF CORRECTION
2017 NURSING PROTOCOLS LETTER OF UNDERSTANDING

These Nursing Protocols are designed for use by the nursing staff of the Tennessee Department of Correction and associated contractors. Treatment by health care personnel other than a physician, dentist, or other independent provider must be performed pursuant to written or direct orders or protocols. Registered and Licensed Practical Nurses may practice within the limits of state and federal laws. These Nursing Protocols constitute directives from the responsible physician to the nurse for the treatment of commonly occurring conditions or emergencies. Each Nursing Protocol is mutually agreed upon by the TDOC Chief Medical Officer, facility Medical Director, and facility nursing staff. Additionally, implementation of these Nursing Protocols will be in adherence to Standard Precautions for infection control unless a specific precaution is warranted or ordered by the physician.

Over the counter medications (OTC) used in these Nursing Protocols will be given on a dose by dose basis during the routine medication pass, unless specifically stated to be given KOP in the protocol. All Limited Activity Notices (LAN) issued during a nursing/patient encounter will be for no more than **3** days without an evaluation by a mid-level provider or physician.

Before a member of the nursing staff is allowed to practice under these protocols, the training credentials and experience level of each nurse shall be verified to the satisfaction of the responsible physician and nursing director/supervisor. It is the option of either the responsible physician or the nursing director/supervisor to restrict an individual nurse in his or her use of these Nursing Protocols based on the individual's education, experience, or ability.

It is essential that a good working relationship be maintained between the nursing staff and the responsible physician. At least annually, Nursing Protocols shall be reviewed jointly by the responsible physician and the nursing staff. It is expected that when questions arise the nurse will obtain a consultation either face-to-face or via phone or refer that patient to the appropriate provider.

TENNESSEE DEPARTMENT OF CORRECTION

2017 NURSING PROTOCOLS LETTER OF UNDERSTANDING

_____
Facility Name

_____
Facility Medical Director's Name *(Please Print)*

_____ _____
Signature of Facility Medical Director Date

TENNESSEE DEPARTMENT OF CORRECTION
2017 NURSING PROTOCOLS LETTER OF UNDERSTANDING
NURSING SIGNATURE SHEET

Name of Facility _____

My affixed signature indicates that I have read and understand the scope of the TDOC Nursing Protocols. I have the necessary skills, knowledge, and understanding to use these protocols. I agree to abide by the conditions of supervision as expressed in the attached Letter of Understanding. I further acknowledge that any variance from the approved procedures is not acceptable. I understand that the protocols are by no means exhaustive, and I am expected to know my limitations and to seek assistance from other healthcare professionals as needed. All nurse/patient clinical encounters will be documented utilizing the pre-printed Problem Oriented-Progress Record, CR 1884, associated with the appropriate Nursing Protocol. Medication and treatment orders will be documented on the Physician Order form, CR 1892, and transcribed to the Medication Administration Record or Treatment Record according to the Transcription Guidelines located on page 11 of these protocols.

NURSE (*Print Name*)	SIGNATURE AND TITLE OF NURSE	LICENSE #	DATE

NURSE (*Print Name*)	SIGNATURE AND TITLE OF NURSE	LICENSE #	DATE

Transcription Guidelines

Transcribing means copying information from the Physician's Order form to the Medication Administration Record (MAR). The purpose of transcription is to set up the Medication Administration Record so that the Medication Nurse can easily **identify the 5 rights of medication administration** and can accurately document the medications that have been given.

This is a legal document. You must use permanent ink. You may not use correction fluid (white out) or other means of covering up errors. If you make an error while transcribing the order strikethrough with a single line, write error, date, and your initials, highlight the area in yellow, and rewrite the entire order in a new block. PRINT the information that you are transcribing.

NEATNESS COUNTS

When transcribing you must use the next available blank on the MAR DO NOT START A NEW PAGE TILL ALL AVAILABLE SPACES ARE FILLED ON THE CURRENT PAGE

Copy what is written on the Physician's Order to the MAR being sure to include:

1. The inmate's name and number shall be entered in the appropriate space, along with the current month and year.
2. For each medication order, the following information shall be entered in the appropriate block:
    a. Date of order and start/stop date.
    b. Name of drug, dose or strength, and dosage form (All liquid medications, should be documented in mg/ml/cc as well as the amount to be administered).
    c. Route of administration and any special instructions i.e. with milk, after meals, etc.
    d. Time interval or frequency of administration.
    e. Duration of order and/or automatic stop order.
    f. Attending provider's name (physician, dentist, etc.).
    g. **Initials** of the nurse who transcribed the order.
    h. Draw a line to the box immediately before the first dose box.
        - If a medication is time or dose limited, draw a line from the last dose box to the end of the MAR.
3. The hour(s) of medication administration shall be entered beside the medication order.
4. All persons transcribing an order shall sign their full **legible** signature, professional title, and initials in the designated area either on the bottom of the back of the MAR.

Medication Orders

There must be a written provider's or Nursing Protocol order for all prescription **and** non-prescription medications. To have a complete order the following information must be included on the Physician's Order Form:

1. The individual's full name, TDOC number, allergies, DOB (at the top)
2. The date and time of the order
3. Name of the medication
4. Dosage and administration information
5. Indication / diagnosis for medication
6. Provider's or nurse's signature (providers have 14 days to sign telephone and Nursing Protocol orders)

SECTION II

EMERGENCY NURSING PROTOCOLS

Any use of an Emergency Protocol requires a provider be contacted as soon as the patient is stable and an order must be obtained for the patient to be discharged back to the compound

Signs and Treatment of SHOCK (to be used as a supplement to other protocols)

Signs of shock:

1. Hypotension
2. Tachycardia
3. Weak/Thready pulse
4. Pallor
5. Cool clammy skin
6. C/O being cold
7. Lethargy
8. Confusion
9. Profuse bleeding

Emergency Treatment:

1. Contact EMS for Emergency Transport to outside ED
2. Administer oxygen at 15 L/min per NRB mask
3. Elevate the person's feet about 12 inches unless head, neck, or back is injured or you suspect broken hip or leg bones. Do not raise the person's head.
4. Turn the person on side if he or she is vomiting or bleeding from the mouth.
5. Apply blankets to keep patient warm
6. Start large bore IV with NS at 1000 ml/hr
7. Contact provider immediately

Glasgow Coma Scale

Verbal Response		Eye Opening		Motor Response	
Oriented	5	Spontaneously	4	Obeys commands	6
Confused	4	To voice	3	Localizes to pain	5
Inappropriate	3	To pain	2	Withdraws to pain	4
Incomprehensible	2	None	1	Abn. Flexion (Decorticate)	3
None	1			Abn. Extension (Decerebrate)	2
				None	1
Total		Total		Total	
Cumulative Total _V+E+M = GCS					

GSC Interpretation <9 Severe
9-12 Moderate
≥ 13 Minor

Signs and Symptoms of an Opiate Overdose

AIRWAYS AND LUNGS
- No breathing
- Shallow breathing
- Slow and difficult breathing

SKIN
- Bluish colored nails and lips

EYES, EARS, NOSE AND THROAT
- Dry mouth
- Extremely small pupils, sometimes as small as the head of a pin (pinpoint pupils)
- Discolored tongue

NERVOUS SYSTEM
- Coma
- Delirium
- Disorientation
- Drowsiness
- Uncontrolled muscle movements

HEART AND BLOOD
- Low blood pressure
- Weak Pulse

NARCAN (naloxone)

Indications

NARCAN (naloxone) is indicated for the complete or partial reversal of opioid depression, including respiratory depression (RR <12 or O2 sat < 90%), induced by natural and synthetic opioids [1]

- Codeine
- Methadone
- Pentazocine (Talwin)
- Percodan
- Morphine Sulfate; Heroin
- Meperidine (Demerol) Paregoric (Darvon, Darvocet)
- Butorphanol tartrate (Stadol)
- Fentanyl (Sublimaze)
- Morphine
- Lomotil
- Propoxyphene (Darvon)
- Nalbuphone (Nubain)
- Hydromorphone (Dilaudid) Methadone
- Codeine Propoxyphene
- Oxycodone (Percocet)
- Buprenorphine (Suboxone)

Naloxone can and should be used for suspected acute opiate overdosage.

When administered in usual doses and in the absence of opioids or agonistic effects of other opioid antagonists, it exhibits essentially no pharmacologic activity.

Contraindications

Known allergy to NARCAN (naloxone)

Adverse Effects

If patient has opiate dependency

Abrupt reversal of opioid effects in persons who are physically dependent on opioids may precipitate an acute withdrawal syndrome which may include, but is not limited to, the following signs and symptoms: body aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness or irritability, diarrhea, nausea or vomiting, abdominal cramps, increased blood pressure, tachycardia.

Cardiac Disorders

Pulmonary edema, cardiac arrest or failure, tachycardia, ventricular fibrillation, and ventricular tachycardia. Death, coma, and encephalopathy have been reported as sequelae of these events.

These effects need to be monitored for. Cardiac disorders are NOT a contraindication to administration.

NARCAN Administration Guidelines

Per Dr. Williams: All patients receiving Narcan are to go to Outside ED for evaluation.

Administration

NARCAN (naloxone) may be administered intravenously, intramuscularly, or subcutaneously.

For use at TDOC administration should be IM and may be through clothing if necessary.

1. Administer 0.4mg Narcan IM (1 dose) outer thigh (may be given through clothing if needed) for RR < 12 and O2 saturation < 90%.
2. **If no contact with provider and patient status has not improved OR patient relapses (3) three minutes after 1st dose.**
   a. 2nd dose: Administer Narcan 0.4mg IM if no improvement after 3 minutes If no contact with provider and patient status has not improved OR patient relapses
   b. 3rd dose: Administer Narcan 0.4mg IM if no improvement after 3 minutes If no contact with provider and patient status has not improved OR patient relapses
   c. 4th dose: Administer Narcan 0.4mg IM if no improvement after 3 minutes If still no contact with provider and patient status has not improved OR patient relapses
   d. 5th dose: Administer Narcan 0.4mg IM
   e. **DO NOT ADMINISTER MORE THAN 5 DOSES without provider order**
   f. If still no communication with On Call provider, contact the Back-Up On Call provider
   g. Monitor closely for relapse of respiratory depression. If occurs begin with next dose in the series of 5 doses total (may require additional dose of Narcan 30 to 60 minutes after improvement due to half-life of Narcan being shorter than half- life of opioid taken).

Since the duration of action of some opioids may exceed that of NARCAN (naloxone), the patient should be kept under continued surveillance. Repeated doses of NARCAN (naloxone) should be administered, as necessary.

Large doses of naloxone are required to antagonize buprenorphine (Suboxone) since the latter has a long duration of action due to its slow rate of binding and subsequent slow dissociation from the opioid receptor. Buprenorphine antagonism is characterized by a gradual onset of the reversal effects and a decreased duration of action of the normally prolonged respiratory depression.

Problem: ACUTE RESPIRATORY DISTRESS / SHORTNESS OF BREATH

(S) SUBJECTIVE:

1. Patient's statements/complaints:
   a. Onset of symptoms
   b. Inquire as to degree of breathlessness patient is experiencing, e.g. while walking, while talking, or while at rest
   c. History:
      i. COPD/Emphysema/ Asthma (see Asthma Protocol)
      ii. Refer to Anaphylactic Reaction Protocol if associated with allergic reaction
      iii. Recent UTI or URI
      iv. Cardiac problems (refer to Chest Pain Protocol if associated with chest pain)
      v. Recent surgery
      vi. Previous spontaneous lung collapse
      vii. Cancer
      viii. Blood clots/pulmonary embolism
      ix. Drug use
      x. Recent exposure to chemicals or Smoke
   d. Associated symptoms:
      i. None
      ii. Dizzy
      iii. Hives
      iv. Weakness
      v. Pain scale 1-10/location
      vi. Cough
      vii. Fever
      viii. Severe anxiety

(O) OBJECTIVE:

1. Vital signs, include pulse oximetry and allergies (Smoke inhalation with suspected Carbon Monoxide poisoning may cause false oximetry reading)
2. General appearance:
   a. No acute distress/acute distress
   b. Calm/anxious
3. Color:
   a. Pink; Pallor; Flushed; Cyanotic; Jaundice
4. Skin:
   a. Warm; Cool; Dry; Moist; Clammy
5. Respiration:
   a. Normal; Slow; Rapid
   b. Labored; Deep; Shallow
   c. Nasal flaring; Accessory muscle use
   d. Audible wheezing; Expiratory grunt; Stridor

Problem: ACUTE RESPIRATORY DISTRESS / SHORTNESS OF BREATH, contd.

6. Lung sounds (bilateral):
    a. Clear
    b. Crackles
    c. Wheezing
    d. Rhonchi
    e. Diminished
7. TB status: date of TB test with results, date of CXR with results
8. HIV status

(A) ASSESSMENT:

- Alteration in gas exchange
- Ineffective breathing pattern

(P) PLAN OF CARE:

Emergency Intervention:

Acute Distress: O2 sat <85% or Smoke Inhalation

1. O2 at 15 l/min via NRB mask
2. Contact EMS for transport to outside ED
3. EKG if patient has a cardiac history
4. Albuterol nebulizer treatment X1 stat for non-trauma related distress
5. Start IV (largest bore possible) with 0.9% Normal Saline at 500 ml/hr

Consult provider if:

1. Adventitious breath sound
2. O2 sat <92% but greater than 85%
3. Meets criteria for Influenza Like Illness (ILI) during flu season

Nursing Interventions:

1. Place in position of comfort to facilitate breathing
2. Administer oxygen at 2-6 liters/minute, titrate to keep sats >90%. Increase flow as ordered by provider
3. Facilitate emergency transfer as ordered by provider
4. Chart disposition of patient (transferred, admitted to infirmary, returned to unit)
5. Patient education regarding possible precipitating factors
6. Return to clinic if condition worsens

Problem: AMPUTATION – PARTIAL or COMPLETE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of event (include type of injury)
    b. Location, pain scale of 1 – 10

(O) OBJECTIVE:

1. VS with O2 Sat
2. Allergies
3. General appearance: Distress; LOC; Orientation
4. Vascular assessment: Pulses; Skin Color / Temp; Capillary Refill; Bleeding; Signs & Treatment of Shock(pg 13)

(A) ASSESSMENT:

- Risk for hypovolemic shock
- Alteration in tissue perfusion
- Pain
- Risk for infection

(P) PLAN OF CARE:

Emergency Interventions

1. Contact EMS immediately for transport to the nearest Emergency Department
2. Start O2 at 6 l/min via NC or if sat <85% using NC 15 l/min via NRB mask
3. Start IV (largest bore possible) with 0.9% Normal Saline at 1000 ml/hr
4. Monitor and treat for shock as needed Signs & Treatment of Shock(pg 13)
5. Notify physician for further orders

Nursing Interventions

1. Control excessive bleeding with direct pressure at pressure point, elevate limb
2. Apply sterile NS moistened pressure dressing to open area
3. Assess VS with capillary refill q 5 mins until transferred

Complete Amputation

1. Wrap part(s) in minimally moistened gauze with sterile NS or LR solution
2. Place the part(s) in plastic bag and seal securely
3. Place the plastic bag in a container filled with crushed ice or ice packs
    a. Label container patient's name, TDOC number, birthdate, contents, and time of amputation

Problem: AMPUTATION – PARTIAL or COMPLETE, contd.

4. DO NOT:
    a. Place part directly on ice
    b. Use any antiseptic or other solution
    c. Float part in a bag of solution
    d. Allow the part to freeze

Incomplete Amputation

1. Clean wound surfaces with sterile Normal Saline
2. Gently return skin to normal position if possible
3. Apply bulky pressure dressing and splint in alignment with extremity avoiding torsion

1. Ensure container with the body part(s) is given to EMS personnel
2. Call report to the receiving hospital

Problem: ANAPHYLACTIC REACTION

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire when symptoms started and what caused symptoms, i.e.: new medication, insect bite, bee sting, other allergen exposure.
    b. Weakness, itching, redness of skin
    c. Difficulty breathing, choking, swelling, wheezing
    d. Fear, anxiety
    e. Hx of reactions, txs, and responses

(O) OBJECTIVE:

1. VS with O2 Sat
2. Allergies
3. General appearance: Distress; LOC; Orientation, Diaphoretic
4. Facial / Cervical Edema
5. Vascular assessment: Pulses; Skin Color / Temp; Capillary Refill; Bleeding; Signs of Shock
6. Respiratory assessment: Quality of Respirations; Lung Sounds

(A) ASSESSMENT:

- Impaired gas exchange
- Ineffective breathing pattern / airway clearance
- Alteration in cardiovascular status

(P) PLAN OF CARE:

Emergency Interventions:

1. Notify EMS for severe distress
2. Start O2 at 6 l/min via NC or is sat <85% O2 at 15 l/min per NRB mask
3. Start IV (largest bore possible) with 0.9% Normal Saline at 500 ml/hr
4. Contact provider for further orders

Nursing Interventions:

1. VS with capillary refill q 5 minutes until transferred or per provider order
2. Document disposition of patient (transferred to outside ED, admitted to the infirmary, returned to unit)
3. Schedule patient for follow-up evaluation within 72 hours

Problem: ASTHMA

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset, duration, aggravating factors, relieving factors and severity of symptoms
    b. Wheezing, coughing, shortness of breath, chest tightness, feelings of severe anxiety, sweating, feeling a pounding in the chest
    c. Precipitating factors: respiratory infection, exercise, emotional upset, ingestion of aspirin or related compound, air pollutants, environmental changes
    d. Typical and most recent use of inhalers and recent sick call encounters
    e. Previous history and treatment

(O) OBJECTIVE:

1. VS with O2 Sat
2. Allergies
3. General Appearance: Distress; LOC; Orientation; Preferred Posture
4. Vascular assessment: Pulses; Skin Color / Temp; Capillary Refill; Bleeding; Signs & Treatment of Shock(pg 13)
5. Respiratory Assessment: Quality of Respirations; Lung Sounds; Degree of SOB; Peak Flow Measurements (Current / Best per medical record); Sputum

(A) ASSESSMENT:

- Alteration in tissue perfusion
- Impaired gas exchange
- Ineffective Breathing Pattern

(P) PLAN OF CARE:

Emergency Interventions:

1. Start O2 at 2-6 l/min via NC or if sat <85% 15 L/min per NRB mask
2. Albuterol Nebulizer Treatment x 1

Contact provider if:

1. Severe respiratory distress, wheezing
2. Abnormal vital signs: pulse greater than 100 bpm, pulse ox less than or equal to 92% on room air
3. Peak flow less than 50% predicted or personal best less than 200 liters per minute
4. Severe and/or productive cough
5. Patient not responding to treatment or for additional orders

Problem: ASTHMA, contd.

Nursing Interventions:

1. Place patient position that best facilitate breathing and comfort
2. Check record for PRN Albuterol inhaler/nebulizer treatment order
3. Arrange transport to outside Emergency Department as ordered by the provider
4. If symptoms are mild, observe a minimum of 30 minutes, repeat vital signs, lung sounds, and peak flow. If WNL and pt stable release back to housing
5. If patient continues to have respiratory distress admit to infirmary/observation; will require order from provider to discharge.
6. Patient education
    a. Use of inhaler and medication compliance
    b. Tobacco cessation if applicable
    c. Document patient's understanding
7. Schedule follow up appointment within 72 hours

Problem: AVULSED TOOTH

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of event
    b. Location, pain scale of 1 - 10

(O) OBJECTIVE:

1. VS with O2 Sat
2. Allergies
3. General Appearance: Distress; LOC; Orientation; Preferred Posture
4. Vascular assessment: Pulses; Skin Color / Temp; Capillary Refill; Bleeding; Signs & Treatment of Shock(pg 13)
5. Trauma / Additional injuries

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection

(P) PLAN OF CARE:

Emergency Interventions:

Contact dental provider immediately or physician

Nursing Interventions:

1. Gently reposition partial avulsed tooth in the socket, being careful that the patient is not pushing the tooth to an abnormal position
    a. Instruct patient to bite gently on sterile saline soaked gauze
2. For total avulsion less than 15 minutes
    a. Gently rinse with warm water
    b. If debris is seen on tooth root
    c. Immediately replace the tooth into socket
    d. Have patient bite gently on sterile saline soaked gauze
3. If avulsed tooth has been extraoral for greater than 15 minutes:
    a. Place the tooth in a plastic storage device with a tight lid
    b. Do not handle roughly.
    c. Do not rinse off, rub, scrape or disinfect the outside of the tooth in any way
    d. Store the tooth in fresh milk or a saline solution for a short period of time (1 hour or less)
    e. Do not use tap water or saliva to store the tooth/teeth as these are not suitable
4. If avulsed tooth has been extra oral for more than 60 minutes, replantation will not be successful
5. Patient education as directed by dentist or physician

Problem: BURNS **2nd Degree: Painful vesicles (blisters) and edema**
3rd Degree: Full thickness, painless, skin can appear white or black in color, sloughs off

(S) SUBJECTIVE:

1. Patient's statements/complaints (get witness statement if patient cannot speak):
    a. Inquire as to onset
    b. Cause of burn:
        i. Flames
        ii. Hot liquids
        iii. Gases
        iv. Chemicals
        v. Radiation
        vi. Electricity
2. Inquire about loss of consciousness
3. Inquire about secondary injuries (trauma)
4. Inquire into last tetanus immunization

(O) OBJECTIVE:

Note: Patients who have suffered an inhalation injury are also at risk for carbon monoxide (CO) poisoning. The pulse oximeter is not accurate in patients with CO poisoning

1. Vital Signs (T, P, R, BP, GSC, O2 Sat and Pain 0-10)
2. Shock assessment, Signs & Treatment of Shock(pg 13)
3. Evaluate level of consciousness
    a. Glasgow Coma Scale (pg 13)
    b. Describe: Alert/lethargic/obtunded/stuporous/comatose)
4. Obtain EKG (if able)if electrical burn, including lightning
5. For Chemical burns- identify type and consult MSDS manual for information
6. Evaluate for facial burns,
    a. Singeing of the eyebrows and/or nasal hair
    b. Pharyngeal burns

Problem BURNS, contd. **2nd and 3rd degree**

c. Carbonaceous sputum
d. Impaired mentation
e. Change in voice quality
f. Stridorous respiration
g. Wheezing

7. Document size, location of burn (Rule of 9's see pg. 26)
8. Document appearance, degree of burn
   a. 2nd Degree: Vesicles (blisters) pain and edema
   b. 3rd Degree: Full Thickness, painless, with skin loss, skin can appear white in color, sloughs off
9. Evaluate for concomitant trauma (such as fractures)
10. Evaluate for circumferential burns to the chest, extremities, digits, because
    a. As the burn progresses, the tissue involved may not allow enough motion of the chest wall to allow adequate breathing to occur
    b. If circumferential burns occur to arms, legs, fingers, or toes, the same constriction may not allow blood flow and put the survival of the extremity at risk
11. Evaluate for burns to areas of the body with flexion creases, like the palm of the hand, the back of the knee, the face, and the groin
12. Visual acuity by Snellen Eye Chart if face or eyes involved
13. Document presence or absence of signs and symptoms of infection:
    a. Drainage
    b. Increased redness
    c. Malodorous drainage
    d. Streaking
    e. Increased warmth

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection
- Alteration in comfort

(P) PLAN:

Emergency Interventions: Arrange EMS Transport for

1. Any third degree burn
2. Large area second degree (> 15% BSA or >10% for patients over 50)
3. Radiation, chemical or electric burn, including lightning
4. Symptoms of shock, respiratory or cardiac distress

Problem: BURNS, contd. **2nd and 3rd degree**

5. Inhalation injury
    1. Start oxygen at 15 l/min via NRB mask
6. Burns that involve the face, hands, feet, genitalia, perineum, or major joints
7. If symptoms of shock(pg 13):
    a. Oxygen administered at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
    b. Place in supine position and elevate feet if possible
    c. Start IV (largest bore possible) with 0.9% NS at 1000ml/hr
    d. Record vital signs with GCS every 15 minutes until transported
    e. Continue to monitor, obtain and record vital signs (P, BP, R, GSC, and O2 Sat) until transported to ED
8. Notify provider of transport and for further orders
9. Copy notes and emergency treatment to send to hospital with patient

Nursing Interventions:

Keep patient NPO for burns greater than 20% BSA or inhalation injury

1. Chemical Burn:
    a. Irrigate with copious amounts of water
    b. Consult MSDS sheet or Poison Control for information
2. Electrical burn:
    a. Obtain EKG
    b. Continue to monitor, obtain and record vital signs (P, BP, R, GSC, and O2 Sat) until transported
3. Third Degree: All 3rd degree burns are to go to outside ER
    a. Establish and maintain airway, breathing and circulation
    b. Contact provider, orders received, documented on provider order sheet and on MAR
    c. Carry out orders received, complete documentation of the event in progress notes
    d. Continue to obtain and record vital signs (P, BP, R, GSC, and O2 Sat) every fifteen (15) minutes until transported
4. Second Degree (<15% BSA)
    a. Cool compress
    b. Keep area clean, cover with clean, dry dressing
    c. Clean and dress area daily, monitor for signs of infection
5. All Burns
    a. Consult Eye Problem protocol if eye involvement or any chemical, or second degree burn of face
    b. Administer tetanus toxoid as ordered

Problem: BURNS, contd. 2nd and 3rd degree

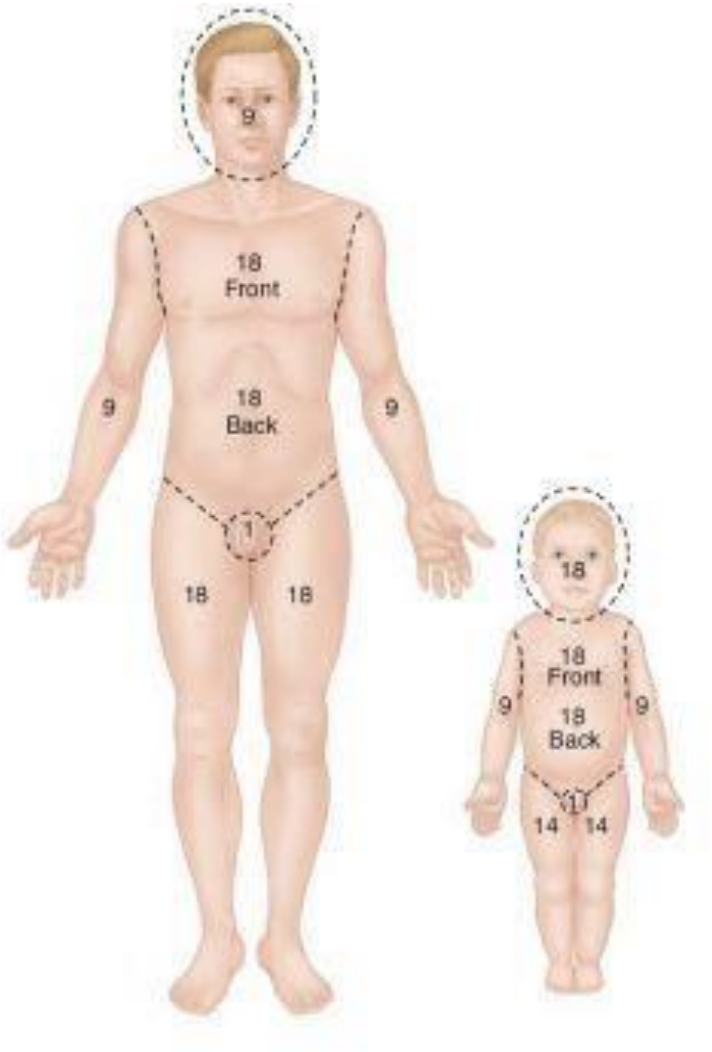
c. Carry out orders received, document on provider order sheet, MAR and complete documentation of the event in progress notes
d. Continue to monitor, obtain and record vital signs (P, BP, R, GSC, and O2 Sat) until transported or released back to security
e. If patient went to outside ED, upon return provider should evaluate and write treatment orders prior to patient returning to housing unit.

6. Follow up:
   a. Individualized per provider related to severity of symptoms and response to treatment.
   b. Patient should be scheduled for nurse visit in 24 hours to evaluate healing and need for further treatment

RULE OF NINES

In an adult, the following are the respective percentages of the total body surface area:

- Head and neck total for front and back: 9%
- Each upper limb total for front and back: 9%
- Thorax and abdomen front: 18%
- Thorax and abdomen back: 18%
- Perineum: 1%
- Each lower limb total for front and back: 18%



Problem: CHEST PAIN

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. New onset or chronic
    b. Location
    c. Gradual or sudden
    d. Associated symptoms:
        i. Nausea, vomiting
        ii. Dizziness
        iii. Weakness
        iv. Numbness
2. Type:
    a. Stabbing
    b. Tight/squeezing
    c. Sharp/dull
    d. Crushing/heavy
    e. Burning
    f. Increases with motion/exertion,
    g. Radiates to the arm/shoulder/jaw/neck
    h. Constant/intermittent
3. Pain scale of 1 – 10
4. Relief measure before coming to clinic:
    a. Rest/lying down
    b. Nitroglycerin,
    c. Activity
    d. Food
    e. Sitting upright
    f. Nothing relieves pain
5. History of:
    a. Cardiac disease
    b. MI
    c. Angina
    d. Peptic ulcer
    e. Anxiety
    f. Drug use
    g. Smoking
    h. Recent respiratory or GI problems

(O) OBJECTIVE:

1. Vital signs including O2 sat and allergies
2. Pulse:
    a. Regular / irregular
    b. Strong / weak / bounding / thready

Problem: CHEST PAIN, contd.

3. EKG
4. Assess for signs of unstable hemodynamics such as
    a. Significant change in BP (less than 90/60 mm Hg or greater than 210 systolic, or greater than 90 diastolic),
    b. Obvious diaphoresis
    c. Pallor with or without cyanosis
    d. Difficulty in breathing (respiration greater than 24/min), and/or O_2 Sat less than 90% on room air
5. Evaluate level of distress:
    a. No apparent distress
    b. Mild, moderate, or severe distress
    c. Use 0-10 scale to rate pain
6. Assess general orientation:
    a. Alert and oriented
    b. Confused
    c. Disoriented
7. Assess skin condition:
    a. Warm/cool,
    b. Diaphoretic/dry/damp,
    c. Pale/cyanotic/mottled/ashen
8. Perform limited lung assessment:
    a. Clear/crackles or wheezing
        i. Crackles or wet lung sounds may be signs of CHF or pneumonia
9. Note if pain increases with deep breathing or coughing or if patient is unable to take a deep breath without pain
10. Palpate chest: Is pain reproduced with palpation
11. Perform abdominal assessment
    a. Note any tenderness and whether it is localized or diffuse
    b. Note any guarding, rigidity or palpable mass
12. Palpate lower legs and ankles
    a. Evaluate presence of swelling or edema, pitting or non-pitting

(A) <u>ASSESSMENT</u>:

- Alteration in comfort
- Alteration in perfusion

Problem: CHEST PAIN, contd.

(P) PLAN OF CARE:

Emergency Interventions:

1. **Arrange for emergency transport to outside ED if hemodynamically unstable**
   - (BP<99/60 or systolic >210 or diastolic >90; diaphoretic; pallor; RR >24/min; O2 sat < 90% on RA; patient took 3 three (3) sublingual nitroglycerin prior to coming to clinic with zero (0) pain relief
2. Administer oxygen at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
3. Contact provider

If patient is hemodynamically stable

Contact provider immediately if:

1. Acute distress, abnormal vital signs
   a. States (s)he took 3 nitroglycerin prior to coming to the clinic
   b. Cardiac history, diabetic, age 30 years or older HIV(+)
   c. History of recent drug use
   d. History of recent injury or surgery

Nursing Interventions:

1. Give Nitroglycerin 1/150 tab x3 (total) taking into account the number the patient took before coming to the clinic; i.e. they took 1 give 2; they took 2 give 1…
   a. 1st dose: Nitroglycerin gr 1/150 tab 1 tab sublingually immediately, if no relief of pain after 5 minutes
   b. 2nd dose: sublingual Nitroglycerin 1/150 gr tab and place call to physician. If pain still not relieved after 5 minutes
   c. 3rd dose: sublingual Nitroglycerin 1/150 gr tab.
   d. Pain still not relieved after 5 minutes AND no contact with the physician alert EMS and transport patient to the Emergency Department
   e. If pain relieved monitor VS q 15 minutes AND consult physician for further orders
2. Aspirin 325mg chew and swallow if no contraindications
3. Ensure AED is readily available
4. Place in semi-Fowler's position (head of bed elevated 15°- 30°) if systolic B/P is greater than 90 mmhg
5. Vital signs (except temp.) with O_2 sat and GSC every 3-5 minutes
6. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
7. Schedule follow up
8. Follow orders as directed by physician

Problem: FRACTURES

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of Event / Mechanism of Injury
    b. Pain at site of injury and/or with movement
    c. Associated symptoms: Numbness; Paresthesia; Loss of Function; C/O of being Cold or Thirsty; Etc…

(O) OBJECTIVE:

1. Vital signs and allergies
2. Tenderness, crepitus, deformity
3. Loss of function, diminished capillary refill, diminished distal pulse
4. Skin:
    a. Pink/pale/cyanotic/mottled/ecchymosis
    b. Warm/flushed/cool
    c. Dry/moist/clammy
5. Mental status:
    a. Alert/oriented x 3
    b. Disoriented/confused
6. Pulse:
    a. Regular/irregular
    b. Weak/strong
    c. Thready/bounding
7. Assess for shock (pg 13):
    a. Hypotension
    b. Tachycardia
    c. Weak/thready pulse
    d. Pallor
    e. Confusion
    f. Bleeding

(A) ASSESSMENT:

- Alteration in comfort
- Alteration in neurovascular status
- Impaired mobility

(P) PLAN OF CARE:

1. Immobilize prior to moving
    a. Apply C collar based on Mechanism of Injury

Problem: FRACTURES Contd.

Emergency Interventions:

1. Signs of Shock(pg 13):
2. Compound Fracture: **DO NOT ATTEMPT TO PLACE BONE BACK INTO SKIN**
    a. Arrange emergency transport to outside ED
    b. Administer O2 at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
    c. Place in supine position and elevate lower extremities if able
    d. Start IV (largest bore possible) with 0.9% with NS at 1000ml/hr

Contact provider immediately d/t:

1. Suspected fracture
2. Abnormal VS
3. Pt on anticoagulation therapy

Nursing Interventions:

1. Control bleeding with direct pressure
2. Cover open wounds with a sterile dressing moistened with normal saline
3. Splint joint in position of comfort above and below injury site
    a. DO NOT TRY TO FORCE BONES INTO ALIGNMENT
4. VS with neurovascular checks q 5 minutes
5. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
6. Provide education as warranted
7. Schedule follow up

Problem: HEAD INJURY (this is to include patients that have been involved in an altercation and have visible facial and/or head trauma)

If patient is non-responsive refer to UNCONSCIOUS PERSON protocol

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of event
    b. Inquire about loss of consciousness immediately before, during and after event/trauma (if applicable)
    c. Inquire about symptoms:
        i. Recent vomiting, with or without preceding nausea
        ii. Fevers/chills/diaphoresis
        iii. Dizziness
        iv. Headache
        v. Skin rashes
        vi. Speech or visual problems (transient
            1. Blindness, diplopia, photophobia)
        vii. Bowel/bladder continence,
        viii. Numbness/weakness in extremities
        ix. Pain scale of 1 – 10, location
2. Current medications (especially aspirin, lovenox, plavix, warfarin, NSAIDS)
3. If the event was witnessed, obtain a witness statement

(O) OBJECTIVE:

1. Vital signs, FSBS, O2 Sat, GCS and allergies
2. Symptoms:
    a. Delayed verbal or motor response/level of consciousness
    b. Bleeding from or bruising behind ears
    c. Uncoordinated movement/loss of balance
    d. Confusion/lack of attention/memory loss
    e. Blurred vision/persistent headache/drowsiness
    f. Seizure activity
3. Exam:
    a. Evidence of trauma, raccoon's eyes
    b. Evaluate for cerebrospinal fluid leakage in ears or sinuses (otorrea or rhinorrhea)
    c. Tender neck, trachea midline
    d. Assess pupils

(A) ASSESSMENT:

- Potential for altered mental status
- Alteration in comfort

Problem: HEAD INJURY, contd.

(P) PLAN OF CARE:

Emergency Interventions:

1. Arrange for emergency transport to outside ED if:
   a. Loss of consciousness
   b. Dilated/Unequal pupils
   c. Respiratory issues
   d. Convulsions
   e. Severe Headache
   f. Dizziness
   g. Nausea and vomiting
   h. Neuro deficits
   i. Cerebrospinal fluid leaking from nose or ears
2. Administer oxygen at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
3. C-spine immobilization for suspected spinal injury until assessed by physician
4. Assess and record vital signs and neuro checks every 5 minutes until transported
5. Once ambulance in route contact provider

Patient with no symptoms or apparent distress or has need for sutures
Immediate consult with provider

Nursing Interventions:

1. Arrange transport to ER if directed by provider
2. Treat any injuries
3. If patient does not go to the ER: VS, GCS, and Neuro check are to be done
   a. q 5mins x4; then q 15mins x4; then q hour x4; then q 4 hours x 4
4. Administer oxygen as ordered
5. Patient education regarding injury
   a. Alert nursing if experiences increased thirst, increased urination, sudden headache, N/V, vertigo, neuro deficits; increased anxiety, increased drowsiness
6. Chart disposition of patient: transferred; admitted to infirmary; returned to unit (requires order from provider)
7. Schedule follow up within 24 hours

Problem: HEAT EXHAUSTION/STROKE

Heat stroke - body temperature greater than 102, hypotension, strong rapid pulse, absent sweating, skin hot to touch, mental status changes such as confusion, delirium, and coma. Heat stroke is a medical emergency.

Heat exhaustion - profuse sweating, pale, cool moist skin, chills, feeling faint, headaches, thirst, nausea and vomiting, malaise, weakness, unsteady gait, muscle cramping

NOTE: Individuals who are at risk for heat exhaustion and heat stroke require closer observation and may need job re-assignment as well as education:

a. Elderly
b. Diagnoses of cardiovascular disease and diabetes
c. Taking diuretics, anticholinergic drugs, phenothiazines, psychotropics
d. Diminished mental functioning
e. Obese
f. Have an infection

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Dizziness, headache, blurred or dim vision, following exposure to heat
    b. Time of onset
2. Patient may be found down following excessive exposure to heat or sun.
    a. History may be obtained from other inmates or security
3. Inquire about recent attempts to cool off and hydrate
4. History of previous occurrences

(O) OBJECTIVE:

1. Vital signs including GCS, FSBS and O_2 Sat and allergies
2. Assessment:
    a. Neuro check:
        i. Pupils, reaction and size
        ii. Vertigo
        iii. Weakness
        iv. Orientation
    b. Unsteady gait
    c. Sweating
    d. Headache
    e. Nausea/vomiting
    f. Chills
    g. Strong, rapid pulse
3. Review current medications

Problem: HEAT EXHAUSTION/STROKE, contd.

(A) ASSESSMENT:

- Alteration in body temperature
- Hyperthermia
- Potential for injury

(P) PLAN OF CARE:

Emergency Interventions:

1. Contact EMS for any symptoms of sever distress or LOC
    a. High fever (greater than 103° F)
    b. Hypotension; rapid heartbeat; rapid shallow breathing
    c. Absent sweating, hot, dry skin
    d. Confusion, delirium
    e. Seizure activity
2. Contact provider immediately for:
    a. Fever greater than 101° F
    b. Muscle weakness or cramps
    c. Nausea and vomiting
    d. Patient on diuretics, anticholinergics, phenothiazines, psychotropics
3. Begin aggressive external body cooling
    a. Fans
    b. Cool (not ice) water bath or wet sheet
    c. Ice to groin, axilla, neck and head
4. Administer O2 at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
5. Place in supine position and elevate lower extremities
6. Start IV (largest bore possible) with 0.9% NS at 1000ml/hr

Nursing Interventions

1. Give room temperature water if alert (avoid salt/sugar in p.o. fluids)
    a. If patient is not conscious, or is vomiting, establish IV access and administer IV fluids as ordered, do not attempt to give fluids orally.
2. Arrange for transportation to hospital as directed by provider
3. Monitor and record vital signs every 5 minutes until transported
4. If patient is not transported to ER then VS q 30 mins until temp <100° F; then q 1hr until <99° F; then as ordered by the provider
5. Patient education regarding activity, fluids, and environment
6. LAN X 3 days for no work, sports, or strenuous activity
7. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
8. Schedule follow up

Problem: HYPOGLYCEMIA

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Feeling of weakness, shakiness, loss of balance
    b. Headache, visual disturbances, fatigue, sweating, tingling of extremities
    c. Excessive thirst, change in food intake
2. Onset of symptoms
3. DX of NIDDM or IDDM and medication taken if any
4. Previous history of hypoglycemic episodes

(O) OBJECTIVE:

1. Vital signs, GCS, finger stick blood sugar if not already done, O_2 sat and allergies
2. Assess for:
    a. Tachycardia
    b. Orthostatic hypotension
    c. Dry mucous membranes
    d. Cold extremities
    e. Weak pedal pulses
    f. Diaphoresis
    g. Decreased temperature perception
    h. Decreased pain perception
    i. Gait disturbances
    j. Tremors/convulsions
    k. Pallor
    l. Slurred speech
    m. Anxiety/agitation
    n. Confusion/delirium

(A) ASSESSMENT:

- Risk of Injury
- Alteration in nutritional requirements

(P) PLAN OF CARE:

Emergency Interventions:

Do not administer Glucose gel without a FSBS < 60 or Glucagon without a FSBS < 40 or patient is unable to swallow

1. FSBS 40 - 60: Glucose gel given po in the cheek
2. FSBS <40 or patient is too confused or combative to administer Glucose gel:
    a. Glucagon injection IM per package directions

Problem: HYPOGLYCEMIA, contd.

Call provider immediately for:

1. Sever lethargy or loss of consciousness
2. Convulsions
3. Violent behavior
4. Delirium
5. Second dose of Glucagon may be given 10 minutes after 1st dose **WITH PROVIDERS ORDER ONLY**

Nursing Interventions:

1. When patient is able, administer some form of protein po (i.e., peanut butter, milk, nutritional supplement)
2. Recheck blood sugar by finger stick in five minutes, 15 minutes, and 30 minutes of the original event, record findings
3. Patient education regarding diabetes
4. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
5. Follow-up appointment with physician as directed

Problem: OVERDOSE – POISONING

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of event:
        i. Intentional/accidental
    b. Amount and drug, poison, or other material involved
    c. Route:
        i. Ingested
        ii. Injected
        iii. Inhaled
        iv. Topically applied
        v. Inserted
    d. Mental status: depressed, suicidal, previous overdoses
2. History of previous drug use/abuse
3. Event witnessed, if yes, get details of event

(O) OBJECTIVE:

1. Vital Signs and Allergies
2. General Appearance
3. Airway:
    a. Clear/obstructed
4. Breathing:
    a. Spontaneous
    b. Shallow/deep
    c. Regular/irregular
    d. Absent
5. Circulation:
    a. Pulse present/absent
    b. Strong/weak,
    c. Regular/irregular
6. Neuro:
    a. Awake/unresponsive
    b. Oriented/confused
    c. Responds to voice/pain
    d. PERRLA/ pupils unequal/constricted/dilated, size
7. Vital signs and allergies

(A) ASSESSMENT:

- Risk of Injury
- Risk for Impaired Gas Exchange
- Altered Mental Status

Problem: OVERDOSE – POISONING, contd.

(P) PLAN OF CARE:

Emergency Interventions:

1. Notify EMS for transport due to severe acute distress.
    a. Seizure activity
    b. O2 sat <85 %
    c. Loss Of Consciousness
    d. Respiratory Rate < 12 or known/suspected Opiate use refer to Narcan Administration Guidelines
2. O2 at 6 L/min. via NC or if O2 sat <85% 15 L/min per NRB mask
3. Start IV (largest bore possible) with 0.9% Normal Saline at 500 ml/hr
4. If known substance contact National Poison Control Center at (800) 222-1222
5. Contact provider

Nursing Interventions:

1. Contact provider for orders
2. Assess, monitor, and document ABC's, vital signs, neuro status checks q 5 minutes or as directed by physician
3. If vomits, obtain sample of emesis for later analysis
4. Mental Health referral
5. Patient education as directed by physician
6. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
7. Follow-up as directed by physician

Problem: RESPIRATORY DEPRESSION (RR<12 and 02 saturation <90%)

(S) SUBJECTIVE :

1. Patient's presentation
   a. Patient found to be unconscious (Refer to Unconscious Person Protocol) (Initiate CPR if no respirations)
   b. Inmate brought to clinic for respiratory depression
   c. Inmate admits opiate usage/suspected opiate overdose (Refer to Narcan Administration Guidelines)

(O) OBJECTIVE : (Evaluate for sign of Opiate Usage/Overdose)

1. Vital signs, include pulse oximetry, GCS, and allergies
   a. FSBS
      i. If < 60 use Hypoglycemia Protocol interventions in addition to Respiratory Depression interventions
2. General appearance:
   a. Color:
      i. Pink; Pallor; Flushed; Cyanotic; Jaundice
   b. Skin:
      i. Warm; Cool; Dry; Moist; Clammy
   c. Oral mucosa
      i. Dry
      ii. Tongue discolored
3. Neuro:
   a. Awake/Lethargic/Unresponsive
   b. Oriented/Confused
   c. Responds to voice/pain
   d. PERRLA/ pupils unequal/constricted/dilated
4. Respiration:
   a. Normal; Slow; Rapid
   b. Labored; Deep; Shallow
   c. Nasal flaring; Accessory muscle use
   d. Audible wheezing; Expiratory grunt; Stridor
5. Lung sounds (bilateral):
   a. Clear
   b. Crackles
   c. Wheezing
   d. Rhonchi
   e. Diminished

(A) ASSESSMENT:

- Alteration in gas exchange
- Ineffective breathing pattern

(P) PLAN OF CARE:

a. Administer O2 at 6 L/min via NC or if O2 sat <85% 15 L/min per NRB mask
   i. If RR <12 or known/suspected opiate use give Narcan per Narcan Administration Guidelines
   ii. **If Narcan given** Contact EMS arrange transport to outside ED
   iii. Have Ambu bag and AED at bedside
   iv. Administer manual ventilation if RR < 8 or O2 saturation < 85% at a rate of (1) one breath every 5 seconds
   - **Contact EMS arrange transport to outside ED**

b. Start IV (largest bore possible) with NS at 200cc/hr
c. Obtain EKG
d. Follow provider's orders once contacted
e. If patient has not improved continue to provide supportive care, continue manual ventilation if RR is < 8 or saturation level < 85%
f. If patient improves
   i. Administer O2 titrate to keep sat above 92%
   ii. Monitor closely for relapse of respiratory depression. If occurs begin with next dose in the series of 5 doses total (without provider's order) (may require additional dose of Narcan 30 to 60 minutes after improvement due to half-life of Narcan being shorter than half- life of opioid taken). (Narcan Administration Guidelines)
g. Provide care as needed until EMS arrives

Problem: SEIZURES

(S) SUBJECTIVE:

1. Patient's statements/ complaints:
    a. New, chronic, witnessed
        i. Witness Statement
    b. Inquire into seizure activity
        i. How long seizure lasted
        ii. Activity pre-episode
        iii. Trauma sustained during episode
        iv. Incontinent
        v. Post-episode activity
        vi. Presence of an aura
2. History:
    a. Epilepsy
    b. Diabetic
    c. Post-traumatic injury
    d. Cardiac
    e. Psychiatric
3. Interview other inmates/ security regarding pre-seizure activity and how long seizure lasted
4. Last menstrual period if female of childbearing age

(O) OBJECTIVE:

1. Vital signs (post seizure) O_2 Sat and allergies
    a. DO NOT obtain an oral or rectal temperature immediately post seizure
    b. Axillary temperatures are acceptable, until patient is stable
2. Finger stick blood glucose
3. Color:
    a. Pink
    b. Pallor
    c. Flushed
    d. Cyanotic
    e. Jaundiced
4. Skin:
    a. Warm/cool
    b. Dry/moist/clammy
5. Neuro:
    a. AAOx3
    b. Post seizure disoriented
    c. Agitated
    d. Unresponsive
    e. Pupils: PERRLA, dilated, size of right and left

Problem: SEIZURES, contd.

6. Assess for injuries, make sure to include scalp and inside of mouth
7. Note if patient was incontinent urine or feces
8. Medications: recent changes or discontinuations
    a. Recent anti-seizure drug level

(A) ASSESSMENT:

- Potential for injury
- Altered level of consciousness
- Medication Non-Compliance

(P) PLAN OF CARE:

Emergency Interventions:

1. If patient is having seizure activity protect from injury
    a. Do not force objects such as oral airway or tongue blade between closed jaws
    b. Position on one side to help maintain airway, and prevent aspiration
2. O2 at 2-6 liters per NC, titrate to keep O2 sat >90%

Immediate consult with provider for:

1. Seizure activity lasting longer than 3 minutes
2. Acute distress / Abnormal VS
    a. O2 sat < 85% (administer 15 L/min per NRB mask)
    b. Any type of injury
    c. Pupils **NOT** ERRL

Nursing Interventions:

1. VS with neurochecks q 15 minutes until awake or as ordered.
2. Treat injuries as needed
3. Observe and monitor the patient in a quiet safe environment post seizure (which may last up to hour).
    a. It is not unusual for the patient to be tired and want to sleep.
        i. During this time, patient will gradually become more lucid
4. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
5. Patient education
    a. Importance of taking medication as ordered if applicable
    b. Avoidance of triggers
        i. Loud noise
        ii. Extreme heat
        iii. Flashing lights
    c. Additional education as directed by physician
6. Follow-up as directed by provider

Problem: UNCONSCIOUS PERSON (begin CPR immediately if no Respiration or Pulse)

(S) SUBJECTIVE:

1. Details of event
2. Witness statement
    a. LOC observed or patient found unconscious
3. Recent medication changes

(O) OBJECTIVE:

1. Vital signs and allergies
2. FSBS
3. Airway:
    a. Clear
    b. Obstruction
4. Breathing:
    a. Spontaneous
    b. Absent/shallow/deep
    c. Regular/irregular
5. Circulation:
    a. Pulse present/absent
    b. Strong/weak
    c. Regular/irregular
    d. Capillary Refill
6. Trauma:
    a. If yes, C-Spine immobilization
7. Neurological assessment:
    a. PERRLA/unequal/constricted/dilated/size
    b. Glasgow Coma Scale (pg 13)

ASSESSMENT:

- Alteration in level of consciousness
- Potential for injury

Consider possible causes (AEIOU TIPS)

A- Alcohol	**T**-Trauma
E- Electrolytes Encephalopathy Endocrinapathy	**I**-Infection Insulin (too much or too little)
I- Infection	**P**- Psychiatric
O-Opiates Other Drugs	**S**-Seizure Shock
U- Uremia or other metabolic D/Os	

Problem: UNCONSCIOUS PERSON, contd.

(P) PLAN OF CARE:

Emergency Interventions:

1. Establish ABC's/ perform CPR if necessary
    a. If CPR initiated contact EMS for transport to ER
2. If RR <12 or known/suspected opiate use give Narcan per Narcan Administration Guidelines
3. Apply C-Spine immobilization if spinal trauma suspected
4. Administer O2 at 6 L/min via NC or if O2 sat <85% 15 L/min per NRB mask
5. Start IV (largest bore possible) with 0.9% Normal Saline at 500 ml/hr
6. Contact provider immediately

Nursing interventions:

1. Ammonia inhalant x 1 crush and place close to nostrils
2. Treat any injuries
3. Prepare for ER transfer as directed by physician
4. Monitor patient in clinic/infirmary until transferred or alert and oriented
5. Patient education as directed by physician when appropriate
6. Physician's order required to release patient back to unit
7. Chart disposition of patient: transferred; admitted to infirmary; returned to unit
8. Follow up as directed by physician

SECTION III

NURSING PROTOCOLS

Problem: ABDOMINAL PAIN

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset
    b. Pain scale of 1-10 with location
    c. Type:
        i. Sharp/dull
        ii. Cramp
        iii. Constant/intermittent
        iv. Radiating
    e. Last bowel movement:
        i. When
        ii. Normal/constipation/diarrhea
        iii. Color
    f. Associated symptoms:
        i. Nausea/vomiting
        ii. Painful urination
        iii. Leg/back pain
2. Inquire if any previous abdominal surgery
3. Females-inquire date of last menstrual period
4. Inquire about other OTC treatment tried recently for this complaint

(O) OBJECTIVE:

1. Vital signs FSBS and allergies
2. General appearance:
    a. No acute distress
    b. Unable to stand erect
    c. Knees drawn up
3. Color:
    a. Pink
    b. Pale
    c. Flushed
    d. Cyanotic
    e. Jaundiced
4. Skin:
    a. Warm/cool
    b. Dry/moist/clammy
5. Hydration assessment:
    a. Mucous membranes
    b. Skin turgor
6. Lower extremities:
    a. Normal color/mottled/cyanotic
    b. Pedal pulses present/absent

Problem: ABDOMINAL PAIN, contd.

7. Abdomen:
    a. Flat; distended; soft; rigid
    b. Bowel sounds present in all four quadrants
        i. Normal/hypoactive/hyperactive
    c. Tenderness:
        i. Rebound/localize/diffuse
    d. Guarding
    e. Location:
        i. RUQ, RLQ, LUQ, LLQ, Midline, Upper, Lower
8. Heart and lung sounds

(A) ASSESSMENT:

- Alteration in comfort (abdominal pain)
- Constipation
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Abnormal vital signs
    a. Temperature greater than 101°F
    b. Pulse greater than 100 bp
    c. Hypo or hypertension
2. Pallor, moist clammy skin
3. C/O severe pain
4. Distended or rigid abdomen
5. Rebound tenderness on R side
6. Bloody or tarry stools
7. Persistent nausea/vomiting
8. Mottled or cyanotic or pulseless lower extremities

Nursing Interventions

1. Clean catch urine for dipstick, contact provider if positive results for blood, leukocytes, nitrates, and urine pregnancy in a female patient who is between age 12 to 52, and whose LMP is reported to have occurred more than 4 weeks ago if not post-menopausal
2. Stool hemoccult
3. Stock antacid (manufacturer's recommended dose) by mouth one time. (Excluding renal patients, contact physician for order)
4. Consult physician before administering laxative
5. Patient education
    a. Good bowel elimination habits
    b. Dietary suggestions to prevent constipation/indigestion
    c. Signs and symptoms of viral infection
6. Return to clinic if condition worsens or not improved

Problem: ABRASIONS/WOUNDS

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Mechanism of injury with associated symptoms:
        i. Active bleeding
        ii. Pain (1-10)
        iii. Numbness,
        iv. Limited motion
    b. Date and time of injury
    c. Inquire as to last tetanus booster

(O) OBJECTIVE:

1. Vital signs and allergies
2. Wound description: Include wound bed and surrounding tissue
    a. Clean/dirty
    b. Foreign material present
    c. Gaping
    d. Dry/crusted
    e. Weeping/discharge/drainage
    f. Odor
    g. Redness
    h. Swelling/induration
    i. Pain
    j. Healing
3. Wound measurements
    a. Length; Width; Depth; Undermining; Tunneling

(A) ASSESSMENT:

- Alteration in skin integrity
- Alteration in comfort
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Wound is more extensive than superficial / needs sutures
2. Wound was sustained in dirty setting and/or obviously contaminated
3. Infection present
4. Wound is near or involving eye/mouth/perineum
5. Wound requires foreign material removal
6. Wound resulted in exchange of body fluids
7. If tetanus status greater than 5 years old

Problem: ABRASIONS/WOUNDS, contd.

Nursing Interventions: Refer to MRSA Protocol if MRSA Suspected

1. Cleanse wound with soap and water and flush with copious sterile NS irrigation
2. Apply stock antibiotic ointment and non-stick dressings if wound location subject to dirt irritation
3. Patient education:
    a. Wound self-care
        i. Issue supplies and red bag for disposal
        ii. Instruct to return contaminated dressing to clinic for proper disposal
    b. Signs and symptoms of infection
        i. Drainage
        ii. Redness
        iii. Increased Pain
        iv. Red streaks
        v. Odor
4. Dressing changes as ordered
5. Return to clinic if condition worsens or signs of infection develop
6. Schedule follow-up for wound evaluation

Problem: ACNE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Location and duration of acne
    b. Hygiene habits including use and type of skin products
    c. Current treatments: prescriptions or OTC

(O) OBJECTIVE:

1. Vital signs and allergies
    a. Appearance of lesions:
        i. Open/ closed pores
        ii. Raised/flat
        iii. Irritated
        iv. Scarring
        v. Red/white/black
        vi. Drainage
        vii. Size
2. Document presence or absence of signs/symptoms of infection:
    a. Drainage / Malodorous discharge
    b. Increased redness / warmth / streaking
3. General skin condition:
    a. Complexion: fair; dark
    b. Skin: dry; oily; mixture

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Secondary infections
2. Red skin greater than 1 cm with purulent drainage
3. Extensive involvement
4. New onset in post-adolescent with severe/extensive involvement

Nursing Interventions

1. Benzoyl Peroxide, preparation from Commissary/ Canteen with instructions to apply two times daily for 14 days.
2. Patient education
    a. Keep hands away from area of involvement
    b. Do not squeeze lesions as this may cause infection
    c. Wash affected area with soap and water at least twice daily
    d. Proper hand washing technique/hygiene
    e. Stay out of sun to prevent burning
4. Return to clinic if condition worsens or signs of infection develop

Problem: ATHLETES FOOT (TINEA PEDIS)

(S) SUBJECTIVE:

1. Patient statements/complaints:
    a. Symptoms:
        i. Itching
        ii. Burning
        iii. Skin peeling
        iv. Pain scale of 1-10
    b. Inquire as to onset
    c. Current or prior treatment
    d. History of diabetes
    e. Type of shoes/socks

(O) OBJECTIVE:

1. Vital signs and allergies
2. Presence of
    a. Edema / Blisters
    b. Discoloration / Red streaks
    c. Drainage
    d. Odor
    e. Dry / Scaly skin
    f. Tender to touch
3. Document presence or absence of signs and symptoms of infection
4. Size and location of affected area

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Condition not responding to protocol
2. Nail involvement present
3. Edema or drainage present
4. Signs or symptoms of infection
5. Patient is a diabetic or pregnant (do not give medication without physician order)

Nursing Interventions:

1. Instructions/ education on hygiene care of feet
    a. Stock topical antifungal cream/ointment 1 tube with instructions to apply to clean, dry area BID for three weeks
    b. Change socks frequently and use shower shoes
    c. May use OTC foot powder from commissary
2. Return to clinic if condition worsens

Problem: BACK PAIN (Acute or Chronic)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset
    b. Location of pain (radiation of pain down leg/below knee)
    c. Pain scale of 1-10, absence or presence of radiation and numbness
    d. Description of pain:
        i. Sharp/dull
        ii. Intermittent/constant
    e. Associated symptoms
        i. Pain on urination
        ii. Change in urine color
        iii. Urinary frequency
        iv. Nausea/vomiting
        v. Pain with cough/breathing
        vi. Range of motion impaired
2. HIV+ status
3. History of any malignancy
4. If associated with an injury, document nature/date of injury
5. Inquire about use of "blood thinners" such as aspirin, warfarin, lovenox, heparin, plavix, or statin drugs for cholesterol
6. Document the impact of pain on activities of daily living and participation in recreation/sports activities
7. Inquire about other OTC treatment tried recently for this complaint
8. Previous history and treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess for:
    a. Edema / Redness / Tenderness
    b. Weakness of extremities / Impaired ROM / Abnormal gait
    c. Tingling
    d. Muscle spasms
    e. Foot drop
3. Lung sounds – right and left
    a. Clear
    b. Rhonchi / Crackles / Wheezing
    c. Diminished
4. Lower extremities:
    a. Normal color or mottled
    b. Pedal pulses are present or absent
    c. Strength / ROM

Problem: BACK PAIN (Acute or Chronic), contd.

(A) ASSESSMENT:

- Impaired physical mobility
- Alteration in comfort

(P) PLAN OF CARE:

Consult provider if:

1. Impaired Musculo/Skeletal status
2. Impaired Neuro/Vascular status
3. Urine dipstick positive for WBC's and/or blood
4. Loss of bowel or bladder control
5. Patient on statin drug with complaint of muscle pain
6. Abnormal vital signs, especially temperature greater than 101°F
7. Numbness and severe pain
8. Edema, discoloration
9. Foot drop, weakness, loss of sensation
10. HIV+, high risk, or prior malignancy

Nursing Interventions:

1. If symptoms of dysuria (difficult or painful urination) or c/o flank pain, do urine dipstick for WBC's and blood
2. LAN X 3 days
    a. Advise no sports x 14 days issued, avoid exercise for 72 hours
3. Acetaminophen 325mg 2 tabs PRN 3x daily x 4 days or Ibuprofen 200mg, 2 tabs PRN 3x daily x 4 days at medication window
4. Give back pain handout
5. Return to clinic if symptoms worsen or do not begin to subside within 72 hrs
6. Schedule follow up appointment as needed

Problem: BITES

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Affected area with probable cause (snake, human, bee, yellow jacket, hornet, wasp)
    b. Pain scale of 1-10, numbness,
    c. Exchange of body fluids
    d. Shortness of breath
        i. Refer to Anaphylactic Protocol for respiratory distress

(O) OBJECTIVE:

1. Vital signs including lung sounds and allergies
2. Document size, appearance, and location of injury
3. Respiratory distress, shortness of breath
4. Redness, edema, streaking, size, marks/fangs
5. Active bleeding, drainage, broken skin

(A) ASSESSMENT:

- Alteration in skin integrity
- Alteration in tissue perfusion
- Ineffective airway clearance
- Alteration in respiratory status
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Wild animal bite
2. Respiratory distress/SOB
3. Body fluid exchanged
4. If snake, animal or human bite and symptomatic
5. Known allergy to stings
6. Abnormal vital signs
7. Major erythema and/or edema
8. If tetanus booster is greater than 5 years
9. Pregnant

Nursing Interventions:

1. For snake bite:
    a. Have victim lie down, keep victim calm
    b. Call 911 for transport
    c. **DO NOT** place tourniquet on the affected limb or cut the area to attempt to suction the venom
    d. Immobilize affected area
    e. Wound evaluation weekly and prn until resolved

Problem: BITES, contd.

Nursing Interventions:

2. For human bite:
    a. Refer immediately to provider
    b. Identify source
    c. Perform HIV and Hepatitis testing (if status unknown)
    d. Wound evaluation weekly and prn until resolved

3. For insect sting/bite:
    a. If still in place, gently remove the stinger and venom sac away from the wound with a scalpel or sharp, sterile object
    b. Ice pack to bite/sting area
    c. Elevate area involved
    d. Stock topical corticosteroid preparation (Hydrocortisone) twice daily to area – one tube if significant local reaction

Note: Do not give medication to pregnant women -contact provider for appropriate intervention

4. For other animal bites:
    a. Clean wound with soap and water
    b. Control bleeding
    c. Wound evaluation weekly and prn until resolved

5. Patient education regarding wound care
    a. Return to clinic
        i. For dressing changes and wound checks as ordered
        ii. For signs of infection

Problem: BLEEDING FOLLOWING DENTAL EXTRACTION

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Date and time of extraction
    b. Location of extraction
    c. Onset of bleeding
    d. History of any known bleeding disorders

(O) OBJECTIVE:

1. Vital signs and allergies
2. Amount of bleeding:
    a. Scant
    b. Minimal
    c. Moderate
    d. Profuse
3. Appearance of gums
    a. Presence of swelling

(A) ASSESSMENT:

- Alteration in comfort r/t bleeding gums
- Potential for infection

(P) PLAN OF CARE:

1. Do not rinse extraction site

Consult dental provider if bleeding persists despite nursing interventions

Nursing Interventions:

1. Place a NS moistened 4 x 4 gauze sponge over extraction site with instructions to bite down for 1 hour,
    a. Change the gauze sponge and repeat process
2. Ice pack to cheek for one (1) hour (on for 15 min., off for 15 min, etc.)
3. Patient education:
    a. Avoid :
        i. Hot/cold liquids
        ii. Smoking
        iii. Sucking on a straw
    b. Chew on opposite side for 48 hours
4. Arrange follow-up dental appointment
5. Return to clinic if breakthrough bleeding occurs or condition worsens

Problem: BLISTERS

(S) SUBJECTIVE
1. Patient statements/complaints:
    a. Inquire as to onset
    b. Affected area with associated symptoms:
        i. Pain
        ii. Active bleeding

(O) OBJECTIVE:
1. Vital signs and allergies
2. Document
    a. Size
    b. Appearance
    c. Location of wound
3. Document presence or absence of signs and symptoms of infection
    a. Drainage
    b. Increased redness
    c. Malodorous drainage
    d. Streaking
    e. Increased warmth
4. Assess for proper fitting shoes if blister is on feet
5. Obtain date of last tetanus vaccine, if open wound

(A) ASSESSMENT:
- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:
Consult provider:
1. Patient is diabetic or has impaired circulation
2. Signs of infection present
3. Open wound with last tetanus booster more than five years

Nursing Interventions:
1. Cleanse gently with mild antiseptic or soap and water taking care not to break the blister
2. Apply non-adhering dressing to area for protection
3. Issue wound care supplies as needed
4. Monitor for proper fitting shoes if applicable
5. Consider LAN/ activity restrictions as needed
6. Patient education regarding:
    a. Prevention
    b. Signs and symptoms of infection
    c. Wound care
7. Return to clinic if symptoms worsen

Problem: BOIL – FURUNCLE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Location
    b. Drainage, bleeding
    c. History of diabetes and/or HIV
    d. History of previous lesions

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess for:
    a. Redness
    b. Maculae
    c. Papules
    d. Pustules
    e. Vesicles
    f. Abscesses
    g. Excoriations
    h. Streaking
    i. Induration
    j. Location, number, size
3. Document presence or absence of signs and symptoms of infection:
    a. Drainage
    b. Increased redness
    c. Malodorous drainage
    d. Streaking
    e. Increased warmth
4. Check current tetanus immunization

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider:

1. If patient is diabetic or has impaired circulation
2. Immunosuppressed
3. Non-compliant with treatment
4. If date of last tetanus immunization is greater than10 years prior

Problem: BOIL – FURUNCLE contd.

6. **Need for Contact Isolation d/t:**
    a. Any patient who is unable/unwilling to understand follow-up management
    b. Noncompliant with active therapy
    c. Any patient with a large abscess, boil, or draining lesion that cannot be adequately covered and kept dry and clean
    d. Any patient who is immunocompromised or who has cellulitis, lymphangitis, or sepsis as a complication

Nursing Interventions: Refer to MRSA Protocol (pg 94) if MRSA Suspected

1. Non- draining instruct patient to apply warm, moist heat at least BID X 15 minutes to allow lesion to point and drain
2. Apply dressing and instruct patient on dressing change/wound care. Issue appropriate wound care supplies, including dressing necessary to use if area begins to drain
3. Draining Wounds
    a. Culture drainage
    b. Apply dry, sterile non-occlusive dressing to any open, draining boil, abscess, or skin lesion
    c. Daily dressing changes and/or antibiotic administration, as ordered by physician
        i. If patient is able to perform self-care: Instruct on wound care and advise to change dressing daily after shower and PRN if it becomes soiled or wet or drainage not contained.
        ii. Have patient demonstrate ability to change dressing appropriately.
        iii. Issue appropriate dressing supplies and “red bag” with instructions to dispose of soiled dressing in “red bag” and return to clinic for proper disposal.
    d. Wound evaluation weekly and prn until resolved
4. Patient education regarding:
    a. Prevention
    b. Signs and symptoms of spreading infection
    c. Wound care
5. Return to clinic if boil worsens or begins to drain
6. Schedule follow-up appointment for wound evaluation

Problem: Burns

First degree burn: The least serious type of burn. It involves only the epidermis (the outer layer of the skin). The burn site is painful and appears red, dry and absent of blisters. The injured area slightly swells and turns white when pressed on. The skin over the burn may peel off after one or two days. Mild sunburn is an example of a first degree burn. This type of burn is also known as a thin or superficial burn.

Second degree burn: Involves the epidermis and the dermis (the layer beneath the epidermis). The burn site is painful and appears red and blistered. Swelling may also occur. This type of burn is also known as a superficial partial-thickness or deep partial thickness burn.

Third degree burn: Involves damage or total destruction of all three layers of the skin- the epidermis, dermis and subcutaneous layer. Underlying muscles, tendons, and bones may also be damaged. The injured skin appears white or charred black. The patient may feel little pain or no pain at all in the area since the nerve endings are often damaged. This type of burn is also known as full-thickness burn.

1ST DEGREE OR SUNBURN

Refer to Emergency BURN Protocol for 2nd and/or 3rd degree burns

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset
    b. Cause of burn:
        i. Flames
        ii. Hot liquids
        iii. Gases
        iv. Chemicals
        v. Radiation
        vi. Electricity
        vii. Sunburn
    c. Inquire about other OTC treatment tried recently for this complaint

(O) OBJECTIVE:

1. Vital signs, (T, P, R, BP, GSC)
2. Document
    a. Size
        i. Estimate total body surface burned. See Rule of Nines Chart (pg. 28)

Problem: Burns, contd. **1ST DEGREE OR SUNBURN**

b. Appearance
   i. 1st Degree: Presence of pink to red, dry, painful, slightly edematous skin
c. Location
d. Visual acuity by Snellen Eye Chart if face or eyes involved
e. Document presence or absence of signs and symptoms of infection:
   i. Drainage
   ii. Increased redness
   iii. Malodorous drainage
   iv. Streaking
   v. Increased warmth

3. For Chemical burns- identify type and consult MSDS (Material Safety Data Sheets) manual for information

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection
- Alteration in comfort

(P) PLAN:

1. Upgrade degree if any question of degree classification

Consult provider:

1. If signs of infection present
2. If condition not responding to protocol

Nursing Intervention:

1. Cool compress
2. Irrigate chemical burns with water
3. Acetaminophen 325 mg tabs 2 PRN 3x daily x 4 days at medication window or if acetaminophen is contraindicated
4. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window

1. Patient Education
   a. Wound care
   b. Signs and symptoms of infection
2. Return on sick call if signs of infection develop or symptoms do not subside

Problem: CALLOUSES/CORNS

(S) SUBJECTIVE:

1. Patient's statements/complaints
    a. Affected area, probable cause
    b. New onset or chronic
    c. Pain scale of 1-10
        i. Describe pain
2. Document associated symptoms
3. Any prior treatment
4. History of diabetes

(O) OBJECTIVE:

1. Vital signs and allergies
2. Deformity, redness, edema, hot, streaking

(A) ASSESSMENT:

- Alteration in skin integrity
- Alteration in comfort

(P) PLAN OF CARE:

Consult provider if:

1. Patient is diabetic
2. Secondary infection present
3. Severe pain or burning sensation
4. Abnormal vital signs

Nursing Interventions:

1. Warm water soaks twice weekly, for 4 weeks
2. Corn pads if indicated by provider, after soaks completed
3. Patient education regarding proper foot care and proper fitting shoes

Problem: CERUMEN IMPACTION

(S) SUBJECTIVE:

1. Patient's statements/complaints
    a. Ear Pain scale of 1-10
    b. Difficulty hearing
    c. Additional symptoms:
        i. Drainage
        ii. Vertigo
        iii. Tinnitus
    d. History of similar problem

(O) OBJECTIVE:

1. Vital signs and allergies
2. Use otoscope to visualize and record condition of both ear canals and tympanic membrane (if visible)

(A) ASSESSMENT:

- Alteration in comfort
- Potential for altered sensory perception

(P) PLAN OF CARE:

Consult provider if:

1. Concern of ruptured tympanic membrane
2. Bleeding or drainage from ear canal
3. Red and/or bulging tympanic membrane
4. Possible foreign body
5. Inability to directly observe ear wax accumulation
6. History of perforated eardrum
    a. Do not use carbamide peroxide or irrigation on patient without physician's exam and order
7. Symptoms unrelieved by protocol
8. Abrupt hearing loss

Nursing Interventions:

1. Carbamide peroxide 5 to 10 drops in ear twice daily for four days
2. Return to clinic for irrigation with warm water
    a. Use ear syringe.
    b. Pull ear up and back to open canal
    c. Reassess canal and drum after irrigation.
3. If above ineffective, contact physician for instructions
4. Patient education regarding ear canal care
5. Return if condition worsens

Problem: CHICKEN POX (VARICELLA ZOSTER VIRUS)

(S) SUBJECTIVE:

1. Patient's statements/complains:
    a. May have history of exposure
    b. Generalized, pruritic vesicular rash
    c. Fever / Headache
    d. Headache
    e. Malaise
    f. Anorexia
    g. URI symptoms

(O) OBJECTIVE:

1. Vital signs and allergies
2. Document affected areas-
    a. Macules, papules, vesicles, crusts, scars, in various stages of development in the same body location. (With smallpox, all lesions are in the same stage of development in a given location.)
3. May have signs of complications:
    a. Bacterial superinfect ion
    b. Cellulitis.
    c. Conjunctivitis
    d. Arthritis

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider:

1. All suspected case of Chicken Pox or Shingles

Nursing Interventions:

1. Place patient in a single cell on contact and airborne precautions, with limited staff contact
    a. Will require a physician's order for discharge
    b. Female staff that may be pregnant are not to enter room
4. Contact infection control nurse.
5. Pruritus should be treated topically with calamine lotion.
6. Fingernails should be cut short.
7. Instruct inmate to shower several time a day with soap to relieve itching.
8. Inmate contacts should be interviewed by a health care provider.

See Appendix pg 149 **Varicella Contact Investigation Steps**

Problem: COLDS and Upper Respiratory Complaints

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset and duration of symptoms:
        i. Nasal congestion or runny nose, post nasal drip, sneezing
        ii. Headache / Earache/ Stiff neck
        iii. Cough
            i. Sputum or phlegm production, amount, and color
        iv. Sore throat
        v. Watery eyes/ Itchy eyes
        vi. Generalized malaise
        vii. Fever
        viii. Night Sweat
        ix. Recent unintended weight loss
    b. Any relieving factors

(O) OBJECTIVE:

1. Vital signs and allergies TB and HIV status
2. Nasal mucosa:
    a. Erythematous
    b. Edematous
    c. Purulent discharge
    d. Clear discharge
3. Conjunctivitis
4. Lymphadenopathy
5. Examination of ears
6. Lung sounds
7. Signs and symptoms of secondary bacterial infection
    a. Purulent nasal discharge
    b. Lymph node involvement
        i. Particularly swollen, reddened or palpable cervical lymph nodes
    c. Drainage from or inflammation of ear canal
    d. Yellow patches at back of throat
    e. Fever
    f. Drooling
    g. Shortness of breath /respiratory distress

(A) ASSESSMENT:

- Ineffective airway clearance
- Alteration in health maintenance
- Potential for infection

Problem: COLDS and Upper Respiratory Complaints, contd.

(P) PLAN OF CARE:

Consult provider if:

a. Temperature above 100.4°F
b. Lymphadenopathy present
c. Signs and symptoms of secondary bacterial infection present
d. Severe HA
e. Stiff Neck
f. Adventitious breath sounds
g. Shortness of breath
h. O2 sat <92% on rom air
i. Productive cough
j. Pain with cough
k. Positive PPD
l. Immunosuppressed
m. Meets criteria for ILI

Nursing Interventions:

1. For symptoms lasting greater than 3 weeks, complete a TB Screening tool.
2. Acetaminophen 325mg tabs 2 by mouth PRN 3x daily at medication window or
3. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
4. CTM 4mg by mouth three times daily for 8 days dose by dose at medication window
5. LAN for up to 3 days for suspected URI
6. Return to clinic if develops
    a. Fever
    b. Colored sputum or nasal discharge
    c. Ear pain
    d. Dyspnea
    e. Persistent sore throat beyond three days of therapy
7. Patient education regarding cough/sneeze etiquette
8. The inmate is not to be charged for follow-up visit

Problem: CONSTIPATION

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Last BM with color and consistency
    b. Associated symptoms:
        i. Nausea/vomiting
        ii. Cramping
        iii. Flatulence
        iv. Bloating
        v. Hemorrhoids
        vi. Pain scale of 1-10
    c. History of laxative use
2. Review of current medications to determine constipation is a side effect

(O) OBJECTIVE:

1. Vital signs and allergies
2. Abdominal assessment:
    a. Soft/firm,
    b. Flat/distended
    c. Tender to palpation
    d. Bowel sounds present in all four quadrants
        i. Hypoactive/hyperactive/normal
3. Hemorrhoids (if applicable):
    a. Protruding
    b. Bleeding
    c. None visualized

(A) ASSESSMENT:

- Alteration in elimination
- Alteration in comfort

(P) PLAN OF CARE:

Consult provider if:

1. Temperature greater than 101°F
2. Abdominal pain (7-10), vomiting, abdominal distention and/or rigidity
3. Unable to stand erect
4. Sluggish or distant bowel sounds, absence of bowel sounds
5. Constipation alternating with diarrhea
6. Recent surgery, chemotherapy, radiation therapy

Problem: CONSTIPATION, contd.

Nursing Interventions:

1. If NO abdominal pain
   a. Biscodyl (Dulcolax) 5mg two tabs now then
   b. Docusate (Colace) once daily for 5 days not to exceed 5 caps (may issue KOP)
2. Patient instructions on
   a. Increase water intake to at least 8 glasses daily
   b. Increase fibrous foods intake
   c. Instructions to exercise and a
   d. Avoid straining when passing stool
3. Return to clinic within 24 hours if no improvement or condition worsens

Problem: CONTUSION

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Mechanism of injury
    b. Associated symptoms:
    c. Pain, scale 0-10
    d. Active bleeding
    e. Limited movement
    a. How and when injury occurred
    b. Inquire about use of blood thinners, including aspirin for pain

(O) OBJECTIVE:

1. Vital signs and allergies
2. Location of injury
3. Appearance
4. Neuro/vascular assessment:
    a. Distal pulses
    b. Sensation
    c. Color,
    d. Temperature
    e. Movement

(A) ASSESSMENT:

- Alteration in comfort and/or mobility
- Alteration in tissue perfusion

(P) PLAN OF CARE:

Consult provider if:

1. New deformity
2. Impaired neurovascular status
3. Injury involving joint
    a. Mechanism of injury suggesting hidden trauma
    b. Patient is on blood thinners

Nursing Interventions:

1. Immobilization of injured part, if applicable.
2. Ice or cool compress to affected area PRN
3. Acetaminophen 325mg tabs 2 by mouth PRN 3x a day x 4 days or
4. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
5. Consider non-weight bearing measures and activity restrictions
    a. Crutch training as warranted
6. Patient education regarding proper care of injury
7. Return to clinic if symptoms worsen

Problem: DANDRUFF – SEBORRHEA

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of symptoms
        i. Scalp itching
        ii. Flaking
2. Previously treated condition
3. Hygiene practices:
    a. Soap and shampoo used
    b. How often is hair washed

(O) OBJECTIVE:

1. Vital signs and allergies
2. Degree of flaking:
    a. Minimal
    b. Mild
    c. Moderate
    d. Extensive
3. Presence of lesions with color, raised, flat, weeping, tenderness
4. Presence of lice, nits,
    a. If present, refer to Lice Protocol

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Ulceration lesions, scabbing
2. Signs/symptoms of infection present
3. Previous treatment by provider

Nursing Interventions:

1. Dandruff shampoo from commissary/canteen
2. Patient education and reassurance
    a. Do not use dandruff shampoo more than three times per week
3. Return to clinic if no response after one month

Problem: DERMATITIS – RASHES

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Anatomic location
    b. Onset of symptoms
    c. Associated symptoms:
        i. None
        ii. Tongue
        iii. Swelling
        iv. Throat closing
        v. Respiratory symptoms
        vi. Fever
        vii. Malaise
        viii. Itching
2. Recent environmental contacts
    a. Chemicals
    b. Laundry detergent (new)
    c. Plants
    d. New food types
    e. Clothing
3. History of new medication
4. HIV status, recent exposure to communicable disease

(O) OBJECTIVE:

1. Vital signs and allergies
2. Description of condition:
    a. Itching
    b. Burning
    c. Redness
    d. Swelling
    e. Flaking
    f. Weeping
    g. Bleeding
    h. Pustules
    i. White/patchy
    j. Lice/scabies/nits
    k. Sign of infection
3. Systemic symptoms:
    a. None
    b. URI
    c. UTI
    d. Allergic reaction

Problem: DERMATITIS – RASHES, contd.

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. New medication, exposures, contacts, recurrent
2. Temperature greater than 101°F
3. Draining/blistering lesions, unfamiliar lesions
4. Systemic symptoms
5. HIV positive
6. Concern of chicken pox or shingles

Nursing Interventions:

1. Remove irritant by washing with water
2. Cool compresses to area
3. Stock Topical Corticosteroid preparation(Hydrocortisone) as directed on package KOP or 3x daily at pill line
4. Calamine Lotion for weeping areas per bottle directions
5. If kitchen worker, work excuse until clear
6. Patient education
    a. Avoid scratching/touching affected area(s)
    b. Signs and symptoms of infection
7. Return to clinic if no improvement within 72 hours or conditions worsens

Problem: DIARRHEA

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Number of stools
    b. History of similar symptoms
    c. Time of last bowel movement
    d. Color:
        i. Brown
        ii. Clear
        iii. Yellow/green
        iv. Red/bloody
        v. Black/tarry
    e. Consistency:
        i. Formed
        ii. Watery
        iii. Mixed
    f. Associated symptoms:
        i. None
        ii. Cramping
        iii. Stabbing
        iv. Ache
        v. Burning
        vi. Fever
        vii. Chills
        viii. Nausea/vomiting
        ix. Intermittent/constant/explosive
        x. Hemorrhoids
    g. Pain scale of 1-10
    h. Last food/drink
    i. Review of medications for diarrhea side effects

(O) OBJECTIVE:

1. Vital signs, weight and allergies
2. Skin color:
    a. Pink
    b. Flushed
    c. Pallor
    d. Cyanotic
    e. Jaundiced
3. Skin condition:
    a. Warm/cool
    b. Dry/moist/clammy

Problem: DIARRHEA, contd.

4. Skin turgor:
    a. Normal
    b. Decreased
    c. Tenting
5. Abdominal assessment:
    a. Soft/firm,
    b. Flat/distended
    c. Tender to palpation
    d. Bowel sounds present in all four quadrants
        i. Hypoactive/hyperactive/normal/absent
6. HIV status

(A) ASSESSMENT:

- Alteration in elimination
- Possible electrolyte imbalance

(P) PLAN OF CARE:

1. Consult provider if:
    a. Temperature greater than 101°F
    b. Bloody stool
    c. Nausea and/or vomiting
    d. Symptoms present for greater than or equal to 24 hours
    e. HIV +
    f. Signs and/or symptoms of dehydration
    g. Severe abdominal pain

Nursing Interventions:

2. Dietary instructions:
    a. Avoid solid food for 24 hours – liquids only.
    b. Once stool returns to normal, avoid irritating, highly seasoned foods for 72 hours
3. Return to clinic within 24 hours if no improvement or condition worsen
    a. Fever
    b. Inability to tolerate fluid
    c. Persistent weakness
4. Education regarding hydration

Problem: Dislocation (Obvious Fx use Fx Protocol)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Details of Event / Mechanism of Injury
    b. Pain at site of injury and/or with movement
    c. Associated symptoms: Numbness; Paresthesia; Loss of Function; C/O of being Cold or Thirsty; Etc…

(O) OBJECTIVE:

1. Vital signs and allergies
2. Tenderness, paresthesia, crepitus, deformity Fracture protocol)
3. Loss of function, diminished capillary refill, diminished distal pulse
4. Skin:
    a. Pink/pale/cyanotic/mottled/ecchymosis
    b. Warm/flushed/cool
    c. Dry/moist/clammy
5. Mental status:
    a. Alert/oriented x 3
    b. Disoriented/confused
6. Pulse:
    a. Regular/irregular
    b. Weak/strong
    c. Thready/bounding
7. Description of Injury site

(A) ASSESSMENT:

- Alteration in comfort
- Alteration in neurovascular status
- Impaired mobility

(P) PLAN OF CARE:

Contact provider immediately d/t:

1. Abnormal VS
2. Pt on anticoagulation therapy

Nursing Interventions:

1. Splint joint in position of comfort above and below injury site apply sling if needed
2. VS with neurovascular checks q 15 minutes until transferred or as ordered
3. Chart disposition of patient: transferred; infirmary; returned to unit
4. Schedule follow up
    a. If splint or sling is applied patient is to be scheduled to follow up with provider the following business day
    b. If crutches are issued patient is to be schedule for 48hr f/u and then at least weekly to assess continuing need

Problem: EARACHE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. History:
        i. Recent trauma
        ii. Similar pain
        iii. Recent foreign body
        iv. Sinus problems
        v. Recent URI
        vi. HIV+
    b. Location of pain:
        i. Right/left ear
        ii. Both ears
        iii. Internal/external
    c. Type and onset of pain
        i. Throbbing/radiating
        ii. Sharp/dull
        iii. Ache
        iv. Intermittent/constant
        v. Pain scale of 1-10
    d. Change in hearing, dizziness, drainage
    e. Last time ears cleaned and method
    f. Inquire about symptoms of ruptured tympanic membrane:
        i. Drainage from the ear (may be clear, pus, or bloody)
        ii. Ear noise/ buzzing
        iii. Ear pain/discomfort (may be severe and increasing)
        iv. Sudden decrease in ear pain followed by ear drainage
        v. Facial weakness or dizziness (in more severe cases)
        vi. Hearing loss in the affected ear (hearing loss may not be complete)
    g. Cardiac status:
        i. Chest pain, nausea or vomiting, angina

    NOTE: Ear pain can be a referred sign of angina chest pain radiating to the ear/jaw area

(O) OBJECTIVE:

1. Vital signs and allergies
2. External exam:
    a. Normal/abnormal
3. Internal exam
    a. Assess signs/symptoms of tympanic membrane rupture
    b. Normal with pale tympanic membrane

Problem: EARACHE, contd.

c. Red/bulging tympanic membrane
d. Foreign body
e. Packed cerumen
f. Drainage
g. Other

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection
- Potential for altered sensory perception

(P) PLAN OF CARE:

Consult provider if:

1. Recent trauma, foreign body
2. Temperature greater than 101°F
3. Change in hearing
4. Abnormal exam findings:
   a. Red/bulging tympanic membrane
   b. Signs/symptoms of tympanic membrane rupture
   c. Tympanic membrane cannot be visualized
   d. Bloody/purulent drainage
5. Severe pain
6. Dizziness, nausea/vomiting

Nursing Interventions:

1. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily for 4 days or
2. Ibuprofen 200mg, 2 tabs by mouth, 3x daily, PRN, at medication window x 4 days
3. Return to clinic within 24 hours if no improvement or condition worsens:
   a. Pain/pressure
   b. Popping sensation followed by sudden release in pressure and drainage from ear canal
   c. Lethargy

Problem: EYE PROBLEMS

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset:
        i. New/chronic
    b. Location:
        i. Right/left
        ii. Both
    c. Pain/irritation/itching/drainage
    d. Trauma,
    e. Photosensitivity
    f. Recent eye surgery/cataract history
    g. Exposure to chemicals/fire
    h. Glasses/contact lens
    i. Blurred vision
    j. Spots/flashes/floaters
    k. Hay fever/allergies
    l. Foreign body:
        i. Location
        ii. Type
    m. Eyelid involvement:
        i. Pain
        ii. Lesion
        iii. Irritation
        iv. Trauma
        v. Inflammation

(O) OBJECTIVE:

1. Vital signs and allergies
2. Visual acuity: right/left
3. Exam:
    a. Eyes:
        i. PERRLA or pupils unequal/abnormal
        ii. Tearing/unable to tear
        iii. Redness/discoloration
        iv. Edema
        v. Rubbing/itching
        vi. Drainage
        vii. Foreign body/debris/grit present, imbedded
    b. Eyelid(s)
        i. Red/discolored
        ii. Inflamed at margin

Problem: EYE PROBLEMS, contd.

iii. Injury/lesion
iv. Scaly
v. Drainage
vi. Sty (a small, inflamed swelling of a sebaceous gland on the rim of an eyelid)
vii. Chalazion (swelling of the upper or lower eyelid caused by obstruction and inflammation of an oil gland of the eyelid)

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection

(P) PLAN OF CARE:

Immediate referral to a provider except for patients with normal visual acuity, experiencing isolated itching

Nursing Interventions:

1. Rinse eye with saline or eye wash solution
2. Check and document visual acuity
3. Patient education on care and/or treatment of conjunctivitis
    a. If sty or chalazion is present instruct patient
        i. Advise patient most will resolve without treatment
        ii. Apply warm compresses for 5 – 10 minutes 3 -5 times a day
        iii. Do not squeeze, allow to drain on own
        iv. Do not wear make-up or contacts till healed
4. Return to clinic if symptoms worsen
    a. Increased pain
    b. Interference with vision

Problem: FEVER

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. History:
        i. None
        ii. Recent injury
        iii. Recent infection
        iv. Chronic illness
    b. Associated symptoms:
        i. Upper respiratory complaints
        ii. Stiff neck
        iii. Headache
        iv. Earache
        v. Night sweats
        vi. Cough
        vii. Urinary tract complaints
    c. Pain scale of 1-10

(O) OBJECTIVE:

1. Vital signs and allergies
2. Asses for:
    a. Obvious injuries/deformity
    b. Infection
    c. Back pain/stiff neck/decreased ROM
    d. Recent weight loss
    e. Lung sounds
3. TB status: date of TB test or CXR with results
4. HIV+

(A) ASSESSMENT:

- Alteration in comfort
- Alteration in health maintenance

(P) PLAN OF CARE:

Consult provider for all cases of Fever prior to patient leaving clinic

Nursing Interventions:

1. Patient education:
    a. Increase fluids, at least 6-8 glasses of water in 24 hours
    b. If respiratory involvement instruct patient on deep breathing and coughing exercises
2. Return to clinic if symptoms continue or worsen

Problem: FLATULENCE (GAS, BELCHING)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Patient's history related to complaint
    b. Diet and medication history for past 24 hours
    c. Recurrence and relief of symptoms
    d. Inquire if lactose intolerant
    e. Pain, scale 0-10
    f. Associated symptoms
        i. Chest pain

(O) OBJECTIVE:

1. Vital signs, including weight, and allergies
2. Cardiac assessment:
    a. Heart sounds
    b. Capillary refill
    c. Skin color/nail beds/gums
3. Abdominal assessment:
    a. Soft/firm,
    b. Flat/distended
    c. Tender to palpation
    d. Bowel sounds present in all four quadrants
        i. Hypoactive/hyperactive/normal/absent

(A) ASSESSMENT:

- Alteration in comfort

(P) PLAN OF CARE:

Contact provider if:

1. Severe abdominal pain
2. Distended, rigid abdomen
3. Symptoms unrelieved with protocol
4. Loss of bowel sounds
5. Symptoms suggesting cardiac involvement

Nursing Interventions

1. Flatulence: Simethicone 125mg, 1-2 tabs TID PRN daily for 5 days
2. Patient education regarding diet, smoking, and medication
3. Return to clinic if condition worsens

Problem: HAYFEVER – ALLERGIES

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    1. Onset of symptoms
    2. Nasal itching/sneezing/congestion
    3. Non-productive cough
    4. Watery eyes
    5. History of allergies:
        i. Seasonal/chronic/family history
    6. Treatment history

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assessment:
    a. Nasal mucosa:
        i. Edema
        ii. Clear/thin nasal drainage
        iii. Enlarged turbinates
    b. Eyes:
        i. Mild conjunctivitis
        ii. Mild periorbital edema
    c. Normal temperature and ear exam

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection

(O) PLAN OF CARE:

Consult provider if:

1. Purulent drainage:
2. Fever or signs of bacterial infection

Nursing Interventions

1. CTM 4mg tabs 1 tab by mouth 3 x daily PRN, x 4 days, dose by dose at medication window
2. Acetaminophen 325mg tabs 2 tabs, 3x daily PRN, x 4 days at medication window or
3. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
4. Patient education regarding allergens
5. Return to clinic if condition worsens

Problem: HEADACHE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset and location of pain, Pain scale of 1-10
    b. Description of pain:
        i. Throbbing
        ii. Sharp/dull
        iii. Constant/ intermittent
        iv. Pressure
        v. Achy
        vi. Different than previously experienced
    c. Associated symptoms:
        i. Nausea/vomiting
        ii. Dizziness
        iii. Drowsiness
        iv. Confusion
        v. Seizures
        vi. Visual changes/photophobia
    d. History of :
        i. Similar headache
        ii. Migraines
        iii. Hypertension
        iv. Sinus problems
        v. Recent trauma
        vi. Any loss of consciousness
    e. HIV+
    f. Any medications taken

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assessment:
    a. AAOX3/GSC
    b. Confused
    c. Irritable
    d. Agitated
    e. Lethargic
    f. Nausea/vomiting
    g. PERRLA/pupils unequal
    h. Visual disturbance
    i. Able to walk with normal gait/difficulty walking or abnormal gait
    j. Range of motion
    k. Weakness of one or more extremity

Problem: HEADACHE, contd.

l. Facial symmetry
m. Stiff neck, able to touch chin to chest with mouth closed

3. Last eye exam per chart review
4. Signs of substance abuse
5. Documented History of
   a. Hypertension
   b. Allergies
   c. Sinusitis
   d. Migraines
   e. Trauma

(A) ASSESSMENT:

- Alteration in comfort

(P) PLAN OF CARE:

Consult provider if:

1. Recent injury, stiff neck, abnormal vitals
2. Change in mental status/ any neuro-deficit
3. Nausea/vomiting, dizziness, fever
4. Visual disturbances, unequal pupils/ redness in one eye
5. Focal weakness/numbness or facial asymmetry
6. Blood pressure systolic greater than 160 mmHg or diastolic greater than 100 mmHg
7. Sever sudden flashes associated with coughing, sneezing, bending over, or straining
8. Sever head ache associated with scalp, temple, and/or jaw pain
9. Patient states “worst headache of their life”
10. Over 40 with no hx of severe headaches
11. Patient has cancer or is immunosuppressed

Nursing Interventions

1. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily x 4 days, at medication window or Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
   a. Excedrin Migraine or generic equivalent is **NOT** to be given without a physician’s order
2. Chart disposition of patient: transferred, admitted to infirmary, returned to unit.
3. Patient education to return to clinic if symptoms worsen or persist for more than 24 hours

Problem: HEMORRHOIDS

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Pain scale of 1-10
    b. Associated symptoms:
        i. Constipation/diarrhea
        ii. Itching
        iii. Bleeding
    c. Last bowel movement
    d. Sexual activity
    e. Previous history and treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Visual inspection
    a. Positive/negative for:
        i. External protrusions
        ii. Edema/Inflammation
        iii. Bleeding around anal area

(A) ASSESSMENT:

- Alteration in comfort
- Alteration in elimination pattern

(P) PLAN OF CARE:

1. Consult provider if:
    a. Temperature greater than 101°F
    b. Active bleeding
    c. Severe pain
    d. Inflamed external protrusions/skin tags
    e. Anal warts, fissure, or rectal lesions

Nursing Interventions:

1. Issue one tube of hemorrhoid ointment with instructions to apply to rectal area 2-4 times daily, as needed, for five days, as directed on package.
2. Hemorrhoidal rectal suppository issue per provider's order
3. Colace or generic equivalent 100mg capsule by mouth twice daily, may issue 30 capsules KOP
4. Patient education regarding
    a. Hygiene
    b. Diet
    c. Sexual activity
5. Return to clinic if condition worsens

Problem: HYPERTENSION

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset, acute, or chronic
    b. Symptoms:
        i. Headache
        ii. Dizzy
        iii. Faint
        iv. Nausea/vomiting
        v. Nosebleed
        vi. Visual disturbance
        vii. Numbness/tingling
        viii. None
    c. History:
        i. None
        ii. Cardiovascular
        iii. Renal disease
        iv. Family
    d. Recent change of medication
    e. Therapeutic diet
    f. Compliance with prescribed regimen (diet, meds, etc.)
    g. Inquire as to recent drug use

(O) OBJECTIVE:

1. Vital signs and allergies (blood pressure lying, sitting, standing)
2. Assess
    a. Abdominal
    b. Cutaneous
    c. Cardiac
    d. Respiratory
    e. Neurological
3. Color: pink, pale, flushed, cyanotic, jaundiced
4. Skin: warm, cool, dry, moist/clammy

(A) ASSESSMENT:

i. Alteration in blood pressure
ii. Impaired tissue perfusion

(P) PLAN OF CARE:

Contact provider immediately if:

1. Systolic > 180 mm hg or Diastolic >100 mm hg with c/o:
    a. Headache
    b. Visual disturbance
    c. Faint

Problem: HYPERTENSION, contd.

Consult provider within 24 hrs if:

1. Systolic > 160 mm hg and diastolic > 90 mm hg
2. Noncompliance with diet, meds, etc.

Nursing Intervention:

1. If systolic > 140 mm hg and diastolic > 90 mm hg,
    a. Schedule BP checks three times over the next week
    b. Refer to provider if BP continues to be elevated
2. Patient education regarding
    a. Compliance of prescribed treatment regimen
    b. The effects of certain OTC medications (including cough syrups, decongestants, and NSAIDS) which may elevate blood pressure
3. Return to clinic if symptoms not improved or worsen

Problem: INSOMNIA

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset
    b. Assess number of hours patient sleeps in 24 hour period
    c. Assess for any excessive worries, any recent disturbing news
    d. Assess current medications

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess for:
    a. Eyes may be darkened
    b. Signs of fatigue
    c. Neurological assessment
        i. Lack of concentration
        ii. Confusion
        iii. Agitation

(A) ASSESSMENT:

- Alteration in sleep pattern
- Potential for sleep deficit

(P) PLAN OF CARE:

Consult provider if:

1. No response to patient education
2. Severe deprivation
3. Neurological deficits present

Nursing Interventions:

1. Behavioral health referral
2. Patient education regarding sleep hygiene
3. Return to clinic as needed

Problem: JOCK ITCH

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Affected area(s)
    b. Onset of symptoms
    c. Associated symptoms:
        i. Itching
        ii. Burning
        iii. Drainage in groin area
    d. Pain scale 1-10
    e. Previous history and treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Location:
    a. Upper inner thighs
    b. Perineal area,
    c. Unilateral/bilateral
3. Skin area:
    a. Normal
    b. Red
    c. Brown
    d. Darker or lighter than normal skin
4. Lesions:
    a. Raised
    b. Smooth/irregular margins
    c. Even/patchy distribution
    d. Ringed-lesion
5. Any other skin eruptions present on other parts of body, evidence of infection

(A) ASSESSMENT:

- Alteration in skin integrity/comfort
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Skin eruptions on body other than thighs/upper perineal area
2. Evidence of infection
3. Failure to improve
4. HIV+

Problem: JOCK ITCH, contd.

Nursing Interventions:

1. Stock topical antifungal cream/ointment– apply after morning and evening showers x 3 weeks
2. Patient education regarding hygiene and importance of treatment compliance
    a. Keep groin clean and dry
    b. Avoid scratching
3. Return to clinic if symptoms worsen or condition persists beyond 10 days

Problem: JOINT PAIN

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire as to onset: acute or chronic
    b. Location of pain; Pain scale 1-10
    c. Pain with weight bearing
    d. Pain with ROM
    e. History of trauma
    f. History of:
        i. Arthritis
        ii. Sickle cell
        iii. Connective tissue disease
        iv. STD status:
            1. R/O gonococcal arthritis with sexual history
            2. Current or recent genital discharge
2. Current medications and/or OTC treatments, especially blood thinners and statin drugs

(O) OBJECTIVE:

1. Vital signs and allergies
2. Location with deformity, discoloration
3. Status of joint:
    a. Hot/cool
    b. Edematous
    c. Crepitus on motion
    d. Other
4. Neuro/vascular assessment:
    a. Pulses
    b. Sensation
    c. Reflexes
    d. Capillary refill
5. Assess range of motion and weight-bearing status

(A) ASSESSMENT:

- Alteration in comfort
- Potential alteration in neuro/vascular or musculo/skeletal status
- Alteration in mobility

(P) PLAN OF CARE:

Consult provider if:

1. Red, edematous joint
2. Limited ROM

Problem: JOINT PAIN, contd.

3. Crepitus
4. Unable to bear weight
5. Suspected fracture
6. Temperature greater than 101° F
7. Decreased pulses or cool extremity
8. Discoloration or deformity
9. Recent genital discharge, STD treatment
10. If patient is on statin drug with a complaint of muscle pain

Nursing Interventions:

1. Reassurance for negative physical findings
2. Immobilization of injury with elastic bandage or other splint
3. Consider crutches or non-weight bearing measures
4. Ice or cool compress as needed
5. Consider activity restriction
6. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily for 4 days or
7. Ibuprofen 200mg 2 tablets by mouth PRN 3x daily x 4 days for pain at medication window
8. Patient education regarding importance of exercise and mobility
9. Return to clinic is pain worsen or persist longer than 5 days
10. Schedule follow up for 48hrs if splint applied

Problem: LACERATIONS

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Document when and how injury occurred
    b. Date of last tetanus immunization
    c. Pain scale 0-10

(O) OBJECTIVE:

1. Vital signs and allergies
2. Describe laceration
    a. Size (Length; Width; Depth)
    b. Location
    c. Amount of blood loss
    d. Bleeding controlled
3. Signs/symptoms of infection
    a. Drainage
    b. Increased redness
    c. Streaking
    d. Hot to touch
    e. Painful

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection
- Alteration in comfort

(P) PLAN OF CARE:

Control/stop bleeding with direct pressure and elevation

Consult provider if:

1. Wounds that have imbedded debris not able to be irrigated out
2. Wound edges that do not approximate easily
3. Wounds that need suturing
    a. Lacerations over joint usually require suturing
4. Bleeding cannot be controlled
5. Wounds with signs of infection
6. Wounds not responding to protocol
7. Any laceration of the eyelid
8. If last tetanus toxoid injection more than 5 years ago
9. Need for pain control

Nursing Interventions: Refer to MRSA Protocol if MRSA suspected

1. Cleanse laceration with soap and warm water, dry area
2. Close with steri-strips if needed and possible

Problem: LACERATIONS, contd.

3. Apply telfa pad, clean dry dressing, or butterfly dressing
4. Patient education regarding wound care
    a. Keep dressing clean and dry
    b. Change dressing as directed or return to clinic as scheduled for dressing change and wound checks
    c. Return to clinic as scheduled for suture removal (if needed)
5. Return to clinic if signs or symptoms of infection develop

Problem: LICE (PEDICULOSIS CAPITIS, CORPORIS, PUBIS)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset and location
    b. Itching of scalp
    c. Itching body
    d. Itching of pubic area
    e. Previous history and treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess for:
    a. Presence of minute white nits attached to hair shaft of pubic area
    b. Excoriation of skin or dermatitis
    c. Lice may be present in clothing seams and appear as small black dots
    d. Intense itching scalp, trunk, buttocks, or pubic area
    e. Presence or absence of signs and symptoms of infection i.e. drainage, increased redness, malodorous drainage, streaking, increased warmth
    f. Female patient should have pregnancy ruled out or obstetrician contact prior to therapy

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Infestation involves eyelashes
2. Failure to respond to course of treatment
3. Secondary infection

Nursing Interventions:

1. Pyrethrin preparation (RID) one application now and one in 7 – 10 days, if indicated
2. Notify the infection control nurse
    a. IC nurse to contact unit management to coordinate cell decontamination.
3. Instructions to return to clinic on S/C as needed or if symptoms persist more than 72 hrs

Problem: MENSTRUAL CRAMPS (DYSMENORRHEA)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    b. Pain related to menstruation
    c. Duration of symptoms
    d. Other episodes
2. Current medications, OTC treatment tried recently for this complaint
3. Denial of pregnancy
4. Inquire if history of reproductive problems

(O) OBJECTIVE:

1. Vital signs and allergies
2. Abdominal assessment:
    a. Bowel sounds
    b. Palpation
        i. Pain/tenderness/distention/rigidity
    c. Nausea/vomiting
3. Menses assessment
    a. Regularity
    b. Heavy flow
    c. Clumps/clots larger than the size of a quarter
4. Signs and symptoms of infection:
    a. Drainage other than blood
    b. Malodorous discharge
    c. Itching or fever

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection

(P) PLAN OF CARE:

Referral to provider if:

1. No relief from analgesics
2. Pain not related to menstrual cramps
3. Excessive bleeding/clots
4. Cramps with symptoms that may indicate pelvic infection
5. Positive urine pregnancy test

Nursing Interventions

1. Obtain clean catch urine and perform dipstick and pregnancy test
2. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily for 4 days or
3. Ibuprofen 200mg tabs 2 tablets by mouth PRN 3x daily x 4 days, at medication window
4. Inmate education
    a. Return to clinic if still symptomatic after 72 hours or symptoms increase

Problem: METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) Refer to MRSA Guidelines

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire about recent exposure to the outdoors
    b. Anatomic location
    c. Type of pain:
        i. Sharp/dull
        ii. Burning sensation
        iii. Constant/intermittent
    d. Pruritus: location and severity
    e. Drainage of lesion

(O) OBJECTIVE:

1. Vital signs and allergies
2. General appearance:
    a. No acute distress
3. Skin:
    a. Warm/cool
    b. Dry/moist/clammy
4. Anatomic location of affected areas
5. Description of condition:
    a. Itching
    b. Burning
    c. Redness
    d. Swelling
    e. Flaking
    f. Weeping
    g. Bleeding
    h. Pustules

(A) ASSESSMENT:

- Alteration in skin integrity
- Alteration in mobility
- Alteration in comfort
- Infection

(P) PLAN OF CARE:

1. Closed, Non-draining Wounds

a. Apply warm moist compresses to facilitate drainage.
b. Consult provider for I&D.
c. Apply bandage if there is a risk for spontaneous drainage.
d. Instruct to return to clinic if wound begins draining

Problem: MRSA contd.

2. **Draining Wounds**
   a. Obtain a culture of drainage for C&S.
   b. Clean the area with stock antiseptic skin cleanser and water.
   c. Apply a bulky, occlusive dressing.
   d. Contact provider for telephone antibiotic order and refer for the next available appointment.
      i. Antibiotics are to be dose by dose to ensure compliance.
   e. Advise provider of inmate job assignment for appropriate issuance of LAN.
   f. Notify by telephone the unit manager that the inmate and cell mate must have their soiled clothing and bed linens sent to central laundry. (If no one from unit management is available then notify shift supervisor).
      i. Follow up phone notification with a 2-way memo
   g. Issue Stock Antimicrobial Soap to inmate for bathing
      i. Instruct inmate to clean shower after use with approved bacterial agent.
   h. Instruct inmate to clean entire cell with approved bacterial agent.
   i. Schedule inmate for daily dressing changes on procedure book until wound no longer draining.
      i. Document wound/dressing changes in Progress Note using the S.O.A.P. format
   j. Notify Unit Management and Infection Control Nurse (ICN)
      i. IC Nurse to oversee disinfection of cell, shower, etc…
3. Refer to MRSA Guidelines (Appendix) for complete list of plans of care and treatment
4. Patient education on prevention of spread to other persons with special emphasis on and washing, proper laundering of bed linens and clothes
5. Schedule follow up wound evaluation in 7 days

Problem: NAUSEA and VOMITING

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of nausea and/or vomiting
    b. Description of emesis with time and date of last episode
    c. Associated symptoms:
        i. None
        ii. Vertigo
        iii. Fever/chills
        iv. Constipation/diarrhea
        v. Black or tarry stools
        vi. Headache/muscle aches
        vii. Pain scale 0-10
2. History of similar symptoms or GI bleed
    1. Treatment
    2. Current medication including OTC treatments tried recently for this condition
3. Last food/drink, recent alcohol intake
4. Last menstrual period and possibility of pregnancy if applicable

(O) OBJECTIVE:

1. Vital signs and allergies
2. General appearance:
    a. No acute distress, acute distress
3. Color:
    a. Pink, pale, flushed, cyanotic, jaundice
4. Skin:
    a. Warm, dry, cool, moist/clammy, normal turgor, decreased turgor
5. Mucous membranes:
    a. Moist, dry
6. Abdominal assessment:
    a. Soft/firm,
    b. Flat/distended
    c. Tender to palpation
    d. Bowel sounds present in all four quadrants
        i. Hypoactive/hyperactive/normal/absent
7. Emesis:
    a. Clear
    b. Gastric
    c. Undigested food particles
    d. Bright red
    e. Coffee grounds

Problem: NAUSEA and VOMITING, contd.

(A) ASSESSMENT:

- Potential for alteration in fluids and electrolyte balance
- Alteration in nutritional status

(P) PLAN OF CARE:

Contact provider if:

1. Abnormal vital signs: temperature greater than101° F, pulse greater than 100 bpm, B/P less than 100 systolic
2. Orthostatic hypotension present with greater than or equal to 20 bpm change in pulse, or greater than or equal to 20 mmHg systolic blood pressure from lying to standing
3. Positive pregnancy test
4. Unexplained and sudden onset, abdominal distention/rigidity, tenderness
5. No bowel sounds
6. Constipation alternating with diarrhea
7. Bloody stools
8. Unexplained nausea and/or vomiting
9. Severe abdominal pain
10. Dry mucous membranes
11. Poor skin turgor
12. Skin cool to touch,
13. Recent 5% weight loss
14. Symptoms present for 48 hours or longer
15. Greater than 6 emesis in 24 hours
16. Bright red or coffee ground emesis
17. Symptoms related to medication
18. Immunocompromised patient

Nursing Interventions:

1. Perform pregnancy test if indicated (non-menopausal female age 12-52 with LMP > 30 days ago)
2. Dietary instructions:
    a. NPO for 2 hours after last emesis
    b. Increase to clear liquids only for 24 hours
        i. Do not extend clear liquids past 24 hours without instructions from provider
    c. Gradually increase to soft foods and then a regular diet
3. Activity restriction for 24 hours
    d. No Kitchen duty until no vomiting for 48 hours
4. Patient education regarding dietary instructions and hydration
5. Return to clinic if symptoms worsen

Problem: NOSE BLEED (EPISTAXIS)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset:
        i. Spontaneous or trauma related
        ii. Chronic - date of last event
2. History of
    1. Recent URI
    2. High blood pressure
    3. Hemophilia/bleeding disorders
3. Current medication, especially blood thinners

(O) OBJECTIVE:

1. Vital signs and allergies
2. Blood in the oral cavity or pharynx vs. bleeding only from nose
3. Respiratory difficulty
    a. Blood in airway
    b. Blocked sinuses
4. Color:
    a. Pink
    b. Pale
    c. Flushed
    d. Cyanotic
    e. Jaundiced
5. Skin:
    a. Warm/cool
    b. Dry/ moist/clammy
6. Amount of bleeding:
    a. Minimal
    b. Moderate
    c. Heavy
    d. Constant
    e. Spurting
    f. Trickle
    g. Frequent swallowing
7. Evidence of trauma/lesions/nasal surgery
    a. Neuro check for evidence of trauma
        i. PERRLA/size
        ii. Alert/oriented/confused

(A) ASSESSMENT:

- Alteration in homeostasis with potential fluid volume deficiency
- Alteration in comfort

Problem: NOSE BLEED (EPISTAXIS), contd.

(P) PLAN OF CARE:

Consult provider if:

1. Taking blood thinners
2. Profuse bleeding
3. Obvious distress
4. Abnormal vital signs
5. Persistent bleeding after 15-20 minutes of pressure
6. Acute trauma/ Possible fracture
    a. Do not place anything in nasal passages until cleared by provider
7. History of hypertension with current elevated reading
8. Possible bleeding or clotting disorder
9. Second spontaneous episode within one week
10. Recurrent bleed within one hour of stopping previous episode

Nursing Interventions:

1. Treat additional injuries
2. Semi-Fowler's position
3. Pressure on nostrils by pinching nostrils together with thumb and forefinger with patient leaning forward
4. Ice or cold pack to neck, bridge of nose, and forehead area
5. Observe for 45-60 minutes after bleeding stops
6. Patient education:
    a. Spit blood out instead of swallowing
    b. Do not to blow or pick nose
7. Return to clinic within 24 hours if symptoms persist or worsen

Problem: PENILE DISCHARGE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of symptoms
    b. Itching, burning, odor, discharge
    c. Urinary frequency, urgency, pain, change in color of urine
2. Recent antibiotic therapy, name of medication
3. Recent sexual activity
4. History of STD

(O) OBJECTIVE:

1. Vital signs and allergies
2. Examination of upper inner thighs and perineal area
3. Assess for lesion present in throat and mouth
4. Skin involved:
    a. Normal
    b. Red/brown
    c. Darker/lighter than normal
5. Lesions:
    a. None
    b. Raised
    c. Smooth/irregular margins
    d. Patchy
    e. Ringed
6. Evidence of infection:
    a. None
    b. Inflamed/edema
    c. Red
    d. Drainage

(A) ASSESSMENT:

- Potential for infection

(P) PLAN OF CARE:

Refer all cases to provider

Nursing Interventions:

1. Perform urine dipstick; report abnormal results to the provider
2. Orders per provider
3. Follow-up as directed by provider
4. Patient education regarding hygiene, importance of compliance with prescribed medications; increase fluids 6-8 glasses of water/day
5. Return to clinic if symptoms worsen or condition persists beyond 10 days

Problem: PEPPER GAS EXPOSURE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Inquire if patient is wearing contacts
    b. Time of exposure
    b. Eye or skin burning
    c. Respiratory complaints

(O) OBJECTIVE:

1. Vital signs including and allergies
2. Eye assessment:
    a. Appearance of conjunctiva
    b. Presence of contact lenses (Remove lenses only after hands are decontaminated, or if done by nurse, use fresh gloves)
    c. Visual acuity
3. Neuro assessment:
    a. Level of alertness
    b. Orientation
    c. Behavior
4. Auscultate lung sounds and note any difficulty breathing
5. Assess skin for irritation

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential alteration in respiratory status

(P) PLAN OF CARE:

Consult provider if:

1. If O2 sat is less than 90%
2. Visual problems or continued discomfort after nursing measures
3. Respiratory problems or skin irritation develop

Nursing Interventions:

1. If COPD/Asthma history, do peak flow and contact provider if less than 250 liters per minute or less than baseline
2. Flush site of exposure with copious amounts of water or saline
3. Flush eyes with at least 1000ml of normal saline or water. Contact lenses must be removed as soon as possible and before flushing eyes.
4. Visual acuity should be checked and recorded after flushing
5. Mucous membranes, including the mouth, should be flushed with copious amounts of water (instruct patient not to swallow)
6. Consider shower if area of exposure is large
7. Patient education: advise patient not to wear contact lenses until they have been carefully decontaminated, wash clothing before wearing
8. Return to clinic if visual, respiratory or skin problems develop

Problem: POISON IVY/POISON OAK EXPOSURE

S) SUBJECTIVE:
1. Patient's statements/complaints:
    a. Inquire about recent exposure to the outdoors
    b. Anatomic location
    c. Type of pain:
        i. Sharp/dull
        ii. Burning sensation
        iii. Constant/intermittent
    d. Pruritus: location and severity

(O) OBJECTIVE:
1. Vital signs and allergies
2. General appearance: no acute distress
3. Skin:
    a. Warm/cool
    b. Dry/moist, clammy
4. Anatomic location of affected areas
5. Description of condition:
    a. Itching/burning
    b. Redness
    c. Swelling
    d. Flaking/weeping/bleeding
    e. Pustules
    f. Signs of infection

(A) ASSESSMENT:
- Alteration in skin integrity
- Potential for infection
- Alteration in comfort

(P) PLAN OF CARE:

Consult provider if:
1. Signs of secondary infection r/t scratching

Nursing Interventions:
1. Cleanse gently with mild antiseptic or soap and water
2. Cool compresses to area
3. No kitchen duty until resolved
4. Calamine lotion topical to affected area twice daily for 7 days
5. Patient education on prevention of spread to other persons, avoiding future contact with poison ivy/oak, proper laundering of bed linens and clothes
6. Return to clinic if no improvement in 7 days or condition worsens

Problem: PREMENSTRUAL SYNDROME (PMS)

SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of symptoms (usually begin 2-10 days prior to menstrual flow and subside with onset of menstruation):
        i. Transitory fluid retention
        ii. Breast swelling
        iii. Abdominal distention
        iv. Irritability/depression
        v. Sleep disturbance/lethargy
        vi. Headache
        vii. Vertigo
        viii. Paresthesia of hands and feet
        ix. Colds
        x. Hoarseness
        xi. Allergies
        xii. Exacerbation of asthma
        xiii. Palpitations
        xiv. Backache
2. History of and previous treatments, any recent OTC treatments related to this complaint

(O) OBJECTIVE:

1. Vital signs and allergies
2. Abdominal assessment: bowel sounds, palpation, pain/tenderness, nausea, vomiting, distention/rigidity
3. Assess for peripheral edema and/or weight gain
4. Mental assessment: alertness, orientation, mood, behavior

(A) ASSESSMENT:

- Alteration in comfort
- Possible alteration in fluid and electrolyte balance

(P) PLAN OF CARE:

Contact Provider if

1. Abnormal abdominal exam
2. Consider Mental Health Referral if depression is suspected

Nursing Interventions:

1. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily for 4 days or
2. Ibuprofen 200mg, 2 tabs PRN 3x daily x 4 days at medication window
3. Patient education regarding comfort measures
4. Return to sick call if no relief in 72 hours or symptoms increase
5. Consult provider if no relief from analgesics

Problem: SCABIES

(S) SUBJECTIVE:

1. Patient's statement/complaints:
    a. Inquire as to onset
    b. Inquire if itching of scalp, body or pubic area. Is it worse at nights or after a shower?
    c. Inquire as to mode of contamination and possible exposure
    d. Previous history and treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Document affected areas
    a. Description: Grouped papules, nodules or burrows
    b. Location: Webs of the fingers, wrist, elbows, knees axilla, thighs or head of penis. On the nipples, abdomen or lower thigh in females.
3. Presence of signs/symptoms of infection
    a. Drainage
    b. Increased redness/ streaking
    c. Malodorous
    d. Increased warmth
4. Females – check for pregnancy prior to treatment and notify provider if pregnant

(A) ASSESSMENT:

- Alteration in skin integrity
- Potential for infection

(P) PLAN OF CARE

Refer all suspected cases of scabies to a provider

Nursing Interventions:

1. Notify Infection Control Nurse
    a. IC Nurse should work with unit management to coordinate cell decontamination
2. Inmate suspected or diagnosed with scabies **and cellmate** should be placed on contact precautions for 24 hours following treatment.
3. At the time of treatment all clothing, linen, towels and other personal items must be washed in hot water and dried on the hot cycle
4. Educate inmate on self-care during treatment.
5. Schedule follow-up appointment with provider for re-examination one week after treatment.

Problem: SEXUAL ASSAULT (Refer to TDOC Policy 502.06.02)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Date, time, and location of alleged assault
    b. Description of alleged assault as needed for treatment

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess for any life and/or limb threatening injuries
3. Assess and document neurological and psychological status

(A) ASSESSMENT:

- Alteration in self-esteem/personal identity
- Risk of self-injury
- Alteration in comfort
- Risk for infection

(P) PLAN OF CARE:

Emergency Intervention

1. Contact shift commander immediately to ensure the SART has been notified
2. If patient has limb or life threatening injuries contact EMS for transport to outside ED
3. Treat any life and/or limb threatening injuries

Nursing Interventions:

1. If no limb/life threatening injuries consult with SART to determine need for transport to outside ED
    a. Suggest EMS or Facility transport as determined by medical assessment
2. Limit contact with patient to decrease chances of cross contamination of evidence
3. Do not allow inmate to take any action that could potentially destroy evidence
4. If inmate's clothing needs to be removed to provide treatment, wear gloves so not to contaminate any evidence present
    a. Any clothing removed should be placed in a **paper bag** marked with the inmates name, number, and the date
    b. If patient to go to outside ED, only perform wound care necessary to stabilize for transport
    c. If clothing removed place patient in hospital gown for transport and remind security to take a full change of clothes to ED

Problem: SEXUAL ASSAULT

5. Give supportive care
    a. Do not question patient about details of assault, however document any details/statements given spontaneously
6. Assist in arranging transport to designated medical facility
7. Mental health referral
8. Follow-up as directed by provider
    a. If patient goes to ER make sure facility MD is aware of recommendations and discharge orders upon patients return

Problem: SINUS COMPLAINTS/SEASONAL ALLERGIES

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of symptoms
    b. Symptoms:
        i. Runny nose/congestion/sneezing
        ii. Eyes red/itchy/watery
        iii. Fever
        iv. Malaise
        v. Headache
        vi. Sore throat
        vii. Cough
    c. History of sinus infections, seasonal allergies, asthma
    d. HIV+

(O) OBJECTIVE:

1. Vital signs and allergies
2. Throat:
    a. Normal
    b. Red/inflamed,
    c. White patches/pustules
    d. Enlarged tonsils
    e. Sputum
3. Nasal mucosa:
    a. Normal
    b. Red/inflamed/swollen
    c. Clear/yellow/green drainage
    d. Sneezing
    e. Bloody discharge
4. Neck glands:
    a. Normal
    b. Swollen
    c. Tender to palpation
5. Lung sounds (bilateral):
    a. Clear
    b. Crackles
    c. Wheezing
    d. Rhonchi
    e. Diminished
6. Assess eyes may have mild conjunctivitis or mild periorbital edema
7. Sinus tenderness

Problem: SINUS COMPLAINTS/ SEASONAL ALLERGIES, contd.

(A) ASSESSMENT:

- Alteration in comfort,
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:

1. Temperature greater than 101° F
2. Chest congestion with wheezing
3. Severe and/or productive cough
4. Swollen, red throat or neck glands
5. Severe headache
6. HIV+
7. Sore red throat with white patches/pustules
8. Colored nasal drainage/sputum
9. Asthma history

Nursing Interventions:

1. TB screening if symptomatic greater than 3 weeks
2. CTM 4mg by mouth three times daily PRN for 4 days, dose by dose at medication window
3. Acetaminophen 325mg 2 tabs by mouth 3x daily PRN, x 4 days at medication window or
4. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
5. LAN for no more than 3 days for suspected URI
6. Patient education:
    a. Increase fluid intake to 6-8 glasses of water in 24 hours
    b. Salt water gargles for throat discomfort
    c. Frequent/appropriate hand washing to prevent spread
    d. Avoid smoking
7. Return to clinic in 72 hours if no change or symptoms worsen

NOTE: Antihistamines should not be given to asthmatics.

Problem: SORE THROAT (PHARYNGITIS)

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of pain/pain scale 0-10
    b. Description of pain:
        i. Sore
        ii. Dry, burning sensation
        iii. Pain with swallowing
    c. Concurrent URI symptoms:
        iv. Runny nose
        v. Hoarse voice
            1. Worse in morning suggesting rhinitis
    d. Muscle aches or general malaise suggesting a viral cause
    e. History of recent oral sex (1-2 weeks)

(O) OBJECTIVE:

2. Vital Signs (T, P, R, BP)
3. Assess throat:
    a. Inflamed/red,
    b. Swollen tonsils
    c. Exudate
    d. Pustules
4. Assess cervical lymph nodes:
    a. Enlarged/normal
    b. Tender/non tender
5. Assess ears:
    a. Abnormalities
    b. Drainage
    c. Inflammation
    d. Pain
6. Signs and symptoms of secondary bacterial infection:
    a. Purulent nasal discharge
    b. Drainage or inflammation of ear canal,
    c. Swollen/reddened/palpable cervical lymph nodes
    d. Yellow patches at back of throat
    e. Fever
    f. Inability to swallow oral secretions (drooling)

(A) ASSESSMENT:

- Alteration in comfort
- Potential for infection

Problem: SORE THROAT (PHARYNGITIS), contd.

(P) PLAN OF CARE:

Consult provider if:

1. If inmate has difficulty breathing, swallowing or excessive pharyngeal swelling, drooling.
2. Sore throat and/or fever persists longer than 48 hours
3. Possible strep throat – patients less than 35 y.o., has red throat, fever, tender cervical nodes and no cold symptoms and white patches on back of throat
4. Suspect mononucleosis (e.g., sore throat, fever, swollen cervical glands, malaise/fatigue and right upper quadrant tenderness)

Nursing Interventions:

1. Acetaminophen 325mg, 2 tabs PRN 3 times daily for 4 days at medication window or
2. Ibuprofen 200mg 2 tabs PRN 3x daily x 4 days at medication window
3. Patient education regarding salt water gargles as needed for throat discomfort (1/2 tsp. salt in 8oz. warm water)
4. Chart disposition of patient: transferred, admitted to the infirmary, returned to unit
5. Return to clinic if not better in 2 days or if symptoms worsen

Problem: SPRAIN

(S) SUBJECTIVE:

a. Patient's statements/complaints:
   1. History of trauma, when and how injury occurred
   2. Identification of joint involved
   3. Type of injury: turned, twisted
   4. Location of pain: lateral, medial
   5. Inability to bear weight or limited weight bearing
   6. Pop or snap heard
   7. Pain scale of 1-10

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assessment:
   a. Tenderness localized to ligament injury
   b. Ecchymosis
   c. Pain with stressing ligament
   d. Decreased ROM due to pain and swelling
   e. Loss of joint stability
   f. Decreased strength
   g. Deformity
   h. Neurovascular assessment
      i. Palpable distal and proximal pulses
      ii. Sensation intact/any numbness or tingling
      iii. Warm to touch
      iv. Reflexes present/intact

(A) ASSESSMENT:

- Alteration in comfort
- Alteration in mobility

(P) PLAN OF CARE:

Consult provider if:

1. Unstable joint
2. Suspected fracture
3. Crepitus sounds
4. Gross swelling
5. Severe pain
6. Ecchymosis, focal or severe tenderness
7. Neurovascular changes

Problem: SPRAIN contd.

Nursing Interventions:

1. No strenuous exercise/sport – Activity Restriction
    a. Provider evaluation needed for LAN more than 3 days
2. Ibuprofen 200mg, 2 tabs PRN 3 times daily for 4 days or
3. Acetaminophen 325mg, 2 tabs PRN 3 times daily for 4 days
4. Immobilization of injury with elastic bandage
5. Appropriate splinting extremities include toes/fingers
6. Patient education regarding joint care
7. Return to clinic if not better in 2 days or splint added

Problem: TOOTHACHE

(S) SUBJECTIVE:
1. Patient's statements/complaints:
2. Onset of pain
3. New/recurrent
4. Recent trauma/injury/dental work
5. Location
6. Pain scale 0-10
7. Associated symptoms
8. HIV+
9. Inquiry about sensitivity to heat, cold or air

(O) OBJECTIVE:
1. Vital signs and allergies
2. Visual evidence of tooth decay:
    a. Swelling/redness/pus surrounding affected tooth
3. Pain upon opening mouth widely
4. Evidence of trauma/injury to jaw

(A) ASSESSMENT:
- Alteration in comfort
- Potential for infection
- Potential for altered nutritional intake

(P) PLAN OF CARE:

Consult provider if:
1. Fever, earache, sore throat, sinus problems
2. Pain upon opening mouth widely
3. Injury/trauma to jaw
4. Concern for fracture
5. HIV+

Consult dentist if:
1. Moderate to severe pain
2. Injury/trauma to jaw
3. Recent dental surgery/procedure
4. Evidence of swelling or pus collection (immediate referral for antibiotic therapy)

Nursing Intervention:
1. Acetaminophen 325mg tabs, 2 tabs PRN 3x daily for 4 days or
2. Ibuprofen 200mg 2 tabs, PRN 3x daily at medication window
3. Refer to dental department with assessment
4. Patient instructions to avoid hot/cold liquids and chew on opposite side
5. Follow-up as arranged by dental department

Problem: URINARY TRACT SYMPTOMS

(S) SUBJECTIVE:
1. Patient's statements/complaints:
2. Onset of symptoms:
    a. Burning or painful urination, frequency, urgency
    b. Nausea/vomiting, fever/chills, malaise
    c. Back pain – scale 1-10
3. History or similar symptoms
4. Vaginal/penile discharge

(O) OBJECTIVE:
1. Vital signs and allergies
2. Urine specimen:
    a. Clear/cloudy/hematuria/malodorous
3. Urine dip results:
    a. Specific gravity/protein/glucose/leukocytes/nitrates/blood

(A) ASSESSMENT:
- Alteration in comfort
- Alteration in elimination
- Potential for infection

(P) PLAN OF CARE:

Consult provider if:
1. Febrile
2. Abnormal urine specimen
3. Moderate to severe discomfort

Nursing Interventions:
1. Clean catch urine sample for dipstick urine
2. Contact provider on call if abnormal results of blood, leukocytes, nitrates
3. Patient education to force fluids, at least 6-8 glasses of water in 24 hours; instructions on medications prescribed
4. Return to clinic if symptoms persist

Problem: VAGINAL DISCHARGE

(S) SUBJECTIVE:

1. Patient's statements/complaints:
    a. Onset of symptoms:
        i. Itching, burning, odor, discharge
        ii. Urinary frequency, urgency, pain, change in color
    b. Recent antibiotic therapy, name of medication
    c. Recent sexual activity
    d. History of STD

(O) OBJECTIVE:

1. Vital signs and allergies
2. Assess and document:
    a. Discharge color, odor, consistency, and amount of discharge. (Yeast infection symptoms include vaginal itching and often a thick, white, discharge resembling cottage cheese)
    b. Examination of upper inner thighs and perineal area
    c. Lesion present in throat and mouth
    d. Skin involved: normal, red, brown, darker or lighter than normal
    e. Lesions: none, raised, smooth margins, irregular margins, patchy, ringed
    f. Evidence of infection: none, inflamed, edema, red, drainage

(A) ASSESSMENT:

- Potential for infection
- Alteration in comfort

(P) PLAN OF CARE:

Refer all cases to provider

Nursing Interventions**:**

1. Perform urine dipstick; report abnormal result to the provider
2. Orders per provider
3. Follow-up as directed by provider
4. Patient education regarding hygiene, importance of compliance with prescribed medications; increase fluids 6-8 glasses of water/day
5. Return to clinic if symptoms worsen or condition persists beyond 10 days

Problem: VERTIGO – DIZZINESS – LIGHT HEADEDNESS

(S) SUBJECTIVE:

1. Patient's statements/complaints:
2. Onset of symptoms
3. Alleviating factors:
    a. Sitting down, closing eyes, lying down
4. Recent new or changed medication
5. Loss of consciousness, duration
6. Incontinence
7. History of:
    a. Recent head injury
    b. Recent exposure to sun
    c. Recent blood loss
    d. Similar past problem and treatment
    e. Inner ear infection
    f. Sinus problems
8. Disease modalities:
    a. Cardiac
    b. Diabetes
    c. Hypertension
    d. Seizures
9. Associated symptoms:
    a. Related to movement of head or body
    b. Nausea/vomiting
    c. Ringing/pain in ears/loss of hearing
    d. Numbness/weakness
10. Room spinning vs. light headedness on standing

(O) OBJECTIVE:

1) Vital signs with weight and pulse oximeter, allergies
    a) Document B/P and pulse readings lying, sitting, and standing
2) Color:
    a) Pink
    b) Flushed
    c) Pallor
    d) Cyanotic
    e) Jaundiced
3) Skin:
    a) Warm/dry
    b) Cool/moist/clammy
4) Turgor:
    a) Normal/decreased

Problem: VERTIGO – DIZZINESS – LIGHT HEADEDNESS contd.

5) Neuro/GCS:
   a) PERRLA/pupils unequal
   b) Moves all extremities
   c) Normal gait
   d) Weakness
   e) Facial symmetry,
   f) Oriented x 3
   g) Trauma/bleeding
6) Heart:
   a) Regular/irregular

(A) ASSESSMENT:

- Alteration in balance
- Potential for injury

(P) PLAN OF CARE:

Consult provider if:

1. Any neuro deficit
2. Abnormal ear symptoms
3. Recent head trauma, nausea/vomiting
4. Abnormal vital signs, greater than 15 mm hg change in B/P reading, pulse greater than 100 bpm or < 60 bpm
5. Change in dizziness from mild to severe
6. History of vertigo, overexposure to sun, bleeding
7. Currently taking medication
8. Signs of dehydrations, i.e., dry mucous membranes, increased heart and respiratory rates, increased thirst, headache, dry mouth, lethargy

Nursing Interventions:

1. Assess ability to move about without assistance, findings may indicate a need to change housing
2. Patient education regarding:
   a. Hydration
   b. Medication compliance
   c. Mobility/safety
3. Return to clinic in 24 to 48 hours if no change or symptoms worsen

SECTION IV

MRSA GUIDELINES

TENNESSEE DEPARTMENT OF CORRECTION
MRSA GUIDELINES

The 2015 Tennessee Department of Correction MRSA Guidelines were developed based on the Federal Bureau of Prison's (FBOP) Management of Methicillin Resistant *Staphylococcus aureus* Clinical Practice Guidelines (April 2012). These guidelines have been implemented for the prevention, treatment and containment of MRSA within the TDOC and are for use within all TDOC correctional facilities.

The TDOC and FBOP MRSA guidelines should be printed and placed in the facility Health Clinic and Intake areas. The FBOP's MRSA Guidelines can be found at http://www.bop.gov/news/PDFs/mrsa.pdf.

The following pages outline the 2015 TDOC MRSA Guidelines.

Tennessee Department of Correction, MRSA Guidelines, adheres to the statutes and regulations governing the control of communicable diseases in Tennessee. Adhering to the MRSA Invasive Disease reporting of T.C.A. §68 Rule 1200-14-01-.02. Tennessee was one of the first states to make Invasive MRSA reportable by adding it to the notifiable diseases in June 2004 to the PH-1600.

Invasive Disease is defined as isolation of MRSA from a normally sterile site (i.e., specimen source is blood, bone or fluid from around the brain, lungs, heart, abdomen or joints). Sputum, wound, urine and catheter tip isolates are not counted. Repeat isolates within thirty days from the same patient are not counted.

The Tennessee Department of Health and the Infections Taskforce January 2008 Executive Summary may be viewed and printed for reference from the link below.
https://health.state.tn.us/Downloads/MRSAreport307.pdf

I. TRANSMISSION

A primary mode of transmission of MRSA is person-to-person via contaminated hands. MRSA may also be transmitted by sharing towels, personal hygiene items, and athletic equipment; through close-contact sports; and by sharing tattoo or injection drug use equipment. Persons with MRSA pneumonia who are in close contact with others can potentially transmit MRSA by coughing up large droplets of infectious particles that can contaminate the environment. Persons with asymptomatic MRSA nasal carriage can also transmit MRSA, especially when symptomatic from a viral upper respiratory infection.

II. SCREENING AND SURVEILLANCE

1. INTAKE: All inmates should be evaluated for skin infections during intake medical screening and physical examinations. If there are noted sores, lesions, or “spider bites” that are open and draining, refer the inmate to the provider, notify the facility Infection Control Nurse (ICN), document the findings in the nursing progress notes, and begin MRSA Case Tracking and Reporting Guidelines. See Appendix 11 of the FBOP MRSA Guidelines. **Note:** The inmate’s TDOC number should be recorded in the column titled Registration #.

2. SCREENING FOR MRSA INFECTION

   A. Questions for inmates regarding skin lesions at the time of the intake medical screening:

      1. “Do you have any skin lesions, sores, or ‘spider bites”?”
      2. “If so, do you have any open/ draining lesions, sores, boils or ‘spider bites’?”
      3. “If so, where are these lesions?”

   B. Observation of the skin for lesions at the time of the intake physical

3. RECENT HOSPITALIZATION

   Inmates who are discharged from hospitals should be screened for skin infections immediately upon return to the prison. Instruct inmates to self-report any new onset of skin infections or fever (MRSA or other hospital associates infections may develop weeks after discharge).

4. HIGH RISK INMATES

Inmates with diabetes, immunocompromised conditions, open wounds, status/post-surgery, indwelling catheters, chronic skin conditions, implants, or paraplegia with decubiti, should be periodically evaluated for skin infectious during routine medical evaluations.

5. BACTERIAL CULTURE REPORTS

The provider and/or Infection Control Nurse/ designee shall review all culture reports for MRSA infection in a timely manner.

6. FOOD HANDLERS

Inmates who are assigned as food handlers will be advised to self- report all skin infections no matter how minor. They should be routinely examined for visible skin infections and if MRSA is suspected or confirmed, inmate food handlers should be removed from their duties until they are no longer infectious. Food Handlers shall be required to be no longer infectious and require a Physician/ Provider order to return to work.

7. TRANSFERS

Inmates with skin or soft tissue infections (SSTIs) should not be transferred to other institutions until fully evaluated and appropriately treated. (Refer to TDOC Policy113.42). Required Transfers: Inmates with SSTIs or contagious whose transfer is **absolutely** required for security or medical reason should have their draining wounds dressed the day of the transfer, with bandages that adequately contain the drainage. The following should occur prior to the transfer:

- Officers should be notified of the inmate's condition and be educated on infection control measures, including the importance of hand hygiene, protective measures, safe disposal of contaminated dressings, and decontamination of security devices (e.g., handcuffs, leg irons, and other reusable restraints). They should be advised to use disposable restraints, when feasible.
- The Health Services Administrator (HSA) or Director of Nursing (DON) of the sending institution should notify the receiving institution's HSA or DON of the pending transfer of an inmate with suspected or confirmed MRSA infection.

8. INMATE WORKERS

Outside **community** assignment (off compound): Inmates with SSTIs and/ or diagnosed with MRSA. Inmates assigned to community jobs shall not be permitted to work until a wound dressing is not required. A Physician/ Provider order shall be required prior to inmate return to their outside community work assignments.

Compound assignment (on compound): Inmates with SSTI and/ or diagnosed with MRSA. Inmates assigned to jobs within the compound setting shall be permitted to work. The wound shall be covered and contained in an occlusive dressing until healed. Food Handlers shall be required to be no longer infectious and require a Physician/ Provider order to return to work.

9. EMPLOYEES

Correctional Health Care Workers should report all skin infections and any confirmed MRSA infections to their supervisor. Supervisors should refer correctional staff with possible skin infections to their health care provider. Employees with SSTIs/ MRSA wound infections; the wound shall be covered and contained in an occlusive dressing until healed.

10. INFECTION CONTROL NURSE (ICN)

All MRSA cases will be tracked by the facility Infection Control Nurse and documented by utilizing Appendix 11, of the FBOP MRSA Guidelines**.** A summary of the findings shall be reported at the facility's monthly Continuous Quality Improvement (CQI) meetings.

III. EDUCATION OF INMATES

1. MRSA handouts will be provided to inmates at the time of the intake physical. See Appendices 5 and 6 of the FBOP MRSA Guidelines.

2. MRSA prevention posters will be placed on guilds, in clinics, and in the intake rooms

3. Education of the housekeeping staff on the proper use of commercial cleaners and disinfectant products will be provided.

4. Education of laundry workers on the proper technique for handling contaminated laundry will be provided.

IV TREATMENT OF INFECTED INMATES

1. WOUND CARE: Recommendations for incising, draining, and culturing wounds can be found in Appendix 2 of the FBOP MRSA Guidelines. Wound care shall be documented in the nursing progress notes and tracked by the ICN utilizing Appendix 11 of the FBOP MRSA Guidelines.

2. MEDICATION MANAGEMENT: See Appendix 3 of the FBOP MRSA Guidelines. A sample algorithm for treatment decisions is provided in Appendix 1.

(*See *FBOP MRSA Guidelines* located in the Health Services Resource Center on the V Drive*)

NOTES

- The TDOC does not recommend the routine use of Zyvox unless consultation with a TDOC infectious disease specialist has occurred.
- Rifampin is *not* recommended for treatment of uncomplicated SSTIs. For treatment of recurrent or complicated SSTIs, Rifampin can be considered on a case-by-case basis with the approval of the TDOC Medical Director.
- Rifampin must always be used in conjunction with another antibiotic.

3. HOUSING AND TRANSFER OPTIONS: Recommendations for the containment of infectious inmates can be found in Appendices 8a and 8b of the FBOP MRSA Guidelines.

V. TRACKING AND REPORTING

The following process will be followed when MRSA infection is suspected or confirmed; skin and soft tissue infections empirically treated as MRSA should also be tracked as a component:

1. Nurses shall notify the ICN of all inmates with suspected or confirmed MRSA infections. The ICN shall begin tracking individual cases of suspected or confirmed MRSA on TDOC MRSA Log**.**

2. After tracking is completed, the ICN shall begin the surveillance and monitoring of each MRSA case utilizing Appendix 10 of the FBOP MRSA Guidelines. A summary of the findings shall be reported during the facility monthly Continuous Quality Improvement (CQI) meetings.

3. All confirmed or suspected cases of MRSA shall be reported to the State Infection Control Nurse (SICN) and the State Continuous Quality Improvement Coordinator (SCQIC). Notification via submitted TDOC MRSA Log on the Health Services Clinical Database (Q:Drive) on or before the 10th day of each month. The report should include:

   a. Number of invasive MRSA reportable to TDOH via PH-1600.
   b. Number of culture- confirmed cases of MRSA;
   c. Number of suspected cases of MRSA, including the type of lesion (e.g., abscess, furuncle, etc.);
   d. Number of non-specified skin and soft tissue wounds.

VI. EDUCATION AND PROTECTION OF EMPLOYEES

The following will be provided to employees for protection against MRSA and other communicable diseases:

1. Education at New Employee Orientation

2. Additional training for employees who may come in contact with infected inmates

3. Personal Protective Equipment (PPE) will be provided to employees as needed for protection against MRSA infection. A list of PPE can be found in the FBOP MRSA Guidelines. See Appendices 5, 7a, 7b, 8a, and 8b.

4. Soap, running water and other hand hygiene supplies will be made available for all employees. Hand washing recommendations can be found in the FBOP MRSA Guidelines. See Appendices 5, 7a, 7b, 8a, and 8b.

VII. PREVENTION OF THE SPREAD OF MRSA

The following will be implemented in order to prevent the spread of MRSA and other infections:

1. Showers with soap and hot running water for all inmates.

2. Laundering clothes, linens, and towels twice weekly in hot water (>160 degrees F for 25 minutes). An alternative is to launder clothes, linens and towels in bleach. Clothes should be completely dry before use. Institutions that use chemicals for laundry disinfection should strictly adhere to the manufacturer's instructions for the appropriate concentration to ensure bactericidal effectiveness.

3. A hospital-grade disinfectant/ detergent registered by the EPA should be used for the daily cleaning of environmental surfaces, including sinks, showers, and toilets. The manufacturers' instructions for use of such products should be followed. A bleach solution is acceptable for environmental cleaning, but care must be taken to ensure that bleach solutions are of the appropriate concentration (i.e. 1:10 dilution of concentrated bleach) and changed when dirty or after 24 hours after diluting. Personnel using disinfectant products should be trained in their proper use and provided with appropriate Personal Protective Equipment.

   Annually, the Institutional CQI/IC Coordinator shall verify all products used in the medical clinic are EPA approved disinfectants against MRSA. The verification shall be noted in the minutes of a CQI meeting. An EPA link of additional disinfectants active against MRSA can be found in the FBOP MRSA Guidelines. See Appendices 7a, 7b, 8a, and 8b.

4. Dishwashers calibrated to correct temperatures

5. Cleaning of weight room equipment and other high touch surfaces such as doorknobs, light switches, telephones, handrails, etc. References for information applicable to correctional healthcare settings can be found in the FBOP MRSA Guidelines. See appendices 7a, 7b, 8a, and 8b

DEFINITIONS

Abscess is an infection characterized by a localized accumulation of polymorphonuclear leukocytes with tissue necrosis involving the dermis and subcutaneous tissue.

Bulla is a raised, circumscribed lesion (> 0.5 cm) containing serous fluid above the dermis.

Carbuncle consists of two or more confluent *furuncles* with separate heads. A furuncle is a well-circumscribed, painful, supporative inflammatory nodule involving hair follicles that usually arises from preexisting *folliculitis*.

Cellulitis involves deep subcutaneous infection of the skin—typically by bacteria—that results in a localized area of *erythema* and inflammation, with or without associated purulence.

Community-associated MRSA (CA-MRSA) refers to an MRSA infection with onset in the community, in an individual lacking established risk factors for *health-care associated* infection, such as recent hospitalization, surgery, residence in a long-term care facility, receipt of dialysis, or presence of invasive medical devices.

Fluctuance is an indication of the presence of pus in a bacterial infection. As the skin becomes infected, redness and induration develop. If the pus does not drain, the skin overlapping the pus remains red, but touching this area produces a soft, boggy feel known as “fluctuance.” In general, lesions that are fluctuant need to be incised and drained.

Folliculitis is inflammation of the hair follicle that appears clinically as an eruption of *pustules* and/or *papules* centered upon hair follicles.

Furuncle is a well-circumscribed, painful, supporative inflammatory nodule involving hair follicles that usually arises from preexisting *folliculitis*. Furuncles can occur anywhere on the skin surface that contains hair follicles and is subject to friction and maceration, e.g., thighs, neck, axillae, groin, and buttocks. They may extend into the dermis and subcutaneous tissues and often are associated with *cellulitis*.

Health-care associated MRSA (HA-MRSA) infections generally are associated with recent hospitalization, surgery, residence in a long-term care facility, receipt of dialysis, or presence of invasive medical devices.

Methicillin-resistant *Staphylococcus aureus* or “MRSA” are staph bacteria that are resistant to *beta-lactam antibiotics*, including: penicillin, ampicillin, amoxicillin, amoxicillin/clavulanate, methicillin, oxacillin, dicloxacillin, cephalosporins, carbapenems (e.g., imipenem), and the monobactams (e.g., aztreonam). MRSA causes the same types of infections as does staphylococcal bacteria that are sensitive to beta-lactam antibiotics.

MRSA outbreak is a clustering of two or more epidemiologically-related, culture-positive cases of MRSA infection. Confirmation that a MRSA outbreak is caused by the same organism is suggested by similar

isolate antibiotic susceptibilities and is further supported if molecular analysis, such as pulsed-field gel electrophoresis, identifies a predominant MRSA strain.

Osteomyelitis is inflammation of bone and bone marrow usually due to a bacterial infection.

Papule is a well-circumscribed, elevated, solid lesion that measures less than 1 cm and is usually dome shaped.

SSTI is skin and soft tissue infection.

Staphylococcus aureus, often referred to as “staph,” is a commonly occurring bacterium that is carried on the skin and in the nose of healthy persons. *Staphylococcus aureus* may cause minor skin or soft tissue infections such as boils, as well as more serious infections such as wound infections, abscesses, pneumonia, and sepsis.

Vesicle is a small, blister-like elevation of the skin (<1 cm), containing serous fluid.

SECTION V

APPENDIX

Nursing Protocols Glossary

Word	Definition
Abrasion	The rubbing or scraping of the surface layer of cells or tissue from an area of the skin or mucous membrane.
Abscess	A localized collection of pus surrounded by inflamed tissue.
Acne	A disorder of the skin caused by inflammation of the skin glands and hair follicles.
Allergy	Exaggerated or pathological reaction (as by sneezing, respiratory embarrassment, itching, or skin rashes) to substances, situations, or physical states that are without comparable effect on the average individual.
Amputation	To cut, as a limb from the body.
Anaphylactic Reaction	Hypersensitivity (as to a foreign proteins or drugs) resulting from sensitization following prior contact with the causative agent.
Anticholinergic	Opposing or blocking the physiological action of acetylcholine.
Anticoagulant	A substance that hinders coagulation and especially coagulation of the blood.
Antiseptic	Free of living microorganisms: scrupulously clean.
Arthritis	Inflammation of joints due to infectious, metabolic, or constitutional causes.
Asthma	A chronic lung disorder that is marked by recurring episodes of airway obstruction manifested by labored breathing accompanied especially by wheezing and coughing and by a sense of constriction in the chest, and that is triggered by hyper reactivity to various stimuli.
Asymmetry	Lack or absence of symmetry, as a lack of proportion between the parts of a thing.
Athlete's Foot	Ringworm of the feet. Also called Tinea Pedis.
Avulsed Tooth	The complete separation of a tooth from its alveolus which under appropriate conditions, may be replanted.
Belch	To expel gas suddenly from the stomach through the mouth, to

	expel gas from the stomach suddenly.
Blister	A fluid-filled elevation of the epidermis
Boil	A localized swelling and inflammation of the skin resulting from usually bacterial infection of a hair follicle and adjacent tissue, having a hard central core, and forming pus – called also *Furuncle.*
Bruise	An injury transmitted through unbroken skin to underlying tissue causing rupture of small blood vessels and escape of blood into the tissue with resulting discoloration.
Burn	Bodily injury resulting from exposure to heat, caustics, electricity, or some radiations, marked by vary degrees of skin destruction and hyperemia often with the formation of watery blisters and in severe cases by charring of the tissues and classified according to the extent and degree of the injury.
Chalazion	A small circumscribed tumor of the eyelid formed by retention of secretions of the meibomian gland and sometimes accompanied by inflammation.
Cluster Headache	A headache that is characterized by severe unilateral pain I the eye or temple, affects primarily men, and tends to recur in a series of attacks – called also *histamine cephalalgia, histamine cephalgia, Horton's syndrome*.
Common Cold	An acute contagious disease of the upper respiratory tract that is marked by inflammation of the mucous membranes of the nose, throat, eyes, and Eustachian tubes with a watery then purulent discharge and is caused by any of several viruses.
Communicable	Capable of being transmitted from person to person, animal to animal, animal to human, or human to animal.
Concussion	A condition resulting from the stunning, damaging, or shattering effects of a hard blow.
Conjunctivitis	Inflammation of the conjunctiva.
Constipation	Abnormally delay or infrequent passage of dry hardened feces.
Contaminate	To soil, stain, or infect by contact or association.
Contusion	Injury to tissue usually without laceration.
Cough	An explosive expulsion of air from the lungs acting as a protective mechanism to clear the air passages or as a symptom of pulmonary disturbance.
Crab Louse	A sucking louse of the genus *Pthirus (P. pubis*) infesting the pubic

	region of the human body.
Cyanosis	A bluish or purplish discoloration (as of skin) due to deficient oxygenation of the blood.
Dandruff	Scaly white or grayish flakes of dead skin cells especially of the scalp, also: the condition marked by excessive shedding of such flakes and usually accompanies by itching.
Dehydration	An abnormal depletion of body fluids.
Delirium	A mental disturbance characterized by confusion, disordered speech, and hallucinations.
Dermatitis	Inflammation of the skin – called also *dermatitis*.
Diaphoresis	Perspiration.
Diarrhea	Abnormally frequent intestinal evacuations with more or less fluid stools.
Dislocation	Displacement of one or more bones at a joint.
Distend	To enlarge or stretch out.
Diuretic	An agent that increases the excretion of urine.
Dry Eye	A condition associated with inadequate tear production and marked by redness of the conjunctiva, by itching and burning of the eye, and usually by filaments of desquamated epithelial cells adhering to the cornea – called also *keratoconjunctivitis sicca*.
Dysmenorrhea	Painful menstruation.
Earache	An ache or pain in the ear – called also *otalgia*.
Ecchymosis	The escape of blood into the tissues from ruptured blood vessels marked by livid black and blue or purple spot area.
Edematous	Affected with edema.
Electrolyte	Any of the ions (as sodium, potassium, calcium, or bicarbonate) that in a biological fluid regulate or affect most metabolic processes (as the flow of nutrients into and waste products out of cells).
Emphysema	A condition characterized by air-filled expansions interstitial or subcutaneous tissues, specifically: a condition of the lung that is marked by distension and eventual rupture of the alveoli with progressive loss of pulmonary elasticity, that is accompanied by shortness of breath with or without cough, and that may lead to impairment of heart action.

Encephalopathy	A disease of the brain.
Endocrinopathy	A disease marked by dysfunction of an endocrine gland.
Erythema	Abnormal redness of the skin due to capillary congestion (as in inflammation).
Erythematous	Relating to or marked by erythema.
Exacerbate	To cause a disease or its symptoms to become more severe.
Excoriation	A raw irritated lesion (as of the skin or a mucosal surface).
Expiratory Grunt	An abnormal sound heard during labored exhalation that indicates a need for high chest pressures to keep the airways open. It is caused by closing of the glottis at the end of expiration.
Extraction	The act or process of extracting something – *extraction of a tooth*.
Fever	An abnormal bodily state characterized by increased production of heat, accelerated heart action and pulse, and systemic debility with weakness, loss of appetite, and thirst.
Feverish	Showing symptoms indicating fever.
First Degree Burn	A mild burn characterized by heat, pain, and reddening of the burned surface but not exhibiting blistering or charring of tissues.
Fissure	A natural cleft between body parts or in the substance of an organ.
Flatulence	The quality or state of being flatulent.
Foot Drop	An extended position of the foot caused by paralysis of the flexor muscles of the leg.
Fracture	The act or process of breaking or the state of being broken.
Gastritis	Inflammation especially of the mucous membrane of the stomach.
Genitourinary	Relating to the genital and urinary organs.
Glasgow Coma Scale	A scale that is used to assess the severity of a brain injury, that consists of values from 3 to 15 obtained by summing the ratings assigned to three variables depending on whether and how the patient responds to certain standard stimuli by opening the eyes, giving a verbal response, and giving a motor response, and that for a low score (as 8 to 15) indicates a good chance of recovery.
Gonococcal Arthritis	Arthritis, often with tenosyvitis and/or rash caused by gonococcal infection. The joints of the knees, wrists, and hands are most commonly affected.

Grand Mal	Severe epilepsy characterized by tonic-clonic seizures.
Head Louse	A sucking louse of the genus *Pediculus (P. humanus capitis*) that lives on the human scalp.
Headache	Pain in the head – called also *cephalalgia*.
Heat Exhaustion	A condition marked by weakness, nausea, dizziness, and profuse sweating that results from physical exertion in a hot environment.
Heat Stroke	A condition marked especially by cessation of sweating, extremely high body temperature, and collapse that result from prolonged exposure to high temperature.
Hematuria	The presence of blood or blood cells in the urine.
Hemorrhoid	A mass of dilated veins in swollen tissue at the margin of the anus or nearby within the rectum – called also *piles*.
Hyperactive	Affected with or exhibiting hyperactivity, more active than is usual or desirable.
Hypertension	Abnormally high arterial blood pressure that is usually indicated by an adult systolic blood pressure of 140 mm Hg or greater or a diastolic blood pressure of 90 mm Hg or greater, is chiefly of unknown cause but may be attributable to a preexisting condition (as a renal or endocrine disorder), that typically results in a thickening and inelasticity of arterial walls and hypertrophy of the left heart ventricle, and that is a risk factor for various pathological conditions or events (as heart attack, heart failure, stroke, end-stage renal disease, or retinal hemorrhage).
Hyperthermia	Exceptionally high fever especially when induced artificially for therapeutic purposes.
Hypoactive	Less than normally active.
Induration	An increase in the fibrous elements in tissue commonly associated with inflammation and marked by loss of elasticity and pliability.
Inflammation	A local response to cellular injury that is marked by capillary dilatation, leukocytic infiltration, redness, heat, pain, swelling, and often loss of function and that serves as a mechanism initiating the elimination of noxious agents and of damaged tissue.
Insomnia	Prolonged and usually abnormal inability to obtain adequate – called also *agrypnia*.
Insulin Shock	Severe hypoglycemia that is associated with the presence of excessive insulin in the system and that if left untreated may result

	in convulsions and progressive development of coma.
Intermittent	Coming and going at intervals: not continuous.
Jaundice	A yellowish Pigmentation of the skin, tissues, and certain body fluids caused by the deposition of bile pigments that follows interference with normal production and discharge of bile or excessive breakdown of red blood cells.
Jock Itch	Ringworm of the crotch – called also *jockey itch*.
Laceration	A torn and ragged wound.
Lesion	An abnormal change in structure of an organ or part due to injury or disease.
Lethargy	Abnormal drowsiness.
Leukocyte	White blood cell.
Ligament	A tough band of tissue that serves to connect the articular extremities of bones or to support or retain an organ in place and is usually composed of coarse bundles of dense white fibrous tissue parallel or closely interlace, pliant, and flexible, but not extensible.
Lymphadenopathy	Abnormal enlargement of the lymph nodes.
Macula	An anatomical structure having the form of a spot differentiated from surrounding tissues.
Malaise	An indefinite feeling of debility or lack of health indicative of or accompanying the onset of an illness.
Malodorous	Having a bad odor.
Migraine	A condition that is marked by recurrent usually unilateral severe headache often accompanied by nausea and vomiting and followed by sleep, that tends to occur in more than one member of a family, and that is of uncertain origin though attacks appear to be precipitated by dilatation of intracranial blood vessels.
Mottled	Condition that is marked by discolored areas.
Nasal Concha	Any of three thin boney plates on the lateral wall of the nasal fossa on each side with or without their covering of mucous membrane.
Neurovascular	Relating to, or involving both nerves and blood vessels.
Nitrate	A salt or ester of nitric acid.
Non-productive	A cough not effective in raising mucus or exudate from the

	respiratory tract.
Nosebleed	An episode of bleeding from the nose – called also *epistaxis*.
Overdose	Too great a dose, a lethal or toxic amount.
Pallor	Lack of color. Paleness.
Palpation	A physical examination in medical diagnosis by pressure of the hand or fingers to the surface of the body especially to determine the condition (as of size or consistency) of an underlying part or organ.
Papule	A small solid usually conical elevation of the skin caused by inflammation, accumulated secretion, or hypertrophy of tissue elements.
Paresthesia	A sensation of pricking, tingling, or creeping on the skin having no objective cause and usually associated with injury or irritation of a sensory nerve or nerve root.
Peak Flow Rate	The maximum flow at the outset of forced expiration which is reduced in proportion to the severity of airway obstruction as in asthma.
Pediculosis	Infestation with lice – also called *lousiness*.
Periorbital	Of, relating to, occurring in, or being the tissues surrounding or lining the orbit of the eye.
Petit Mal	Epilepsy characterized by absence seizures.
Phenothiazine	Any of various phenothiazine derivatives that are used as tranquilizing agents especially in the treatment of schizophrenia.
Photophobia	Intolerance to light. Painful sensitiveness to strong light.
Premenstrual Syndrome	A vary constellation of symptoms manifested by some women prior to menstruation that may include emotional instability, irritability, insomnia, fatigue, anxiety, depression, headache, edema, and abdominal pain – called also *PMS*.
Productive	Raising mucus or sputum: *a productive cough*.
Protrude	To cause to project: to jut out from the surrounding surface.
Pulse Oximeter	A device that determines the oxygen saturation of the blood of an anesthetized patient using a sensor attached to a finger, yields a computerized readout, and sounds an alarm if the blood saturation becomes less than optimal.
Purulent	Containing, consisting of, or being pus.

Quadrant	Any of the four more or less equivalent segments into which an anatomic structure may be divided by vertical and horizontal partitioning through its midpoint.
Rash	An eruption on the body typically with little or no elevation above the surface.
Respiratory Depression	A respiratory rate of less than 12 breaths per minute or an oxygen saturation level of less than 90%. Patient may be either conscious or unconscious.
Rhonchus	A whistling or snoring sound heard on auscultation of the chest when the air channels are partly obstructed.
Rigid	Deficient in or devoid of flexibility: characterized by stiffness.
Second Degree Burn	A burn marked by pain, blistering, and superficial destruction of dermis with edema and hyperemia of the tissues beneath the burn.
Seizure	An abnormal electrical discharge in the brain.
Semi-Fowler's position	A position in which the patient lies on the back with the trunk elevated at an approximate 30 degree angle.
Sexual Assault	Illegal sexual contact that may involve force, but not required, upon a person without consent or is inflicted upon a person who is incapable of giving consent.
Shortness of Breath	Difficulty in drawing sufficient breath: labored breathing.
Sinusitis	Inflammation of a sinus of the skull.
Standard Procedures	Precautions that integrate and expand the elements of universal precautions into a standard of care designed to protect health-care personnel and patients from pathogens that can spread by blood or any other body fluid, excretion, or secretion. Standard precautions apply to contact with 1) blood, 2) all body fluids, secretions, and excretions, and 3) mucous membranes. Saliva has always been considered a potentially infectious material in dental infection control, thus, no operational difference exists in clinical dental practice between universal precautions and standard precautions.
Sore Throat	Painful throat due to inflammation of the faucets and pharynx.

Sprain	A sudden or violent twist or wrench of a joint causing the stretching or tearing of ligaments and often rupture of blood vessels with hemorrhage into the tissues, also, a condition resulting from a sprain that is usually marked by swelling, inflammation, hemorrhage, and discoloration.
Sputum	The matter discharged from the air passages in diseases of the lungs, bronchi, or upper respiratory tract that contains mucus and often pus, blood, fibrin, bacterial products.
Sty	An inflamed swelling of a sebaceous gland at the margin of an eyelid – called also *hordeolum*.
Sunburn	Inflammation of the skin caused by overexposure to ultraviolet radiation especially from sunlight.
Superficial	Of, relating to, or located near the surface.
Symmetry	Correspondence in size, shape, and relative position of parts on opposite sides of a dividing line or median plan or about a center or axis.
Symptomatic	Having the characteristics of a particular disease but arising from another cause.
Tachycardia	Relatively rapid heart action whether physiological (as after exercise) or pathological.
Tarry Stool	An evacuation from the bowels having the color of tar caused especially hemorrhage in the stomach or small intestine.
Tension Headache	Headache marked by mild to moderate pain of variable duration that affects both sides of the head and is typically accompanied by contraction of neck and scalp muscles.
Third Degree Burn	A severe burn characterized by destruction of the skin through the depth of the dermis and possibly into underlying tissues, loss of fluid, and sometimes shock.
Tinea Cruris	A fungal infection involving especially the groin and perineum.
Tissue Perfusion	The state in which an individual experiences a decrease in nutrition and oxygenation at the cellular level due to a deficit in capillary blood supply.
Toothache	Pain in or about a tooth – called also *odontalgia*.
Torsion	A twisting or rotation of a part on its long axis.
Tourniquet	A device (as a bandage twisted tight with a stick) to check bleeding or blood flow.
Turgor	The normal state of turgidity and tension in living cell.

Tympanic Membrane	A thin membrane separating the middle ear from the inner part of the external auditory canal that vibrates in response to sound energy and transmits the resulting mechanical vibrations to the structures of the middle ear.
Unconscious	Not marked by conscious thought, sensation, or feeling
Uremia	Accumulation in the blood of constituents normally eliminated in the urine that produces a severe toxic condition and usually occurs in severe kidney disease.
Urgency	A sudden compelling need to urinate or defecate.
Vertigo	A disordered state which is associated with various disorders (as of the inner ear) and in which the individual or the individual's surrounding seem to whirl dizzily.
Vesicle	A small abnormal elevation of the outer layer of skin enclosing a watery liquid.
Wheeze	To breathe with difficulty usually with a whistling sound.

TENNESSEE DEPARTMENT OF CORRECTION 2015 CLINICAL SERVICES APPROVED ABBREVIATION LIST

A		D	
AAOx3	awake, alert, oriented to time, place, person	**DOA**	dead on arrival
ABC	airway, breathing, and circulation	**DOT**	directly observed therapy
abd	abdomen	**DT**	diphtheria and tetanus toxoid
ad lib	as desired	**Dx**	diagnosis
AFB	acid-fast bacillus		
AIDS	acquired immunodeficiency syndrome		
AMA	against medical advise		
amt	amount		
		E	
B		**ECG or EKG**	electrocardiogram
BE	barium enema	**Echo**	echocardiogram
bil	bilateral	**EDC**	expected date of confinement
BM	bowel movement	**EEG**	electroencephalogram
BP	blood pressure	**EENT**	eye, ear, nose and throat
bpm	beats per minute	**ENT**	ear, nose and throat
BRP	bathroom privileges	**ER**	Emergency Room
BUN	Blood Urea Nitrogen		
		F	
C		**F**	Fahrenheit
C & S	culture and sensitivity	**FBS**	fasting blood sugar
C/O	Complain(t)s of	**F/U**	follow-up
		FME	Forensic Medical Exam
CA	cancer	**FUO**	fever of unknown origin
Caps	capsules	**Fx**	fracture
cath	catheterization or catheter		
CBC	complete blood count	**G**	
CHF	Congestive Heart Failure	**GB**	gallbladder
cm	centimeter	**GC**	gonorrhea culture/ gonococcal
CNS	Central Nervous System	**GCS**	Glasgow Coma Scale
COPD	Chronic Obstructive Pulmonary Disease	**GI**	gastrointestinal
CSF	cerebral spinal fluid	**gm**	gram
c-spine	cervical spine	**GU**	genitourinary
CT Scan	computer tomography scan	**GYN**	gynecology
CTM	Chlor-trimeton	**H**	
CVA	Cerebral Vascular Accident	**HA**	headache
CXR	chest x-ray	**H & P**	history and physical
C-PAP	continuous positive airway pressure	**Hct**	hematocrit
D		**hgb**	hemoglobin
D & C	dilation and curettage	**HIV**	human immunodeficiency virus
DC	discontinue	**hr(s)**	hour(s)
Diff	differential	**Ht**	height
DM	dextromethorphan/cough suppressant	**Hx**	history

TENNESSEE DEPARTMENT OF CORRECTION 2015 CLINICAL SERVICES APPROVED ABBREVIATION LIST

I		**N**	
I & D	incision and drainage	**NS**	normal saline
I & O	intake and output	**N/S**	no show
IM	intramuscular	**N&V**	nausea and vomiting
inj	injection		
IPPB	intermediate positive pressure breathing	**O**	
IUD	intrauterine device	**O2**	oxygen
IV	intravenous	**OB**	obstetrics
IVP	intravenous pyelogram	**OD**	overdose
		oint	ointment
K		**OPD**	out-patient department
kg	kilogram	**Ophth**	ophthalmology
KOP	keep on person	**OT**	occupational therapy
KUB	x-ray of kidney, ureter, and bladder	**OTC**	over-the -counter
KVO	keep vein open	**oz**	ounce
L			
L	liter		
lab	laboratory	**P**	
lat	lateral	**P**	pulse
lb	pound	**PAP**	Papanicolaou's smear
liq	liquid	**per**	by or through
LLQ	left lower quadrant	**PERRLA**	pupils equal, round, reactive to light and accommodation
LMP	last menstrual period	**PID**	pelvic inflammatory disease
LP	lumbar puncture	**po**	by mouth
lt	left	**post**	posterior
LUQ	left upper quadrant	**Post Op**	post-operative
		PP	post-partum
M		**pp**	post-prandial
MD	medical doctor	**PPD**	purified protein derivative
mEq	milliequivalent	**Pre-Op**	pre-operative
mg	milligram	**Prep**	prepare
ml	milliliter	**PRN**	as needed
mm	millimeter	**Pro-time**	prothrombin time
MRSA	methicillin resistant staphylococcus aureus	**pt**	patient
MI	myocardial infarction	**PT**	physical therapy
N			
neg	negative	**Q**	
NKA	no known allergies		
NPO	nothing by mouth		
NRB	non-rebreather		

TENNESSEE DEPARTMENT OF CORRECTION 2015 CLINICAL SERVICES APPROVED ABBREVIATION LIST

R		T	
R	respiration	**T**	temperature
RBC	red blood count	**T&A**	tonsils and adenoids
resp	respiratory	**Tabs**	tablets
RL	Ringer's Lactate Solution	**TB**	tuberculosis
RLQ	right lower quadrant	**Tbsp**	tablespoon
R/O	rule out	**TMJ**	Temporal Mandibular Joint
ROM	range of motion	**TO**	telephone order
rt	right	**TPR**	temperature, pulse and respiration
RTC	return to clinic	**Tsp**	teaspoon
RUQ	right upper quadrant	**TUR**	transurethral resection
Rx	prescription	**Tx**	treatment
S		**U**	
S/C	sick call	**UA**	urinalysis
Sc	subcutaneously	**UCG**	urinary chorionic gonadotrophin
sed rate	sedimentation rate		(pregnancy test)
SGOT	serum glumatic oxalacetic	**URI**	upper respiratory infection
SGPT	serum glutamic pyruvic transaminase	**UTI**	urinary tract infection
SOAP	subjective data, objective data, assessment, plan		
SOB	shortness of breath	**V**	
sol	solution	**VD**	venereal disease
spec	specimen	**VO**	verbal order
SS Enema	soap suds enema	**VS**	vital signs
S/S	Signs and symptoms		
STAT	immediately		
STD	sexually transmitted disease	**W**	
STI	Sexually transmitted infection	**WBC**	white blood count
		w/c	wheelchair
		WNL	within normal limits
		wt	weight

The Joint Commission

Official "Do Not Use" List[1]

Do not use	Potential Problem	Use instead
U (unit)	Mistaken for "0" (zero), the Number "4" (four) or "cc"	Write "unit"
IU (International unit)	Mistaken for "IV" (intravenous) or the number "10" (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or any medication-related documentation.

Additional Abbreviation, Acronyms, and Symbols
(For possible future inclusion on the Official "Do Not Use" List)

Do not use	Potential Problem	Use instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar Abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practioners	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for "U" (units) when poorly written	Write "mL" or "ml" or "milliliters" (mL is preferred)
µg	Mistaken for mg (milligrams) resulting in a one thousand-fold overdose	Write "mcg" or micrograms

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Appendix 3a. Varicella Contact Investigation Steps

The steps involved in conducting a varicella contact investigation are listed below. For detail about each step, see *Appendix 3b,*

Varicella Contact Investigation Checklist.

1. Identify, isolate, confirm, and characterize the varicella case.

2. Make notifications regarding the potential for a varicella outbreak.

3. Convene contact investigation team.

4. Stop movement of potential inmate contacts pending "evidence of immunity."

5. Identify and prioritize contacts.

6. Check if contacts have varicella symptoms or "evidence of immunity."

7. Consider STAT VZV IgG for contacts *without* "evidence of immunity."

8. Develop containment plan for inmate contacts.

9. Observe for new cases of chickenpox.

10. Summarize outbreak.

GOTO: http://www.bop.gov/news/PDFs/varicella.pdf for complete document.

NURSE (*Print Name*)	SIGNATURE AND TITLE OF NURSE	LICENSE #	DATE

Copy as needed

Federal Bureau of Prisons. (February 2010). Management of Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infections: Federal Bureau of Prisons Clinical Practice Guidelines. Retrieved on November 30, 2010 from, http://www.bop.gov/news/PDFs/mrsa.pdf.

Management of Varicella Zoster Virus (VZV) Infections
Federal Bureau of Prisons Clinical Practice Guideline
December 2011 Retrieved on December, 10, 2013 from
http://www.bop.gov/news/PDFs/varicella.pdf

Merriam-Webster. (c2007) Merriam-Webster Medical Dictionary. Retrieved on July 7, 2007, from http://www.merriam-webter.com/medical

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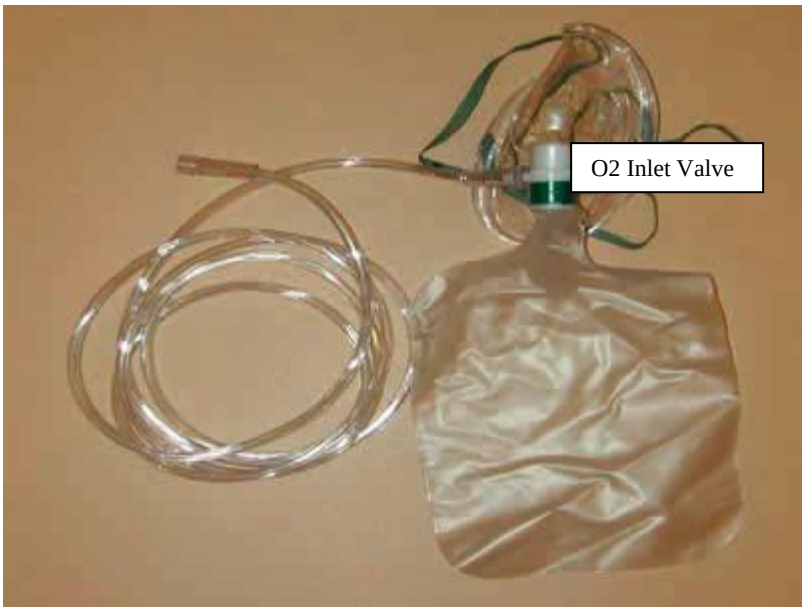
Centers for Disease Control and Prevention, http://www.cdc.gov/

PROPER USE OF A NON-REBREATHER MASK



1. CONNECT THE TUBING TO AN OXYGEN SOURCE (CYLINDER OR WALL OXYGEN ONLY! NO CONCENTRATORS) AND TURN THE FLOW REGULATOR TO **15 LPM.**

2. WAIT FOR THE RESEVIOR BAG TO INFLATE FULLY AND *THEN* PLACE THE MASK ON THE PATIENT.

***To inflate bag fully, place a finger over the oxygen inlet valve inside the mask to block oxygen flow until bag is fully inflated.**

3. IT IS NORMAL FOR THE BAG TO PARTIALLY DEFLATE DURING INHALATION BUT SHOULD REFILL QUICKLY. MONITOR THE PATIENT'S RESPIRATORY STATUS INCLUDING BREATH SOUNDS, RESPIRATORY RATE, HEART RATE AND PULSE OXIMETRY.

4. PATIENTS AT RISK FOR VOMITING MUST BE MONITORED AT CLOSELY IF WEARING A MASK.

PLEASE NOTE THAT A NON-REBREATHER MASK IS FOR EMERGENCY SITUATIONS ONLY AND IS NOT INTENDED TO BE A LONG-TERM SOLUTION FOR PATIENTS REQUIRING OXYGEN. A PATIENT REQUIRING A NON-REBREATHER SHOULD BE EVALUATED FOR NEED OF TRANSPORT TO AN OUTSIDE EMERGENCY DEPARTMENT!

Approved Nursing Protocols Medications List

Acetaminophen 325mg (Tylenol)
Albuterol Nebulizer Treatment Unit Dose
Asprin 325mg
Bisacodyl 5mg
Calamine Lotion
Carbamide Peroxide (Debrox)
Chlorpheniramine 4mg (CTM)
Docusate Sodium 100mg (Colace)
Glucagon Injection
Glucose Gel 15gm
Ibuprofen 200mg (Advil)
Narcan Inj 0.4mg/ml
Normal Saline
Oxygen
Pyrethrin Preparation (RID)
Simethicone 125mg
Stock Antacid
Stock Antibiotic Ointment
Stock Antiseptic Skin Cleanser
Stock Hemmorrhoid Preparation
Stock Topical Corticosteriod Preparation
Stock Topical Antifungal Preparation
Sublingual Nitroglycerin 0.4mg

Chief Medical Officer, TDOC Kenneth Williams MD, PhD Date 4/21/2017

Facility Medical Director_____Date_____