

**Community Oriented Programs Primary Care**  
**Satellite Programs: TWUH/TWIMS**  
**DPH Nursing Standardized Procedures**

**Written by Registered Nurses of SFDPH**



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**GENERAL STATEMENT OF PROCEDURE** General Guidelines<sup>[US3]</sup>

The following guidelines describe the steps to follow ~~for all Standardized Protocols~~ for DPH Registered Nurses who are ~~working independently in the community~~ working under this standardized procedure .

1. Legibly document encounter in S.O.A.P. format, including protocol followed under assessment, time seen and name with title. Complete site-specific encounter form.
2. Refer to definitions for each protocol.
3. Collect data thoroughly and consistently.
4. Perform physical exam pertinent to presenting problem.
5. Consult medical provider as necessary.
6. Follow the intervention, education and follow-up steps of action plan for each individual protocol.
7. Perform brief social assessment related to health maintenance, housing status, nutrition needs, clothing needs, etc. Make necessary referrals.
8. Complete billing sheets as appropriate for your site.
10. Provide every client with next primary care clinic appointment and encourage appointment adherence. If client is not scheduled, assist in scheduling client for clinic appointment in appropriate timeline. Refer client to medical home if not yet assigned.
11. Consult regularly with assigned provider that oversees your site utilizing verbal orders when appropriate.

Title: Community Oriented Programs- Nursing Standardized Satellite Programs – TWUH (Tom Waddell Urban Health)/TWIMS (Tom Waddell Integrated Medical Services)

I. Policy Statement

A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Registered Nurses, Physicians, Pharmacists, Administrators and other Affiliated Staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725.

B. A copy of the signed procedures will be kept in an operational manual located in the Share “S” Drive [us6] and on file in the Medical Staff Office.

II. Functions to be performed

The Registered Nurse based upon the nursing process determines the need for a standardized procedure. The RN provides health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek physician consultation.

III. Circumstances under which RN may perform function

A. Setting

The Registered Nurse may perform the following standardized procedure functions in the CPC Satellite Programs—TWUH/ TWIMS community-based program [u7] consistent with their experience and training.

B. Scope of Supervision Required:

1. The RN is responsible and accountable to their Charge Nurse, Nurse Manager, and -Medical Director.
2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available, at all times, to the RN, by phone or in person, including but not limited to the clinical area.
3. Physician/PCP consultation is to be specified in the protocols.

IV. Scope of Practice

- Protocol #1: Allergic Reaction
- Protocol #2: ~~Athlete's Foot~~ Tinea Pedis
- Protocol #3: Body Lice (Pediculosis Corporis)
- Protocol #4: Cold
- Protocol #5: Constipation
- Protocol #6: Dental Pain
- Protocol #7: Diarrhea
- Protocol #8: Hay Fever / Allergic Rhinitis
- Protocol #9: Headache
- Protocol #10: Head Lice (Pediculosis Capitis)
- Protocol #11: Impacted Cerumen
- Protocol #12: Menstrual Cramps / Dysmenorrhea
- Protocol #13: Musculoskeletal Pain ~~+~~ (non-traumatic)
- Protocol #14: Scabies
- Protocol #15: Sore Throat
- Protocol #16: Suture Removal<sup>[US8]</sup>

V. Requirements for the Registered Nurse

- A. Experience and Education
  1. Active California Registered Nurse license.
  2. Current Basic Life Support certification from an approved American Heart Association provider.
- B. Special Training
  1. Specified in protocols, if any
- C. Evaluation of the Registered Nurse competence in performance of standardized procedures.
  1. Initial:
    - At the conclusion of the standardized procedure training the Nurse Manager and Medical Director or designated physician will assess the RN's ability to perform the standardized procedure by:
      - a. Successful completion of the RN orientation program
      - b. Review of a minimum of 10 patient cases for completeness of documentation by the Nurse Manager or preceptor. <sup>[US9]</sup>

~~At the conclusion of the standardized procedure training the Charge Nurse, Nurse Manager, Medical Director or designated physician will assess the RN's ability to perform the procedure:~~

a. ~~Clinical Practice~~

~~Length of proctoring period will be time sufficient for protocol review~~

2. Annual:

Charge Nurse, Nurse Manager, Medical Director or designated physician will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation and no fewer than 3 chart reviews~~along with feedback from colleagues, physicians, direct observation or chart review may be used~~. The [JS10] standardized procedures will be a required competency for annual review.

3. Follow-up:[JS11]

Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Charge Nurse, Nurse Manager, Medical Director or designated physician at appropriate intervals until acceptable skill level is achieved.

VI. Development and Approval of Standardized Procedures

A. Method of Development

Standardized procedures are developed collaboratively by the registered nurses, charge nurses, nurse managers, physicians and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval

All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee and the Joint Conference Committee prior to use.

C. Review Schedule

The standardized procedure will be reviewed every three years or as practice changes, by the registered nurses, nurse managers and medical directors.

D. Revisions

All changes or additions to the standardized procedures are to be approved by CIDP accompanied by the dated and signed approval sheet.

## ALLERGIC REACTION

### EXCLUSIONARY CRITERIA

- **Altered Mental Status**
- **Hypotension SBP < 90 or evidence of hypoperfusion**
- **Bronchospasm, stridor/ hoarseness (indicative of laryngeal edema)**
- **Swelling of hands/ lips/ tongue**

***\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate***

### I. DEFINITION

An allergic reaction is a hypersensitive state caused by an antigen-antibody reaction that releases histamine from the body's storage sites and results in a complex of characteristic conditions, which may include eczema, allergic rhinitis, bronchial asthma or urticarial/ hives. Anaphylaxis is a life threatening allergic reaction which may occur within seconds or minutes following exposure to a specific allergen.

### II. DATA COLLECTION

#### A. Subjective (History/Symptoms):

- History of exposure to known allergen
- Recent injection/ oral medication
- Itching/ rash/ hives
- Shortness of breath/ wheezing/ chest tightness
- Swelling of hands, lips, tongue
- Dizziness
- Palpitations
- Abdominal pain/ nausea/ diarrhea

#### B. Objective (Physical Assessment):

- Rule out any exclusionary criteria
- Document onset, duration, overall general appearance, note distress
- Vital Signs: BP/P/T/O2 Sat/RR rate/depth/quality
- Note: Rash/Hives, swelling of hands/lips/tongue, Stridor/ Hoarseness (indicative of laryngeal edema), wheezing, hypotension, weak thread pulse, pallor
- —

### III. ACTION PLAN

#### A. Intervention (Based on signs and/or symptoms):

##### 1. Mild symptoms<sup>[JS12]</sup>: (hHives, Rashrash, Allergic-allergic Rhinitisrhinitis)

- Diphenhydramine (Benadryl) 50 mg PO, then QID PRN x 2 days.
- Monitor Symptoms. If symptoms unresolved within 2 days, notify Primary Care Provider
- Document per site specific requirements
- Update patient's allergy record

##### 2. If in the course of care the patient develops mModerate to Ssevere symptoms: (Bronchospasmbronchospasm, aAltered Mmental Sstatus, Hypotension SBP<90, swelling of hands/ lips/ tongue, severe SOB, stridor/ hoarseness, severe SOB, altered mental status, hypotension SBP<90, airway difficulty)

- Activate EMS/ call 911
- Be prepared to initiate CPR
- Remain with patient until EMS arrive
- Continue to monitor VS
- Notify SFHOT medical director
- Notify Primary Care Provider
- Document per site specific requirements
- Update patient's allergy record

##### 2.3. If in the course of care the patient develops severe symptoms: (severe SOB, altered mental status, hypotension SBP<90, airway difficulty)

- In addition to steps above in #2, administer Epinephrine 0.3 mg IM x it has been prescribed for patient<sup>[BL14]</sup>
- Be prepared to initiate CPR
- Remain with patient until EMS arrive
- Continue to monitor VS
- Notify SFHOT medical director
- Notify Primary Care Provider
- Document per site specific requirements
- Update patient's allergy record

#### B. Patient Education (Health Promotion):

- Advise patient to avoid contact with known allergen
- Advise patient to notify medical staff when allergic reactions occur for prompt treatment
- Medication teaching if patient prescribed own Epi Pen

C. Follow-up (Re-evaluation):

- PRN
- Evaluate signs/ symptoms, refer to primary clinic if ~~condition~~ mild symptoms ~~does~~ not respond to treatment in 2 days

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

**ATHLETE'S FOOT/TINEA PEDIS**

**EXCLUSIONARY CRITERIA**

- **Edema or red streaking**
- **Purulent drainage**
- **Raw and bleeding areas**
- **Known allergies to any medications indicated in protocol**

***\*If any of the above conditions are present, refer to Urgent Care/  
Primary Care/ or EMS as appropriate***

I. DEFINITION

A superficial infection of the feet caused by fungi of the dermatophyte group. The fungi invade dead tissues of the skin, usually producing mild or no inflammation and creating scaly lesions with raised borders or maceration. A stronger immunologic reaction to the fungus causes itching, redness and/or erosion. The condition may be acute or chronic, usually affecting the interdigital web space and soles of the feet.

Contributing factors include tight, ill-fitting shoes, nonporous socks, sweaty feet, and walking barefoot in public showers or on damp floors.

Cellulitis and lymphangitis may be seen if bacterial superinfection occurs.

## II. DATA COLLECTION

### A. Subjective (History/Symptoms):

- Document onset duration, frequency of occurrences, and the nature of symptoms
- Document pertinent past medical history
- Self-care history

### B. Objective (Physical Assessment – wear gloves for examination<sup>[US15]</sup>):

- Rule out any exclusionary criteria
- Maceration between toes
- Mild erythema in affected areas
- Scaling and cracking of the skin
- Edema and erythema
- Difficulty walking
- Scaling thickening and cracking on the sole and heel that may extend over the side of the feet in a “moccasin” distribution
- Toenails may be brittle, discolored, and abnormally shaped.

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

- Foot soak/wash with soap and warm water.
- Clotrimazole cream 1%, apply sparingly to affected area BID x 2 weeks or anti-fungal foot powder apply to affected area BID x 2 weeks
- If any symptoms of secondary infection or if interdigital blistering – refer to MD/NP/[PA](#)
- Provide supplies as needed – foot soak basin and clean socks.

### B. Patient Education (Health Promotion):

- Wash feet daily and dry thoroughly between toes
- Vinegar soaks for 20-30 minutes (one cup vinegar to 2 quarts water)
- Expose feet to air whenever possible
- Wear clean dry socks (preferably white cotton), change as needed
- Wear properly fitting dry shoes
- Do not share footwear
- If patient has rubber thongs, they should be worn in shower areas
- Give patient education sheet on athlete's foot
- Give Foot Clinic referral sheet<sup>[US16]</sup>

### C. Follow-up (Re-evaluation):

- Return to clinic if pain, pus, or swelling develops
- Return to clinic if condition does not respond to treatment in 2 weeks
- Encourage/assist client in reconnection or referral to primary care.

#### IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

Pediculus corporis (**BODY LICE** (Pediculosis Corporis))

#### EXCLUSIONARY CRITERIA

- **Secondary bacterial infection**
- **Abnormal vital signs**
- **Constitutional**<sup>[JS17]</sup> **symptoms** (e.g. fever, chills, night sweats, weight loss)

*\*If any of the above conditions **are present**, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

#### I. DEFINITION

Body lice is an infestation caused by an insect. They feed on the blood of humans and live in the seams of clothing and bedding of the host. Their saliva can produce an intensely irritating small red popular rash in sensitized persons and later, wheals. If removed from the host, they can survive 8-10 days. Body lice are typically seen in people who have poor hygiene. Body lice can transmit Trench fever, **epidemic-t** Typhus and other diseases.

Body lice can infect their host with Bartonella also known as Trench Fever. Infection is often mild but in serious cases it can affect the whole body. Early signs are fever, fatigue, headache, poor appetite, and an unusual, streaked rash. Swollen glands are typical, especially around the head, neck and arms. Other symptoms may include gastritis, lower abdominal pain, sore soles, and tender subcutaneous nodules along the extremities. Lymph nodes may be enlarged and the throat can be sore.

## II. DATA COLLECTION

### A. Subjective (History/Symptoms):

- Has patient noticed insects in clothing or on skin
- Document onset, duration and nature of symptoms. Examples: itching and scratching, rash around waist, between shoulders, and buttocks, and blood spotted clothing or bedding.
- Ask client about constitutional symptoms
- Past history of body lice and treatment

### B. Objective (Physical Assessment – wear gloves for examination):

- Rule out any exclusionary criteria
- Document Vital Signs (BP/T/P/R)
- Assess for enlarged/tender lymph nodes
- Document presence of red macules, papules or papular urticaria with central hemorrhagic punctum noted on trunk, waist, between shoulder blades and buttocks.
- Look for nits and adult lice in the seams of clothes. Adults are grayish white. The males are 1/11” long and females are 1/6” long.

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

- MD/NP/PA consultation as necessary
- Refer client to urgent or primary care provider as appropriate should client present with secondary symptoms suspicious for Bartonella/Trench Fever.
- Assess mental health and substance use history

### B. Patient Education (Health Promotion):

- Assess clients access to shower/laundry and assist with plan as needed
- Instruct patient to shower with soap and water. Recommend he/she has a clean set of clothes and bedding afterwards.

- Instruct patient to wash clothing and bedding in hot water and dry on “high.” For clothes and bedding unable to be washed, store in plastic bag for 2 weeks before using again.
- Instruct patient to vacuum lice from couches, chairs, mattresses, carpets and rugs where applicable.
- Discourage patient from using commercial insecticides or “bombs” in living space

C. Follow-up (Re-evaluation):

- Return to clinic in 2 weeks if no improvement, or sooner if symptoms worsen
- Reconnect or refer to case manager, mental health, substance use treatment as appropriate
- Assess for need for IHSS to assist with ADLs
- Follow up on referrals to UC/PC
- Encourage/assist client in reconnection or referral to primary care.

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

COMMON COLD (Upper Respiratory Infection)

**EXCLUSIONARY CRITERIA**

- **Fever >100° F (38° C)**
- ~~Elevated blood pressure~~ **SBP<90 or DBP<60**
- ~~Elevated heart rate~~ **HR>120**
- ~~RR >24 and/or~~
- **O2 sat. on RA <96%**
- **Neck stiffness**
- **Exudate in throat and/or on tongue**
- **Abnormal breath sounds**
- **Swollen glands**
- **Ear pPain**
- **Sinus pain with purulent drainage**
- **Shortness of breath**
- **Uncontrolled asthma**
- **Cold symptoms for >7 days**
- **Untreated +PPD**

***If any of the above conditions are present, refer to Urgent Care/  
Primary Care/ or EMS as appropriate***

## I. DEFINITION

An acute, catarrhal respiratory tract infection, with major involvement in any of the airways, including the nose, paranasal passages, throat, larynx, and often the trachea and bronchi. A self-limited viral syndrome caused by any of the over 200 viruses which is managed symptomatically.

## II. DATA COLLECTION

### A. Subjective (History/Symptoms)

- Document onset, duration and nature of symptoms (sore throat, nasal congestion, rhinorrhea, sneezing, cough, nature of sputum, aches, pains, fever, chills, fatigue, headache, ear pain, shortness of breath).
- Document pertinent past medical history
- Self-care history

### B. Objective (Physical Assessment)

- **Rule out any exclusionary criteria**
- Document overall general appearance, note distress
- Document Vital Signs: BP/T/P/R (rate/depth/quality), O2 sat RA
- Note:
  - Red eyes
  - Tearing, discharge
  - Runny nose
  - Nasal congestion
  - Sneezing
  - Throat redness, swelling
  - Quality of cough
  - Auscultate chest
  - Palpate sinuses for pain

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

- MD/NP/PA consultation prn
- For nasal congestion/ sinus pressure:  
Phenylephrine HCL 10mg, 1 tablet every 6 hours x 2 days
  - Consult with Medical Provider for patients with HTN
  - Contra-indicated for patients also taking MAOIs
- For chest congestion/ cough:

Guaifenesin (expectorant)/ Dextromethorphan (cough suppressant) syrup (Robitussin DM, Mucinex DM) one adult dose (varies based on brand) every 4-6 hours x 2 days PRN cough. Note 24 hour dosing limits.

- For non-hacking coughs with thick mucus:  
Plain Guaifenesin (expectorant) cough syrup, one adult dose (varies based on brand) every 4-6 hours PRN cough. Note 24 hour dosing limits.
- For fever/ pain:  
Acetaminophen (Tylenol) 325 mg 1-2 tabs every 4-6 hours PRN x 2 days for fever/ pain. NTE 12 tablets (4 gm) in 24 hour period.
  - Consult medical provider for patients with liver disease
- Cepacol lozenges for sore throat
- Saline nasal spray
- Consider multi-vitamins and Vitamin C
- Assure that clients with aAsthma have meds/refills

B. Patient Education (Health Promotion):

- Medication instruction
- Use and disposal of tissues
- Wash hands frequently
- Cover mouth when coughing
- Steam inhalation and humidification
- Warm salt water gargle
- Rest as much as possible
- Increase fluids (limit alcohol and caffeine)
- Avoid sharing eating utensils
- Flu shot
- These medications can be dangerous, do not exceed recommended dosages
- For clients with Aasthma, review importance of adherence to medications and review asthma education.

C. Follow-up (Re-evaluation):

- Return to clinic in 1 week if no improvement, or sooner if signs and/or symptoms worsen or fever develops.
- Assist client with a plan should symptoms worsen based on their location and medical home
- Encourage/assist client in reconnection or referral to primary care.

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

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**CONSTIPATION**

### EXCLUSIONARY CRITERIA

- Severe abdominal pain with cramping, nausea, vomiting, and/or distention
- No BM x 24 hours after enema
- Fever
- Heart palpitations
- Vomiting with sediment of feces
- Absence of bowel sounds
- History of GI disease including Crohn's, Ulcerative Colitis

*※If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

#### I. DEFINITION

An abnormal infrequency of bowel movement, or the passage of hard, dry fecal matter. The normal frequency of bowel movements varies from 3/day to 2/week. Contributing factors to constipation are variable and include: lack of privacy, mobility impairment, inactivity, poor nutrition, dehydration, opioid use, anxiety, painful hemorrhoids, anal fissures, and recent anesthesia.

#### II. DATA COLLECTION

- Subjective (History/Symptoms):
  - Document frequency and consistency of stools, last bowel movement, abdominal pain, rectal pain and/ or bleeding, abdominal fullness (bloating), Flatulence, indigestion, vomiting, previous history of constipation, medical history, current medications that cause constipation including OTC meds.
- Objective (Physical Assessment):
  - Rule out any exclusionary criteria
  - Document general appearance, note distress
  - Vital Signs: BP/P/T/R
  - Abdominal Exam:
    - Symmetry
    - Abdominal distension
    - Presence or absence of bowel sounds in all four quadrants
    - Rigidity or tenderness

#### III. ACTION PLAN

A. Intervention (Based on signs and/or symptoms):

1. Mild Symptoms (complaints of constipation lasting < 2 days, normal VS, mild abdominal discomfort, no vomiting)

- [Psyllium](#) (e.g. [Metamucil](#)<sup>[US18]</sup>) 1-2 tsp in 8 oz water QD x 2 days
- Docusate Sodium (Colace) 250 mg, continue twice daily x 2 days if no BM
- Senna 8.6 mg 1-2 pills once at bedtime, continue x 2 days if no BM

OR

- Magnesium Hydroxide (osmotic-type laxative) 400 mg/5 mL, 30-60 mL PO at bedtime, continue x 2 days if no BM.
  - Take with at least 8 oz water
  - Used to treat occasional constipation, not indicated for long-term chronic use
  - Contra-indicated due to drug reactions with: doxycycline, ciprofloxacin, levofloxacin, raltegravir (Isentress), dolutegravir (Tivicay)
- Monitor symptoms. If symptoms unresolved or worsen in 2 days, notify primary care provider.
- Document per site specific requirements

2. Moderate- Severe Symptoms (severe abdominal pain with cramping, nausea, vomiting, and/or distention, no BM x 24 hours after enema, fever, heart palpitations, vomiting with sediment of feces, absence of bowel sounds)

- Refer to Urgent Care, Primary Care, or EMS as appropriate
- Notify Primary Care Provider
- Document per site specific requirements

B. Patient Education (Health Promotion):

- Encourage increase of PO fluids, adequate daily hydration
- Encourage increase nutritional fiber with fruits and vegetables
- Fiber supplements such as Metamucil can help regulate bowel movements

C. Follow-up (Re-evaluation):

- PRN
- Notify patient's Primary Care Provider if frequent symptoms (recurrence of constipation every 2-3 weeks)
- Confirm patients taking opiate pain medication are also prescribed stool softeners

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## DENTAL PAIN

### EXCLUSIONARY CRITERIA

- **Facial or Jaw Swelling**
- **Fevers**
- **Enlarged Lymph Nodes**

***\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate***

#### I. DEFINITION

Toothache - A painful tooth or an acute suppurative process of the periapical tissues often the result of dental abscess or trauma. Dental abscess may be dental or periodontal in origin. A normal appearing tooth may be the source of much pain, and a broken rotted tooth may be painless. Teeth with acute abscesses are generally extremely sensitive to the tap of an instrument. Complications of chronic abscess may include fistulas, cellulitis, and osteomyelitis.

#### II. DATA COLLECTION

##### A. Subjective (History/Symptoms):

- Duration and severity of symptoms
- Quality of pain (i.e., dull, throbbing continuous)
- Gingival or facial swelling
- Fever and/or chills
- Difficulty eating with sensitivity to hot/cold/sweet/pressure
- Bad taste in mouth
- Difficulty swallowing
- Allergies to medications

##### B. Objective (Physical Assessment):

- Rule out any exclusionary criteria
- Temperature
- Localized inflammation, intra-oral or facial swelling
- Loose teeth, broken teeth, or dental caries
- Foul breath
- Tenderness with percussion (tap tooth with a tongue blade)
- Drooling

III. ACTION PLAN

A. Intervention (Based on signs and/or symptoms):

1. No facial swelling, minimal discomfort and no elevated temp:
  - Give acetaminophen, 325 mg po qid x 3 days<sup>[US19]</sup>  
OR
  - Ibuprofen 200 mg, 2 tablets PO every 8 hours x 3 days. NTE 6 tablets (1.2 gm) in 24 hour period
    - Take with at least 8 oz water and with food to prevent upset stomach
    - Contraindicated in patients with history of GI ulcers/ GI bleeds.
    - Avoid alcohol while taking Ibuprofen
  - Dispense Oil of Clove and instruct to apply locally as needed
  - Refer client to dentist
2. ANY facial swelling and/or moderate pain:
  - Consult with on-call MD for your site  
Assist client in obtaining an urgent dental appointment/plan.
3. Facial swelling, difficulty swallowing or drooling, moderate to severe pain, or elevated temp:
  - Consult with on call MD for your site
  - Refer client to UC/ER as appropriate. Facial swelling can increase rapidly and may require IV antibiotics.

B. Patient Education (Health Promotion):

- Advise warm salt water mouth rinses prn.
- Take antibiotics as prescribed if ordered by dentist or clinician.
- Advise good oral hygiene, brushing (flossing and routine dental evaluations).
- Avoid extremes of hot and cold foods and liquids.
- Assist with plan should symptoms worsen, when to go to Urgent Care, Emergency room.

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## DIARRHEA

### EXCLUSIONARY CRITERIA

- **Altered Mental Status**
- **Vomiting**
- **Fever**
- **Blood in stool**
- **Evidence of severe dehydration (hypotensive, orthostatic hypotension, tachycardia, oliguria/ anuria, dry mucous membranes, decreased skin turgor)**

***\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate***

### I. DEFINITION

Increased volume, fluidity, or frequency of bowel movements relative to patient's usual pattern. Because the etiology of diarrhea is varied, it is important to look at the overall clinical picture before treatment is initiated. Diarrhea is oftentimes viral in cause. The most important goal of therapy is to prevent dehydration.

### II. DATA COLLECTION

#### A. Subjective (History/Symptoms):

- Document
  - Onset/ duration/ possible precipitating factors
  - Nature of stools (watery, bloody, etc)
  - Frequency
  - Cramping, Nausea, Vomiting
  - Incontinence
  - Fever
  - Past Medical History (including chronic medical conditions, substance use)

#### B. Objective (Physical Assessment)

- Rule out any exclusionary criteria
- Document Vital Signs

- BP, orthostatic BP, T, P, RR
- Note abdominal distension, increased tympany, abdominal pain
- Note hydration status (mucous membranes, skin turgor, infrequent or dark urine, sunken eyes, marked thirst)
- Urine Dipstick when able

### III. ACTION PLAN

#### A. Intervention (Based on signs and/or symptoms):

1. Mild Symptoms: (diarrhea lasting < 2 days, no observed blood in stool, normal vital signs, no vomiting)
  - Bismuth Subsalicylate (Pepto Bismol) PO 2 chewable tablets every ½ to 1 hour as needed. DNE 8 doses (16 tablets) in 24 hours. Use until diarrhea stops but not more than 2 days.  
Note: Pepto Bismol can darken stool and turn tongue black  
OR
  - Loperamide (Immodium) PO 2 caplets after 1<sup>st</sup> loose stool, 1 caplet after each subsequent loose stool, NTE 4 caplets in 24 hours
    - Contra-indicated if possible cause of diarrhea is Clostridium Difficile (C-Diff) occurring after recent (within last 4 weeks) antibiotic treatment. Treatment with Loperamide can actually worsen condition.
  - Monitor Symptoms x 2 days. If symptoms unresolved, notify Primary Care Provider
  - Document per site specific requirements
2. Moderate-Severe Symptoms: (watery stools lasting more than 2 days, altered mental status, vomiting, fever, blood in stool, evidence of severe dehydration: hypotensive, orthostatic hypotension, tachycardia, oliguria/ anuria, dry mucous membranes, decreased skin turgor)
  - Refer to Urgent Care, Primary Care, or EMS as appropriate
  - Notify Primary Care Provider
  - Document per site specific requirements

#### B. Patient Education (Health Promotion):

- Prevent Dehydration: Encourage increased PO Fluid Intake (avoiding coffee and other caffeinated beverages)
- Infection Control: proper hand washing for patient and staff
- Harm Reduction: decrease stimulant drug use[us20]

#### C. Follow-up (Re-evaluation):

- PRN

- Evaluate signs/ symptoms, refer to primary clinic if condition does not respond to treatment in 2 days

#### IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

### HAY FEVER / ALLERGIC RHINITIS

#### EXCLUSIONARY CRITERIA

- **Fever**
- **Wheezing, stridor, or diminished lung sounds**
- **Hypoxia**

*\*If any of the above conditions **are** present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

#### I. DEFINITION

Inflammation of the mucous membranes due to inhaled allergen causing symptoms of edema, nasal obstruction, rhinorrhea, cough, sore throat, sinus pressure, itchy/ watery eyes, itchy nose/ mouth/ throat, swollen/ blue color under eyes. Symptoms present without a fever, persists as long as exposure to allergen, and can be chronic, depending on cause.

#### II. DATA COLLECTION

##### C. Subjective (History/Symptoms):

- Document
  - Onset/ duration/ severity of symptoms
  - Past history of seasonal rhinitis
  - Concomitant symptoms **including**,

##### D. Objective (Physical Assessment)

- **Rule out any exclusionary criteria**
- Document Vital Signs
  - BP, T, P, RR, O2 sat
- Document general appearance/ distress
- Note: tearing/ affected eyes, rhinitis, sneezing, nasal congestion, throat redness
- Lung Sounds

#### III. ACTION PLAN

A. Intervention:

- Diphenhydramine (Benadryl) 25-50 mg PO every six hours, NTE 300 mg/ day for 2 days<sub>[JK21]</sub>
- Advise patient to avoid alcohol while taking diphenhydramine
- Document per site specific requirements

B. Patient Education (Health Promotion):

- Advise patient to increase PO fluid intake
- Advise patient to breathe humidified air by running hot shower in bathroom
- Advise patient to close windows and avoid outdoors on windy/ high pollen days
- Advise patient to keep personal space clean to reduce dust, pet hair and dander, and pests

C. Follow-up (Re-evaluation):

- PRN
- Evaluate for chronic condition not relieved with PRN medications and notify advise patient to address with Primary Care Provider

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## HEADACHE

### EXCLUSIONARY CRITERIA

- Recent head trauma
- Altered Mental Status
- Fever
- Sudden severe onset/ sudden severe onset stiff neck
- Sudden numbness/ weakness of face/ arm/ leg
- Sudden difficulty speaking
- Sudden loss of balance/ coordination, dizziness
- Sudden vision disturbances
- DBP > 120

*\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

### I. DEFINITION:

Headache is one of the most common of all symptoms and may occur either in the absence of organic pathology (EGe.g.: ~~for example~~ due to mild dehydration or caffeine withdrawal, secondary to nervous tension and anxiety), or as a manifestation of a serious illness (EGe.g.: ~~such as~~ extremely high blood pressure, meningitis, head trauma/ injury, CVA (stroke), glaucoma, and sinusitis.)

Migraine headaches are usually paroxysmal, ~~usually~~ unilateral, throbbing pain beginning around the eyes and spreading to the involved side of head and may be accompanied by anorexia, nausea, and vomiting.

### II. DATA COLLECTION

#### A. Subjective (History/Symptoms):

Document:

- Onset, nature, severity, and duration of symptoms
- Location, unilateral vs. bilateral, radiation
- Associated symptoms such as:

- Nausea/ Vomiting
- Photophobia/ visual disturbances
- Weakness/ numbness
- Fever
- Neck stiffness
- Dizziness
- History of headaches (diagnosis?), HTN, head trauma
- Nutritional assessment (has client eaten recently, PO fluid intake?)

B. Objective (Physical Assessment):

Document:

- Rule out any exclusionary criteria
- Vital signs BP/P/T/RR
- Mental status: alert, oriented, appropriate
- Eyes: tearing, redness
- Pupils: equal and reactive
- Head/neck/shoulders: tenderness, signs of trauma (neck: supple vs. stiff)
- Hand grips: equal in strength
- Gait/balance/coordination: normal

III. ACTION PLAN

A. Intervention (Based on signs and/or symptoms):

1. Mild symptoms: (headache with no exclusionary criteria)

- Acetaminophen (Tylenol) 325 mg 1-2 tabs PO every 4-6 hours PRN x 2 days for fever/ pain. NTE 12 tablets (4 gm) in 24 hour period
  - Consult medical provider for patients with liver disease
  - Avoid alcohol while taking Acetaminophen
- OR
- Ibuprofen 200 mg, 1-2 tablets PO now, and then 1-2 tablets every 4-6 hours PRN x 2 days. NTE 6 tablets (1.2 gm) in 24 hour period
  - Take with at least 8 oz water and with food to prevent upset stomach
  - Contraindicated in patients with history of GI ulcers/ GI bleeds.
  - Avoid alcohol while taking Ibuprofen
- Monitor Symptoms. If symptoms worsen or are unresolved within 2 days, notify Primary Care Provider
- Document per site specific requirements

2. Moderate to Severe symptoms: (s/sx consistent with CVA or meningitis, DBP > 120, recent head trauma/ injury)

- Activate EMS/ call 911
- Notify Primary Care Provider
- Document per site specific requirements

B. Patient Education (Health Promotion):

- Encourage adequate PO fluid and nutritional intake
- If migraine headache, advise against precipitating foods, encourage regular sleep patterns

- If tension type, encourage relaxation techniques

C. Follow-up (Re-evaluation):

- PRN

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

pediculosis capitis (**HEAD LICE**) (Pediculosis Capitis)

**EXCLUSIONARY CRITERIA**

- **Oozing crusting matted hair**
- **Secondary bacterial infection**
- **Regional lymphadenopathy**
- **Abnormal vital signs**

*\*If any of the above conditions **are** present, refer to Urgent Care/  
Primary Care/ or EMS as appropriate*

I. DEFINITION

The head louse is a small insect that feeds on the blood of humans. They infest the scalp of humans. They feed several times a day and reside close to the scalp to maintain body temperature. The saliva of lice can produce an intensely irritating maculopapular or urticarial rash in sensitized persons. The females cement their eggs (nits) on hair follicles, about 6 mm from scalp. The nits hatch in 1 week, so all nits must be removed for effective treatment. Head lice are spread from head to head by close contact, sharing hats, combs, clothing and bedding.

II. DATA COLLECTION

A. Subjective (History/Symptoms):

- Has patient seen lice or nits in their hair or close contacts hair
- Document onset, duration and nature of symptoms: itching and scratching of the scalp, neck, shoulders
- Document pertinent past medical history, including when/how treated last for head lice
- Self-care history
- Allergies

B. Objective (Physical Assessment – wear gloves for examination):

- Rule out any exclusionary criteria
- Document Vital Signs (BP/T/P/R)
- Look for nits cemented to the hair. They will not shake off like dandruff. Nits (eggs) are cylindrical grayish white and 1 mm long. Begin at the back of the neck and behind the ears. Lice may be on the scalp and range from 1-4 mm in length. You may have to inspect with a magnifying glass or bright light. Small sections of the hair (1" – 2" wide) should be examined.
  - Chronic scratching and rubbing can lead to eczema and lichen simplex chronicus. Excoriations, crusts and secondarily impetiginized lesions are common and may mask the presence of nits/lice.

### III. ACTION PLAN

#### A. Intervention (Based on signs and/or symptoms):

- MD/NP/PA consultation as necessary
- NIX, Permethrin Cream Rinse 1%

#### B. Patient Education (Health Promotion):

- Assess clients access to shower/laundry and assist with plan as needed
- Wash hair with shampoo. No conditioner should be in the shampoo or added after shampoo. Conditioners weaken NIX's effectiveness.
- Saturate the hair and scalp with the NIX. Apply behind ears and back of neck. Keep NIX out of eyes!
- Leave NIX on for 10 minutes. Rinse off with warm water. Do not wash hair 1-2 days after treatment.
- Remove lice and nits by combing the hair with the special comb in the box. Start close to the scalp. Keep hair moist as you comb. Divide the hair into four sections. Clean comb completely as you go. Wipe the nits from the comb with a tissue and throw away the tissue in a sealed plastic bag. After combing, check the entire head for nits and repeat combing. Put on clean clothes.
- Instruct patient to wash clothing and bedding in hot water and dry on "high." For clothes and bedding unable to be washed, store in plastic bag for 2 weeks before using again.
- Instruct patient to vacuum lice from couches, chairs, mattresses, carpets and rugs where applicable.
- Teach client to inspect other household members and give extra Nix as needed
- If combing out nits is undoable for client due to hair quality (dreads, matted hair, extremely long thick hair) then discuss cutting hair.
- Assist client when possible with outside support (inquire about free low cost haircuts, lice removal services) or established care giver such as IHSS worker.

#### C. Follow-up (Re-evaluation):

- If some live lice are found moving slowly 8-12 hours after treatment, do not treat. Comb dead and remaining lice out of hair. If there are no dead lice or lice are moving actively, a different treatment is needed. Refer to Medical Provider.
- Return to clinic 7-10 days for re check

- If live lice are seen 7-10 days after treatment, return to nurse clinic weekly after treatment for 3 weeks until all lice and nits are gone.
- Encourage/assist client in reconnection or referral to primary care

#### IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

### IMPACTED CERUMEN

#### EXCLUSIONARY CRITERIA

- **Ear Pain**
- **History of TM rupture**
- **Current ear tubes**
- **Fever**
- **Regional lymphadenopathy**

#### I. DEFINITION

A mixture of sebum from sebaceous glands and from apocrine sweat glands produced in the ear canal. The purpose of cerumen (ear wax) is unknown, but is suspected to be to carry foreign matter away from the tympanic membrane and avoid damage to that area. Excess or impacted cerumen can press against the eardrum and/or occlude (block) the external auditory canal potentially hindering hearing.

#### II. DATA COLLECTION

##### A. Subjective (History/Symptoms):

- A feeling of fullness in the ear
- Pain in the ear
- Difficulty hearing, which may continue to worsen
- Ringing in the ear (tinnitus)
- A feeling of itchiness in the ear
- Discharge from the ear
- Odor coming from the ear
- Dizziness
- Self-care history
- Past history of ear irrigations
- Past history of ear infections or ruptured TM

##### B. Objective:

- Rule out any exclusionary criteria

- Observed soft, yellow wax or a drier, black and brown wax on the outer surface of the external auditory canal.
- Noticed hearing impairment.
- Visible drainage or redness
- Assess for regional lymphadenopathy
- Check temperature

### III. ACTION PLAN

Excessive cerumen production does not equal impaction. If any portion of the eardrum can be visualized or if there is no hearing impairment or discomfort, there is no need to be aggressive about cerumen removal.

#### A. Intervention (Based on signs and/or symptoms):

- Debrox (Carbamide Peroxide) 5-10 gtt to affected ear 1-2 times daily for up to 4 days. Mineral Oil may also be used in place of Carbamide Peroxide
  - If no improvement client should return to clinic for re assessment and ear irrigation as indicated.
- **Ear irrigation: Do not irrigate an ear with an ear tube in place or an ear where there is any suspicion of ear drum perforation (e.g., draining ear).**
- Explain the procedure to the client
- Place client in either a sitting or lying position with the head tilted slightly toward the affected side and drape using chux pad or towels. Have client hold a container (kidney/emesis basin) under the ear to catch the liquid and expelled cerumen for examination.
- Using a 20cc syringe attach the plastic sheath of an angio catheter (**remove needle before attaching to syringe**) cut tip down to a 1/4#. An 18g or 20g works best. Draw up warm water (95-105 degrees F.). Test temperature on the inner aspect of your wrist before proceeding. Gently irrigate the ear observing basin for loose cerumen. May repeat as tolerated visualizing canal with otoscope in between irrigations.
- Stop procedure and refer to Urgent Care Provider for evaluation if:
  - Client complains of pain
  - Ear canal is inflamed or TM is perforated
  - After cerumen is removed TM is perforated or there are s/s of infection
  - Unable to remove impaction after several attempts

#### B. Patient Education (Health Promotion):

- Wax often loosens after carbamide peroxide usage and drains self after a warm shower. If hearing, discomfort improves there is no need to irrigate.
- If client plans on irrigating self at home using a bulb syringe (ear kits can be purchased over the counter) Teach proper safe usage.
- Instruct to clean the ears properly, preferably with a washcloth.
- Instruct not to insert Q-tips or other objects in ears; explain that this can cause impaction or injury.
- Offer reassurance that cerumen production is a normal process.
- Excessive cerumen production does not equal impaction. If any portion of the eardrum can be visualized or if there is no hearing impairment or discomfort, there is no need to

be aggressive about cerumen removal.

C. Follow-up (Re-evaluation):

- Return to clinic for reevaluation as needed
- Go to an Urgent Care clinic for pain, increased hearing loss, swelling or fevers after treatment

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

**PAINFUL MENSTRUAL CRAMPS (DYSMENORRHEA)**

**EXCLUSIONARY CRITERIA**<sup>[MOU22]</sup>

- **Hemodynamic instability (Orthostatic hypotension)**
- **Abnormally heavy bleeding**<sup>[US23]</sup> **that is atypical for the patient or saturating 2 pads per hour for more than 2 consecutive hours**<sup>[MOU24]</sup>
- **Fever**
- **Possibility of pregnancy**

*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

I. DEFINITION

Dysmenorrhea refers to painful, crampy lower abdominal pain that is recurrent and occurs during menses in the absence of other diseases that could account for these symptoms<sup>[MOU25]</sup>.

II. DATA COLLECTION

A. Subjective (History/Symptoms):

Document onset/ duration/ severity of symptoms

- Assess for symptoms of anemia
- Date of last menstrual period and past history of dysmenorrhea, fibroids, or other gynecological problems
- Concomitant symptoms including nausea, vomiting, diarrhea, headache, dizziness
- Sexual history including assessment for risk of STI, recent intercourse and contraception if used

B. Objective (Physical Assessment)

- Rule out any exclusionary criteria
- Document Vital Signs  
-BP, T, P, RR  
Urine pregnancy test
- Document general appearance/ distress

### III. ACTION PLAN

#### A. Intervention:

- Ibuprofen 600 mg PO, with food, three times daily for three days[MOU26]. As an alternative or in addition to ibuprofen, patients may take 1000mg acetaminophen PO three times daily for 3 days.
- Monitor Symptoms x 2 days.
- Document per site specific requirements

#### B. Patient Education (Health Promotion):

- Encourage avoidance of caffeine, alcohol, and nicotine[MOU27]
- Recommend patient to increase physical activity (vs.bedrest) prior to and during menses
- Advise patient to apply heat to abdomen with heat pad or hot bath or shower
- Refer for family planning counseling if patient is sexually active and interested in contraception

#### C. Follow-up (Re-evaluation):

- PRN
- Evaluate signs/ symptoms, refer to primary clinic if condition does not respond to treatment in 2 days

### IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## MENSTRUAL CRAMPS (DYSMENORRHEA)

### EXCLUSIONARY CRITERIA

- Hemodynamic instability (Orthostatic hypotension)
- Abnormally heavy bleeding
- Fever

*\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

#### I. DEFINITION

Painful menstruation is classified as either whether primary (excess prostaglandin production on ovulatory cycle) or secondary (associated with other conditions including endometriosis, fibroids, adenomyosis, PID, and IUDs). Often described as a dull ache or a sense of pressure in the lower abdomen that can be constant or intermittent. Ache may radiate to hips, lower back, and thighs.

#### II. DATA COLLECTION

##### A. Subjective (History/Symptoms):

- Document
- Onset/ duration/ severity of symptoms
- Date of last menstrual period and past history of dysmenorrhea, fibroids, or other gynecological problems
- Concomitant symptoms including nausea, vomiting, diarrhea, headache, dizziness

B. Objective (Physical Assessment)

- Rule out any exclusionary criteria
- Document Vital Signs
  - BP, T, P, RR
- Document general appearance/ distress

III. ACTION PLAN

A. Intervention:

- Ibuprofen 200-600 mg PO, twice daily PRN pain for three days.
- Monitor Symptoms x 2 days.
- Document per site specific requirements

B. Patient Education (Health Promotion):

- Advise patient to avoid caffeine, alcohol, and nicotine
- Advise patient to increase physical activity (vs. bedrest)
- Advise patient to apply heat to abdomen with heat pad or hot bath

C. Follow up (Re-evaluation):

- PRN
- Evaluate signs/ symptoms, refer to primary clinic if condition does not respond to treatment in 2 days

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## MUSCULOSKELETAL PAIN *†*(non-traumatic)

### EXCLUSIONARY CRITERIA

- Sudden onset severe/ debilitating pain
- Nausea/ Vomiting
- Flank pain
- Hematuria
- Tachycardia, elevated blood pressure, fever
- Recent trauma resulting in possible fracture/ head injury
- Chronic pain condition

*\*If any of the above conditions **are** present, refer to Urgent Care/  
Primary Care/ or EMS as appropriate*

### I. DEFINITION:

Muscle or joint pain sometimes with accompanying swelling, stiffness, inflammation, with no known precipitating traumatic cause. Pain may be due to osteoarthritis, undiagnosed infection, degenerative joint disease, obesity, positioning during sleep, gait, posture, and more.

### II. DATA COLLECTION

#### A. Subjective (History/Symptoms):

- Describe the pain in detail including characteristics of symptoms
  - Provoking factors: what improves the condition? What makes it worse?
  - Quality: Sharp, dull, cramping, etc

- **Region/ Radiation:** Where is the pain? Is it radiating? Where?
- **Severity:** Mild, Moderate, Severe? Use Pain Scale (1-10)
- **Time:** When did it start? Consistent or intermittent? Is it getting worse or better with time?

- Document **H**istory of similar problem
- Document any other concomitant symptoms, illness, or injury during past several weeks (e.g. sore throat, constipation, fall, etc.)
- Document history of chronic disease
- Document systemic symptoms such as fever, chills, malaise, insomnia, etc.
- Review current medications and adherence

B. Objective (Physical Assessment):

- Rule out any exclusionary criteria
- Document overall appearance, note distress
- Vital Signs: BP/P/T/Resp rate, depth, quality
- Note: posturing, guarding, use of affected area, tenderness, swelling, redness, pain with movement, range of motion, numbness, weakness

III. ACTION PLAN

A. Intervention (Based on signs and/or symptoms):

1. Mild-Moderate Symptoms: (Extremity, **J**oint, back pain and/ or stiffness, normal vital signs, and when patient does not appear ill or in distress)

- Rest, elevation, heat and/or ice to affected **extremityarea**
- Acetaminophen (Tylenol) 325 mg, 1-2 tablets **PO** now, and then 1-2 tablets **PO** every 4-6 hours PRN x 2 days. NTE 12 tablets (4 gm) in 24 hour period
  - Contraindicated in active ETOH use, HCV+, end-stage liver disease
  - Avoid alcohol while taking acetaminophen

OR

- Ibuprofen 200 mg, 1-2 tablets **PO** now, and then 1-2 tablets **PO** every 4-6 hours PRN x 2 days. NTE 6 tablets (1.2 gm) in 24 hour period
  - Take with at least 8 oz water and with food to prevent upset stomach
  - Contraindicated in patients with history of GI ulcers/ GI bleeds.
  - Avoid alcohol while taking ibuprofen

2. Severe Symptoms (Sudden onset, nausea/ vomiting, tachycardia, HTN, fever, debilitating pain, recent trauma resulting in possible fracture/ head injury)

- Refer to Urgent Care, Primary Care, or EMS as appropriate
- Notify Primary Care Provider
- Document in MAR and LCR with Nursing Progress Note

~~3. Low Back Pain: If UA chemstrip is positive for blood, leukocytes, or nitrites, refer to next Primary Clinic appointment within 24 hours or contact primary care provider~~

- ~~• Encourage client to increase PO fluids~~
- ~~• Document per site specific requirements~~

B. Patient Education (Health Promotion):

- Encourage increase in PO fluids
- Advise patient to rest affected area
- Teaching on proper body mechanics, supportive sleep positioning

C. Follow-up (Re-evaluation):

- PRN
- Notify Primary Care Provider if symptoms recur or appear to be chronic

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## SCABIES

### EXCLUSIONARY CRITERIA

- Abnormal vital signs
- Secondary bacterial infection
- Suspicion for Crusted (Norwegian) scabies\*

*\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate*

I. DEFINITION

Scabies is an infestation caused by a mite, usually spread by skin-to-skin contact including sexual contact. The mites burrow into the skin and deposit feces in tunnels. Puritis generally begins 21 days after first infestation, and 1-3 days after reinfestation. Skin lesions occur at the site of infestation from hypersensitivity to the mite, from scratching and from secondary infection.

**\*Crusted (Norwegian) scabies**

Crusted scabies is a severe form of scabies that can occur in some persons who are immunocompromised (have a weak immune system), elderly, disabled, or debilitated.

The condition is also called Norwegian scabies. Persons with crusted scabies have thick crusts of skin that contain large numbers of scabies mites and eggs. Persons with crusted

scabies are very contagious to other ~~s~~-persons and can spread the infestation ~~easily~~ both by direct skin-to-skin contact and by contamination of items such as their clothing, bedding, and furniture. Persons with crusted scabies may not show the usual~~ly~~ signs and symptoms of scabies such as the characteristic rash or itching (pruritus). Persons with crusted scabies should receive quick and aggressive medical treatment for their infestation to prevent outbreaks of scabies.

## II. DATA COLLECTION

### A. Subjective (History/Symptoms):

- Document onset, duration and nature of symptoms: intense itching, usually sparing the head and neck, often interfering with sleep. Rash occurs below the neck.
- Document when diagnosed and treated last for scabies.

### B. Objective (Physical Assessment – wear gloves for examination):

- Rule out any exclusionary criteria
- Document Vital Signs (BP/T/P/R)
- Document and look for gray or skin colored, wavy or linear lines in epidermis 5-10 mm ending in pearly blebs. These are most often found in interdigital webs of hand, wrists, shaft of penis, elbows, feet, genitalia, buttocks, waist and axilla. Rash from hypersensitivity can range from none ~~to urticarial papules to urticaria~~ ~~to eczema~~. Chronic scratching can cause atopic dermatitis or hyper/hypo-pigmentation.
- Assess for signs and symptoms of crusted scabies as described above.

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

- MD/NP/PA consultation as necessary
- Consult with Provider for all pregnant patients and children under 5
- Refer client to UC/ED if Norwegian/Crusted scabies are suspected
- Elimite 5% cream. Elimite cream is approved for ages 2 months and older. It is a Pregnancy category B drug and is used when clearly indicated to treat obvious scabies infestation.

### B. Patient Education (Health Promotion):

- Assess clients access to shower/laundry and assist with plan as needed
- Apply Elimite, 5% Permethrin cream from the neck down: under fingernails, toenails, around nail bed, between fingers and toes, cleft of buttocks, and genital area.
- Avoid contact with eyes. Flush immediately with water if Elimite gets in eyes.
- Leave cream on overnight 8-12 hours and remove the next morning by bathing and shampooing.
- Itching and mild burning or stinging may occur after application of Elimite Cream.

- Clean all clothes and bed linens used 2 days before treatment on hot cycle or remove from body contact for 72 hours.
- All contacts should be treated at the same time.
- Thorough cleaning of room or residence.
- You will not be contagious after one treatment if directions have been followed carefully, though rash and itching may persist up to 23 weeks after treatment.
- Rash or itching may persist up to 3-3 weeks after treatment<sup>[JS30]</sup>

C. Follow-up (Re-evaluation):

- If symptoms persist 21+ days after treatment, patient should be seen by Medical Provider, for possible retreatment.
- Encourage/assist client in reconnection or referral to primary care.

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

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## PHARYNGITIS SORE THROAT

### EXCLUSIONARY CRITERIA

- **Difficulty**~~y/~~unable to swallow
- **Respiratory** ~~-~~distress
- **Secretions, drooling**
- **Dysphonia or muffled voice**
- **Neck swelling**
- **Tonsillar exudate**

***\*If any of the above conditions are present, refer to Urgent Care/ Primary Care/ or EMS as appropriate***

I. DEFINITION

Sore throat, a symptom of acute pharyngitis (inflammation of throat), is one of the most common conditions encountered in outpatient practice. Sore throat may be described as discomfort, pain, burning, and/or scratchiness in back of throat, worse when swallowing. Sore throat can be caused by multiple pathogens including viruses (most common, including influenza, infectious mononucleosis, and herpes simplex) and bacteria (least common, including Group A Strep), as well as non-infectious causes (including allergies and smoking).

Sore throat is often accompanied with symptoms of fever, headache, malaise, lymphadenopathy (“swollen glands”), and other signs/ symptoms associated with upper respiratory infection (nasal congestion, cough, sinus pain).

## II. DATA COLLECTION

### A. Subjective (History/Symptoms):

Document:

- Onset, nature, severity, and duration of symptoms
- Associated symptoms such as:
  - Presence or absence of cough
  - Fever
  - Malaise
  - Nasal congestion
  - Sinus Pain

### B. Objective (Physical Assessment):

Document:

- Rule out any exclusionary criteria
- Overall appearance
- Vital signs BP/P/T/RR
- Presence or absence of tonsillar exudate (white or yellow coating on tonsils)
- Cervical adenopathy (swelling of lymph nodes around head/ neck)
- Medical history including increased risk for severe infection (poorly controlled diabetes, HIV+)

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

1. Low-risk symptoms: (sore throat without tonsillar exudate, may or may not be accompanied by signs and symptoms/sx of upper respiratory or influenza infection)

- Benzocaine/ Menthol (Cepacol) throat lozenges PO, PRN
- Acetaminophen (Tylenol) 325 mg 1-2 tabs every 4-6 hours PRN x 2 days for fever/ pain. NTE 12 tablets (4 gm) in 24 hour period
  - Consult medical provider for patients with liver disease
  - Avoid alcohol while taking Acetaminophen
- Monitor Ssymptoms. If symptoms unresolved within 2 days, refer to Urgent Care, Primary Care, or EMS as appropriate
- Notify Primary Care Provider
- Document in MAR and LCR with Nursing Progress Note

2. Moderate to sSevere symptoms: (Difficulty/inability swallowing, respiratory distress, secretions, drooling, dysphonia, neck swelling)

- Rapid Antigen Detection Test and/ or throat culture indicated to rule in/out Group A Strep when 2 or more of following symptoms present:

- tonsillar exudate
- tender anterior cervical adenopathy
- fever
- absence of cough
- Refer to Urgent Care, Primary Care, or EMS as appropriate
- Notify Primary Care Provider
- ~~Document in MAR and LCR with Nursing Progress Note~~

B. Patient Education (Health Promotion):

- Encourage adequate PO fluid and nutritional intake
- Wash hands frequently
- Cover mouth when coughing
- Steam inhalation and humidification
- Warm salt water gargles (do not swallow)
- Rest as much as possible
- Avoid sharing eating utensils
- Medication teaching

C. Follow-up (Re-evaluation):

- PRN

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

## SUTURE REMOVAL

### EXCLUSIONARY CRITERIA

- Signs of wound infection (redness, swelling, fever, drainage, tenderness).
- Concern regarding adequacy of healing.
- Request for suture removal earlier than prescribed
- Embedded Sutures
- ~~Post-surgical sutures when surgery follow up is warranted~~

*If any of the above conditions are present, refer to Urgent Care/  
Primary Care/ or EMS as appropriate*

I. DEFINITION

~~Superficial sutures can easily be removed by an RN when appropriate. Drop in RN clinics is a very convenient way for clients to have their sutures removed when~~

~~appropriate.~~ Sutures, depending on where on the body they are placed, have varying lengths of time appropriate for removal:

- Face 4-5 days
- Scalp 7 days
- Arms/Hands 7 days
- Legs/Feet 10-14 days
- Joints (extensor surface) 14 days

## II. DATA COLLECTION

### A. Subjective (History/Symptoms):

- Why sutures were placed
- When they were placed
- Where they were placed
- How many were placed (if client knows)
- Instructions given to client for follow up by provider at time of placement

### B. Objective:

- Rule out any exclusionary criteria
- Signs and symptoms of infection
- Adequacy of healing
- Can sutures be easily removed (broken, hard to visualize, embedded)

## III. ACTION PLAN

### A. Intervention (Based on signs and/or symptoms):

#### **Removing Sutures:**

- Cleanse wound with warm water or saline and gauze to remove any encrusted blood and loosened scar tissue.
- Use suture removal kit: ~~t~~ Tweezers are used to pick up the knot of each suture, and then the surgical scissors are used to cut the suture. Tweezers are then used again to remove the loosened suture and pull the thread from the skin.
- If wound is closed appropriately then continue until the sutures have all been removed.
- Cleanse wound again using warm water/mild soap
- Allow wound to dry thoroughly
- Apply adhesive strips (Steri-Strips, butterfly adhesives) over the wound to ~~allow the wound to continue strengthening.~~ encourage continued healing.
  - **If the wound dehisces during or after suture removal, apply butterfly adhesive strips or Steri-Strips to approximate and support the edges, refer to Urgent Care for provider evaluation.**
  - **If unsure if all sutures have been removed or if unable to remove all, refer to Urgent Care for provider evaluation.**

### B. Patient Education (Health Promotion):

- Wound care after suture removal is just as important as it was prior to removal of the stitches. Take good care of the wound so it will heal and not scar.
- Keep adhesive strips on the wound for about 5 days. Then soak them for removal. Do not peel them off.
- Continue to keep the wound clean and dry.
- Skin regains tensile strength slowly. At the time of suture removal, the wound has only regained about 5%-10% of its strength. Therefore, protect the wound from injury during the next month.
- Injured tissue also requires additional protection from sun's damaging ultraviolet rays for the next several months. The use of sunscreen during this period of healing is well advised for those areas that are exposed.
- The use of vitamin E topically has also been suggested to be helpful in the healing process of the damaged skin. This should only be considered once the skin edges are healed and are closed together.

C. Follow-up (Re-evaluation):

- Follow up with provider as appropriate
- Return to clinic for reevaluation/wound care as needed.

IV. RECORD KEEPING

All records relevant to patient care will be recorded in the appropriate electronic health records.

Image source: <https://www.phhealthcare.org/data/uploads/media/image/CHNA-ART-2.jpg?w=640>