



NURSING PROTOCOLS

May 1, 2005

Michelle Staples-Horne, M.D., M.P.H.
Medical Director

NURSING PROTOCOLS

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IV. Bibliography

Physician Acknowledgement of Nursing Protocols

The following nursing Protocols have been approved for use by nursing staff at all Department of Juvenile Justice YDCs and RYDCs as of May 1, 2005.



Michelle Staples-Horne, MD, MPH
Medical Director

As the local facility responsible physician, I have read and approved the Georgia Department of Juvenile Justice Nursing Protocols for use by nursing staff at the

(YDC OR RYDC NAME)

Facility Responsible Physician

Name _____

Signature _____

Date _____

Additional Facility Physicians

Name _____

Signature _____

Date _____

Name _____

Signature _____

Date _____

NURSING PROTOCOL REVIEW

Physician _____ Date _____

GUIDELINES FOR USE OF NURSING PROTOCOLS

Nursing Protocols are guidelines approved by the Medical Director to assist nursing personnel in the assessment of common health conditions and the implementation of health care. The treatment may be education of the youth in self-care, the initiation of approved over-the-counter medications and the initiation of emergency first aid care.

1. The Medical Director will approve all treatment protocols before implementation. Each protocol will be signed and dated by the Medical Director.
2. The Medical Director will review protocols and make needed revisions at least annually. Each protocol will be signed and dated to reflect the review and revisions.
3. The use of approved over-the-counter medications may be utilized in the Treatment protocols. Standing medical orders will not be utilized.
4. Emergency Nursing Protocols guide the nurse in providing care until the physician or emergency medical system responds. The physician must be contacted each time an emergency protocol is used. Prescription medications must receive telephone or verbal approval and be documented on the Physician Order sheet with a counter-signature.
5. Referral to the physician may involve immediate referral to the physician, telephone contact with the physician or scheduling the youth to see the physician.
6. If a youth has been seen more than two times with the same complaint and has not been a physician, he/she will be scheduled to see the physician.
7. The nursing staff will be familiar with the approved Nursing Protocols and will treat the youth presenting with the signs of symptoms of specific conditions as listed in the Subjective section of the Nursing Protocols. All treatment provided will be in strict accordance to the approved protocol.
8. The nursing staff will utilize the SOAP format documenting the Subjective complaint, Objective findings, Assessment and impression and Plan given in the youth's Medical Record. The health care practitioner will review the nursing treatment given as part of the ongoing Quality Improvement Program. (Any prescription medications ordered and administered must be counter-signed by the physician.)
9. Over-the-counter (OTC) medication will be documented in the inmate Health Record as part of the Plan. The Medication Administration Record will be used to document any OTC medication that must be dose-by-dose administered to the youth.
10. Drug allergies must be carefully documented and any drug a youth is allergic to should never be administered to that youth.
11. The youth's Health Record must always be reviewed when treating by these protocols.
12. The appropriate use of treatment protocols will be monitored as part of the Quality Improvement Program on a quarterly basis.
13. Youth education will be provided according to the approved Youth Education Sheet that follows each Nursing Protocol. The Youth Education includes pertinent information for self-care and follow-up. It is recommended that the youth receive a printed copy of the appropriate Youth Educational material.

GUIDELINES FOR USE OF NURSING PROTOCOLS

A. Purpose:

Protocols represent a standard of care to be provided to youths in a given situation. The protocol describes an intervention or set of interventions, provides structure for youth care and justification for action.

B. Rationale:

1. Protocols represent a standard of care.
2. Protocols are developed and approved by the disciplines involved in adhering to that standard of care.
3. Protocols recognize that there may be several methods of intervening with the youth in the same or similar situation, and therefore identify the method to be used within a given organization.
4. Protocols will be reviewed and updated annually.
5. Protocols pull together facts and information about specific health problems and, thereby, facilitate the nurse's ability to draw logical conclusions about how to assess, manage and follow-up a particular problem.
6. Protocols are plans or guides to action in the management of clinical problems.
7. Protocols are guidelines for collecting data, making an assessment and planning what action to take in response to a specific youth problem. They are based on the nursing process: assessment, planning, implementation and evaluation.
8. Protocols relate to a specific presenting problem or diagnosis and they include some form of logic, which individualizes the data collected from each youth.
9. The Assessment section of the SOAP note is the nursing diagnosis. The nurse should include with the nursing diagnosis the condition/symptom(s) that supports the nursing diagnosis.

Protocol #1

ABDOMINAL PAIN

I. Definition

A persistent complaint of pain in the abdominal region, which is a frequent problem in young adults and is usually related to tension and anxiety in time of stress. In most cases of recurrent abdominal pain in adolescents/children, no organic pathology is found.

II. Etiology

- A. Non-organize or psychosomatic
- B. Irritable bowel syndrome

III. Clinical Manifestations

A. Subjective

1. Student states, "My stomach hurts."
 - a. Complains of pain
 - b. Complains of sleep interruption
2. Record the reports of the following data:
 - a. Description of pain
 - b. Pain in relationship to foods, exercise, bowel movements
 - c. Family history of abdominal pain
 - d. Current stresses
 - e. Stool pattern and diet habits
 - f. History of prescribed and non-prescribed drug use
3. Record the pain characteristics as reported by student
 - a. Location, e.g. periumbilical; upper or lower quadrant; etc.
 - b. Radiation
 - c. Duration; pain lasts less than 3 hours
 - d. Relationship to eating, bowel movements, physical activity; etc.
 - e. Description; e.g. cramping, dull, sharp, etc.
4. Record associated symptoms as reported by student:
 - a. Vomiting
 - b. Headaches
 - c. Fatigue
 - d. Dizziness
 - e. Diarrhea
 - f. Menstrual history for females

Abdominal pain (cont'd)

B. Objective

1. Physical Exam
 - a. Vital signs
 - b. Bowel sounds
 - c. Palpation; tender, soft, rigid, etc.
 - d. Hepatosplenomegaly
 - e. Abdominal Masses
 - f. Perianal, Rectal exam: refer if needed
 - g. Pelvic Exam: refer if needed

2. Laboratory test, as requested by physician
 - a. CBC with differential
 - b. Urinalysis/ urine culture
 - c. GC/Chlamydia test/Wet mount
 - d. Stool for occult blood/stool culture
 - e. Blood Chemistry
 - f. Pregnancy test

C. Assessment

1. Acute pain related to:
 - a. Recurrent abdominal pain
 - b. Lactose intolerance
 - c. Abdominal wall injury
 - d. Peptic ulcer disease
 - e. Inflammatory bowel disease
 - f. Hepatitis
 - g. Mononucleosis
 - h. Pregnancy or ectopic pregnancy
 - i. Urinary tract infection
 - j. Pelvic inflammatory disease
 - k. Chronic constipation
 - l. Acute appendicitis
2. Activity intolerance related to acute abdominal pain.
3. Sleep pattern disturbance may be related to acute abdominal pain.

D. Plan

1. Consult/Refer to physician for:
 - a. Severe abdominal pain or tenderness with (1) rigidity (2) rebound tenderness
 - b. Presence of blood in stool
 - c. Prolonged vomiting/diarrhea
 - d. Severe anemia (HGB<8 gm/dl)
 - e. Pregnancy concerns or suspected ectopic pregnancy

- f. Other abnormal findings, including abnormal labwork
- 2. Revise diet as ordered
- 3. Therapeutic treatment for temporary relief of abdominal pain
 - 1. Pepto-Bismol, Maalox; Maalox Plus; Mintox; Mintox Plus
 - 2. May repeat above dose in 2 hours if no relief.
 - 3. If third dose in one day requested, refer to physician for evaluation.
 - 4. If unrelieved or daily pain, refer to physician for evaluation.

E. Education

- 1. Relationship of stress to GI distress
- 2. Stress reduction technique
- 3. Nutritional counseling regarding high fiber diet, gastrointestinal distress
- 4. Instruct student to return to the clinic if needed for evaluation of effectiveness of management or worsening symptoms.

F. Follow-up

- 1. As needed

STUDENT EDUCATION ABDOMINAL PAIN

There can be many causes of abdominal pain. Some may be medically related, so if you experience abdominal pain, you should put in a sick call for evaluation.

The most common cause of abdominal pain in young adults and adolescents is related to tension and anxiety in times of stress. Another common cause of abdominal pain is constipation. If you are unable to have a bowel movement in several days and are experiencing pain, you should put in a sick slip to alert the nurse and may possibly need a laxative.

To prevent constipation:

1. Drink plenty of fluids each day, especially water.
2. Eat food high in fiber such as oatmeal, vegetables, etc.
3. If possible, whenever you feel the need to have a bowel movement ask to use the restroom at that time.

If you experience abdominal pain and have other symptoms such as:

Vomiting
Nausea
Chills
Headache

you should alert your JCO to notify the nurse.

Protocol #2

ABRASIONS AND/OR LACERATIONS

I. Definition

Injuries to the skin which can be managed by the nurse are defined as abrasions and/or lacerations that:

- A. Are small and sufficiently clean so that edges can be easily approximated using Adhesives.
- B. Do NOT penetrate the subcutaneous tissue.
- C. Are NOT associated with functional disturbances, that is, not involving tendons, Ligaments, vessels, or nerves.
- D. Have NOT been made by a grossly contaminated object.

II. Etiology

Any of innumerable objects could abrade or sever skin.

III. Clinical Manifestations

A. Subjective

1. Student states, "I cut myself." or I scraped myself."
2. Record the reports of the following data:
 - a. Physical
 - b. Time of injury
 - c. How injury occurred and with what object
 - d. Symptoms of decreased motor or neurological function

B. Objective

1. Record presence or absence of following data:
 - a. Physician
 1. Location of wound
 2. Size of wound
 3. Depth of wound
 4. Extent of bleeding
 5. Contamination
 6. Erythema
 7. Heat
 8. Presence of exudate
2. Evaluate range of motion and neurological function distal to wound.

Abrasions/Lacerations (cont'd)

C. Assessment

1. Impaired skin integrity may be related to mechanical factors (i.e. Shearing forces, Restraint, trauma, or surgery).
2. Impaired tissue integrity may be related to mechanical or surgery.
3. Acute pain may be related to physical injury.

D. Plan

1. Consult/Refer to physician or emergency room:
 - a. Wound that requires suture (within 6 hours from time of injury)
 - b. Follow-up for suture removal at the clinic (may be done by nurse as physician orders).
 - c. Infected wounds
 - d. Fever, chills or evidence of systemic infection
 - e. Wounds associated with functional disturbance
 - f. Facial wounds
 - g. Bleeding cannot be easily controlled
2. Wounds that do not require sutures.
 - a. Clean with warm water and soap, or peroxide, making sure dirt and foreign bodies are removed.
 - b. Cover with loose bandage that will keep out dirt and protect wound from trauma.
 - c. May use steri-strips to hold edges together
 1. If there is inflammation, refer to physician
 2. Tetanus Prophylaxis is given according to immunization protocols.
 3. Reassess wound at 24 and 72 hours.

E. Education

1. Wound care
2. Need for tetanus
3. Regarding follow-up as indicated by the nature and type of wound
4. Regarding possible complication

F. Follow-up

1. As ordered by physician for suture removal.
2. As needed.

STUDENT EDUCATION
ABRASIONS

An abrasion occurs when the very top layer of skin is scraped away. You should avoid rubbing this area while it heals. In 2-3 days, a scab may form. This is normal healing. The scab should not be removed.

You should do the following things:

1. Wash the area gently with soap and water 1-2 times a day. Gently pat dry, don't rub. Protect the area from more injury.
2. Abrasions usually heal faster and better as they are left open to the air. If your abrasions is on a part of the body that clothing may rub against, or the abrasion could be injured, you may get a dressing. Keep the dressing dry, change it at least 2 times a day. Only use the Band-Aid for 1-2 days.

If you experience any of the following symptoms, you should return for sick call:

increased redness
increased swelling
pus formation
heat
red streaks
increased pain

STUDENT EDUCATION LACERATIONS

A laceration is a tear or cut of the skin. The area must be cleaned and the edges held together. Stitches or steri-strips (butterfly) can be used to hold a cut together while it heals.

If you have steri-strips (butterfly), you should do the following things:

1. Keep the steri-strips dry. They come off if they get wet.
2. If you have a dressing over the steri-strips, the nurses will change the dressing or teach you how to change it. Keep the dressing dry.
3. The steri-strips should stay on for at least 3-4 days. Don't pull them off. Put in a sick slip and the nurse will help you.

If you have stitches, you should do the following things:

1. 24 hours after you had your stitches put in, you may shower or gently wash the stitches, ONE time a day.
2. Stitches heal better if you don't cover them with ointment or dressings like Band-Aids. If you have a dressing, keep it dry. The nurse will change the dressing or teach you how to change it.
3. You will be called back to the clinic for the stitches to be removed.

Whether you have stitches or steri-strips (butterfly), you should return for sick call if you experience any of the following:

increased redness
increased swelling
pus formation
heat
red streaks
increased pain

Protocol #3

ACNE

I. Definition

Comedones (blackheads, whiteheads), pimples and tender red bumps on the face, chest, or back, or a combination of these. Usually occurs during puberty.

II. Etiology

Increased hormone activity causes the sebaceous glands of skin to secrete large amounts of sebum, the hair follicle opening becomes enlarged and plugged. Gradually, the sebaceous gland is destroyed and releases surrounding tissue resulting in an inflammatory reaction producing an acne nodule.

III. Clinical Manifestations

A. Subjective

1. Student states "I have pimples or bumps on my face."
2. Record the reports of the following data:
 - a. Lesions on face, back, chest; lesions may be tender.
 - b. Use of acne causing medications (corticosteroid, dilantin) or greasy cosmetics, or oils.
 - c. Underlying endocrinopathy (Cushing syndrome, Stein-Leventhal Syndrome)
 - d. Condition worsens during periods of stress and periods of menses.
 - e. Psychological distress
 - f. Diet is not thought to play a significant part of exacerbation of symptoms, but some students will attribute flare-ups to consumption of certain foods

B. Objective

1. Increasing number of blackheads, whiteheads, pimples and tender red bumps on face, chest or back is noted. Lesions may lead to pitted scars. One type of lesion may predominate or all may be present.
2. Classification of acne:
 - a. Grade 1: Comedones and papules
 - b. Grade 2: Comedones, papules and pustules
 - c. Grade 3: Comedones, papules, pustules and cysts
 - d. Grade 4: Grade 3 plus abscesses and communicating sinus tracts

Acne (cont'd)

C. Assessment

1. Acute pain related to open lesions.
2. Body image disturbance may be related to psychological distress caused by the Presence of facial lesions.
3. Knowledge deficit [learning need] may be related to lack of information on Personal hygiene.

D. Plan

1. Refer/Consult physician:
 - a. Grades 2,3 and 4
 - b. If no improvement from below regimen
2. Therapeutic nursing intervention:
Mild acne (Grade 1)
 - a. Benzoyl Peroxide Gel 5% or 10% (OTC)
 - b. If no improvement with above regimen, refer to physician.

E. Education

1. Use of topical treatments
2. Explain the cause and prolonged course of the condition and that treatment goals Are not for cure but for control. Discuss with the student proper skin cleansing and the rationale for keeping hands away from face. **DO NOT PICK AT LESIONS.**
3. Avoid greasy cleansing creams, oils and cosmetics.
4. Shampoo hair regularly. Style away from face.
5. Wash face regularly to remove oil film.
6. Expect outbreaks during menstrual periods and during episodes of emotional stress.
7. Avoid foods that may worsen the condition. Eat a well balanced diet.
8. Using rubbing alcohol does NOT help.

F. Follow-up

1. Student should be seen in four weeks to assess response or sooner if treatment Cannot be tolerated.
2. Student should return as needed on basis of severity of lesions and as ordered by the physician.

STUDENT EDUCATION
ACNE

Acne is a build-up of oil at hair roots and oil glands. Acne may be blackheads, whiteheads, or pimples. No one really knows why some people have acne and some people don't, but there are some factors that may cause acne to get worse. Some foods, hormones, stress and contact with irritating or oily substances may cause the breaking out to get worse. Acne starts during teenage years and usually gets better with age.

You should do the following things:

1. Wash your face and other area that breaks out at least 2-3 times a day. Use mild soap and don't rub hard.
2. **DO NOT SQUEEZE OR PICK THE PIMPLES.** This may cause them to get Worse or get infected.
3. Wash your hair at least 3 times a week and don't use oils or pomades on your hair.
4. If certain foods like chocolate candy, fried or greasy foods cause you to break out, don't eat them. Eat a well balanced diet.
5. Don't use any oily make-up or creams on your face.
6. Using rubbing alcohol **DOES NOT** help.
7. Acne takes a long time to clear up. Even when you are not breaking out, you should continue good skin care.
8. If your acne does not improve after doing these things for 4 weeks, put in a sick slip.

Protocol #4

AMENORRHEA

I. Definition

Absence or suppression of menstruation.

A. Primary Amenorrhea

1. No menstruation by 14 years of age and lack of growth or development of secondary sex characteristics.
2. No menstruation by 16 years of age with or without normal growth and development or appearance of secondary sex characteristics.

B. Secondary Amenorrhea

Absence of menstruation for 3 months or more in females who have had past menses.

C. Delayed Menarche (Physiologic DeLay)

Onset of menses between age 16 and 18.

II. Etiology

A. Abnormalities of reproductive tract (structural/genetic disorders)

B. Metabolic disorder

1. Obesity
2. Malnutrition
3. Diabetes

C. Systemic diseases

1. Syphilis
2. TB
3. Nephritis

D. Psychosomatic and neurogenic disorders

1. Excitement
2. Anorexia Nervosa (nutritional/psychological disorder)

E. Endocrine disorder involving

1. Ovaries
2. Pituitary gland
3. Thyroid gland
4. Adrenal gland

F. Hormone imbalance

G. Pregnancy

H. Medications

I. High aerobic exercise level

Amenorrhea (cont'd)

III. Clinical Manifestations

A. Subjective

1. Student states, "I haven't gotten my period yet."
2. Record student's report of any of the following:
 - a. Acute weight loss or gain
 - b. Mild to severe anxiety
 - c. Inability to handle daily routine without feeling stressed
 - d. Premenstrual symptoms on a cyclic basis
3. For secondary may report:
 - a. Past menstrual cycles, but no menses for at least three months
 - b. Signs and symptoms of pregnancy
 - c. Discharge of milk from breast
 - d. Abdominal pain
 - e. Mood changes
 - f. Fatigue
 - g. Headaches

B. Objective

1. Physical assessment
 - a. Primary
 - (1) Check body definitions and habitus (may be small or large for stated age)
 - (2) Check extent and distribution of hair
 - (3) Check breast development and secretions
 - (4) Pelvic exam may reveal such abnormalities as:
 - (a) Imperforate hymen
 - (b) Obliteration of vaginal orifice
 - (c) Lapses in continuity of canal
 - (d) Absent uterus or cervix
 - (e) Ovarian cyst or mass
 - (f) Uterus may be enlarged
 - b. Secondary
 - (1) Thyroid may be normal size or enlarged
 - (2) Vagina should be patent without defects

Amenorrhea (cont'd)

2. Laboratory tests (as ordered by physician or per protocol)
 - a. Serum HCG
 - b. Urine HCG

C. Assessment

Body Image, Disturbance may be related to

1. Biophysical (pregnancy)
2. Maturation changes not occurring (menses)

D. Plan

1. Refer/Consult physician:
 - a. All primary and secondary cases
 - b. Suspected pregnancy with or without positive serum/urine HCG
2. Therapeutic nursing intervention:
Per physician's orders

E. Education

See Student Education sheet (following page)

F. Follow-up

1. As recommended by physician
2. As needed

STUDENT EDUCATION
AMENORRHEA

NORMAL MENSTRUATION:

The first day of menstrual flow is day 1 of the cycle. The interval is 25-31 days for 65% of women, with a range of 18-40 days. Once it is established, it usually does not vary more than 5 days. The average duration is 3-7 days. The blood loss is usually the greatest on the second day.

You may not begin having menstrual cycles until the age of 16. If you do not have your period by the time you are 16, you may need to be evaluated by a physician.

AMENORRHEA:

Absence of menstruation either by lack of bleeding or stopping bleeding cycles.

If you normally have regular “periods” and you stop having them, you should see the doctor. There may be a number of causes for this.

Protocol #5

ANAPHYLAXIS

I Definition

A hypersensitivity reaction usually occurring within seconds to minutes after exposure to an antigen. The reaction ranges from mild, self-limited symptoms to rapid death.

II. Etiology

Agents commonly associated with anaphylaxis include the following:
(This list is not exhaustive.)

- A. Antibiotics (especially penicillin and its semisynthetic derivatives).
- B. Aspirin
- C. Hymenoptera stings (bee, yellow jacket, wasp, and hornet)
- D. Allergic extracts (skin-testing and treatment solutions)
- E. Foods (especially eggs, nuts, and shellfish)

Generally, agents administered parentally are more likely to result in life-threatening or fatal anaphylactic reactions than those ingested orally or administered topically to mucous membranes. Medications administered orally, such as aspirin or penicillin, however, has been associated with fatal reactions.

III. Clinical Manifestations

A. Subjective

1. Student states, "I'm itching and I can't breathe right."
2. Record student's complaint of any of the following:
 - a. Feeling of weakness
 - b. Itching
 - c. Difficulty breathing
 - d. Swelling of face and/or extremities
 - e. Flushing of skin

B. Objective

Assess for the following:

1. Diaphoresis
2. Erythemic Rash
3. Periorbital edema

Anaphylaxis (cont'd)

4. Laryngospasm
5. Drop in blood pressure
6. Weak pulse
7. Wheezing
8. Known allergen exposure

C. Assessment

1. Alteration in tissue perfusion related to hypoxia.
2. Ineffective airway clearance may be related to tracheobronchial obstruction.

D. Plan

1. Severe reaction
 - a. Call 911 IMMEDIATELY.
 - b. Students with known severe allergic reactions should have Epi-Pen prescribed by the physician. This contains Adrenaline (Epinephrine) 1:1000 in a already calibrated dose ready for injection. Inject immediately.
 - c. Lay student down and elevate legs.
 - d. Establish an airway and administer oxygen.
 - e. Record vital signs every five minutes until EMS arrives.
2. Mild reaction (Only itching of skin WITHOUT respiratory symptoms)
 1. Benadryl 5 mg/kg/24 hours, given Q.I.D.
 2. Calamine lotion to lesions on skin
 3. Record allergen in chart in "MEDICAL ALERT" style.

E. Education

1. Caution the student to avoid the allergen and if it is in food what to avoid.
2. If Epi-Pen is prescribed, instruct student on use.
3. Educate student of signs/symptoms to recognize allergic reaction.

F. Follow-up

1. Place allergy label on chart and all medication sheets.
2. Arrange student follow-up and education is directed by physician.

STUDENT EDUCATION
ANAPHYLAXIS

Anaphylaxis is an allergic reaction of the body to an allergen. This is something that you are allergic to. Symptoms can occur in seconds to minutes after you are exposed to the allergen. It can be very mild reaction to very serious reaction. If not properly treated, it can cause death.

The symptoms can be any of the following:

irritability
shortness of breath
seizures
fever (slight)
redness of skin
itching
rash
violent cough
chest tightness
loss of consciousness

If you begin experiencing any of these symptoms, alert your staff IMMEDIATELY.

If you know you have allergic reactions and have been seen by a doctor, the doctor may have prescribed you something called “Epi-pen”. This is an injection that someone can give themselves in case they begin having symptoms.

If you ever experience any difficulty breathing, you should notify your staff, who will in turn notify the nurse.

Protocol #6

ANEMIA

1. Definition

Anemia, in general, may be defined on the basis of a lowered hematocrit level.

<u>Age</u>	<u>Hemoglobin</u>
6 mos. – 23 mos.	Less than 10.3
2 – 5 years	Less than 11.3
6 – 8 years	Less than 12.3
Over 9 years	Less than 12.3

II. Etiology

- A. Impaired production of red blood cells and hemoglobin
 - 1. Nutritional Anemia
 - a. Iron deficiency
 - b. Megaloblastic anemia (Vitamin B12 deficiency)
 - 2. Anemia of Infection and Chronic Disease
 - a. Aplastic anemia
 - b. Hypoplastic anemia
- B. Accelerated destruction of red blood cells
 - 1. Extra corpuscular defects
 - a. Erythroblastosis fetalis
 - b. Auto-immune and drug induced hemolytic anemia
 - c. Abnormalities of the plasma or vasculature
 - d. Splenetic enlargement
 - 2. Intra-corporcular defects
 - a. Abnormalities of hemoglobin structure and synthesis (sickle cell thalassemia)
 - b. Abnormalities of red cell membrane
 - c. Abnormalities of red blood cell metabolism
 - 3. Blood loss

III. Clinical Manifestations

A. Subjective

- 1. Student states. "I feel tired all the time."
- 2. Record the students response when questioning about the following:
 - a. Dietary habits
 - b. Exposure to drugs
 - c. Recent infection or any chronic diseases
 - d. When symptoms began

Anemia (cont'd)

B. Objective

1. Physical examination
 - a. Pallor
 - b. Lethargy
 - c. Anorexia
 - d. Poor weight gain (record weight and height and compare to past records.)
 - e. Systolic flow murmurs
 - f. Splenomegaly
 - g. Enlarged lymph nodes
 - h. Petechia
2. Review labs that have been done

C. Assessment

1. Altered tissue perfusion related to reduction of red blood cells.
2. Activity intolerance may be related to imbalance between oxygen supply and demand.
3. Knowledge deficit [learning need] regarding condition and treatment needs related to inadequate knowledge of dietary needs.

D. Plan

1. Consult/Referral to physician
 - a. Hemoglobin less than 12%
 - b. History of normal hematocrit or hemoglobin in the past.
 - c. History of unexplained blood loss (i.e. red blood in stools/tarry stools)
 - d. History of siblings with anemia due to a cause other than iron deficiency.
 - e. Abnormality on physical exam not explained by an unrelated diagnosis.
 - f. Abnormal red blood cell morphology.
2. Nursing plan
Sickle cell screen and anemia labwork done on all students with Hemoglobin <12.

E. Education

Teach students of foods with good sources of iron

F. Follow-up

Have student return to the clinic after 1 month of iron therapy or as ordered by the physician.
Draw labs as ordered by the physician.

STUDENT EDUCATION
ANEMIA

Anemia is a condition in which there is a reduction in the number of red blood cells circulating in the blood. The red blood cell is important for carrying oxygen throughout the body.

Some symptoms of anemia are:

weakness
poor weight gain
dizziness
headache
sore tongue
drowsiness
shortness of breath
chest pain
slight fever

There are many different causes of anemia. It can be caused by blood loss from an acute or chronic hemorrhage. It also can be caused by a diet with poor intake of iron. Foods that are a good source of iron are:

liver
egg yolks
dried fruits
whole grain cereals
dark green leafy vegetables
beans
flour products

To be checked for anemia, you will be required to get a blood test. If you have been diagnosed, you may be required to have additional blood tests. You may be required to get iron supplements or injections.

Protocol #7

ANOREXIA NERVOSA (SUSPECTED)

I. Definition

A clinical syndrome (usually seen in females 12-21 years of age, but may occur in older women and men. It is usually characterized by fear of gaining weight and voluntary refusal to eat.

II. Etiology

Unknown. Probably a combination of Biologic, Physiologic, Familial, Environmental, Psychologic and Sociologic Factors. Biological vulnerability combined with family problems, low self esteem and emotional problems can combine in a social climate to produce the typical dieting patterns of anorexia.

III. Clinical Manifestations

A. Subjective

Record the presence of the following as reported by the student:

- a. Intense fear of becoming obese
- b. Disturbance of body image, "I feel fat"
- c. Preoccupation with food
- d. Restriction of food intake, "I only eat one meal a day".
- e. Constipation
- f. Disturbed sleep patterns
- g. Amenorrhea

B. Objective

1. Physical examination
 - a. Weight loss of at least 25% of original body weight, or if under 18 years old, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.
 - b. Amenorrhea
 - c. Aberrant behavior (Irritability, isolation/withdrawal, sleep disturbances, compulsive behavior.
 - d. Hyperacusis or optic hyperesthesia
 - e. Cachexia, emaciation, debilitation or dehydration, possible signs of shock or impending shock.
 - f. Skin changes (dryness, yellowish palms and soles, desquamation, and "dirty" appearance to skin)

Anorexia Nervosa (suspected) (cont'd)

- g. Scalp and pubic hair loss or lanugo hair or increased pigmented body hair.
 - h. Vital signs
 1. Hypothermia (Rectal temperature < 96.6 degrees F)
 2. Bradypnea (respiratory compensation for alkalosis)
 3. Bradycardia (decreased basal metabolic rate) (< 60 BPM)
 4. Hypotension (often < 80/50 mm Hg)
 - i. Heart murmur (infrequent) or arrhythmias (later finding).
 - i. Edema of lower extremities
2. Laboratory findings
- A. CBC
 1. Leukopenia
 2. Thrombocytopenia
 3. Anemia
 - B. Chemical profile
 1. Normal early in process
 2. Elevated BUN
 3. Elevated serum cholesterol

C. Assessment

1. Altered nutrition: less than body requirements related to decreased food intake.
2. High risk for fluid volume deficit related to decreased fluid intake.
3. Body image disturbance related to possible altered perception of body.

D. Plan

1. Refer all suspected eating disorders to the physician
2. Refer all abnormal labs to the physician.

E. Education

1. Alert all appropriate staff of medical prescriptive diet.
2. Listen – encourage ventilation.

F. Follow-up

1. As ordered by physician.
2. Daily or weekly weights as ordered by the physician.

STUDENT EDUCATION
ANOREXIA NERVOSA (SUSPECTED)

Anorexia nervosa is a disorder that is characterized by a disturbed sense of body image, large weight loss, mortal fear of obesity (becoming fat), and loss of menstrual cycle.

It is most common in females between the ages of 12 and 21 but may occur in older women and men.

Someone suffering from this disorder is always afraid of becoming overweight and might feel that they are overweight although they may not appear to be.

If left untreated, it can result in serious illness and death.

Protocol #8

ASTHMA

I. Definition

A lung disease characterized by airway obstruction that is reversible (but not completely in some), either spontaneously or with treatment, airway inflammation and increased airway responsiveness to a variety of stimuli.

II. Etiology

- A. Extrinsic asthma (caused by an allergen)
- B. Intrinsic asthma (Difficult to define clear causative agent, but factors thought to include colds, exercise, and emotional stress.)

III. Clinical Manifestations

A. Subjective

1. "I'm having an asthma attack, I can't breathe."
2. Record reports of any of the following by the student:
 - a. Cough
 - b. Dyspnea
 - c. Chest tightness
 - d. Vomiting following paroxysmal coughing
 - e. Abdominal pain associated with coughing
 - f. Family history of asthma

B. Objective

1. Assess the student for the absence or presence any of the following:
2. Prolonged expiration with expiratory, and occasionally, inspiratory wheezes.
3. Hyperresonant percussion note
4. Tachypnea
5. Sometimes, inspiratory and expiratory rhonchi and/or rates
6. Intercostal retractions
7. Use of accessory muscles of respiration
8. Pulse rate > 150
9. Fever, if infection is present
10. Sometimes with respiratory failure and decreased effort, less labored respirations and less audible wheezes.
11. Student breathes easier sitting
12. Level of consciousness, ability to talk without shortness of breath increasing
13. Obtain expiratory flow rate using Peak Flow Meter. Three measurements should be taken.

Asthma (cont'd)

C. Assessment

1. Ineffective airway clearance related to increased secretions and Bronchospasm.
2. Impaired gas exchange related to decreased oxygen intake on inspiration.
3. Anxiety may be related decreased oxygen supply and feeling of Impending death.

D. Plan

1. Consult/refer to physician
 - a. Failure of acute attack to respond to treatment
 - b. Persistent wheezing at follow-up
 - c. Peak Flow Meter Reading <200
2. Nursing interventions (Non-emergency)
The following should ONLY be initiated if the student is stable, has only scattered wheezes, has an inhaler prescribed and/or has NOT had a sick call evaluation for similar symptoms within the past week:
 - a. Assess vital signs and lung sounds.
 - b. Assess Peak Flow Meter Reading.
 - c. Initiate oxygen by cannula 2-3 L/min if shortness of breath is present.
 - d. Give student ordered inhaler to use (leave ordered inhaler in cottage for staff to keep in a secure place for student to use as needed.)
 - e. Assist student to a sitting position.
 - f. Carry out individual physician order, which may include nebulizer treatment and/or inhalant steroids.
 - g. If student's vital signs and P are not within normal limits, lungs are not clear and peak flow is <200 after above interventions, contact physician.

E. Education

1. What to avoid (allergen) and how to avoid them.
2. Use of inhaler (if prescribed)
3. Use of Peak Flow Meter

F. Follow-up

1. Individualized according to physician order
2. If wheezing returns
3. When student coughs up colored sputum

STUDENT EDUCATION
ASTHMA

An asthma attack is when your airway becomes blocked due to the air tubes getting smaller or the large amount of phlegm produced. This can make it harder for air to get in and out of your lungs. The closing of the airway causes the wheezing sound when you breathe.

Below is a list of things you should do:

1. Avoid things that may cause you to have an asthma attack. Those things may be:
 - A. Dust, pollens, Fumes
 - B. Too much exercise/Getting too tired
 - C. Breathing cold air
 - D. Medications such as aspirin and Motrin
 - E. Emotional stress
2. If you have been prescribed an inhaler by the doctor, be sure you use it correctly and only as often as you have been directed. Overuse of the inhaler can be very dangerous. (Attached is a sheet of instruction on how to use an inhaler.)
3. Take medications as directed at the correct times.
4. Drink plenty of water.
5. Practice breathing exercises to make your lungs stronger. Take slow, deep breaths through your mouth and blow out slowly through your lips several times a day.
6. Do not smoke. Smoking will make your asthma worse. Smoking can also cause other serious breathing problems and cancer.

You should return for sick call or alert the staff to contact the clinic if:

1. If you start wheezing
2. Have difficulty breathing and are not able to breathe better after using your inhaler.
3. You become sick with chills or cough up colored phlegm.

STUDENT EDUCATION
USING AN INHALER

1. PLACE THE ALUMINUM MEDICATION BOTTLE IN THE TOP OF THE MOUTHPIECE. TAKE THE CAP OFF OF THE MOUTHPIECE.
2. EXHALE FULLY THROUGH PURSED LIPS. HOLD THE INHALER UPSIDE DOWN WITH THE MOUTHPIECE FACING YOUR MOUTH. PLACE YOUR MOUTH AND TEETH LOOSELY AROUND THE MOUTHPIECE.
3. TILT YOUR HEAD BACK SLIGHTLY AND TAKE A SLOW DEEP BREATH. AT THE TIME YOU TAKE IN THE SLOW DEEP BREATH, PRESS THE ALUMINUM MEDICATION BOTTLE FIRMLY DOWN. MAKE SURE YOUR MOUTH IS AROUND THE MOUTHPIECE WITHOUT ANY GAPS. CONTINUE INHALING THE MEDICATION UNTIL YOUR LUNGS FEEL FULL.
4. TAKE THE MOUTHPIECE AWAY FROM YOUR MOUTH AND HOLD YOUR BREATH FOR SEVERAL SECONDS.
5. PURSE YOUR LIPS AND EXHALE SLOWLY. IF YOUR DOCTOR WANTS YOU TO TAKE MORE THAN ONE "PUFF", WAIT A FEW MINUTES AND THEN REPEAT STEPS 3 THROUGH 6. RINSE YOUR MOUTH OUT, GARGLE AND TAKE A FEW SIPS OF WATER.
6. REMEMBER TO CLEAN YOUR INHALER ONCE A DAY BY TAKING IT APART AND RINSING THE MOUTHPIECE AND CAP UNDER WARM RUNNING WATER FOR ONE MINUTE. SHAKE OFF THE EXCESS FLUID, ALLOW TO AIR DRY AND THEN REASSEMBLE IT.

Protocol #9

BACK PAIN (INJURY OR CHRONIC)

I. Definition

Any trauma or chronic pain involving neck or back.

II. Etiology

Same as above

III. Clinical Manifestations

A. Subjective

1. Student states, "My back hurts."
2. Complains of back discomfort with mobility, position change following injury.
3. Complains of pain radiating to arms or legs.

B. Objective

1. Asymmetry
2. Poor coordination and range of motion
3. Discoloration
4. Abnormal gait pattern

C. Assessment

1. Activity intolerance may be related to back pain/injury.
2. Sleep pattern disturbance may be related to back pain/injury.
3. Acute pain may be related to recent trauma.
4. Chronic pain may be related to past trauma.

D. Plan

1. Chronic pain
 - a. Refer/Consult physician:
 1. If pain is recurrent or if seen by nurse for same complaint more than twice.
 2. Severe pain and/or peripheral numbness.
 3. Pain with positive findings on assessment
 - b. Nursing interventions
 1. Ibuprofen 200 milligrams B.I.D. or T.I.D. for 5 days or Acetaminophen
 2. Restriction from activities for 2-5 days.

Back pain (cont'd)

3. Check compliance of activity restriction with cottage staff
4. Acute pain/injury
 - a. Do not move, bend or rotate neck of student.
 - b. Assess student's ability to move extremities slowly, and only a small amount.
 - c. Test response to stimuli such as finger touch or pin prick.
 - d. If sensation is intact, pain is minimal to absent, and student to slowly sit up and then walk.
 - e. If pain, sensory impairment, or weakness persist, have student remain lying down, stabilize head, CALL 911.

E. Education

1. Teach student to do warm up exercises prior to strenuous Activities.
2. Teach student how to pick up heavy objects correctly.
3. Assist student in a weight reduction if obese.

F. Follow-up

Return for sick call if discomfort prevents carrying out normal activities, or increased symptoms.

STUDENT EDUCATION
BACK PAIN (INJURY OR CHRONIC)

Almost everyone has had a backache. Your back has a tough job since it carries most your weight. The most common cause of backache is from muscles that have been sprained, strained, wrenched, pulled, or torn. Muscle problems are caused by overwork or exercise, bending or lifting something the wrong way, twisting the back, being overweight, falling or even sitting or standing the wrong way (poor posture).

The first two to three days after a backache occurs:

1. The most important thing to do is to avoid stress to your back. Do not play sports, lift heavy objects or bend over from the waist until your back has not hurt for a few days.
2. Use cold packs made by cold tap water on a towel as often as possible for the muscle spasms. If you have had backaches in the past the warmth works better than cold, then heat applications or warm showers may help.
3. For pain relief, you may request Tylenol or you may be given Ibuprofen by the nurse. You should take Ibuprofen with food.
4. If you are not any better in 2 days or if you get worse, return to sick call.
5. After your back does not hurt anymore, you should start to do gentle exercises to strengthen your back. Gradually begin these exercises and if you get pain at any time, stop the exercise. **REMEMBER TO START SLOWLY.**

STUDENT EDUCATION
BACK PAIN
EXERCISE

EXERCISE # 1:

1. Lie flat on floor, knees bent, feet flat on floor.
2. Arms may be at your sides or folded across your chest.
3. Raise your head, chest and shoulders off the floor.
4. Relax. Repeat

EXERCISE # 2:

1. Lie flat on your back, legs straight.
2. Grasp one knee and bring it as close to your chest as possible. Hold for a count of 10.
3. Relax, Repeat
4. For a more difficult exercise, draw both legs up at once.

STUDENT EDUCATION
BACK PAIN

SLEEP

Try to sleep on your side with your knees
Bent, or on your back. Never sleep on your
Stomach. The firm surface of your bunk is
Good for your back.

SIT

Sitting is hard on your back. Sit with your back
Pressed against the chair and feet flat on the floor.
Dangling legs put a strain on your back.

BEND

Always bend from the knees. Stooping over or
Bending from the waist is hard on your back.

SPORTS

Always warm and stretch your muscles before you
Exercise. Start easy and work your way up.
Remember to lift the right way.

BE TRIM

Extra pounds put extra strain on your back.

LIFT

Bend your knees and squat to lift or pick up anything.
Any object you are lifting should be close to your
Body. Let your legs do the work.

Protocol #10

BLISTERS

I. Definition

A collection of fluid below or within the epidermis.

II. Etiology

- A. Primary irritants
- B. Allergic contact dermatitis
- C. Physical trauma
- D. Sunburn
- E. Insect bites
- F. Viral infections

III. Clinical Manifestations

A. Subjective

Student states, "I have a blister on my foot, hand, etc."

B. Objective

- 1. Document size, appearance, and location of wound.
- 2. Take temperature, if signs of infection.
- 3. Check date of last tetanus, if blister (bullae) is open.

C. Assessment

- 1. Impaired skin integrity may be related to tissue trauma.
- 2. High risk for infection may be related to inadequate primary defenses
From traumatized tissue.

D. Plan

- 1. Refer/Consult physician:
 - a. If signs of infection are present.
 - b. If condition not responding to protocol
- 2. Nursing intervention:
 - a. Cleanse gently with mild antiseptic or soap and water. Take care not to break the blister.

Blisters (cont'd)

- b. Apply non-adhering dressing to area for protection.
- c. If open wound and last tetanus shot more than 5 years contact the physician for orders to administer tetanus.
- d. Send cottage a supply of non-adhering dressings (i.e. Band-Aids, etc.) for student to reapply after showering.
- e. Activity restrictions may be required.
- f. Monitor for proper fitting shoes.

E. Education

1. Keep the area clean and dry.
2. Protect the blister from rubbing by using Band-Aids or other dressing given.
3. Wash gently every day with soap and water.
4. Signs and symptoms of infection.

F. Follow-up

As needed for any of the following:

1. Increased redness
2. Increased swelling
3. Pus formation
4. Heat
5. Red streaks
6. Increased pain

STUDENT EDUCATION
BLISTERS

Blisters usually happen when your skin rubs against something over a period of time. You should not try to break a blister or pull the skin off. If the blister breaks open, you have a chance for infection.

The blister should heal in a few days if you do the following things:

1. Keep the area clean and dry.
2. Protect the blister from rubbing by using Band-Aids or other dressing you may be given.
3. If a blister is caused by shoes:

Try to wear clean socks
Remove shoes and socks whenever possible

4. Wash gently every day with soap and water.
5. The following are signs that infection may be starting:

increasing redness
increasing swelling
pus formation
heat
red streaks
increased pain

If you experience any of the symptoms listed, return for sick call.

Protocol #11

BOILS/FURUNCLE

I. Definition

Acute, tender, perifollicular inflammatory nodules resulting from infection by staphylococci.

II. Etiology

Same as above

III. Clinical Manifestations

A. Subjective

Student states, "I have a sore on me." (Usually on nose, neck, face, underarms, or buttocks.)

B. Objective

1. Tender nodule with boggy center, soft yellow or white head apparent.
2. Lesions bright red
3. Isolated single lesions or a few multiple lesions.
4. **Temperature**

C. Assessment

1. High risk for infection related to open lesion causing inadequate primary defenses.
2. Impaired skin integrity related to swelling of skin.
3. Acute pain may be related to swelling of skin and/or hair follicle.

D. Plan

1. Refer/Consult physician
 - a. Boils on face
 - b. Suspected cellulitis
 - c. Lymphangitis
 - d. Fever
 - e. Failure of lesions to resolve or recurrence.
2. Nursing intervention
 - a. Apply intermittent moist heat to area.

Boils (cont'd)

- b. Give antibiotics as prescribed by the physician.

E. Education

Instruct student to do the following:

1. Wash with soap and water twice a day. Pat the area dry.
2. Apply warm compresses for 15 minutes four times a day.
3. Expose area to air as much as possible.
4. NO NOT squeeze the area.
5. Do not use cosmetics or lotion in the area.
6. If area begins to drain or boil does not improve after 2 days, return for sick call.

F. Follow-up

Return to sick call if area begins to drain or if area does not open or resolve.

STUDENT EDUCATION
BOILS (FURUNCLE)

Boils are generally an inflamed hair follicle and usually occur in areas subject to rubbing and sweating, such as your nose, neck, face, underarm or buttocks. It is important to keep the area clean and dry.

You should do the following:

1. Wash with soap and water twice a day. Pat the area dry.
2. Apply warm compresses for 15 minutes four times a day.
3. Expose area to air as much as possible.
4. DO NOT squeeze the area.
5. Do not use cosmetics or lotion in the area.

If area begins to drain or boil does not improve after 2 days, return for sick call.

Protocol #12

BREAST MASS

I. Definition

A quantity of material, such as cells that unite or adhere to each other in the breast.

II. Etiology

The prevalence of breast carcinoma in the adolescent/child is extremely low. The most frequent type of benign tumor in the adolescent/child is fibroadenoma, which comprises 76-90% of benign lesions.

III. Clinical Manifestations

A. Subjective

Student states, "I have a knot on my chest."

B. Objective

1. Location of mass
2. Size of mass
3. Characteristics of mass (i.e. firm, mobile, smooth)

C. Assessment

1. Acute pain may be related to swelling of breast tissue.
2. Moderate anxiety related to threat of change in health status.

D. Plan

Refer/Consult physician

- a. Erythema
- b. Tenderness
- c. Bloody discharge from nipple
- d. An increase in size of mass
- e. Skin changes
- f. Mass present > 6 weeks

E. Education

Instruct student on how and when to do Breast Self Exams.

F. Follow-up

1. One month (or as ordered by physician) for re-check
2. Three months to ensure medical follow-up

STUDENT EDUCATION
BREAST MASS

We generally think of women when we think of breast cancer, but men can develop this as well. It can occur at any age.

The most effective way of dealing with this type of cancer is by early detection. Breast self-examination is one of the most effective and inexpensive methods available for the early detection of breast cancer.

You should follow the same procedure once a month about a week after your period. If you do not have periods, you should check them the same day each month. Below are instructions in breast self-examination:

DO THE FOLLOWING IN FRONT OF A MIRROR:

1. Inspect your breasts with arms at your sides.
2. Raise your arms overhead and look for changes in shape or contour of each breast, a swelling or dimpling of skin, or changes in the nipple.
3. Rest palms on hips and press down firmly to flex chest muscles to compare breasts for any dramatic differences (breasts usually do not match exactly).

DO THE FOLLOWING WHILE LYING DOWN

1. Lie down with a pillow under your right breast.
2. Completely feel all of the breast and chest area from the collarbone to bottom of a properly fitting bra.
3. Feel for lumps or changes using a rubbing motion (press firmly enough to feel the Different breast tissue.
4. Completely feel all of the breast and chest area from the collarbone to bottom of a Properly fitting bra.
5. Use a circular, oval, or vertical strip and wedge pattern to completely to cover breast Tissue.
6. Gently squeeze the nipple and look for a discharge.
7. Do left breast using the same method.

DO THE FOLLOWING WHILE IN THE SHOWER:

1. With fingers flat, move gently over every part of each breast.
2. Check for lumps, hard knots, or thickening.

Protocol #13

BRONCHITIS

I. Definition

An infectious inflammatory disease primarily of the bronchi characterized by one or more of these:

- A. Hyperemia of the bronchial mucosa
- B. Increased production of mucosa
- C. An inflammatory exudate of mucous and white blood cells

II. Etiology

- A. Viruses – most common cause
- B. Bacteria
 - 1. Streptococcus Pneumonia
 - 2. Hemophilus influenza
 - 3. Mycoplasma pneumonia

III. Clinical Manifestations

A. Subjective

- 1. Student states, “I’m having chest pain and I have been coughing.”
- 2. Record the presence of the following as reported by the student:
 - a. A history of URI
 - b. Exposure to respiratory irritants
 - c. History of cough
 - 1. Duration
 - 2. Frequency
 - 3. Past treatments and response to these treatments
 - 4. Presence/absence of sputum (color, amount, consistency)
 - 5. Wheezing
 - 6. Chest pain (usually substernal and aggravated by coughing)
 - 7. Dyspnea on exertion

B. Objective

- 1. Physical assessment
 - a. Cough presence
 - b. Sputum (Viral bronchitis rarely produces more than 2 tablespoons of mucopurulent sputum daily. Bacterial bronchitis produces purulent sputum. Amount often exceeds 2 tablespoon daily.)
 - c. Temperature usually > 101 degrees F orally.
 - d. Chest clear to percussion
 - e. Rhonchi or wheezing present
 - f. Scattered transient coarse rales may be present and disappear after coughing.
 - g. No Tachypnea at rest.

C. Assessment

1. Ineffective airway clearance related to thick mucous secretions.
2. Activity intolerance related to possible imbalance between oxygen supply and demand.
3. Acute pain related to persistent cough and aching from fever.

D. Plan

1. Refer/Consult physician
 - a. Suspected pneumonia (fever 101 degrees F orally, shaking chills, Toxic appearance)
 - b. Respiratory distress
 - c. Failure to improve in 48 hours

E. Education

1. When to report for sick call.
2. Take medications as prescribed.

F. Follow-up

Follow-up in 24 hours to assure student's condition is not worsening.

STUDENT EDUCATION
BRONCHITIS

Bronchitis is an inflammation of the mucous membranes and bronchial tubes leading to the lungs. It most commonly occurs in the winter and usually follows a cold.

The following are symptoms of bronchitis:

chilliness
slight fever
back and muscle pain
sore throat
weakness
cough
shortness of breath

If you experience a cough that does not go away, especially after a cold, you should return for sick call. If you experience any of the above symptoms, return for sick call.

If you are told you have bronchitis you should drink plenty of fluids and get plenty of rest.

Protocol #14

BULIMIA (SUSPECTED)

I. Definition

Bulimia is a neurotic disorder especially of your adolescents and young women characterized by bouts of overeating following by voluntary vomiting, fasting, or induced diarrhea.

II. Etiology

There is no single proven cause of bulimia. Some experts propose the etiology as physiologic or socio-cultural; others believe bulimia is a learned behavior for dealing with stress, anxiety, anger, and other unpleasant feeling.

III. Clinical Manifestations

A. Subjective

1. Student may present with depression, anxiety, despair, and suicidal Ideation.
2. Reports of student eating a large amount of food rapidly in a discrete Period of time.
3. Student may complain of bloating, diarrhea, and swelling.
4. Student may complain of muscle cramping.
5. Student may complain of abdominal pain.

B. Objective

1. Usually normal weight or mild to moderate obesity.
2. Frequent weight fluctuations > 10 pounds
3. Physical findings of extreme weight loss:
 - a. Loss of scalp hair, skin changes
 - b. Amenorrhea
 - c. Hypothermia
4. Dental enamel dysplasia and discoloration due to gastric juices (vomiting).
5. Bruises and lacerations of palate and posterior pharynx; lesions of fingernails, fingers, and dorsum of hand(s) trauma from self induced vomiting).
6. Pyorrhea and other gum disorders.
7. Diminished reflexes, muscle weakness.
8. Muscle cramping (induced hypoxia) Positive Trousseau's sign)

Bulimia (suspected) (cont'd)

9. Signs of hypokalemia:
 - a. Cardiac dysrhythmia
 - b. Hypotension
 - c. Decreased cardiac output
 - d. Weak pulse
 - e. Abdominal distention
 - f. Ileus
 - g. Shortness of breath

C. Assessment

1. Disturbance of body image related to perceived ideal body weight.
2. Acute pain related to overuse of laxatives causing abdominal cramping.
3. Fatigue related to not receiving inadequate nutrition.

D. Plan

1. Refer/Consult physician
2. Refer all suspected cases to physician

E. Education

1. Counsel student of ideal weight.
2. Reinforce keeping medical appointments.

F. Follow-up

As ordered by the physician

STUDENT EDUCATION
BULIMIA

Bulimia is a disorder that is characterized by episodes of eating large amounts of food when the person experiences a loss of control overeating and then causes themselves to vomit, use laxatives and/or undergoes a vigorous exercise program or diet. These people are over concerned about their body weight and body shape.

This usually afflicts females of upper to middle class status.

People suffering from bulimia that make themselves vomit can suffer from other problems, such as, erosion of dental enamel, esophagus inflammation or rupture.

This can also lead to death if left untreated.

If you feel that you are not the right weight, you should consult a nurse for a counseling on diet, instead of doing any of the things mentioned above.

Protocol #15

BURNS

I. Definitions

Tissue injury resulting from excessive exposure to thermal, chemical, electrical, or radioactive agents. Below are the different degrees of burns:

1. First Degree: Erythema only
2. Second Degree (Partial thickness): Blister formation with or without peeling and weeping.
3. Third Degree (Full thickness): Early, may have charred or whitish appearance and areas of anesthesia.

II. Etiology

Contact with any heat sources. For adolescents/children, one of the most common burns is sunburn, or burn from heat lamp or tanning machines. The degree of damage depends on the duration of exposure and source of heat. Scalds generally cause second-degree burns, whereas flame or hot metal may cause third degree burns.

III. Clinical Manifestations

A. Subjective

1. Student usually only complains of pain.
2. Record reports of the following:
 - a. Time of occurrence
 - b. Source of heat
 - c. Degree of pain (using a 1-10 scale)
 - d. Loss of nerve/motor function

B. Objective

1. Physical assessment
 - a. Time of occurrence
 - b. Source of heat
 - c. Degree of pain (using a 1-10 scale)
 - d. Loss of nerve/motor function

C. Assessment

1. High risk for fluid volume deficit related to capillary damage and evaporation.

Burns (cont'd)

2. High risk for infection related to loss of protective dermal barrier.
3. Acute pain related to destruction of tissue and nerves.
4. Impaired skin integrity related to tissue trauma.

D. Plan

1. Refer/Consult to physician or emergency room
 - a. All third degree burns
 - b. Second-degree burns that involve an area greater than 2 cm.
 - c. All facial burns.
 - d. All burns of the genital area.
 - e. Any suspicious abuse.
2. Therapeutic
 - a. First degree burns
 1. Apply ice to affected area for several minutes
 2. Clean gently with soap and water
 3. No dressings are necessary
 4. Remove rings, bracelets, or any constricting jewelry before swelling occurs.
 - b. Second degree burns (Equal or > 2 cm size not on face or hands)
 1. Apply ice to affected area for several minutes> If less than 45 minutes has elapsed since burn injury.
 2. Clean gently with soap and water.
 3. Leave blisters intact – do not apply ointments or attempt to break blisters or remove tissue.
 4. Cover loosely with sterile non-stick dressing.
 5. Refer for tetanus prophylaxis (If last tetanus > 5 years)
 6. Remove rings, bracelets, or any constricting jewelry before swelling occurs.
 7. Refer to physician.
 - c. Third degree burns
 1. Remove rings, bracelets, or any constricting jewelry before Swelling occurs.
 2. Do NOT apply cold water, cold compresses, ice packs or Ointments.
 3. Do NOT attempt to remove garments that are clinging to Area.

Burns (cont'd)

4. Cover area with sterile gauze or clean cloth or sterile burn Sheet.
5. Call 911
6. If legs or arms are burned, elevate them above the student's heart level.
7. Keep student warm, calm, and reassured.
8. If necessary, treat student for shock or administer CPR.

E. Education

1. Degree of burn
2. Care of burn (dressing changes)

F. Follow-up

As ordered by the physician

STUDENT EDUCATION **BURNS**

A burn is a tissue injury that happens when your skin comes into contact with thermal, electrical or chemical sources. They can range from minor to life threatening.

There are different types or degrees of burns:

1. First degree burn – results in reddened skin only.
2. Second degree burns – results in formation of blister with or without peeling and/or Drainage.
3. Third degree burns – when they first occur they may be charred (darkened) or whitish Appearance with loss of feeling.

A burn can affect the motor or neuralgic function at the area it occurs. This loss can be temporary or permanent.

A sunburn is considered a first-degree burn. It can be treated with burn gel or cream. Any other burn should be evaluated by a doctor.

Protocol #16

CALLUS

I. Definition

A superficial circumscribed area of hyperkeratosis at a site of repeated trauma.

II. Etiology

Calluses are usually caused by pressure or friction, usually over bony prominence.

III. Clinical Manifestations

A. Subjective

1. Student states, "I've got a sore on the bottom of my foot."
2. Record the following as reported by the student:
 - a. How long has the "sore" been present
 - b. What caused the "sore".

B. Objective

Physical assessment

- a. Size
- b. Appearance
- c. Location
- d. Temperature (if signs of infection)

C. Assessment

1. Impaired skin integrity may be related to trauma from shearing forces or Pressure.
2. Acute pain related to traumatized tissue.
3. High risk for infection may be related to traumatized tissue.

D. Plan

Refer/Consult physician:

1. If signs of infection are present.
2. Student is not responding to treatment or may require trimming.
3. Student is diabetic or has impaired circulation.

Callus (cont'd)

E. Education

1. Educate student of how calluses are formed.
2. NEVER pick at or cut a callus. This could cause infection.
3. Identify when shoes are ill fitting to prevent calluses.
4. Return for sick call if student notices the following signs:
 - a. Increased swelling
 - b. Increased redness
 - c. Pus formation
 - d. Area is warm to touch
 - e. Red streaks are present.
 - f. Increased pain

F. Follow-up

1. If not improved in 2 weeks
2. If signs of infection develop

STUDENT EDUCATION
CALLUS

A callus is a hardened layer of skin. It is caused by continued rubbing or pressure. A callus will usually get better if you do the following:

1. If the callus is on your hands, wear gloves when you work.
2. If the callus is on your feet, you should soak your feet in warm water 15-30 minutes 2 times a week and use plaster as directed.
3. After you soak your feet, rub the callus with your washcloth and put lotion on your feet. **DO NOT WALK AROUND BAREFOOT AFTER PUTTING LOTION ON YOUR FEET.**
4. **NEVER PICK AT OR CUT A CALLUS. THIS CAN CAUSE INFECTION.**
5. It may take several weeks for your callus to get better. If there is no improvement after 2 weeks, return to sick call.
6. The following are signs of infection, if you experience any of the symptoms, you should return for sick call:

increased redness
increased swelling
pus formation
heat
red streaks
increased pain

Protocol #17

CHANCROID

I. Definition

An acute, localized, contagious disease characterized by painful genital ulcers and Suppuration of the inguinal lymph nodes.

II. Etiology

The causative agent is Hemophilus ducrey, a gram-negative bacillus.

III. Clinical Manifestations

A. Subjective

1. Student states, "I've got a sore in my private area."

B. Objective

1. Physical assessment
 - a. Moderately shallow, painful, non-indurate pustular ulcer(s); Usually singular, but may not be multiple.
 - b. Ulcer is not hard and usually has a ragged edge.
 - c. Enlarged, painful inguinal nodes often with central fluctuance.

C. Assessment

1. Acute pain may be related to open lesions.
2. Knowledge deficit [learning need] related to transmission and prevention of transmission of this infection.

D. Plan

Refer/Consult physician:

All suspected/confirmed cases: to the county health department STD clinic for diagnosis and treatment.

E. Education

1. Cause of this infection
2. Prevention of this infection
3. Complications/consequences of STDs
4. Perineal hygiene, perianal hygiene, penile hygiene
5. Cotton-crotch undergarments, daily clean undergarments

F. Follow-up

As ordered by the physician and/or STD clinic

STUDENT EDUCATION
CHANCROID

A chancroid is a contagious disease that is seen as painful ulcers in the genital area. It usually takes 3-7 days after you are exposed to it before you begin getting symptoms.

The ulcers begin as small, painful sores that quickly break down to become flat ulcers with ragged edges. Each ulcer is surrounded by a reddish border. They may be different sizes. It can cause destruction of tissue around the area.

If you notice any sores or drainage around your genital area, you should go for sick call. If you do have a chancroid, you will have to be prescribed an antibiotic by the doctor and you should take all of the medication, even if the sores go away.

Chancroid lesions are spread by sexual contact with someone that has these lesions. Abstinence is the **ONLY** way to ensure that you will not get sexually transmitted diseases.

Protocol #18

CHEILITIS

I. Definition

Inflammation of the lip.

II. Etiology

Over-exposure to sun radiation, cold temperatures or wind.

III. Clinical Manifestations

A. Subjective

1. Student states, "My lips are chapped."
2. Student complains of painful, chapped and possibly bleeding lips.

B. Objective

Record the presence of the following:

- a. White hyperkeratosis
- b. Fissuring
- c. Erythema

C. Assessment

1. Acute pain related to open lesions on lips.
2. Knowledge deficit [learning need] related to prevention and treatment of cheilitis.

D. Plan

1. Refer/Consult physician
 - a. If no response to treatment
 - b. If inflammation worsens
2. Nursing intervention
 - a. Petroleum jelly or other moisturizer/lubricant for lips
 - b. Use sunscreen ointment prior to exposure to sun radiation or wind.

E. Education

1. Prevention (using sunscreen prior to sun exposure)
2. Treatment (using petroleum jelly or moisturizer)

F. Follow-up

1. As needed
2. Refill of petroleum jelly, lubricant, or sunscreen

STUDENT EDUCATION
CHEILITIS

Cheilitis is an inflammation of the lip. It is most commonly called “chapped lips”. It can occur with overexposure to sun, cold temperatures or wind.

The most effective treatment for this petroleum jelly (Vaseline) or other moisturizer/lubricant for lips.

To prevent this, you should apply petroleum jelly PRIOR to getting in the sun, wind or cold temperatures.

If left untreated, it can lead to infection. The signs of infection are:

drainage
redness
enlargening of lesions
heat

If you experience any signs of “chapped lips”, you should notify staff. If you have cheilitis and begin experiencing signs or symptoms of infection, you should go for sick call.

Protocol #19

CHEST PAIN

I. Definition

Pain in the chest, a common complaint in adolescents/children, is rarely indicative of a serious problem.

II. Etiology

Below is a list in order of frequency:

- A. Musculoskeletal
- B. Anxiety
- C. Pleuropulmonary
- D. Cardiac

III. Clinical manifestations

A. Subjective

1. Student states, "My chest hurts."
2. With musculoskeletal pain student may complain of:
 - a. Localized tenderness
 - b. Pain increase with movement of arms and chest
 - c. Pain related to strain during exercise or lifting
 - d. Pain increases with deep breaths
3. With anxiety student may complain of:
 - a. Tightness or heaviness in chest
 - b. Sharp, intermittent or "knife-like"
 - c. Pain not related to exertion
 - d. Accompanied with hyperventilation
4. With pleuropulmonary pain student may complain of:
Shortness of breath
5. With cardiac pain student may complain of:
 - a. Pain on exertion
 - b. Heart "fluttering" or "skipping beats"

Chest pain (cont'd)

B. Objective

Physical Assessment

1. Student's overall general state
 - a. Anxiety present?
 - b. Hyperventilation?
2. Vital signs
 - a. Heart rate
 - b. Heart rhythm
 - c. Respirations
 - d. Blood pressure
 - e. Temperature
3. Palpate chest wall for tenderness
4. Auscultate heart and lungs

C. Assessment

1. Acute pain may be related to:
 - a. Musculoskeletal pain (localized tenderness, strain)
 - b. Anxiety
 - c. Pleuropulmonary
 - d. Cardiac
 - e. Heartburn
2. Anxiety may be related to perceived threat of death.

D. Plan

1. Consult/Refer to physician:
 - a. Any suspicion of pleuropulmonary or cardiac chest pain
 - b. Failure to respond to therapy within 72 hours
 - c. Severe anxiety or pain
 - d. If suspect Marfan's syndrome
2. Nursing intervention for musculoskeletal pain:
 - a. Reassurance
 - b. Tylenol 325 milligrams, 2 tables P.O. four times a day
OR
 - c. Ibuprofen 400 milligrams, four times a day

Chest Pain (cont'd)

3. Nursing intervention if suspected cardiac: (consider EMERGENCY)
 - a. Place student in comfortable position (lying with head up)
 - b. Continue to monitor vital signs
 - c. Start oxygen at two liters/minute per nasal canula
 - d. Contact physician
 - e. Arrange for transport to hospital (if student remains stable)
 - f. Reassure student
 - g. Follow out any orders received by physician

E. Education

1. The cause of chest pain and how to treat it
2. Medication being used
3. Stress reduction
4. Return for sick call if pain not relieved or worsens

F. Follow-up

1. If no relief within two days
2. If condition worsens
3. If additional symptoms

STUDENT EDUCATION
CHEST PAIN (INSPIRATORY)

The chest pain you are having is caused by an inflammation or injury to the lining inside your chest wall. This causes pain when you breathe or move. You should have less pain in a day or two and feel much better in 5-7 days.

You should do the following:

1. Request Tylenol, not more than three times a day. You may be given Ibuprofen by the Nurse. You should take this with food.
2. Apply warm towels or take warm showers whenever possible for the next 2-3 days.
3. Hold the painful area when you move or cough. This will help with the pain.

You should return for sick call if:

1. You have not improved in 2 days
2. Get a fever
3. Cough up mucous

STUDENT EDUCATION
CHEST PAIN (INSPIRATORY)

The chest pain you are having is caused by an inflammation or injury to the lining inside your chest wall. This causes pain when you breathe or move. You should have less pain in a day or two and feel much better in 5-7 days.

You should do the following:

1. Request Tylenol, not more than three times a day. You may be given Ibuprofen by the Nurse. You should take this with food.
2. Apply warm towels or take warm showers whenever possible for the next 2-3 days.
3. Hold the painful area when you move or cough. This will help with the pain.

You should return for sick call if:

1. You have not improved in 2 days
2. Get a fever
3. Cough up mucous

STUDENT EDUCATION
CHEST PAIN (MUSCULAR)

The pain in your chest is caused by straining or overuse of muscles. The pain will get better in 1-2 days.

You should do the following things:

1. Do not play sports for several days.
2. Do not lift heavy weights for several days.
3. For pain relief, request Tylenol or you may be given Ibuprofen by the nurse.
4. Warm showers or warm towels over painful area

Return for sick call if:

1. You have not improved in 2 days
2. Get worse
3. Have nausea, vomiting, sweating, weakness with pain

Protocol #20

CHICKENPOX (varicella)

I. Definition

An acute viral disease, usually beginning with mild constitutional symptoms that are followed shortly by an eruption appearing in crops and characterized by macules, papules, vesicles, and crusting.

II. Etiology

Chicken pox and herpes zoster are caused by the varicella-zoster virus, chickenpox being the acute invasive phase of the virus and zoster (shingles) being the reactivation of the latent phase. Chickenpox is highly communicable. Epidemics occur in winter and early spring in 3 to 4 year cycles. It is believed to be spread by infected droplets and is most communicable during the short prodrome and early stages of the eruption.

III. Clinical manifestations

A. Subjective

1. Student states initially, "I have a headache, and I don't feel good", then 24-36 hours later, student may complain, "I have a rash and it itches."
2. Student complains of:
 - a. Rash
 - b. Headache
 - c. Weakness/Feeling tired
 - d. No appetite
 - e. Itching

B. Objective

1. Physical assessment
 - a. Moderate fever
 - b. Malaise
 - c. Macular eruption
2. Secondary infections may result in:
 - a. Erysipelas – Acute febrile disease with localized inflammation and redness of the skin and subcutaneous tissue accompanied by systemic disturbance.
 - b. Septicemia – Presence of pathogenic bacteria in the blood.
 - c. Impetigo – inflammatory skin disease marked by isolated pustules, which become crusted and rupture

Chickenpox (cont'd)

- d. Cellulitis – Inflammation of cellular of connective tissue.
 - e. Conjunctivitis – Inflammation of the conjunctiva
3. Edema of the glottis may occur due to lesions in the vicinity of the glottis.

C. Assessment

- 1. Sleep pattern disturbance may be related to intense itching.
- 2. Impaired tissue integrity may be related to open lesions from scratching.
- 3. High risk for secondary infection may be related to broken skin from itching.

D. Plan

- 1. Refer/Consult physician:
 - a. All students with a history of steroid or immunosuppressive therapy, immunologic deficiency, or malignant disease.
 - b. All students with complications or secondary bacterial infections.
 - c. All pregnant students.
- 2. Nursing interventions
 - 1. Relieve itching with: (per protocol)
 - a. Benadryl 2.5 milligrams, one capsule, four times a day as needed OR
 - b. Benadryl Elixir two teaspoons, four times a day as needed
 - c. Isolate from other students who have not had chickenpox until vesicles have dried and no new vesicles are occurring.

E. Education

- 1. Mode of transmission – first respiratory then by touch
- 2. Keep skin clean with soap and water
- 3. Keep bed clothes and sheets clean
- 4. Keep fingernails short and clean

F. Follow-up

As needed

STUDENT EDUCATION
CHICKEN POX (VARICELLA)

Chicken pox is a viral disease that usually begins with mild symptoms followed shortly by an eruption of a rash. Chicken pox is highly contagious and usually occurs in winter and early spring, but can occur at any time.

It is thought to be spread by infected droplets, and is most contagious in the early stages after lesions appear. The droplets can be from coughing.

You usually begin with the lesions 14 – 16 days after being exposed to someone who is contagious and you are contagious 10 – 21- days after being exposed to it. You are no longer contagious when the lesions have crusted.

The following are symptoms of chickenpox:

Mild headache
fever
weakness
rash
itching

You can occasionally have complications from chicken pox. The lesions may become infected or you could get pneumonia.

If you suspect you might have chicken pox, or begin having any of the symptoms above, you should put in a sick slip to be seen by a nurse in the clinic.

If you do have chicken pox, you will probably be isolated from others. It is also important for you to try not to scratch the lesions. You should keep your nails cut short and wash your hands frequently.

Protocol #21

CONTUSIONS

I. Definition

An injury in which the skin is NOT broken. A bruise.

II. Etiology

Trauma area.

III. Clinical manifestations

A. Subjective

1. Student states, "I was hit and now it's purple."
2. Document student's report of the following:
 - a. How it occurred.
 - b. What he was hit with.
 - c. When it occurred.

B. Objective

Document the following:

1. Location of injury
2. Appearance
3. Size
4. Neuro/Vascular assessment
 - a. Check distal pulses
 - b. Sensation
 - c. Color
 - d. Range of motion
 - e. Vital signs

C. Assessment

Acute pain may be related physical injury.

D. Plan

1. Refer/Consult physician:
 - a. Deformity
 - b. Impaired neuro/vascular status

Contusion (cont'd)

- c. Mechanism of injury suggesting hidden trauma
 - d. Injury involving joint
 - e. Condition not responding to protocol
2. Nursing intervention
- a. Stabilize/immobilize site of injury if needed
 - b. Consider crutches
 - c. Acetaminophen 325 milligrams, two tablets B.I.D. or T.I.D. for pain **OR**
 - d. Ibuprofen 200 milligrams, two tablets T.I.D. for pain
 - e. Restrict from activities

E. Education

- 1. Keep area elevated above the heart, if possible, decrease swelling.
- 2. Apply ice as often as possible. (Do not place ice directly on skin or leave on for more than 15 minutes at a time).
- 3. Rest injured area.
- 4. Notify staff if have
 - a. Numbness
 - b. Tingling
 - c. Cold
 - d. Blueness area below bruise

F. Follow-up

- 1. Sick call if area markedly swollen in 24-48 hours.
- 2. Sick call if no improvement in 3-4 days.

STUDENT EDUCATION CONTUSIONS

A contusion is a bruise usually caused by hitting a part of your body with or against a hard object. Swelling usually occurs and can cause pain. Small blood vessels under the skin can be damaged and leak a little blood. This is what causes the black and blue area.

Your should do the following things:

1. Keep the injured area elevated as often as you can for the next 1-2 days. This will help with the swelling and throbbing.
2. Place cold water on a cloth and place the cloth on the bruised area as often as you can for the next 1-2 days. If possible, immediate after the injury, apply ice in a cloth to the area for 15 minutes. This will also help the swelling. **DO NOT PUT ICE DIRECTLY ON THE SKIN OR LEAVE IT ON FOR MORE THAN 15 MINUTES AT A TIME.**
3. Avoid using the injured area.
4. Request Tylenol for pain not more that 4 times a day.
5. If the injured area is wrapped with an ace bandage by the nurse, do not rewrap it too tight. Do not wear elastic bandage to bed.
6. Notify staff to alert medical staff if you have any numbness, tingling, cold or blueness to area below your contusion (bruise).

Return for sick call if increased swelling or pain after 2 days.

Protocol #22

CONJUNCTIVITIS

I. Definition

Inflammation and infection of the conjunctiva that lines the eyelid and extends over the sciera producing irritation, erythema, discharge, itching and tearing.

II. Etiology

1. Bacterial infection
 - a. Pneumococcus
 - b. Staphylococcus
 - c. Streptococcus
 - d. Hemophilus Influenza
2. Viral infection
 - a. Upper respiratory tract infection
 - b. Sore throat
 - c. Adenopathy
 - d. Vaccinia
 - e. Herpes Simplex Type 1
3. Allergic reaction usually associated with seasonal allergies.
4. Foreign body or trauma
5. Chemical irritants
6. Systemic Infections

III. Clinical manifestations

1. Student states, "My eye itches and it's red."
2. Student complains of the following:
 - a. Eye irritation
 - b. Watery eyes
 - c. Itching
 - d. Mild photophobia
 - e. Discharge
 - f. Foreign body sensation

Conjunctivitis (cont'd)

G. Objective

Physical Assessment

1. Redness of conjunctiva
2. Discharge
 - a. Purulent in bacterial infection
 - b. Mucopurulent in viral infection
 - c. Stringy and white or watery in allergic reaction
3. Pupils normal in size and reactive to light
4. Edema of conjunctiva
5. Clear cornea
6. Preauricular node enlargement with bacterial infection

H. Assessment

1. Acute pain may be related to inflammation of the conjunctiva.
2. Impaired tissue integrity may be related to irritation from scratching.
3. High risk for infection related to spreading from scratching eyes.

I. Plan

1. Refer/Consult physician:
 - a. Change in vision
 - b. Trauma or foreign body
 - c. Abnormal funduscopic exam
 - d. Failure to improve within 48 hours
 - e. Grossly purulent eye - ASAP
 - f. Iritis, glaucoma, corneal trauma or infection
2. Nursing Intervention for mild allergic conjunctivitis:
 - a. Over-the-counter systematic antihistamine
(Murine, Visine, Clear eyes, one to two drops four times a day)

OR

 - b. Local vasoconstrictive ophthalmic solution per protocol

J. Education

1. Avoid using eye cosmetics (use only hypo-allergenic brands; discard all current eye cosmetics to avoid re-infection)
2. Prevention - teach regarding mode of transmission, hand washing, sharing of eye cosmetics
3. Instruct student on proper cleaning of eye.

K. Follow-up

As needed

STUDENT EDUCATION
CONJUNCTIVITIS

Conjunctivitis is an inflammation of the mucous membranes that line the eyelids. It can be caused by virus, bacteria, or allergy. Conjunctivitis can also accompany a cold.

Conjunctivitis is highly contagious and can easily spread from one person to another. You should do the following to prevent it.:

1. Avoid using eye cosmetics and discard the cosmetics after diagnosed with the infection. Do not share cosmetics with anyone.
2. Wash hands frequently.
3. Do not share towels with anyone.

The following are symptoms of conjunctivitis:

redness
drainage
swelling
watery eyes
itching
feeling of foreign body in eye

If you have any of the symptoms listed above, you should put in a slip for sick call.

Protocol #23

CONSTIPATION

I. Definition

Difficult defecation; infrequent defecation with passage of unduly hard and dry fecal material; sluggish action of the bowels.

II. Etiology

1. Acute constipation:
 - a. Acute intra-abdominal disease (localized peritonitis, diverticulitis)
 - b. Traumatic conditions (head injuries, spinal fractures)
 - c. Drugs/Medications (aluminum hydroxide, bismuth salts, iron salts, cholestyramine)
 - (1) Anticholinergic
 - (2) Opiates
 - (3) Ganglionic blockers
 - (4) Tranquilizers
 - (5) Sedatives
 - d. Local anorectal conditions (anal fissures)
2. Chronic constipation
 - a. Systemic disorders
 - (1) Debilitating infections
 - (2) Hypothyroidism
 - (3) Hypocalcaemia
 - (4) Uremia
 - (5) Porphyria
 - b. Local neurogenic disorders
 - (1) Irritable bowel syndrome
 - (2) Colonic inertia
 - (3) Megacolon (Hirschsprung's disease)
 - c. Neurologic disorders
 - (1) Parkinson's disease
 - (2) Cerebral thrombosis
 - (3) Tumor
 - (4) Injury to the spinal cord
 - d. Psychogenic

III. Clinical manifestations

A. Subjective

1. Student states, "My bowels can't move," or "My stomach hurts" .:

Constipation (cont'd)

2. Record reports of the following from student:
 - a. Last bowel movement
 - b. Hardness of stools
 - c. Diet
 - d. Nausea/vomiting

B. Objective

Physical Assessment

1. Vital signs
2. Weight
3. Auscultate bowel sounds (usually hypoactive with constipation)
4. Palpate abdomen (May feel fullness over colon with complaints of mild tenderness)

C. Assessment

1. Acute pain may be related to fullness and pressure.
2. Knowledge deficit (learning need) may be related to dietary needs.

D. Plan

1. Refer/Consult physician:
 - a. Chronic problem
 - b. Onset sudden and unexplained
 - c. Abdominal distention and tenderness with emesis
 - d. Absence of high-pitched, tinkling bowel sounds
 - e. Constipation alternating with diarrhea/bloody stool
 - f. Nausea/vomiting
2. Therapeutic nursing intervention:
 - a. Milk of Magnesia 30 cc and Cascara 5cc by mouth.
OR
 - b. Per protocol at facility

E. Education

1. Drink at least 8 glasses of fluid each day. (Preferably water).
2. Eat foods high in fiber (Grains, vegetables, fruit) when possible.
3. Exercise each day.
4. When to return to sick call (see below).

Constipation (cont'd)

F. Follow-up

1. If student complains of chills
2. If abdominal pain worsens
3. If begin vomiting
4. If blood is in stool
5. If no improvement in 3 days

STUDENT EDUCATION CONSTIPATION

Sometimes people think they are constipated because they don't have a bowel movement every day, or the bowel movement is hard. Most of the problems with constipation can be helped by doing the things listed below. If you use laxatives too often you can have worse constipation problems. Remember you don't have to have a bowel movement everyday to be "normal".

To prevent or relieve constipation you should:

1. Drink at least 8 glasses of fluid a day.
2. Eat high fiber foods like grains, vegetable, or fruit whenever possible.
3. Exercise as much as possible every day, if permitted.
4. Try to have a regularly scheduled time to have a bowel movement.
5. You may be given a laxative by the nurse.
6. You should return to sick call if:

you get a fever
you have a stomachache that gets worse
you start vomiting
you have blood in your stool
if you don't feel better in 3 days.

Protocol #24

COUGH

a. **Definition**

A sudden explosive expiratory maneuver that tends to clear material from the airways.

II. **Etiology**

1. Induced by postural changes
 - a. Chronic lung abscess
 - b. Cavitory TB
 - c. Bronchiectasis
2. Associated with eating
 - b. Disturbance of the swallowing mechanism
 - c. Tracheoesophageal fistula
3. Appears on exposure to cold air
Asthma
4. Morning cough
Chronic bronchitis
5. Associated with rhinitis or wheezing
Allergic response

III. **Clinical manifestations**

d. **Subjective**

- e. Student states, "I have a cough.:"
- f. Record student's reports of the following:
 - a. Onset
 - b. When it occurs
 - c. Productive/Non-productive
 - d. Associated symptoms:
 - (1) Chills
 - (2) Sore throat
 - (3) Chest pain

g. **Objective**

Physical assessment

1. Vital signs (especially temperature)
2. Auscultate lungs

Cough (cont'd)

C. Assessment

1. Acute pain related to persistent cough causing musculoskeletal pain.
2. Ineffective airway clearance related to thick mucous.

D. Plan

1. Refer/Consult physician:
 - a. Recurrent, persistent or productive cough, suggestive of TB
 - b. Productive cough suggestive of lower respiratory infection
 - c. Cough associated with shortness of breath and wheezing suggestive of asthma
 - d. Cough with fever
 - e. Cough not responding to cough protocol
 2. Therapeutic nursing intervention:
 - h. Alcohol-free Guaifenesin containing cough syrup, 5cc by mouth every 4 hours as needed
- OR**
- i. Per physician orders and/or facility protocol

E. Education

1. Drink plenty of liquids, especially water
2. Cover your mouth when you cough to prevent spread
3. Wash your hands frequently
4. When to return for sick call (see below)

F. Follow-up

1. If cough persists for more than 3 days
2. If fever develops
3. If other symptoms develop
4. If coughing up thick, colored sputum

STUDENT EDUCATION **COUGH**

A cough may be due to many conditions. A cough can be caused by drainage from your nose or other irritations in your throat. These are not serious. It is usually better not to completely stop a cough.

You should do the following things:

1. Drink plenty of fluids, like water.
2. Cover your mouth when you cough.
3. Wash your hands frequently throughout the day.
4. Take medications as given by the clinic.

You should return to sick call if:

1. Your cough lasts longer than 3 days.
2. You get a fever or develop other symptoms
3. You start coughing up thick, colored sputum.

Protocol #25

CRYPTORCHIDISM (Undescended Testicle)

I. Definition

Incomplete or improper prenatal descent of one or both testes.

II. Etiology

Testicular descent usually occurs in the eighth month of fetal life. If a testis cannot be drawn into the scrotum by the third or fourth month after birth (in term infant), there is little evidence to suggest it will descend later.

III. Clinical manifestations

A. Subjective

1. Usually student has known this was present but has not yet sought medical Attention. This is usually found on admission physical exam by physician.
2. Obtain and record a history from student.

B. Objective

Physical assessment

1. Testicle(s) not palpable in scrotal sac.
2. Gentle massage along inguinal ligament and inguinal canal from anterior superior iliac medial and downward to the public tubercle does not lead to testis becoming palpable in scrotum.

C. Assessment

Disturbance in body image related to significant body part development.

D. Plan

1. Refer/Consult physician:
All Cases
2. Therapeutic nursing intervention:
None

Cryptorchidism (cont'd)

E. Education

1. Reassure
2. Answer any questions

F. Follow-up

As needed

STUDENT EDUCATION
CRYPTORCHIDISM (UNDESCENDED TESTICLE)

Cryptorchidism is when the testicle(s) do not descend as they should before birth. This usually occurs in the eight month of fetal life. If it cannot be drawn down by the third to fourth month after birth, there is little evidence to suggest that it will descend later.

This is usually found during a physical exam. You may be sent to a specialist for evaluation.

You should not have any symptoms to alert you to this.

Protocol #26

CYSTITIS (FEMALES)

a. Definition

An acute, usually uncomplicated infection/inflammation of the bladder usually occurring secondary to ascending urinary tract infections.

b. Etiology

- c. Bacteria are identified in 75 – 90% of patients (females) with symptoms of cystitis; of these *Escherichia coli* is most frequently encountered in the ambulatory population.
- d. Recurrent infections are usually caused by organisms different from those that caused the previous infection.

C. Predisposing factors may include:

Congenital anomalies of urinary tract

- e. Neurogenic bladder dysfunction
- 3. Vaginal foreign body

1.

f. Clinical manifestations

g. Subjective

- 1. Student states, “It burn when I pee.”
- 2. Record student’s report of any of the following:
 - a. Dysuria
 - b. Frequency
 - c. Urgency
 - d. Occasionally, gross hematuria
 - e. Lower abdominal pain
 - f. No symptoms of pyelonephritis
 - (1). No flank, back or costovertebral angle pain
 - (2). No shaking chills
 - g. Occasionally may have fever, flank pain, foul smelling urine
 - h. No vaginal discharge
 - i. Usually, no gastrointestinal complaints
 - j. History of sexual activity

Cystitis (cont'd)

h. Objective

2. Physical examination
 - a. Record temperature (occasionally febrile, usually afebrile)
 - b. Slight suprapubic tenderness
 - c. Normal bowel sounds
 - d. No peritoneal tenderness
 - e. No costovertebral angle tenderness
3. Laboratory (per protocol)
 - a. Urinalysis (send to laboratory)
 - (1). Usually see > 10 WBCs per high power field
 - (2). May have RBCs
 - b. Urine dipstick
 - (1). Nitrite (positive)
 - (2). Lymphocytes (positive)
 - (3). Albumin (positive)

C. Assessment

1. Acute pain may be related to inflammatory process and bladder spasm.
2. Urinary elimination, altered patterns may be related to inflammation and irritation of the bladder.
3. Knowledge deficit (learning need) may be related to inadequate information regarding pathophysiology, treatment and prevention of recurrence.
4. Potential for injury; urinary tract may be related to inadequately treated or recurrent infections.

D. Plan

1. Refer/Consult physician:
All cases of suspected cystitis
2. Therapeutic nursing intervention
Per physician's orders

E. Education

See Student Education sheet (following page)

F. Follow-up

As ordered by physician

STUDENT EDUCATION
CYSTITIS

Cystitis is a bacterial infection or inflammation of the lower urinary tract.

The following are some signs and symptoms of cystitis:

frequent urination
pain when urinating
bed-wetting
back pain

Cystitis is caused by an organism. If you use perfumed feminine hygiene products, perfumed sanitary napkins, spermicidal jellies or bubble baths, you may be susceptible to getting this.

If you experience any of the symptoms listed above, you should be evaluated by the doctor. He may order a urine culture. This is obtained by you urinating in a sterile container.

If you are diagnosed as having cystitis, you may be given an antibiotic. It is important that you take this medication until it is finished. You may be given a medication to relieve burning when you urinate. This medication will turn your urine a red-orange color, so do not be alarmed.

You may be encouraged to drink plenty of liquids, 16 glasses of water a day will help. Cranberry juice is sometimes given as well as encouraging to eat meats, eggs, nuts, cheese and whole grains.

You should also empty your bladder regularly and when as soon as it feels full.

Protocol #27

DERMATITIS, ATOPIC (eczema)

I. Definition

A chronic inflammatory disorder of the skin manifested by pruritic, erythematous, papular, vesicular, weeping lesions with scaling or crusting with tendency to occur in patients with an allergic predisposition.

II. Etiology

In part it is an atopic allergic response, exact etiology is unknown. It is probably the most common problem in pediatric dermatology. Manifestations are usually secondary to pruritus and scratching of the sensitive skin. The following may initiate and aggravate the itching and inflammation:

1. Dry skin (cold weather)
2. Perspiration (hot, humid weather)
3. Certain foods
4. Irritating clothing
5. Certain soaps, detergents, or cosmetics
6. Emotional stress
7. Respiratory infections

III. Clinical manifestations

A. Subjective

1. Student states, "I'm itching."
2. Record any report from the student regarding the following:
 - a. Onset
 - b. Location
 - c. Precipitating factors
 - d. Family history of allergic diseases (asthma, allergic rhinitis, urticaria) or atopic dermatitis.
 - e. History of asthma or allergic rhinitis

B. Objective

Physical assessment

1. Dry, thickened skin with accentuation of normal lines and folds.
2. Hyperpigmented skin

Dermatitis, Atopic (cont'd)

3. Location
 - a. Flexor areas of extremities
 - b. Eyelids
 - c. Dorsum of hands and feet

C. Assessment

1. Acute pain related to scratching causing lesions and inflammation.
2. High risk for infection related to open lesions caused by scratching.

D. Plan

1. Refer/Consult physician:
 - a. Dermatitis with crusting or weeping lesions
 - b. Student with mild dermatitis that worsens or does not improve after 2 weeks of treatment.
 - c. Any student with suspected secondary bacterial or viral infection - IMMEDIATELY.
2. Therapeutic nursing intervention:
 - a. For mild cases: shower with mild soap. Apply moisturizer to damp skin.
OR
 - c. Hydrocortisone lotion 1% - gently massage into affected are
B.I.D.
 - d. Benadryl 25 milligram capsule T.I.D. or Q.I.D. PRN for itching.
OR
 - e. Benadryl Elixir two teaspoons, T.I.D. or Q.I.D. PRN for itching.

E. Education

1. Avoid factors that initiate pruritus and irritate skin.
2. Prevent dry skin:
 - b. Minimize duration of shower.
 - c. Avoid excessive exposure to soap – use a mild soap.
 - d. Apply moisturizer after shower to damp skin.
 - e. Avoid using hot water in shower (causes pruritus).
 - f. Avoid rough clothing.
 - g. Keep fingernails short.
 - h. When to return for sick call. (See below)

F. Follow-up

1. In one week
2. As needed

STUDENT EDUCATION
DERMATITIS, ATOPIC (ECZEMA)

Eczema is an inflammatory disorder that causes itching and reddened lesions on the skin. These lesions may drain. You are more likely to have this if you suffer from allergies or are allergic to things.

Things that can cause eczema are:

dry skin
cold weather
perspiration
certain foods
irritating clothing
soaps, detergents, or cosmetics
emotional stress
respiratory infections

To prevent dry skin that can lead to eczema you should:

1. Take short showers.
2. Do not shower in extremely hot water.
3. Apply moisturizer after shower to damp skin.
4. Avoid using a lot of soap.
5. Avoid rough clothing.
6. Keep fingernails short.

If you experience any of the following, you should return for sick call:

lesions that drain
no improvement after 2 weeks
increase redness
increase swelling
heat
red streaks

Protocol #28

DERMATITIS, CONTACT

1. Definition

An inflammatory reaction of the skin caused by contact with the resin of poison oak or poison ivy or other sensitizing agent.

2. Etiology

Contact dermatitis affects individuals of all ages. The capacity to become sensitized to an agent is probably determined to some degree by genetics. The two basic causative mechanisms include the action of a primary irritant or of a cutaneous sensitizer. Primary irritants usually cause a cutaneous reaction with a few hours following exposure. Examples may include soaps and other chemicals. Cutaneous sensitization involves a delayed hypersensitivity reaction. An example is poison ivy.

3. Clinical manifestations

4. Subjective

1. Student states, "I'm itching."
2. Record student's reports of the following:
 - a. History of exposure to contact allergen or irritant.
 - b. Onset of pruritus
 - c. Location

5. Objective

Physical assessment

1. Dry skin
2. Rash or blisters
3. Mild dryness
4. Redness
5. Oozing bullae with exfoliation
6. Linear conformation
7. Dry, thick, scaly skin (chronic contact dermatitis)
8. Edema if soft tissue involved (eyes, mouth)

Dermatitis, Contact (cont'd)

6. Assessment

7. Acute pain related to scratching causing open lesions and inflammation.
8. High risk for infection related to open lesions caused by scratching.

9. Plan

10. Refer/Consult physician:

- a. Widespread involvement.
- b. Severe discomfort
- c. Involvement of eyes, mucous membranes or genitalia
- d. Secondary infection
- e. Failure to respond to treatment in 48 hours.

11. Therapeutic nursing intervention:

- a. Use cold compress applied for 20 minutes (four times a day)
- b. Apply drying lotion (Calamine) after each soak.
- c. Benadryl 25 milligrams by mouth T.I.D. or Q.I.D. as needed (Sedation is a side effect). OR
- d. As ordered by the physician
- e. If there is no weeping, apply Hydrocortisone lotion 1% Q.I.D. on non-facial lesions.

12. Education

13. Medication side effects
14. Avoid scratching and keep nails filed and cleaned (to avoid impetigo)
15. Avoid contact with allergen or irritant.
16. Have clothes that were worn at the time of contact washed.
5. After future exposure, wash contact area with soap as soon as possible.
6. When to return for sick call. (See below)

G. Follow-up

1. If no improvement in 48 hours.
2. If condition worsens.
3. If any other symptoms develop. (Fever, difficulty breathing)
4. As needed.

STUDENT EDUCATION
DERMATITIS, CONTACT

Contact dermatitis is an inflammatory reaction of the skin that is caused when it contacts anything that you are allergic to. It affects anyone at any age.

The following are symptoms of contact dermatitis:

dry skin
rash or blisters
redness
drainage with peeling
dry, thick, scaly skin
swelling if around eyes or mouth

This usually causes severe itching. You may be given a medication to prevent itching that might make you sleepy. It will also be helpful if you apply cold cloths for 20 minutes 4 times a day. You can request Calamine lotion to help with the itching. The doctor may prescribe another type of anti-itch cream.

You should:

17. Avoid scratching.
18. Keep nails cut short.
19. Keep hands and nails clean.
20. Avoid contact with the allergen.
21. Have clothes that were worn at the time of contact washed.
22. After future exposure, wash area with soap as soon as possible.

You should return for sick call if:

23. No improvement in 48 hours
24. Condition worsens
25. Other symptoms such as fever or difficulty breathing occur

Protocol #29

DERMATITIS, SEBORRHEIC

1. Definition

An inflammatory scaling disease of the scalp, face and occasionally other areas.

2. Etiology

1. Genetic
2. Climate factors (usually worse in the winter)

3. Clinical manifestations

4. Subjective

1. Student states, "My head itches."
2. Record the following reports from the student:

5. Onset
6. Duration
7. Hygiene practices
8. Location

9. Objective

Physical assessment (Presence of the following):

1. Assess areas of dermatitis
 - a. Yellow-red scaling papules
10. Hairline
11. Behind the ears
12. External auditory canals
13. Eyebrows
14. Bridge of nose
15. Nasolabial folds
16. Over the sternum
 - b. Thick, tenacious, scaly plaques in the scalp (1-2cm in diameter)
2. Assess for signs of secondary infection:
 - a. Redness
 - b. Fever
 - c. Heat
 - d. Drainage

Dermatitis, Seborrheic (cont'd)

17. Assessment

1. Impaired skin integrity related to trauma from scratching.
2. High risk for infection related to open lesions from scratching.

18. Plan

1. Refer/Consult physician:
 - a. Multiple lesions with signs of secondary infection
19. Condition not responding to protocol
20. Therapeutic nursing intervention:
 21. Reassure (Usually a benign condition)
 22. Selenium Shampoo (use two to three times a week)

E. Education

1. Only shampoo hair 2 or 3 times weekly in cool or barely warm water.
2. Use Selenium shampoo sent by the clinic. Rinse all shampoo from hair.
3. Do not rub scalp a lot. (This increases the production of oil from oil glands).
4. When to return to sick call. (See below)

F. Follow-up

23. Return to sick call if no improvement from treatment in one month.
24. As needed.

STUDENT EDUCATION
DERMATITIS, SEBORRHEIC

Seborrheic dermatitis is an inflammatory scaling disease of the scalp, face and occasionally other areas.

It is usually characterized as dry or greasy scaling lesions on the scalp also known as dandruff. It can cause itching. If it is severe it can be yellow-red, scaling lesion along the hairline, behind the ears, in the ear canals, on the eyebrows, on the bridge of the nose, and over the chest. There may be irritation of the eye.

It is believed to be hereditary or due to climate (worse in the winter).

You may be required to shampoo with a special shampoo if this involves the scalp.

You should:

25. Only shampoo hair 2 to 3 times weekly in cool or barely warm water.
26. You should only use the shampoo sent by the clinic for treatment.
27. Do not rub scalp a lot. This can increase the production of oil from oil glands.

You should return for sick call if:

28. No improvement in one month after treatment.
29. Any worsening/spreading of lesions.

Protocol #30

DIARRHEA

I. Definition

Increased volume, fluidity, or frequency of fecal discharges.

II. Etiology

1. Osmotic diarrhea-occurs when non-absorbable, water-soluble solutes remain the bowel where they retain water.
2. Secretory diarrhea-occurs when the small and large bowel secretes rather than absorb electrolytes and water.
3. Malabsorption-Malabsorption of fat causing colonic secretion and/or malabsorption of carbohydrate causing osmotic diarrhea.
4. Exudative diarrhea-Mucosal inflammation, ulceration, or tumefaction may result in an outpouring of plasma, serum proteins, blood, and mucus thus increasing fecal bulk and fluidity. (Regional enteritis, ulcerative colitis, TB, lymphoma and carcinoma)
5. Altered intestinal transit-Decrease in amount of time chyme is exposed to adequate absorptive surface of the GI tract. (Small or large bowel resection, gastric resection, pyloroplasty, vagotomy, surgical bypass of intestinal segments, and drugs (magnesium-containing antacids, laxatives) or humoral agents (prostaglandin, serotonin)

III. Clinical manifestations

A. Subjective

1. Student states, "I have diarrhea."
2. Record complaints of the following:
 - a. Loose, watery stools
 - b. Frequent stools (>than twice daily)
 - c. Time of onset
 - d. Color of stools
 - e. Consistency of stools
 - f. Odor of stools
 - g. Mucous in stools
 - h. Dietary intake

Diarrhea (cont'd)

B. Objective

Physical assessment

1. Vital signs
2. Weight
3. Palpate abdomen (usually soft and nontender)
4. Auscultate abdomen (usually hyperactive)
5. Hydration status (mucous membranes and skin turgor)
6. Current medications
7. Consider epidemic if several students appear for sick call with same symptoms

C. Assessment

1. High risk for fluid volume deficit related to excessive losses through GI tract.
2. Acute pain related to abdominal cramping.
3. Diarrhea related to:
 - a. Stress/anxiety
 - b. Medications
 - c. Dietary intake

D. Plan

1. Refer/Consult physician:
 - a. Diarrhea persisting 48 hours
 - b. Diarrhea not responding to protocol
 - c. Weight loss > 5% of body weight
 - d. Fever 100 degrees F or greater
 - e. Known epidemic
2. EMERGENCY treatment required:
 - a. Grossly bloody stool
 - b. Severe abdominal pain
 - c. Severe dehydration
3. Therapeutic Nursing Intervention:
 - a. Pepto-Bismol or generic tablets, two tablets B.I.D.
OR
 - b. Pepto-Bismol liquid or generic, two tablespoons B.I.D.
(These should only be used if diarrhea does not respond to dietary changes in 24 hours).

Diarrhea (cont'd)

E. Education

1. Limit solid foods.
2. Eat only bland type foods.
3. Do not eat or drink dairy products until diarrhea has stopped for 2-3 days.
4. Drink lots of clear fluids.
5. Once diarrhea has stopped for 1-2 days, eat foods like whole grain breads, cereals, and fruits to keep bowel movements normal.
6. Wash your hands after each use of toilet.
7. When to return to sick call. (See below)

F. Follow-up

Return for sick call if:

1. Diarrhea lasts longer than 48 hours.
2. Develop severe stomach pains
3. Blood in stool
4. Vomiting
5. As needed

STUDENT EDUCATION
DIARRHEA

Diarrhea is passing several loose or watery stools. Several things can cause diarrhea including viruses, stress, foods and you have eaten, bacteria, other illnesses, and even some medications. Most of the time diarrhea is an infection in the bowel and will run its course in 12 – 24 hours without any problems.

You should do the following things:

1. You should limit the solid foods you eat while you have diarrhea. You should eat bland type foods. Don't eat dairy products like cheese or ice cream until you have not had diarrhea for 2-3 days.
2. It is important to drink lots of clear fluids. Warm liquid is usually better than cold when you have diarrhea. Don't drink milk or fruit juice until you have not had diarrhea for 2-3 days.
3. Once you have not had diarrhea for 1-2 days, it is important to eat foods that make bulk. Foods like whole grain breads, cereals and fruits will help your bowel movements to be normal.
4. Use good personal hygiene. Wash your hands after each use of the toilet.
5. Sometimes a medication may be used to help control diarrhea. The nurse will start you on this.

Return to sick call if:

1. Your diarrhea lasts longer than 48 hours.
2. You develop severe stomach pains (cramping pains are usual with diarrhea especially right before you have a stool).
3. You start bleeding when you have a stool.
4. You get a fever or start vomiting.

Protocol #31

DIABETES MELLITUS, JUVENILE

1 Definition

Diabetes mellitus is a deficiency in the production of the hormone insulin, which is usually produced by specialized cells in the islets of Langerhans located in the pancreas. There are different types of diabetes, each with its own etiology, clinical course, and treatment/management. Juvenile diabetes is also known as insulin dependent diabetes.

2 Etiology

In juvenile diabetes there is an inability to produce insulin due to destruction of the inlets of Langerhans, reduction of cell mass of the inlets of Langerhans or the production of defective insulin. Heredity seems to play an important role in juvenile diabetes, as well as injury to the immune response from viral infections. Changes in the body induced by obesity, pregnancy, or the use of certain medications may also trigger the onset of diabetes.

3 Clinical manifestations

4 Subjective

1. Undiagnosed Diabetes Mellitus:
 - a. Student states, "I'm always thirsty and I go to the bathroom a lot."
 - b. Record any of these complaints reported by the student:
 - 5 Excessive eating (polyphagia)
 - 6 Excessive drinking (polydypsia)
 - 7 Excessive urination (polyuria)
 - 8 Weakness
 - 9 Fatigue
 - 10 Nausea and vomiting
 - 11 Dry skin
 - 12 Skin infections that heal slowly
 - 13 Blurred vision
 - (10) Constipation
2. Diagnosed Diabetes Mellitus:
 - a. Student states, "I feel weak and shaky."
 - b. Record the following reports from the student:
 - 14 Weakness
 - 15 Shakiness
 - 16 Sweating
 - 17 Last insulin injection (can check the medication log sheet)
 - 18 Last food intake

Diabetes Mellitus, Juvenile (cont'd)

19 Objective

1. Hyperglycemia with acidosis:
 - a. Gradual drowsiness
 - b. Increased thirst and urination
 - c. Flushed skin
 - d. Vomiting
 - e. Anorexia
 - f. Fruity or wine-like breath
 - g. Tachycardia
 - h. Tachypnea
 - i. Large amounts of sugar and ketone in urine (dipstick)
 - j. If untreated, eventual stupor or unconsciousness
 - k. Check last dose and insulin injection. (If IDDM)

2. Hypoglycemia (Mild insulin reaction):
 - a. Behavior problems, temper tantrums, irritable
 - b. Tachypnea
 - c. Tachycardia
 - d. Pale

3. Hypoglycemia (Moderate insulin reaction):
 - a. Confusion/Disorientation
 - b. Poor coordination
 - c. Increased irritability
 - d. Blood glucose severely low
 - e. Sweating
 - f. Extreme nervousness, tremors
 - g. Vomiting
 - h. Hypotension
 - i. Tachycardia worsens

4. Hypoglycemia (Severe insulin reaction):
 - a. Tachycardia
 - b. Loss of consciousness
 - c. Seizure activity
 - d. Deep coma
 - e. Hyporeflexia

Diabetes Mellitus, Juvenile (cont'd)

5. Causes:
 - a. Hyperglycemia (Less common than insulin reaction, slow onset)
 - 20 Undiagnosed diabetes
 - 21 Too little or no insulin
 - 22 Infection, illness or injury
 - 23 Emotional stress
 - 24 Diet not followed
 - 25 Hypoglycemia (rapid onset, usually occurs before mealtime and at peak effective times of insulin)
 - 26 Too much insulin
 - 27 Delayed or missed meal
 - 28 Excessive exercise without adequate food

29 Assessment

1. Knowledge deficit (learning need) related to disease process, treatment and individual care needs.
2. Altered nutrition (less than body requirements) related to imbalance of nutrient intake and utilization of glucose.
3. High risk for impaired adjustment related to change in lifestyle.
4. High risk for infection related to delayed healing.

30 Plan

1. Refer/consult physician:
 - a. Any student with suspected diabetes
 - b. Any student with mild to moderate hypoglycemia not responding to orange juice
 - c. Any student with poorly controlled diabetes.
2. Therapeutic nursing intervention:
 - a. Mild insulin reaction (hypoglycemia):
 - 31 Provide immediate source of food. (Give ½ cup of juice followed by 1 starch exchange of 6 saltines OR ¼ to ½ cup of milk plus 1 starch exchange of 6 crackers and 1 glucose tablet)
 - 32 Do not use diet drinks.
 - 33 Monitor blood glucose
 - 34 Do not give insulin.
 - b. Moderate insulin reaction (hypoglycemia):
 - 35 Give ½ cup juice followed by 1 oz. Of meat (cheese) OR 8 oz. Of milk plus 1-2 starch exchanges (i.e. 2 slices of bread or 6 graham crackers).
 - 36 If no response repeat in 10-15 minutes

Diabetes Mellitus, Juvenile (cont'd)

- 37 Monitor pulse (should decrease in 2-3 minutes)
- 38 Provide rest and food
- 39 Monitor blood glucose level (Do not give insulin)
- c. Severe insulin reaction (hypoglycemia):
CALL 911
- d. Diabetic coma (hyperglycemia with acidosis):
40 If uncertain whether hyperglycemia or hypoglycemia, give conscious student $\frac{1}{2}$ cup juice.
41 CALL 911

42 Education

2. Check blood glucose regularly and before taking insulin each time.
3. Report any symptoms of hyperglycemia or hypoglycemia to staff.
4. Eat meals regularly and snacks as served.
5. Follow ADA diet when eating foods not on meal tray.
6. Report any vomiting IMMEDIATELY to staff.
7. Rotate injection sites.
8. Have ALL injuries reported to medical staff. (Abrasions, lacerations, etc.)
9. Always wear shoes when walking outside.

1 Follow-up

1. Individualized by physician.
2. Any injuries.
3. Any symptoms of hyper-or hypo-glycemia
4. Any gastrointestinal symptoms.

STUDENT EDUCATION
DIABETES MELLITUS, JUVENILE

When you are a diabetic, your body does not properly use the energy from the food you eat. When you eat, the food is broken down into a form of sugar, which is the body's main source of fuel. Diabetes takes away your body's ability to keep the amount of sugar in your blood at a normal level.

When your blood sugar is out of control, you have a greater chance of developing any of these health problems

heart attacks
strokes
a foot or leg amputated (removed by surgery)
frequent infections
eye problems that can cause blindness
kidney disease

A normal blood sugar level is between 7- and 115 mg/dl (milligrams of sugar in each deciliter of blood).

Along with controlling your blood sugar, you should do the following:

- 2 Have your blood pressure and blood fats checked regularly.
- 3 Have a complete eye exam every year. (This is more than an eye exam)
- 4 Have a dental exam every year
- 5 Check your feet and skin every day. If you suffer an injury, have pain, or see any signs of infection, alert your staff to notify the clinic to see you for sick call.
- 6 Avoid walking in bare feet.
- 7 Don't smoke.
- 8 Have your blood and urine checked every year to monitor your kidneys for any problems. Learn what to do to protect your kidneys.
- 9 Follow your meal plan. Eat at regular times and eat snacks when you are supposed to.
- 10 Take your medicine every day. (The right amount at the right times)
- 11 Follow your activity routine.
- 12 Test your blood sugar regularly or as ordered by the doctor.

When diabetes medicines, food and exercise get out of balance, the blood sugar level in your body can drop. When this happens, you may:

feel shaky, tired, or hungry
become sweaty
become crabby or confused
have a rapid heart beat
PASS OUT

Diabetes, Student Education (cont'd)

If you feel any of these symptoms and you think your blood sugar is low, IMMEDIATELY eat one of the following:

½ cup of juice followed by 1 starch exchange of 6 saltines

OR

¼ to ½ cup of milk plus 1 starch exchange of 6 crackers

OR

1 glucose tablet

Diabetic ketoacidosis is a dangerous condition that occurs when your blood sugar gets too high. It happens most often when you get sick. If it is not treated, it can lead to coma and death. If you are experiencing ketoacidosis, you may feel the following:

more thirsty or hungry than usual
have to pass urine more often
lose weight unexpectedly
more tired or sleepy than usual
throw up or feel sick
have stomach pain
have a fruity smell on your breath
notice that you are breathing fast and deep

If your blood sugar is too high (greater than 240 mg/dL), HAVE YOUR STAFF ALERT THE NURSE IMMEDIATELY.

Protocol #32

DYSMENORRHEA

1. Definition

Cyclic pain associated with menses during ovulatory cycles but without demonstrable lesions affecting the reproductive structures.

2. Etiology

3. About 50% of menstruating females experience this disorder and about 10% of these are incapacitated for several days each period.
4. The pain is usually spasmodic and located in the lower abdomen and may also radiate to the back and thighs. It may include nausea, vomiting, diarrhea, lower back pain, headache, dizziness and in severe cases, syncope and collapse.
5. It may last from a few hours to several days, but usually no more than 3 days.
6. It is thought to be caused by uterine ischemia due to an increase in the production of prostaglandins with increased contractility of muscles of the uterus.
7. It usually occurs just before or at the onset of menstruation.

8. Clinical manifestations

9. Subject

1. Student may state, "I've got my period and I have cramps."
2. Record student's report of any of the following:
 - a. Nausea
 - b. Vomiting
 - c. Dizziness
 - d. Fainting
 - e. Headache
 - f. Backache
 - g. Fatigue

10. Objective

1. Physical examination
 - a. Bloody discharge (menses)
 - b. Palpate abdomen (usually soft with no focal tenderness)
 - c. Obtain vital signs
2. Laboratory
None

Dysmenorrhea (cont'd)

11. Assessment

1. Acute pain may be related to increased uterine contractions.
2. High risk for impaired physical mobility related to:
 - (a). Severe pain
 - (b). Presence of secondary symptoms including nausea, vomiting, syncope, chills.
3. Ineffective individual coping may be related to:
 - (a). Chronic, recurrent nature of problem
 - (b). Anticipatory anxiety
 - (c). Inadequate coping methods

12. Plan

13. Refer/Consult physician:
 - a. Severe dysmenorrhea
 - b. Excessive bleeding/clots
 - c. For menses more frequently than once a month
 - d. Suspected PID
 - e. If no relief from analgesics
14. Therapeutic nursing intervention:
 - a. Ibuprofen 200 milligrams, two tablets by mouth 3 – 4 times a day with food.
OR
 - b. Tylenol 2 tablets by mouth every 4 – 6 hours for pain

15. Education

Refer to Student Education sheet (following page)

16. Follow-up

As needed

STUDENT EDUCATION
DYSMENORRHEA

Dysmenorrhea is commonly called “menstrual cramps”. An estimated 50% of menstruating women experience this disorder. If you are going to have menstrual cramps, they start when you are young and first start menstruating, usually by age 20. They tend to decrease or disappear after childbirth and with age.

The pain usually begins just before or when your “period” begins and may last from a few hours to no more than 3 days.

If you have never had cramps with your period before and then start to have menstrual cramps, you should tell the nurse. You may need a check-up.

You should do the following:

17. Request something for pain. You may be given Ibuprofen (Motrin) 200 milligrams by mouth every 6 – 8 hours as needed with food, or Acetaminophen (Tylenol) 2 tablets by mouth every 4 – 6 hours as needed for pain. Use these no more than 3 days.
18. Warm towel to the lower abdomen. Gentle massage of the lower abdomen and mild exercises may help relieve the cramps.

Return to sick call if you cramp more than three days or have usually heavy bleeding and clots.

Protocol #33

EAR WAX, EXCESS (cerumen)

1. Definition

A thin film of cerumen is normally secreted by apocrine glands in the external canal; it serves as a protective and cleansing function.

2. Etiology

Accumulation of cerumen obstructs the ear canal causing itching, pain and a temporary conductive hearing loss.

3. Clinical manifestations

4. Subjective

1. Student states, "My ear is stopped up".
2. Record complains of the following:
 - a. Difficulty hearing
 - b. Itching
 - c. Pain

5. Objective

Physical assessment

1. Temperature
2. Visualize both ear canals for:
 - a. Thick, dark brown, waxy material
 - b. Flaky, crumbly cerumen (especially in oriental children)
 - c. Blood
 - d. Possible foreign body

6. Assessment

Sensory-Perceptual alterations (auditory) related to occluded ear canal.

7. Plan

1. Refer/Consult physician:
 - a. Bleeding or drainage from ear canal
 - b. Possibly foreign body
 - c. Inability to directly observe earwax accumulation

Earwax, excess (cont'd)

- d. Symptoms not relieved by protocol
2. Therapeutic Nursing Intervention
- a. Instill Debrox (carbamide peroxide 6.5% in anhydrous glycerol). 3-5 drops in affected ear(s) twice a day for 2 days, then irrigate.
 - OR
 - b. Per protocol
- 8. Education**
9. Remember the saying, “Don’t put anything in your ear smaller than your elbow!” Using a Q-tip or anything else to remove the wax only pushes the wax deeper into the outer ear tube, possibly damaging your ear.
10. If student has thick ear wax, encourage him/her to return to the clinic periodically to have ears cleaned by medical staff.
- 11. Follow-up**
- 12. Instill Debrox and irrigate as indicated.
 - 13. If increase or change in symptoms.

STUDENT EDUCATION
EAR WAX, EXCESS (CERUMEN)

Some people have more earwax or thicker ear wax than other people. When you have thick ear wax it can get hard and block the outer ear tube. This blocked wax can cause a “stuffed up” feeling, a feeling like something is stuck in the ear, itching, decreased hearing, ringing in the ears or dizziness.

After the wax has been removed by the medical staff, you should feel much better.

You should do the following things:

14. “Don’t put anything in your ear smaller than your elbow!” Using a Q-tip or anything else to remove the wax often just pokes the wax deeper into the outer ear tube, so don’t do it.
15. Since you have earwax that is thick, you may need to have your ears cleaned out by the medical staff at other times. If you have problems, return to sick call.

You should return for sick call if:

16. You get an earache
17. Have chills
18. Drainage from your ear

Protocol #34

EARACHE

I. Definition

Pain that occurs in the external or middle ear.

II. Etiology

1. May be referred to the ear from remote disease processes.
2. Mild inflammation in the external auditory canal
3. Perichondritis of the pinna
4. Eustachian tube obstruction
5. Middle ear infection
6. Otitis Media

III. Clinical manifestations

A. Subjective

1. Student states, "My ear hurts."
2. Record complaints of the following:
 - a. Earache
 - b. Feeling of fullness
 - c. Pressure in ear
 - d. Decreased hearing ability
 - e. Onset of symptoms
 - f. History of recent URI
 - g. Headache
 - h. Dizziness

B. Objective

Physical assessment of ear canal:

1. Swelling/bulging/red eardrum – usually otitis media
2. Pain/swelling ear canal – usually otitis externa
3. Drainage/purulent fluid – usually perforated eardrum
4. Wax, unable to visualize eardrum – excess wax
5. Vital signs with elevated temperature – usually otitis media

Earache (cont'd)

C. Assessment

1. Acute pain may be related to:
 - a. Swelling/increased pressure of eardrum
 - b. Swelling of ear canal
 - c. Perforated eardrum
 - d. Excess earwax
 - e. Fever
2. Sensory-Perceptual alterations (auditory) may be related to:
 - a. Perforated eardrum
 - b. Occlusion of ear canal
 - c. Swelling of ear canal
3. High risk for injury related to vertigo

D. Plan

1. Refer/Consult physician:
 - a. Evaluation and treatment of elevated temperature and intractable pain
 - b. Stiff neck (may be indicative of meningitis)
 - c. Pain, swelling behind ear (may be indicative of mastoiditis)
 - d. Otitis media/external
2. EMERGENCY: Abrupt hearing loss with:
 - a. Pain
 - b. Drainage
 - c. Dizziness
 - d. Bloody discharge
3. Therapeutic Nursing Intervention:
If excess earwax, see protocol for excess earwax

E. Education

1. Do not put anything in your ear.
2. Do not attempt to clean your ear with matches, toothpicks, Q-tips, etc.
3. Avoid vigorous blowing of your nose.
4. Avoid getting water in your ear during showers.
5. When to return for sick call (see next page)

Earache (cont'd)

F. Follow-up

Return for sick call if:

1. Discomfort increases and/or symptoms become more severe
2. Increase in pain/pressure
3. There is a popping sensation followed by sudden release in pressure and drainage from ear canal
4. Student has a sensation of lethargy
5. As needed

STUDENT EDUCATION
EARACHE

Earaches are caused by many different things. It is important that you avoid activities, which could further irritate your ear.

1. Do not put anything into your ear.
2. Do not attempt to clean your ear with matches, toothpicks, Q-tips, etc.
3. Avoid vigorous blowing of your nose.
4. Avoid getting water in your ear during showers.
5. You may apply a well wrung out warm washcloth to the ear for comfort.

You should return for sick call if:

1. You experience an increase in pain or pressure
2. You experience a popping sensation followed by a sudden release in pressure and/drainage from your ear canal.
3. You experience a feeling of extreme tiredness.

ENURESIS

1. Definition

An involuntary passage of urine during the day or night.

2. Etiology

3. Unknown cause
4. Psychologic factors
5. Limited bladder capacity
6. Delayed neurologic maturation
7. Profound sleep state
8. Urinary tract infection
9. Obstructive lesions of the urinary tract
10. Primary neurologic disorder
11. Disorders associated with decreased urine-concentrating ability and increased volume

12. Clinical manifestations

13. Subjective

1. Usually cottage staff reports student's bed wetting.
2. Record complaints of the following from staff and/or student:
 - a. Urine-stained and wet clothes
 - b. Odor
 - c. Emotional/behavioral problems
 - d. Poor appetite
 - e. Poor nutritional status
 - f. Itching
 - g. Foul odor
 - h. Stained underpants from constant dribbling
 - i. Redness and/or impetigo in genital area
 - j. When began (recent onset)

14. Objective

1. Physical assessment
 - a. Evidence of psychologic and behavior problems
 - b. Lumbosacral skin abnormalities
 - c. Abnormalities of the genitalia, including urethral meatus
 - d. Poor rectal sphincter tone
 - e. Decrease perineal sensation to pinprick

Enuresis (cont'd)

- f. Infection under an excessively long foreskin
 - g. Fever
 - h. Foul odor
 - i. Family history (familial tendency)
 - j. Boys are affected somewhat more frequently than girls
 - k. How many times a day/day and night
2. Laboratory (Urinalysis)
- a. Specific gravity (concentrating ability)
 - b. Dipstick for nitrite, albumin and/or lymphocytes
- 15. Assessment**
16. Urge incontinence related to possible irritation of bladder receptors causing spasm from:
17. Bladder infection
18. Stimulants
- c. Increased fluid intake
19. Defensive coping related to reticule from others caused by incontinence.
- 20. Plan**
1. Refer/Consult physician:
All cases
2. Diagnostic:
- a. Urinalysis
21. Specific gravity
22. Dipstick for nitrite, albumin, lymphocytes
- b. Complete history and physical
- 23. Education**
- 1. Reassure
 - 2. Listen to student's concerns and try to answer questions.
- 24. Follow-up**
- 25. As ordered by physician
 - 26. As needed

STUDENT EDUCATION
ENURESIS

Bed-wetting is also called *nocturnal enuresis*. This occurs in at a time when urinary control is expected. It is more common in boys than girls and can be associated to sleep disorders such as sleepwalking and night terrors (nightmares). It is rarely caused by physical problems, but the doctor may want to check for these first.

The nurse may ask you some questions about your history and the doctor may do a physical exam on you. You may be asked to urinate in a cup for the laboratory to test for any infections.

There are some things you can do to try to prevent wetting the bed. These include:

27. Try not to drink a lot of fluids any closer than 2-3 hours before going to bed.
28. Empty your bladder just before going to bed.
29. If you awaken at night, empty your bladder at that time.

The doctor may prescribe medication for this problem that can be helpful. He/she will explain this medication to you.

If you have any questions, you can talk with the nurse or the doctor.

Protocol #36

EPISTAXIS

I. Definition

The spontaneous discharge of blood from the nose.

II. Etiology

1. Spontaneous rupture of a blood vessel in the nose (usually the anterior septum), occurring most frequently in children and in the elderly.
2. Higher incidence in winter, when heating causes drying and cracking of nasal mucosa.
3. Trauma from a direct blow to the nose.
4. Picking of dry, crusted nostrils.
5. Rarely, hypertension
6. Rarely, a bleeding disorder

III. Clinical manifestations

A. Subjective

1. Student states, "My nose is bleeding".
2. Record reports of the following:
 - a. History of recurrent nose bleeds
 - b. History of blood in urine
 - c. History of easy bruising
 - d. History of prolonged bleeding
 - e. Hot temperature in cottage
 - f. Recent trauma to nose
 - g. Complaints of headache

B. Objective

Physical assessment

1. Vital signs
2. Origin of bleeding
3. History on chart of chronic condition (bleeding disorder, clotting disorder)
4. Fresh blood in pharynx
5. Evidence of scratching or "picking" at nose
6. Onset and duration of active bleeding

Epistaxis (cont'd)

C. Assessment

1. High risk for aspiration related to blood draining into the posterior nasopharynx.
2. Fluid volume deficit (active loss) related to excessive bleeding from nose.

D. Plan

1. Refer/Consult physician:
 - a. Bleeding is not controlled after 15 minutes of compression
 - b. Recurrent bleeding within one hour
 - c. Evidence of bleeding/clotting disorder
 - d. Third episode within one week
 - e. Blood pressure > 100 diastolic
2. Therapeutic nursing intervention:
 - a. Keep student in an erect sitting position with head tilted slightly forward to prevent blood from going down the posterior nasopharynx.
 - b. With thumb and forefinger, apply continuous external compression on both sides of the nose for 15 minutes. (Do NOT release for 15 minutes).
 - c. Breathe through mouth.
 - d. Spit blood from mouth.
 - e. Cold pack to bridge of nose.
 - e. Observe 45 – 60 minutes after bleeding stops

E. Education

1. Discourage picking of the nose.
2. Rub petroleum jelly over the nasal septum twice a day when dry or crusted. (DO NOT stick large globs of the jelly up the nostrils, since it can be aspirated).
3. Return to sick call if notice bleeding in other parts of the body.
4. How to stop bleeding if it recurs.
5. Do not blow nose hard.

F. Follow-up

1. Return for sick call if nosebleed recurs and can't be controlled.
2. Return for sick call in 24 hours if blood pressure was elevated initially.
3. Return for sick call to remove packing.

STUDENT EDUCATION
EPISTAXIS

Many things can cause a nosebleed. The most common causes are:

too dry a nose that causes crusts
blowing your nose too hard
an injury to your nose
picking at your nose

Sometimes a nosebleed can be caused by high blood pressure or some medicines, like too much aspirin.

You should do the following things:

1. Do not blow your nose hard.
2. Do not pick your nose.
3. If your nose starts to bleed again you should:
 - a. Remain calm
 - b. Squeeze the soft part of your nose together for 10-15 minutes
 - c. Sit up and lean a little forward
 - d. Put a cold cloth or ice wrapped in a cloth
4. Ask to see the nurse if:
 - a. Bleeding does not stop when you squeeze your nose
 - b. Bleeding lasts longer than 10 minutes
 - c. You get dizzy or light-headed
5. If packing is placed in your nose, you should return for sick call in 24 hours and **DO NOT REMOVE THE PACKING**

Protocol #37

EYE: FOREIGN BODY

1. Definition

Object(s) that lodge in the eye.

2. Etiology

Same as above

3. Clinical manifestations

4. Subjective

1. Student states, "I have something in my eye."
5. Record the following:
 - a. Time of occurrence/injury
 - b. How the injury/occurrence occurred

6. Objective

Physical assessment:

1. Visual acuity with Snelling Visual Acuity Chart
2. Appearance of conjunctiva and cornea
3. Shape and size of pupil
4. Location of foreign body

7. Assessment

1. Acute pain related to foreign body in eye.
2. High risk for infection related to tissue trauma caused by foreign body.
3. Sensory-Perceptual alterations (visual) related to trauma to sense organ.

8. Plan

1. Refer/Consult physician:
 - a. Foreign body not easily removed
 - b. Continued pain after removal of foreign body
 - c. Foreign body caused by steel or glass

Eye – foreign body (cont'd)

2. Therapeutic nursing intervention:
9. Attempt to remove freely movable object with moistened applicator. cotton-tip
10. Rinse eye with saline eyewash solution.
11. Re-check and document visual acuity.

3. EMERGENCY:
 - a. Imbedded objects
 - b. Penetrating injuries

12. Education

1. If suspect object is in eye DO NOT rub your eye.
2. Wear safety glasses when there is a chance something may fly into your eyes.
3. Return for sick call if you get increase in pain or blurry vision.

13. Follow-up

14. Return to sick call in 24 hours for re-check.
15. As needed.

STUDENT EDUCATION
EYE – FOREIGN BODY

Injury to the eye is one of the world's six main causes of blindness. Accurate diagnosis and prompt treatment are very important in prevention of blindness. The following are four major categories of eye injuries:

16. Sharp injuries – injuries involving foreign bodies (metal, wood, and any environmental material), automobile accidents, gunshot wounds, scissors, arrows from bow sets, and darts. There can result in penetration (goes into but not through) and perforation (goes through) of the eye.
17. Blunt trauma – injuries caused by blows from fists, projectile objects such as tennis balls, and blows to head and/or eye in automobile accidents.
18. Chemical injuries – caused by substances that are vapor, liquid or solids. These can be cleaning chemicals such as ammonia.
19. Head and radiation – include thermal burns of the body such as the head, hot metals, high voltage and radiation from infrared, ultraviolet, and x-ray.

ALL injuries to the eye should be considered an emergency and should be reported to the staff.

DO NOT rub your eye(s) when you feel like there is something in it. It should be flushed with sterile saline made especially for the eye.

Any change in your vision should be reported to the staff.

NEVER attempt to remove a penetrating object from the eye. This can cause further injury to the eye.

Protocol #38

FATIGUE

I. Definition

A feeling of tiredness or weariness.

II. Etiology

1. Psychological causes (89% - 90% of fatigue in adolescents/children)
 - a. Depression
 - b. Anxiety
 - c. Stressful situations
 - d. Boredom
2. Physiological causes
 - a. Inadequate sleep
 - b. Dieting
 - c. Too much activity
 - d. Pregnancy
 - e. Rapid growth spurts
3. Organic causes (infrequent during adolescence)
 - a. Drugs/Medication
 - b. Infections (mononucleosis, hepatitis, influenza, mycoplasma pneumonia)
 - c. Allergies
 - d. Anemia
 - e. Hypothyroidism
 - f. Hypoglycemia
 - g. Diabetes mellitus
 - h. Obesity

III. Clinical manifestations

1. Student states, "I feel tired all the time".
2. Record the complaints of the following:
Emotional fatigue:
 - a. Fatigue on arising, stays the same or improves through the day.
 - b. Fatigue unchanged despite adequate sleep.
 - c. Fatigue level changes frequently during the day.
 - d. Conflict with other
 - e. Boredom
 - f. Anxiety

Fatigue (cont'd)

- g. Depression (acting out behavior, insomnia, apathy, withdrawal)
- h. Anxiety (headache, abdominal pain, chest pains, palpitations)

Organic fatigue:

- a. Fatigue increases during the day,
 - b. Fatigue decreases with rest.
 - c. Night sweats
 - d. Change in bowel habits
 - e. Skin changes
3. Question student about the following and record answers:
- a. Peer relationships
 - b. Family situation
 - c. Nutritional intake
 - d. Sleep patterns
 - e. Daily activities

B. Objective

- 1. Physical assessment
 - a. General appearance
 - b. Height and weight
 - c. Lymph nodes
 - d. Thyroid gland
 - e. Auscultate heart (possible heart murmur)
 - f. Hepatosplenomegaly
- 2. Laboratory
 - a. Hematocrit and/or hemoglobin
 - b. Any ordered by physician (i.e. urinalysis, monospot, blood glucose, pregnancy test).

C. Assessment

Fatigue related to:

- a. Decreased metabolic energy production
- b. Altered body chemistry (medications, drug withdrawal)
- c. Increased energy requirements to perform activities required (i.e. PT)
- d. Overwhelming psychological or emotional demands

Fatigue (cont'd)

D. Plan

1. Refer/Consult physician:
 - a. Suspected endocrine disorders
 - b. Suspected neoplasm
 - c. Appearance of chronic illness
 - d. Failure to respond to treatment within four weeks
 - e. Pregnancy

2. Therapeutic nursing intervention:
 - a. Reassurance
 - b. Advise about needed lifestyle changes (sleep, diet and activities)
 - c. Address emotional problems and concerns
 - d. Any treatments ordered by physician (anemia, mononucleosis, influenza)

E. Education

1. Cause, treatment and prevention
2. Lifestyle (sleep, diet, activities)
3. When to return to clinic

F. Follow-up

1. As ordered by physician
2. In one week to verify management plan
3. As needed

STUDENT EDUCATION FATIGUE

Fatigue is defined as a feeling of tiredness or weariness. There can be a number of causes of fatigue. Below is a list of some causes:

excessive activity
Malnutrition
anemia (“low blood”)
heart disease
breathing disturbances
infectious diseases
diabetes
emotional problems
frustration
anxiety
boredom

There are three types of fatigue:

1. Acute fatigue – can result from excessive exertion and is relieved by rest.
2. Chronic fatigue – not relieved by rest and can indicate diseases.
3. Muscular fatigue – reduces ability of muscles to perform because of excessive overuse of that particular muscle.

There can be many treatments for fatigue depending on the cause. The nurse can explain this further to you and explain the possible cause of your fatigue after examination by the doctor.

Protocol #39

FRACTURE/DISLOCATION

1. Definition

A fracture is a sudden breaking of a bone.

2. Etiology

3. Certain diseases (no trauma required)
4. Osteomalacia
5. Syphilis
6. Osteomyelitis

7. Direct violence – the bone is broken directly at the spot where the force was applied. (i.e. Fracture of the tibia by being run over).

8. Indirect violence – the bone is fractured by force applied at the distance from the site of fracture and transmitted to the fractured bone. (i.e. Fracture of the clavicle by falling on the outstretched hand).

9. Muscular contraction – the bone is broken by a sudden violent contraction of the muscle.

10. Clinical manifestations

11. Subjective

1. Student states, “My (arm, leg, finger, etc.) hurts and I can’t move it.”
2. Record the following information as reported by the student:
 - a. How injury occurred
 - b. When the injury occurred
 - c. Location of injured part

12. Objective

Physical Exam

1. Vital sign (Blood pressure from uninjured arm, if arm injury).
2. Location of injury
3. Appearance of injury
 - (1) Swelling
 - (2) Bruising
 - (3) Deformity
 - (4) Possible shortening
4. Neuro/vascular assessment

Fractures (cont'd)

13. Assessment

1. Acute pain related to possible movement of bone fragments and tissue trauma.
2. Impaired physical mobility may be related to:
 - a. Neuromuscular skeletal impairment
 - b. Pain/discomfort
 - c. Limited range of motion
 - d. Decreased muscle strength/control

14. Plan

1. IMMEDIATE nursing intervention:
15. Immobilize the limb or part. Splint joint above and below injury site.
16. Clothing should NOT be removed unless dangerous hemorrhage is present.
17. Cover wound with sterile dressing
18. If necessary, remove clothing by cutting to prevent disturbing the area.
 - e. If upper extremity – support with a sling, then student can walk.
 - f. If lower extremity – student should remain supine and make no attempt to walk.
 - g. Monitor student's overall condition for shock and other complications.
 - h. Refer to physician/emergency room
19. EMERGENCY:
 - a. Impaired circulation
 - b. Displaced fracture
 - c. Shock
 - d. Hemorrhage
 - e. Spinal fracture
 - f. Skull fracture

20. Education

1. Instruct student not to move injured area.
2. Calm/reassure student.
3. After emergency/physician care.
21. Report signs or symptoms of swelling, pain and/or loss of sensation.
 - c. Keep injured area if limb, elevated to prevent swelling.

22. Follow-up

23. As ordered by physician
24. If any signs and/or symptoms above (education)

STUDENT EDUCATION
FRACTURE

Most fractures are the result of trauma caused by stress being placed on the bone. The following are types of stress to the bone:

25. A direct blow to the bone
26. An indirect twisting motion or a severe muscle contraction
27. Disease, such as cancer.

There are two classifications of fractures. One is a closed fracture and the other is an open fracture. An open fracture is when the bone protrudes through the skin and can be seen.

The following are signs and symptoms of a fracture:

swelling
pain
tenderness
loss of function
deformity
discoloration (bruising)
grating sensation heard when bones rub together
bleeding at the site from open wound

The doctor may order an x-ray to check if an injured bone is broken (fractured). If it is, the doctor may put a cast on. It is important that you do not remove the cast and that it stays on until the doctor removes it. If you notice any swelling or discoloration around the area of the cast, you should alert your staff IMMEDIATELY.

STUDENT EDUCATION **DISLOCATION**

A dislocation is the displacement of a bone from the normal position in the joint. This is usually the result of trauma of great force.

Some signs and symptoms of dislocation are:

severe pain
change in length of the extremity
inability to move the extremity without severe pain
change in shape of the joint

It is important that you do NOT move the area that is injured. The doctor may order an x-ray to check for a dislocation. You may be required to have a cast placed. It is important that you keep the cast on and it should be removed by the doctor ONLY.

It is important that you alert the staff IMMEDIATELY if you notice any swelling or change in sensation or color of the area that the cast is placed.

Protocol #40

GASTROENTERITIS, ACUTE

I. Definition

An acute inflammation of the gastrointestinal tract characterized by passage of stools that are more liquid than normal, usually with an increase from the student's normal frequency. The disorder is often preceded by, or associated with, vomiting.

II. Etiology

1. Usually known cause
 - a. Nonspecific gastroenteritis
 - b. Simple diarrhea
2. Occasionally
 - a. Specific bacterial infection (shigella, salmonella, campylobacter)
 - b. Side effects of oral antibiotics
 - c. Food poisoning (salmonella, staphylococcal enterotoxin)

III. Clinical manifestations

A. Subjective

1. Student reports, "My stomach hurts and I keep going to the bathroom."
2. Record presence or absence of following as reported by student:
 - a. Liquid content of stools
 - b. Frequency of stools
 - c. Vomiting (frequency)
 - d. Abdominal pain
 - e. Flecks of blood in stool
 - f. Weakness

B. Objective

Physical assessment

1. Vital signs
2. Palpate abdomen
 - a. Distention
 - b. Tenderness
3. Auscultate bowel sounds

Gastroenteritis, Acute (cont'd)

4. Assess for dehydration
 - a. Sunken eyes
 - b. Dry mucous membranes
 - c. Decreased skin turgor
 - d. Weight loss

C. Assessment

1. Acute pain may be related to irritation/inflammation of gastric mucosa.
2. High risk for fluid volume deficit may be related to excessive losses through vomiting and/or diarrhea
3. Altered nutrition (less than body requirements) may be related to inability to ingest adequate nutrients.

D. Plan

1. Consult/refer to physician:
 - a. Severe dehydration
 - b. Severe abdominal pain
 - c. Blood in stools
 - d. Failure to improve with treatment in 48 hours
 - e. Suspected Salmonella or Shigella infections
 - f. Chronic diarrhea
 - g. Uncontrolled vomiting with treatment
2. Therapeutic nursing intervention:
 - a. Identify early signs of dehydration.
 - b. Record intake and output.
 - c. Weight student carefully at initial visit and each follow-up visit.
 - d. Management of vomiting and/or diarrhea for first 12 hours:
 - (1) Discontinue present diet, especially milk and milk products
 - (2) Have student drink small amounts of clear liquids with low electrolyte concentration (i.e. ginger ale at room temperature without carbonation).
 - e. Management of vomiting and/or diarrhea for next 12 hours:
Increase amounts of clear liquids
 - f. Management of vomiting and/or diarrhea for next 24 hours:
 - (1) If diarrhea not improved, continue clear liquids.
 - (2) If diarrhea is improved, add easily absorbed solids (i.e. Jell-o, saltine crackers, or bananas) to clear liquid diet.
 - g. If diarrhea continued to improve after 48 – 72 hours of clear liquids and simple solid foods listed in c., you may gradually add dry toast, baked potato (without butter).

Gastroenteritis, acute (cont'd)

- h. Withhold the following until foods in g. are tolerated well:
 - (1) milk
 - (2) cheese
 - (3) eggs
 - (4) fried foods

E. Education

1. Explain the importance of fluid intake even if not desired.
2. Explain the importance of recording the intake and output.

STUDENT EDUCATION
GASTROENTERITIS

Gastroenteritis is manifested by upper GI tract symptoms that include:

diarrhea
vomiting
nausea
abdominal pain

It can be caused by a number of things and some that are uncertain. It can be caused by bacteria, virus or parasites.

The symptoms are usually sudden in onset and can be severe depending on the cause. If you vomit or have diarrhea, it can cause severe dehydration and shock. It is important that if you experience these, you replace the fluid that is lost by drinking.

You will be placed on a clear liquid diet until the vomiting stops. If the vomiting is severe and you are unable to drink fluids, you may need to be hospitalized for IV fluids. You may be given medication to help the nausea and vomiting.

After the vomiting diminishes, you will be advanced to a diet of bland foods (cereal, jell, soups). After 24 – 48 hours of this diet you should be able to advance to your regular diet.

Protocol #41

GONORRHEA

G. Definition

An acute infectious disease of the epithelium of the urethra, cervix, rectum, pharynx, or eyes that may lead to bacteremia and result in metastatic complications.

H. Etiology

Neisseria Gonorrhoea bacteria, a gram-negative diplococcus.

I. Clinical manifestations

J. Subjective

1. Student states, "I have a drainage from my penis."
2. Record the reports of the following from the FEMALE student:
 - a. Dysuria
 - b. Frequency
 - c. Vaginal discharge
 - d. Swelling of perineal area
 - e. Lower abdominal pain
3. Record the reports of the following from the MALE student:
 - a. Testicular pain or swelling
 - b. Dysuria
 - c. Purulent discharge
 - d. Frequency
 - e. Urgency
 - f. Swollen glans of penis
 - g. Burning

K. Objective

Physical assessment

1. Female
- L. No discharge, mucoid, mucopurulent urethral or endocervical discharge
- M. Enlarge inguinal lymph nodes
- c. Enlarged Bartholin cyst
 - d. Fever

Gonorrhea (cont'd)

2. Male
 - a. Slight urethral discharge with “stripping” of urethra
 - b. Diffuse penile edema
 - c. Enlarged epididymis
 - d. Enlarged inguinal lymph nodes

N. Assessment

- O. Acute pain related to irritation/inflammation of mucosa and effects of circulating toxins.
- P. Knowledge deficit (learning need) related to:
 - a. Disease cause
 - b. Disease transmission
 - c. Therapy
 - d. Self-care needs

Q. Plan

Consult/refer to physician or health department STD clinic ALL suspected or confirmed cases.

R. Education

1. How transmitted.
2. How prevented.
3. Medication
 - a. Effects and side effects
 - b. Importance of taking medications as prescribed
4. Complications and consequences of STD's
5. Perineal hygiene, perianal hygiene, penile hygiene.
6. Clean cotton-crotch undergarments daily

S. Follow-up

1. One week or as ordered by physician.
2. PRN
3. No improvement or worsening of symptoms.

STUDENT EDUCATION
GONORRHEA

Gonorrhea is a sexually transmitted disease that is easily spread. It can cause other problems if left untreated.

Some signs and symptoms of this disease are:

MALE

yellow discharge from the penis

painful urination

FEMALE

sometimes no symptoms

vaginal discharge

painful or frequent urination

lower abdominal pain

The **ONLY** way to prevent gonorrhea is by **NOT** having sex. Use of a condom or avoiding sex with an infected person can help prevent it. Because some people that have this disease do not have any symptoms, it may be difficult to tell if someone is infected.

If you think that you might have gonorrhea, you should tell the nurse so you can be tested. If you are diagnosed, you may be given an antibiotic. It is important that you finish this antibiotic.

If you have any questions, the nurse is available to answer them.

Protocol #42

GRANULOMA INGUINALE (DONOVANOSIS)

G. Definition

A chronic granulomatous condition usually involving the genitalia and probably spread by sexual contact.

H. Etiology

Caused by *Donovania granulomatous*; mildly contagious.

I. Clinical manifestations

J. Subjective

1. Student states, "I have bumps in my private area."
2. Document the reports of the following from student:

K. When symptoms began.

L. If experiencing pain.

M. Objective

Physical assessment

1. Beefy red genital ulcers with clear sharp margins and granulated centers.
2. Lesions may enlarge and coalesce to form single large ulcer.
3. Inguinal swelling

N. Assessment

Knowledge deficit (learning need) may be related to:

1. Cause of infection
2. Prevention of spread of infection

O. Plan

Consult/refer all suspected cases to physician or local health department STD clinic.

Granuloma inguinale (cont'd)

P. Education

1. Cause
2. Prevention
3. Medication
 - a. Effects
 - b. Side effects
4. Complications/consequences
5. Perineal hygiene, perianal hygiene, penile hygiene
6. Clean cotton-crotch undergarments daily

Q. Follow-up

1. In one week or as ordered by physician
2. As needed
3. No improvement or worsening of symptoms

STUDENT EDUCATION
GRANULOMA INGUINALE

Granuloma inguinale is a condition that usually involves the genitals and is probably spread by sexual contact.

They present as lesions that are usually found:

MALE

penis
scrotum
groin
thighs
anus
buttocks
face

FEMALE

vulva
vagina
perineum
anus
buttocks
face

The lesions are usually painless and can be in your system for 1 – 12 weeks without appearing.

If you have any sores or lesions, you should report it to the medical staff and you may need to be examined by the doctor. The doctor may prescribe an antibiotic. It is important that you take the whole course of the medication and do not stop until finished.

The only way to prevent getting this is by not having sex. Condoms may decrease the chances of your getting this, but it is not a definite prevention.

Protocol #43

GYNECOMASTIA

I. Definition

Gynecomastia refers to a benign increase in glandular and stromal tissue associated with puberty.

Peak prevalence at 14 years and prevalence falls thereafter. Mean age of onset is 13 years, 2 months.

II. Etiology

Unknown, but following hypothesis exist as to cause:

1. Increase in biologically active estrogen or increased sensitivity to estrogen.
2. Decrease in ratio of testosterone/estradiol or androstenedione/estrone.

III. Clinical manifestations

A. Subjective

1. Student states, "I've got a lump on my chest".
2. Record reports of the following from student:
 - a. Enlargening of breast (unilateral or bilateral)
 - b. Tenderness
 - c. Drainage

B. Objective

Physical assessment (palpation)

1. Type I – One or more subareolar nodules, freely movable.
2. Type II – Breast modules, beneath areola, but also extending beyond areolar perimeter.
3. Type III – Resembles breast development of sexual maturity rating 3 in the female.
4. Types I and II are associated with a firm, rubbery consistency of the breasts.
5. Type III is associated with a consistency similar to female breasts.
6. Assess for testicular mass or atrophy.

C. Assessment

1. Acute pain may be related to lobular formation.
2. Disturbance in body image may be related to enlargement of breast(s).
3. Knowledge deficit (learning need) may be related to changes occurring during puberty.

Gynecomastia (cont'd)

D. Plan

Refer/consult physician.

1. Appearance before the onset or after the completion of puberty.
2. Massive gynecomastia
3. Psychologically incapacitating
4. When any of the following suspected:
 - a. Hypogonadism
 - b. Hyperthyroidism
 - c. Hypothyroidism
 - d. Liver disease

E. Education

1. Teach monthly breast self exams (BSE) in BOTH males and females.
2. Reassurance – usually resolves in 12 – 18 months.
3. Explain changes in puberty.

F. Follow-up

1. In one month to review BSE
2. Re-examine in 12 –18 months
3. As needed
4. As ordered by physician

STUDENT EDUCATION
GYNECOMASTIA

Gynecomastia is an enlargement of the breasts in males. It is normal and usually occurs during puberty. It may be in both breasts or only in one. There may be some tenderness or pain. There is usually no need for treatment and usually disappears.

Although it may be embarrassing, many males suffer from this. If you have any concerns or questions, you can talk with the nurse.

Protocol #44

HAY FEVER/ALLERGIC RHINITIS

1. Definition

An allergic disease of mucous membranes of nose and upper air passages induced by external irritation.

2. Etiology

1. Spring type:
Pollen of trees (i.e. oak, elm, hickory, ash)
2. Summer type:
Pollen of plants (i.e. grasses, plantain, sorrel)
3. Fall type:
Pollen of ragweed
4. Non-seasonal type:
 - a. Inhalation of:
 3. Dander of animals
 4. Dust
 5. Hay
 - (4) Straw
 - (5) House dust
 - b. Ingestion of:
 6. Drugs
 7. Foods

8. Clinical manifestation

9. Subjective

1. Student states, "I'm sneezing and my eyes are watering".
2. Record the following as reported by student:
 - a. Sneezing
 - b. Nasal itching
 - c. Watery eyes
 - d. Nasal stuffiness
 - e. Non-productive cough
 - f. Fatigue
 - g. Irritability
 - h. Anorexia
 - i. Frontal headaches

Hay fever/Allergic rhinitis (cont'd)

10. Objective

1. Clear, thin nasal discharge
2. Pale or blue edematous and/or erythematous nasal mucosa
3. Enlarged nasal turbinates
4. Mouth-breathing
5. Conjunctival injection and edema (dark circles or lines under eyes)
6. Lacrimation
7. Sneezing
8. Temperature

11. Assessment

1. Acute pain may be related to:
 - a. Edematous nasal mucosa
 - b. Headache caused by swelling of sinus cavity or fever
2. Sleep pattern disturbance may be related to edematous nasal mucosa and/or nasal congestion.

12. Plan

1. Refer/consult physician:
 - a. Purulent drainage
 - b. Fever or other signs of bacterial infection
 - c. Medication orders
 - d. Failure to respond to treatment

13. Education

14. Avoid damp and dusty places.
15. Do not use wood or other rough fabrics that hold dust on beds

STUDENT EDUCATION
HAY FEVER/ALLERGIC RHINITIS

Hay fever can cause many symptoms, one of the most frequent is a runny nose. Most hay fever occurs during seasons when pollens are high.

You should do the following:

16. Try to avoid the pollens or other things that may cause or aggravate the hay fever, if you can.
17. Drink plenty of fluids.
18. Request Tylenol if you have a headache.
19. You may be given a medication to treat hay fever from the clinic.

Return to sick call if:

20. You get a fever, chills.
21. You begin having yellow or green drainage.
22. Do not get better in 3 days.

Protocol #45

HEADACHES

I. Definition

A diffuse pain in different portions of the head and not confined to any nerve distribution area. May be acute or chronic, frontal, temporal, or occipital, confined to one side of head or the region immediately over one eye.

II. Etiology

For many headaches, the etiology is unknown, however other causes include intra-cranial infection, intra-cranial tumor, head injuries, severe hypertension, cerebral hypoxia and many diseases of eyes, nose, throat, teeth, and ears.

III. Clinical manifestations

A. Subjective

1. Student reports, "My head hurts",
2. Record the student's report of the following:
 - a. Duration
 - b. Location
 - (1) Migraines tend to be well localized
 - (2) Frontal headaches suggest sinusitis
 - (3) Temporal headaches may be a symptom of a dental abscess or of involvement of the temporomandibular joint
 - c. Family history
 - d. Nausea
 - e. Vomiting
 - f. Dizziness
 - g. Photophobia
 - h. Seizures
 - i. Double vision
 - j. Character of pain
 - (1) Throbbing – vascular/migraine
 - (2) Dull - tension
 - k. Pattern
 - (1) Paroxysms or attacks – migraine/vascular headaches
 - (2) Constant and occur daily for long periods of time – tension headaches
 - (3) Persistent with worsening over the course of several weeks - increased intra-cranial pressure or hypertension
 - l. History of head trauma
 - (1) Post-concussion syndrome – chronic headaches without physical findings

Headache (cont'd)

- (2) Subdural hematoma – stiff neck, focal neurologic signs or personality change
- m. Stiffness and pain of neck
- n. Tenderness of sinuses

B. Objective

1. General appearance:
 - a. Physically well or depressed – tension headaches
 - b. Acutely ill – migraine, meningitis, or brain tumor
2. Vital signs:
 - a. Temperature – if elevated, consider meningitis, encephalitis if severe headache
 - b. Blood pressure – increased intra-cranial pressure (if with bradycardia)
 - c. Pulse
3. Pupil size and reaction
4. Mental status
5. Check ears

C. Assessment

Acute pain related to:

1. Sinusitis
2. TMJ dysfunction
3. Medication
4. Organic (i.e., tumor, injury)
5. Fever
6. Elevated blood pressure

D. Plan

1. Consult/refer to physician:
 - a. Students with headaches that have associated focal neurological findings
 - b. Students with headaches, fever and stiff neck
 - c. Chronic headaches that are getting more frequent or more severe
 - d. Suspicion of sinus infection
 - e. Mild headache that fails to resolve with therapy

Headache (cont'd)

2. Therapeutic nursing intervention
 - a. Acetaminophen 325 milligrams, two tablets by mouth every 4 – 6 hours as needed for pain
 - b. If history of migraines documented, have student lie down in dark quiet room

E. Education

1. Try cool moist cloths to your head.
2. Do not watch TV or read while suffering from headache.
3. Sick call if:
 - a. Start vomiting
 - b. Feel dizzy
 - c. Double vision
 - d. Neck stiffness
 - e. No improvement after treatment
 - f. Frequent occurrences

F. Follow-up

1. Recheck student following day.
2. As ordered by physician
3. If no improvement after treatment
4. If continues

STUDENT EDUCATION **HEADACHE**

Most people have headaches from time to time. Without any other symptoms most headaches are not serious. Many things can cause headaches like tension, sinus congestion, too much caffeine or some medications and high blood pressure.

If you have a headache, you should:

1. Try to find out what causes it and avoid the causes if you can. You need to talk to the medical staff if you think your headache is because of a medication or you have a history of high blood pressure or a family history of high blood pressure.
2. Request Tylenol for headache.
3. Try cool moist cloths on head, if it helps.
4. Rest if you can. Don't watch TV, read or other things like this while you have a headache.

Return to sick call if:

1. Start vomiting
2. Get a fever
3. Don't get better

Protocol #46

HEAD INJURY/TRAUMA

I. Definition

Trauma or damage to head caused by external force or violence.

II. Etiology

Damage results from skull penetration or from rapid brain acceleration or deceleration, which injures tissue at the point of impact, at its opposite pole, and also diffusely within the frontal and temporal lobes.

III. Clinical manifestations

A. Subjective

1. Student or staff reports, "I (he) got hit in my (his) head".
2. Record the student's or staff's report of any of the following:
 - a. Description of the injury.
 - b. Location of injury (blow).
 - c. Change/loss of consciousness
 - d. Headache – severity
 - e. Nausea and/or vomiting
 - f. Excessive drowsiness
 - g. Slurred speech or absence of speech
 - h. Double vision
 - i. Dizziness

B. Objective

1. Physical assessment:
 - a. Location
 - b. Type (abrasion, laceration, bruise, etc.)
 - c. Pupil size and reaction
 - d. Vital signs
 - e. Level of consciousness
 - f. Gait
2. Types of injuries:
 - a. Laceration – more bleeding because skin over scalp has larger blood supply

Head injury/trauma (cont'd)

- b. Bruise – mildly painful swelling.
- c. Skull fracture
 - (1) Non-displaced linear fracture – no symptoms except pain.
 - (2) Basal skull fracture – severe injury, almost always produces disturbance of consciousness or leak of blood or spinal fluid from mouth, nose, or ear.
 - (3) Depressed skull fracture – due to a fragment or larger piece of bone pressing down on brain. Usually cannot be felt on palpation. Requires x-ray for diagnosis.
- d. Brain injury - concussion
 - (1) Mild – momentary clouding of consciousness or memory lapse (seeing stars, ringing bells) and then apparent normality.
 - (2) Moderate – brief period of unconsciousness, distinct memory loss, short period of unusual behavior. Requires 15 – 30 minutes to return to normal. Interview student to check for post-traumatic amnesia, which has the same significance as retrograde amnesia. Orientation to person, place and time.
 - (3) Severe – deeper loss of consciousness lasting 1 –2 minutes or longer, vomiting, fast or slow pulse, irregular breathing, neurological signs such as irregular pupils of the eye, seizure, unilateral weakness, abnormal reflexes, etc.
- e. More severe brain injury usually accompanied by moderate to severe loss of consciousness. Watch for a delayed or second episode of unconsciousness after apparent awakening. May be seen in subdural or epidural hematoma. Usually has vomiting, unequal size of pupils of eyes, unusually rapid or slow pulse rate, excessive drowsiness, slurred speech or absence of speech, double vision, unsteady gait, and/or incoordination of arms and legs.
 - (1) Contusion
 - (2) Laceration
 - (3) Subdural hematoma
 - (4) Epidural hematoma

C. Assessment

1. Acute pain may be related to trauma to head.
2. Altered thought processes possibly related to brain injury.
3. Impaired tissue integrity may be related to trauma causing destruction of tissue.

Head injury/trauma (cont'd)

D. Plan

1. Refer/consult physician or EMERGENCY:
 - a. Any depression of skull
 - b. Any loss of consciousness
 - c. Leak of fluid from mouth, nose, or ear.
 - d. Memory loss
 - e. Unusual behavior
 - f. Amnesia
 - g. Vomiting
 - h. Fast or slow pulse
 - i. Irregular breathing
 - j. Seizure after injury
 - k. Unilateral weakness
 - l. Abnormal reflexes
 - m. If sutures are needed for minor laceration
 - n. Appearance of progression of swelling beneath scalp.

2. Immediate first-aid:
 - a. Keep student quiet and lying down.
 - b. If unconscious and no evidence of neck injury, turn head to side so secretions can drool from corner of mouth.
 - c. Never position student so head is lower than rest of body.
 - d. Do not give fluids by mouth.
 - e. Do not clean scalp wounds if possible fracture because cleaning may cause more bleeding or contaminate brain.

3. Therapeutic nursing intervention:
 - a. Abrasion/laceration
 - (1) Wash with cleanser or soap.
 - (2) Apply slight pressure with 4x4 gauze or other clean cloth until bleeding stops.
 - (3) Apply steri-strips or if needed, refer for sutures.
 - b. Bruise
 - (1) Apply ice to relieve pain.
 - (3) DO NOT apply pressure

E. Education

Alert staff and student to notify clinic if any symptoms below occur:

1. Excessive drowsiness
2. Changes in breathing
3. Persistent vomiting
4. Weakness on one side, limping

Head injury/trauma (cont'd)

5. Worsening headache
6. Double vision
7. Difficulty speaking
8. Seizure
9. Appearance of progression of swelling beneath scalp.

F. Follow-up

1. Check injury site for 1-2 days
2. As ordered by physician
3. Worsening or no improvement of symptoms.

STUDENT EDUCATION
HEAD INJURY/TRAUMA

Head injury is a leading cause of disability. There are difference classifications of head injuries. These classifications are:

1. Mild Head Injury – usually only a momentary loss of consciousness associated.
2. Moderate to Severe Head Injury – usually experience a momentary loss of consciousness and an alteration in neurological functioning, which could mean:
 - altered level of consciousness
 - sluggishness
 - confusion
 - partial paralysis
3. Severe Head Injury – usually unable to follow simple commands because of the decrease in the level of consciousness. This is the most serious and can lead to death.

Depending on the type and severity of the head injury, one may experience any of the following symptoms:

decreased level of consciousness
restlessness
irritability
confusion
headache
nausea
vomiting

If you experience any of the above symptoms following an injury or blow to the head, you should have someone alert the medical staff.

HEART MURMUR

G. Definition

Sounds from the heart other than those normally present. A murmur is produced by the blood passing over a roughened valve, by flowing through a constricted opening, or by back flow of blood through an incompetent valve.

H. Etiology

I. Systolic murmurs

1. Functional (innocent):
 - a. Commonly in adolescents/children and young adults
 - b. Produced by a normal cardiovascular system
 - c. Usually do not radiate
 - d. Often disappear with inspiration in the upright position
 - e. Vary with position of student
 - f. Best heard with bell of stethoscope
 - g. Occasionally continuous, but usually heard in first part of systole
 - h. Ejection-type
 - i. Usually softer than grade III/IV
2. Aortic stenosis (ejection murmur):
 - a. Best heard in the 2nd intercostals space to the right of the sternum
 - b. Radiates toward the right clavicle and both sides of the neck
 - c. May be associated with systolic thrill
3. Mitral regurgitation (mitral valve insufficiency):

J. Best heard in apex of heart with student lying down in left lateral decubitus position

K. Radiates toward the left axilla

4. Mitral valve prolapse

L. Diastolic murmurs (always pathologic):

1. Mitral stenosis
 - a. Low pitched apical
 - b. Best heard after mild exercise, with student in the left lateral decubitus position
2. Aortic Insufficiency (Regurgitation)
 - a. Blowing, high pitched, decrescendo murmur
 - b. Best heard along the left sternal edge and toward the apex.
3. Atrial septal defect

M. Clinical manifestations

N. Subjective

Heart murmur (cont'd)

1. Student reports, "I have a heart murmur".
2. Record student's report of any of the following:
 1. Usually asymptomatic
 2. Chest pain
 3. Shortness of breath
 4. Heart "skipping beats"
 5. Dizziness/lightheadedness
 6. Fatigue

O. Objective

1. Location
2. Quality
3. Radiation
4. Timing in cardiac cycle
5. Loudness
 - a. Grade I/VI – very soft
 - b. Grade II/VI – easily heard with stethoscope
 - c. Grade III/VI – moderately loud
 - d. Grade IV/VI – loud murmur, may have accompanying thrill
 - e. Grade V/VI – loud murmur heard with stethoscope barely on chest
 - f. Grade VI/VI – loud murmur heard with stethoscope off chest

P. Assessment

- Q. High risk for injury may be related to dizziness caused by cardiac arrhythmias.
- R. Knowledge deficit (learning need) regarding pathophysiology and potential complications may be related to lack of information and misinterpretation.
- S. High risk for infection may be related to potential of bacterial invasion of heart caused by invasive procedures.

T. Plan

1. Refer/consult physician:
 - a. All symptomatic murmurs
 - b. All diastolic murmurs (whether symptomatic or not)
 - c. All murmurs louder than grade III/VI
 - d. All widely radiating murmurs

Heart murmur (cont'd)

U. Education

1. Restrictions (per physician)
2. Type of murmur
3. Limitations (if any)

V. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
HEART MURMURS

Many children and adolescents have heart murmurs. These murmurs are usually harmless and do not require treatment. If the doctor finds that you have a heart murmur, you may be required to have some tests done. One such test is an echocardiogram. In this test, a gel is applied to the chest and a transducer (a device that sends and receives sound wave signals and can be seen as a picture) is moved across the chest. This test is painless and tells the doctor the cause of the murmur.

You may be required to take an antibiotic whenever you have any dental procedures done. This is very important to prevent an infection around the heart. The bacteria can enter the body through the mouth during dental procedures and circulate throughout the body to the heart. This can be very dangerous and can lead to damage. If you have a heart murmur, you should let the doctor or dentist know immediately.

Protocol #48

HEAT EXHAUSTION

I. Definition

A state of very definite weakness produced by the excess loss of normal fluids and sodium chloride in the form of sweat.

II. Etiology

Exposure to high ambient temperature, which may lead to excessive fluid loss and hypovolemic shock.

III. Clinical manifestations

A. Subjective

1. Student states, "I'm feeling dizzy and I can't see".
2. Record the student's reports of the following:
 - a. Headache
 - b. Dizziness
 - c. Blurred and/or dim vision
 - d. Time of onset
 - e. Previous occurrence
 - f. Gradual weakness
 - g. Muscle cramps
 - h. Nausea/vomiting
 - i. Chills
 - j. Anxiety

B. Objective

1. Unsteady gait
2. Excess sweating
3. Vomiting
4. Vital signs
 - a. Blood pressure (usually normal to low)
 - b. Heart rate (usually bradycardia)
 - c. Temperature (usually normal to elevated > 102 F)
 - d. Weight (usually normal)
5. Appearance
 - a. Pale
 - b. Grayish
 - c. Clammy skin

Heat exhaustion (cont'd)

C. Assessment

1. Hyperthermia may be related to prolonged exposure to hot environment or vigorous activity with failure of regulating mechanism of the body.
2. High risk for fluid volume deficit related to excessive perspiration in hot environment or during vigorous activity.
3. High risk for altered body temperature related to:
 - a. Exposure to warm/hot environment
 - b. Dehydration
 - c. Vigorous activity
 - d. Illness or trauma affecting body temperature regulation

D. Plan

1. Refer/consult physician/emergency room:
 - a. If student does not respond to therapeutic nursing interventions
 - b. Student that is on diuretics, anticholinergic, phenothiazines
 - c. If vital signs are not stable.
2. Therapeutic nursing intervention:
 - a. Place student flat or with head down.
 - b. Small amounts of cool, slightly salty fluids should be given orally every few minutes, if student is alert.
 - c. Continue to monitor vital signs.

E. Education

See following page.

F. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
HEAT EXHAUSTION

Heat exhaustion is commonly caused by exercising in a hot and humid environment. The symptoms of heat exhaustion are a result of not enough water in your body to maintain your body temperature at a proper level.

The symptoms you might have with heat exhaustion are:

increasing fatigue
weakness
anxiety
drenching sweats
headache
blurred or dim vision
dizziness
nausea/vomiting
muscle cramps
chills

If you are suffering from heat exhaustion, you should do the following:

1. Decrease your activity for 24 hours.
2. Drink at least eight glasses of water every day. More if you are sweating a lot.
3. Avoid strenuous exercise (such as running) during the heat of the day (usually 10:00 AM to 2:00 PM).
4. When outside, keep your head covered and wear light-weight clothing, if possible.
5. If you become dizzy, get weak, get muscle cramps, **STOP EXERCISING OR WORKING AND COOL YOURSELF OFF AND ASK YOU A DRINK OF WATER.**
6. Return to sick call if you are not better after you rest and drink plenty of fluids.

Protocol #49

HEATSTROKE

1. Definition

A condition or derangement of the heat-control centers due to exposure to the rays of the sun or very high temperature. Loss of heat is inadequate or absent.

2. Etiology

Inadequacy or failure of heat loss mechanism.

3. Clinical manifestations

4. Subjective

5. Record the reports from student, but usually from staff stating student has “fallen out”.

6. Record the following as reported by staff and/or students.

- a. Complaints of headache
- b. Complaints of weakness
- c. Sudden loss of consciousness

7. Objective

8. Face red, dry and hot
9. Skin hot, dry, and no sweating
10. Possible seizures
11. Pupils dilated but not equal
12. Vital signs
 - a. Temperature – high 106 – 110 F
 - b. Pulse – full, strong and bounding
 - c. Respirations – dyspneic and sonorous

13. Assessment

14. Hyperthermia may be related to prolonged exposure to hot environment or vigorous activity with failure of regulating mechanism of the body.
15. Decreased cardiac output may be related to functional stress or hyper metabolic state, altered circulating volume/venous return, and direct myocardial damage secondary to hyperthermia.

Heatstroke (cont'd)

16. Plan

1. ALL CASES REQUIRE EMERGENCY MEDICAL ATTENTION 911!
17. Immediate therapeutic nursing intervention:
 - a. Absolute rest with head elevated
 - b. Cool by any means available
 - c. DO NOT use alcohol applied to skin
 - d. Take temperature every 10 minutes until EMS arrives.
 - e. If available, give infusion of normal saline per doctor's orders
 - f. Monitor all vital signs and level of consciousness

18. Education

Prevention (see following page)

19. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
HEATSTROKE

20. Avoid strenuous exertion:
21. In a very hot environment
22. In an inadequately ventilated space
23. In insulating clothing

24. When sweating, drink plenty of fluid (sports drinks, if possible).

25. If you become dizzy, get weak, get muscle cramps, stop exercising or working and cool yourself off and drink water.

26. When outside, keep your head covered and wear lightweight clothing, if possible.

27. Drink at least eight glasses of water each day.

28. Avoid strenuous activities outdoors during heat of the day (10:00 AM – 2:00 PM).

Protocol #50

HEMORRHOIDS

a. Definition

A mass of dilated, tortuous veins in the anorectum involving the venous plexuses of that area.

b. Etiology

The most common cause of hemorrhoids is increased intra abdominal pressure (frequent Straining at the stool).

c. Clinical manifestations

d. Subjective

1. Student states, "I have hemorrhoids."
2. Record reports of the following from student:
 - a. Rectal pain and bleeding following defecation
 - b. Burning and itching around rectum
 - c. Constipation
 - d. Family history
 - e. Protrusion
 - f. Mucous discharge (internal hemorrhoids)

e. Objective

1. Physical findings
 - a. Protrusion of hemorrhoids
 - b. Exam following straining at stool or enema will reveal extent
2. Laboratory
Rarely leads to anemia

f. Assessment

1. Acute pain may be related to inflammation and edema or prolapse varices.
2. Constipation may be related to pain on defecation and reluctance to defecate.

g. Plan

2. Refer/consult physician:
 - a. Significant rectal bleeding
 - b. No improvement after one week of treatment

Hemorrhoids (cont'd)

- c. Noted anal warts or fissures
 - d. Suspected syphilis
 - e. Student with other chronic illness
3. Therapeutic nursing intervention:
- a. Hemorrhoidal cream two – three times a day for 5 days for pain and itching.
OR
 - b. Hemorrhoidal suppository with corticosteroid two – three times day.
OR
 - c. Per facility protocol
 - d. Per physician – stool softener
- d. Education**

See following page

- e. Follow-up**
- 1. As ordered by physician
 - 2. As needed
 - 3. If symptoms persist for more than 7 days
 - 4. Bleeding
 - 5. No improvement after treatment

STUDENT EDUCATION
HEMORRHOIDS

Hemorrhoids are veins around the opening for bowel movements that have gotten big and filled with old blood. They get hard and cause pain, itching and burning, or produce bright red blood after you have a bowel movement and wipe with tissue.

You should:

- f. Keep area around the hemorrhoids clean. Wash with soap and water at least daily.
- g. Drink lots of fluids and increase fiber in your diet by eating cereals, breads, vegetables and fruits. This will prevent constipation.
- h. Avoid straining when you have a bowel movement and do not sit on the toilet for a long time.
- i. Avoid standing in one place for long times. Do not lift heavy things.
- j. When hemorrhoids are painful, use warm cloths around the area 3 – 4 times a day for 3 days.
- k. To use hemorrhoid suppositories or cream:
 - l. Wash hands
 - m. Insert one suppository or squeeze cream in rectum each morning and evening
 - n. Wash hands
- o. Return to sick call if:
 - p. Not better within 1 week
 - q. Increased bleeding
 - r. Increased pain

Protocol #51

HEPATITIS

I. Definition

An inflammatory process in the liver characterized by diffuse or patchy hepatocellular necrosis affecting all acini.

II. Etiology

1. Alcohol
2. Drugs
3. Viruses
 - a. Infectious mononucleosis
 - b. Yellow fever
 - c. Cytomegalovirus

III. Clinical manifestations

A. Subjective

1. Student states, "I feel tired all the time."
2. Record student's report of the following:
 - a. Fatigue
 - b. Drowsiness
 - c. Nausea
 - d. Vague epigastric distress
 - e. Heartburn
 - f. Headache
 - g. Backache

B. Objective

1. Physical assessment
 - a. Icteric sclera and skin
 - b. Dark urine
 - c. Tenderness over liver and spleen on palpation
 - d. Enlarged liver and splenomegaly (10% of cases)
 - e. Arthritis
 - f. Skin rash
2. Laboratory findings
 - a. Hematocrit (mild anemia)
 - b. White cell count (usually low-normal)

Hepatitis (cont'd)

- c. Hepatitis A (IgM anti – HAV; IgG anti – HAV)
 - d. Hepatitis B (AbsAG; Anti – Hbs; Anti – HBC; AgeAg)
3. Viral characteristics
- a. Hepatitis A
 - (1) Transmission – oral – fecal route
 - blood (contaminated syringes and needles)
 - contaminated food, milk, or shellfish
 - (2) Excreted through stool prior to signs and symptoms
 - (3) Incubation – 3 to 7 weeks
 - b. Hepatitis B
 - (1) Documented in almost ALL body secretions
 - (2) Transmission – parenteral route-blood/blood products (transfusion, contaminated needles and syringes)
 - skin puncture – medical instruments
 - mucosal transmission – dental instruments, sexual contact
 - (3) Incubation – 6 weeks to 6 months
 - c. Hepatitis C (Formerly Non-A, Non-B Hepatitis)
 - (1) Transmission – contaminated water
 - person-to-person, oral-fecal route
 - (2) Incubation – 15 days – 160 days

C. Assessment

- 1. Fatigue may be related to decreased metabolic energy production and altered body chemistry.
- 2. Altered nutrition (less than body requirements) may be related to inability to ingest adequate nutrients (nausea, vomiting, anorexia) and/or hyper metabolic state, altered absorption and metabolism.
- 3. Acute pain may be related to:
 - a. Swelling of the liver
 - b. Urticarial eruption
 - c. Arthralgia
 - d. Pruritus

D. Plan

- 1. Refer/consult physician:
ALL SUSPECTED CASES

Hepatitis (cont'd)

2. Therapeutic nursing intervention:
As ordered by physician

E. Education

See following page

F. Follow-up

1. As ordered by physician
2. Any symptoms or illnesses
3. As needed

STUDENT EDUCATION
HEPATITIS

A. PREVENTION

1. Use good sanitation
2. Wash hand thoroughly after using the bathroom.
3. Practice careful personal hygiene: no sharing toothbrushes, food utensils, or towels.

B. LIVING WITH HEPATITIS

1. Decreased activity until you feel better.
2. Eat as much as you can tolerate. No special diet.
3. Do not share toothbrush, food utensils or towels with others.

Protocol #52

HERPES (GENITAL)

G. Definition

Infection of the genital and anorectal skin and mucosa with herpes simplex virus type 2.

H. Etiology

Usually herpes simplex virus type 2, but also type 1.

I. Clinical Manifestation

J. Subjective

1. Student states, "I've got sores in my private area".
2. Record student's reports of the following:
 - a. Painful genital ulcers or blisters in both male and female
 - b. Swelling, pain, irritation and burning sensation of the vulva.
 - c. Painful or difficult urination
 - d. Malaise
 - e. Lesions

K. Objective

Physical assessment

1. One or several small vesicles
 - a. External genitalia
 - b. Vagina
 - c. Cervix
2. Soft, open sores
3. If secondarily infected, sores may discharge pus or blood
4. After 4 – 5 days, sores less painful and begin to heal
5. Enlarged lymph glands in the groin
6. Cervical lesions – covered by a yellow-gray secretion
7. Lesions on labia or shaft of penis:
 - a. Edema
 - b. Urinary retention

L. Assessment

1. Acute pain may be related to:
 - M. Enlarged lymph glands
 - N. Genital ulcers or blisters

Herpes, Genital (cont'd)

2. High risk for secondary infection related to open lesions.
3. Altered urinary elimination related to inflammation from infection.

O. Plan

Refer/consult physician or local health department STD clinic ALL suspected cases.

P. Education

1. Prevention
2. Medication effects and side effects
3. Complications

Q. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
HERPES, (GENITAL)

Herpes genitalis or herpes simplex virus is a treatable, but not curable, infectious viral disease that causes recurrence of painful, red based, blisters on or in the genitalia or rectum.

This is usually visualized 2 – 7 days after exposure to the body, usually by sexual contact. Someone can be contagious without having any symptoms, and there may be lesions that cannot be seen.

After an incubation period of 2 – 7 days, someone infected with this may have symptoms such as:

fever
tired feeling
loss of weight
itching blisters
burning pain

Genital lesions are usually infectious and uncomfortable. They should be kept clean and dry to avoid any secondary infection from entering the body.

If you suspect that you have this, you should alert the medical staff. The doctor will examine you and may order laboratory studies, such as blood work.

Some of the complications that can result from this for females are:

If become pregnant, transmission to the child
cervical cancer
miscarriage

Many complications from this virus can occur later. Early detection and treatment is important.

Protocol #53

HYPERTENSION

I. Definition

Elevation of systolic and/or diastolic blood pressure, either primary (essential hypertension) or secondary. A blood pressure greater than 140/90 on three separate occasions during the teenage years are close enough to use as a cut-off point for hypertension.

II. Etiology

In adolescents, 45 – 55% of hypertension is primary. Below are some of the possible causes.

idiopathic
possible essential
bilateral renal parenchymal disease
unilateral renal parenchymal disease
renal artery stenosis
other vascular
catecholamine-secreting tumors
other tumors
miscellaneous

Associated factors that could contribute to hypertension in adolescents:

1. Weight – positive correlation with increased weight
2. Age – positive correlation
3. Salt intake – possible positive correlation
4. Stress – possible positive correlation
5. Triglycerides – positive correlation
6. Race – although a factor in adults, not a factor in teens.
7. Genetics – strong positive correlation for familial aggregation

III. Clinical manifestations

A. Subjective

1. Student states, “I have a headache almost every day.”
2. Record student’s reports of any of the following:
 - a. Headache
 - b. Chest pain
 - c. Shortness of breath
 - d. History of muscle weakness
 - e. Swelling of lower extremities
 - f. Flushing attacks
 - g. Heart “skipping”

Hypertension (cont'd)

- h. Increased urination
- i. Past history of kidney, thyroid or heart disease
- j. Drug use
- k. History of smoking
- l. Family history of hypertension, heart attack, diabetes, or strokes.

B. Objective

Physical assessment

- 1. Blood pressure in both arm – lying, sitting and standing
- 2. Pulses in all extremities for one full minute
- 3. Check lower extremities for edema
- 4. Apical pulse for one full minute
- 5. If initial blood pressure is high, wait 15 minutes and recheck

C. Assessment

- 1. Knowledge deficit (learning needs) regarding pathophysiology therapeutic regimen, lifestyle changes, and potential complications.
- 2. Impaired adjustment may be related to condition requiring changes in lifestyle, absence of feelings of illness/denial.

D. Plan

- 1. Refer/consult physician:
 - a. Any student with a blood pressure reading of 170/110 or over on any single reading.
 - b. Elevated blood pressure above 140/90 on three separate occasions.
 - c. Any student with an elevated blood pressure and a history of:
 - (1) Headache
 - (2) Chest pain or dyspnea
 - (3) Muscle weakness
 - (4) Edema
 - (5) Pallor
 - (6) Flushing
 - (7) Palpitations
- 2. Therapeutic nursing intervention:
IF BORDERLINE OR MILD HYPERTENSION (DIASTOLIC < 100 MMHG)
 - a. Periodic blood-pressure determinations (QD at about same time each day)

Hypertension (cont'd)

- s. Diet counseling
- t. Avoidance of excess salt (send diet notice to dining hall – 2GM Sodium diet)
- u. Restrict from all activities until evaluated by physician

E. Education

1. No added salt and abide by diet of 2 gm sodium
2. Weight reduction if indicated.

F. Follow-up

1. For blood pressure check every one to two weeks until normal achieved
2. Every three months
3. As ordered by physician
4. When having headache
5. As needed

STUDENT EDUCATION HYPERTENSION

Hypertension (high blood pressure) is the single most important predictor of cardiovascular risk. The exact cause of hypertension is not known. It is known that genetics and environment are contributing factors. Genetic factors relate to one's family history, gender, age, and ethnic group. Environmental factors relate to the nutrition, life-style habits, and personal stress profile of the individual.

Genetic Factors:

1. Family History – certain families have predisposition or increased chance to develop hypertension. If your parent has hypertension you have a greater risk of developing it.
2. Sex – men experience hypertension at a higher rate and have a greater risk of severe illness and death than women, but men tend to benefit from medical intervention than women.
3. Age – hypertension occurs across the lifespan. In young adults, it is often associated with women taking birth control pills.
4. Ethnic Group – in the United States the prevalence of hypertension in blacks far exceeds that of whites. Blacks tend to develop hypertension at an earlier age, with greater severity, and have more frequent complications:

strokes
end-stage kidney disease
congestive heart failure
left ventricular hypertrophy (enlarging of the left side of the heart)

Environmental Factors:

1. Stress – stress may be associated with work situations, choices, socioeconomic levels and personality characteristics.
2. Occupations – certain occupations that are stressful in nature can cause rapid heart rates and constriction of vessels that elevates the blood pressure.
3. Nutrition – obesity, especially childhood obesity, may account for an increased risk of hypertension.
4. Life-Style Habits-
 - a. Alcohol – it has been found that there is a relationship between alcohol consumption and increased blood pressure.
 - b. Smoking – it is also thought that nicotine in cigarettes may cause an increase in blood pressure because of vasoconstriction (narrowing of blood vessels).
 - c. Physical fitness – physical fitness clearly has a role in prevention and control of hypertension.

Protocol #54

IMPETIGO

G. Definition

Inflammatory skin disease marked by isolated pustules, which become crusted and rupture.

H. Etiology

- I. Caused by certain strains of group A beta-hemolytic streptococci, by *staphylococcus aureus*, or by a combination of both organisms.
- J. Infants and children are affected, but children more often.
- K. It occurs primarily in late summer and early fall and is often associated with poor hygiene and is very contagious.
- L. It may be spread by direct contact with infected persons or it may be secondary to streptococcal infections of the upper respiratory tract.
- M. Incubation period is 2 – 10 days.
- N. The untreated patient is contagious until the lesions are healed. Treatment shortens the period of contagiousness.

O. Clinical Manifestations

P. Subjective

- 1. Student states, “I have this sore that won’t heal.”
- 2. Record student’s report of any of the following:
 - 1. Symptoms are unusual unless lesions are widespread.
 - 2. Itching is common
 - 3. Onset (onset usually sudden)
 - 4. Duration (can last for several months if untreated)

Q. Objective

Physical assessment

- R. Lesion begins as red macule, evolves into a vesicle, and then a pustule forms
- S. Size – vary from a few millimeters to several centimeters
- 3. Location
- T. Nose

Impetigo (cont'd)

- b. Mouth
- c. Neck

U. Hands

V. Legs

W. Pustules rupture, dry centrally, and form a honey-colored crust

X. Regional lymphadenopathy may occur (more often in streptococcal)

Y. Bullous impetigo – very large vesicles (bullae), that rupture and form circular, raw lesions resembling a second-degree burn, eventually form a crust.

Z. Assessment

AA. Impaired skin integrity may be related to presence of infectious process and pruritus.

BB. Acute pain may be related to inflammation and pruritus.

- 3. High risk for secondary infection with risk factors being:
 - a. Broken skin
 - b. Traumatized tissue
 - c. Altered immune response
 - d. Virulence/contagious nature of causative organisms

CC. High risk for transmission of infection due to virulent nature causative organism.

DD. Plan

- 1. Refer/consult physician:
ALL CASES OF SUSPECTED IMPETIGO
- 2. Therapeutic nursing intervention:
 - a. Small, localized skin lesions, gently scrub lesions with warm soapy water T.I.D.

EE. Apply topical antibiotic ointment

FF. If lesions are large or not localized refer to physician.

GG. Education

- 1. Avoid scratching any open lesion (fingernails harbor bacteria)
- 2. Keep lesions clean and dry.
- 3. Wound care treatment as prescribed by physician.
- 4. Trim fingernails
- 5. Do not share towels, wash cloths or hygiene items with anyone

HH. Follow-up

- 1. If lesions not cleared or worsen after treatment.
- 2. If lesions spread to other areas during or after treatment.
- 3. As ordered by physician

STUDENT EDUCATION
IMPETIGO

Impetigo is a superficial skin infection. The most usual sites of impetigo are the arms, legs and face. It usually follows superficial trauma with break in the skin or can be secondary to pediculosis (lice, “crabs”), scabies, fungal infections, or insect bites.

It is usually seen as blisters that drain and then turn honey-colored, crusted lesions. They may be small, draining ulcers with thick, brown-black crusts and surrounded by redness. Itching is common, and scratching can spread the infection.

If you are found to have impetigo, you may be required to put an antibiotic ointment on the lesions or may have to take an antibiotic by mouth.

If you notice a lesion that does not heal or becomes red or drains, medical staff should be notified.

Protocol #55

INFLUENZA

I. Definition

A specific acute viral respiratory disease characterized by fever, coryza, cough, headache, malaise, and inflamed respiratory mucous membranes. It is usually self-limiting and lasts from 2 - 7 days.

II. Etiology

One of three myxoviruses having similar properties and categorized as influenza virus types A, B, and C.

III. Clinical Manifestations

A. Subjective

1. Student may report, "I'm having chills and coughing".
2. Record student's report of an abrupt onset of any of the following:
 - a. Headache
 - b. Malaise
 - c. Myalgia
 - d. Non-productive cough
 - e. Nausea, vomiting and/or diarrhea (less frequent)
 - f. Chills
 - g. Sore throat
 - h. Eyes injected
 - i. Sneezing
 - j. Hoarseness
 - k. Weakness/fatigue (may persist for several days to weeks)

B. Objective

Physical assessment

1. Fever up to 102 to 103 degrees (may last up to 5 days)
2. Skin warm and flushed
3. Reddened
 - a. Soft palate
 - b. Posterior hard palate
 - c. Tonsillar pillars
 - d. Posterior pharyngeal wall (no exudates)
4. Eyes watery
5. Conjunctiva mildly inflamed

Influenza (cont'd)

C. Assessment

1. Pain (discomfort) may be related to inflammation and effects of circulating toxins.
2. High risk for fluid volume deficit may be related to:
 - a. Excessive gastric losses
 - b. Hyper metabolic state
 - c. Altered intake
3. Hyperthermia may be related to effects of circulating toxins and dehydration.

D. Plan

1. Refer/consult physician:
 - a. Appears severely ill
 - b. Has a history of other chronic illness
 - c. Respiratory distress
 - d. Widespread rales or rhonchi
2. Therapeutic nursing intervention:
 - a. Acetaminophen 325 milligrams, two tablets every 4-6 hours as needed for pain and/or fever.
DO NOT EXCEED 12 TABLETS IN 24 HOURS
OR
 - b. Per facility protocol
 - c. Increase fluid intake
 - d. Non-alcohol containing cough suppressant, 2 teaspoons by mouth ever 6-8 hours when needed for cough.

E. Education

Refer to Student Education Sheet (following page)

F. Follow-up

1. If condition worsens
2. If no improvement in 48 hours after treatment
3. As needed

STUDENT EDUCATION
INFLUENZA

You may have difficulty telling the difference between the flu and a cold. Below are lists of symptoms that you may experience with each:

COLD

runny or stuffy nose
chills
sneezing
mild fatigue
sore throat
slight aches and pains
mild to moderate cough
chest discomfort
usually lasts 3-7 days

FLU

high fever
headaches
severe muscle aches
runny or stuffy nose
sneezing
sore throat
extreme fatigue and weakness
may last 2 – 3 weeks
dry cough may last longer than 2 – 3 weeks

If you have the flu

1. Get plenty of rest
2. Drink plenty of fluids
3. For sore throat gargle with warm salt water
4. For congestion (stuffy nose), use moist heat (warm wet cloth over nose).
5. You should return to the clinic:
 - a. If you have thick, dark phlegm
 - b. If you have shortness of breathe at rest
 - c. A earache with drainage
 - d. Sinus pain with green or yellow discharge
 - e. Rash
 - f. Severe headache not relieved by acetaminophen
 - g. Symptoms lasting more than 7 days after treatment

Protocol #56

INDIGESTION

I. Definition

Incomplete or imperfect digestion characterized by gaseousness, fullness, or pain that is gnawing or burning in quality and localized to the upper abdomen or chest.

II. Etiology

Symptoms can have many etiologies, and correlation of symptoms with pathophysiologic states is difficult.

III. Clinical Manifestations

A. Subjective

1. Student states, "I have heartburn".
2. Record student report of any of the following:
 - a. Burning
 - b. Fullness
 - c. Belching
 - d. Gas
 - e. Discomfort in upper stomach and/or chest
 - f. No radiation of pain to suggest cardiac symptoms
 - g. Bowel habits
 - h. Nausea

B. Objective

1. Record vital signs
2. Palpation of abdomen (distended)

C. Assessment

1. Acute pain related to increased acid production.
2. Sleep pattern disturbance related to epigastric pain

D. Plan

1. Refer/consult physician:
 - a. Abnormal vital signs
 - b. Symptoms suggesting cardiac origin
 - c. Symptoms unrelieved by nursing intervention.
 - d. Severe abdominal pain

Indigestion (cont'd)

- e. Distended, rigid abdomen
 - f. Loss of bowel sounds
2. Therapeutic nursing intervention:
- a. Aluminum Hydroxide (Mylanta/Maalox) – 2 tablets well chewed between meals and at bedtime. OR
 - b. Aluminum Hydroxide (Mylanta/Maalox) – 30 cc liquid between meals and at bedtime.
 - c. Student education

E. Education

See next page

F. Follow-up

- 1. If discomfort increases or persists after treatment
- 2. As needed

STUDENT EDUCATION **INDIGESTION**

Indigestion can be caused by eating gas-formed foods (like cabbage, coffee, tea, carbonated beverages, etc.) or swallowing air. It is usually not serious.

If you have indigestion, you should do the following:

1. Avoid eating foods that are known to cause your distress.
2. Avoid overeating.
3. Remain in an upright position 1-2 hours after eating.
4. Chew your food well and avoid eating fast.
5. Avoid chewing gum, which creates more air in your stomach.
6. Avoid eating 1 – 2 hours before bedtime.
7. Return to sick call if symptoms persist or worsen after treatment.

Protocol #57

INFECTIOUS MONONUCLEOSIS

I. Definition

Infectious mononucleosis is an acute, self-limiting infectious disease, which is an important cause of prolonged fatigue.

II. Etiology

1. Ninety percent (90%) is caused by Epstein-Barr Virus (EBV).
2. Transmitted by oral/body fluids (kissing, sexual contact, probable blood contact)
3. Equal prevalence in both males and females.
4. Increases in the spring and fall among college students, otherwise no variation.
5. Peak incidence in adolescents and young adulthood.
6. Incubation period is 20 – 50 days.

III. Clinical Manifestations

A. Subjective

1. Student states, “I feel tired all the time.”
2. Record student’s complaint of any of the following:
 - a. History of malaise
 - b. Headache
 - c. History of sore throat
 - d. No respiratory symptoms

B. Objective

1. Physical assessment
 - a. Fever (101-103 degrees F)
 - b. Inflammation of pharynx (often with exudates)
 - c. Bilateral, lymphadenopathy of cervical, axillary and inguinal nodes
 - d. Splenomegaly
 - e. Hepatomegaly
 - f. Palatine, Petechiae
 - g. Periorbital edema
 - h. Rash

Infectious mononucleosis (cont'd)

2. Laboratory studies for diagnosis as ordered by physician:
 - a. Monospot rapid test
 - b. Rapid test for B-hemolytic Strep A

C. Assessment

1. Fatigue may be related to:
 - a. Decreased energy production
 - b. States of discomfort
 - c. Increased energy requirements (inflammatory process)
2. Pain (discomfort) may be related to:
 - a. Inflammation of lymphoid and organ tissues
 - b. Irritation of oropharyngeal mucous membranes
 - c. Effects of circulating toxins
3. Hyperthermia may be related to fever from infection.

D. Plan

1. Refer/consult physician ALL suspected cases for diagnosis and treatment.
2. Therapeutic nursing interventions:
 - a. Force fluids by mouth
 - b. Rest according to physician's recommendation
 - c. Acetaminophen 325 milligrams, 2 tablets P.O. every 4 hours as needed DO NOT EXCEED 12 TABLETS IN 24 HOURS.
 - d. Restrict student from activities (Sent note to cottage)

E. Education

1. Diagnosis, disease process and treatment
2. Medication side effects
3. Possible complications
4. See following page.

F. Follow-up

1. Weekly until recovery
2. As ordered by physician
3. As needed

STUDENT EDUCATION
INFECTIOUS MONONUCLEOSIS

Infectious mononucleosis is an infectious disease that affects the lymph nodes causing them to swell and become tender. It can make your spleen enlarged. You may have a fever, sore throat and feel tired. The virus that causes this is the Epstein-Barr Virus.

1. Drink plenty of fluids.
2. Do not overexert yourself.
3. Do not play any contact sports. You may damage your spleen.
4. Complete recovery usually takes 3 – 8 weeks.
5. This virus can be transmitted by:
 - a. kissing (do not share eating utensils or share drinks with anyone)
 - b. sexual contact
 - c. blood contact

Protocol #58

INSOMNIA

I. Definition

Difficulty in sleeping, or disturbed sleep patterns leaving the perception of insufficient sleep.

II. Etiology

1. Primary
No signs of or symptoms of a mental or physical condition
2. Secondary
 - a. Pain
 - b. Anxiety
 - c. Drug-alcohol withdrawal
 - d. Depression

III. Clinical Manifestations

A. Subjective

1. Student states, "I can't sleep at night."
2. Record student or staff complaint of any of the following:
 - a. Drowsiness in the morning
 - b. Dozes during the day
 - c. Difficulty concentrating

B. Objective

1. Eyes darkened (Dark circles around the eyes)
2. Possibly napping while waiting
3. Listlessness

C. Assessment

Sleep pattern disturbance may be related to:

1. Internal sensory alterations:
 - a. Illness
 - b. Pain
 - c. Psychologic stress (anxiety, depression)
 - d. Inactivity
2. External sensory alterations
 - a. Environmental changes (change in daily routines)
 - b. Social cues (demands of caring for others)

Insomnia (cont'd)

1. Refer/consult physician/psychiatrist:
If no improvement in 3 – 4 days, after treatment
2. Therapeutic nursing intervention:
 - a. Have student keep a log of how much sleep he/she gets in 24 hour period.
 - b. Evaluate for recent stressors
 - c. Instruct per student education (see next page)

E. Education

Instruct per student education (see next page)

F. Follow-up

If no improvement after treatment in 2 – 3 days

STUDENT EDUCATION
INSOMNIA

Many people are bothered with insomnia from time to time. This is a problem that is usually solved by behavioral changes. These changes have to be done by you, for you. Normally if these changes are made, the problem with insomnia will subside in a day or two.

YOU SHOULD:

1. Get up from bed at the same time each morning.
2. Increase your daily activities (if possible).
3. Do not nap or lay down during the day.
4. Do not eat or drink products containing caffeine (colas, chocolate)
5. Avoid a lot of sugar.
6. Drink plenty of fluids.
7. If after 3 days, you are still having problems, resubmit a sick slip to be seen.

Protocol #59

LYMPHOGRANULOMA VENEREUM (LGV)

G. Definition

An infectious venereal disease.

H. Etiology

Caused by a limited number of immunotypes of *Chlamydia trachomatis* and rarely group B (C. Psittaci).

I. Clinical Manifestations

J. Subjective

1. Female student may state, "I have some sores".
2. Record student's report of any of the following:
 - a. Lesions on genitals (may have bloody drainage)
 - b. Tenderness in lymph node area
 - c. Feeling tired
 - d. Headache
 - e. Joint pain
 - f. Vomiting
 - g. Backache

K. Objective

1. Physical assessment
 - a. Vaginal exam (refer to physician)
 - b. 3 – 12 days after infected – non-indurated vesicular lesions (ulcerates then heals)
 - c. Unilateral enlarged inguinal lymph nodes
 - d. Sinuses with discharge purulent or bloodstained material
 - e. Fever

L. Assessment

- M. Impaired tissue integrity may be related to invasion and irritation by pathogenic organism(s).
2. Knowledge deficit (learning need) may be related to lack of information Regarding pathophysiology of condition and sequelae.

LGV (cont'd)

N. Plan

1. Refer/consult physician:
All suspected cases
2. Therapeutic nursing intervention
Per physician's orders

O. Education

Refer to Student Education sheet (following page)

P. Follow-up

Per physician

STUDENT EDUCATION
LYMPHOGRANULOMA VENEREUM (LGV)

Lymphogranuloma venereum (LGV) is an infection that can linger and cause damage to your body. It begins as small painless lesions or ulcers 3 days to 3 weeks after exposure. The lesions can become painful and swollen in the vagina or rectum. It can permanently damage your lymphatic system. Exposure occurs after sexual contact with someone already infected.

You can be diagnosed by examination and laboratory tests.

If diagnosed with this, you may be started on antibiotics. It is important that you take all of the medication.

You should keep the lesions or sores clean and as dry as possible and wash your hands frequently. You may use cold compresses (cloths) to decrease discomfort and clean the areas carefully.

Protocol #60

MUCOPURULENT CERVICITIS (PROBABLE CHLAMYDIA)

I. Definition

A sexually transmitted disease with a clear-to-mucopurulent discharge.

II. Etiology

Chlamydia trachomatis, a micro-organism similar to bacteria

III. Clinical Manifestations

A. Subjective

1. Student may state, "I have a discharge."
2. Record student's report of any of the following:
 - a. Vaginal discharge
 - b. Frequent urination
 - c. Painful urination
 - d. Pelvic pain

B. Objective

1. Physical assessment
 - a. Pelvic exam (per physician)
 - b. Vaginal discharge (mucopurulent)
2. Labs (per physician's orders)
 - a. Wet Mount
 - b. Chlamydia and GC culture (if positive, do RPR)

C. Assessment

1. Acute pain may be related to irritation and inflammation of mucosa.
2. Knowledge deficit (learning need) may be related to lack of information about disease cause and transmission, therapy, and self-care needs.

D. Plan

1. Refer/consult physician
All suspected cases

Muco-purulent cervicitis (cont'd)

2. Therapeutic nursing intervention
Per physician's orders

E. Education

Refer to Student Education sheet

F. Follow-up

1. As ordered by physician
2. As needed

MUCO-PURULENT CERVICTIS
(PROBABLE CHLAMYDIA)

Mucopurulent cervicitis is a sexually transmitted disease that causes a clear to mucous-like foul smelling discharge. You may also experience any of the following:

frequent urination
pain when urinating
pelvic pain
vaginal itching
back pain

If you experience any of the above symptoms, you should be evaluated by the doctor. The doctor may do a vaginal exam and some laboratory studies.

The only way to definitely prevent this is by not having sex. Consistent use of condoms may decrease your chances of getting this.

It is important that you complete all medications if the doctor orders them.

You should wear clean undergarments daily.

Protocol #61

MUSCLE-STRAIN/OVERUSE

1. Definition

Overuse of a muscle causing muscle discomfort, within 24 – 48 hours following unaccustomed exercise or of exercise of greater intensity than usual.

2. Etiology

Can occur with:

1. Any great force (pushing or pulling against great resistance)
2. Sudden twisting of muscle

3. Clinical Manifestations

4. Subjective

1. Student states, “I was playing basketball and I hurt my back”.
2. Student reports any of the following:
 - a. Sore, painful muscle
 - b. No report of injury
 - c. History of recent overuse
 - d. Increased activity
 - e. Increased sports/lifting
 - f. Location of pain

5. Objective

Physical assessment

6. Appearance of area
 - a. Swelling (usually none)
 - b. Bruising (usually none)
 - c. Deformity (usually none)
7. Palpation (Tenderness)
8. Range of motion (no or minimal limitations)

9. Assessment

10. Acute pain related to physical factor of injury to area causing swelling or tearing.
11. Impaired physical mobility may be related to pain/discomfort.

Muscle strain/overuse (cont'd)

12. Plan

1. Refer/consult physician:
 - a. Injury that suggests need for x-ray (i.e. inability to move, deformity)
 - b. No response to protocol

2. Therapeutic nursing intervention
 - a. Acetaminophen 325 milligrams 2 tablets by mouth every 4 – 6 hours P.R.N.
OR
 - b. Ibuprofen 200 milligrams 2 tablets by mouth T.I.D. P.R.N. for pain.
OR
 - c. Per facility protocol
 - d. Restrict from activities (send note to cottage)
 - e. Instruct per student education (see next page)

13. Education

Refer to student Education Sheet (see next page)

14. Follow-up

1. If no improvement in 2-3 days
2. As needed

STUDENT EDUCATION
MUSCLE STRAIN/OVERUSE

Muscles can ache or become painful if you overuse them or do not warm-up properly before exercising.

If you suffer from muscle strain/overuse you should:

15. Avoid sports or other activity that caused the muscle strain/overuse for 1-2 days.
16. You should GRADUALLY increase activity.
17. ALWAYS warm-up your muscles and stretch before you play sports.
18. Use warm, moist towels on muscle soreness 3-4 times a day for 1-2 days.
19. Return for sick call if you do not feel an improvement in 2 days.

Protocol #62

NAUSEA AND/OR VOMITING

I. Definition

1. Nausea – Unpleasant sensation usually preceding vomiting.
2. Vomiting – Ejection through the mouth of the gastric contents, and, in cases of obstruction, intestinal contents.

II. Etiology

Various illness and/or conditions.

III. Clinical Manifestations

A. Subjective

1. Student states, “I feel like I’m gonna throw-up”.
2. Record student’s report of any of the following:
 - a. Feeling of queasiness
 - b. Vomiting
 - c. Time of onset
 - d. Number and characteristics of emesis

B. Objective

Physical assessment

1. Vital signs (Temp. may be elevated 99-100 degrees F, other V.S. normal)
2. Bowel sounds – normal to hyperactive
3. Palpation of abdomen (soft, nontender)
4. Baseline weight
5. Assess for dehydration
 - a. Mucous membranes
 - b. Skin turgor

C. Assessment

1. Fluid volume deficit (active loss) related to vomiting causing active loss of fluids.
2. Altered nutrition: less than body requirements related to inability to digest food.

Nausea and/or vomiting (cont'd)

D. Plan

1. Transport to EMERGENCY ROOM:
 - a. Blood in emesis
 - b. Extreme pain

2. Refer/consult physician:
 - a. Intractable vomiting
 - b. If due to head injury
 - c. If dehydration probable
 - d. If bowel sounds are absent
 - e. If associated with abdominal pain
 - f. Symptoms continue for more than 24 hours after protocol initiated

3. Therapeutic nursing intervention:
 - a. Clear liquid diet for 24 hours (send notice to Dining Hall)
 - b. Restrict from activities until nausea/vomiting ceases.
 - c. Instruct per Student Education (see next page)

E. Education

See Student Education sheet (next page)

F. Follow-up

1. In 24 hours if no improvement
2. Blood in emesis
3. Chills/fever
4. Abdominal pain

STUDENT EDUCATION
NAUSEA AND/OR VOMITING

Nausea (feeling like you are going to throw up) and vomiting (throwing up) can have many causes. If you have the “stomach flu” you may have diarrhea and vomiting for 24-36 hours.

If you are throwing up, you should:

1. Drink only clear liquids for 24 hours. (Liquids that you can see through – tea, water, broth). Drink small, frequent amounts. Wait 2-3 hours since you threw up last to drink.
2. Do not take antacids while you are sick to your stomach.
3. When you begin feeling better, start eating food GRADUALLY.
4. Do not eat spicy, greasy foods at first.
5. Return to sick call, if:
 - a. You do not feel better in 24 hours
 - b. You cannot keep any liquids down.
 - c. You start vomiting blood
 - d. You have chills
 - e. You have an increase in stomach pain.

Protocol #63

NONGONOCOCCAL URETHRITIS

7. Definition

Also known as nonspecific urethritis. Inflammation and irritation of the urethra that in the past was not directly attributable to a specific organism.

8. Etiology

1. *Chlamydia trachomatis* – responsible for about 50% of cases
2. *Ureaplasma urealyticum*
3. Some cases remain unexplained.

9. Clinical Manifestations

10. Subjective

1. Student may state:
 - a. Male – “I have a drainage”.
 - b. Female – “I have a discharge”.
2. Record male student’s reports of any of the following:
 - a. May be asymptomatic
 - b. Urethral discharge
 - c. Dysuria
 - d. Testicular pain
 - e. Testicular swelling
3. Record female student’s reports of any of the following:
 - a. Vaginal discharge (yellow, mucopurulent secretion)
 - b. Dysuria
 - c. Frequency
 - d. Pelvic pain
 - e. Dyspareunia

11. Objective

Physical assessment

1. Male
 - a. Scant, mucoïd or mucopurulent discharge from urethra
 - b. Swollen testicles
 - c. May be no signs

Nongonococcal urethritis (cont'd)

2. Female
 - a. Vaginal discharge
 - b. Cervicitis (characterized by yellow, mucopurulent secretion)

12. Assessment

1. Acute pain may be related to testicular swelling.
2. High risk for transmission of infection related to contagious nature of infecting agent and insufficient knowledge to avoid exposure to/transmission of pathogens.
3. Altered urinary elimination may be related to inflammation of urethra.

13. Plan

1. Refer/consult physician:
ALL SUSPECTED CASES
2. Therapeutic nursing intervention:
 - a. Refer all cases to physician or local health department
 - b. Per physician's orders

14. Education

See Student Education Sheet (following page)

15. Follow-up

1. One week after treatment
2. As needed

STUDENT EDUCATION
NONGONOCOCCAL URETHRITIS

Nongonococcal urethritis, or NGU, is transmitted sexually that causes symptoms for both male and females. Some people that have this may not have any symptoms at all. It can lead to other problems if not treated.

16. The best way to ensure that you will not get sexually transmitted diseases is to say “no” to sex.
17. If you choose to have sex, make certain a condom is used.
18. This infection is caused by sexual contact with someone that already has this.
19. Make certain that you take all of the medication that was prescribed to you.
20. DO NOT have sexual contact with anyone while taking the medication. It will not clear until after all the medication is taken and at that time you must be rechecked because you may still have it.
21. There may be complications when you get sexually transmitted diseases. These complications can be other diseases, AIDS, and a female may be unable to have children.
22. Practice good perineal hygiene, perianal hygiene, and penile hygiene.
23. Wear cotton-crotch undergarments and clean undergarments DAILY.

Protocol #64

OTITIS MEDIA, ACUTE

I. Definition

A bacterial or viral infection in the middle ear, usually secondary to a URI.

II. Etiology

Causative organisms may vary with age. Viruses and bacteria can cause otitis media. The most common bacterial organisms are:

1. *Streptococcus Pneumonia*
2. *Haemophilus Influenza*

Other bacterial organisms include:

1. *Branhamella Catarrhalis*
2. Group A Beta Hemolytic Streptococcus
3. *Staphylococcus aureus*

III. Clinical Manifestations

A. Subjective

1. Student may state, "My ear is popping and hurts".
2. Record the student's report of any of the following:
 - a. Recent history of URI
 - b. Chills, especially at night
 - c. Ear pain
 - d. Ear popping or fullness
 - e. Decreased hearing

B. Objective

1. Physical assessment
 - a. Tympanic membrane is erythematous
 - b. Bulging of tympanic membrane
 - c. Light reflex is displaced
 - d. Bloody, then serosanguineous and finally purulent otorrhea may follow spontaneous perforation of tympanic membrane

Otitis media (cont'd)

2. Vital sign
Temperature – up to 105 degrees F, especially in children

C. Assessment

1. Acute pain may be related to:
 - a. Inflammation of middle ear
 - b. Fever
2. Sleep pattern disturbance may be related to pain.
3. Alteration in sensory-perceptual (auditory) may be related to decreased hearing possibly caused by inflammation of middle ear and/or perforated tympanic membrane.

D. Plan

Refer/consult physician for all suspected cases.

E. Education

See Student Education Sheet (following page)

F. Follow-up

1. In 24 hours for re-evaluation
2. In 48 hours for response to treatment
3. As needed

STUDENT EDUCATION
OTITIS MEDIA

Otitis media is an infection that is in the middle ear. It can be caused by bacteria or virus.

Below are some of the symptoms you might have with this:

severe earache
decreased hearing
nausea
vomiting
chills
diarrhea
popping in ear
feeling of fullness in ear
bloody and/or yellow drainage from ear
dizziness

If the infection is not treated, you may have serious complications. It can lead to an infection in the brain, which is very dangerous.

Here are some things you should do if you have a middle ear infection (otitis media):

1. Do not get water in your ears.
2. Put in a sick slip if you have ANY of the symptoms above.
3. Prevent this infection by:
 - a. Making sure water does not stay in the ears.
 - b. Not sticking ANYTHING in your ear, including your finger.
4. Take all medications as they were ordered.
5. Return for sick call if you do not feel better in 24-48 hours after treatment began.

Protocol #65

OTITIS EXTERNA

1. Definition

Infection in the ear canal may be localized or diffuse, involving the entire canal.

2. Etiology

1. *Escherichia coli*
2. *Pseudomonas aeruginosa*
3. *Proteus vulgaris*
4. *Staphylococcus aureus*
5. Fungus (rarely)

3. Clinical Manifestations

4. Subjective

1. Student states, "My ear hurts".
5. Record student's report of any of the following:
 - a. Pain in ear
 - b. Itching in ear
 - c. Foul smelling discharge
 - d. Loss of diminished hearing

6. Objective

Physical assessment

1. Pre-auricular or post-auricular lymphadenopathy
2. Foul-smelling discharge
3. Skin of external auditory canal appears red, swollen and littered with moist, purulent debris.

7. Assessment

1. Acute pain related to inflammation of the external ear canal.
2. Sleep pattern disturbance related to pain from:
 - a. Inflammation of external ear canal
 - b. Localized accumulation of pus (Furuncle)

Otitis Externa (cont'd)

8. Plan

1. Refer/consult physician:
 - a. Probable otitis external
 - b. Probable otitis media
 - c. Severe pain
 - d. Complete closure of canal
 - e. Hearing loss
2. Therapeutic nursing intervention:
9. Acetaminophen 325 milligrams, 1-2 tablets every 4-6 hours. DO NOT EXCEED 12 TABLETS IN 24 HOURS.
10. Refer to physician

11. Education

See Student Education (see following sheet)

12. Follow-up

13. In 48 hours
14. As ordered by physician
15. If no improvement in 48 hours after treatment

STUDENT EDUCATION
OTITIS EXTERNA

Otitis external is an infection in the ear that causes swelling and pain. It is caused by moisture accumulating in the ear from swimming or showering, discharge from the sebaceous glands, allergic reaction, or accumulation of pus causing a boil.

To prevent an ear infection such as otitis external, you should:

16. Keep fingers and instruments, including cotton swabs out of ears. (“Do not put anything in your ear smaller than your elbow.”)
17. Keep head out of water when taking a bath to avoid filling the ears with dirt and soap.
18. Do not scratch the external ear canal.
19. When swimming, limit your stay in the water and let ears dry out for 1-2 hours before going back in.
20. Return for sick call if condition does not improve after one week.

Protocol #66

PEDICULOSIS CAPITIS/PUBIS

I. Definition

1. Pediculosis capitis – Infestation of the scalp and hair by the crab louse.
2. Pediculosis pubis- Infestation of pubic hair by crab louse.

II. Etiology

1. Pediculosis capitis is caused by the parasite, *pediculus humanus capitis*.
2. Pediculosis pubis is caused by the parasite, *phthirus pubis*

III. Clinical

A. Subjective

1. Student may state, “I’m itching.”
2. Record the student’s report of any of the following:
 - a. Intense itching of scalp or pubic area.
 - b. Lice found on head or pubic area.

B. Objective

Physical Assessment

1. Adult lice found clinging to hairs or moving about the scalp (especially around the occiput and behind the ears) or pubic area.
2. Nits (live eggs) are firmly attached to the hair shaft. (small, ovoid, grayish white)
3. Pyoderma (skin disease)
4. Lymphadenopathy
5. Dermatitis of the neck and pinnae of the ears (in head lice)

C. Assessment

1. High risk for impaired skin integrity related to mechanical trauma from scratching and development of vesicles/bullae that may rupture.
2. Sleep pattern disturbance related to intense itching.
3. High risk for infection related to mechanical trauma from scratching causing developing vesicles/bullae to rupture, opening an avenue for bacterial invasion.

D. Plan

1. Refer/consult physician:
 - a. If condition fails to resolve after 2 courses of treatment

Pediculosis Capitis/Pubis (cont'd)

- b. For secondary infection
 2. Therapeutic nursing intervention:
 - a. TREAT ALL STUDENTS IN THE COTTAGE WITH A PYRETHRIN CONTAINING PREPARATION SUCH AS LICEALL OR RID AND ISOLATE STUDENTS UNTIL TREATED. (Pyrethrin is contraindicated in pregnancy).
 - b. Follow treatment procedure (see following page)

E. Education

See Student Education sheet.

F. Follow-up

1. Retreat entire cottage in 7 days.
2. If condition fails to resolve after 2 courses of treatment
3. If signs of secondary infection occur

STUDENT EDUCATION
PEDICULOSIS CAPITUS/PEDICULOSIS PUBIS

Pediculosis capitus is lice that is found on the head. Pediculosis pubis is also known as “crabs” and is found in the pubic area. These lice are parasites that spread easily from person to person. Lice are small insects that live and grow in the clothing and warm hairy areas of the body. They are dirty white to gray in color. They attach themselves to the hairs near the skin where they lay and “glue” their eggs (nits) to the hair strand.

The eggs (nits) hatch in about one week. These new lice are able to bite and irritate your skin. They attach the new eggs to hair strands.

When you have crabs or head lice, you may experience intense itching. You may also see the “nits” or eggs on the hair shaft. You may actually see the parasites moving on your body.

When you have been found to have lice, you must be treated with LICEALL or a solution that kills the lice and eggs. It is important that you follow the directions of the person treating you.

Below are ways to prevent infestations of this parasite:

1. Do not share combs, brushes, hair ornaments, wave caps or hats with anyone.
2. Do not share towels or clothes, especially undergarments.
3. If you suspect that you might have crabs, IMMEDIATELY have staff notify the clinic.
4. Follow directions from staff in cleaning the cottage.
5. Return for sick call if you begin having signs of infection such as:
 - a. Increased redness
 - b. Increased swelling
 - c. Pus formation
 - d. Heat
 - e. Red streaks
 - f. Increased pain
6. You must be retreated in one week.

LICE TREATMENT

1. Remove all bed linen, including blankets. Place in a WASH AWAY bag, alert the laundry and send the bags to the laundry.
2. Send all dirty clothing, already in the cottage, to the laundry in WASH AWAY bags, alerting the laundry prior to sending them.
3. Spray all mattresses, living quarters and day room with the LICEALL (or other pyrethrin containing preparation) spray provided by the clinic.
4. Spray the line room AFTER removing all dirty clothing.
5. Apply LICEALL solution to the student's body especially areas containing hair (pubic area, underarms, head).
6. Leave the solution on to soak for 10-15 minutes.
7. Have students comb through pubic hairs, underarms hairs, and head hairs with the lice comb provided, while showering.
8. Be careful not to spray the solution into eyes.
9. Place all combs in the solution (Cidex) provided by the clinic and soak overnight.
10. In the morning, rinse all combs and place in plastic bag to return to the clinic.
11. Retreat entire cottage, following above treatment in 7 days.

Protocol #67

PELVIC INFLAMMATORY DISEASE

1. Definition

An infection of the fallopian tubes, ovaries, pelvic peritoneum, pelvic veins, or connective tissue.

2. Etiology

Pathogenic organisms are usually introduced from the vagina and ascend the cervical canal into the uterus. They pass into the pelvis by the fallopian tubes through thrombosed uterine veins or through the lymphatics of the uterus. Many of the organisms causing PID lodge in the fallopian tubes. Causative organisms are gonococcal, *Chlamydia*, *Haemophilus*, *Streptococcus*, *Mycoplasma*, and anaerobes.

3. Clinical Manifestations

4. Subjective

1. Student may state, "I'm having bad cramps."
2. Record student's report of any of the following:
 - a. Severe abdominal pain and/or pressure
 - b. Lower abdominal cramping
 - c. Spotting (inter-menstrual)
 - d. Chills
 - e. Malaise
 - f. Nausea/vomiting

5. Objective

1. Physical assessment
 - a. Vital signs (temperature may be elevated)
 - b. Inter-menstrual spotting
 - c. Foul-smelling purulent vaginal discharge
 - d. Vaginal exam (per physician)
 - e. Palpate abdomen (rebound tenderness)
 - f. Bowel sounds (progressing to ileus in untreated persons)
 - g. Excoriation of vulva from vaginal discharge

Pelvic Inflammatory Disease (cont'd)

2. Laboratory (per physician's orders)
 - a. Culture and gram stain
 - b. Leukocyte count (elevated)
 - c. Erythrocyte sedimentation rate (increased)

- 6. Assessment**

7. Knowledge deficit related to pelvic inflammatory disease.
8. Potential fluid volume deficit related to nausea and vomiting.
9. Potential impaired skin integrity related to excoriation of vulva from vaginal discharge and pruritus.
10. Hyperthermia may be related to inflammatory process, possibly evidenced by fever, warm, flushed skin, and tachycardia.

- 11. Plan**

1. Refer/consult physician
ALL suspected cases

2. Therapeutic nursing intervention
Per physician's orders

- 12. Education**

- Refer to Student Education sheet

- 13. Follow-up**

1. As needed
2. Per physician's orders

STUDENT EDUCATION
PELVIC INFLAMMATORY DISEASE

Pelvic inflammatory disease or PID is an infection of the reproductive tract (fallopian tubes, ovaries, pelvic peritoneum, pelvic veins, or connective tissue). It can involve only one structure or all.

This is caused by organisms that can invade the pelvic organs during sexual intercourse, childbirth, after childbirth or when an abortion is done. It can also occur with the use of intrauterine devices such as those used in birth control.

Below are symptoms of PID:

severe abdominal pain or pressure
lower abdominal cramping
bleeding between periods
chills
feeling tired
nausea and/or vomiting
foul-smelling vaginal discharge

This can damage the reproductive system making it unable for you to have children.

To prevent PID:

14. Wipe from front to back.
15. Do not douche frequently.
16. Wear clean, cotton, loose-fitting undergarments.
17. Avoid strong soaps, bubble baths, sprays, powders, and deodorants, which may be irritating to the perineal skin.
18. Do not wear pads or tampons longer than 6 hours, which preferably should be changed every 4 hours.

You should return for sick call if you have no relief after treatment or if the symptoms worsen.

Protocol #68

PHARYNGITIS (SORE THROAT)

I. Definition

Acute inflammation of the pharynx.

II. Etiology

1. Viral (usually)
2. Group A Beta hemolytic streptococcus
3. *Mycoplasma pneumoniae*
4. *Chlamydia pneumoniae*
5. Other bacteria

III. Clinical Manifestations

A. Subjective

1. Student may state, "My throat is sore".
2. Record student's report of any of the following:
 - a. Sore throat
 - b. Dry throat
 - c. Burning sensation of throat
 - d. Pain when swallowing
 - e. Concurrent URI symptoms (runny nose, hoarse voice worse in the morning)
 - f. Muscle aches
 - g. General malaise

B. Objective

1. Physical assessment
 - a. Inflamed, red throat
 - b. Swollen tonsils
 - c. Exudate
 - d. Enlarged cervical lymph nodes
 - e. Normal eardrum
2. Vital signs
 - a. Temperature elevated
 - b. Other vital signs normal

Pharyngitis (cont'd)

C. Assessment

1. Acute pain related to:
 - a. Inflammation of tonsils
 - b. Enlarged cervical lymph nodes
 - c. Fever
2. High risk for activity intolerance related to body aches from fever.

D. Plan

1. Refer/consult physician:
 - a. Sore throat and/or fever lasting longer than 48 hours
 - b. Suspected strep throat
 - (1) Red throat
 - (2) Fever
 - (3) Tender cervical nodes
 - (4) No visual symptoms
 - c. Suspected mononucleosis
 - (1) Sore throat
 - (2) Fever
 - (3) Swollen cervical glands
 - d. Student has performed oral sex in previous 1-2 weeks
 - e. Failure to improve in 72 hours after treatment.
2. Therapeutic nursing intervention:
 - a. Acetaminophen 325 milligrams, 2 tablets by mouth every 4-6 hours as needed for fever, aches and pain.
 - b. Warm saline gargle (no more than ½ tsp. salt per 8 ounces of warm water).
 - c. Increase fluid intake
 - d. Throat lozenges or anesthetic/antiseptic throat spray.
3. Labs (as ordered by physician):
 - a. Rapid strep test
 - b. Throat culture

E. Education

Refer to Student Education sheet (next page)

F. Follow-up

1. If no relief in 3 days
2. If symptoms worsen

STUDENT EDUCATION
PHARYNGITIS (SORE THROAT)

Sore throat is defined as a pain in the throat that becomes worse with swallowing. You may experience fever, headache, abdominal pain, nausea and/or vomiting. There may be some swelling and redness of the throat and tonsils and tender swollen glands in the neck.

Cause of a sore throat may be viral or bacterial. Most sore throats are caused by viruses. Your immune system will get rid of the virus within a few days. It is important to always treat STREP THROAT and put in a sick slip to the clinic when you suffer from any of the symptoms listed below. If strep throat is not treated it can cause rheumatic fever, which can damage your heart.

If you have any of the symptoms listed below with a sore throat, put in a sick slip:

chills (suspected fever)
fine rash over chest, arms and legs
severe headache not relieved by acetaminophen (Tylenol)
severe sinus pain with green or yellow nasal discharge
any symptoms lasting more than 7 days

If you have been told you have a fever by the medical staff you should:

1. Get plenty of rest
2. Drink plenty of fluids
3. Request Tylenol every 4-6 hours if you have a headache and/or body aches.

If you have a sore throat, you should:

1. Drink plenty of fluids
2. Gargle with warm salt water (1 teaspoon per 16 ounces of water).
3. Suck on throat lozenges provided by the clinic.

Protocol #69

PINWORM

I. Definition

Small white worms found in the intestinal tract, ¼ - ½ inch long with pointed tails.

II. Etiology

1. Enterbius vermicularis
2. Infestation usually results from finger transfer of eggs from the perianal area to fomites (clothing, bedding, toys), from which the ova are picked up by the new host, transmitted to the mouth, and swallowed.

III. Clinical Manifestations

A. Subjective

1. Student may state. "I am itching around my bottom".
2. Record student's report of any of the following:
 - a. Intense itching around the rectum, worse at night
 - b. Abdominal cramps/pain
 - c. Nausea/vomiting
 - d. Insomnia or restlessness
 - e. Bed wetting
 - f. Secondary infection due to scratching
 - g. Presence of white worms in stools
 - h. Some may be asymptomatic

B. Objective

Physical assessment

1. Obtain weight
2. Vaginal discharge
3. Assess perianal area
 - a. Secondary infection due to scratching
 - b. Excoriations in area
 - c. Dried white worms (resembling uncooked rice) visualized
 - d. Vaginitis (in young girls due to irritation)

C. Assessment

1. Sleep pattern disturbance related to severe anal itching, worse at night.
2. High risk for infection (secondary) related to scratching, causing excoriated lesions.

Pinworm (cont'd)

D. Plan

1. Refer/consult physician:
 - a. ALL SUSPECTED CASES
 - b. If no relief after treatment
2. Therapeutic nursing intervention:
Per physician's orders

E. Education

See Student Education sheet (following page)

F. Follow-up

1. If symptoms do not improve after treatment.
2. If symptoms worsen
3. As needed
4. As ordered by the physician

STUDENT EDUCATION
PINWORM

Pinworms are caused by a small intestinal worm, enterobius vermicularis, and can cause severe itching around the anal area and disturbed sleep. It can cause irritability and irritation from scratching. You may notice the itching is worse at night.

It may take months before you begin experiencing symptoms.

To prevent pinworm:

1. Wash hands before eating.
2. Wash hands before using the bathroom each time.
3. Keep your fingers away from your mouth and nose.
4. Keep fingernails well clipped.
5. Do not share undergarments or towels with anyone.

If you experience symptoms of itching around the anal area, severe stomach pains, or think you see white worms in your bowel movement, submit a sick slip to the clinic.

Protocol #70

PITYRIASIS ROSEA

1. Definition

Acute inflammatory skin disease marked by a macular eruption on the trunk, obliquely to the ribs, and the upper extremities.

2. Etiology

Possibly due to an unidentified infectious agent.

3. Clinical Manifestations

4. Subjective

1. Student may state, "I'm itching".
5. Record student's report of any of these complaints:
 - a. Itching (usually mild, sometimes intense)
 - b. Occasionally, mild malaise
 - c. Occasionally, symptoms of a mild URI
 - d. Rash on trunk, obliquely to ribs, and upper extremities

6. Objective

Physical assessment

1. Herald patch (initial lesion)
 - a. 4-5 cm round or oval scaling lesion
 - b. Erythematous plaque
 - c. Occurs anywhere on the body
2. Multiple small lesions (after several days to a week)
 - a. 1-2 cm maculopapular lesions
 - b. Pale red and round or oval
 - c. Wrinkled surface and peripheral rim of small, fine scales.
 - d. Occur in crops
 - e. Trunk and proximal extremities
 - f. With their long axis oriented in the direction of the skin cleavage planes parallel to the ribs.

7. Assessment

8. High risk for impaired skin integrity related to mechanical trauma (scratching) and development of vesicles/bullae that may rupture.
9. Body image disturbance may be related to cosmetically unsightly skin lesions.

Pityriasis rosea (cont'd)

10. Plan

1. Refer/consult physician (dermatologist):
For definitive diagnosis
2. Therapeutic nursing intervention
 - a. Usually none
 - b. Comfort measures
11. Calamine lotion (relieve itching)
12. Oral antihistamines (as ordered by physician)

13. Education

Refer to Student Education sheet (following page)

14. Follow-up

15. If condition worsens
16. If no improvement of rash in 6-8 weeks

STUDENT EDUCATION
PITYRIASIS ROSEA

Pityriasis rosea is a skin disease that causes scaly lesions. It is possibly caused by an unidentified infectious agent. It is most often seen in young adults.

It causes a rash of the arms and body and possibly the face. It does not usually cause any other symptoms other than itching, but can occasionally cause you to feel weak/tired and have a headache.

There is no treatment required. It resolves itself and goes away in usually 6-8 weeks. You can apply Calamine lotion to help with the itching. The doctor may order a pill to help relieve the itching.

You should put in a sick slip if the rash and itching is not better in 6-8 weeks or if the symptoms get worse. If you scratch and cause sores on your body, you may get an infection. Some signs of infection is swelling, redness, heat and red streaks from the area. If any of this happens you should return for sick call.

To prevent infection when scratching:

17. Try not to scratch. Instead apply Calamine lotion.
18. Keep fingernails cut low.
19. Wash hands frequently and especially after using the bathroom and playing outside.

Protocol #71

PREGNANCY

G. Definition

The condition of having a developing embryo in the body.

H. Etiology

The union of an ovum and spermatozoan in the fallopian tube followed by uterine implantation leaving a functional corpus luteum.

I. Clinical Manifestations

J. Subjective

1. Student may state, "I think I'm pregnant".
2. Record student's report of any of the following:
 - a. Missed menstrual period for 6 weeks
 - b. Unprotected sexual intercourse
 - c. Nausea and/or vomiting (especially in the morning)
 - d. Breast tenderness or fullness
 - e. Nipple tenderness
 - f. Frequent urination
 - g. Fatigue

K. Objective

1. Physical assessment
Pelvic exam (per physician)
2. Laboratory (per physician's orders)
 1. Serum HCG
 2. Urine HCG

Pregnancy (cont'd)

L. Assessment

- M. Alteration in comfort may be related to effects of changing hormonal levels, increase in body size, and altered physical activity.
- N. Altered nutrition: less than body requirements may be relate to increasing metabolic needs and presence of gastrointestinal upsets.
- O. Constipation may be related to changes in dietary and fluid intake, decreased peristalsis, effects of medication, e.g. iron.

P. Plan

1. Refer/consult physician:
ALL suspected and/or confirmed cases
2. Therapeutic nursing intervention:
Per physician's orders

Q. Education

See Student Education sheet

R. Follow-up

Per physician's orders

STUDENT EDUCATION PREGNANCY

If your periods are usually normal, the absence of a period after 1-2 weeks can be a first sign of pregnancy. Other signs of pregnancy are:

breast enlargement and tenderness
nausea with or without vomiting
fatigue
abdominal enlargement

If you suspect that you might be pregnant, you should alert the medical staff as soon as possible. A blood or urine test may be ordered to verify that you are pregnant. The doctor will do a vaginal exam to also verify a pregnancy. Throughout the pregnancy, you will need to see the doctor on a regular basis and will be required to have laboratory studies periodically. The usual schedule is a visit every 4 weeks until 32 weeks of pregnancy, then every 2 weeks until 36 weeks of pregnancy then weekly until the delivery date. This may be different for you. It is important that you see your doctor when scheduled.

The doctor may order an ultrasound. This is a way for the doctor to see the baby and other internal organs. This can detect sudden changes in fetal growth and check fetal size with predicted delivery dates.

Weight gain for an average size woman is usually 25-30 pounds or 2-3 pounds per month. You should not diet during your pregnancy. It is important that you eat a well balanced diet that includes fresh fruits and vegetables.

If you experience any of the following symptoms, you should alert the staff immediately:

persistent headache
persistent nausea and vomiting
dizziness
visual disturbances (blurred vision or vision change)
pain or cramps in the lower abdomen
contractions
vaginal bleeding
rupture of membranes (gush of water from vagina)
swelling of hands or feet
decrease in urinary output
any illness or infection
any other problems that trouble you

You may be required to take vitamins and extra iron during your pregnancy. It is very important for your health and the health of your baby to take these. You should avoid any other medications unless prescribed by your doctor. Nicotine is a drug and should be avoided during pregnancy. You should not smoke.

If you have any questions regarding your pregnancy, you should talk with the doctor or nurse.

Protocol #72

PREMENSTRUAL SYNDROME (PMS)

I. Definition

The presence of somatic and psychological symptoms in the premenstruum or early menstruation with the absence of postmenstrual symptoms.

II. Etiology

Occurs in more than 25% of all menstruating women. The exact cause is not known. It is believed to be related to decreasing estrogen and progesterone concentrations. Other theories suggest vitamin deficiencies, excessive prostaglandins, abnormal magnesium metabolism, endorphin malfunction, and multiple psychological disturbances.

III. Clinical Manifestations

A. Subjective

1. Student may state, "I'm feeling so tired."
2. Record student's report of any of the following:
 - a. Behavioral changes (tension, irritability, mood swings, anxiety, crying, Depression, insomnia)
 - b. Fatigue
 - c. Breast tenderness
 - d. Abdominal bloating
 - e. Increase appetite
 - f. Headache
 - g. Backache

B. Objective

1. Physical assessment
 - a. Vital signs (may have palpitations) (no fever)
 - b. Signs of water retention and sodium retention (edema, weight gain)
 - c. Abdominal assessment (palpation – WNL)

2. Laboratory

NONE

Premenstrual Syndrome (cont'd)

C. Assessment

1. Anxiety related to PMS.
2. Knowledge deficit related to lack of information regarding pathophysiology of condition, side effects, and self-care needs.
3. Altered fluid volume (excess) may be related to abnormal alterations of Hormonal levels beginning approximately one week prior to menstruation.
4. Acute pain may be related to vascular congestion.

D. Plan

1. Refer/consult physician
 - a. No relief from anagesics
 - b. Worsening of symptoms
2. Therapeutic nursing intervention:
 - a. Acetaminophen, 2 tablets by mouth every 4 – 6 hours for pain as needed
OR
 - b. Ibuprofen 200 mg, 2 tablets by mouth every 6 – 8 hours as needed for pain.
 - c. Acknowledge the existence of the syndrome and its symptoms.

E. Education

Refer to Student Education Sheet

F. Follow-up

1. If no relief from treatment
2. If condition worsens
3. As needed

STUDENT EDUCATION PREMENSTRUAL SYNDROME (PMS)

Many symptoms may be related to PMS. Some of the symptoms are listed below:
Behavioral changes(tension, irritability, mood swings, anxiety, crying, depression)

insomnia
emotional tension
headaches
breast tenderness and swelling
water retention
acne eruptions
bloating
fatigue
increased appetite
backache

The symptoms usually begin 2 – 12 days before the onset of your period and stop when your period starts.

There is not a good understanding of the causes of PMS and there is no single treatment or specific medication for it. You may be able to relieve some of the symptoms by the following:

1. Reducing salt intake. This may control fluid retention.
2. Reduce the concentration of sweets, like candy. This may control the changes in your blood sugar.
3. Try to avoid stress-producing activities.
4. Practice relaxation techniques, such as deep breathing and imagery.
5. Limit your intake of caffeine.
6. You may request Tylenol (acetaminophen) 2 tablets by mouth every 4 – 6 hours for pain or Motrin (ibuprofen) 400 milligrams by mouth every 6 – 8 hours for pain.

Return to sick call if your symptoms continue after your period starts or gets worse even After you try the things listed above.

Protocol #73

SCABIES

I. Definition

A highly communicable skin disease caused by an arachnid (mite), which bores into the stratum corneum, forming cuniculi or burrows to deposit eggs.

II. Etiology

1. Caused by sarcoptes scabiei.
2. Incubation period is 24 hours to 3 weeks.
3. Lesions are thought to result from hypersensitivity to the parasites.
4. Transmitted from skin-to-skin contact.

III. Clinical Manifestations

A. Subjective

1. Student may state, "I'm itching".
2. Record student's report of any of the following:
 - a. Intense itching, worse in the evening
 - b. Rash

B. Objective

1. Physical assessment
 - a. Initial lesion – burrow appearing as a fine, wavy, dark blue line boring from a few millimeters to 1 cm in length with a minute papule at its open end.
 - b. Papules or vesicles containing the mite.
 - c. Red, itching rash, pustules and excoriation
 - d. Lesions
 - (1). Interdigital spaces of hands
 - (2). Wrist
 - (3). Elbows
 - (4). Areola of breasts in females
 - (5). Lower buttocks
 - (6). Male genitalia
 - (7). Beltline

Scabies (Cont'd)

- d. Secondary infection from scratching

C. Assessment

1. Sleep pattern disturbance related to intense itching, especially in evening.
2. Acute pain related to open lesions from scratching.
3. High risk for infection related to secondary bacterial infection from open lesions caused by scratching.
4. Impaired skin integrity may be related to presence of invasive parasite and development of pruritus.
5. Knowledge deficit [learning need] regarding communicable nature, possible complications, therapy and self-care needs may be related to lack of information/misinterpretation.

D. Plan

1. Refer/consult physician (dermatologist):
For treatment medication prescription (Elimite or Kwell)
2. Therapeutic nursing intervention:
 1. Entire cottage return to cottage for treatment.
 2. Triple antibiotic ointment as needed for secondary infection.
 3. Benadryl 25 milligrams by mouth TID for itching (may cause drowsiness).

OR

 4. Per facility protocol
 5. Refer to next page on Treatment Protocol

E. Education

See Student Education page

F. Follow-up

1. One week to monitor effectiveness of treatment.
2. As needed.

SCABIES
TREATMENT PROTOCOL

1. Staff should supply student with 1 small plastic cupful (all provided by clinic) of solution (Kwell or Lindane) to their body from the neck down, rubbing in thoroughly. DO NOT USE ON OPEN CUTS OR LESIONS ON BODY.
2. Leave lotion on body for 8 hours.
3. Remove all linen from the beds and place linen in marked WASH AWAY bags for the laundry. ALERT LAUNDRY PERSONNEL OF LINEN BEING SENT.
4. Spray all beds with LICEALL spray.
5. After removing dirty linen from cottage, spray rooms with LICEALL spray.
6. All jackets, sweatshirts and any clean linen that has come in contact with soiled linen, need to be sent to the laundry.
7. Plastic laundry bins should be cleaned with disinfectant solution. Cloth bins should be sprayed with LICEALL spray.
8. After 8 hours has passed since application of lotion, have student(s) take a hot soapy shower to remove medication from skin.
9. Students should be retreated in 7 days.
10. KWELL IS A TOXIC COMPOUND, AND OVERTREATMENT SHOULD BE AVOIDED.
11. ITCHING MAY CONTINUE FOR WEEKS, EVEN AFTER SUCCESSFUL TREATMENT.
12. STUDENTS SHOULD REMAIN IN THEIR COTTAGE UNTIL AFTER #6 IS COMPLETE.

STUDENT EDUCATION
SCABIES

Scabies is a highly communicable (passed from person to person) skin condition caused by the itch mite.

You should follow the instructions given by the clinic to treat yourself for this.

Students should be retreated in 7 days to ensure the scabies is gone.

You may continue to itch for several days after using the lotion, because dead mites are still on your body. You cannot spread dead mites.

If the itching continues for more than three days or gets worse, put in a sick slip.

Protocol #74

SCROTAL SWELLING/MASS

I. Definition

An abnormal transient enlargement (swelling) or a quantity of cells that unite or adhere to each other (mass) of the scrotum.

II. Etiology

1. Neoplasm
2. Infections
3. Congenital
4. Trauma
5. Developmental anomalies
6. Torsion (medical emergency)

III. Clinical Manifestations

A. Subjective

1. Student may state, "My private area is swollen".
2. Student may state, "My private area hurts".
3. Record student's report of any of the following:
 - a. Pain
 - (1). Abrupt onset (suggests torsion)
 - (2). Lack of pain (suggests tumor or cystic mass)
 - b. History of trauma to scrotum
 - c. Recent change in testicular size
 - d. Sexual activity (Epididymitis is rare without history of sexual activity or genitourinary pathology.)
 - e. Prior history of pain (Torsion is often preceded by episodes of mild pain.)

B. Objective

Physical assessment:

1. Examine the testis:
 - a. Examiner's hands should be warm.
 - b. Have student in a standing position for initial exam, the sitting.
 - c. Use two hands, supporting the testis in one hand while palpating with the other.

Scrotal swelling/mass (cont'd)

- d. Palpate for:
 - (1). Size
 - (2). Shape
 - (3). Tenderness
 - (4). Masses
- e. Inspect testis for torsion:
 - (1). The affected testis is often higher than the contra lateral side.
 - (2). The affected and often the contra lateral testis lie horizontally instead of in the usual vertical position, secondary to the contential defect involved.
 - (3). Usually no change in pain when elevating scrotum
- f. Inspect the testis for infection:
 - (1). The affected testis is often lower.
 - (2). Pain is usually diminished when elevating the scrotum.
- g. Transilluminate the mass with a light source.
 - (1). Clear transillumination suggests hydrocele or spermatocele.
 - (2). Absence of transillumination suggests a testicular tumor.
- h. Palpate to assess location (if painless):
 - (1). Mass associated with testis is more likely a tumor.
 - (2). Mass unassociated with testis is less likely a tumor.
 - (3). “Bag of worms” on left spermatic cord is probably a varicocele
 - (4). Mass located near the epididymis is likely a spermatocele or hydrocele.

C. Assessment

- 1. Acute pain may be related to swelling from trauma or mass.
- 2. Mild anxiety may be related to threat of change in health status.

D. Plan

- 1. Refer/consult physician:
 - a. Scrotal mass
 - b. Painful scrotum
 - c. Urethral discharge
 - d. Dysuria
 - e. Fever
 - f. Scrotal swelling
 - g. If suspected torsion – emergency referral
- 2. Therapeutic nursing intervention:
 - None

Scrotal swelling/mass (cont'd)

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
SCROTAL SWELLING/MASS

The scrotum is the double pouch below the penis on a male that contains the testicles and part of the spermatic cord (the cord containing veins, arteries, lymphatics, nerves and the ductus deferens).

The left testicle has a longer spermatic cord and is therefore often lower than the right. This is normal for every male.

If you are injured or kicked in the scrotum, you should put in a sick slip to be examined, especially if there is swelling. If you experience or see any of the below, you should be examined:

Swelling for no reason

A hard mass

Pain in the scrotum

Discharge

Inability to urinate

SEIZURE

I. Definition

Paroxysms of involuntary muscular contractions and relaxations.

II. Etiology

Seizures may be associated with a variety of cerebral or systemic disorders, as a result of a focal or generalized disturbance of cortical function.

1. Hyperpyrexia
 - a. Acute infection
 - b. Heatstroke
2. CNS infections
 - a. Meningitis
 - b. AIDS
 - c. Encephalitis
 - d. Brain abscess
 - e. Neurosyphilis
 - f. Rabies
 - g. Tetanus
 - h. Falciparum malaria
 - i. Toxoplasmosis
 - j. Cysticercosis of the brain
3. Metabolic disturbances
 - a. Hypoglycemia
 - b. Hypoparathyroidism
 - c. Phenylketonuria
4. Convulsive or toxic agents
 - a. Camphor
 - b. Chloroquine
 - c. Phentyletetrizol
 - d. Strychnine
 - e. Picrotoxin
 - f. Lead
 - g. Alcohol
 - h. Cocaine
5. Cerebral hypoxia
 - a. Adams-Stokes syndrome
 - b. Carotid sinus hypersensitivity
 - c. Anesthesia
 - d. CO poisoning
 - e. Breath-holding

Seizure (cont'd)

6. Expanding brain lesions
 - a. Neoplasm
 - b. Intracranial hemorrhage
 - c. Subdural hematoma in infancy
7. Brain defects
 - a. Congenital
 - b. Developmental
8. Cerebral edema
 - a. Hypertensive encephalopathy
 - b. Eclampsia
9. Cerebral trauma
 - a. Skull fracture
 - b. Birth injury
10. Anaphylaxis
 - a. Foreign serum
 - b. Drug allergy
11. Cerebral infarct or hemorrhage

III. Clinical Manifestations

A. Subjective

1. Usually call from cottage staff or security stating, "Student is having a seizure."
2. Report the following information as reported by person who witnessed the seizure:
 - a. Describe the movement student made. (What body parts involved)
 - b. Duration of seizure
 - c. Any other information regarding of what lead up to the seizure and the seizure activity
 - d. If student was easy to arouse after the seizure.

B. Objective

1. Physical Assessment:
 - a. Vital signs
 - b. Neurological status (frequently post-ictal)
 - c. Injuries (especially scalp for lacerations)
2. Seizure components:
 - a. Prodrome: Altered behavior occurring minutes to hours before a seizure (Present in one-third of patients, may occur hours or days before seizures, includes headache, pallor, instability, change in appetite)

Seizure (cont'd)

- b. Aura: Altered sensation or other warning just prior to a seizure (autonomic changes – palpitations, sweating, pallor, increased gastrointestinal motility; viscera – abdominal pain; somatosensory – numbness of hands or lips, choking sensation, abnormal taste, smell or vision; Psychic – dream, rage, fear, déjà-vu feeling)
- c. Postictal state: After a seizure (symptoms of confusion, lethargy and weakness)

C. Assessment

1. High risk for trauma/suffocation may be related to:
 - a. Weakness
 - b. Balancing difficulties
 - c. Cognitive limitations/altered consciousness
2. Fear may be related to unpredictable nature of condition and potential harm.
3. Self-esteem/body image disturbance may be related to perceived neurologic functional change/weakness, stigma associated with condition.

D. Plan

1. Refer/Consult physician:
 - a. Any student with a seizure disorder should be under medical management.
 - b. Student who experiences a seizure and is not under medical care. If after hours, make arrangement for transport to emergency room.
2. Therapeutic nursing intervention:
 - a. Make no attempt to halt seizure.
 - b. If student is sitting or standing at beginning of attack, ease student to floor immediately.
 - c. DO NOT FORCE ANY OBJECT INTO STUDENT'S MOUTH.
 - d. Loosen constrictive clothing.
 - e. Protect student from hitting hard or sharp objects that might cause injury.
 - f. Remain with student until conscious and oriented.
 - g. If salivation is excessive, turn student onto side.
 - h. If student appears in respiratory distress and skin excessively blue, extend neck and gently pull jaw forward.
 - i. If breathing does not resume, start CPR and call 911.

E. Education

1. Reassure student
2. Answer any questions
3. Avoid precipitating factors
4. Inform of side effects of medication

Seizure (cont'd)

F. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION SEIZURE

A seizure is an attack of involuntary muscle contractions and relaxation. The most common form of these attacks, which begins with a loss of consciousness, loss of muscle control and jerking of the arms and legs that happens at times, is called *epilepsy*.

1. This condition is not contagious.
2. People who suffer from seizures (epilepsy) usually have to take medication.
3. Most seizures can be prevented with medication. Take medications as prescribed by the doctor.
4. Get plenty of rest.
5. Try to avoid the things that usually trigger a seizure (i.e. bright lights, loud noise, excitement, stress, overexertion).
6. You usually do not remember what happens during the seizure and you might lose control of your bladder and bowels.
7. You may have an altered sensation or other warning just before you have a seizure. This is known as an *aura*. These sensations may be sweating, stomach pain, numbness of hands or lips, a choking sensation, abnormal taste, smell or vision.
8. After a seizure, you may be confused, have a headache, sleepy and/or weak.
5. You may be very tired after a seizure and may need to take a nap.
6. You should avoid heights and sleep in a bed that is low to the ground to avoid injury in case a seizure begins.
7. The seizures may disappear with age.
8. Having seizures (epilepsy) does not lower your intelligence.
9. When giving a medical history, you should always inform others that you have seizures.
10. You should wear a medical alert bracelet and/or necklace.
11. You should NEVER swim alone, scuba dive or mountain climb.

SINUSITIS

I. Definition

An inflammatory process in the paranasal sinuses.

II. Etiology

1. Streptococci
2. Pneumococci
3. *Hemophilus influenzae*
4. Staphylococci

III. Clinical Manifestations

A. Subjective

1. Student may state, "I have a headache in the front of my head".
2. Record student's report of any of the following:
 - a. Tenderness of area over the involved sinus
 - b. Toothache (if maxillary sinus involved)
 - c. Frontal headache
 - d. Malaise
 - e. Chills
 - f. Yellow or green purulent nasal discharge (indicative of bacterial)
 - g. Clear nasal discharge (indicative of viral/allergic)
 - h. Cough at night

B. Objective

Physical assessment:

1. Fever
 - a. < 101 degrees F - viral
 - b. > 101 degrees F - bacterial
2. Nasal discharge:
 - a. Yellow or green - bacterial
 - b. Clear – viral/allergic
3. Post nasal drip – purulent discharge on posterior pharyngeal wall
4. Nasal mucous membrane
 - a. Red
 - b. Turgescient

sinusitis (cont'd)

night.

C. Assessment

1. Sleep pattern disturbance may be related to coughing especially at
2. Acute pain may be related to:
 - a. Fever
 - b. Edematous, hyperemic turbinates

D. Plan

1. Refer/consult physician:
 - a. For antibiotic (if bacterial is suspected)
 - b. If severe pain present
 - c. Temperature > 101 degrees F
 - d. No change in symptoms after 3 days
 - e. Failure to respond to treatment within 14 days
2. Therapeutic nursing intervention:
 - a. Acetaminophen 325 milligrams, 2 tablets by mouth every 4 – 6 hours as needed. (Do not exceed 12 tablets in 24 hours)
 - b. Saline nose drops four times a day (for 1 week)
 - c. Moist warm compress for 30 minutes three times a day

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. If no improvement in 2 – 3 days
2. Two weeks for re-check
3. As needed

STUDENT EDUCATION
SINUSITIS

Sinusitis is an inflammation of the sinus due to viral, allergic, or bacterial reactions. The sinus is a canal or passage. The function of the sinuses are not definitely known. The theory is that they function the same as the nasal cavities by warming, moistening and filtering the air that you breathe in. These sinuses can become infected and swollen. This is caused sinusitis.

If you have a drainage from your nose that is clear, this could mean that you have allergic or viral sinusitis. If you have a drainage from your nose that is yellow or green, this could mean that you have a bacterial infection.

If you have any of the following, you should submit a sick slip:

yellow/green drainage from nose
chills
have severe pain in head (especially from above eyebrows)
coughing, especially at night
tenderness and/or pressure over front of head above eyebrows
feel weak/tired
experience toothache pain

The usual treatment for bacterial sinusitis is antibiotics. You must be seen in the clinic to get antibiotics and you must finish all medication to get rid of this bacteria.

It can be helpful if you:

1. Place a warm cloth for 30 minutes over the nose and head area, while lying down.
2. Request Tylenol for pain and/or fever.
3. The clinic may give you saline nose drops to use three to four times a day.

You should return for sick call if:

1. There is no improvement in 2 – 3 days
2. In two weeks for re-check
3. Do not respond to treatment within 14 days
4. Experience severe pain

SPRAIN, ANKLE

I. Definition

Trauma to the ankle or foot or both, with soft tissue and possible ligament and tendon injury, but without fracture.

II. Etiology

1. Sprain is most often due to inversion-plantar flexion injury.
2. Ankle sprains are classified according to the extent of soft tissue damage.
 - a. Grade 1 - mild or minimal sprain with no ligamentous tear.
mild tenderness with some swelling may be present.
 - b. Grade 2 - moderate sprain consisting of incomplete or partial rupture
obvious swelling, ecchymosis, and difficulty walking.
 - c. Grade 3 - complete tear of a ligament
swelling, hemorrhage, ankle instability, and inability to walk

III. Clinical Manifestation

A. Subjective

1. Student may state, "I twisted my ankle".
2. Record student's report of any of the following:
 - a. Pain over lateral aspect of ankle/knee/joint
 - b. History of turning/twisting ankle/knee/joint
 - c. How happened
 - d. When happened
 - e. Inability to bear weight or limited weight
 - f. No "pop" or "snap" heard

B. Objective

Physical assessment:

1. No ecchymosis
2. Minimal diffuse tenderness over the medial and lateral malleolus
3. No focal area of exquisite tenderness of the involved area
4. Minimal swelling of the involved area
5. No instability of joint
6. Limited range of motion due to pain and swelling
7. Neuro-vascular assessment WNL

Sprain, ankle (cont'd)

C. Assessment

1. Acute pain may be related to trauma to/swelling in joint.
2. Impaired physical mobility may be related to musculoskeletal injury, pain and therapeutic restrictions.

D. Plan

1. Refer/consult physician:
 - a. Any suspicion of fracture
 - b. Ecchymosis
 - c. Focal area of exquisite tenderness
 - d. Report of hearing a “pop” or “snap” at time of injury
 - e. More than minimal swelling
 - f. Swelling involving more than medial and lateral malleolar area
 - g. Instability of joint
2. Therapeutic nursing intervention:
 - a. Immediate ice application for 15 minutes every 2-4 hours for the first 24 hours. (DO NOT PLACE ICE DIRECTLY ON STUDENT'S SKIN)
 - b. Avoid heat during first 24-72 hours when swelling is increasing.
 - c. Compression with ace bandages. (If student is not on suicide precautions)
 - d. Elevation
 - e. Avoid weight bearing by using crutches
 - f. Acetaminophen 325 milligrams 2 tablets by mouth every 4 hours. (Not to exceed 12 tablets in 24 hours)
OR
 - g. Ibuprofen, 200 milligrams 2 tablets by mouth TID as needed for pain. (TAKE WITH FOOD)
 - h. Restrict student from activities for 1 – 2 weeks or as ordered. (Send note)

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. 24 hours for re-evaluation
2. If no improvement in pain and swelling
3. As ordered by physician

STUDENT EDUCATION
SPRAIN, ANKLE

A sprain is usually caused by stressing or twisting a joint of your body. Swelling occurs and can cause pain.

You should do the following things:

1. Keep the injured area elevated as often as you can for 48 hours. This will help with the swelling and throbbing.
2. Place cold water or ice wrapped in a cloth on for 15 minutes every 2 – 4 hours for the first 24 hours. This will also help decrease the swelling. **DO NOT PUT ICE DIRECTLY ON YOUR SKIN OR LEAVE ON FOR MORE THAN 15 MINUTES AT A TIME.**
3. Avoid using the injured area, you may need to use crutches for 2 – 3 days. If you have been instructed to bear weight, you should slowly bear weight to leg.
4. Request Tylenol for pain. (Can take 2 tabs. Every 4-6 hours for pain.)
5. If you use an elastic bandage, do not wrap too tight. Do not wear elastic bandage to bed.
6. Have staff notify the clinic if you feel any numbness, tingling, cold or blueness to the area below your injury.
7. Return for sick call if increased swelling or pain after 2 days.

Protocol #78

STY (HORDEOLUM)

I. Definition

A localized circumscribed inflammatory swelling of one of several sebaceous glands of the eyelid.

II. Etiology

Staphylococci

III. Clinical Manifestations

A. Subjective

1. Student may state, "I have a sty."
2. Record the student's reports of any of the following:
 - a. Irritation of lid margin
 - b. Tenderness
 - c. Swelling
 - d. Localized pain
 - e. Vision impairment
 - f. Foreign-body sensation

B. Objective

Physical assessment

1. External hordeolum
 - a. Redness
 - b. Small, round area of induration
 - c. Lacrimation
 - d. Localized edema
 - e. Small, yellowish spot in center of induration
 - f. Discharge of pus (ruptured abscess)
2. Internal hordeolum
 - a. Redness
 - b. Localized edema
 - c. Small elevation or yellow area at site of affected gland
 - d. Abscess pointing on the conjunctival side of the lid or through skin

Sty (cont'd)

C. Assessment

Acute pain may be related to erythematous swelling along lid margin.

D. Plan

1. Refer/consult physician:
 - a. Vision impairment
 - b. Non-painful swelling
 - c. Failure to resolve within 3 days.
2. Therapeutic nursing intervention:
 - a. Warm compresses for 30 minutes three to four times a day.
 - b. DO NOT USE any ointments unless prescribed by physician.

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. In three days to document response.
2. As needed
3. As ordered by physician

STY (HORDEOLUM)

A sty is a localized inflammatory swelling of one or several of the oil secreting glands located on the eyelid (sebaceous gland). It is caused by a bacteria named staphylococci. It can occur at any time and may occur again and again.

A sty is a painful swelling on the eyelid. It may be red and a “bump” might be seen. It can rupture and cause pus to drain out.

If you have a sty, you may be instructed to:

1. Apply a warm cloth to the eye for 30 minutes, three to four times a day.
2. You should NOT put any ointment on or around the eye, unless prescribed by a doctor.
3. You should always wash your hands before doing any treatments on the eye.
4. You should wash your hands after playing (basketball, football, volleyball, etc.) and after using the bathroom.
5. Return for sick call if the sty becomes worse, your vision changes, or does not get better within 3 days.

Protocol #79

SYNCOPE

I. Definition

A transient loss of consciousness due to inadequate blood flow to the brain.

II. Etiology

A decrease in cerebral perfusion or inadequate cardiac output. May be triggered by emotional factors or may have metabolic or other neuropsychological factors involved.

III. Clinical Manifestations

A. Subjective

1. The staff may report, "He/She passed out".
2. Record staff or student's report of any of the following:
 - a. Loss of consciousness preceded by a sensation of faintness. (Often associated with slight nausea and mild diaphoresis).
 - b. Prompt return to consciousness.
 - c. No headache or neurological symptoms.
 - d. No history of organic heart disease.
 - e. Description of episode.
 - f. Any previous attacks
 - g. Drug use
 - h. Circumstances preceding the attack (i.e. stressful situation)
 - i. Precipitating factors
 - (1). Stress
 - (2). Recent infection
 - (3). Fasting
 - (4). Sudden movements
 - j. Sudden onset or prodrome
 - k. Position during attack
 - l. Duration of attack (may have to question staff or other students)
 - m. Last menstrual period (females)

B. Objective

1. Physical assessment
 - a. Skin and mucous membranes for pallor and dehydration
 - b. Cardiac exam – for murmurs, extra heart sounds, arrhythmias
 - c. No seizure activity

Syncope (cont'd)

- d. No incontinence
- e. No postictal confusion

2. Neurological

- a. Pupils
- b. Orientation
- c. Strength (limbs)

3. Vital signs

- a. Blood pressure (both arms – lying, sitting, standing)
- b. Pulse (rate, rhythm)

4. Labs (per physician orders)

- a. Blood sugar
 - (1). Finger stick
 - (2). Fasting
 - (3). Post-prandial
- b. Hematocrit
- c. Pregnancy test

C. Assessment

- 1. Fear may be related to recurrence, potential for harm.
- 2. High risk for injury related to falling during loss of consciousness or dizziness.

D. Plan

- 1. Refer/consult physician:
 - a. Seizure
 - b. Abnormal neurological finding
 - c. Orthostatic fall in blood pressure that persists after recovery
 - d. Abnormal heart sounds or arrhythmias
 - e. Failure of blood pressure and pulse to return too normal in 5 minutes.
 - g. Recurrent episodes

Syncope (cont'd)

2. Therapeutic nursing intervention:
 - a. During episode:
 - (1). Position with head lower than feet or supine with legs elevated
 - (2). Record blood pressure and pulse every 5 minutes for 30 minutes
 - b. Preventive measures:
 - (1). If related to poor diet, encourage regular meals
 - (2). Treat anemia, if indicated
 - (3). If hyperventilation-reassure, breathing and relaxation techniques, breathe into paper bag, counseling if indicated.

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

As needed

SYNCOPE

Syncope is an episode of loss of consciousness or “passing out”. It is caused by a decrease in blood flow to the brain.

Things that can cause syncope:

Fatigue
Prolonged standing, especially in one place
Nausea
Pain
Emotional problems
Anemia (“low blood”)
Dehydration
Poor ventilation
Many others

You may begin to have other symptoms, just before you have a syncopal episode. They can be any of the following:

Faintness
Light-headedness
Dizziness
Confusion
Visual blurring

ANYTIME you have any of these sensations or any episode of syncope, you should alert your staff to notify the medical staff for you to be evaluated.

Protocol #80

SYPHILIS

I. Definition

An infectious, chronic, venereal disease characterized by lesions that may involve any organ or tissue.

II. Etiology

Treponema palladium, a spirochete organism. Usual transmission is sexual, although needle-borne transmissions among drug users is possible. Health department workers have developed infection after professional examinations of lesions with ungloved hands.

III. Clinical Manifestations

A. Subjective

1. Student may state, "I have a sore in my private area".
2. Record student's report of any of the following:
 - a. Swollen glands
 - b. Painless genital sore present or that healed in 3 – 9 weeks untreated
 - c. Rash on body or extremities, palms of hands or soles of feet
 - d. No signs or symptoms with a history of prior genital lesions and/or rash.

B. Objective

Physical assessment

1. Non-tender, firm lesion(s) with slightly elevated border usually on the genitalia, anal area, or mouth. (Approx. 3-4 weeks after infection at the site of portal persists from 1-5 weeks, then heals spontaneously)
2. Generalized or localized non-pruritic rash appears about 8-10 weeks after infection.
3. May have condylomata lata (a mucous patch on the vulva or anus)
4. Lymphadenopathy – diffused or localized
5. Patchy alopecia on scalp, eyebrows and eyelashes
6. Mucus patches of mouth or cervix
7. Fever

Syphilis (cont'd)

C. Assessment

1. Acute pain may be related to swollen glands.
2. Impaired skin/tissue integrity may be related to development of lesions/rash and irritation of mucous membranes.

D. Plan

1. Refer/consult physician or local health department:
All suspected/confirmed cases and contacts
2. Therapeutic nursing intervention:
Per physician orders

E. Education

See Student Education sheet (following page)

F. Follow-up

1. One week
2. As needed

STUDENT EDUCATION
SYPHILIS

Syphilis is a sexually transmitted disease that is highly contagious. Initially, you may have symptoms of a lesion that heals in 3 to 4 weeks and you may not have any other symptoms until a rash appears on your body, arms/legs, palms of hands and soles of feet.

The only way you can ENSURE that you will not get sexually transmitted diseases is by NOT having sex. Using a condom can decrease your chances, but cannot ensure.

Practice good hygiene by cleaning yourself well when showering and wearing clean undergarments daily.

Protocol #81

TINEA CAPITUS (RINGWORM OF SCALP)

I. Definition

A fungal infection of the scalp. It is contagious and may become an epidemic.

II. Etiology

May be due to one of several types of *Microsporum* or *Trichophyton tonsurans*.

II. Clinical Manifestations

A. Subjective

1. Student may state, "My head itches".
2. Record student's report of any of the following:
 - a. Loss of hair
 - b. Itching
 - c. Small, scaly patches

B. Objective

Physical assessment:

1. Single or multiple patches on scalp
 - a. Occipital
 - b. Temporal
 - c. Parietal
2. Patches, rounded or oval in outline covered by scales and lusterless
3. Irregularly broken hairs
4. Boggy, raised and suppurative lesions (kerion) may be present
5. Wood's lamp causes microspiroin infections to fluoresce with Brilliant yellow-green light.

Tinea capitis (cont'd)

- dermis.
- C. Assessment**
1. Impaired skin integrity may be related to fungal infections of the
 2. Knowledge deficit (learning need) regarding contagious nature, possible complications, and self-care needs may be related to lack of information/misinformation.

D. Plan

1. Refer/consult physician/dermatologist:
 - a. Medication prescription
 - b. Secondary bacterial infection
 - c. No response to antifungal agents
 - d. Worsening of condition after treatment started
 - e. Side effects from oral medication
2. Therapeutic nursing intervention:

Refer to physician for medication prescription

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. As ordered by physician
2. As needed
3. No response to treatment
4. Worsening after treatment

TINEA CAPITIS (RINGWORM OF SCALP)

Ringworm is a widespread highly contagious fungus infection that can occur at any time.

Usually the ringworm appears on the scalp as round, scaly patches with short, broken off hairs. The doctor may look at your scalp with a special light and is ultra-violet (wood's lamp).

The period after exposure and before the ringworm appears is 10-14 days.

It can be spread through direct or indirect contact. This can include sitting in a high back chair, barber clippers, toilet or clothing contaminated with hair. Animals can also spread the infection to you.

To prevent ringworm, you should:

1. Clean scalp and hair regularly.
2. Do not share combs, brushes, towels, caps or any hats with anyone.

You may be required to take a prescription medication.

You should return for sick call if:

1. You notice the areas getting worse after treatment
2. It does not get better after treatment
3. You experience side effects from medications given by mouth

TINEA CORPORIS (RINGWORM OF THE BODY)

I. Definition

Superficial fungal infection involving the trunk or limbs.

II. Etiology

Usually caused by a *Trichophyton*. Transmitted by direct contact with infected persons, lesions of animals, or contaminated articles.

III. Clinical Manifestations

A. Subjective

1. Student may state, "My arm is itching".
2. Record student's reports of any of the following:
 - a. Itching
 - (1). Limbs
 - (2). Trunk
 - b. Lesions (red, scaly patches)

B. Objective

Physical assessment

1. Patches
 - a. Erythematous
 - b. Scaly
 - c. Usually one or two
 - d. Round or oval
 - e. Start small, then expand outward
 - f. Clearing of eruption in center
 - g. Activity restricted to the border
 - h. Border usually raised and scaly
2. Location
 - a. Trunk
 - b. Face
 - c. Arms
 - d. Can be found anywhere

Tinea corporis (cont'd)

C. Assessment

- dermis.
possible
information
1. Impaired skin integrity may be related to fungal infections of the
 2. Knowledge deficit [learning need], regarding contagious nature, complications, and self-care needs may be related to lack of /misinformation.

D. Plan

- as
1. Refer/consult to physician (dermatologist):
 - a. Severe or widespread infection (may need prescription)
 - b. Secondary bacterial infection
 - c. Failure to respond to treatment
 2. Therapeutic nursing intervention:
 - a. Clean with soap and water BID.
 - b. Treatment with topical anti-fungal agent
 - (1). Tolnaftate 1% cream or solution, apply to affected area BID
OR
 - (2). Miconazole nitrate 2%, cream or lotion apply BID
OR
 - (3). Lotrimin AF cream apply BID
 - c. Investigate contact and sources of infection and promote treatment appropriate.

E. Education

See Student Education sheet (following page)

F. Follow-up

1. If not resolved in one week
2. As ordered by physician
3. As needed

STUDENT EDUCATION
TINEA CORPORIS (RINGWORM OF THE BODY)

Ringworm is a very contagious fungus infection that occurs in the United States and throughout the world.

When you have ringworm of the body, it usually occurs in places that do not have a lot of hair. The lesions are round, slightly red with a raised border and might have a clear center. They may be moist and crusted or dry and scaly. Pus or clear fluid may be present in the area.

Ringworm is spread by:

1. Direct or indirect contact with skin and scalp lesions of infected persons
2. Lesions on animals
3. Contaminated floors
4. Shower stalls
5. Benches and similar articles

The time that you are exposed to it until you begin showing signs is 4-10 days.

You are contagious as long as the lesions are on your body and the fungus remains on contaminated material.

You can prevent spreading of ringworm by:

1. Proper laundering of linens
2. General cleanliness of rooms and showers
3. Cleanliness of public places
4. Do not share towels or clothing with anyone
5. Do not share caps, brushes, combs or hair ornaments with others

When you are diagnosed with ringworm, you will be started on a cream or solution that will be placed on the lesion three times a day. If you have a lot of lesions, you may need to take a medication by mouth.

Protocol #83

TINEA CRURIS (JOCK ITCH)

I. Definition

A fungus skin disease of surfaces of contact in the scrotal, crural, anal and genital areas.

II. Etiology

May be caused by various dermatophyte or yeast organisms. The infections are Transmitted from person to person or may be acquired from animals or soil.

III. Clinical Manifestations

A. Subjective

1. Student may state, "I have jock itch".
2. Record student's reports of any of the following:
 - a. Swelling in genital area
 - b. Intense itching in genital area

B. Objective

Physical assessment:

1. Lesions
 - a. Sharply marginated
 - b. Erythematous
 - c. Scaly
 - d. Elevated borders
 - e. Little central clearing
 - f. May contain vesicles
2. Location
 - a. Medial thighs
 - b. Inguinal folds

C. Assessment

1. Impaired skin integrity may be related to fungal invasion, humidity or secretions.
3. High risk for secondary infection may be related to multiple breaks in skin.

Tinea cruris (cont'd)

D. Plan

1. Refer/consult physician (dermatologist):
 - a. If condition worsens or fails to respond 2 weeks after treatment
 - b. If student is allergic to topical antifungal agent
 - c. Signs and symptoms of secondary infection
2. Therapeutic nursing intervention:
 - a. Tolnaftate powder or cream apply BID
 - OR
 - b. Other antifungal agent per protocol

E. Education

See student Education sheet (following page)

F. Follow-up

1. If no relief within 2 weeks after treatment
2. If condition worsens
3. If condition recurs
4. As ordered by physician

**STUDENT EDUCATION
TINEA CRURIS (JOCK ITCH)**

Jock itch is caused by a fungus. Fungus likes to grow in warm, moist paces.

To treat jock itch, you should do the following:

1. Keep the area clean and dry.
2. Wash every day with warm, soapy water. Rinse the soap off. Dry the groin well.
3. Wear loose fitting pants.
4. Wear clean underwear every day. Wear cotton underwear if you have them.
5. Apply Tolnaftate cream after shower and drying groin area. It does not take much cream, but make sure you spread it evenly and rub it in. Wash your hands before and after you use the cream. Use the cream as you have been instructed by the nurse.

The following are signs that infection may be starting:

Increased redness
Increased swelling
Little lumps in your groin
Red streaks
Pus
Increased pain

If you experience any of the above, you should return for sick call.

If you don't get better in two weeks after treatment or if the rash is spreading, you should return to sick call.

Protocol #84

TINEA PEDIS (ATHLETES FOOT)

I. Definition

A pruritic cracking and peeling eruption of the feet, especially the toe webs.

II. Etiology

Trichophyton mentagrophytes infections begin in the third and fourth interdigital spaces and later involve the plantar surface of the arch.

III. Clinical Manifestations

A. Subjective

1. Student may state, "My feet are peeling and itching".
2. Record student's reports of any of the following:
 - a. Itching
 - b. Burning
 - c. Scaling of skin between toes and bottom of feet
 - d. Rash between toes and bottom of feet
 - e. Swelling of feet

B. Objective

Physical assessment

1. Lesions
 - a. Red, dry, scaly and fissured eruptions between toes
 - b. Acute, tense, papulovesicular, and bullous eruptions on soles or sides of feet
 - c. Dry, scaly, thickened areas between the toes or on soles
 - (1). Toenails may be thickened
 - (2). Debris under nails
2. Secondary bacterial infection may occur

C. Assessment

1. Impaired skin integrity may be related to fungal invasion, humidity, secretions.
2. High risk for spread of infection may be related to multiple breaks in skin, exposure to moist/warm environment.

Tinea pedis (cont'd)

D. Plan

1. Refer/consult physician (dermatologist):
 - a. Secondary bacterial infection suspected
 - b. Worsening of condition after treatment started
 - c. Allergy to antifungal agent
 - d. No response to treatment
 - e. Fungal infection is elsewhere on body (may need prescription)
 - f. Nail involvement

2. Therapeutic nursing intervention:
 - a. Tolnaftate cream or powder to clean, dry area BID
OR
 - b. Other antifungal agent per facility protocol

E. Education

See Student Education sheet (following page)

F. Follow-up

1. Two weeks for recheck.
2. If signs of infection develop
3. Lesions spread
4. No relief after treatment

STUDENT EDUCATION
TINEA PEDIS (ATHLETES FOOT)

Athlete's foot is caused by a fungus. Fungi like to grow in warm, moist places.

If you have athlete's feet, you should do the following:

1. Keep your socks and shoes off whenever you can.
2. Do not sleep in your socks.
3. Wash your feet with warm, soapy water every day. Pat dry between toes. Dry your feet last to keep from spreading the fungus.
4. Wear shower shoes whenever you shower.
5. Wear clean socks (white, cotton if possible) every day.
6. Put your socks on before your underwear to prevent spreading.
7. Apply antifungal cream sent by the nurse in the affected area two times a day after you wash and dry your feet. Rub in well. Wash hands well before and after applying cream.

If you don't get better after treatment for a week,, if fungus spreads to other parts of your body or if you experience:

Increase redness
Increased swelling
Heat
Pus formation
Red streaks
Increased pain

You should return for sick call.

Even after your athlete's foot clears, you should continue to do numbers 1-6.

Protocol #85

TINEA VERSICOLOR

I. Definition

An infection characterized by multiple, usually asymptomatic, patches of lesions varying in color from white to brown.

II. Etiology

Pityrosporum orbiculare (formerly *Malassezia fur fur*)

III. Clinical Manifestations

A. Subjective

1. Student may state, “I have a rash on my chest”.
2. Record student’s reports of any of the following:
 - a. Lesions
 - b. Location
 - (1). Chest
 - (2). Neck
 - (3). Abdomen
 - (4). Face (occasionally)
 - c. Itching (rare)

B. Objective

1. Physical assessment
 - a. Patches
 - (1). Multiple
 - (2). Flat
 - (3). Scaling
 - (4). Differing in size and shape
 - b. Color
 - (1). White
 - (2). Light pink
 - (3). On dark skin – pale, white OR dark brown, black
 - (4). On pale skin – tan
 - c. Location
 - (1). Upper trunk
 - (2). Upper arms

Tinea versicolor (cont'd)

- (3). Neck
- (4). Palms, face (occasionally)

2. Woods lamp
 - a. Golden fluorescence
 - b. Pigment changes

C. Assessment

1. Social isolation may be related to alterations in physical appearance.
2. Body image disturbance may be related to presence of skin lesions.

D. Plan

1. Refer/consult physician (dermatologist):
 - a. If not improved after treatment
 - b. Side effects from treatment
 - c. Widespread lesions (may need prescription)
2. Therapeutic nursing intervention:
 - a. Selenium sulfide lotion to affected areas during shower per instructions.

OR

 - b. Per facility protocol

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. In one week for re-evaluation
2. As needed
3. No improvement in 1 week

STUDENT EDUCATION
TINEA VERSICOLOR

Tinea versicolor is a fungus that is quite common. It is especially noticeable in the summer because the areas of fungus do not tan. It usually appears on the chest, neck and abdomen and occasionally on the face.

On dark skin the lesions appear pale, and on light skin they appear tan. The color can vary between white to light pink.

If you have this fungus, you will be instructed to use a lotion (Selenium sulfide) before showering. You should spread the lotion on the affected areas and leave it on for 10-15 minutes, then shower. You should continue this for one week and then be rechecked by the nurse.

Protocol #86

TRICHOMONAS VAGINALIS (Trichomoniasis)

I. Definition

An inflammation of the vagina and possible the labia and vulva, characterized by a discharge and pruritus.

II. Etiology

Trichomonas vaginalis is an oval, flagellated, motile protozoan that readily attaches to mucous membranes and other surfaces. It is transmitted sexually and rarely on moist clothing or towels. The incubation period is variable, although most women develop symptoms within a few days of sexual contact.

III. Clinical Manifestations

A. Subjective

1. Student may report, "I have a discharge and itching".
2. Record student's report of any of the following:
 - a. Vaginal discharge
 - (1). Malodorous
 - (2). Thin
 - (3). Frothy
 - (4). Greenish-gray or yellow
 - b. Intense vulvular irritation and itching
 - c. Urinary frequency

B. Objective

1. Physical assessment
 - a. Pelvic exam (per physician)
 - b. Vaginal discharge
 - (1). Malodorous
 - (2). Thin
 - (3). Frothy
 - (4). Greenish-gray or yellow
2. Laboratory (per physician's orders)
 - a. Wet mount
 - b. Chlamydia and GC culture (if positive, do RPR)

Trichomonas Vaginalis (cont'd)

C. Assessment

1. Impaired tissue integrity may be related to irritation or inflammation and mechanical trauma (scratching) of sensitive tissues.
2. Acute pain may be related to localized inflammation and/or tissue trauma.

D. Plan

1. Refer/consult physician
All suspected cases
2. Therapeutic nursing intervention
Per physician's orders

E. Education

Refer to Student Education sheet

F. Follow-up

1. As ordered by physician
2. As needed

STUDENT EDUCATION
TRICHOMONAS VAGINALIS (Trichomoniasis)

Trichomoniasis is a genitourinary tract infection caused by a protozoan that attaches to the mucous membrane. It usually presents itself as a vaginal discharge. It is transmitted by sexual contact. Someone that has this may not have any symptoms at all.

If you do get symptoms, they usually occur within a few days after sexual contact. Some symptoms are as follows:

- Foul smelling, thin frothy greenish-gray or yellow vaginal discharge
- irritation
- itching
- frequent urination
- pain on urination

If you experience any of the symptoms above, you should alert the medical staff as soon as possible. The doctor may do a vaginal exam and culture the discharge. You may be started on an antibiotic. Metronidazole is commonly used. It is important that you take the whole course of the medication to ensure that you have been treated sufficiently. While on this medication, you should not take anything containing alcohol (i.e. cough syrup) for 24 hours before and 48 hours after. If you do it may cause vomiting.

You should practice good perianal hygiene. Keep the area clean and dry. Avoid constrictive clothing.

Abstinence is effective and acceptable to prevent STDs and pregnancy. The consistent use of condoms may reduce your chance of getting this.

Protocol #87

UPPER RESPIRATORY INFECTION

I. Definition

An acute, usually afebrile, viral infection of the upper respiratory tract, with inflammation in any or all airways, including the nose, paranasal sinuses, throat, larynx, and often the trachea and bronchi.

II. Etiology

Many viruses cause the common cold, including those in the picorna0 (rhino-, certain echo-, and Cocksackie viruses), influenza, parainfluenza, respiratory syncytial, corona-, and adenovirus groups. Most colds 30-50%) are caused by one of the > 100 serotype of the rhinovirus group.

III. Clinical Manifestations

A. Subjective

1. Student may report, "I have a cold."
2. Record student's report of any of the following:
 - a. Stuffy nose
 - b. Runny nose
 - c. Headache
 - d. Sneezing
 - e. Coughing
 - f. Mild sore throat
 - g. Watering eyes
 - h. General malaise
 - i. Decreased appetite

B. Objective

Physical assessment

1. Nasal mucosa
 - a. Erythematous
 - b. Edematous
 - c. Clear nasal discharge (initially)
 - d. Serous to purulent (later stages)
2. Mild erythematous pharynx
3. Mild conjunctivitis
4. Occasional low grade fever
5. No lymphadenopathy
6. Normal exam of ear

Upper respiratory infection (cont'd)

C. Assessment

1. Acute pain may be related to edematous nasal mucosa, middle ear canal and tonsils.
2. Sleep pattern disturbance may be related to cough and difficulty breathing (edematous nasal mucosa).

D. Plan

1. Refer/consult physician
 - a. Temperature above 102 degrees F
 - b. Lymphadenopathy present
 - c. Symptoms of secondary bacterial infection
 - d. Symptoms not improved or worsened after treatment
2. Therapeutic nursing intervention:
 - a. Increase fluid intake
 - b. Rest if febrile
 - c. Fever, aches: Acetaminophen 325 milligrams 2 tablets by mouth (Not to exceed 12 tablets in 24 hours)
 - d. Cough: Non-alcohol containing cough medication per instructions
 - e. Nasal stuffiness: Saline nose drops

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. In 24 hours for recheck
2. If condition worsens (increase temp)

STUDENT EDUCATION
UPPER RESPIRATORU INFECTION

The common cold is an inconvenience and makes you feel “bad”, but it is not serious. The cold is caused by many different types of viruses. The usual symptoms include:

sneezing
stuffy nose
watery nasal discharge
scratchy throat
cough
achy
tired
headache
chills

Colds are not cured by medicine. A cold must run its course. Any medications for a cold simply help control the symptoms only.

All symptoms generally are worse the second and third days and stop within 4-7 days. A cough may last longer than this.

Colds usually occur more in the fall and winter. The viruses that cause colds are spread mostly by the drainage form the nose, coughing and sneezing. You should cough and blow your nose into paper (Kleenex or toilet paper) and throw it into the trash can right away. **ALWAYS WASH YOUR HANDS AFTER YOU BLOW YOUR NOSE OR SNEEZE.**

Cold symptoms **DO NOT** get better by taking antibiotics like penicillin. You should do the following things:

1. Drink lost of fluids, especially clear liquids like water.
2. Request Tylenol if needed for fever, headache, aches and pain of the common cold.
3. Rest as much as possible.

If you get different symptoms or are not better in 3 days, return for sick call.

Protocol #88

URINARY TRACT INFECTION

I. Definition

Infection of the urinary tract.

II. Etiology

1. E. Coli
2. N. Gonorrhoea
3. Proteus
4. Klebsiella
5. Staphylococcus aureus
6. Beta hemolytic streptococcus
7. Numerous others

III. Clinical Manifestations

A. Subjective

1. Student may stat, "It burns when I pee."
2. Record student's reports of any of the following:
 - a. Duration
 - b. Onset
 - c. Frequency
 - d. Dysuria
 - e. Chills
 - f. Back pain
 - g. Suprapubic pain
 - h. Vaginal discharge
 - i. History of previous UTI
 - j. Nausea/vomiting

B. Objective

1. Physical assessment
 - a. Urethra may appear slightly reddened
 - b. Abdomen
 - (1). Soft
 - (2). Bowel sounds present
 - (3). Pain on palpation (suprapubic and/or flank)
2. Vital signs
Low grade fever

Urinary tract infection (cont'd)

C. Assessment

1. Acute pain may be related to:
 - a. Fever
 - b. Inflammation
 - c. Bladder spasm
2. Altered urinary elimination may be related to dysuria caused by inflammation.

D. Plan

1. Refer/consult physician:

All suspected UTI
2. Therapeutic nursing intervention:
 - a. Obtain clean catch urine (per physician orders)
 - b. Dipstick urine for white blood cells and blood (per physician orders)
 - c. Contact physician with results
 - d. Increase fluid intake > 12 glasses of water per day

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. If symptoms persist after treatment
2. If vomiting occurs
2. Pain becomes worse or not relieved after treatment
3. As ordered by physician

STUDENT EDUCATION

URINARY TRACT INFECTION

Lower urinary tract infections are more common in females. They are caused by bacteria that enter the urine system through the short tube that leads to the bladder.

Most lower urine infections get better very quickly with antibiotics to destroy the bacteria. Since it is easier for females to get urinary infections, they should do the following:

1. Drink 8 glasses of fluid (preferably water) each day.
2. Limit drinking caffeine containing drinks (coffee, tea, soda) especially while you have symptoms.
3. Go to the bathroom (pass your urine) when you feel the urge. This will lessen the chance of getting bacteria into the urine tube.
4. Wipe your BM or voiding from front to back. This will lessen the chance of getting bacteria into the urine tube.
5. Avoid activities (like masturbation) that can also cause introduction of bacteria into the urine tube.
6. Take all medications until gone (antibiotics). The symptoms should be much better or gone in 24-36 hours after you start antibiotics. This does not mean that you are cured. If you do not continue the medication until finished, you could suffer a relapse.

Return for sick call if:

1. You are not much better in 2 days.
2. Symptoms get worse,
3. Vomiting occurs,

Protocol #89

URTICARIA (HIVES)

I. Definition

A vascular reaction of the skin characterized by the eruption of pale evanescent wheals, which are associated with severe itching.

II. Etiology

Urticaria is an allergic reaction, usually to drugs (oral or injected), foods, insect bites, inhalants, or injections. Occasionally it is due to an infection (e.g. herpes simplex, upper respiratory tract infection, tooth abscess, urinary tract infection). No cause is found in many cases.

IV. Clinical Manifestations

A. Subjective

1. Student may state, "I'm itching all over."
2. Record student's report of any of the following:
 - a. Itching
 - b. "bumps" that may enlarge
 - c. Stinging (occasionally)

B. Objective

Physical assessment

1. Wheals, plaques or welts
 - a. Red
 - b. Raised
 - c. Sharp borders
 - d. Vary in number
 - e. Vary in size
2. Location
 - a. Trunk
 - c. Extremities
3. Duration
 - a. Usually fade in less than 12 hours
 - b. Sometimes fade in 20-30 minutes
4. Auscultate lungs (assess for anaphylaxis)
3. Vital signs (assess for anaphylaxis)

C. Assessment

1. Acute pain may be related to cutaneous hyperesthesia and inflammation.
2. High risk for impaired skin integrity may be related to mechanical trauma caused from scratching.

D. Plan

1. Refer/consult physician:
 - a. Evidence of edema of larynx- IMMEDIATE MEDICAL ATTENTION - 911
 - (1) Hoarseness
 - (2) Inspiratory stridor
 - b. Evidence of anaphylaxis – IMMEDIATE MEDICAL ATTENTION - 911
 - (1) Hypotension
 - (2) Tachycardia
 - (3) Paroxysmal coughing
 - (4) Severe anxiety
 - (5) Dyspnea
 - (6) Wheezing
 - (7) Cyanosis
 - c. Chronic or recurrent urticaria lasting more than one week
 - d. Widespread urticaria
2. Therapeutic nursing intervention:
 - a. If clinical features of anaphylaxis are present, institute immediate specific treatment (see ANAPHYLAXIS).
 - b. For less severe urticaria – Benadryl 25 milligrams capsule by mouth QID.
 - c. Search for offending agent and eliminate or avoid it. Inquire about diet history, drug history, insect bites.
 - d. Calamine lotion to lesions for antipruritic effect.

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

1. 48 hours if lesions persist or new signs or symptoms develop
2. If recurs
3. As needed

STUDENT EDUCATION
URTICARIA (HIVES)

Hives is a reaction of the skin when someone is exposed to something they are allergic to. This could be by eating, drinking, injection or inhaling.

The hives appear as lesions, which are called wheals, or welts that are red and raised on the skin and usually appear on the body or extremities. They cause severe itching.

They usually disappear in 20-30 minutes, but may persist for up to 12 hours.

If you experience these, you should ask the staff to alert the medical staff for you to be evaluated. They are usually not harmful, but if you are having a severe reaction, it can cause you to go into anaphylaxis, which is harmful.

Symptoms of anaphylaxis are:

dizziness
faint feeling
racing heart
sudden coughing
shortness of breath
vomiting
hoarseness

If you begin feeling any of these symptoms, you should alert your staff IMMEDIATELY so you can get fast medical attention. This can be life threatening.

You should try to remember what you ate or what you were exposed to just before you begin itching or noticed the hives.

You may be given a medication to control the itching, but it might make you sleepy. You can also request Calamine lotion from your staff to rub on the lesions to lessen the itching.

VAGINAL YEAST INFECTION
MONILIA, CANDIDIASIS

3. Definition

Inflammation of the vagina due to a fungal infection.

4. Etiology

Candida albicans

5. Clinical Manifestations

6. Subjective

7. Student may report, "I have a yeast infection."
8. Record student's report of any of the following:
 9. Increase of normal vaginal secretions
 10. Vaginal/genital itching or burning (abrupt onset favors yeast)
 11. Abdominal pain
 12. Dysuria and/or dyspareunia
 13. Discharge – thick, white cottage cheese-like
 14. History of recent antibiotic therapy
 15. Douche history

16. Objective

17. Physical Assessment
 18. Pelvic exam (per physician)
 19. Vital signs including temperature
 20. Abdominal assessment (soft, non-tender or mild supra pubic tenderness)
 21. Bowel sounds (normal)
 22. Check for predisposing factors:
 23. Recent antibiotic use
 24. Pregnancy
 25. Diabetes
 26. HIV infection
 - a. Thick, white cottage cheese-like discharge
27. Laboratory (per physician)

Culture and Gram stain

28. Assessment

- 29. Impaired tissue integrity may be related to irritation or inflammation and mechanical trauma (scratching) of sensitive tissues.
- 30. Acute pain may be related to localized inflammation and/or tissue trauma.
- 31. Knowledge deficit [learning need] may be related to lack of information regarding hygienic and therapy needs and sexual behavior.

32. Plan

- 33. Consult/refer to physician:
All suspected cases
- 34. Therapeutic nursing intervention:
Per physician's orders

35. Education

Refer to Student Education sheet

36. Follow-up

As needed

STUDENT EDUCATION
VAGINAL YEAST INFECTION
(MONILIA, CANDIDIASIS)

Increase or change in vaginal discharge can be caused by many organisms. Yeast or *Candida albicans* is a normal inhabitant of the vagina, mouth, and digestive tract of most adult women. An alteration in vaginal pH by any of the following:

prolonged use of antibiotics
steroid use
oral contraceptive use
excessive douching
diabetes
pregnancy

can produce favorable conditions for yeast production.

It causes intense vaginal itching, soreness and irritation that can extend to the inner thighs. The vaginal discharge usually becomes thick, white “cottage cheese” discharge.

You may be started on a topical cream to apply or tablet to be taken by mouth.

You should:

37. Avoid activities that may spread organisms, such as masturbation.
38. Avoid use of douches, because they can change the normal protective actions that you have.
39. Keep yourself clean and as dry as possible.
40. If the doctor treats you for a yeast infection, use the medication at bedtime to prevent leakage and complete the medication

Return to sick call if you don't get better after using the medicine, or your condition gets worse.

Protocol #91

VENEREAL WARTS (CONDYLOMA ACUMINATA)

I. Definition

An ordinary wart in the genital or perianal areas.

II. Etiology

Genital warts are caused by papilloma viruses (human papillomavirus types 1, 2, 6, 11, 16, 18) and usually are transmitted sexually. They have an incubation period of 1–6 months and occur most commonly on warm, moist surfaces in the subpreputial area, the coronal sulcus, within the urethral meatus and on the penile shaft in men; and on the vulva, the vaginal wall, the cervix, and the perineum in women.

III. Clinical Manifestations

A. Subjective

1. Student may state, “I have bumps on my private area.”
2. Record student’s report of any of the following:
 - a. Bumps or growths
 - b. Location - Females
 - (1) Anogenital area
 - (2) Vagina
 - (3) Cervix
 - c. Location -Males
 - (1) Penis
 - (2) Anogenital area

B. Objective

1. Physical assessment
 - a. Warty growths
 - (1) Soft
 - (2) Moist
 - (3) Minute
 - (4) Pink or red
 - (5) Several in same area resembling cauliflower
 - (6) Occasionally solitary
 - b. Location in females
 - (1) Vulva
 - (2) Adjacent perineum
 - (3) Buttock
 - (4) Inner thigh
 - (5) Lower vagina

Venereal warts (cont'd)

- (6) Upper vagina
- (8) Cervix
- c. Location in males
 - (1) Perirectal area
 - (2) Urethral meatus
 - (3) Penile shaft
 - (4) Rectal area
- 2. Labs (as ordered by physician)
RPR to rule out syphilis

C. Assessment

- 1. High risk for transmission of infection may be related to contagious nature of infecting agent and insufficient knowledge to avoid exposure to transmission of pathogens.
- 2. Impaired skin/tissue integrity may be related to invasion of/irritation by pathogenic organism(s).
- 3. Knowledge deficit [learning need] regarding pathophysiology of condition, outcomes/complication, therapy needs, and transmission may be related to lack of information/misinterpretation, lack of interest in learning.

D. Plan

- 1. Refer/consult physician or local health department:
ALL suspected cases
- 2. Therapeutic nursing intervention:
Per physician's orders

E. Education

Refer to Student Education sheet (following page)

F. Follow-up

One week and as needed

STUDENT EDUCATION
VENEREAL WARTS (CONDYLOMA ACUMINATA)

Venereal warts are ordinary warts that are found in the genital and perianal areas. It is caused by a virus and may be easily spread from area to area and person to person, usually by sexual contact.

The only way to prevent the spread of these is by wearing a condom during sex or abstaining from sexual activity.

If the medical staff suspects that you have this, you will be taken to the local health department for evaluation and treatment. The warts can usually be removed by the doctor and/or you may be started on medication.

You should return for sick call if:

1. You notice spreading of the warts.
2. You experience any problems from the medication
3. For any questions you have.

Protocol #92

DENTAL SCREENING

I. Objective

Differentiate between normal and abnormal dental findings

Record findings on the dental screening form

Alert and inform the dental provider about acute oral conditions before the dental exam appointment

II. Supplies

Red pencil or pen - indicates pathology (cavities)

Black pen or pencil - existing fillings and crowns (caps).

Light source

Tongue blade or mouth mirror

Dental Screening Form

III. Basic Terminology

There are four classifications of teeth, incisors, canines, premolars, and molars.

Permanent teeth are numbered 1 to 32. Count right to left. Starting on the upper right. Teeth #1 thru #16 are upper teeth. On the lower arch count from left to right starting with #17 the lower left 3rd molar and ending with #32 the lower right 3rd molar. Most youth will have only 28 teeth. Four Wisdom Teeth normally erupt between the ages of 17 and 21.

The primary teeth are A thru T. Younger youth may have retained primary teeth.

IV. Procedure

Check all area of the oral cavity as outlined on the screening form. It is not critical that each minor cavity is charted at the screening appointment. The dentist will do a comprehensive exam.

A. Dental Caries

1. Types

- Pit and fissure
- Smooth surface
- Root caries
- Inter-proximal (in between the teeth)

2. Color – generally darker than healthy enamel

- Black/grey
- Brown/yellow
- White/tooth colored (detected during complete dental exam)

B. Periodontal Disease

1. Types

- Gingivitis – red swollen gums that bleed easily
- Periodontitis – loss of the bone that supports the teeth

2. Warning Signs

- Gums bleed when brushed
- Gums red, swollen, tender
- Gums pulled away from teeth
- Pus between teeth and gums
- Permanent teeth loose or displaced
- Change in way teeth come together
- Bad breath

C. Oral Cancer

1. Manifestations

- Sites: Lips, tongue, floor of the mouth, soft palate, hard palate
- Look for lesions that are red, white, flat, raised or any asymmetry of the nose or jaws

2. Warning Signs

- Repeated bleeding
- Numbness of lower lip
- Pain – ear or tongue
- Chronic sore throat
- Loose teeth
- Dentures don't fit
- Less movement – tongue or jaw
- Dry mouth

D. Tobacco Use

1. Cigarettes

Explain the health effects (oral cancer, lung cancer, emphysema, etc.)

Signs of use: brownish stain usually seen on the inside surfaces of the teeth

2. Spit Tobacco

Explain the health effects (oral cancer)

Signs of use: black stain seen on the facial and lingual (tongue side)

E. Racial Pigmentation

Melanin pigmentation can appear bilateral or unilateral on upper and/or lower gum tissue.

Color can vary from light brown to almost black.

Protocol #93

DENTAL NURSING PROTOCOLS

I. Objective

Recognize common dental conditions and respond appropriately

II. Supplies

Personal protective equipment – gloves, mask, eyewear

Cotton swabs

Gauze

Toothbrush

Dental floss

Ice pack

Saline

Flashlight

Tongue blade

Dental mouth mirror

III. Knocked Out Tooth / Loss of Permanent Tooth

Time is critical. Look for the tooth.

Hold the tooth by the crown and gently rinse off the root of the tooth in water if it is dirty. Do not clean, wipe, scrub or remove any attached tissue fragments. If possible, hold tooth by the crown and gently insert and hold the tooth in its socket. If that isn't possible, put the tooth in a cup of milk or saline.

Refer for immediate dental care.

IV. Loss of Primary Tooth

Do NOT attempt to replace tooth in mouth. Refer youth to facility dentist for next available appointment.

V. Lost Cap / Crown

Keep in safe place in clinic. Refer youth to facility dentist for next available appointment.

VI. Broken, Chipped Tooth

Broken/Chipped Tooth may or may not require immediate care. Contact dentist if fractured tooth has exposed pulpal tissue (pink/red color at fracture line).

Rinse the mouth with warm water to keep the area clean. Do not use cold water. If there is facial swelling, put cold compresses on the face to reduce swelling.

Refer youth to facility dentist for next available appointment.

VII. Displaced Tooth

Refer for immediate dental care to save the tooth. Dentist will splint the tooth with a composite or wire splint.

VIII. Bitten Tongue or Lip

Clean the area gently with a 50/50 mix of hydrogen peroxide and water. Apply cold compresses to reduce swelling.

If bleeding is excessive, refer for immediate dental care. (Sutures will be required.)

IX. Objects Caught Between Teeth

Gently try to remove the object with dental floss. Do not use a sharp or pointed instrument.

If object cannot be removed with dental floss, refer youth to facility dentist for next available appointment.

X. Possible Jaw Dislocation / Fracture

Requires immediate attention. Refer to facility dentist or hospital emergency room for immediate dental care.

Apply cold compresses to control swelling. Do not allow patient to apply biting pressure to the area. Order a liquid diet for the resident. If possible, stabilize the jaw.

Post-Operative Care: Liquid diet, monitor for compliance. Many youth will attempt to loosen or remove the inter arch wires. Refer to dentist for follow up care and frequent oral hygiene appointments.

XI. Abscessed Tooth

If there is facial swelling, contact the facility dentist. He/she may prescribe an antibiotic.

Refer youth to facility dentist for next available appointment.

XII. Post-Operative Dental Pain

Youth with a recent history of invasive dental procedures such as surgical extractions, root canals, large amalgam restorations, or third molar extractions should be treated with Ibuprofen 600mg po BID prn pain for 3 days. Immediately inform facility dentist that the youth is experiencing post-operative pain and will need to be evaluated.

XIII. Prolonged / Recurrent Bleeding After Extraction

Fold 2 x 2 gauze place on extraction site with firm pressure for 30-45 minutes. If not controlled in one hour, contact facility dentist.

XIV. Mild Pain

Tylenol 325 mg 1-2 tabs every 6 hours, prn pain for 2-3 days. Advise youth to write a Help Request Form requesting dental care.

XV. Severe Pain

Tylenol 325 mg 2 tabs every 4-6 hours prn pain. Contact facility dentist as soon as possible.

XVI. Toothache

Refer to facility dentist for next available appointment. (not classified as true emergency)

If there is facial swelling, contact facility dentist as soon as possible.

XVII. Inflamed / Irritated Gum Tissue

Refer for next available appointment

XVIII. Oral Ulcers (with or without fever)

Refer for next available appointment

XIX. Orthodontic (Braces) Appliance Problem

Typically residents will report loose wires or brackets. Contact facility dentist promptly if a broken wire is causing injury to surrounding soft tissue.

Refer to facility dentist for next available appointment if the broken appliance is not causing tissue injury.

Protocol #94

YOUTH ADMISSION PROTOCOL

Medical Intake Screen

Medical Orientation

Nurse Health Appraisal

Laboratory Studies:

Urinalysis

Hemoglobin

Tuberculosis Skin Test (PPD)

Pregnancy Test (for females)

STD testing as warranted

Vision Screening

Hearing Screening

Physical exam (completed by NP/PA/MD)

See DJJ policy 11.1, Physical Assessment for timeframes within which assessments must be completed.

Protocol #95

ANTI-DEPRESSANT MEDICATION LABORATORY MONITORING

Pre-Treatment / Treatment Initiation

Pre-treatment laboratory tests will be ordered as clinically indicated and based upon physical examination, previous history of adverse drug reactions and knowledge of the potential adverse effects of the individual antidepressants.

An EKG must be done for any dose of more than 25mg of tricyclic antidepressant medication prior to initiation of higher doses.

Follow-Up

Follow-up tests will be ordered as clinically indicated and based on the patient's past medical history, results of the physical examination, previous history of adverse drug reactions and knowledge of the potential adverse effects of the individual antidepressants.

Thyroid functions should be considered, especially in cases of failure to respond to treatment. Periodic electrolytes, CBCs, and liver enzymes should be considered based on the clinical presentation.

An EKG must be done during titration of tricyclic antidepressants.

Dosage Adjustment

Dosage adjustments after initial titration to an appropriate dosage and medication changes should generally be initiated in response to non-transient ill effects or non-response. A period of compliance consistent with average response times for a particular medication should be noted prior to consideration of medication changes or dosage adjustments. It is acceptable to change doses and medications if clinically indicated; however, it is important to document the reason for the change to assist with medication management once the youth is in another setting.

Protocol #96

ANTI-PSYCHOTIC MEDICATION LABORATORY MONITORING:

Pre-Treatment / Treatment Initiation

Pre-treatment laboratory tests will be ordered as clinically indicated and based upon physical examination, previous history of adverse drug reactions and knowledge of the potential adverse effects of the individual antipsychotics.

Electrolytes, CBC and liver enzymes may be indicated, but are not generally required. Initiation of antipsychotics often may be done when testing is ordered.

An EKG must be done prior to initiation of Geodon, Mellaril, Orap or Thorazine. An EKG should be considered with other antipsychotics.

Fasting glucose levels must be done at initiation and every 6 months for the newer antipsychotics (e.g., Clozaril and Zyprexa). Lipid levels are recommended, but not required. Fasting glucose levels and lipid levels should be considered with other antipsychotics.

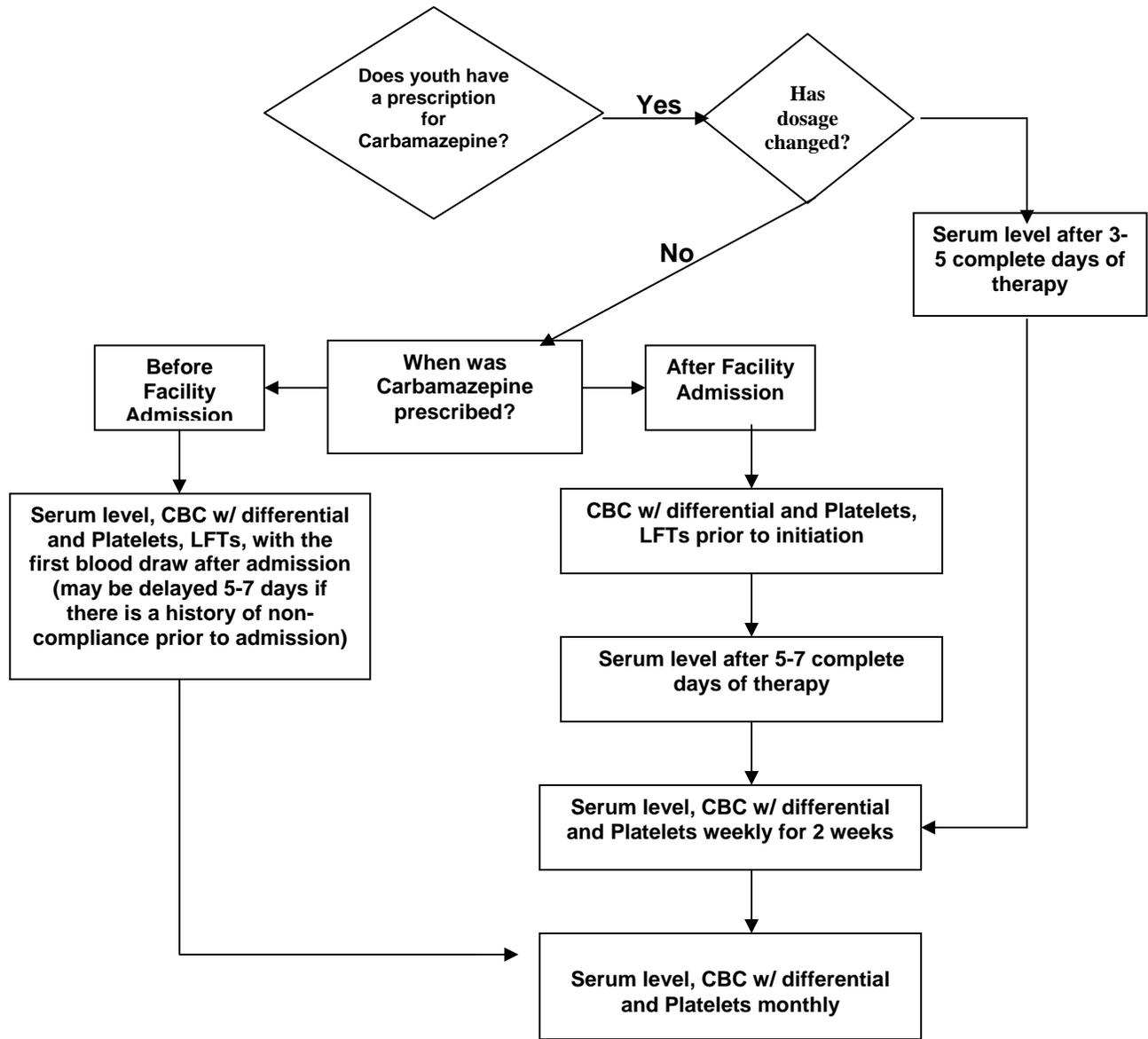
Follow-Up

Follow-up tests will be ordered as clinically indicated and based on the patient's past medical history, results of the physical examination, previous history of adverse drug reactions and knowledge of the potential adverse effects of the individual antipsychotics.

Electrolytes, CBC and liver enzymes are generally followed with long term use of antipsychotics, especially when a youth is on multiple medications metabolized via the liver.

Periodic EKGs must be done with Geodon, Mellaril, Orap or Thorazine.

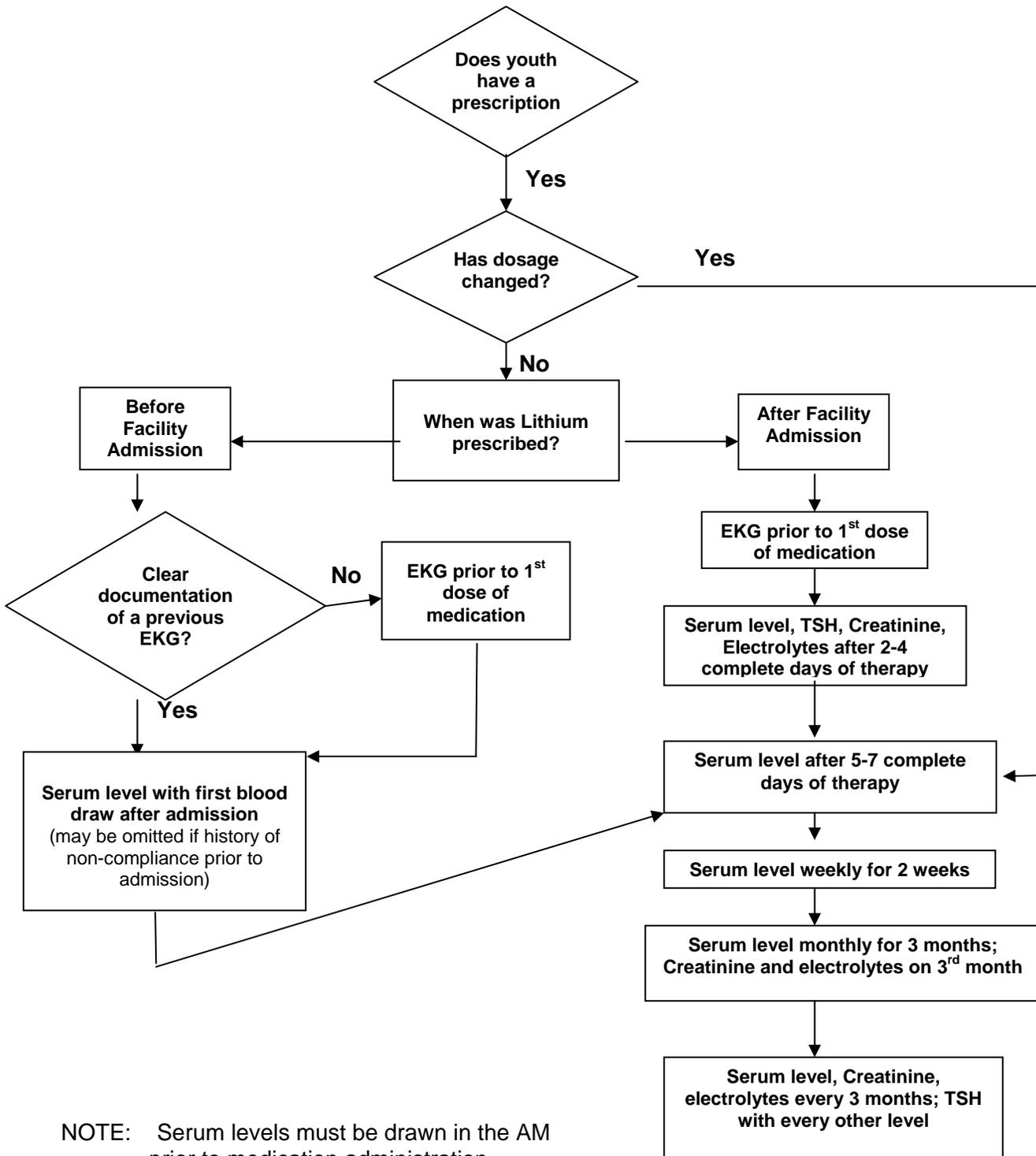
Carbamazepine (Tegretol) Monitoring Process



NOTE: Serum levels must be drawn in the AM prior to medication administration.

If a medication with a known interaction with Carbamazepine is added or deleted from the medication regimen, serum levels should be obtained appropriately and in addition to the above guidelines.

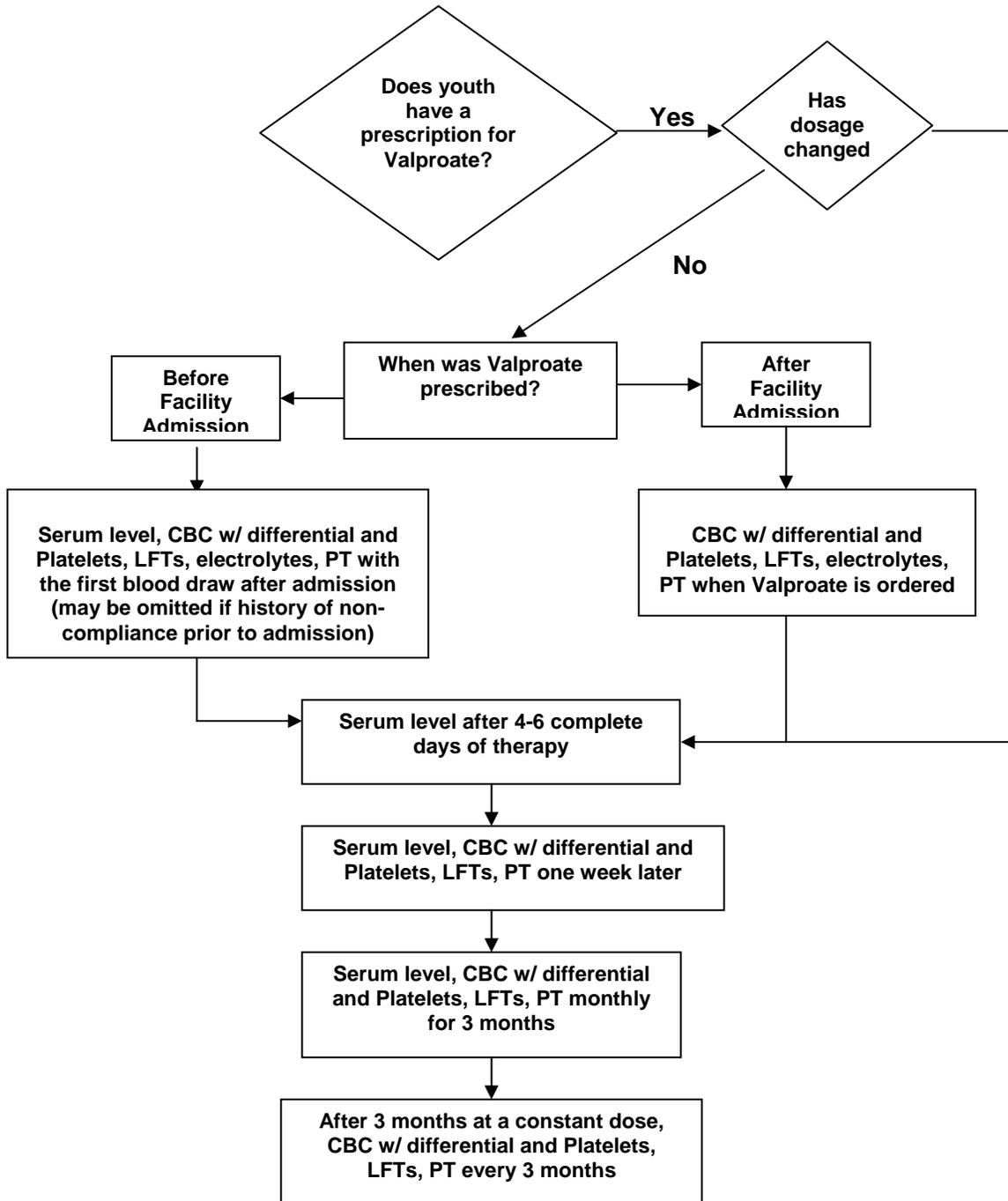
Lithium Monitoring Process



NOTE: Serum levels must be drawn in the AM prior to medication administration

EKG must be done at least every 2 years

Valproate (Depakote)



NOTE: Serum levels must be drawn in the AM prior to medication administration.

There may be significant interactions between Valproate and other medications. Serum levels of Valproate and these medications should be monitored.

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