PATIENT CONDITIONS

I. Patient will have an observable break in the skin that is not infected. (For infected wounds, refer to the SNP for Cellulitis).

SUBJECTIVE

I. Mechanism of injury. Pain to other portions of extremity not associated with superficial abrasion (also refer to the SNP for Muscular Strains).

II. When injury occurred.

OBJECTIVE

I. Vital signs, history of Diabetes, HIV positive, or other chronic medical illnesses that promote poor healing.

II. Appearance of wound or wounds. Note signs, symptoms, or infection. Refer to the following SNP's: Cellulitis, Bites: Animal or Human, or Draining Wounds, if appropriate.

ASSESSMENT

Nursing Diagnosis:

I. Risk for Infection

II. Impaired Skin Integrity

TREATMENT PLAN

I. Superficial Abrasions
   A. Clean with Normal Saline.
   B. Apply triple antibiotic ointment (Bacitracin) to wound; may provide keep on person (KOP) supply as needed.
   C. Apply a sterile dry dressing if necessary.
   D. Administer Tetanus prophylaxis (Adult Td) if over five (5) years have transpired since last tetanus immunization.
   E. RN wound check as needed, until healed.

II. Open Wounds (requiring dressing change)
- A. Irrigate with copious amounts of sterile Normal Saline.
- B. Apply triple antibiotic ointment (Bacitracin) to wound; may provide keep on person (KOP) supply as needed.
- C. Administer Tetanus prophylaxis (Adult Td) if over five (5) years have transpired since last Tetanus immunization.
- D. Apply a sterile dry dressing.
- E. Schedule for daily dressing changes and refer to next MD sick call for wound evaluation.

PATIENT EDUCATION

I. Report increased pain, swelling, redness, drainage, or suspected fever to the medical staff.

II. Keep area of injury dry and clean.

Implemented: 11/22/1995
Revised: 2/16/1996, 8/5/1999, 8/10/2001, 1/20/2004, 6/13/2007, 1/31/2018, 6/1/2018
Reviewed: 10/1996, 8/9/2004, 8/12/2005, 7/31/2006, 8/1/2007, 7/10/2008, 8/4/2009

PATIENT CONDITIONS

I. History of alcohol use as evidenced by documentation (prior incarceration), self-report, and/or signs or symptoms consistent with either the presence of alcohol or active withdrawal.
   Risk factors to include:
   A. Daily or chronic alcohol use
   B. Morning drinking
   C. Previous history of shaking or seizures when withdrawing from alcohol
   D. Previous history of delirium tremens or visual hallucinations

II. Polysubstance withdrawal:
   A. If patient is withdrawing from both alcohol and heroin simultaneously, initiate both alcohol and heroin withdrawal protocols. Follow the longer protocol (Opiate SNP.H.4) for housing/bed/tier assignments, and contact a qualified medical provider for guidance on medication use.
   B. Schedule the patient for follow on assessment at MDSC.

NOTE: Delirium Tremens (DT's) is a medical emergency and occurs as a result of severe alcohol withdrawal. Symptoms can include: agitation, disorientation, memory disturbance, tactile and/or visual hallucinations, delusions including paranoia, increased pulse, blood pressure, and/or temperature, sweating and tremors. Send patient to ED via 911.

SUBJECTIVE

I. List the type, amount consumed daily, the time of last drink, years patient has been drinking, past history of shaking or seizures when withdrawing from alcohol or DT's. Complete comprehensive detoxification questionnaire at receiving screening.
II. Chronic Diseases: Obtain past medical history of seizures, diabetes, asthma, COPD, hypertension, gastritis, bleeding ulcers, liver problems or pancreatitis.
III. FEMALE Patient – If the patient claims she is pregnant note gravida, para, prenatal care, drug abuse and problems with this pregnancy or previous pregnancies or deliveries.

OBJECTIVE

I. Vital Signs
II. Observation: presence/absence of agitation, change in gait, affected speech, mental status exam: (e.g. state of consciousness, orientation, memory, presence of auditory/visual/tactile hallucinations)
III. Physical exam findings
IV. Presence of tremor – patient extends arms and spreads fingers apart
V. Lab test: FEMALES- conduct urine pregnancy test screening; if positive, perform the following:
   A. Contact the on-call physician for orders/guidance.
   B. Initiate protocol for pregnant women (SNP P.4 Pregnant Women).
VI. Signs or symptoms of dehydration such as:
   A. Slow or tenting of skin

B. Confusion
C. Dry or cracked oral cavity
D. Decreased urinary output
E. Sunken eyes
F. Increased capillary refill greater than 2 seconds
G. Presence of spider angioma, jaundice (yellow skin/sclera discoloration), flushing (redness) of skin, and presence or absence of alcohol on breath

ASSESSMENT

I. Potential nursing diagnosis for individuals withdrawing from alcohol:
   A. Alteration in nutrition: less than body requirements
   B. Potential risks for acute confusion
   C. Potential Risks for fluid deficit
   D. Alteration in health maintenance due to chronic alcoholism
   E. Alteration in comfort
   F. Risk of suicide
   G. Medical assessment: Acute withdrawal. If patient in acute distress, or has abnormal vitals, then contact a medical provider for orders/guidance and stabilize patient.

TREATMENT PLAN

I. Treatment for potential alcohol withdrawal will include all patients who meet criteria based on their responses to the comprehensive detoxification questionnaire which may include but not limited to one or more of the criteria listed below:
   A. Daily or chronic alcohol use
   B. History of morning drinking
   C. History of recently drinking and stopping prior to his/her incarceration
   D. Previous history of shaking or seizures when withdrawing from alcohol
   E. History of delirium tremens

II. If patient in acute distress, then contact a medical provider for orders/guidance and stabilize patient. If there is an indication of head trauma, contact medical provider immediately.

III. Abnormal vital signs
   - Pulse less than 50 beats per minute
   - Systolic blood pressure below 90 and diastolic pressure below 60.

   [Contact a medical provider immediately]

IV. If patient is visibly impaired [e.g. slurred/affected speech, stumbling gait, and no indications of head/neurologic trauma], hold Librium, place in a sobering cell and reassess on next scheduled nursing assessment (every 4 hours) or sooner if clinically indicated.

V. Initiate the following treatment unless patient is pregnant or visibly impaired.
   A. Librium 50mg PO STAT
   B. Start tapering dose schedule at next standard medication pass time as follows:
      1. Librium 50mg PO TID x 1 day
      2. Librium 50mg PO BID x 1 day

3. Librium 25mg PO BID x1 day

C. Vitamin Supplement:
   1. Thiamine 100mg PO BID x 3 days

D. Nausea and vomiting
   1. Zofran 4mg PO BID x 3 days for nausea and vomiting.

*[**NOTE:** *Use appropriate scheduled dosing Tech Care guideline template depending on the time the protocol is initiated*].

VI. If feasible, patients should be in cohort housing for improved observation, management and ease of intervention.
   A. If cohort housing is not possible, (e.g. due to space limitations, possible contagion, higher priority medical conditions, etc.) notify health staff for any logistical concerns.

VII. FOR ALL PATIENTS PLACED ON ALCOHOL WITHDRAWAL PROTOCOL:
   A. Add "CIWA A" and "Lower Bunk/Lower Tier" patient flag for 3 days.
   B. Schedule a follow-up nurse sick call (RNSC) within 48 hours of protocol initiation.
      1. Assess the patient for dehydration and if indicated, initiate the SNP for dehydration and consider IV therapy.
      2. Conduct follow-up assessment and administer treatment plan as outlined below (see Follow-Up Assessment and Treatment Plan section).
   C. At each Librium administration, offer fluids and observe for presence of withdrawal symptoms. If symptomatic, same day assessment by a registered nurse is indicated.

      *****HOLD Librium if the patient is sedated, ataxic or develops respiratory distress. If clinically indicated, have the patient evaluated by the MD immediately or call on-call MD.**
   D. Common Side Effects of Medications:
      1. Librium – drowsiness, ataxia (unsteady on feet), confusion
      2. Zofran – confusion, tachycardia, fever, headache, shortness of breath, dizziness, or weakness.

PATIENT EDUCATION

I. Assess patient's sobriety and readiness to learn. Provide teaching compatible with level of understanding.
   A. Notify medical staff if you experience these symptoms: fever, sweating, shaking, hallucinations, anxiety, restlessness, pain, vomiting and diarrhea, and/or homicidal/suicidal ideation.
   B. Advise the patient to increase food and fluid intake as tolerated.
   C. Discuss alcohol programs available to patient while in jail as well as follow up programs.

TRANSFERS

I. Patients undergoing treatment for alcohol withdrawal shall not be transferred to a detention facility that does not that 24 hour nursing care.

II. Patients who completed treatment for alcohol withdrawal in jail and are free of symptoms for 2 consecutive weeks can be transferred to a detention facility that does not have 24 hour nursing care.

FOLLOW-UP ASSESSMENT & TREATMENT PLAN

I. SUBJECTIVE
    A. Document subjective findings based on patient's report
II. OBJECTIVE
    A. Assess for the following signs/symptoms associated with withdrawal progression.
        1. Evidence of sweating
        2. Evidence of tremor when patient extends arms and spreads fingers apart
        3. Evidence of agitation
        4. Evidence of vital sign changes (i.e. increased temperature, pulse or BP)
        5. Evidence of visual, auditory or tactile hallucinations
        6. Describe other observed symptoms if present

III. ASSESSMENT
    A. Applicable nursing diagnoses include but are not limited to:
        1. Risk of acute confusion
        2. Risk of injury
        3. Risk of body temperature imbalance
        4. Risk of disturbance of sensory perception
        5. Risk of seizures
IV. PLAN
    A. If patient has **no withdrawal symptoms**, continue with protocol
    B. If patient has one **(1) withdrawal symptom**, administer Librium 50mg PO STAT, continue protocol and schedule follow-up RNSC within 24 hours.
    C. If patient has **two (2) withdrawal symptoms**, administer Librium 100mg PO STAT, continue protocol and contact a qualified health provider for consultation.

ALCOHOL WITHDRAWAL ALGORITHM

Patient presents with symptoms of **Delirium Tremens** including but not limited to: agitation, disorientation, memory disturbance, tactile and/or visual hallucinations, delusions including paranoia, increased pulse, blood pressure and /or temperature, sweating and tremors.

→ Emergency Department send out via **911**

Asymptomatic patient reporting one or more of the following:
1) Daily or chronic alcohol use
2) History of morning drinking
3) History of recently drinking and stopping prior to his/her incarceration
4) Previous history of shaking or seizures when withdrawing from alcohol
5) History of delirium tremens

→ Initiate alcohol withdrawal treatment protocol and schedule for RNSC follow-up assessment within 48 hours.

Patients observed to exhibit withdrawal symptoms at the time of medication administration for the duration of alcohol withdrawal treatment protocol.

→ Same day RNSC for follow-up assessment and treatment plan.

Reference

Holt, S., & Tetrault, J. (2020, January 10). Ambulatory management of alcohol withdrawal. *UpToDate*. Retrieved January 30, 2020, from www.uptodate.com/contents/ambulatory-management-of-alcohol-withdrawal

Implemented: 10/1/1995
Reviewed: 10/96, 08/18/03, 08/09/04, 08/12/05, 7/31/06, 7/30/07 and 07/10/08
Revised: 02/16/96, 08/05/99, 11/00, 07/01, 08/02, 01/24/05, 10/11/07, 11/27/07, 05/04/09, 5/18/09, 12/7/09, 4/8/11, 9/8/11, 2/24/12, 9/6/12, 6/23/14, 2/13/2020, 2/21/2020

PATIENT CONDITIONS

I. Allergic reactions are serious and have the potential to be life threatening.
II. In general, an individual is exposed to a substance to which the patient has had recent (previous one 1 hour) contact and who has had a past history of an allergic response.
- A. Most common allergens
  1. Animal dander
  2. Insect and bee stings
  3. Foods (especially nuts, fish and shellfish)
  4. Medications
  5. Plants

III. Mild allergic symptoms include:
- A. Sneezing
- B. Hives
- C. Itching
- D. Nasal congestion
- E. Rashes
- F. Watery eyes

IV. Moderate to severe allergic symptoms include:
- A. Cramps/abdominal pain
- B. Chest discomfort and tightness
- C. Difficulty breathing
- D. Difficulty swallowing
- E. Nausea, vomiting or diarrhea
- F. Palpitations
- G. Swelling of face, eyes and/or tongue
- H. Weakness
- I. Wheezing
- J. Coma

V. NOTE: Any patient in severe respiratory distress should be transported to the hospital via 911. These patients decompensate quickly, notify qualified healthcare provider immediately.

SUBJECTIVE

I. Note patient's chief complaint and history of contact or ingestion of any substance.
II. Review medical history for any known allergies with the patient.
III. Specifically, query the patient as to the presence of pruritus (itching).
IV. Inquire prior use of Epi pen.

OBJECTIVE

I. Obtain vital signs and pay careful attention to respiratory status.
II. Observe skin status and record findings. (Note swelling and/or redness of skin including location).
III. Female patient – If pregnant always chart presence of fetal heart tones and movement along with the mother's vital signs. Refer to emergency department if in severe respiratory distress, access 911.

ASSESSMENT

Potential Nursing Diagnosis

I. Ineffective breathing pattern
II. Decreased cardiac output
III. Anxiety

TREATMENT PLAN

I. For severe reactions of chest tightness, wheezing, inability to talk, swelling of tongue, or if evidence of respiratory distress:

A. Assess vital signs, oxygen saturation and respiratory status.
B. If patient is exhibiting signs of respiratory distress, contact onsite qualified healthcare provider, if not available send to emergency care via 911.
C. If patient is severely hypotensive (systolic BP < 80) give bolus of 500 cc normal saline solution and call 911.
D. Administer the following:
   1. Aqueous Epinephrine 1:1000 SC injection of 0.3 ml or a pre-filled Adult Epipen (0.3 ml).
   2. Benadryl 50 mg intramuscular (IM)/intravenous (IV). If administering IV administer slowly over a 3 minute period.
E. Repeat Aqueous Epinephrine 1:1000 SC injection of 0.3 ml or a pre-filled Adult Epipen (0.3 ml) in 10 minutes if symptoms persist or re-occur.
F. Administer oxygen at 10-15 liters per non-rebreather mask.
G. NOTE: Anytime a patient is give epinephrine for an allergic reaction and a qualified healthcare provider is not onsite to evaluate, send to emergency care via 911.

II. Mild allergic reaction – If there is no evidence of respiratory distress and symptoms indicate a mild allergic reaction:

A. Administer Benadryl 25 mg two capsules PO BID x 2 days.
B. If no symptom improvement and remains without symptoms of respiratory distress, schedule for next qualified healthcare provider sick call clinic within 24 hours.

III. If patient is taken to the hospital for an allergic reaction, schedule the patient for the next MD Sick Call for follow-up upon return.
IV. Document treatment rendered and patient's response to treatment.
V. Flag allergy information in patient's record, if not yet flagged.

PATIENT EDUCATION

I. Avoid known allergens.
II. Notify medical staff of exposure to or ingestion of known allergens.
III. Notify medical staff of itching, rash or hives, swelling of eyes, lips or hands, or difficulty breathing.

References

Advance medical life support (1 edition ed.). (2011). Philadelphia: Mosby/JEMS

"Allergic Reaction." *eMedicineHealth*. N.p., n.d. Web. 6 Sept. 2011. <http:www.emedicinehealth.com/allergic_reaction/page6_em.htm>.

Allergic reactions: MedlinePlus Medical Encyclopedia. (2011, May 2). *National Library of Medicine - National Institutes of Health*. Retrieved May 16, 2011, from http://www.nlm.nih.gov/medlineplus/ency/article/000005.htm

Patient insert. (n.d.). *EpiPen*. Retrieved May 16, 2011, from files.epipen.gethifi.com/footer-pdfs/patient-packaging-insert-pdf/Patient-Information.pdf

Implemented: 10/1/1995
Reviewed: 10/1996, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/5/2009
Revised: 2/12/1996, 8/5/1999, 8/2001, 1/20/2004, 5/16/2011, 1/10/2013, 8/20/2018

DEFINITION:

Asthma – a respiratory condition marked by spasms in the bronchi of the lungs, resulting in a reversible airway restriction and causes difficulty in breathing.

Standardized Nursing Procedure (SNP) - Immediate actions to provide patient stabilization until an individualized treatment plan is established by a qualified health provider (MD/DO/PA/NP).

BACKGROUND:

Generally presenting with a history of asthma, reactive airway disease, or patient actively experiencing some form of respiratory difficulty (e.g. experiencing shortness of breath, dyspnea, or demonstrating cyanosis).

PATIENT CONDITIONS

I. The patient may complain of one or more of the following:
   A. Difficulty breathing
   B. Shortness of breath
   C. Rapid, shallow breathing (respiratory rate $\geq$ 30 per minute)
   D. Cyanosis
   E. Pallor

PROCEDURE

I. Assess patient as outlined below (subjective and objective) including vital signs and document in the health record.
II. Make preliminary assessment:
   A. If **general appearance is unremarkable and vital signs are within normal limits,** schedule for upcoming nurse sick call (RNSC) for asthma assessment to include three peak expiratory flow rates and complete the 'Asthma Control Test' questionnaire to determine score (see Appendix A). Provide patient education (see 'Patient Education' section below).
   B. If **general appearance is distressed with atypical vital signs,** consult with qualified health provider presenting vital signs and physical examination findings as part of SBAR (situation, background, assessment, recommendation) report.

SUBJECTIVE

I. History of asthma, chronic obstructive pulmonary disease or any other respiratory disease.
II. Medications patient is currently taking and when last dose was taken. If patient is currently taking Theophylline, note the last Theophylline level, if known.
III. Past Medical History: any other medical problems or medications.
IV. Identify any precipitating factors.
V. Note reported symptoms, date and time of onset and last episode, such as:
□ Wheezing
□ History of respiratory infection
□ Ingestion of ASA/related compound
□ Shortness of breath
□ Exercise
□ Environmental (temperature changes)
□ Chest tightness
□ Anxiety
□ Coughing
□ Air pollutants
□ Pain on deep inspiration
□ Other

OBJECTIVE

I. Vital signs, level of consciousness, and patient's ability to talk, i.e. able to speak in full sentences.

II. Lung sounds, inspiratory and expiratory. Use of accessory muscles both abdominal and intercostals.

III. Document the following:
A. General appearance: □ No acute distress □ Acute distress
B. Vital signs: B/P ____/____ P _____ T _____ R _____ O2 sat ___% Wt. _____
C. Peak flow rate: _____/_____/_____ Last documented peak flow: _____
D. Bilateral lung sounds (Identify location):

Right		Left
□	Clear	□
□	Absent	□
□	Crackles	□

- □ Wheezing □
- □ Rhonchi □
- □ Diminished □

E. Respirations
- □ Shallow
- □ Rapid
- □ Labored
- □ Relaxed
- □ Deep
- □ Stridor
- □ Retractions
- □ Expiratory grunt
- □ Accessory muscle use

F. Sputum
- □ Color/Consistency: _____

G. Skin: □ Warm □ Cool □ Dry □ Moist/clammy

H. Skin color: □ Pink □ Pale □ Flushed □ Cyanotic □ Jaundiced

I. Skin turgor: □ Normal □ Decreased

J. Cough: □ Yes □ No If yes, note if productive and describe.

ASSESSMENT

Nursing Diagnosis:

I. Ineffective Airway Clearance
II. Potential for Suffocation
III. Anxiety
IV. Ineffective Breathing Pattern
V. Impaired Gas Exchange
VI. Potential for Respiratory Distress

TREATMENT PLAN

I. For patients presenting with acute respiratory distress:
   A. Administer small volume nebulizer (SVN) with Albuterol 2.5 mg in 3 ml Normal Saline (Pre-mixed ampule). Note time of administration.
   B. Contact on duty or on call physician. Note provider name, time of notification and recommendation.

C. May repeat SVN x 1 in 20 minutes if no improvement. Note time of repeat administration.
D. Repeat VS: B/P ____/____ P _____ R _____ O2 sat __% Peak flow rate: ____
E. If oxygen sat < 95% administer oxygen at 15 L / min via non-rebreather mask unless known history of COPD in which case oxygen should be administered by nasal cannula at no more than 2 L / min. Note time of administration.
F. Activate emergency medical services (911) as needed and document accordingly.

II. For those patients without any demonstrable symptoms, but have a reported history of asthma, COPD and/or other respiratory disease:
    A. Following the completion of the RNSC encounter, schedule for initial asthma chronic care evaluation within 30 days of incarceration.
    B. Results of the three peak expiratory flow rates and the score from the 'Asthma Control Test' from the RNSC encounter are to be made available for provider's review during the chronic care evaluation encounter.

PATIENT EDUCATION

I. Instruct patient to notify health staff if symptoms are present.
II. Recommend increased fluid intake.
III. Reduce/avoid precipitating factors.
IV. Document understanding of instructions.

Implemented: 11/22/1995
Reviewed: 10/1996, 8/10/2001, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 8/1/2007, 7/10/2008, 8/4/2009
Revised: 2/16/1996, 8/5/1999, 2/2000, 8/2002, 9/11/2002, 1/24/2005, 4/25/2005, 9/11/2007, 9/29/2009, 3/12/2018, 10/26/2020

Name: _____ **Today's Date:** _____

ASTHMA CONTROL TEST™

Know your score.

The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Take this test if you are 12 years or older. Share the score with your healthcare provider.

Step 1: Write the number of each answer in the score box provided.

Step 2: Add up each score box for the total.

Step 3: Take the completed test to your healthcare provider to talk about your score.

IF YOUR SCORE IS 19 OR LESS, **Your asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your healthcare provider to talk about the results.**

NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

					SCORE
1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?					
All of the time **[1]**	Most of the time **[2]**	Some of the time **[3]**	A little of the time **[4]**	None of the time **[5]**	.....
2. During the past 4 weeks, how often have you had shortness of breath?					
More than Once a day **[1]**	Once a day **[2]**	3 to 6 times a week **[3]**	Once or twice a week **[4]**	Not at all **[5]**	.....
3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?					
4 or more nights a week **[1]**	2 to 3 nights a week **[2]**	Once a week **[3]**	Once or twice **[4]**	Not at all **[5]**	.....
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?					
3 or more times per day **[1]**	1 to 2 times per day **[2]**	2 or 3 times per week **[3]**	Once a week or less **[4]**	Not at all **[5]**	.....
5. How would you rate your asthma control during the past 4 weeks?					
Not Controlled at All **[1]**	Poorly Controlled **[2]**	Somewhat Controlled **[3]**	Well Controlled **[4]**	Completely Controlled **[5]**	.....

TOTAL: .....

This material was developed by GSK.

PATIENT CONDITIONS

I. Patient reports being bitten by a human or an animal.

SUBJECTIVE

I. Ascertain source of bite (human or animal).
   A. Obtain health history of source, i.e. HIV or Hepatitis.

II. Obtain (the injured) patient's health history of illnesses and assess whether patient is immune compromised.
   A. Diabetes
   B. History of alcohol abuse
   C. Hypertension
   D. Other chronic debilitating diseases
   E. Obtain immunization history (tetanus)

OBJECTIVE

I. Assess skin integrity and determine type of injury.
   A. Bruising but no skin break
   B. Minimal skin break
   C. Skin puncture
   D. Crushing injury with potential underlying tissue damage

II. Assess range of motion (ROM) if the injury is involving an extremity.

III. Vital signs – any patient with a fever (T>101) should be evaluated by provider onsite. If not available onsite, notify provider on call.

IV. Determine patient's immunization status with respect to tetanus immunization.

V. If a domestic animal bite, determine potential for rabies.

VI. If a human bite, determine potential for HIV and Hepatitis transmission.

VII. Pursue source testing as indicated.

ASSESSMENT

Nursing Diagnosis:

I. Risk for Infection
II. Impaired Skin Integrity

TREATMENT PLAN

I. Treatment will be predicated on the location and severity of the injury; however, initially wound should be irrigated thoroughly with normal saline.

II. If the injury involves the hand, the joint, or if there is a loss/impairment of ROM, the patient will require immediate care by onsite provider. If not available onsite, refer the patient to the emergency department.

III. If last Tetanus immunization has been 10 years or more, give Tdap 0.5 cc IM.

IV. If the bite appears minor, **schedule the patient for the next MDSC** and give the following:

A. If patient has no Penicillin allergy: Augmentin 875 mg PO BID x 7 days (for both human and animal bite).
B. If patient claims Penicillin allergy, DO NOT GIVE AUGMENTIN. If patient does not have Sulfa allergy, give the following:
    1. For animal bite: Doxycycline 100 mg PO BID x 7 days.
    2. For human bite: Clindamycin 450 mg PO TID and Bactrim DS PO BID x 14 days
C. If patient has allergy to both Penicillin and Sulfa medications, give the following:
    1. Clindamycin 450 mg PO TID x 14 days
    2. Cipro 500 mg PO BID x 7 days
D. Take the following precaution involving human bite:
    1. For female patient, perform urine pregnancy test as needed to ascertain status.
    2. Consult with provider to determine indication for post exposure prophylaxis (PEP). If indicated, initiate PEP within 72 hours from the time of potential exposure. Information regarding aggressor's health history related to HIV and Hepatitis B & C is needed for this determination.
E. Schedule patient for daily wound check.

PATIENT EDUCATION

I. Notify medical staff if fever develops (T>101) and/or increased pain, redness, swelling or drainage from affected area occurs.
II. Encourage elevation of affected area.
III. Keep affected area clean using mild soap and water.
IV. Potential medication side effects:

A. Augmentin: diarrhea, rash, gastrointestinal (GI) upset, and N/V. Take with food
B. Doxyclycline: photosensitivity, rash, hives, and GI upset. Take with food and a full glass of water, and sit upright for at least 30 minutes after taking the medication.
C. Clindamycin: diarrhea, GI upset, nausea, vomiting and rash. Take with a full glass of water to decrease GI upset.
D. Bactrim DS: photosensitivity, rash/hives, GI upset, N/V an decrease in appetite. May be taken with food and water.

References

Balentine, J. (n.d.). Human bites. eMedicineHealth. Retrieved September 7, 2011, from emedicinehealth.com/human_bites/article_em.htm

Human bites. (n.d.). American Academy of Orthopedic Surgeons. Retrieved September 8, 2011, from http://orthoinfo.assos.org/topic.cfm?topic=A0003

Human bites. (n.d.). MedlinePlus. Retrieved September 8, 2011, from www.nlm.nih.gov/medlineplus/ency/article/000035.htm

Tetanus, diphtheria, tetanus, diphtheria and pertussis- What you need to know. (n.d.). CDC. Retrieved September 8, 2011, from www.immunize.org/vis/td_tdap.pdf

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SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

BURNS – FIRST RESPONSE

PATIENT CONDITIONS:

1. This is intended for the I/P who has sustained a new onset burn(s)
2. Refer to Wound SNP, if burn area is two (2) or more days old.

SUBJECTIVE:

1. Description of the mechanism of injury including when, where, how and why it occurred
2. Location of burn and degree
3. Treatment measures already taken

DEFINITIONS

1. First degree – Involves only the outer layer (epidermis) of the skin causing pain, redness and swelling. The skin may turn white when pressed.

2. Second degree – Affects both the outer layer (epidermis) and the underlying layers (dermis) of the skin causing pain, redness, swelling and blistering.

3. Third degree- Burns extend through the epidermis, dermis and into deeper tissues causing the skin to appear, white, blackened or charred. The I/P may feel little or no pain depending on the damaged nerves of the skin.

OBJECTIVE:

1. Classify burn according to degree:
2. Assess vital signs including pain level, O2 saturation & circulatory status, if able.
3. Description of the injury including location and extent of burn area/s. Determine the depth of the most serious part of the burn. (See burn chart on list page)
4. Assess for level of consciousness

ASSESSMENT:

Nursing Diagnosis:

1. Burns
2. Impaired Skin Integrity
3. Alteration in comfort
4. Potential risks for infection
5. Potential risks for altered tissue perfusion
6. Anxiety
7. Potential risks for dehydration

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

BURNS – FIRST RESPONSE

TREATMENT PLAN:

1. Move I/P to a safe environment
2. Ensure that the I/P is no longer in contact with the causative agent.
3. Ensure a patent airway and monitor O2 saturation..
    a. If I/P shows signs of respiratory compromise, Administer 10-15 liters with a non re-breather mask.
4. In the presence of respiratory distress with bronchospasm:
    a. Mix Ventolin (Albuterol) 0.083% 6 ml and Atrovent 0.02% 2.5ml with 3 ml of Normal Saline administer via Nebulizer over 5 minutes.
5. Call 911, if unresponsive and when physician on-site is not available to evaluate I/P at once (if no on-site MD evaluation is possible within 30 minutes from the time of request).
6 Start IVF NS @ 1000ml/hr in the 1st hour for I/P with > 20% 2nd or >5% 3rd degree burns.
7. If a first-or-second-degree burn covers an area larger than 2-to-3 inches in diameter, or is on the face, hands, feet or genitals, refer to the physician immediately.

8. **First-and-Second-Degree Burns**:
    a. For Thermal Burns of < 10% body surface are, cool with non-chilled water or saline.
    b. If thermal burn area is > 10% body surface area, cover with **DRY** dressing and keep warm.
    c. Wrap the gauze loosely to avoid putting pressure on the burned skin. Bandaging keeps air off the burned skin; reduces pain and protects blistered skin.
    d. If a first or second degree burn covers an area larger than 2-3 inches in diameter, or is on the face, hands, feet or genitalia, refer to the MD immediately
    e. Schedule for immediate MD s/c for proper evaluation of burnt area(s)
    f . Administer Tylenol 325mg three tablets bid X5 days

9. **Third-Degree Burns:**
    a. Do not remove burnt clothing material that is stuck to the skin.
    b. Cover the area with dry, sterile bandage. If the burned area is large, a sheet will do.
    c. If fingers or toes have been burned, separate them with dry, sterile, non-adhesive dressing.
    d. Elevate the body part that is burned above the level of the heart, if possible.
    e. Prevent shock. Lay the person flat, elevate the feet about 12 inches and cover with a blanket if possible.

f. Do not apply any ointment. Avoid breaking burn blisters.
g. Do not place a pillow under the person's head if there is an airway burn. This can close the airway.
h. Transfer to the nearest hospital immediately.

10. **For Chemical Burns:**
    a. Flush with copious water
    b. Brush off dry chemicals.

11. **For Tar Burns:**
    a. Cool with water then immediately transport. DO NOT REMOVE TAR.

12. Update I/P's tetanus immunization of the date of the last vaccination is unknown or if it has been 10 years or longer.
    a. Adult tdap o.5ml IM
    b. Refer to MDSC within 24 hrs to evaluate need for Hypertet.

PATIENT EDUCATION:

1. Do not put butter, oil, ice or ice water on burns. This can cause more damage to the skin. Ice can cause frostbite.
2. Don't break blisters, as these can be portals for infection.
3. Minor burns will usually heal without further treatment

References

Burn Chart . (n.d.). *Royal Children's Hospital*. Retrieved September 8, 2011, from www.rch.org.au/emplibrary/clinicalguide/burn.gif

Burns. (n.d.). *New York University Langone Medical Center.* Retrieved September 7, 2011, from http://www.med.nyu.edu/content?ChuckID=22574

First aid for burns. (n.d.). *Medicinenet*. Retrieved September 8, 2011, from www.medicinenet.com/burns/article.htm

Implemented; 03-04-08
Revised: 9.7.11
Reviewed: 07/10/08 and 8.31.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

BURNS – FIRST RESPONSE

DEFINITION:

Immediate actions to provide patient stabilization until an individualized treatment plan is established by a clinical provider (MD/DO/PA/NP).

BACKGROUND:

Cellulitis, abscess, or both are among the most common skin and soft tissue infections. Cellulitis (which includes erysipelas) manifests as an area of skin erythema, edema, and warmth; it develops as a result of bacterial entry via breaches in the skin barrier. A skin abscess is a collection of pus within the dermis or subcutaneous space. Misdiagnosis of these entities is common, and possible alternative diagnoses should be considered carefully.

DIFFERENTIAL DIAGNOSES:

Most Emergent:

- Necrotizing fasciitis
- Toxic shock syndrome
- Gas gangrene
- Myonecrosis

Other Infections:

- Erythema migrans
- Herpes zoster
- Septic arthritis
- Septic bursitis
- Osteomyelitis

Non-Infectious Elements:

- Contact dermatitis
- Acute gout
- Drug reaction
- Deep vein thrombosis (DVT)

PATIENT CONDITIONS

I. Most commonly presents as areas of skin redness, swelling and warmth.
II. There may or may not be fever present.

III. Almost always unilateral… if it presents on BOTH sides, should consider other causes.

Cellulitis - involves deeper dermis and subcutaneous fat. Purulence may or may not be present.

*Erysipela*s - involves the upper dermis and lymphatics. It has an acute onset, is non-purulent with clear border/boundary.

SUBJECTIVE

I. Obtain a medical history:
- A. When did the signs and symptoms begin?
- B. How did the injury or illness occur (e.g. stab wound, pimple, and insect bite)?
- C. How has the cellulitis changed/progressed?

II. Obtain history of IV drug abuse and ascertain whether this is a site where drugs are injected?

III. Obtain a past medical history: Significant for autoimmune diseases, HIV positive, history of endocarditis, diabetes.

IV. If the patient states that she is pregnant, refer to the first available MD sick call or the provider on call.

OBJECTIVE

I. Vital signs: Temperature > 101^{o}F if untreated or 100^{o}F if treated; notify the provider on duty or the provider on call.

II. Assess the affected area for the, presence of redness, swelling or drainage. Measure the boundaries, determine the size and obtain digital photo and attach to medical record.

III. Documentation to include but not limited to
- A. Initial wound description, size, and drainage
- B. Laboratory testing and results
- C. Ongoing update of the wound
  1. Status at each dressing change
  2. Serial photos taken
  3. Resolution of the wound

IV. If patient is exhibiting symptoms consistent with COVID-19, wear appropriate personal protective equipment (PPE). Include a lung and pulmonary assessment in the physical exam.

ASSESSMENT

Nursing Diagnosis:

I. Impaired Skin Integrity
II. Alteration in Health Maintenance
III. Pain

TREATMENT PLAN

I. Identify/mark affected area. If a wound is present, then culture. Mark/measure, photograph wound and attach to the electronic health record.

II. Provide pain management:
A. If there is no history of peptic ulcer disease give: Ibuprofen (Motrin) 200mg 2 tabs PO BID x3 days; may provide as keep on person (KOP) supply.
B. If there is a history of peptic ulcer disease and the patient denies a history of liver disease/failure, give: Acetaminophen 500mg two tabs PO BID x3 days; may provide as keep on person (KOP) supply.

III. Contact staff physician or on call provider using SBAR (Situation, Background, Assessment, Recommendation) protocol to provide report of findings and obtain permission to start antibiotic therapy, and other management as indicated.

Implemented: 10/1/1995
Reviewed: 10/1996, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/5/2009
Revised: 2/16/1996, 8/5/1999, 9/11/2002, 1/20/2004, 10/2004, 6/27/2005, 11/28/2005, 7/1/2008, 9/8/2011, 8/20/2018, 4/20/2020

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

CHEST PAIN

PATIENT CONDITIONS:

1. This is intended for the patient who is complaining of chest pain.

2. The patient may complain of one or more of the following complaints:
   a. Difficulty breathing
   b. Rapid respiratory rate (>30/minute)
   c. Cyanosis
   d. Diaphoresis
   e. Pallor
   f. Blood pressure abnormalities
   g. Pulse abnormalities

SUBJECTIVE:

1. Character of pain. What provokes pain, quality of pain, radiation, and severity on 1-10 scale and duration.

2. Past Medical History:
   a. Previous episodes of chest pain or cardiac disease.
   b. Note risk factors: Smoking, Obesity, HTN, Diabetes, family history, excessive alcohol usage.

OBJECTIVE:

1. Vital signs with pulse oximetry
2. Characteristics of breath and heart sounds including rate and rhythm
3. Evidence of respiratory distress (breathing difficulty, skin color, diaphoresis, use of respiratory accessory muscles)
4. Obtain a 12 lead EKG

ASSESSMENT:

Nursing Diagnosis:
   1. Altered Tissue Perfusion: Cardio-Pulmonary 1.4.1.1
   2. Decreased Cardiac Output 1.4.2.1
   3. Pain 9.1.1

TREATMENT PLAN:

1. Obtain 12 lead EKG
2. Assess if chest pain is cardiac vs non-cardiac,
3. If the EKG is abnormal, notify MD for further instructions

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

CHEST PAIN

4. For Cardiac Chest Pain:
    a. If systolic BP is >90 mm Hg and heart rate is between 50-100 beats per minute, give 1-tab Nitroglycerine, 1/150grain (400 mcg) sublingually.
    b. Recheck BP after Nitroglycerine administration or as indicated by signs and symptoms.
    c. May repeat nitroglycerine dosage every 5 minutes if pain is persistent for a total of 3 doses.
    d. Apply 1-inch Nitroglycerin Ointment 2%
    e. Give ASA 325mg 1 tab PO x 1.
    f. Administer oxygen (0_2) at 10-15 liters per minute per non re-breather mask.
    g. If the I/P has a history of angina and improves with Nitro, consult with the onsite or on call physician, otherwise transfer the I/P to the ER via 911, if indicated,

If patient becomes unresponsive or pulseless while awaiting 911, then begin CPR

For Non Cardiac Chest Pain:
    a. Consider Muscular Strain or Indigestion SNP

PATIENT EDUCATION:
1. Teach importance of compliance with medication and medical regimen, i.e.; diet, rest, exercise.
2. Instruct patient to advise staff as soon as chest pain and/or shortness of breath begins. Note type of pain and location.
3. Instruct patient to stop activities during episode of chest pain.
4. Instruct patient of risk factors:
    a. Smoking
    b. Obesity
    c. Diabetes
    d. Hypertension
    e. Excessive alcohol usage

Implemented: 10/01/95
Revised: 02/16/96, 08/05/99, 08/10/01, 09/11/07, 5/16/11
Reviewed: 10/96, 08/16/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08 and 8.05.09

References
Advance medical life support (1 edition ed.). (2011). Philadelphia: Mosby/JEMS

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

Conjunctivitis (Acute Bacterial- Pink Eye)

PATIENT CONDITIONS:

1. This is intended for the patient who appears to have reddened and infected conjuctiva.

SUBJECTIVE:

1. History of reddened conjuctivea, and waking up in the morning with dried discharge in and around the eye.
2. The I/P may complain of itching or a feeling of grittiness in eyes.
3. The I/P may complain of pain in the effected eye.

OBJECTIVE:

1. Note condition of conjunctiva
2. Note presence/absence of discharge if present.
3. Note color and consistency of dischare if present.
4. Obtain a visual acuity, (corrected if eyeglasses if worn), and place results in the medical record. If the patient wears contact lenses, insruct the patient to NOT use them until otherwise directed by Medical Staff.

ASSESSMENT:

Nursing Diagnosis:

1. Pain 9.1.1
2. Risk for Infection 1.2.11

TREATMENT PLAN:

1. Provide eye drops for self administration
2. Give to I/P and instruct them to use Ciprofloxacin 0.3% opthalmic solution 1 to 2 drops in affected eye QID x 5-7 days.
3. Recommemd warm compressess (cloth in warm water) to affected eyes every 6 hours until seen by physician.

PATEINT EDUCATION:

1. Instruct the I/P in self administering the eye drops.
2. Instruct I/P to keep their hands away from their eyes.
3. Advise I/P that pink eye is highly contagious and is tranmitted by contact. It is

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

Conjunctivitis (Acute Bacterial- Pink Eye)

imperative that he/she washes their hands frequently.

4. Advise I/P to throw away eye cosmetics they have used in ;the past several days.
5. Advise I/P to avoid sharing eye cosmetics.
6. Advise the I/P that their eyes should be kept free of discharge and to use a clean tissue to wipe each eye to prevent cross contamination.

Implemented: 11/22/95
Revised: 08/05/99, 04/01, 09/11/02, 03/24/04, 1/2/14
Reviewed: 10/96, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08 and 8.11.09

PATIENT CONDITIONS

I. This is not intended for the patient with fevers, vomiting, or severe abdominal pain.

SUBJECTIVE

I. Vomiting, diarrhea, or pain. (Refer patient to MD sick call if these symptoms are present). Do not administer milk of magnesia.
II. Determine frequency of bowel movements/week and the characteristics of the stool.
III. Inquire about OTC drug/medication use that may influence bowel function (such as use of laxatives).
IV. Assess diet/exercise history with attention to fluid intake, fiber intake, and activity level.

OBJECTIVE

I. Vital signs
II. Abdominal Assessment:
    A. Observe scars or recent surgical procedures
    B. Abdominal distention
    C. Bowel sounds
    D. Palpate for tenderness

ASSESSMENT

I. Nursing Diagnosis:
    A. Constipation 1.3.1.1
    B. Risk for Constipation 1.3.1.4

TREATMENT PLAN

I. Use for non-pregnant or pregnant patient
    A. Moderate Constipation: Dulcolax 5 mg PO x 3 days; may provide keep on person (KOP) supply.
    B. Severe constipation (no BM >3 days): Dulcolax 10 mg PO or PR BID x 3 days; may provide KOP supply.
    C. Schedule patient for MD sick call if constipation not relieved within 48 hours.

PATIENT EDUCATION

II. Increase fluids, fiber, and exercise.
III. Proper hand washing.

Implemented: 10/01/95
Reviewed: 10/96, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08
Revised: 08/99, 05/03, 5/3/13, 6/2/14, 11/15/17, 6/1/18

DEFINITION:

Immediate actions to provide patient stabilization until an individualized treatment plan is established by a clinical provider (MD/DO/PA/NP).

BACKGROUND:

The common cold is a benign self-limited syndrome representing a group of diseases caused by members of several families of viruses. It is the most frequent acute illness in the United States and throughout the industrialized world. The term "common cold" refers to a mild upper respiratory viral illness. The common cold is a separate and distinctly different entity than influenza, pharyngitis, acute bronchitis, acute bacterial rhinosinusitis, allergic rhinitis, and pertussis.

Over 200 subtypes of viruses have been associated with the common cold. New viruses capable of causing colds, such as the human metapneumovirus and bocaviruses, have been identified using polymerase chain reaction (PCR) and pan-viral DNA microarrays (Virochip) technology.

Rhinoviruses, which include more than 100 serotypes, are the most common viruses associated with cold symptoms and collectively cause 30 to 50 percent of colds. Coronaviruses cause about 10 to 15 percent of common colds. Viruses with marked seasonal variation, such as influenza and parainfluenza, typically cause more systemic symptoms than other cold viruses; however, they can rarely also cause illnesses similar to the common cold. Influenza virus causes about 5 to 15 percent of colds, and respiratory syncytial virus (RSV) and parainfluenza virus are each responsible for about 5 percent.

EMERGENCY VARIANT- EVALUATE PATIENT FOR CORONAVIRUS/COVID-19

DIFFERENTIAL DIAGNOSES:

Although the common cold is usually diagnosed clinically and readily identified by symptoms, several other conditions may mimic the common cold.

- Allergic or seasonal rhinitis
- Bacterial pharyngitis or tonsillitis
- Acute bacterial rhinosinusitis
- Influenza
- Pertussis
- COVID-19

PATIENT CONDITIONS:

I. Most commonly presents as cough and nasal discharge; may or may not also present with a headache, malaise, loss of appetite, sore throat and fever.

SUBJECTIVE:

I. Duration of symptoms.
II. Rhinorrhea (clear nasal discharge).
III. Past Medical History (example: HIV infections, allergies, asthma, medication sensitivities, pregnancy status, etc.)

OBJECTIVE:

I. Vital Signs
II. Physical Exam
III. Pulmonary exam including lung sounds
IV. If patient has tender palpable enlarged cervical nodes or tonsillar exudate, this SNP may be started, but patient shall be referred to the first available MDSC.
V. If patient is exhibiting symptoms consistent with COVID-19, wear appropriate personal protective equipment (PPE).

ASSESSMENT:

Nursing Diagnosis:

I. Potential for Infection
II. Hyperthermia
III. Fatigue

TREATMENT PLAN

IF SYMPTOMATIC - TREAT AS POTENTIAL CORONAVIRUS CASE

I. If not conducted already, place barrier mask on patient
II. Isolate patient, notify supervisory staff
III. Provide pain management/medication: Acetaminophen (Tylenol) 500mg 2 tabs PO BID x3 days; may provide keep on person (KOP) supply at the time of encounter.
VI. Contact staff physician or on call provider using SBAR protocol to provide report of findings and obtain permission to test for COVID if /when indicated.

COMMON SIDE EFFECTS OF MEDICATION

I. Acetaminophen – nausea, itching or rash.

PATIENT EDUCATION

I. Encourage fluid and rest.
II. Advise patient that Coryza is normally a self-resolving viral syndrome.
III. Wash hands frequently.
IV. Observe proper cough etiquette.
V. Maintain isolation if applicable.
VI. Inform nursing staff if symptoms persist or worsen.

Implemented: 11/22/1995
Reviewed: 10/1996, 8/10/2001, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 6/4/2007, 7/30/2007, 7/10/2008, 8/5/2009
Revised: 12/16/1996, 8/5/1999, 7/24/2002, 6/11/2003, 3/24/2004, 4/5/2004, 2/22/2005, 12/22/2006, 3/6/2007, 8/20/2009, 11/15/2017, 4/20/2020

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DEHYDRATED PATIENT

I. PATIENT CONDITIONS:

A. Dehydration occurs when the amount of fluid leaving the body is greater than the intake of fluid.
B. Dehydration can occur when an individual has
    1. Excessive vomiting or diarrhea
    2. Excessive sweating
    3. A fever
C. Dehydration can occur when an individual has certain health conditions such as
    1. Diabetics with high blood sugars
    2. Individuals withdrawing from alcohol or heroin
D. Dehydrated individuals will manifest one of more of the following symptoms
    1. Dry sticky mouth
    2. Poor tissue turgor with tenting
    3. Sunken eyes
    4. No tears
    5. Scanty urine output
    6. Drowsiness
E. Dehydrated individuals manifesting one or more of these serious symptoms requires immediate transport to an emergency department.
    1. Confusion
    2. Fever of 103 or greater
    3. Seizure
    4. Fainting
    5. Changes in vital signs
        a. Decreased BP
        b. Increased respiratory rate
        c. Rapid and thread pulse

II. SUBJECTIVE:

A. History of ETOH or heroin abuse, reports a dry mouth or concentrated urine.
B. The patient may complain of nausea, vomiting and/or diarrhea.
C. Note duration and ability to keep fluids and/or food down.
D. Note any history of cardiac, pulmonary or renal disease.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DEHYDRATED PATIENT

III. OBJECTIVE:

A. Weigh I/P and compare most recent weight.
B. Vital signs
    1. Evidence of orthostatic hypotension
    2. Evidence of rapid heart rate
    3. Evidence of temperature
C. Blood glucose
D. Urinalysis
E. The patient may have concentrated urine (determined by increased specific gravity, NL 1.005-1.030). A dipstick of the urine will normally reveal a specific gravity more than 1.025.
F. Poor capillary filling
G. Auscultate lungs
H. Assess for clinical signs of alcohol/heroin withdrawal

IV ASSESSMENT:

Nursing Diagnosis:

A. Fluid Volume Deficit
B. Risk of electrolyte imbalance
C. Risk of instability of fluid volume

V. TREATMENT PLAN:

A. Obtain vital signs
B. Obtain weight of patient (actual)
C. Collect a urine specimen
D. Obtain capillary blood sugar
E. Obtain a brief history of cardiac, pulmonary or renal conditions.
F. Review assessment template for dehydration (see page 4)
    a. If I/P's symptoms are mild:
        i. Hydrate with 1 liter of oral fluids
        ii. Observe I/P while he/she is consuming fluids or longer if clinically indicated.
        iii. Schedule I/P for the next available RNSC
    b. If I/P's symptoms are moderate to severe:
        i. Hydrate using 2-liters IV LR or NSS over 2 hours, unless the patient has a history of heart, pulmonary, or renal problems.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DEHYDRATED PATIENT

c. Contact MD after the IV has been started to review the case.
d. Continue to monitor for 1 to 4 hours as clinically indicated.
e. Schedule patient for NEXT available MD sick call for follow-up.

PATIENT EDUCATION:

A. Instruct patient to report continued nausea, vomiting, diarrhea, continued withdrawal symptoms or other problems.
B. Increase fluid intake.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DEHYDRATED PATIENT

Dehydration Symptom Assessment Template

Signs and Symptoms	Mild Dehydration	Moderate Dehydration	Severe Dehydration
Level of consciousness	Alert	Drowsy	Stuporous
Capillary refill	2 seconds	3-4 seconds	Greater than 4 seconds
Mucous membranes	Normal	Dry	Parched cracked
Heart rate	Slightly increased	Increased	Very increased
Respiratory rate	Normal	Increased	Increased and hyperpnea
Blood pressure	Normal	Normal, but decreased BP upon standing	Decrease
Pulse	Normal	Thready	Faint or not palpable
Skin turgor	Normal	Slow	Tenting
Eyes	Normal	Sunken	Very Sunken
Urine output	Decreased	Oliguria	Oliguria/anuria

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DEHYDRATED PATIENT

Implemented: 11/22/95
Revised: 12/16/96, 08/05/99, 6.6.12
Reviewed: 09/95, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08 and 8.05.09

References

Dehydration. (n.d.). *Medicinenet*. Retrieved January 3, 2012, from http://www.medicinenet.com/dehydration/article.htm

Dehydration Symptoms, Treatments, Causes, Emergencies. (n.d.). *WebMD - Better information. Better health.*. Retrieved January 4, 2012, from http://www.webmd.com/a-to-z-guides/dehydration-adults

Dehydration in Geriatrics: Treating the Frail Older Adult. (n.d.). *Medscape*. Retrieved January 4, 2012, from www.medscape.com/viewarticle/567678_7

Mentes, J. (n.d.). Geriatric Nursing Resources for Care of Older Adults :: Hydration Management. *Geriatric Nursing Resources for Care of Older Adults*. Retrieved January 4, 2012, from http://consultgerirn.org/topics/hydration_management/want_to_know_more

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DENTAL: INFLAMED GUMS

PATIENT CONDITIONS:

1. Patient shall have reddened inflamed tender gums without observable purulent discharge.

SUBJECTIVE:

1. Complains of bleeding or tender gums.

OBJECTIVE:

1. Poor oral hygiene, reddened inflamed gum tissue.
2. May observe some bleeding after brushing.

ASSESSMENT:

Nursing Diagnosis:

1. Pain 9.1.1
2. Potential for Infection 1.2.1.1
3. Altered Oral Mucous Membrane 1.6.2.1.1

TREATMENT PLAN:

1. Instruct brushing and flossing after meals.
2. Refer to dentist if no improvement.

PATIENT EDUCATION:

1. Good oral hygiene.

Implemented: 10/01/95
Revised: 02/16/96, 08/05/99, 12/31/14
Reviewed: 10/96, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08 and 8.05.09

PATIENT CONDITIONS

I. This is intended for the patient with observable dental pain or dental abscess.
II. This is NOT intended for patients with facial cellulitis.

SUBJECTIVE

I. General complaints of dental pain at specific site or pain on entire side of mouth. Note duration.
II. Difficulty chewing.
III. Past medical history: History of recent dental treatment, poor dentition, IVDA and HIV status.

OBJECTIVE

I. Vital signs (Temperature >101^{o}F notify onsite or on call physician), appearance of tooth (surrounding teeth & gums), facial asymmetry, affected tooth may be painful to percussion with tongue blade ad note presence of tooth cavity.
II. If patient complains of difficulty swallowing or eating, assess throat.

ASSESSMENT

Nursing Diagnosis:
I. Pain
II. Potential for Infection
III. Altered Dentition

TREATMENT PLAN: DENTAL PAIN

I. For pregnant patient, administer the following:
    A. Tylenol 500 mg two tablets PO BID x 5 days.
    B. Schedule for dental sick call.

II. Minor to Moderate Pain (non-pregnant patient):
    A. If patient has no history of peptic ulcer disease administer:
        1. Motrin 200 mg two tablets PO BID x 5 days; may provide keep on person (KOP) supply.
    B. If patient has history of peptic ulcer disease administer:
        1. Tylenol 500 mg two tablets PO BID x 5 days.

III. Severe Pain:
    A. If patient has no history of peptic ulcer disease administer:
        1. Motrin 200 mg two tablets PO BID x 5 days; may provide KOP supply AND
        2. Tylenol 500 mg two tablets PO BID x 5 days.
    B. If patient has history of peptic ulcer disease administer:
        1. Tylenol 500 mg two tablets PO BID x 5 days.

IV. Schedule for a follow-up nurse sick call (RNSC) assessment in 72 hours. If symptoms worsen or no improvement noted at the follow-up RNSC visit, refer to next dental sick call clinic.

V. Regular diet as tolerated.

TREATMENT PLAN: DENTAL ABSCESS

I. If no allergies administer:
    A. Amoxicillin 500 mg BID x 7 days.

II. If allergic to Penicillin (PCN) administer:
    A. Cleocin 300 mg BID x 7 days.

III. Schedule for a follow-up RNSC assessment in 72 hours. If symptoms worsen or no improvement noted at the follow-up RNSC visit, refer to next dental sick call clinic.

IV. Regular diet as tolerated.

COMMON SIDE EFFECTS OF MEDICATION:

Gastro intestinal upset such as epigastric pain, nausea, heartburn or diarrhea.

PATIENT EDUCATION:

I. Instruct patient to report increased pain and/or swelling or no symptom relief.
II. Instruct patient not to apply pills to tooth or gums, a chemical burn may result.
III. Instruct patient to rinse mouth with warm water and/or brush teeth to clear out food particles, which may be causing pain.
IV. If applicable, inform patient that tooth extraction is not an indication for tooth pain due to erupting wisdom tooth in the absence of cavity or other complications.

Reference

[redacted] professional communication, September 6, 2011.

Implemented: 1996
Reviewed: 6/1999, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/5/2009, 10/1/2011
Revised: 2/16/1996, 8/5/1999, 3/24/2004, 12/12/2006, 8/20/2009, 1/31/2014, 6/23/2014, 6/1/2018

PATIENT CONDITIONS

I. The patient gives a history of diabetes mellitus
   A. Type 1 (insulin dependent),
   B. Type II (non- insulin dependent)
   C. Currently pregnant with diagnosis of gestational diabetes.
II. The patient reports a history of diet controlled diabetes and is not currently taking oral diabetes medication.

SUBJECTIVE

I. Obtain past history and current treatment including:
   A. Medications
      1. Insulin
         a. Name of insulin
         b. Amount and time of last dose
   B. Oral diabetic medications
      1. Name of oral diabetes medication(s)
II. Obtain information re: prior hospitalization or complications related to diabetes i.e. diabetic, ketoacidosis or hypoglycemic coma.
III. For females of child-bearing age, note LMP and inquire about the possibility of being pregnant.
   A. If pregnancy is confirmed by a urine test, schedule for MDSC or OBSC within the next 24 hours.

OBJECTIVE

I. Vital Signs.
II. Results of fingerstick blood sugar.
III. Presence of Ketones in the urine
IV. Presence of any of the following:

SYMPTOMS OF HYPERGLYCEMIA	SYMPTOMS OF HYPOGLYCEMIA
Increased Blood Sugar Skin warm/hot & dry, Polydipsia Polyuria, Urine Dip-+Ketones, +Glucose, Acetone Breath, Confusion Dehydration, Signs and Symptoms of Shock	Low Blood Sugar Skin cool/clammy, Tremulous Increased anxiety Confusion or Unresponsive Palpitations, Tachycardia Headache, Seizures

ASSESSMENT

I. Altered Health Maintenance
II. Potential altered nutrition (less than body requirements) related to imbalance between insulin need and insulin dose.
III. Potential non-adherence related to complexity of management regimen
IV. Knowledge deficit of therapeutic regimen
V. Anxiety related to diabetes and its prognosis

TREATMENT PLAN

I. Insulin Dependent Diabetics (Type I) No oral agents used
    A. Obtain initial capillary blood sugar and collect a urine specimen as needed for the presence of ketones and document results in JIMS
    B. If results are greater than 250 mg/dl collect urine and test for ketones, if specimen is available.
        1. Follow orders (Table 1) for sliding scale insulin, blood sugar retesting and medical follow-up
    C. Order a diabetic diet with snack
    D. Schedule I/P for MDSC
    E. Routine testing
        1. Blood sugar testing should be done:
            a. Twice a day testing for the duration of custody unless discontinued by the physician.
            b. Each time prior to insulin administration.
            c. More often if ordered/indicated.

******Inmates refusing glucose testing will not be given insulin and educated on importance of compliance and monitoring blood sugar. ******

II. Non-Insulin Dependent Diabetes (Type II)
    A. Obtain initial capillary blood sugar and collect a urine specimen as needed for the presence of ketones and document results in JIMS
    B. If results are greater than 250 mg/dl collect urine and test for ketones, if specimen is available.
        1. Follow orders (Table 1) for sliding scale insulin, blood sugar retesting and medical follow-up
    C. Order a diabetic diet with NO SNACK
    D. Schedule I/P for MDSC
    E. Routine testing
        1. Blood sugar testing should be done:
            a. Initially for twice a day routine testing x 3 days then MD chart review to determine recommended routine testing for the duration of custody.
            b. Enter the prescribed frequency for routine testing as determined by MD in JIMS Instruction e.g. weekly (BS QW).

c. Each time prior to insulin administration.
d. More often if ordered/indicated.

III. For I/P's claiming they are diabetic and managed with diet only
   A. Obtain blood sugar
   B. If results are greater than 250 mg/dl collect urine and test for ketones, if specimen is available.
      1. Follow orders (Table 1) for sliding scale insulin, blood sugar retesting and medical follow-up
      2. Schedule I/P for MDSC
   C. Continue BID blood sugar checks until seen by MD.

TREATMENT PLAN

I. Hyperglycemia Sliding Scale (Table 1):

Blood Sugar	Give Insulin SC Now
<250	None
250-300	5 units regular*
301-375	7 units regular*
376-450	10 units regular*
>450	12 units regular*

* Schedule MDSC evaluation for risk of diabetic ketoacidosis (DKA) or hyperosmolar hyperglycemia nonketotic syndrome (HHNS) with the urine dip result indicating presence or absence of ketones.

Re-check blood glucose within 4 hours of insulin administration.

If BS >450mg/dl with positive ketone urine dip, notify onsite provider immediately.

II. For hyperglycemia with ketoacidosis (blood sugar>450 mgm% and ketones are positive on dipstick):
   A. Begin an IV of normal saline at 1000 cc/hour for the first hour and 500 cc/hour for the second hour if necessary.

   B. Give human regular insulin, 10 units IV bolus.
   C. If physician is available on site, physician to evaluate patient at once. If on-site physician evaluation is not possible within one hour from the time of the request and/or the patient is unresponsive, send the patient to the emergency room by 911 transport.

III. For hypoglycemia (blood sugar <70mgm%) exhibiting one or more hypoglycemic symptoms as stated above:

A. If responsive give:
    1. Glucose tab or jelly.
    2. Monitor closely and re-check capillary blood glucose for response to the intervention provided. Resume current intermediate and long acting medication regimen. Document corrected capillary blood glucose level. If not corrected, consult physician.

B. If unresponsive:
    1. Start an IV and push 1 ampule of 50% Dextrose. Use D5W at 125 cc/hr once 50% Dextrose has been given.
    2. If unable to establish an IV give Glucagon one unit (1 mg) IM X 1 dose.
    3. Recheck blood sugar after 10 minutes.
    4. If patient remains unresponsive and blood sugar is <60 give 50 cc of 50% glucose intravenously.
        a. A physician should evaluate the patient immediately. If there is no on-site physician, notify the physician on call for further instructions.
        b. Re-check responsiveness in 3 5 minutes. If still unresponsive, send the patient to the emergency room by 911 transport.
        c. Hold all diabetic medications until evaluated by a physician.

PATIENT EDUCATION

I. Test blood glucose as directed, use blood glucose information to manage disease. Test more frequently when ill or under stress.
II. Take insulin as directed. Used properly, insulin can control diabetes, but not cure it.
III. Choose healthy foods and eat them in the right amounts on a routine basis.
IV. Exercise regularly.
V. Learn to manage stress to lessen its effects on your body.
VI. Follow diabetic diet as prescribed.
VII. Proper skin and nail care.
VIII. Routine carrying of sugar, candy, or other readily absorbed carbohydrate so that it may be taken at the first sign of an impending reaction.
IX. Instruct the I/P on the signs and symptoms of hypoglycemia and the use of glucose tablets.

Implemented: 11/22/95
Reviewed: 10/96, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08, 08/05/09
Revised: 02/16/96, 08/05/99, 02/00, 09/11/02, 11/07/03, 07/15/04, 04/25/05, 10/04/07, 11/28/11, 01/8/13, 4/29/16, 11/30/16, 12/7/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DIALYSIS CARE (Chronic)

PATIENT CONDITION:

1. The patient shall give a history of receiving dialysis.

SUBJECTIVE:

1. Past Medical History, duration of illness and duration of dialysis treatment.
2. Note specific treatment and location of dialysis clinic as well as all medications, dose, and last dose taken.
3. Note date of last prescription, name of prescribing doctor and dispensing Pharmacy.

OBJECTIVE:

1. Complete the Initial Screening and Dialysis Nursing Admission Record.
2. Check access site. Auscultate for bruit and palpate for thrill in the presence of a graft or fistula. In the presence of a vascular catheter as a dialysis access, observe for signs and symptoms of infection and refer to physician on duty of call UCSD Physician on-call for abnormalities.
3. Refer to the appropriate SNP as it relates to other conditions as needed.

ASSESSMENT:

Nursing Diagnosis:

1. Alteration in Health Maintenance 6.4.2

TREATMENT PLAN:

1. The patient is to sign an authorization to release of medical records from their Dialysis Center. Include in the request copies of the last set of lab reports, medications, and “run record”. They are to be faxed to SDCJ.
2. The nurse will write lab and draw blood for the following lab tests:
   a. Chem 7 Panel
   b. CBC
   c. Hepatitis B (Hep B Surface Antigen will be done STAT)
   d. Hep B Quantitative will be done ASAP
   e. Hep C Antibody Test

   Note: If taking Coumadin, write a lab request and draw blood for a PT and INR.
3. For STAT lab results. Call the lab if results are not faxed within four hours.
4. Results are to be available for the MD and Nephrologist by the next sick call.
5. Report all abnormal blood tests results to the MD at SC, or MD on-call.
6. Give PPD and/or chest x-ray if immunocompromised.
7. Schedule the patient for MD sick call for H&P early in AM patient to go to dialysis after sick call if M-W-F.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DIALYSIS CARE (Chronic)

8. Order Renal Diet
9. Notify Sheriff Dietician of admission.
10. For new admissions, notify the [redacted] Acute Dialysis Unit at ([redacted] during office hours. Leave message on answering machine.
11. Notify Deputies of scheduled dialysis.

PATIENT EDUCATION:

1. Instruct the patient to report any signs or symptoms of unusual bleeding of the dialysis access site to staff.

New: 08/10/01
Revised:
Reviewed: 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08 and 8.05.09

PATIENT CONDITIONS

I. This is NOT intended for
   A. The patient with HIV infection
   B. The post-surgical patient
   C. The patient with chronic diarrhea (defined as diarrhea continuing for two or more weeks.
II. If patient complains of fever (102^{o}F or greater, bloody, black or mucoid stools, severe pain or diarrhea for more than two days, schedule for MDSC).
III. The patient complains of watery stools x 1-2 days.

SUBJECTIVE

I. Patient may complain of mild cramping prior to bowel movement.
II. Obtain characteristics of stool.
III. Obtain past medical history such as HIV status, chronic medical conditions, chronic disease, irritable bowel syndrome, diabetes, etc.
IV. Obtain dietary history 48 hours prior to symptoms.
V. Obtain current medication history (especially antibiotics).

OBJECTIVE

I. Vital signs
II. Actual patient weight and note significant loss.
III. Assessment of skin turgor and mucosa.
IV. Assessment: bowel sounds (should be hyperactive), may have mild generalized tenderness.

ASSESSMENT

Nursing Diagnosis:
I. Diarrhea
II. Potential fluid loss

TREATMENT PLAN

I. Offer oral fluids at a level of 1-2 liters/hour. If patient is dehydrated and cannot tolerate oral fluids follow SNP Dehydrated Patient (SNP.D.1) and notify onsite or on-call physician for further instruction.
II. If the patient can tolerate oral fluids and medication, administer one dose of Imodium 2 mg two capsules PO.
III. If patient is an inmate worker; remove from duties until cleared by RN.
IV. If diarrhea persists for more than 48 hours, schedule for MDSC.

PATIENT EDUCATION

I. Increase fluid intake gradually and take medicine as instructed. Return if no improvement in 1-2 days.
II. Advise patient to avoid caffeine (coffee, tea, some colas) and lactose containing products (milk, ice cream) until diarrhea is resolved.
III. MDSC for recurrent symptoms.
IV. Reinforce the importance of thorough hand washing at all times to prevent spread or recurrence.

References

Cunha, J. (n.d.). Diarrhea. *emedicine*. Retrieved January 10, 2012, from http://www.emedicinehealth.com/diarrhea/article_em.htm

Diarrhea. (2010, June 26). *Mayo Clinic*. Retrieved January 10, 2012, from http://www.mayoclinic.com/health/diarrhea/DS00292/DSECTION=lifestyle-and-home-remedies

Diarrhea - National Digestive Diseases Information Clearinghouse. (n.d.). *Home - National Digestive Diseases Information Clearinghouse*. Retrieved January 10, 2012, from http://digestive.niddk.nih.gov/ddiseases/pubs/diarrhea/

Guandailini, S., & Cuffari, C. (2010, April 8). Diarrhea. *Medscape*. Retrieved January 10, 2012, from http://emedicine.medscape.com/article/928598-overview

Implemented: 10/1/1995
Reviewed: 9/1995, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/5/2009
Revised: 4/9/1998, 8/5/1999, 1/10/2012, 6/1/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

DRUG LEVELS: MONITORING THERAPEUTIC SERUM DRUG LEVELS

PATIENT CONDITIONS:

1. The patient shall give a history of taking any of the following medications: Dilantin, Theophylline, Phenobarbital, Tegretol, Lithium, Depakote, Digoxin, Coumadin. (may be additional medications for which levels are desired, such as psychotropic medications)
2. Also refer to the appropriate SNP according to the condition.

SUBJECTIVE:

1. Past medical history and duration of illness and duration of medication.
2. Note specific medication, dose, last dose taken.
3. Note date of last prescription, prescribing Dr. and Pharmacy where it was filled.

OBJECTIVE:

1. Vital sign. Physical condition as it relates to the illness being treated.

ASSESSMENT:

Nursing Diagnosis:

1. Altered Health Maintenance 6.4.2

TREATMENT PLAN:

1. If patient claims to have been taking his/her medication regularly, the nurse at his/her discretion may obtain an initial baseline blood level on admission.
2. Any results shall be referred for the physician's review.
3. When drug levels are reported above or below the normal range, notify the on-call or on-site physician for advice.
4. Schedule the patient for the next psych sick call for chart check if on psychotropic medications.

PATIENT EDUCATION:

1. Report any signs or symptoms of toxicity including: slurred speech, double vision/blurred vision, nausea, vomiting, tinnitus and altered level of consciousness.

Implemented: 10/01/95
Revised: 04/09/98, 08/05/99
Reviewed: 10/96, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08 and 8.05.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

EXTRAPYRAMIDAL SIDE EFFECTS

PATIENT CONDITION:

1. To be treated the patient will either report or have a history of taking neuroleptic medications or suddenly stopping neuroleptic medication and will be exhibiting extrapyramidal reactions.

SUBJECTIVE:

1. The patient may complain of stiffness, muscle spasm or rigidity. They may have difficulty talking or swallowing, feel restless and can't sit still.
2. The patient reports taking neuroleptic medications, either on a regular basis or he/she may have taken someone else's medication, or they may have abruptly stopped taking neuroleptic medications.

OBJECTIVE:

1. Torticollis, the head turned to one side.
2. Oculo-gyric crisis, the eyes looking upward, rigidity of the limbs.
3. The patient may also have laryngospasm, visible tremors, cogwheeling of the wrist, elbow or tardive dyskinesia.
4. Vital signs (elevated temp, pulse and blood pressure) may be altered due to anxiety or neuroleptic malignant syndrome.

ASSESSMENT:

Possible Nursing Diagnosis:

1. Impaired Physical Mobility 6.1.1.1
2. Potential for Injury 1.6.1
3. Anxiety 9.3.1

TREATMENT PLAN:

1. Medications
    a. Cogentin 2 mg IM. May repeat in 45-60 minutes if only slight reduction in symptoms then Cogentin 2 mg PO in 6 to 8 hours x 2 days.
2. Alternative Treatment:
    a. Benadryl 50 mg IM, then Benadryl 25 mg PO bid x 1 day.
3. Any patients with difficult breathing and /or suspected of having the neuroleptic malignant syndrome.
    a. Contact the physician on duty or on call for further instructions.
    b. If no MD available, call 911 and have patient transported to the emergency department.
4. Schedule for the first available MD sick call, or psychiatric MD sick call whichever occurs within 24 hours.

PATIENT EDUCATION:

1. Inform the patient to report reoccurrence of symptoms.

Implemented: 10/01/95
Revised: 04/09/98, 08/05/99
Reviewed: 10/96, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05. 07/31/06, 7/30/07, 07/10/08 and 8.05.09

DEFINITION:

Emergency contraception (EC) is a form of birth control that may be employed by women who have had unprotected intercourse, or who had used a birth control method that had failed (e.g. condom failure, missing two or more oral birth control pills during a monthly cycle). Treatment is generally reserved for specific situations and is not considered a regular form of birth control. Process is not abortive; Emergency Oral contraception is used to prevent a pregnancy, not to end one.

BACKGROUND:

NCCHC standards and AB732 both relate to the provision of women's health issues, to include the need for the availability of emergency contraceptive measures within the first 72 hours of entering into custody.

The use of a Standardized Nursing Protocol (SNP) provides a means for urgent clinical engagement, patient counseling and, potentially, the enabling of patient self-care through the use of over the counter pre-packaged medications.

PATIENT CONDITIONS:

I. Female patient presenting to custody, with a concern about possible pregnancy and/or recently experienced unprotected intercourse. [MUST BE WITHIN 72 HOURS OF BOOKING]
II. Negative pregnancy test [If pregnant- DO NOT COMPLETE EC PROCESS; start pregnancy SNP and schedule for MD follow up appointment.

SUBJECTIVE:

I. Reports recent (within the past 72 hours) of unprotected intercourse.
II. Past Medical History: (e.g. DM, HTN, substance use disorder, MH/BH issues, etc.)
III. Current medications
IV. Allergies

OBJECTIVE:

I. Vital Signs

II. Physical Exam
III. Urine pregnancy test result

ASSESSMENT:

I. Contraception

TREATMENT PLAN

I. Patient counseling (see attached Fact Sheet)
II. Substance use counseling [if applicable]
III. Recommend STD/STI laboratory testing
IV. Medications: Over the counter (OTC) dosing of Plan B 'one step'. 1.5 mg Levonorgestrel 1 tab PO x1
V. Scheduled follow up appointment

COMMON SIDE EFFECTS OF MEDICATION

I. Levonorgestrel – nausea, cramping

PATIENT EDUCATION

I. Encourage fluid and rest.
II. Inform nursing staff if symptoms persist or worsen.

Implemented: 7/15/2020
Reviewed:
Revised:

PATIENT CONDITIONS

I. Patient complaints of burning/tingling and itching at infected site.

II. The patient with gross redness, drainage, or swelling at the site is to be referred to the MD Sick Call for evaluation.

DEFINITION

A. Tinea Pedis (Athlete's feet) – a fungal infection occurring on the feet. This fungus grows in warm moist environments such as shoes, socks, locker rooms and public showers. Symptoms include peeling, cracking, itching or burning of the feet.
B. Tinea Crusis (Jock itch) – a superficial fungal infection that occurs in the groin, inner thighs and buttocks. The area affected is reddened, raised and individuals complain of itching, burning, chaffing, flaking or peeling.
C. Tinea Corporis (Ringworm) – a superficial fungal infection that is found anywhere on the body. Its appearance is red, circular, flat and individuals can experience some itching.

SUBJECTIVE

I. Affected body part (s).

II. Duration of symptoms.

OBJECTIVE

I. Cracking between fissures of hands and feet or body folds.

II. Slightly excoriated reddened skin.

III. May have peeling or sloughing of skin at the site.

ASSESSMENT

Nursing Diagnosis:

I. Impaired skin integrity

II. Altered Health Maintenance

TREATMENT PLAN

I. Clotrimizole 1% cream apply BID to affected area x 14 days, may provide keep on person (KOP) supply (1 oz. tube).
II. If there is no improvement at the completion of treatment, schedule for qualified healthcare provider sick call clinic for further evaluation and treatment.

PATIENT EDUCATION

I. Wash and completely dry affected area before each application.
II. Apply thin layer of cream to site.
III. If possible, clothes worn over the affected area should be changed after each application.
IV. Report no improvement or re-infection.
V. Use shower shoes.

Implemented: 10/1/1995
Reviewed: 10/1996, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/11/2009
Revised: 4/9/1998, 8/5/1999, 8/20/2009, 8/22/2011, 1/2/2014, 6/1/2018

PATIENT CONDITIONS

I. To be treated, patient should have no history of hypertension (HTN), cerebrovascular accident (CVA), gastrointestinal (GI) disease, eye, ear, nose, throat (EENT) problem, heart disease or recent fall/injury.
II. Patient needs immediate evaluation by physician if patient develops severe sudden head pain, headache with stiff neck, fever $\geq 101^{o}$F, nausea, vomiting, weakness, paralysis, numbness, visual disturbance, mental and behavioral changes. If no onsite MD available, contact on-call MD.

SUBJECTIVE

I. Headache – complains of headache with no past history of the above complaints.

OBJECTIVE

I. Normal vital signs. Note duration, location and quality of pain. Note the patient's current medications (some headaches may be side effects of medication).

II. Patient has no neurological deficits, fever or trauma.

ASSESSMENT

Nursing Diagnosis:

I. Pain

TREATMENT PLAN

I. Headache: Tylenol 500 mg two tablets PO x 1 dose OR Motrin 200 mg two tablets PO x 1 dose, may repeat x1 within 24 hours if necessary (only use Motrin if no history of peptic ulcer disease).

II. Refer to MDSC clinic if no relief within 24 hours.

III. Pregnant patient:
A. Tylenol 500 mg two tablets PO x 1 dose.
B. If no relief, refer to MDSC clinic.

COMMON MEDICATION SIDE EFFECTS

I. Tylenol – nausea, itching and rash.
II. Motrin – abdominal pain/cramps and heartburn.

PATIENT EDUCATION

I. Reduce emotional/physical tension/stress by daily exercise, relaxation technique.
II. For migraine headache, consider eliminating: caffeine, chocolate, nuts, cheese and alcohol.

Implemented: 4/9/1998
Reviewed: 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/11/2009
Revised: 8/5/1999, 8/10/2001, 2/22/2005, 8/20/2009, 6/1/2018

PATIENT CONDITIONS

I. **Not** intended for patient with severe bleeding hemorrhoid with intractable pain, unrelenting pruritus, strangulation and thrombosis. If continuous rectal bleeding and/or severe pain occur contact on-site or on-call MD for instructions if not available call 911.

SUBJECTIVE

I. Patient complains of blood and pain with defecation.
II. Patient claims to have H/O chronic constipation.

OBJECTIVE

I. Normal vital signs.
II. May have presence of nodules with possible bluish hue. Nodules may be erythematous. If internal hemorrhoids are present, external examination may be completely normal.

ASSESSMENT

I. Risk for Infection 1.2.1.1
II. Pain 9.1.1
III. Risk for Constipation 1.3.1.4

TREATMENT PLAN

I. If burning sensation or pain on defecation is a prominent symptom, apply hemorrhoid cream after each bowel movement x 3 days. May provide keep on person (KOP) supply.

PATIENT EDUCATION

I. Report to medical staff if bleeding and pain persist.
II. Drink plenty of fluid and increase bulk with diet.
III. Avoid straining and prolonged sitting.
IV. Good hand washing.

Implemented: 04/09/98
Reviewed: 04/98, 04/01, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08, 8/11/09
Revised: 08/05/99, 09/04/02, 5/3/13, 11/30/17, 6/1/2018

PATIENT CONDITIONS

I. Respiratory rate less than 8 or be completely apneic.
II. History of heroin/opioid abuse
III. Noted track marks.

THIS IS NOT INTENDED FOR THE PATIENT IN CARDIAC ARREST. IF THE PATIENT IS PULSELESS BEGIN CPR AND INITIATE EMERGENCY PROCEDURES.

SUBJECTIVE

I. Patient may or may not admit to recent heroin use.
II. Patient may or may not be responsive.

OBJECTIVE

I. Vital signs
    A. Pulse - bradycardic
    B. BP- hypotensive
    C. Respirations - apneic or respirations may be < 8.
II. Auscultation of lungs may reveal basal dullness or moist rales

ASSESSMENT

I. Potential Nursing Diagnosis
    A. Ineffective breathing pattern
    B. Decreased cardiac output
    C. Impaired gas exchange
    D. Decreased cardiac output

TREATMENT PLAN

I. Start an IV
II. Normal Saline and running at a rate of 125cc/hour.
III. Administer Narcan kit; may repeat in 3 minutes if no improvement.
IV. Administer 50cc 50% Glucose IV push (if vein is accessible)
V. If patient improves and becomes apneic again, repeat Narcan administration.
VI. Immediately refer to the emergency department (ED) and transport 911 if the patient remains apneic after two doses of Narcan or is unarousable.
VII. NOTE: Anytime a patient is given Narcan for suspected opioid overdose and a provider is not present to evaluate the individual, the patient shall be transported to an emergency department for further evaluation and treatment.

PATIENT EDUCATION

I. Health issues and risks surrounding the use of heroin or opioids.

STAFF TRAINING

I. Complete the division's online training regarding Narcan administration. Additional information on the indication and proper use of Narcan kit can be found at https://www.narcan.com

Resources

Medscape: Medscape Access. (2010, November 9). Medscape: Medscape Access. Retrieved March 7, 2012, from http://emedicine.medscape.com/article/815784-treatment

Opioid Overdose. (n.d.). Epocrates.com. Retrieved March 7, 2012, from https://online.epocrates.com/u/2941339/Opioid+overdose/Treatment/Approach

Opioid overdose prevention: Guideline for training the responder. (2006). New York: New York State Dept. of Health.

Implemented: 10/01/95
Reviewed: 10/96, 8/02, 8/18/03, 08/09/04, 8/12/05, 7/31/06, 7/30/07, 07/10/08, 8/11/09
Revised: 04/09/98, 08/05/99, 08/10/01, 3/7/12, 11/30/17, 7/23/18

PATIENT CONDITIONS

I. History of heroin abuse as evidenced by needle track marks and/or symptoms of withdrawal.
II. History of opiate abuse.
Examples of Opiates: Methadone, Suboxone, Morphine (MS Contin), Norco, Vicodin, Oxycontin, Oxycodone, Percocet, Codeine, Fentanyl, Duragesic.
III. DO NOT initiate protocol if
    A. The patient is pregnant; Contact MD and refer to MSD.A.2 Addicted Arrestee Care.
    B. The patient is an active participant of a methadone clinic and is not withdrawing from Methadone. If patient is unable to make arrangements for future dosing while incarcerated, schedule for RNSC within 24 hours to start the protocol for heroin/opiate withdrawal.
IV. Polysubstance withdrawal:
    A. If patient is withdrawing from both alcohol and heroin simultaneously, initiate both alcohol and heroin withdrawal protocols. Follow the longer protocol (Opiate SNP.H.4) for housing/bed/tier assignments, and contact a qualified medical provider for guidance on medication use.
    B. Schedule the patient for follow on assessment at MDSC.

SUBJECTIVE

I. Obtain information from patient regarding the drug(s) taken: List the name(s), type, quantity, frequency of use, time of last dose, and how long has the substance been used. Use comprehensive detoxification questionnaire at receiving/screening.
II. Patient may relate symptoms or complaints secondary to withdrawal such as:
    A. Anorexia
    B. Cravings
    C. Fatigue
    D. Sleep Disturbance
    E. Abdominal Cramps
III. Obtain medical history (i.e. chronic disease and other drug use).
IV. Identify if patient has history of Substance Use Disorder treatment:

OBJECTIVE

I. Vital Signs
II. Physical exam findings: Assess for the following
    A. Presence or absence of track marks and/ or skin abscesses.
    B. Pupillary size
        i. Dilated- continue with protocol

ii. Constricted – contact medical provider
iii. Unequal (one larger than the other) – **CONTACT MEDICAL PROVIDER**

III. Lab test: FEMALES- conduct urine pregnancy test screening; if positive, contact the on-call physician for orders/guidance.

IV. Observe and document presence/absence of agitation, change in gait, affected speech, mental status exam: (e.g. state of consciousness, orientation, memory, presence of auditory/visual/tactile hallucinations).

V. Signs and symptoms of opiate withdrawal may include the following:
   A. Rhinorrhea
   B. Lacrimation
   C. Yawning
   D. Sneezing
   E. Diaphoresis (Sweating)
   F. Vomiting
   G. Fever
   H. Hypertension
   I. Tachycardia
   J. Increased respiratory rate
   K. Gooseflesh
   L. Agitation
   M. Myoclonus (especially kicking)
   N. Dilated pupils
   O. Diarrhea
   P. Tremors

ASSESSMENT

I. Potential nursing diagnosis for individuals withdrawing from Opioids:
   A. Alteration in nutrition: less than body requirements
   B. Potential risks for acute confusion
   C. Potential Risks for fluid deficit
   D. Alteration in comfort
   E. Risk of suicide
   F. Medical assessment: Acute withdrawal. If patient in acute distress, or has abnormal vitals, then contact a medical provider for orders/guidance and stabilize patient.

TREATMENT PLAN

I. Contact qualified medical provider **immediately** for the following conditions:
   A. Confirmed pregnancy – refer to MSD.A.2 Addicted Arrestee Care
   B. Patient is stuporous – responds to voice as evidenced by eye movement but no eye contact and does not attempt to speak when spoken to.
   C. Abnormal vital signs
      - Pulse less than 50 beats per minute

- Systolic blood pressure below 90 and diastolic pressure below 60.

D. Patient also qualifies for alcohol or benzodiazepine protocol.

II. Please note the following considerations when patient states that they are currently taking an opiate for a medical condition such as chronic low back pain and staff is unable to substantiate prescription from pharmacy records:
   A. Patient may be at risk for opiate withdrawal – consult with qualified health provider for recommendations which may include opioid tapering dose if indicated.

III. Initiate the following opiate withdrawal protocol unless patient is pregnant:
   A. Benadryl 50 mg PO BID x 5 days
   B. Imodium 2 mg PO BID x 5 days
   C. Zofran 4 mg PO BID x 5 days
   D. Lower bunk x 5 days
   E. Diet as tolerated
   F. For dehydration management, refer to SNP D.1 Dehydrated Patient

IV. Conduct follow-up assessment- Patient to be seen within 48 hours of protocol initiation for symptom review.

V. Add patient flag "COWS" in health record with an end date of 5 days.

VI. If feasible, patients should be in cohort housing for improved observation, management and ease of intervention.
   A. If cohort housing is not possible, (e.g. due to space limitations, possible contagion, higher priority medical conditions, etc.) notify health staff for any logistical concerns.

TRANSFERS

I. Patient undergoing treatment for heroin/opiate withdrawal shall not be transferred to a detention facility that does not have 24-hour nursing care.

II. For a patient in a Methadone program prior to incarceration and is receiving tapered dosing administered by the Methadone clinic, transfer [redacted] will be deferred.

PATIENT EDUCATION

I. Encourage patient to notify medical staff immediately when symptoms of withdrawal occur.

II. Instruct patient to increase food and fluid intake as tolerated.

III. Provide information on common medication side effects:
   A. Benadryl – drowsiness, dizziness, blurred vision, fatigue, disturbed coordination, constipation, or dry mouth/nose/throat.
   B. Imodium – dizziness, drowsiness, tiredness, or constipation.
   C. Zofran – confusion, tachycardia, fever, headache, shortness of breath, dizziness, or weakness.

Reviewed: 10/1996, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/10/2008, 8/11/2009
Revised: 4/9/1998, 8/5/1999, 8/10/2001, 1/20/2004, 10/11/2007, 4/8/2011, 5/21/2012, 5/13/2013, 3/27/2019, 2/13/2020, 2/21/2020

PATIENT CONDITIONS

I. This is intended for the patient with central upper abdominal discomfort and/or burning sensation in upper abdomen or lower central chest region. It may be associated with eating of meals, particularly those containing a high fat content.
II. This is not intended for the patient who has had recent abdominal trauma, surgeries, or complains of vomiting blood.

SUBJECTIVE

I. Complaints of burning sensation in the esophagus, usually after eating. (For complaints of chest pain, refer to chest pain SNP.) Note nausea, vomiting, diarrhea.
II. For history of GI bleeding, ulcers, or recent abdominal surgery, refer to first available MD sick call.

OBJECTIVE

I. Vital signs.
II. Evaluate for abdominal pain or abdominal swelling.
III. Note presence or absence of bowel sounds.
IV. Note palpate for epigastric tenderness.

ASSESSMENT

I. Nursing Diagnosis:
    A. Pain 9.1.1

TREATMENT PLAN

I. Tums 2 tablets PO with meals and at bedtime x 2 days. May provide keep on person (KOP) supply.
II. Schedule for MD sick call if symptoms are recurrent.

COMMON SIDE EFFECTS OF MEDICATIONS

I. Nausea
II. Vomiting
III. Distaste for food

PATIENT EDUCATION

I. Advise patient that antacids are available through commissary stores.
II. Instruct patient in use of antacids between meals.
III. Inform patient that alcohol and smoking must be avoided for maximal relief.
IV. Inform patient that not eating within 2 to 3 hours of bedtime will provide additional relief.
V. Patient should be informed that overeating may make symptoms worse.

Implemented: 11/22/95
Reviewed: 10/96, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08, 8/11/09
Revised: 08/05/99, 04/01, 09/11/02, 03/24/04, 1/2/14, 6/2/14, 11/30/17, 6/1/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

INFLUENZA

Inmate/Patient with Influenza-Like-Illness (ILI), Suspected H1N1

I/P CONDITIONS:

1. I/P complains of influenza-like-illness (ILI) in the absence of other underlying medical conditions.
2. I/P presents with the following symptoms: Temperature of 100 or greater, sore throat and/or cough, muscle and body aches.

SUBJECTIVE:

1. Symptoms - Complains of sore throat and/or cough

OBJECTIVE:

1. Vital signs - Temperature > 100 without the use of Tylenol, ASA or Motrin

ASSESSMENT:

Nursing Diagnosis:

1. Potential for Infection 1.2.1.1.
2. Hyperthermia 1.2.2.3.

TREATMENT PLAN:

1. Mask, isolate and transfer [redacted] (males only).
2. Contact the Infection Control Nurse or designee
3. Documentation in JIMS - Create an Encounter, in the Encounter Detail Screen under REASON, select “FLU”. Continue documenting in JIMS per current business process.
4. Take Vital Signs:
    i. Temperature checks (only) bid x 5 days
    ii. Document temperatures in JIMS
5. Obtain a weight and height for the I/P for the purpose of calculating the BMI. Include this information when contacting the pharmacist so that the correct dosage of Tamiflu is ordered.
6. Laboratory Testing:
    a. Influenza A rapid screening test
    b. H1N1 viral culture (Upon recommendation of Infection Control Nurse)
7. Medication Management:
    a. Tylenol 325mg 2 tabs PO 1 qd or bid as needed x 2 days
    b. Tamiflu 75mg bid X 5 days
    c. Special Conditions: I/P is obese. BMI will be calculated by Pharmacist. If BMI is 30% or greater- Tamiflu 150mg bid X 5 days
8. Clearance from isolation will be the responsibility of the Infection Control Nurse or designee and will be predicated on the basis of the individual being afebrile (without the use of antipyretics) for 24 hours.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

INFLUENZA

PPE REQUIREMENTS:

Follow recommendations of DOC

a. Don gloves, mask and gown

ADDITIONAL INSTRUCTIONS:

1. I/P will have BID temps taken during treatment phase.
2. The Infection Control Nurse or her designee will review the electronic medical record and monitor temperature.
3. I/P clearance from the symptomatic ward will be the responsibility of the Infection Control Nurse or her designee. However, BID temperatures should continue to be taken until the completion of antiviral (Tamiflu).

I/P EDUCATION:

1. Encourage fluids and rest.
2. Instruct I/P in good hand hygiene and importance of washing hands frequently.
3. Instruct I/P in good cough etiquette by covering their mouth with a tissue and then throwing the tissue away or turning their head away from people and coughing into the upper arm.
4. Instruct I/P to inform nursing staff if symptoms persist or worsen.

Common Side Effects of Medications:

a. Tylenol – nausea, itching & rash.
b. Tamiflu- nausea, diarrhea

SNP for High Risk Exposure Contact

I/P CONDITIONS:

1. Definition of High Risk Exposure Contact: Those I/P's sharing a single cell module with an inmate that has been identified and treated for an influenza-like illness.
2. Those I/P's sharing housing whereby two or more inmates from the same housing unit have been identified and are being treated for influenza-like illness.

SUBJECTIVE:

1. Remains asymptomatic

OBJECTIVE:

2. Vital signs – temperature < 100 without the use of Tylenol, ASA or Motrin

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

INFLUENZA

ASSESSMENT:

Nursing Diagnosis:

1. Potential for Infection 1.2.1.1
2. Hyperthermia 1.2.2.3

TREATMENT PLAN:

1. Quarantine I/P for 5 days
2. Documentation in JIMS - Create an Encounter, in the Encounter Detail Screen under REASON, select “FLU”. Continue documenting in JIMS per current business process.
3. Medication Management:
    a. I/P will receive chemoprophylaxis
        i. Tamiflu 75mg qd X 10 days (Order in JIMS as STAT. In medication instructions document I/P advised of self administration QD X 10 days).
    b. I/P will keep medication on his/her person and self administer.
4. Vital Signs:
    a. Temperature only bid X 5 days
        i. If I/P develops Temperature of 100 or greater at anytime during the 5 day treatment-
            1. Follow SNP for Influenza, Suspected H1N1- Inmate/Patient with Influenza Like Illness.
5. Clearance:
    a. Prior to release from quarantine, the Infection Control Nurse or designee will review I/P’s temperature reading over the past 24 hours.

PPE REQUIREMENTS:

1. Don gloves only

I/P EDUCATION:

1. Instruct I/P in good hand hygiene and importance of washing hands frequently.
2. Instruct I/P in good cough etiquette by covering their mouth with a tissue and then throwing the tissue away or turning their head away from people and coughing into the upper arm.
3. Instruct I/P to inform nursing staff if they experience symptoms of temperature, cough and/or sore throat.

Common Side Effects of Medications:

a. Tamiflu - nausea, diarrhea

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

INFLUENZA

SNP for Low Risk Exposure

I/P CONDITIONS:

1. Definition of Low Risk Exposure Contact: Those I/P's housed in either dormitory or module type housing where a single symptomatic case of influenza- like- illness has been identified.
2. I/P lives in a dormitory or module (not sharing a single cell) where an I/P has flu-like symptoms and there is a suspicion of H1N1.
3. No other individuals within the module or dormitory present with >100F temperature within 72 hours of last exposure).

SUBJECTIVE:

1. Reports no symptoms.

OBJECTIVE:

1. Vital signs - Temperature < 100 without the use of Tylenol, ASA or Motrin

ASSESSMENT:

Nursing Diagnosis:

1. Potential for Infection 1.2.1.1.
2. Hyperthermia 1.2.2.3

TREATMENT PLAN:

1. Isolation is not required
2. Documentation in JIMS - Create an Encounter, in the Encounter Detail Screen under REASON, select "FLU". Continue documenting in JIMS per current business process.
3. Vital Signs:
    a. Take Temperature bid X 5 days and log on Temperature Log.
    b. Individuals remain afebrile
        i. Antivirals are NOT started and I/P will be monitored by temperatures only.In the event an I/P spikes a fever, they would no longer be considered a low risk exposure.
        ii. Follow SNP for Influenza, Suspected H1N1- I/P with Influenza Like Illness.
4. Observation
5. Infection Control Nurse or designee will review but will not need to "Clear" module or dormitory as there is no mandated quarantine.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

INFLUENZA

I/P EDUCATION:

1. Instruct I/P in good hand hygiene and importance of washing hands frequently.
2. Instruct I/P in good cough etiquette by covering their mouth with a tissue and then throwing the tissue away or turning their head away from people and coughing into the upper arm.
3. Instruct I/P to inform nursing staff if they experience symptoms of temperature, cough and/or sore throat.

Draft Copy 9.09.09
Revised 11.03.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

KIDNEY STONES

INMATE-PATIENT CONDITION:

1. I/P with excruciating pain and passing of a stone or bloody urine.

SUBJECTIVE:

1. The I/P may complain of severe pain in the flank (kidney area), groin, testicles (men), or labium (females).
2. The I/P may be in constant movement in an attempt to alleviate the discomfort.
3. Nausea and/or vomiting may accompany the pain.

OBJECTIVE:

1. Tenderness to percussion over the affected side in the flank area or the abdomen.
2. Presence of blood on urine dipstick.

ASSESSMENT:

Nursing Diagnosis:

1. Pain 9.1.1

TREATMENT PLAN:

1. Toradol 60 mg IM x 1 dose.
2. Start an IV and give 1000 cc NS at 500 cc/hour.
3. Patient to be seen by on-site MD immediately, if not available, send to ED.

INMATE-PATIENT EDUCATION:

1. Stress the importance of high fluid (water) intake.

Implemented: 11/22/95
Revised: 04/09/98, 08/05/99, 08/10/01 and 9.30.09
Reviewed: 04/98, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 9/23/08 and 8.11.09

PATIENT CONDITIONS

I. Pelvic area pain that occurs with menstruation and consists of cramping and is usually centered in the lower abdomen.
II. **This is not intended for the patient who is pregnant or post-menopausal.**

SUBJECTIVE

I. Pain-cramping (twisting, spasmodic), colicky, cyclic, nagging, dull heavy backache, usually lower abdomen, may radiate down back of legs. May be severe enough to require bedrest for 1-2 days. Usually occurs before or at the onset of menstruation.
II. With severe dysmenorrhea the patient may exhibit the following signs: chills, headache, nausea, vomiting, diarrhea and syncope.
III. Note past menses history: last menstrual period (LMP) and past use of oral contraceptives.

OBJECTIVE

I. Pregnancy test is negative.
II. Patient is afebrile and with normal vital signs.
III. May have abdominal discomfort and/or appearance of being in discomfort.
IV. Vaginal bleeding may or may not be present.

ASSESSMENT

Nursing Diagnosis:

I. Pain

TREATMENT PLAN

I. If patient has no history of peptic ulcer disease, Motrin 200 mg two tablets PO BID x 3 days. May provide keep on person (KOP) supply.
II. If patient has history of peptic ulcer disease, Tylenol 500 mg two tablets PO BID x 3 days.
III. Schedule for MDSC clinic if no relief in 48 hours.
IV. If a patient has abnormal vital signs including fever with or without evidence of vaginal infection (vaginal discharge, irritation or burning), refer to MDSC clinic immediately. If no physician is onsite, contact on-call physician for direction.

MENSTRUAL CRAMP

PATIENT EDUCATION

I. Recommend regular exercise and activity as helpful adjuncts.

Implemented: 1998
Reviewed: 4/1998, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 3/23/2009
Revised: 8/5/1999, 8/10/2001, 6/8/2004, 6/1/2018

PATIENT CONDITIONS

I. This is not intended for the patient with an extremity deformity secondary to injury; gross swelling; unstable joints; extensive bruising or extensive pain. Patients with the above will be referred to the MD sick call (splint extremity when appropriate).
II. To be treated, patient will provide a history of minor trauma to the given muscular or ligamentous area.

SUBJECTIVE

I. Description of the mechanism of injury, including when, where, how and why it occurred.
II. Location, intensity and duration of pain.
III. Treatment measures already taken.
IV. History of prior injury in the same or similar area.

OBJECTIVE

I. Vital signs, including circulatory status to the area if it can be determined.
II. Description of the injury.
III. Assessment of range of motion and any limitations due to the injury.

ASSESSMENT

Nursing Diagnosis:

I. Alteration in comfort
II. Alteration in mobility

TREATMENT PLAN

I. If injury has occurred with the preceding 24 hours,
II. Motrin 200 mg two tablets PO BID x 2 days (if no history of peptic ulcer disease); may provide keep on person (KOP) supply.
III. Tylenol 500 mg two tablets PO BID x 2 days (if with history of peptic ulcer disease or if patient is pregnant).
IV. If no improvement in 2 days, schedule patient for next available MDSC clinic.

PATIENT EDUCATION

I. Instruct patient in proper body mechanics, lifting and stretching exercises prior to and after physical exertion.

Implemented: 11/22/1995
Reviewed: 6/1999, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/19/2009
Revised: 4/9/1998, 8/5/1999, 12/24/2007, 6/1/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE
NAUSEA / VOMITING

INMATE-PATIENT CONDITIONS:

1. Nausea and vomiting are manifestations of a large number of disorders not limited to the digestive system or abdomen.
2. This is not intended for the I/P with head or abdominal trauma, fever or complaint of abdominal pain.

SUBJECTIVE:

1. Note the timing and character of the vomiting (total estimated amount, early morning, relation to eating, color, odor, projectile)
2. Note any associated symptoms (vertigo, tinnitus, weight loss, effect of vomiting on any associate abdominal pain)
3. History of food ingestion.
4. Recent use of medication including type and amount.
5. History for unusual stressors.

OBJECTIVE:

1. Vital signs with attention to possible intravascular volume depletion (tachycardia, hypotension, skin pallor)
2. Breath odor (ketosis? alcohol?)
3. Weight and any evidence of wasting.
4. Altered autonomic activity (diarrhea, increased perspiration, hypersalivation)
5 Hematemesis (vomiting blood), coffee-ground emesis, feculent (foul smelling) emesis. Refer to on-site or on-call MD, if not available send to ED
6. Abdominal tenderness, rebound, guarding, distention, abnormal bowel sounds.

ASSESSMENT:

1. Risk for Fluid Volume Imbalance 1.4.1.2
2. Risk for Fluid Volume Deficit 1.4.1.2.2.2

TREATMENT PLAN:

1. Prevent dehydration: Restrict intake to clear liquids and crackers for 24 hours. Diet as tolerated the next 24 hours.
2. Compazine 25 mg suppository PR bid x 2 days; if pregnant, give no medication and refer to OB-GYN.
3. Monitor vital signs bid or more frequently if indicated.
4. If vomiting persists beyond 12 hours, notify on-site MD, if no MD available, send to ED.
5. Check blood sugar.
6. Consider urine pregnancy test if symptoms suggest possibility of pregnancy.

INMATE-PATIENT EDUCATION:

1. Inform I/P that most cases of nausea and vomiting are self-limiting.
2. Advise I/P to report to medical services if symptoms reoccur.

Revised: 08/05/99, 08/10/01, 12/03/07 and 9.30.09
Reviewed: 04/98, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08and 8.20.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

Orthopedic Emergencies

A. PATIENT CONDITIONS:

1. Any patient with an extremity swelling, discoloration or deformity, secondary to trauma.

B. SUBJECTIVE:

1. The patient complains of severe localized pain following trauma.
2. The patient complains of numbness or tingling distal to the injury.
3. The patient complains of difficulty moving extremity.

C. OBJECTIVE:

1. An extremity with apparent swelling and/or bruising.
2. An extremity that is pale and has absent or faint pulses.
3. An unstable joint.
4. An open wound near an apparent fracture site.
5. An extremity that is deformed, misaligned, or shortened.

D. ASSESSMENT:

Nursing Diagnosis:

1. Risk for infection
2. Acute Pain
3. impaired Physical Mobility
4. Ineffective tissue perfusion

E. TREATMENT PLAN:

1. If there is evidence of a bone protruding from the extremity, if there is a piercing of the skin or laceration at the site of injury, consider that this is an open fracture. The following treatment should occur:
    a. Control the bleeding;-caution should be taken in controlling bleeding, applying pressure and dressing when there is an obvious bone protrusion.
    b. Apply a moist sterile dressing over the laceration or pierced area.
    c. Check pulses proximal and distal to the injury.
    d. Check pulses proximal and distal in unaffected side.
    e. Apply a splint if injury is to an extremity.
    f. Re-check neurovascular status.
    g. Apply a splint if injury is to an extremity.
    h. Elevate the injured extremity at the level of the heart, if possible.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

Orthopedic Emergencies

i. Apply ice to the injured area.
j. Start IV 1 liter NSS TKO, Start IV on opposite extremity if upper extremity is injured.
k. If bone is obviously protruding through the skin, give one gram of Cefazolin (if allergies permit) and make sure tetanus is updated.
l. Transport to the emergency room.

2. Dislocation is the separation of two bones at a joint. Nerve and vascular damage can occur if reduction is delayed. Check for capillary refill (normal is less than 2-3 seconds) and documented findings.
   a. Check pulses in both extremities proximal and distal to the injury.
   b. Immobilize joint by splinting.
   c. Re-check neurovascular status.
   d. Apply ice to the injured area.
   e. Transport to the Emergency Room.
   f. In the event the joint spontaneously reduces itself, call on-site or on-call MD for further instructions.
3. Any fracture, dislocation or crush injury associated with absence or decrease of pulse and/or sensation of loss of function must be transported to an emergency room via 911.

4. A closed fracture is defined as a fracture where the skin remains intact.

   a. Check for capillary refill (normal is 2-3 seconds).
   b. Check pulses in both extremities proximal and distal to the injury.
   c. Apply a splint if injury is to an extremity.
   d. Re-check neurovascular status.
   e. Elevate the injured extremity above the level of the heart, if possible.
   f. Apply ice to the injured area.
   g. If X-Ray Tech in facility obtain an x-ray of the injured bone, include the joint above and below, if patient not being sent to the Emergency room.
   h. Call on-site or on-call MD for further instructions.

F. DOCUMENTATION**:**

1. Document the initial assessment of the extremity including the skin integrity.
2. Document all neurovascular results, including capillary; refill and pulses.

PATIENT EDUCATION:

1. Educate patient on the importance of maintaining proper alignment to extremity.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

Orthopedic Emergencies

2. Inform medical staff of any decrease in sensation, numbness, or tingling in effect extremity.

References

Dislocation: MedlinePlus Medical Encyclopedia, (n.d.), *National Library of Medicine-National Institute of Health,* Retrieved August 18, 2011, from www.nlm.nih.gov/medlineplus/ency/article /000014.htm

Lun-fung, T. (n.d.), Management of Open Fractures*, Asian Association of Dynamic Osteosynthesis,* Retrieved August 15, 2011, from www.aado.org/file/open=fracture-wsmar09/LFT se.pdf

Perioperative care of the patient with an open fracture, (n.d.), *Asian Association of Dynamic Osteosynthesis*, Retrieved August 15, 2011, from www.aado.org/file/open-fracture-ws_mar09/PMcjai.pdf

Smelzer, M. (n.d.), Making a point about open fractures, NursingCenter, Retrieved August 15, 2011, from http://www.nursingcenter.com/library/JournalArticle,asp?Article-ID+993089.

Implemented: 04/1999
Revised: 08/05/99, 6/11/13, 6/23/14
Reviewed: 04/98, 08/10/01, 08/02, 08/18/03, 08/09/04, 08/12/05, 7/31/01, 07/30/07, 07/10/08, 8/20/09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE
OTITIS EXTERNA

PATIENT CONDITIONS:

1. This is not intended for the patient who complains of hearing loss or dizziness or who has an abnormal appearing ear drum.
2. For ear infections that are refractory to previous treatments, refer patient to the first available MD sick call.

SUBJECTIVE:

1. Symptoms: i.e., complains of "earache", pain when pinna is pulled on or when tragus is pushed in.
2. Duration of symptoms, any change in hearing.
3. Past Medical History: Significant for autoimmune diseases; i.e., Lupus, HIV positive or other chronic illnesses, or repeated infections.

OBJECTIVE:

1. Vital signs - Temperature > 101 untreated or 100 treated, patient must be referred to MD sick call.
2. Ear exam: Record appearance of the external canal and the eardrum. Record redness, swelling, drainage or tenderness to touch.

ASSESSMENT:

Nursing Diagnosis:

1. Pain 9.1.1
2. Sensory/Perceptual Alteration: Auditory 7.2

TREATMENT PLAN:

1. Cleanse ear of wax with ear irrigation using debrox to clear additional wax if necessary using 5-10 gtts BID up to 4 days if needed.
2. Cortisporin Otic Suspension (Neomycin/PolymixinB/Hydrocortisone) 4 drops to the affected ear 3 times a day X 5 days. (Give to I/P for self administration).
3. If ear canal is tight; refer to MDSC.
4. Advise I/P that if symptoms persist after the treatment is completed to sign up for sick call.

PATIENT EDUCATION:

1. Dispense one bottle to the patient with instructions to administer drops to the affected ear(s).
2. Instruct I/P to lie with the affected ear upward for 5 minutes after instilling the drops
3. Instruct the I/P not to touch the dropper to the ear, fingers, or other surfaces.
4. Keep ear dry.
5. Report increased pain, fevers, decreased hearing.

Implemented: 10/01/95
Revised: 08/05/99, 08/10/01, 8.25.09 and 9.30.09
Reviewed: 10/96, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08, 8.20.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

LAB TESTING PRIOR TO ALL CT AND MRI STUDIES

I. PATIENT CONDITIONS:

A. An I/P's medical condition has been evaluated by a physician and a CT and/or an MRI study has been ordered as part of their work up.

II. SUBJECTIVE:

A. I/P's symptoms/complaints at the time of the exam warranted the ordering of additional radiological studies including but not limited to a Computed Tomography (CT) and/or MRI.

III. OBJECTIVE:

A. A CT and/or MRI study is a non-invasive radiological test used but not limited to:

1. Confirm the presence of tumors.
2. Identify vascular disease, pulmonary emboli and abdominal aortic aneurysms.
3. Identify injuries/trauma.
4. Visualize internal body structures.

B. CT and /or MRI studies can image bone, soft tissue and blood vessels simultaneously.

C. At times, contrast is used at times to highlight specific organs.

1. Contrast is an Iodine based liquid that can be administered orally, intravenously, or rectally.
2. A physician or radiologist will determine the need for contrast.
3. Contrast can be toxic to the kidneys and can cause kidney failure.

ASSESSMENT:

Nursing Diagnosis:

1. Risk of ineffective renal perfusion
2. Risk of poisoning
3. Potential for Injury

PROCEDURE :

1. MD will order CT and/or MRI study.
2. Once the facility has received authorization for the exam, schedule I/P for Lab and Treatment and draw blood.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

LAB TESTING PRIOR TO ALL CT AND MRI STUDIES

3. Complete the (Quest) lab requisition and enter test request as Basic Metabolic Panel #10165.
4. Ask the I/P if they have a history of renal disease or medical or any medical condition involving the kidneys and document information in JIMS.

Reference

Computed Tomography (CT): Questions and Answers - National Cancer Institute. (2003, September 8). *Comprehensive Cancer Information - National Cancer Institute*. Retrieved August 25, 2011, from http://www.cancer.gov/cancertopics/factsheet/detection/CT

CAT Scan (CT) - Body. (n.d.). *Mobile RadiologyInfo.org*. (2010, November 9). Retrieved August 25, 2011, from http://www.radiologyinfo.org/en/info.cfm?pg=bodyct#part_one

Computed Tomography (CT). (n.d.). *U S Food and Drug Administration Home Page*. Retrieved August 25, 2011, from http://www.fda.gov/radiation-emittingproducts/radiationemittingproductsandprocedures/medicalimaging/medicalx-rays/ucm115317

Implemented: 11.2.11

PATIENT CONDITIONS

I. To be treated, the patient shall have a rash that can be identified as scabies or lice.
II. The patient shall also have complaints of pruritus (itching).

SUBJECTIVE

I. Note patient's description of pruritus, rash, open sores and presence of eggs on hair shaft.
II. Women - note last menstrual period (LMP), if she is pregnant note gravida, para prenatal care, drug abuse, problems with this pregnancy or previous pregnancies or deliveries.

OBJECTIVE

I. Location of pediculosis/lice or scabies.
II. Note description of rash and appearance of skin.
III. Presence of open sores.
IV. Bites appear in a linear formation or in webs of fingers and toes.
V. Presence of eggs on hair shaft.

ASSESSMENT

Scabies, Pubic Lice (Pediculosis Pubis) or Head Lice (Pediculosis Capitis)

Nursing Diagnosis:
I. Impaired skin integrity
II. Potential for infection
III. Altered health maintenance

TREATMENT PLAN

Recommended treatment is also safe for pregnant women. Refer to MDSC for follow up.

I. Scabies
    A. Elimite Cream
    B. Benadryl 50 mg PO TID x 3 days as needed for itching.
    C. Follow up with provider as needed if no symptom relief.
II. Pubic Lice or Head Lice
    A. Nix Cream
    B. Follow up with provider as needed if no symptom relief.

COMMON SIDE EFFECTS OF MEDICATIONS:

I. Elimite & Nix cream – pruritus, burning, stinging, edema, tingling, scalp numbness or discomfort, mild erythema & scalp rash.
II. Vistaril – drowsiness, involuntary motor activity, dry mouth & constipation.

PATIENT EDUCATION

I. Scabies:
   A. Patient to turn in all bedding and clothing.
   B. After a bath, apply Elimite cream from the neck down and wash off thoroughly 8-14 hours after application.
   C. Scabies are spread through skin to skin transfer.
   D. Itching may persist for as long as 4 weeks, even though all mites have been killed. This is not an indication for retreatment.

2. Lice:
   A. Patient to turn in all bedding & clothes.
   B. Shampoo hair first.
   C. Work Nix thoroughly into hair, leave 10 minutes, and then rinse thoroughly.
   D. Nits should be combed out with a nit comb.
   E. Notify nursing staff if no improvement within 6-7 days.
   F. Instruct patient **not** to share any personal items with others.
   G. Inform patient that itching may increase right after treatment and that head lice is confined to the scalp but pubic lice is transmitted by sexual contact and may affect other hairy areas of the body.
   H. Olive oil treatment. See Nursing Guidelines.

Implemented: 10/1/1995
Reviewed: 10/1996, 8/10/2001, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/19/2009
Revised: 4/8/1998, 8/5/1999, 2/22/2005, 9/30/2009, 4/5/2018, 6/1/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

PHARYNGITIS (ACUTE BACTERIAL)

PATIENT CONDITION:

This patient will present with sore throat, fever and pharynx will be swollen, and red **with** exudates present.

SUBJECTIVE:

Complaints of sore throat and fever. May also complain of difficulty swallowing food.

OBJECTIVE**:**

1. Vital signs, documentation of appearance of pharynx (redness, swelling, presence of exudates and condition of cervical nodes).
2. Note any allergies.

ASSESSMENT:

1. Altered health maintenance 6.4.2
2. Pain 9.1.1
3. Risk for Infection 1.2.1.1

TREATMENT PLAN:

1. Swab throat for C&S before starting any medication
2. .Medications:
   a) PCN 500 mg PO bid x 10 days **OR** Rocephin 1 gm. I.M. x 1 dose
   b) Motrin 600 mg PO bid x 5days (if no peptic ulcer disease) for pain, inflammation and fever
   c) Schedule I/P for next provider sick call.
   d) **If allergic to Penicillin:**
   Keflex 500 mg 2 caps (1000mg) PO bid x 10 days

Common Side Effects of Medications:

a) PCN - mild diarrhea, vomiting & nausea
b) Rocephin - rash & diarrhea.
c) Motrin - abdominal cramps/pain & heartburn
d) Keflex - diarrhea

PATIENT EDUCATION:

1. Advise patient that symptoms usually go away in 2-5 days.
2. Gargle with warm H2O.
3. Advise patient to notify medical if symptoms worsen or do not go away.

Implemented: 10/01/95
Reviewed: 10/96, 08/10/01, 08/02, 08/18/03, 08/09/04, 8/12/05 and 8.19.09
Revised: 02/16/96, 04/09/98, 08/05/99, 07/00, 10/10/05, 7/31/06, 07/30/07, 07/10/08, 9.30.09

PATIENT CONDITIONS

I. This intended for any woman who suspects she may be pregnant or is obviously pregnant (has fetal heart tones).

SUBJECTIVE

I. Last Menstrual Period (LMP), Gravida, Para, and Abortions.
II. History of prenatal care and where followed.
III. Past Medical History: History of problems with previous pregnancies; i.e., gestational diabetes, spontaneous abortions, cesarean sections.

OBJECTIVE

I. Mother's vital signs, including fetal heart tones and fetal movement.
II. Urine pregnancy test (clinic or hospital where and when it was done).
III. Urinalysis to rule out infection (urine dipstick).
IV. Presence or absence of contractions or discharge.

ASSESSMENT

Nursing Diagnosis:

I. Altered Nutrition: Risk for More than Body Requirements
II. Altered Health Maintenance

TREATMENT PLAN

I. Perform urine pregnancy test.
II. If positive or obviously pregnant, schedule for MDSC and obtain previous prenatal records if any.
III. Pregnant women:
    A. Prenatal vitamins with iron 1 tablet PO QD x 60 days.
    B. Pregnancy diet x 60 days.
    C. Lower bunk for duration of pregnancy.
    D. Cleared to have an extra mattress noted in JIMS under Instructions with the appropriate duration period.

PATIENT EDUCATION

I. Take daily vitamins, appear for sick call and notify nursing staff if any cramping, vaginal spotting, vaginal bleeding or any other problems.

Implemented: 10/1/1995
Reviewed: 10/1996, 8/2002, 8/18/2003, 8/9/2004, 8/12/2005, 7/31/2006, 7/30/2007, 7/10/2008, 8/19/2009
Revised: 10/6/1996, 8/5/1999, 8/10/2001, 6/11/2003, 6/8/2004, 11/8/2010, 4/8/2011, 6/23/2015, 4/5/2018, 6/1/2018

PATIENT CONDITIONS

I. Patient who is discharged from a hospital after delivering a baby.
II. Patient who is newly arrested and who has recently delivered a baby.

SUBJECTIVE

I. History of a viable pregnancy.
II. History of the delivery process.
III. Pain.

OBJECTIVE

I. Vital signs.
II. Assessment of fundus height and firmness.
III. Assessment of lochia as to color, odor and amount.
IV. Assess bladder function.
V. Refer to hospital documents.

ASSESSMENT

Nursing Diagnosis:

I. Pain
II. Risk for infection

TREATMENT PLAN

I. All forms of vaginal deliveries:
    A. Overnight observation in MOB.
    B. Pain Control
        1. Pain Control
            a. If patient has no history of peptic ulcer disease give: Motrin 200 mg two tablets PO BID x 7 days as needed for pain, may provide keep on person (KOP) supply.
            b. If patient has a history of peptic ulcer disease give Tylenol 500mg two tablets PO BID x 7 days as needed for pain.
    C. Colace 100 mg PO BID for 7 days.
    D. Schedule ALL postpartum patients to be seen at the next MDSC.
    E. Discontinue extra mattress.

F. Read the hospital discharge paperwork carefully and contact onsite provider to verify orders, if not available, contact on-call provider.

II. C-Section:
- A. Overnight observation in MOB.
- B. Schedule post op C-section patients to be seen at the next MDSC.
- C. Instruct patient not to perform strenuous activity or lifting more than 10 pounds for 6 weeks.
- D. Pain Control
  1. If patient does not give a history of peptic ulcer and while in MOB give: Motrin 200 mg two tablets PO TID for 7 days may provide KOP supply.
  2. If discharged from MOB give: Tylenol 500 mg two tablets PO BID x 7 days
- E. Colace 100 mg PO BID for 7 days.
- F. Order middle or lower bunk x 6 weeks.
- G. Read the hospital discharge paperwork carefully and contact onsite provider to verify orders, if not available, contact on-call provider.

III. Breast feeding: The Nurse will ask each postpartum patients about their plans for breastfeeding.

A. If the patient plans to breastfeed:
1. Prenatal vitamins with iron1 tab PO q AM x 60 days.
2. Continue pregnancy diet (still needs extra calories for breastfeeding).
3. Refer to NSG.B.3: Breast Feeding (Milk Collection).

B. If the patient is NOT breastfeeding:
1. Ice packs to each breast for 15 minutes TID for 3 days.
2. Abdominal binder to use as a breast binder for 3 days.
3. Discontinue pregnancy diet and prenatal vitamins.
4. Request clearance for a family member to bring a support/sports bra from home.
5. Limit fluid intake.

PATIENT EDUCATION

I. Instruct patient to massage abdomen and report any heavy bleeding, pain in legs, and any other discomfort.

II. Instruct patient to contact Medical if she notices changes in her condition
A. Increased vaginal bleeding.
B. Difficult or painful urination.
C. Changes in vaginal discharge.
D. Fever.

E. Redness or swelling in legs.

III. In addition to the above, if the patient has had a C-Section, instruct her to contact Medical if she notices the following:
   A. Increased redness or temperature at surgical site.
   B. Drainage or swelling at surgical site.

IV. Instruct patient to change pad frequently.

V. Instruct patient to shower daily and encourage personal hygiene.

References

Caesarian Birth Aftercare. (2007, May 1). *American Pregnancy Association*. Retrieved September 7, 2011, from www.americanpregnancy.org/labornbirth/cesareanaftercare.html

Post Partum Home Care for Mom, Family Birthing Center | St. Vincent's Medical Center. (n.d.). *St. Vincent's Medical Center | Bridgeport, Connecticut*. Retrieved September 7, 2011, from http://www.stvincents.org/healthservices/familybirthing/postpartumcare.cfm

Postpartum care: What to expect after a vaginal birth - MayoClinic.com. (2010, February 2). *Mayo Clinic*. Retrieved September 7, 2011, from http://www.mayoclinic.com/health/postpartum-care/PR00142

Implemented: 6/21/2004
Reviewed: 8/9/2004, 8/12/2005, 7/30/2007, 7/10/2008, 8/19/2009, 4/8/2011, 9/7/2011
Revised: 7/31/2006, 9/30/2009, 12/31/2014, 4/5/2018, 6/1/2018

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

PERITONEAL DIALYSIS CARE

PATIENT CONDITION:

1. The patient shall give a history of receiving peritoneal dialysis.

SUBJECTIVE:

1. Past Medical History, duration of illness and duration of peritoneal dialysis treatment
2. Note specific treatment, as well as all medications, dose, and last dose taken.
3. Prescribed dialysate
4. Note date of last prescription, name of prescribing doctor, and dispensing Pharmacy.

OBJECTIVE:

1. Complete the initial Screening and Dialysis Nursing Admission Record.
2. Check access site, observe for signs and symptoms of infection and refer to physician on duty or call [redacted] Physician on-call for abnormalities.
3. Refer to the appropriate SNP as it relates to other conditions as needed.

ASSESSMENT:

1. Alteration in Health Maintenance 6.4.2

TREATMENT PLAN:

1. The patient is to sign an authorization to release of medical records from the treating physician. Include in the request, copies of the last set of lab reports and medications, the time that peritoneal dialysis is done each day, and the amount of dialysate. This information for male I/Ps is to be faxed to [redacted]
2. The nurse will write orders and draw blood for the following lab tests.
    a. Chem 7 panel
    b. CBC
    c. Hepatitis B (Hep B Surface Antigen will be done STAT)
    d. Hep B Quantitative Assay will be done ASAP
    e. Hep C Antibody Test

    Note: if taking Coumadin, write a lab request and draw blood for PT and INR
3. Call the lab if STAT results are not faxed within four hours.
4. Results are to be available for the MD and Nephrologist by the next sick call.
5. Report all abnormal blood tests results to the MD at SC, or MD on-call.
6. Give PPD and/or chest x-ray.
7. Determine if the patient has a supply of dialysate at home and if someone can bring the supply to the jail on behalf of the I/P.
8. If the patient's supply of dialysate is inaccessible, refer the patient to the [redacted] Emergency Department for evaluation and disposition.
9. Schedule the patient for MD sick call for H&P early in AM.
10. All male patients are to be transferred to [redacted] Notify [redacted] desk nurse of pending transfer.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

PERITONEAL DIALYSIS CARE

11. Order Renal Diet
12. Notify Sheriff Dietician of admission.

PATIENT EDUCATION:

1. Instruct the patient to report any signs or symptoms: cloudy fluid, fever, abdominal pain, and tenderness.

Implemented: 04/08
Revised:
Reviewed: 07/10/08 and 8.19.09

PATIENT CONDITIONS

I. Inmate presents to 2nd stage screening and gives a medical history of seizures with one of the following.
   A. I/P is currently under the care of an MD.
   B. The I/P has a history of seizures but is not currently under an MD's care.
II. An inmate that is having a seizure.
   A. Symptoms of a seizure can include but not limited to:
      1. Drooling
      2. Eyes fluttering or rolling up
      3. Incontinence
      4. Shaking or tremors
      5. Staring
      6. Teeth Clenching
   B. These individuals might include but not limited to:
      1. An individual never having had a seizure
      2. An individual withdrawing from alcohol
      3. An individual currently being treated for a seizure disorder
      4. An individual having an acute head injury

SUBJECTIVE

I. The inmate admits to a history of a seizure disorder,- medical staff should note the year the seizure disorder was diagnosed and whether the seizure was secondary to a trauma, infection or substances (alcohol, heroin, benzodiazepines).
II. Information regarding last seizure
III. Obtain a list of current medications, last dose and last therapeutic blood level.

OBJECTIVE

I. Vital signs, orientation, and mentation.
II. Note old head injury, surgery scars or track marks.
III. Injuries from recent seizure activity; i.e. tongue trauma, ecchymosis, lacerations, etc.

ASSESSMENT

I. Nursing Diagnosis:
   A. Potential for Injury 1.6.1

TREATMENT PLAN

I. For the I/P that has a history of seizures, is currently not being treated and presenting to medical screening:
   A. Request lower bunk and lower tier for this patient
   B. Enter JIMS instruction “Seizure Disorder”
   C. Schedule I/P for MD Sick Call.

II. For the I/P that gives a past history of alcohol seizures and is currently withdrawing from alcohol initiate the Alcohol Withdrawal SNP.

III. For the I/P that is pregnant with a history of seizures presenting to medical screening
   A. Do not start them on Dilantin.
   B. Refer I/P to the next available MD or OB sick call for follow-up.

IV. For the I/P presenting to medical screening who has been compliant with seizure medication regimen:
   A. The I/P has been compliant with his/her medications with the last dose being within 48 hours, has had no recent seizure activity, and no signs of Dilantin toxicity (nystagmus, ataxia, confusion, bradycardia or lethargy or increased seizure activity).
   B. Start the I/P on their regular dose of Dilantin (if known).
   C. If patient does not know his/her usual regimen: Start the I/P on Dilantin 300 mg PO q hs x 30 days.
   D. Request lower bunk and lower tier for this patient
   E. Enter JIMS instruction “Seizure Disorder”
   F. Schedule I/P for MD Sick Call.

V. For the I/P presenting to medical screening who has been compliant with Dilantin as their seizure medication regimen but whose last Dilantin dose is greater than 48-hours:
   A. Draw Lab: Dilantin level prior to giving the Loading dose.
      1. If the I/P states or if outside medical or pharmacy records indicate that Dilantin hasn’t been taken for 1 month or longer, it is not necessary to draw a Dilantin level.
   B. Start medication: Dilantin 700 mg PO x 1 (Loading dose), the Dilantin 300mg PO qhs X 30 days. (**May be given no sooner than 4hours after loading dose.)
   C. Request lower bunk and lower tier for this I/P.
   D. Enter in the JIMS instruction section “Seizure Disorder”
   E. Schedule I/P for the next available MD Sick Call.

VI. For the I/P with a different medication regimen other than Dilantin:
   A. Verify medication orders as per guideline, with I/P’s pharmacy or physician.
   B. Contact the on-site or on-call physician for orders of verified medications.
   C. If the medications cannot be verified, contact the on-site or on-call MD for anticonvulsant orders.
   D. Request lower bunk and lower tier for patient.
   E. Enter JIMS instruction “Seizure Disorder”
   F. Schedule I/P for MD sick call for a follow up evaluation.

VII. For the individual that is having a seizure (with or without previous history of Seizures), contact the on-site MD or on-call physician.

VIII. Immediate emergency care is required when the seizures are ongoing, prolonged or repeated over a few minutes. This is a condition known as Status Epilepticus:

A. Call 911
B. Protect the airway
C. Protect I/P from self-harm
D. Administer oxygen (O2) at 10-15 liters/minute per non-rebreather mask.
E. Insert oral airway or nasal trumpet as indicated
F. Perform a capillary blood glucose test and if glucose is < 60 give 1 ampule of 50% Dextrose.
G. Start an IV with Normal Saline
H. Call the on-site or on-call MD for possible anticonvulsant medication.

PATIENT EDUCATION

I. Assess I/P's knowledge of his/her medical history.
II. Teach importance of compliance with medication and medical regime.
III. Educate I/P on the importance of a lower bunk for sleeping to avoid major injury if seizure should occur.

Implemented: 10/01/95
Reviewed: 10/96, 8/02, 8/18/03, 8/9/04, 8/12/05, 7/31/06, 7/30/07, 7/10/08, 8/11/09
Revised: 2/16/96, 8/05/99, 8/10/01, 1/20/04, 5/7/07, 5/16/11, 6/15/16

REFERENCE

Advance medical life support (1 edition ed.). (2011). Philadelphia: Mosby/JEMS.

Epilepsy: MedlinePlus Medical Encyclopedia. (n.d.). *National Library of Medicine - National Institutes of Health*. Retrieved May 16, 2011, from http://www.nlm.nih.gov/medlineplus/ency/article/000694.htm

PATIENT CONDITIONS

I. This is intended for the palliative relief of minor skin irritations.
II. Treatment may be initiated on any patient with the following symptoms or complaints. **Any patient who is potentially immunocompromised shall be referred to the MD for follow up.**

DEFINITIONS

I. **Bug Bite(s) Irritation** – Localized irritation caused by flea or mosquito bites. Itching at site with slightly raised reddened area.
II. **Chapped Lips** – A condition whereby the lips become dry and possibly cracked. It may be caused by the evaporation of moisture.
III. **Dermatitis** – Inflammation of the skin that may be acute with the clinical hallmarks being erythema, itching, blistering, scaling and thickening of the skin.
IV. **Dry Skin** – Dry, flaky, redness or itching skin.
V. **Pityriasis Rosea** – Inflamed annular (shaped like a ring) patch with a characteristic narrow scaling border. The trunk is most commonly affected. (Frequently misdiagnosed as ringworm) A week or so after the initial appearance there may be the eruption of similar but smaller lesions.

SUBJECTIVE

I. Inmate's complaints including:
    A. History
    B. Location

OBJECTIVE

I. Vital signs.
II. Skin condition.
III. Note color, texture, duration, itching, pain and drainage.

ASSESSMENT

I. Nursing Diagnosis:
    A. Alteration in Skin Integrity 1.6.2.1.2.1
    B. Risk for Infection 1.2.1.1
    C. Altered Health Maintenance 6.4.2

TREATMENT PLAN

I. **Chapped Lips:**
   A. Vitamin A + Vitamin D Ointment (Emollient) 1 sachet with instructions to apply a thin layer to lips as needed for 1-7 days.
   B. Encourage hydration

II. **Dermatitis: Acute**
   A. Give Hydrocortisone Cream 1% to patient and instruct him/her to apply topically bid for 1-7 days.

III. **Dry Skin:**
   A. Give 2 A&D ointment packets apply BID for 10 days.
   B. Encourage hydration

IV. **Pityriasis Rosea:**
   A. No specific treatment required, if inflammation and itching is present, refer to MD sick call.

VI. **In General** - Refer the patient to MD Sick Call Clinic if skin irritation has not resolved with initial treatment or if the patient is immunocompromised.

PATIENT EDUCATION

I. Keep skin clean and dry.
II. Apply medication as directed.
III. Educate patient to report to medical staff signs and symptoms of infection, i.e. redness, swelling, or/and drainage appear.

Reference

Dermatitis: Contact Dermatitis, Nummular Dermatitis, Atopic Dermatitis, and More. (n.d.). WebMD Better information. Better health. Retrieved May 4, 2011, from http://www.webmd.com/skin-problems-and-treatments/understanding-dermatitis-basics

Selenium Sulfide: MedlinePlus Drug Information. (2008, September 1). National Library of Medicine -National Institutes of Health. Retrieved August 29, 2011, from http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682258.html

Implemented: 10/01/95
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Revised: 08/05/99, 08/10/01, 09/04/02, 04/20/09, 8/22/11, 1/3/14, 2/28/14, 11/30/17, 7/23/18

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

SEXUALLY TRANSMITTED DISEASES
(Syphilis, Gonorrhea & Chlamydia)

PATIENT CONDITIONS:

1. An inmate/patient who has a positive laboratory result for Syphilis, Gonorrhea and/or Chlamydia.

2. An I/P identified by San Diego Public Health STD Department as being a contact to an active STD case.

SUBJECTIVE:

1. Complaints of burning on urination.

2. Vaginal itching.

3. Pain in the suprapubic area.

4. Painful or swollen testicles.

5. History of unprotected sex.

6. Rectal itching

OBJECTIVE

1. Vital signs.

2. Genital warts

3. Ulcerations or chancres

4 Drainage
   a. Males may have white, yellow, or green discharge from the penis.

   b. Females may experience increased vaginal discharge or vaginal bleeding between menses.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

SEXUALLY TRANSMITTED DISEASES
(Syphilis, Gonorrhea & Chlamydia)

ASSESSMENT:

Nursing Diagnosis:

1. Risk of infection
2. Alteration in Health Maintenance
3. Acute Pain

PROCESS

1. An I/P will advise medical that they would like to be tested for a sexually transmitted disease(s).

2. The I/P will be scheduled for either Lab & Treatment or RNSC.
   a. A specimen shall be collected for Syphilis, Gonorrhea, & Chlamydia and sent to the Public Health Laboratory.

   b. Documentation should include subjective and /or objective.

   c. Documentation should include if the I/P is asymptomatic (if applicable).

TREATMENT PLAN:

1. Ascertain whether the female inmate is pregnant.

   a. If she states that she is, prior to treatment, schedule for OBSC.

   b. If the I/P is unsure obtain a urine specimen and do a pregnancy test prior to treatment.

2. Ascertain whether the inmate is allergic to any medications

   a. Refer to MDSC if the inmate is allergic to antibiotics in either the Cephalsporin or Erythromycin family

3. Syphilis
   a. 1st dose- Bicillin LA (Long Acting) 2.4 MU Intramuscularly

   b. Additional treatment will be determined by either the physician or by the local Public Health STD Division if they are suspicious of either late latent or tertiary syphilis.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

SEXUALLY TRANSMITTED DISEASES
(Syphilis, Gonorrhea & Chlamydia)

1) In this event two additional injections will be ordered:
   a). #2 Bicillin 2.4 LA IM 7 days after the initial dose
   b). #3 Bicillin 2.4 LA IM 7 days after the second dose

c. Failure to treat on a weekly basis could require initiating the series again.

4. Gonorrhea and/or Chlamydia

   a. Ceftiazone (Rocephin) 250mg IM X1 dose

   b. Zithromax 1 GM p.o. X 1 dose

COMMON SIDE EFFECTS OF MEDICATIONS:

1. Bicillin –Pain at the injection site, nausea, vomiting, headache

2. Ceftiaxone (Rocephin)- pain/irritation at injection site, mild nausea or diarrhea, stomach cramping, rash, yeast infections of the mouth or vagina and headache.

3. Zithromax- Nausea, vomiting, diarrhea, abdominal cramps/pain, dizziness, ringing in the ears, decreased sense of smell

ALLERGIC REACTIONS

1. Allergic reactions can be life threatening.

2. Symptoms can include but not limited to:
   a. Hives

   b. Swelling of tongue, lips, face and/or throat

   C. Difficulty breathing and wheezing.

3. If indicated follow SNP for Anaphylactic Reaction.

PATIENT EDUCATION:

1. Practice safe sex by using condoms.

2. Discuss safe sex practice with your sexual partner.

3. Practice good personal hygiene.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

SEXUALLY TRANSMITTED DISEASES
(Syphilis, Gonorrhea & Chlamydia)

References

CDC - Gonococcal Infections - 2010 STD Treatment Guidelines. (2011, January 28). *Centers for Disease Control and Prevention*. Retrieved August 25, 2011, from http://www.cdc.gov/std/treatment/2010/gonococcal-infections.htm

MMWR Sexually Transmitted Disease Treatment Guideline 2010. (2010, December 17). *Centers for Disease Control*. Retrieved August 24, 2011, from www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf

Rocephin. (n.d.). *Drugs.com | Prescription Drug Information, Interactions & Side Effects*. Retrieved August 29, 2011, from http://www.drugs.com/rocephin.html

RX List. (n.d.). *RX List*. Retrieved August 29, 2011, from www.rxlist.com/bicillin_l-a_inj__tubex-drug.htm

Sexually Transmitted Diseases- Your Guide to STDs. (2010, March 12). *WebMD-Better information. Better health*. Retrieved August 25, 2011, from http://www.webmd.com/sexual-conditions/guide/sexual-health-stds

Zithromax (azithromycin) Information from Drugs.com. (n.d.). *Drugs.com | Prescription Drug Information, Interactions & Side Effects*. Retrieved August 29, 2011, from http://www.drugs.com/zithromax.html

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SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE
TETANUS ADMINISTRATION

PATIENT CONDITION:

The inmate/patient has not been immunized for Tetanus within the last 10 years and presents with one for the following conditions

Laceration
Any laceration that is potentially contaminated
Partial or complete nail avulsions,
Human or animal bites
Burns
Wounds with signs or symptoms of infection

SUBJECTIVE:

1. If the I/P gives a past medical history of medication allergies, specifically Tetanus-Diphtheria (Td) vaccine or Tetanus-Diptheria-Pertussis (Tdap), do not give the vaccine.
2. Inmate offers information on past immunizations to Adult Td, Tdap, Tetanus Toxoid, or Hypertet.

OBJECTIVE:

1. Vital signs, signs of infection, description of wound including size and exudate
2. Note mechanism of injury, date & time injury occurred.

ASSESSMENT:

Nursing Diagnosis:

1. Potential for Infection 1.2.1.1
2. Impaired Skin Integrity 1.6.2.1.2

TREATMENT PLAN:

1. Inmate/Patient has not had an immunization for Tetanus within the past 10 years. and now poses a risk of tetanus exposure due to his/her current injury.
    - Ascertain whether the Inmate/Patient is pregnant and schedule her to discuss the risks/benefits of the vaccine with the onsite MD.
    - Have Inmate/Patient read the information provided by the CDC regarding Tetanus immunizations. If the Inmate/Patient verbalizes understanding of risks and benefits continue protocols for administration.
    - After thoroughly cleansing the area, administer Tdap (Adacel) 0.5ml IM for adults 18-64 years of age, and for those who are pregnant
    - For Inmate/Patients 65 and older, administer 0.5ml IM of Td
        - Side Effects: localized pain, redness or swelling at injection site, fever, headache, fatigue, nausea, vomiting, diarrhea, stomachache
2. If I/P denies ever having an immunization for Tetanus, refer to next MD sick call within 24 hours to evaluate need for Hypertet.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE
TETANUS ADMINISTRATION

PATIENT EDUCATION:

1. Keep area clean and dry.
2. Instruct patient on signs and symptoms of infection.
3. Instruct patient to report to medical services if any signs of infection.
4. Instruct patient to keep Tetanus immunization current.
5. Give Vaccine handout.

Implemented: 10/01/95
Revised: 02/16/96, 08/05/99, 08/10/01, 03/17/08
Reviewed: 10/96, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08 and 8.11.09

ALL PATIENTs SHALL BE SCREENED FOR ACTIVE TB

TB RISK FACTORS:

I. High risk for TB exposure and infection:
   A. Immune compromised:
      1. HIV Positive
      2. Cancer treatment
      3. Organ transplant
      4. Prolonged use of Prednisone or other immunosuppressive agents.
      5. Others
   B. Have a history of chronic medical condition:
      1. Diabetes
      2. Respiratory – Complaints of cough (see Subjective Complaints)
      3. Renal disease (Chronic Renal Failure or on Dialysis)
      4. Gastric surgery i.e. Gastrectomy or Jejunostomy
   C. Have a history of ***high risk behaviors***:
      1. IV drug abuse
      2. Promiscuous sexual behavior
   D. Recent close contacts of a person with Infectious TB
   E. Pregnant
   F. Homeless
   G. Foreign born persons who have immigrated from TB endemic regions of the world (i.e. Mexico, Philippines, Vietnam, India, China, Haiti & South Korea)
   H. Patients in jails and prisons
   I. Previously infected persons
   J. History of positive TB Skin Test

ALL INMATES SHALL BE SCREENED FOR TB:

I. A digital CXR will be taken at the time of booking with the following exceptions:
   A. If the patient is visibly pregnant or states that she is pregnant
      1. The nurse will follow the algorithm for screening pregnant women (see attachment: page 5 of 5)
      2. The nurse will obtain QFT
   B. If the patient states that they have been x-rayed within the past 6 months through the San Diego Sheriff's detentions system then:
      1. The nurse will be required to ascertain the date of the last CXR and review the results.
      2. If the CXR was abnormal then a repeat CXR is required

SUBJECTIVE COMPLAINTS

I. Nurses shall interview patient for the following complaints:
   A. Cough
   B. Fever
   C. Night sweats
   D. Weight loss
   E. Hemoptysis
   F. Recent exposure to person(s) with active TB

DOCUMENTATION OF SYMPTOMS

Document the onset, duration, triggers and relief of symptoms in JIMS.

OBJECTIVE

Review of systems include vital signs and weight. Glean information from current and past medical history obtained during the Second Stage Medical Screening Questions. Obtain results of CXR and if abnormal complete the J204A and fax to the ICN (see Attachment 1 Decision Tree).

ASSESSMENT

Nursing Diagnosis: Altered Health Maintenance 6.4.2.

SCREENING/ASSESMENT

I. ABNORMAL CXR:
   A. The nurse will follow the decision tree algorithm for isolation based on the results of the CXR (see Attachment 1: page 4 of 5)
   B. The nurse will complete the J204A form and fax to the ICN
   C. The patient will be placed in a negative pressure respiratory isolation room as needed.
II. SYMPTOMATIC
   A. Inmates admitting to a cough, fever, night sweats, weight loss, hemoptysis regardless of CXR results
   B. The nurse will complete the J204A form and fax to the ICN
   C. The patient will be placed into a negative pressure respiratory isolation room
   D. Perform complete laboratory work-up to rule out tuberculosis as listed below.
III. LABORATORY TESTING:
   A. Full laboratory work-up to rule out tuberculosis includes but is not limited to the following tests:
      1. QuantiFERON – TB Gold (QFT) blood test
      2. Induced sputum collection X3 with the first specimen obtained upon rising and the next two collected at 8 hour intervals
      3. HIV testing or confirmed by history

4. MTB testing will be ordered by the ICN (when indicated) and does not require further collection of a specimen

SPUTUM COLLECTION

I. The initial induced sputum collection is obtained upon rising with two additional induced sputum collected at 8 hour intervals
II. The current contracted lab delivers sputum specimens to the Public Health Laboratory.
III. AFB smear testing is done M-F with the exception of holidays
IV. If AFB smears are received and results are negative, contact the ICN for instructions
V. If AFB smear is positive the ICN will be advised by Public Health. The ICN will then contact the facility MOB staff to advise that the patient remains in isolation until additional testing through the Public Health is completed.
VI. The ICN will advise the MOB staff of the final results and treatment plan

INFECTION CONTROL

I. Use of mask
   A. When the patient requires services outside of their isolation room, then the patient must wear a surgical mask
   B. When any staff member enters the isolation room or is in close contact with the patient, they shall wear an N-95 mask

PATIENT EDUCATION

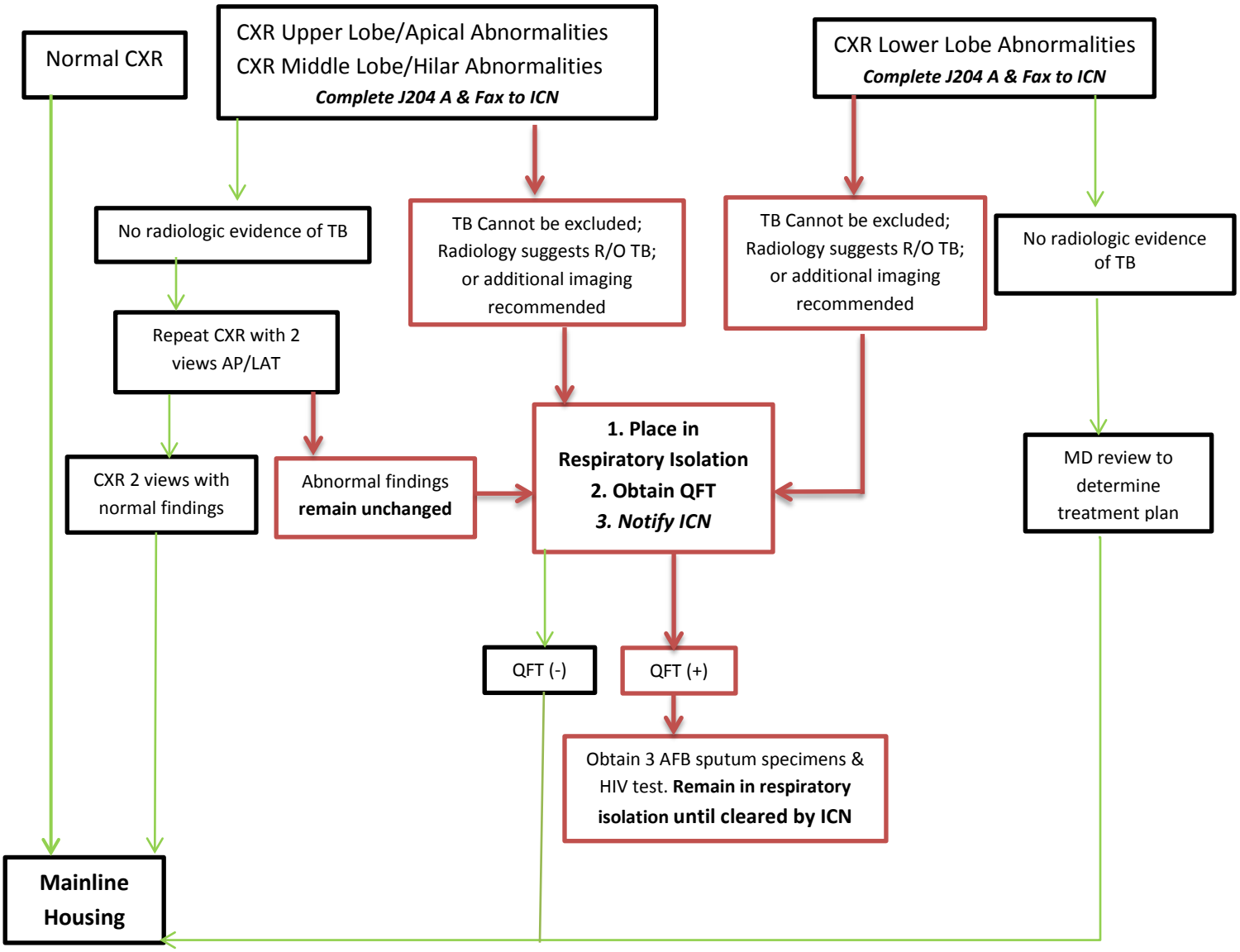
I. Cover mouth when coughing
II. Use provided surgical mask when instructed
III. Emphasize the importance of completing prescribed TB medication treatment
IV. Report any adverse reactions to medication

Implemented: 10/1/95
Reviewed: 10/96, 8/02, 8/18/03, 8/9/04, 8/12/05, 7/31/06, 07/30/07, 07/10/08
Revised: 2/16/96, 8/5/99, 8/10/01, 6/8/04, 11/30/06, 03/10/06, 03/27/08, 12/8/09, 7/30/11, 11/2/11, 10/13/16, 5/1/17

*****See Attachments #1 and #2:**
#1 Decision Tree Based on Chest x-ray located on page 4 of 5
#2 Decision Tree for X-Raying Pregnant Females located on page 5 of 5

Attachment 1: Decision Tree Based on Chest x-ray

(**NOTE:** *Symptomatic patients are placed in respiratory isolation for a complete work-up to rule out tuberculosis regardless of CXR result; Fax the J-204A to ICN*)



Attachment #2: Decision Tree for X-raying Pregnant Females

Scenario #1:
Individual states she is pregnant

↓

Do pregnancy test unless individual is visually pregnant

↓

Pregnancy test is negative

↓

Proceed with Chest X-ray

Scenario #2:
Individual states she is pregnant

↓

Do pregnancy test unless individual is visually pregnant

↓

Pregnancy test is positive
Complete J204A for all pregnant individuals and fax to ICN @ 619.258.3302

↓

Proceed to either #2A or 2B

Scenario #2A- Pregnant individual is asymptomatic
Obtain QFT, individual can be placed in general housing
Contact ICN with results of QFT in 24-48 hours

Scenario #2B - Pregnant individual is symptomatic
Place in isolation and advise ICN.

Implemented: 3/08
Revised: 12/09, 1/05/10, 7/30/11, 10/13/16, 5/1/17

INTRODUCTION

I. A high proportion of people at greater risk for TB occurs in the incarcerated population compared with the overall population. Effective TB prevention and control measures in correctional facilities include early identification of persons with active TB through entry and periodic follow-up screening, and successful treatment of active TB disease and TB infection.

PURPOSE

I. To describe an alternate procedure utilizing tuberculin skin test (TST) also known as purified protein derivative (PPD) skin test for tuberculosis (TB) screening will be in effect in the absence of chest x-ray screening.

PROCEDURE

I. Receiving Screening
   A. All inmates shall be screened for symptoms consistent with active infections or contagious diseases during receiving screening.
   B. TST is not indicated for patients denying general symptoms of infection or contagious disease during receiving screening with a normal chest x-ray on record within the last 6 months. Continue with routine booking process.

II. Symptomatic
   A. A positive response to the general symptoms for infection or contagious illness, namely: fever, lethargy, weight loss, loss of appetite or night sweats during receiving screening will be recommended for isolation in a negative pressure room, if available. If not available, coordinate with jail population management unit (JPMU) for alternate single cell housing.
   B. Add patient flag 'TB Workup' in the electronic health record denoting TB workup in progress to jail population management unit (JPMU) via jail information management system (JIMS).
   C. Perform the following work-up if inmate is determined to be fit for jail:
      1. Complete the Tuberculosis Assessment Form in the electronic health record.
      2. Obtain blood specimen for Interferon Gamma Release Assay (IGRA) testing, e.g. QuantiFERON-TB Gold (QFT-G) or QuantiFERON-TB Gold In-Tube test (QFT-GIT).
      3. HIV testing or confirmed by history.
   D. Schedule for provider evaluation, review available test results and determine indication for 2 views chest x-ray.

E. Notify infection control for follow up and further instructions.
F. Infection control to update 'TB Workup' patient flag accordingly based on provider evaluation and test results.

III. Asymptomatic (No TB Screening on record within the last 6 months)
A. Inmates denying general symptoms referenced above and have not had a normal chest x-ray on record within the last 6 months will be scheduled for second stage nurse evaluation for TST.
B. At the completion of TST placement with no significant clinical findings noted, inmate will continue with routine housing process per JPMU.

IV. TST Refusal (Asymptomatic)
A. Add patient flag 'Generic 5' in the electronic health record denoting pending TB screening to JPMU via JIMS. Cohort housing is recommended.
B. Schedule for next day registered nurse sick call (RNSC) to perform the following:
1. Complete the TB Assessment Form in the electronic health record.
2. Obtain blood specimen for IGRA testing e.g. QuantiFERON-TB Gold (QFT-G) or QuantiFERON-TB Gold In-Tube test (QFT-GIT).
3. If IGRA testing is declined, schedule for 2 views chest x-ray.
4. Obtain HIV status either by testing or confirmed by history.
C. Notify infection control for follow up and further instructions.
D. Infection control to discontinue 'Generic 5' patient flag accordingly when TB screening results become available i.e. TST skin test result, IGRA test result or 2views chest x-ray results.

V. PRIOR HISTORY OF POSITIVE TST (Asymptomatic)
A. If at any time, inmate reports a history of prior positive TST or have a prior documented positive TST in the system, do not administer TST.
B. Add patient flag 'Generic 5' in the electronic health record denoting pending TB screening to JPMU via JIMS. Cohort housing is recommended.
C. Schedule for next day registered nurse sick call (RNSC) to perform the following:
1. Complete the Tuberculosis Assessment Form in the electronic health record.
2. Obtain blood specimen for Interferon Gamma Release Assay (IGRA) testing, e.g. QuantiFERON-TB Gold (QFT-G) or QuantiFERON-TB Gold In-Tube test (QFT-GIT).
3. If IGRA testing is declined, schedule for 2 views chest x-ray.
4. Obtain HIV status either by testing or confirmed by history.
D. Notify infection control for follow up and further instructions.

E. Infection control to discontinue 'Generic 5' patient flag accordingly when TB screening results become available i.e. IGRA test result or 2views chest x-ray results.

VI. TST RESULT INTERPRETATION

A. Negative TST (<5mm)
   1. No additional work up indicated.

B. Positive TST (>5mm) - Asymptomatic
   1. Add patient flag 'Generic 5' in the electronic health record denoting pending TB screening to JPMU via JIMS. Cohort housing is recommended.
   2. Obtain blood specimen for Interferon Gamma Release Assay (IGRA) testing, e.g. QuantiFERON-TB Gold (QFT-G) or QuantiFERON-TB Gold In-Tube test (QFT-GIT).
   3. If IGRA testing is declined, schedule for 2 views chest x-ray.
   4. Schedule for provider evaluation including review of available test results and recommended precautions based on findings.

C. Notify infection control for follow up and further instructions.

D. Infection control to discontinue 'Generic 5' patient flag when TB screening results become available i.e. IGRA test result or 2views chest x-ray results.

VII. IGRA (aka QFT-GIT) RESULT INTERPRETATION

A. Negative Result
   1. Schedule for provider evaluation to determine indication for latent TB infection (LTBI) treatment, review available test results and presenting symptoms.
   2. Discontinuation of current precautions will be in collaboration with provider and infection control.

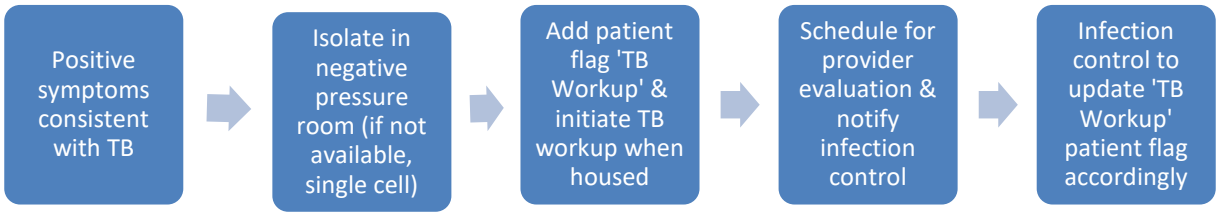
B. Positive Result
   1. Observe airborne precautions and recommend isolation housing in a negative pressure room.
   2. Add patient flag 'TB Workup' in the electronic health record denoting TB workup in progress to jail population management unit (JPMU) via jail information management system (JIMS).
   3. Obtain induced sputum specimen x3 with the first specimen obtained upon rising and the next two collected at 8-hour intervals.
   4. HIV testing or confirmed by history, if not already done.
   5. Schedule for provider evaluation, review test results and order 2 views chest x-ray.
   6. Notify infection control for follow up and further instructions.

7. Infection control to update 'TB Workup' patient flag accordingly based on provider evaluation and test results.
8. Discontinuation of current precautions will be in collaboration with provider and infection control.

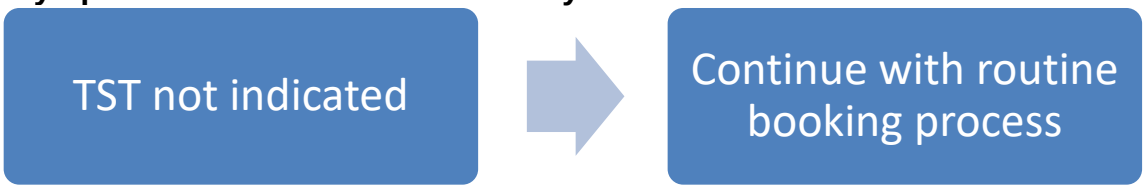
Implemented: 6/23/2020
Reviewed: Enter Dates
Revised: Enter Dates

TUBERCULIN SKIN TESTING (TST) ALGORITHM DURING RECEIVING SCREENING

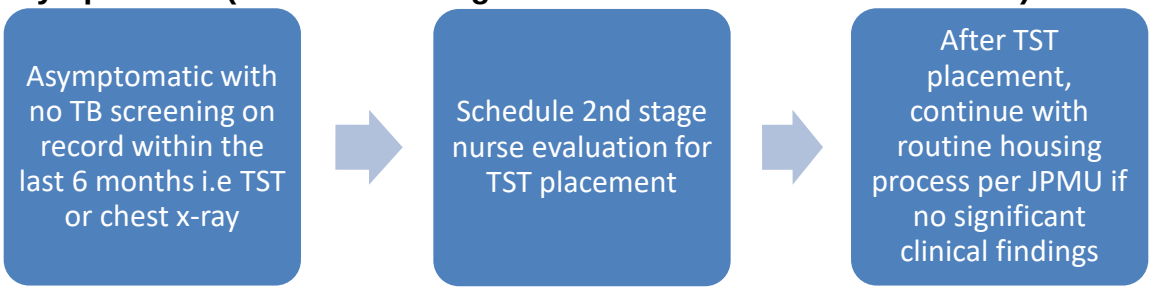
A. Symptomatic



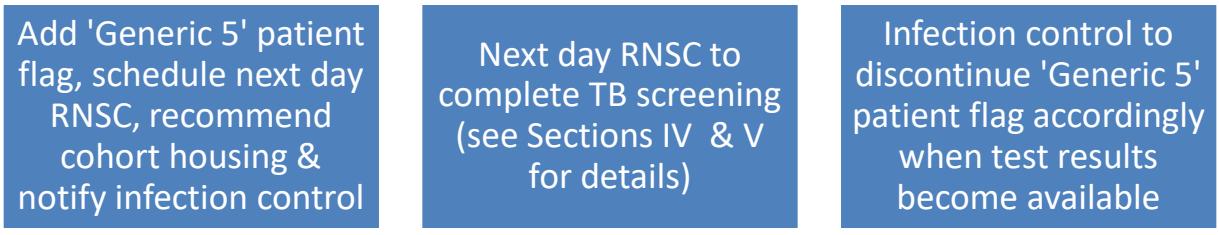
B. Asymptomatic with normal chest x-ray on record within the last 6 months



C. Asymptomatic (No TB screening on record within the last 6 months)



D. Asymptomatic (Refusing TST or with History of Positive TST)



SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

URINARY TRACT INFECTION

PATIENT CONDITIONS:

1. This is not intended to treat the inmate/patient (I/P) with gross hematuria and/or recent trauma to flank or costal vertebral angle tenderness (CVA tenderness).
2. This is not intended to treat the I/P who complains of penile or vaginal discharge and may have a sexually transmitted disease, start SNP for STDs.
3. This is also not intended for pregnant women.

SUBJECTIVE:

1. I/P complains of urgency, frequency and pain or discomfort with urination,
2. I/P states that their urine color is cloudy or pink
3. I/P might state that their urine has a strong odor
4. The following subjective complaints should not be treated using the SNP and needs to be referred to the MD
    a. If the I/P gives a history of renal disease or renal insufficiency
    b. If the I/P reports a history of recent trauma to flank
    c. If the I/P states that she is pregnant

OBJECTIVE:

1. Vital signs
    a. An I/P with a urinary tract infection can run a mild temperature. (Temp less than 101).
    b. I/P's with a temperature of 101 or greater could indicate a more serious kidney infection and needs to be referred to the next MDSC.
2. Suprapubic pain on palpation.
3. Flank pain on percussion
4. Lab- Positive UA dipstick
    a. To initiate treatment: urine should be positive for WBC's;

ASSESSMENT:

Nursing Diagnosis:

1. Pain 9.1.1.
2. Altered Urinary Elimination 1.3.2.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

URINARY TRACT INFECTION

TREATMENT PLAN:

1. Bactrim DS PO bid x 3 days if I/P is not allergic to Sulfa.
2. If the I/P is allergic to Sulfa give: Cipro 500 mg bid X 7 days
3. Pyridium 100 mg PO bid X 1day
4. Refer to MD sick call for follow-up.

Common Side Effects of Medications:

a. Bactrim DS – Nausea, vomiting, headache & loss of appetite.
b. Pyridium – Headache, dizziness, rash and GI upset.
c. Cipro- Nausea, vomiting and headache

DOCUMENTATION:

1. Note the color and clarity of the I/P's urine
2. Note the results from UA dip.
3. Note the action taken and if a urine specimen for culture and sensitivity was indicated.

PATIENT EDUCATION:

1. Inform the I/P that if he/she should advise medical if they
   a. Develop a fever of 101 or greater over the next 5 days
   b. Continue to have urinary symptoms for more than 3 days
2. Inform I/P that his/her urine will change from orange to red color after taking the Pyridum.
2. Encourage I/P to drink more fluids.
3. Inform the I/P to notify nursing staff if they develop a skin rash or redness, unusual bruising, or bleeding.

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

URINARY TRACT INFECTION

References

Cipro. (n.d.). *RX List*. Retrieved September 6, 2011, from www.rxlist.com/cipro-drug.htm

Pyridium. (n.d.). *RX List*. Retrieved September 6, 2011, from www.rxlist.com/pyridium-drug.htm

Urinary tract infection (UTI): Symptoms - MayoClinic.com. (n.d.). *Mayo Clinic*. Retrieved September 6, 2011, from http://www.mayoclinic.com/health/urinary-tract-infection/DS00286/DSECTION=symptoms

Urinary tract infection - Medications. (n.d.). *University of Maryland Medical Center | Home*. Retrieved September 6, 2011, from http://www.umm.edu/patiented/articles/how_antibiotics_used_treating_urinary_tract_infections_000036_8.htm

Implemented: 10/01/95
Revised: 08/05/99, 08/10/01, 3/6/07, 9/6/11
Reviewed: 02/16/96, 10/96, 08/02, 08/18/03, 08/09/04, 8/12/05, 7/31/06, 06/04/07, 07/30/07, 07/10/08 and 8.11.09

SAN DIEGO COUNTY SHERIFF'S MEDICAL SERVICES
STANDARDIZED NURSING PROCEDURE

WOUNDS

PATIENT CONDITIONS:

1. The I/P presents with an open wound, blister, abscess, etc.

SUBJECTIVE:

1. The I/P reports an infection of the skin or underlying tissue.
2. I/P may report spider bite.

OBJECTIVE:

1. An open area of the skin may have drainage, redness, swelling, and area may be warm to touch.
2. Physician drains an area by aspiration or I & D.

ASSESSMENT:

Nursing Diagnosis:

1. Alteration to Skin Integrity 1.6.2.1.2.1
2. Pain 9.1.1
3. Risk for Infection 1.2.1.1

TREATMENT PLAN:

1. Measure and photograph wound. Label photo with I/P's name, booking # and date picture was taken.
2. **Obtain a wound culture specimen**.
3. Send specimen to laboratory requesting a bacterial culture and sensitivity.
4. Complete the laboratory slip appropriately, noting if I/P is receiving any antibiotics and if so, name and length of antibiotic treatment.
5. Wound care (see SNP Abrasions SNP.A.1)
    a. Clean wound with Normal Saline.
    b. If prior to MD evaluation cleanse and dress wound and schedule patient for MD sick call.
6. Notify Infection Control Nurse of open and cultured wound.
7. Document on-going status of wound after every dressing change.

PATIENT EDUCATION:

1. Keep area clean and dry.
2. Keep wound dressing in place, report soiled dressing to Nursing Staff.

Implemented:
Revised: 01/20/04, 05/27/05, 06/13/07
Reviewed: 08/18/03, 08/09/04, 8/12/05, 7/31/06, 08/01/07, 07/10/08 and 8.06.09