

STANDING ORDERS FOR RN
[Only for Established patients]
Call MD/NP for new Patient.

If no consent form is on file, a telephone call to the parent or guardian is required to attempt to get a verbal consent. Document the reply. Ask for the consent to be signed and returned the next day. Also refer to the Emergency Protocol. Interim care can be given for an emergency without a consent form signed

Students with frequent complaints should be seen by MD/NP after the second visit.

Documentation and Billing:

- RN should use only 99211 billing code for their services.
- Can only bill for established patient and with standing orders in place.
- All billable encounters should be co-signed by Physician.
- Billing sheet should also be used for tracking services which are not billable.
- Tracking services encounter goes in a Tracking Box
- Billable services encounter goes to Mary for MD Serve.

Treatment for Acute Asthma Attack

Question to ask?

1. Have you wheezed before?
2. Do you have asthma?
3. Do you take any medications for your wheezing?
4. Are you allergic to medications, foods, and pollens/? If so, what type of reactions do you have?

Orders

1. Take vital signs: Temp, RR, HR and BP.
2. Listen to the lungs for wheezing. Wheezing may/may not be heard. The patient may complain of difficulty in breathing and have a history of asthma, and no wheezing, but the patient may still be having an asthma attack.
3. Use a peak flow meter to assess respiratory status. Follow asthma action plan.
4. Call MD/NP to discuss patient IF NEEDED
5. Albuterol pre-mix nebulizer solution. 2.5mg/3ml
6. After Nebulizer treatment repeat HR and RR. The HR may be elevated after the treatment that is considered a side effect of the medication. Let patient rest for 5–10 minutes and retake HR and RR. The HR should decrease slightly.
7. Evaluate the lungs for wheezing. Re-check peak flow meter readings. (reading should improve.)

If patient feels better and no wheezing is present, then refer the patient to Nurse Practitioner or MD for further treatment. Give patient an appointment to return to the clinic within 1 – 2 days.

8. If patient is still wheezing, but the wheezing has improved slightly, may give a second Nebulizer treatment. Re-check vital signs and peak flow.
9. Re-check after 10-15 minutes, if still wheezing or complaining of respiratory distress, notify the main office that EMS needs to be called, notify parents of patient. Document all attempts to notify parents and main office. Document vitals signs and the time that EMS leaves with patient.

**Problem: Musculoskeletal Injuries, Pain, and Swelling of Extremities
and Pain Associated with Sports**

Ask

1. Were you injured (in sports activity or fall, etc.) in last two days? When?
2. What did you do after the injury?
3. Are you able to use the involved body part at all?
4. How much pain are you having now (Middle School) with pain score
5. How is the problem interfering with your normal activities?
6. Have you ever injured this body part before?
7. Is there any swelling or bruising?

Orders:

Take vitals and do brief assessment

1. Apply ice to all injuries immediately for 15-20 minutes, 3 to 4 times per day for 48 hours.
2. Acute injuries (falling down stairs, etc.) refer to NP or MD if needed
3. Old injuries (injuries over 24 hours) apply ice and refer to NP or MD for evaluation. The patient should be seen that day – immediately if unable to use the body part.
4. you may give Motrin or Tylenol according to Protocol.

Problems: Menstrual Cramps

Ask:

1. Is the pain you feel usual for you?
2. When was your last menstrual period?
3. Is it different from your other periods?
4. Are you allergic to any medications?
5. Are you nauseated or have you vomited?
6. Have you had any vaginal discharge?
7. How many pads are you using?
8. Are you using any medication for cramps?

Orders:

Take vitals and do brief assessment

1. For usual Menstrual Pain
 - a. Discuss the problem with NP or MD and give as ordered:
Motrin according to Protocol Plan.
 - b. Hot water bottle may be placed on the lower abdomen.
 - c. Rest as indicated – return to class.
2. For severe pain or possible pregnancy
 - a. Refer to NP or MD
 - b. If not available, refer to school office.

Problem: Earache

Ask

1. How long have you had this pain?
2. Is the pain constant or intermittent?
3. Is there any drainage from your ears?
4. Is the earache accompanied by other symptoms, i.e., popping or clicking in the ears?
5. Do you have a cold or did you in the last two weeks?
6. Have you had a fever with this earache?
7. Have you inserted anything into your ears? What did you insert in your ear?
8. Have you been swimming recently?
9. Have you had this problem in the past?
10. Are you doing any home treatment?

Orders

1. **Take complete set of vital signs. And do brief assessment**
2. Patient with temp > 100F or 38C refer or discuss with NP or MD
3. Patients complaining of constant severe pain or pain for more than one day should be seen by NP or MD.
4. Patients with drainage from the ears should be seen that day by NP or MD
5. Patients with intermittent discomfort and no fever or drainage from ears, can remain in school and be seen by NP by appointment ASAP.
6. Tylenol or Ibuprofen tabs can be given for discomfort after discussing with NP or MD. Or per protocol

Problem: Discharge from Eye or Pain in Eyes

Ask

1. Was there any discharge on your eyelashes this morning when you woke up?
2. Were you hit in the eye in the last 24 – 48 hours?
3. Are your eyes burning or watering?
4. Did you notice something in your eye?
5. What were you doing special before this problem started?
6. Has this ever happened to you before?
7. Do you wear contact lenses?

Orders:

Take vitals and do brief assessment

1. If the student feels like something is in the eye or there is the possibility that the eye was irritated with a chemical, have NP or MD see the patient. If ordered, or per Standing order flush eye with normal saline.

Note: Students who are wearing contact should remove them first.

1. If the student has purulent discharge from the eye, refer to:
 - a. NP or MD
 - b. Patient should be referred to their Primary Care Physician for treatment if they do not have a consent form on file.
2. Eyes that are burning or watering refer to NP or MD
3. If there has been a blow to the eye:
 - a. Place a cold cloth over the eye.
 - b. Have a NP or MD see patient immediately
4. For an infectious condition – do not send to class, send him home!

Problem: Rashes and Insect Bites

Ask

1. How long have you noticed the rash?
2. Is it itchy? Is there any drainage from the rash?
3. Has the rash spread to other parts of your body? Location, appearance, size, lymph nodes?
4. Does anyone in your family have a rash like this?
5. Have you ever had a rash like this before?
6. Have you been outside in the last few days? (wooden areas)
7. Could you have been bitten by an insect?
8. Do you have any animals in your house?
9. Are you allergic to anything? (foods, medications, bees, etc.)

Orders:

TAKE VITALS AND DO BRIEF ASSESSMENT

1. All students who state they are allergic to bee stings should be seen by a NP or MD IMMEDIATELY!
2. Clinical caution here – if visible, pluck stinger. Once out, put ice on the area; observe the patient for 20 minutes.
3. Apply calamine lotion to insect bites.
4. All other rashes should be evaluated by the NP or MD. If the rash is extensive or if you think there is a possibility of contagious disease, e.g., chicken pox, have the rash evaluated immediately.
5. A cool cloth can be applied to rashes that are itchy.
6. If stinger is visible, remove with tweezers.

Problem: Nosebleeds

Ask

1. Were you hit in the nose or face prior to the onset of bleeding?
2. Has this ever happened before?
3. Do you have a cold or allergy? Symptoms – nasal discharge, a stuffy nose?
4. History of nose picking? Dry house, heat on in the house?

Orders:

Take vital and do brief assessment

1. Apply ice and pressure to the bridge of the nose and keep the patient sitting upright. Pressure should be applied for at least 5 minutes.
2. If bleeding does not stop in 5-10 minutes, take pulse, respiratory, and blood pressure and refer to the NP or MD.

Note: Patients who have frequent nosebleeds (once per week), should be referred to the MD or primary care physician for evaluation.

Problem: Stiff Neck or/or Pain in Neck or Shoulders

Ask

1. Did you wake up with this problem? How long has this been a problem?
2. Were you injured in the last 24 – 48 hours? Any swelling in the neck?
3. Has this ever happened to you in the past?
4. Do you have any other symptoms? e.g., headaches, blurred vision, vomiting, fever? Tingling or numbness? Sore throat?
5. Any voice changes – can't speak, can't swallow?
6. Have you been ill with a cold or any type of illness in the past week?
7. Any vision problems?
8. Have you been to the doctor for your frequent headaches?
9. What do you do at home for headaches?
10. Did anyone in your family get frequent headaches?

Orders:

1. **Take vital signs – Temp, Pulse RR,BP and DO BRIEF ASSESSMENT**

Refer Immediately to NP or MD if:

- a. Temp > 100
- b. Severe headache and stiff neck
- c. Elevated BP, pulse, or blurred vision
- d. Any swelling in neck? Throat?
- e. Always check spine
- f. History of cold or illness in past week
- g. Complaint of vomiting or blurred vision
- h. Look drowsy or ill

Scheduled Appointment with NP or MD

Call MD IMMEDIATELY if patient has high fever, stiff neck or sent to Primary Care Physician IMMEDIATELY.

Patient who reports that they woke up with a mild stiff neck that has gradually increased during the day (and who have normal vital signs) can be scheduled for same day or next day, to see MD.

Patients who report that they were injured in the last 24 – 48 hours and are not experiencing severe discomfort can be treated as outlined below and scheduled for walk-in time.

1. Warm water for 20 minutes.
2. Motrin according to Protocol.
3. The patient may return to class if pain has decreased. They should be instructed to return to clinic if pain continues or increase.

Problem: Toothache

Ask

1. How long have you had this problem?
2. Any other symptoms – i.e., earache, headaches, fever?
3. When was the last time you saw a dentist?
4. Mouth injury – look for gum swelling
5. Any recent dental procedure?

Orders:

TAKE VITALS AND DO BRIEF ASSESSMENT

1. Patient with no additional symptoms should return to class.
2. Take temp; if above 100 degrees, refer to NP or MD.
3. Tylenol according to Protocol.
4. Patient who have additional symptoms (i.e., earache, swelling of face and neck), elevated temp, should be referred to NP or MD.
5. Refer to dentist.

Problem: Sore Throat

Ask

1. How long have you had a sore throat?
2. Do you have any other symptoms, i.e., cold, runny nose, fever, rough voice
3. Any neck swelling?

Orders

1. Take vital signs and do brief assessment
2. If patient has fever and cervical lymph Adenopathy refer patient to Physician
3. For patient with temp > 100, give Tylenol according to Protocol .

Problem: Headache

Ask

1. Is this usual urgency type of headache you get?
2. How often do you get headaches?
3. Do you have any other symptoms, i.e., blurred vision, thick green or yellow nasal draining, vomiting or dizziness?
4. Any sensitivity to light
5. What do you do at home when you have a headache?
6. What makes your headache better?
7. Have you seen the doctor for headaches?
8. Did you receive a blow to the head in the last 24 – 28 hours?
9. Does anyone in your family get frequent headaches?
10. Did you eat before lunch?

Orders

1. **Check vital signs, temp, RR,HR,BP AND DO BRIEF ASSESSMENT**
2. Mild headaches:
 - a. Give Tylenol according to Protocol Plan. (be careful of the medications)
3. Patients with additional symptoms, or who describe headaches as severe:
Refer to NP or MD/PA.
4. Any patient who had a blow to head should be evaluated by NP or MD.
5. Snack if student had no breakfast or lunch.

Note: Patients with frequent headaches (2-3 x month) should be evaluated by NP or MD.

Problem: Abdominal Pain

Ask

1. Where is your pain?
2. What does it feel like?
3. Are you nauseated?
4. Have you vomited? Color
5. Have you had diarrhea in the last 24 to 48 hrs?
6. Are you sexually active? (females – ask for vaginal discharge)
7. When was last period? (females – are they in menstrual period now?)
8. History of trauma?
9. Are you constipated?
10. Any treatment of fever, cough, DIB, chest pain?
11. Have you been to the doctor for the pain?
12. How long has there been pain? Where? Severity?
13. Ask for urinary symptoms like burning, frequency.
14. Anyone in family get frequent stomachaches?
15. Ask for changed in diet, school, and home situation.
16. What did you eat today?

Orders

1. **Take all vitals signs AND DO BRIEF ASSESSMENT**
2. For mild-moderate stomach ache or abdominal pain – or looks sick (toxic look) refer to NP or MD
3. All patients with temp higher than 100 refer to NP or MD
4. All patients who are vomiting or have frequent diarrhea, should be seen by NP or MD.
5. If patient is sexually active and has abdominal pain, refer to MD.
6. If abdominal pain appears to be due to menstrual cramps , follow menstrual cramps protocol.

Note: Students with frequent complaints of abdominal pain or stomach ache (2-3 x months) should be scheduled to see MP or NP or Primary Physician.

Problem: Lacerations and Abrasions

Ask :

1. How did you get the cut?
2. When did it happen?
3. Size, location and depth of laceration.
4. Check record for tetanus shot if wound is deep and/or dirty.
5. Ask for last tetanus shot.
6. Wearing gloves, cleanse the wound with soap, water and hydrogen peroxide.
Lacerations less than 1cm in length and abrasions are no larger than a silver dollar in diameter, apply antibiotic ointment and cover with a bandage.

ORDERS:

1-Take vital signs and do brief assessment

- 2- Clean wound with normal saline and Betadine [Make sure no allergy to any meds]
- 3 Apply Bacitracin and Bandaid or dressing as needed.

Referral to NP/MD

1. Wounds on the head that were caused by a blow to the head should be evaluated by NP or MD after wound is cleaned.
2. Wounds that you suspect might have a foreign body in them.
3. Wounds caused by human bites (**MUST**) see MD or NP.
4. Animal bites
5. Wounds that do not stop bleeding in 1-2 minutes after direct pressure was applied.
6. Any wound that looks deep and gapping.

BURNS

Ask:

Brief history and assessment, take vitals

1. Note size – how did it happen.
2. New burns: **Immediately**, first aid should include application of ice pack for 20-30 minutes.
3. Cleanse old burns and new burns, after applying ice packs, with soap and water.
Do not break blisters.
 - a. Sterile dressing after discussing with NP or MD.
 - b. NP and MD should see all patients with 2nd degree burns.
4. If burned area is large (extends more than 2 inches, is blistered or there is evidence of skin loss) apply Silvadine and local sterile dressing
5. refer patient to MD OR NP for evaluation

Problem: Chest Pain

Ask

1. Where exactly is your pain?
2. What makes it better? Or worse?
3. Is pain constant, or comes and goes?
4. How long have you had pain like this before?
5. How long has the problem been there?
6. How and when did it start?
7. Have you had pain like this before?
8. Do you have other symptoms, such as pain in your arms, nausea, and abdominal pain, difficulty breathing, coughing or wheezing?
9. Have you ever been told you have Asthma, a heart murmur, or any other medical problem?
10. Have you been playing sports in the last 2 days or have you been hit in the chest?
11. Any history of anxiety, [nervousness] or hyperventilation , [rapid breathing]?
12. Any history of heart problems or heartburn?
13. What were you doing before the chest pain started?

Orders

Immediate Referral to NP or MD if patient is in distress. And /or has following symptoms

1. Take vital signs: If temp > 100 HR > .100, RR > 24, BP > 130/90 or less than 90/50 with severe chest pain. BP, age specific refer to MD or NP.
2. If patient is having difficulty breathing.
3. Patient who report a blow to chest in last 2 days.

Schedule appointment for same day.

1. Patient who is complaining of nausea, abdominal pain, coughs, etc., but vital signs normal.

Schedule appointment within 48 hours

1. Patient feels normal and in no obvious distress and states they have had similar episodes of pain in the past, should be allowed to rest 20 minutes, Tylenol

Note: Chest pain in teens is usually due to upper respiratory infection, colds, heartburn, and musculoskeletal injuries, but because some causes of chest pain may be serious such as (overdose, heart disease), all patients with this complaint should be discussed with NP or MD.

Ace Wrap Application

The RN may apply an ace wrap if:

1. Patient has diagnosed sprain or strain to a joint area and requires supportive therapy.
2. The patient requires the securing and compression of an ice pack to an injured area.
3. Motrin/ Tylenol according to Protocol Plan.

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| Immunizations and medications | ----- |

STANDING ORDERS FOR RN
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Documentations and Billing:

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- Billing sheet should also be used for tracking services which are not billable.
- Tracking services encounters goes in a tracking box.
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Immunizations and medications:

- **For Immunization please follow Immunization Protocol. Must be updated every year by replacing with new Recommendations from AAP, CDC, AIM kit, Email from Medical Directors and Physician etc.**
- **For Medication follow Medication Protocol.**

**HENRY FORD HEALTH SYSTEM
SCHOOL BASED HEALTH INITIATIVE
RN STANDING ORDERS
2005 – 2006**

Standing orders for the RNs at the Henry Ford Health System School-Based Health Initiative will be as follows:

RNs will provide health care following the guidelines and accepted practices established by the American Nurses Association and the Henry Ford Health System Ambulatory Nursing guidelines.

HFHS – SBHI PHYSICIAN SUPPORT

In addition to the standing orders and reference text, RNs will have continuous access, either directly or by pager to SBHI/HFHS physicians.

REFERENCES:

- 1- Clinical Guidelines in Child Health
- 2- Clinical Guidelines for School Nurses
- 3- Pediatrics Nursing Procedures
- 4- HFHS Online Ambulatory Nurse
Guidelines/protocols (<http://henry.hfhs.org>)
- 5- Nursing Drug Handbook
- 6- Harriet Lane Handbook of Pediatrics

STANDING ORDER: ACETAMINOPHEN ADMINISTRATION
(PAIN AND FEVER)

AURORA SCHOOL-BASED HEALTH PROGRAM

DATE: _____

1. Student demonstrates:
 - . fever over 101° F ('po')
 - . severe pain caused by a new acute injury

 2. Student has current Aurora School-Based Health Program 'Consent for Care Form' on file --- no evidence of prior history of Acetaminophen hypersensitivity

 3. Student's parent/contact person has been notified of (or attempt has been made to notify):
 - . fever and related symptoms causing need for antipyretic
 - . pain and injury causing need for analgesia

 4. ('po') dose:
 - .

 5. For a student with a fever, if possible, also:
 - . sponge with room temperature tepid water
 - . dress in lightweight cotton clothes
 - . increase oral fluid intake
 - . if the student is still at school, recheck the student's temperature 1 hour after the antipyretic was administered --- temperature should be less than 101° F ('po') then. If the temperature has not decreased to less than 101, contact covering Aurora FNP to further discuss plan of care

 6. For a student using acetaminophen for pain control:
 - . if possible, evaluate level of pain prior to administration (and 1 hour after) as verbalized by patient using scale of 1-10
 - . assist with basic comfort measures
 - . one hour after analgesic administration, pain should be reduced. If the pain has not decreased in intensity, contact covering Aurora FNP to further discuss plan of care
-

7. Patient/parent education:

- . do not exceed 5 doses in 24 hours in children
- . many over-the-counter products contain acetaminophen --- parents must remain alert to this when considering the total daily dose of this med
- . acetaminophen is for short-term use only. When using this for pain control, parent should contact Primary Provider if giving to children (less than 14 years old) for longer than 5 days or adults (over 14 years old) for longer than 10 days
- . if fever persists longer than 3 days, becomes recurrent, does not decrease to less than 101° F ('po') 60 minutes after administering correct acetaminophen dose/weight or if temperature is over 103° F ('po'), parent should contact Primary Provider to discuss
- . long-term use of acetaminophen may cause liver damage

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MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols and Standing Orders

NUMBER: PNH.09.29

TITLE: Asthma: Emergency Treatment in SBHCs

ORIGINATED: 06/04

LAST REVIEW DATE: 06/04

APPROVED:



CONTACT

PERSON/S: J. Fisher

PAGE 1 OF 3

Applies to: MCHD CHNs/RNs in School Based Health Centers

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE STATEMENT:

To allow MCHD CHNs/RNs to begin nebulizer treatment in MCHD Medical Director's name when a provider is not immediately available to assess the asthmatic client.

PROTOCOL:

Document presence or absence of any of the following in S-O-A-P format in the client medical record:

Subjective

Client may report any or all of the following:

- Client states or medical record documents a history of asthma
- Shortness of breath
- Wheezing
- Unremitting cough
- Tightness in the chest
- Unable to do routine activity
- Negative history of cardiac disease, hypertension, or hyperthyroidism

Objective

Client may demonstrate any or all of the following:

- Inability to speak, stops for breath mid-sentence or is gasping
- Appears frightened or wide-eyed
- Audible wheezing
- Wheezing on auscultation, minimal or absent breath sounds
- Tachypnea
- Cyanosis
- Retractions, nasal flaring or accessory muscle use

Assessment

Acute exacerbation of asthma/respiratory distress

Plan

1. Call 9-1-1 and notify another team member to contact the parent or guardian and school personnel.
2. Initiate [standing order](#), below.
3. Obtain vital signs as able.
4. Observe any progression of symptoms and prepare for possible respiratory arrest. **See [AGN.15.03](#), *Anaphylaxis and Acute Urticarial Reactions***
5. Remain with client until emergency response team arrives
6. Begin oxygen administration if a supply is available at the clinic
7. Put client in tracking for following day to obtain an outcome report via telephone from the parent or guardian. Arrange a follow-up clinic visit for the client within the next 3 clinical days.
8. Provider will order the CHN/RN to give education about prevention of future asthma exacerbations when the client is no longer in the acute stage.

STANDING ORDER FOR ALBUTEROL

CHN/RN will administer in the medical director Patsy Kullberg MD's name:

1. Albuterol with Saline prepackaged unit dose (.083%) per nebulizer stat.

DIRECTIONS:

Break open unit dose vial and squeeze contents into nebulizer reservoir. Set machine on full flow. Have client hold mask or mouthpiece and breathe in medication. This treatment will last between 5-15 minutes, depending on the client's respiratory rate. If emergency team has not arrived and client remains in distress, add a second unit dose vial and repeat the treatment.

2. Observe for drug side effects.
 3. If rash or swelling develop, activate standing order for anaphylaxis. See [AGN.15.03](#), ***Anaphylaxis and Acute Urticarial Reactions***
 4. Common side effects of albuterol include nervousness, shakiness, tachycardia, headache, chest pain, nausea, and lightheadedness. These should be noted in the chart if they occur.
 5. The 9-1-1 response team, upon arrival, will evaluate the client and recommend next steps.
 6. CHN/RN will document treatment in medical record and write "per standing order PNH.09.29 of Patsy Kullberg MD." CHN/RN will write medication on medication sheet with " PK/ his/her initials"
-

Last review date: June 2004

Also see [AGN.15.03](#), ***Anaphylaxis and Acute Urticarial Reactions***



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols and Standing Orders

NUMBER: PNH.09.27

TITLE: Chlamydia: Treatment of Positive Tests

ORIGINATED: 03/04

LAST REVIEW DATE: 03/04

APPROVED:

CONTACT
PERSON/S: Daniels

PAGE 1 OF 3

Applies to: CHNs/RNs in SBHCs and NHA clinics

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE:

To allow MCHD CHNs/RNs to write an order in the MCHD Medical Director's name for antibiotics to treat a positive or suspect positive Chlamydia test.

PROTOCOL:

Document pertinent positives and negatives in the medical record.
Document current medication and allergies

| | |
|---|---|
| SUBJECTIVE | |
| Uncomplicated CT | CT with possible complications |
| May have vaginal discharge or bleeding after sex Normal LMP within 30 days | Pelvic pain Unusual pain with sex Abnormal or no menses in last 30 days |
| OBJECTIVE | |
| Uncomplicated CT | CT with possible complications |
| Positive or suspect positive CT test Neg. UCG (if done) | Pos. or suspect pos. CT test Pt. appears ill, fever Positive HCG |
| ASSESSMENT | |
| Uncomplicated CT | CT with possible complications |
| PLAN | |
| Uncomplicated CT | CT with possible complications |
| Health teaching • Diagnosis - share information about CT using | Consult with provider |

| | |
|---|--|
| <p>CDC STD FAQs or current accepted department handout.</p> <ul style="list-style-type: none"> • Medication Teaching (According to Medication from standing order) <ul style="list-style-type: none"> * Azithromycin <ul style="list-style-type: none"> ○ Do not take if allergic to erythromycin. If allergic use Docycycline standing order and information. ○ Side effects: occasional GI problems. If vomiting within 2 hours of dose, notify clinic—may need repeat dose ○ Commonly used in pregnant and breast feeding women, no known ill effects ○ Suspension should not be given with food | |
| <ul style="list-style-type: none"> * Doxycycline <ul style="list-style-type: none"> ○ Do not take if allergic to tetracycline ○ Side effects: <ul style="list-style-type: none"> - Hypersensitivity - GI distress - Photosensitivity (avoid direct sun) ○ Drug interactions <ul style="list-style-type: none"> - May interfere with oral contraceptives Use back up method for OC through next cycle <p>Partners</p> <ul style="list-style-type: none"> • CHN/RN to advise and/or arrange for testing and treatment of partner • CHN/RN calls STD Disease Intervention Specialist to make report. 503 988 3702 • Based on client's age, CHN/RN arranges client interview with DIS regarding contacts or gives client STD exposure referral card and notifies client that DIS will be contacting client. • Advise sexual abstinence until any symptoms are gone and both patient and partner have been adequately treated. This means 7 days after single dose or completion of 7 days of doxycycline <p>Follow up</p> <p>Reinfection is common in adolescents. Advise females with CT to have repeat CT test in 3-4months.</p> | |

STANDING ORDER

For treatment of positive or “suspect” Chlamydia:

1. CHN/RN will offer treatment in the medical directors name with:
 - **Azithromycin,**
 - 1 gram orally, single dose,
 - Directly observed treatment in the clinic by CHN/RN

2. If patient unable to take Azithromycin CHN/RN will write a prescription in the Medical Director’s name for:
 - **Doxycycline**
 - 100 mg orally twice daily for 7 days
 - Do not use and consult with provider if pt. thinks she might be pregnant or is late on her period.
 - Do not use and consult with provider if pregnant or breast feeding patient.
 - CHN/RN to negotiate best access to medication with the patient including MCHD pharmacy.

3. CHN/RN will documents treatment in the medical record and write “per standing order of (insert name of current medical director, MD)” CHN/RN will write medication on medication sheet with “(Insert medical director’s initials)/CHN’s/RN’s initials”

Last review date: March 2004

changes, improper home washing of diapers. More common in infants >2-3 mos.

begin perianally and spread outward.

IRRITANT

Plan

1. Mild soap/water cleansing at each diaper change, air dry, then apply a thick layer of diaper cream (A&D, Desitin, Diaparene, others) or Vaseline. These act as a barrier to protect skin from irritants.
2. Frequent diaper changes.
3. Avoid plastic pants.
4. Expose diaper area to air as much as possible.
5. One cup vinegar added to final diaper rinse, if home laundering cloth diapers.
6. Provider referral or consult if no response to treatment in three days or if recent recurrence (two or more episodes within three to four weeks)

MONILIAL

Plan

1. Mild soap/water cleansing at each diaper change, air dry, then apply antifungal cream (OTC preparations available - clotrimazole or miconazole, prescription Rx. Nystatin Cream. None of these are currently covered by OHP. Treatment with Clotrimazole or miconazole is to apply to affected area 2 times per day until clear. Nystatin Cream is applied 3- 4 times per day (See [AGN.01.01, Guidelines for Drugs and Standing Orders.](#))
2. Frequent diaper changes
3. Avoid plastic pants.
4. Expose diaper area to air as much as possible.
5. Provider referral or consult if no response to treatment in three days or if recent recurrence (two or more episodes within three to four weeks).

OTHER

Plan

1. Provider referral.



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols and Standing Orders

NUMBER: PNH.09.19

TITLE: Dysmenorrhea: Immediate Treatment

ORIGINATED: 12/02

LAST REVIEW DATE: 12/02

APPROVED:



CONTACT

PERSON/S: Judy Fisher, FNP

PAGE 1 OF 2

Applies to: CHNs working in School Based Health Centers

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE: To allow MCHD CHNs to administer Ibuprofen in MCHD Medical Director's name

PROTOCOL

Document pertinent positives and negatives in the medical record in SOAP format

Subjective

Patient presents requesting analgesia for dysmenorrhea. Desires to complete school day activities. Denies allergy to Ibuprofen.

UNCOMPLICATED DYSMENORRHEA

- Pain scale (1:10) 6 or less
- Able to continue normal activities
- History of dysmenorrhea
- Expected time for menses
- If sexually active: denies painful intercourse or abnormal vaginal discharge
- Normal urination

COMPLICATED DYSMENORRHEA

- Pain scale 7 or greater
- Disrupts normal activities
- May lack history of dysmenorrhea
- Unexpected time for menses
- Sexually active: painful intercourse and or abnormal vaginal discharge
- Dysuria or history of urinary tract Infection
- Fainting, dizziness, fever or chills
- Excessive vaginal bleeding
- No menses within last 30 days

Objective

Appears in little or no distress

- Appears in acute distress
- Fever

Assessment

| | |
|--|---|
| Pelvic pain consistent with dysmenorrhea | <i>If any of the above are present:</i> Pelvic pain of unknown origin |
|--|---|

Plan

| | |
|---|-------------------|
| <ul style="list-style-type: none"> • If patient is less than 15 years in age contact parent or guardian regarding treatment plan. • If patient is 15 years old or greater offer parent or guardian contact regarding treatment plan. • Initiate standing order <p>Health teaching</p> <ul style="list-style-type: none"> • Dysmenorrhea is common in women under age 20 • Patient may want to continue Ibuprofen use at home • Rest with heat to the area PRN <p>Teaching: Ibuprofen</p> <ul style="list-style-type: none"> • Do not exceed 3.2grams/day • Take with food or milk <p>Follow up</p> <ul style="list-style-type: none"> • Return to see provider if treatment does not improve pain in 30-60 minutes or if pain worsens • If pain or bleeding increases, fever, chills or painful intercourse, seek urgent medical care. | Refer to provider |
|---|-------------------|

STANDING ORDER FOR Ibuprofen

1. CHN will administer in the medical director's name
 - Ibuprofen
 - Tablets
 - Ages 6-11 200mg
 - Ages 12 and over 400mg
 - Stat dose

2. CHN will document treatment in medical record and write "per standing order of (insert name of current medical director, MD)" CHN will write medication on medication sheet with "(Insert medical director's initials)/ CHN's initials"

Last review date: December 2002

SAMPLE RN PROTOCOL & STANDING ORDER

**Nurse Protocols and Standing Orders
TITLE: Headache Pain – Immediate Treatment**

LAST REVIEW DATE:

Applies to: RNs working XXXX Name of site and agencyXXXXX
Responsible MD:

PURPOSE: To allow RNs to administer a single dose of Acetaminophen in Medical Director’s name.

PROTOCOL: Document pertinent positives and negatives in the medical record in SOAP format

| | |
|---|--|
| <u>Subjective</u> | |
| Patient requesting analgesia for headache pain. Desires to complete school day activities. Denies allergy to Acetaminophen. | |
| UNCOMPLICATED HEADACHE | COMPLICATED HEADACHE |
| Pain scale (1:10) 6 or less | Pain scale 7 or greater |
| Able to continue normal activities | Disrupts normal activities |
| No recent head trauma | Recent head trauma |
| Gradual development of pain | Abrupt onset of pain |
| Full range of movement in neck | Neck stiffness |
| Normal vision | Vision disturbance and/or aura |
| | Vomiting or drowsiness |
| | Fever and or flu-like symptoms |
| | Mental status or behavior changes |
| | Weakness, paralysis, numbness, or slurred speech |
| <u>Objective</u> | |
| Appears in little or no distress | Appears ill: grimacing, holding head, eyes tearing |
| <u>Assessment</u> | |
| If any of the above are present, Uncomplicated headache pain | Complicated headache pain |
| <u>Plan</u> | |
| If patient is less than 15 years in age contact parent or guardian regarding treatment plan. | Refer to provider |
| If patient is 15 years old or greater offer parent or guardian contact regarding | |

SAMPLE RN PROTOCOL & STANDING ORDER

| | |
|--|--|
| treatment plan. | |
| Initiate standing order | |
| Instruct patient to make clinic appointment if headache is a recurring problem | |
| Return to clinic if analgesia does not relieve pain or if pain increases | |
| | |
| <i>Teaching: Acetaminophen</i> | |
| Do not exceed 5 doses in 24 hours | |
| | |
| <i>Follow up</i> | |
| Return to see provider if treatment does not improve pain in 30-60 minutes or if pain worsens | |
| Seek immediate medical treatment if: pain becomes severe, stiff neck develops, visual changes, unsteadiness, mental changes, protracted vomiting | |

STANDING ORDER FOR Acetaminophen

1. RN will administer in the medical director's name:

- Acetaminophen
- Tablets
 - Ages 6-11 325mg
 - Ages 12 and over 650mg
- Stat dose

2. RN shall document treatment in medical record and write "per standing order of (insert name of current medical director, MD)" RN shall write medication on medication sheet with " (Insert medical director's initials)/ RN's initials."




MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV NUMBER: PNH.09.20
CHAPTER: Nurse Protocols and Standing Orders

TITLE: Headache Pain – Immediate Treatment ORIGINATED: 12/02
LAST REVIEW DATE: 12/02

APPROVED:  CONTACT PERSON/S: Judy Fisher, FNP PAGE 1 OF 2

Applies to: CHNs working in School Based Health Centers

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE: To allow MCHD SBHC CHN's to administer a single dose of Acetaminophen in MCHD Medical Director's name.

PROTOCOL

Document pertinent positives and negatives in the medical record in SOAP format

Subjective

Patient requesting analgesia for headache pain. Desires to complete school day activities. Denies allergy to Acetaminophen.

| UNCOMPLICATED HEADACHE | COMPLICATED HEADACHE |
|--|--|
| <ul style="list-style-type: none"> • Pain scale (1:10) 6 or less • Able to continue normal activities • No recent head trauma • Gradual development of pain • Full range of movement in neck • Normal vision | <ul style="list-style-type: none"> • Pain scale 7 or greater • Disrupts normal activities • Recent head trauma • Abrupt onset of pain • Neck stiffness • Vision disturbance and/or aura • Vomiting or drowsiness • Fever and or flu-like symptoms • Mental status or behavior changes • Weakness, paralysis, numbness, or slurred speech |

Objective

| | |
|----------------------------------|--|
| Appears in little or no distress | Appears ill: grimacing, holding head, eyes tearing |
|----------------------------------|--|

Assessment

| | |
|-----------------------------|---|
| Uncomplicated headache pain | <i>If any of the above are present:</i> Complicated headache pain |
|-----------------------------|---|

Plan

| | |
|---|--------------------------|
| <ul style="list-style-type: none"> • If patient is less than 15 years in age contact parent or guardian regarding treatment plan. • If patient is 15 years old or greater offer parent or guardian contact regarding treatment plan. • Initiate standing order • Instruct patient to make clinic appointment if headache is a recurring problem • Return to clinic if analgesia does not relieve pain or if pain increases <p>Teaching: Acetaminophen</p> <ul style="list-style-type: none"> • Do not exceed 5 doses in 24 hours <p>Follow up</p> <ul style="list-style-type: none"> • Return to see provider if treatment does not improve pain in 30-60 minutes or if pain worsens • Seek immediate medical treatment if: pain becomes severe, stiff neck develops, visual changes, unsteadiness, mental changes, protracted vomiting | <p>Refer to provider</p> |
|---|--------------------------|

STANDING ORDER FOR Acetaminophen

1. CHN will administer in the medical director's name:
 - Acetaminophen
 - Tablets
 - Ages 6-11 325mg
 - Ages 12 and over 650mg
 - Stat dose
2. CHN shall document treatment in medical record and write "per standing order of (insert name of current medical director, MD)" CHN shall write medication on medication sheet with " (Insert medical director's initials)/ CHN's initials"

Last review date: December 2002



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols & Standing Orders

NUMBER: PNH.09.09
PREVIOUS NUMBER: 1530(1)

TITLE: Hormonal Contraceptive Refills: Assessment

ORIGINATED: 04/90
LAST REVIEW DATE: 01/04

APPROVED: 

CONTACT
PERSON/S: Salisbury

PAGE 1 OF 2

Applies to: RNs/CHNs in Primary Care, Neighborhood Health Access, HIV, SBHC

Responsible MD: Patsy Kullberg

Attachments: None

PURPOSE:

To allow MCHD RNs/CHNs to assess clients returning for hormonal contraceptive continuation and order refills as dictated by previous provider prescription.

PROTOCOL

Subjective

1. Client reports no interruption or discontinuation of method since initial visit.
2. Client denies any hospitalizations or serious illnesses since last visit.
3. Client is taking no new medications since last visit.
4. Client's last menstrual period (LMP) is within the last 30 days.
5. Client reports none of the following:
 - missed periods (except for DepoProvera®)
 - bleeding between periods (except for DepoProvera®)
 - severe abdominal pain
 - severe chest pain
 - severe headaches
 - dizziness
 - weakness
 - numbness
 - loss of vision or blurred vision
 - swelling, redness or pain in calf or thigh
 - recent onset of depression symptoms

6. Clients over 35 years old have not started smoking.

Objective

1. Take client's blood pressure
BP is not to be above the following based on age.

| Age: | BP |
|-------|--------|
| 12-17 | 125/85 |
| 18-24 | 137/86 |
| 25-44 | 140/90 |
2. Weigh client.

Assessment

1. If normotensive and interim history negative, may refill hormonal contraceptive per provider's prescription.
2. If blood pressure is elevated for age, consult provider before dispensing further hormonal contraceptives
3. If the interim history is positive, except for amenorrhea or break through bleeding on Depo-Provera, consult a provider before dispensing further hormonal contraceptives.
4. If the client is over 35 years old and just started smoking, consult a provider
5. Evra patch clients who now weigh >200 lbs, consult a provider.

Plan

- Refill hormonal contraceptive as prescribed by provider
- Instruct client on how to obtain method at pharmacy.
- Document refill on medication page of medical record.

Health Teaching

- Reinforce taking hormonal contraceptives as prescribed (see Hatcher Pocket Managing Contraception)
- Instruct on emergency contraception if interruption in use of method.

Last review date: January 2004

STANDING ORDERS**NOSEBLEED****REVIEW**_____
Initial_____
Date_____
Initial_____
Date_____
Initial_____
Date

- S. Use nosebleed worksheet to obtain subjective history to include if occurrence is an injury; if not an injury, obtain information regarding recent URI or sinusitis and how often they have been occurring.
- O. Amount of bleeding from nose; any bruises.
- A. Nosebleed related to:
- 1 Injury
 - 2 URI
 - 3 Sinusitis
 - 4 Dry humidity environment
- P:
- 1 Sit up, head tilted forward to prevent blood from running down back of throat.
 - 2 With thumb and index finger, apply firm continuous external pressure for 5 minutes (by the clock). If bleeding continues, repeat for another 5 minutes. If continues after 10 minutes, refer to physician or emergency room.
 - 3 Follow-up; Restrict excessive physical exertion remainder of that day only, especially if it is hot and sunny.
 - 4 Repeated nosebleeds: Refer to physician.

MEDICATION PROTOCOL FOR RN

Allergy status must be asked at each visit before administering any meds.

Tylenol: 10-15mg/kg /dose can be given every 4hr.as needed. Max- 5 doses/24 hrs.

Ibuprofen: 10mg/kg/dose can be given every 6hrs. as needed. Max -40 mg/kg/24hrs.

Sudafed: Less than 12 yr: 4mg/kg/day divide q 6hrs.

12 and above: 30mg/dose q 6hrs as needed. [Max dose is 240mg/day]

Oragel [Orabase]: can be use for local application for toothache. [Be careful ointment can interfere with Gag Reflex.]

Bacitracin/ Neosporine Ointment: can be use for local application for abrasion, laceration, open wound etc. Twice or three times a day as needed.

Lotrimin lotion/ointment: can apply locally for Tinea Corporis.

Hydrocortisone ointment1%: can be use locally for Eczema.

Antacid: Maalox /Mylanta – 5-15 ml as needed every 4hrs.

Call Physician / NP if you have any questions.



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols and Standing Orders

NUMBER: PNH.09.21

TITLE: Minor Trauma Pain: Immediate Treatment

ORIGINATED: 12/02

LAST REVIEW DATE: 12/02

APPROVED: 

CONTACT

PERSON/S: Judy Fisher, FNP

PAGE 1 OF 2

Applies to: CHNs working in School Based Health Centers

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE: To allow MCHD CHNs to administer Ibuprofen in MCHD Medical Director's name

PROTOCOL

Document pertinent positives and negatives in the medical record in SOAP format

Subjective

Patient presents requesting analgesia for minor injury. Desires to complete school day activities. Denies allergy to Ibuprofen.

UNCOMPLICATED BONE, SOFT TISSUE TRAUMA

- Pain scale (1:10) 6 or less
- History consistent with injury
- Mechanism of injury not suggestive of fracture (low velocity, low impact)
- Able to continue activity post injury

COMPLICATED BONE, SOFT TISSUE TRAUMA

- Pain scale 7 or greater
- History inconsistent with injury
- Mechanism of injury or force suggestive of fracture (high velocity/impact)
- Unable to bear weight
- Decreased ability to move limb normally because of weakness not pain
- Pain and swelling worsen 2 to 4 hours after trauma

Objective

- Absence of complications other than soft edema and/or discoloration
- Walks with a normal gait
- Full use of involved extremity

- Bone deformity to area
- Firm, tense edema
- Splinting or supporting injured area
- Decreased range of motion
- Grating or popping sounds at injured site
- Numbness, tingling, paresthesia in distal limb

Assessment

| | |
|--|---|
| Uncomplicated bone or soft tissue injury | <i>If any of the above are present:</i> Soft tissue or bone injury with complications |
|--|---|

Plan

| | |
|---|-------------------|
| <ul style="list-style-type: none"> • If patient is less than 15 years in age contact parent or guardian regarding treatment plan. • If patient is 15 years old or greater offer parent or guardian contact regarding treatment plan. • Initiate standing order <p>Health Teaching: RICE</p> <ul style="list-style-type: none"> • Rest: decrease weight bearing activity for 24 to 48 hours. • Ice: apply ice immediately then every 2 hours for 20 minutes. • Compression: compression bandage may be used for support. Instruct patient to take off at night. • Elevate: elevate injury above level of the heart <p>Teaching: Ibuprofen</p> <ul style="list-style-type: none"> • Do not exceed 3.2grams/day • Take with food or milk <p>Follow up:</p> <ol style="list-style-type: none"> 1. Patient may continue ibuprofen at home per over the counter instructions 2. Contact medical provider if pain fails to improve over 48 hours. 3. Contact medical provider if pain or swelling worsens over next 24 hours. | Refer to provider |
|---|-------------------|

STANDING ORDER FOR Ibuprofen

1. RN will administer in the medical director's name
 - Ibuprofen
 - Tablets
 - Ages 6-11 200mg
 - Ages 12 and over 400mg
 - STAT dose

2. CHN will document treatment in medical record and write "per standing order of (insert name of current medical director, MD)" CHN will write medication on medication sheet with " (Insert medical director's initials)/ CHN's initials"

Last review date: December 2002



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health, & HIV

NUMBER: PNH.09.12

CHAPTER: Nurse Standing Orders

PREVIOUS NUMBER: 1530(1)

Oral Contraceptive Refills:

ORIGINATED: 04/90

TITLE: Emergency Pack

LAST REVIEW DATE: 01/04

APPROVED:

CONTACT
PERSON/S: Salisbury

PAGE 1 OF 2

Applies to: RNs in Primary Care, Neighborhood Health, & HIV

Attachments: None

Responsible MD: Patsy Kullberg

PURPOSE:

To allow MCHD RN's to write a prescription in the MCHD Medical Director's name for one month of oral contraceptives to established MCHD clients who will run out of oral contraceptives before their next scheduled annual exam.

PROTOCOL

Document the following in the medical record in S-O-A-P format.

Subjective

| Uncomplicated OC refill | Possible contraindications to OC refill |
|---|---|
| <ul style="list-style-type: none"> No serious illness or hospitalizations since last visit No new medication since last visit Last LMP was within 30 days Client has not been off oral contraceptives more than two days. | <ul style="list-style-type: none"> Serious illness or hospitalizations since last visit New medication since last visit No LMP was within 30 days Client has been off oral contraceptives more than two days. |

Objective

Take client's weight and blood pressure (may omit if telephone contact only).

BP is not to be above the following based on age.

| Age: | BP |
|-------|--------|
| 12-17 | 125/85 |
| 18-25 | 137/86 |
| 25-55 | 140/90 |

Assessment

| Uncomplicated OC refill | Possible contraindications to OC refill |
|---|--|
| Normotensive and interim client history negative. Proceed with Plan | If the client has contraindications they should not be prescribed a hormonal contraceptive and must be referred to provider. |

Plan

- Initiate standing order for one cycle of O.C. most recently prescribed by MCHD provider.

Teaching

- Reinforce taking oral contraceptives as prescribed.

Follow up

- Schedule annual appointment now to avoid running out of O.Cs.

STANDING ORDER

RN/CHN will write a 1 month prescription in the MCHD Medical Director's name for the O.C. the client was most recently prescribed by MCHD provider.

Take 1 tablet by mouth daily.

Documentation


RN/CHN will document in the medical record and write "per standing order of MCHD Medical Director PNH.09.12". RN/CHN will write medication on medication sheet with "____" (insert MCHD Medical Director's initials)/his/her initials.

Last review date: January 2004



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

| | |
|---|--------------------------------|
| SECTION: Primary Care, Neighborhood Health, & HIV | NUMBER: PNH.09.25 |
| CHAPTER: Nurse Protocols & Standing Orders | PREVIOUS NUMBER: N/A |
| TITLE: Plan B – RN Standing Order | ORIGINATED: 01/04 |
| | LAST REVIEW DATE: 01/04 |
| APPROVED:  | CONTACT PERSON/S: M. Salisbury |
| | PAGE 1 OF 3 |

Applies to: RNs, CHNs in Primary Care, Neighborhood Health Access, Early Child Services, SBHC
Attachments: 1

Responsible M.D.: Patsy Kullberg

PURPOSE:

To allow MCHD RNs/CHNs to issue a prescription in the Medical Director's name for current or future use of Plan B.

PROTOCOL:

Protocol may be completed over the telephone if pregnancy testing is not indicated.

Document the following in the medical record in S-O-A-P format

Subjective:

| Uncomplicated Plan B initiation | Possible Contraindications for Plan B |
|--|--|
| Client requests emergency contraceptives for immediate or future use. | |
| Determine that the client's act(s) of unprotected intercourse has occurred within the last 72 hours. | More than 72 hours has elapsed since unprotected act of intercourse. |
| Last menstrual period has been within last 30 days. If LMP has been greater than 30 days run a pregnancy test. | Client is pregnant |

Objective:

| Uncomplicated Plan B initiation | Possible Contraindications for Plan B |
|--|--|
| if indicated: Pregnancy test is negative | if indicated: Pregnancy test is positive |

Assessment:

| Uncomplicated Plan B initiation | Possible Contraindications for Plan B |
|---------------------------------|---------------------------------------|
| Proceed with plan | Refer to provider |

Plan:

Initiate standing order for one cycle of Plan B for current or future use

Health Teaching:

- Plan B is an emergency contraceptive method and is not recommended as the primary contraceptive method.
- Review contraceptive methods.
- Plan B is most effective when taken as soon after unprotected intercourse as possible.
- Plan B should be taken within 72 hours after unprotected intercourse. Contact your provider if more than 72 hours has elapsed since unprotected intercourse. Once taken Plan B will not protect you from pregnancy with future acts of intercourse.
- Both pills in the package should be taken simultaneously.
- As with all hormonal contraception Plan B does not protect you from STDs.

Follow up:

- If the client has not had a menstrual period within three weeks of taking Plan B return to clinic for a pregnancy test.

STANDING ORDER:

RN/CHN will write a prescription in the Medical Director's name for one package of Plan B for immediate or future use.

Take both pills together within 72 hours of unprotected intercourse.



MULTNOMAH COUNTY
HEALTH DEPARTMENT

FOR _____ DOB _____

ADDRESS _____ DATE _____

Rx

Plan B

Sig. Take both pills by mouth together within 72 hours of unprotected intercourse

REFILLS _____ PROVIDER _____ DEA# _____
AFS# _____

Documentation

RN/CHN will document in the medical record and write “per standing order of MCHD Medical Director PNH.09.25.” RN/CHN will write medication on medication sheet with “___” [insert MCHD Medical Director’s initials]”his/her initials”

Last review date: January 2004

Attachment: Consent for Emergency Post-Coital Contraception (Morning After Pill)



MULTNOMAH COUNTY OREGON

HEALTH DEPARTMENT CLINICAL STANDARDS

SECTION: Primary Care, Neighborhood Health & HIV
CHAPTER: Nurse Protocols and Standing Orders

NUMBER: PNH.09.22

TITLE: Tooth Pain: Immediate Treatment

ORIGINATED: 12/02

LAST REVIEW DATE: 12/02

APPROVED:



CONTACT

PERSON/S: Judy Fisher, FNP

PAGE 1 OF 2

Applies to: CHNs working in School Based health Centers

Attachments: None

Responsible MD: Patsy Kullberg MD, MCHD Medical Director

PURPOSE: To allow MCHD CHNs to administer Acetaminophen in MCHD Medical Director's name

PROTOCOL

Document pertinent positives and negatives in the medical record in SOAP format

Subjective

- Patient presents requesting analgesia for tooth pain.
- Patient may report cause of tooth pain (recent orthodontic or dental work)
- Patient may be unaware of cause of tooth pain
- Denies allergy or adverse reaction to Acetaminophen

UNCOMPLICATED TOOTH PAIN

- Pain Scale (1:10) less than 6
- Able to continue normal activities
- Recent orthodontic visit

COMPLICATED TOOTH PAIN

- Pain Scale 7 or greater
- Disrupts normal activities

Objective

Appears in little or no distress

- Appears ill (grimacing, holding mouth, eyes tearing)
- Facial or jaw swelling
- Fever

Assessment

Uncomplicated tooth pain

If any of the above are present:
Complicated tooth pain

Plan

| | |
|---|--------------------------|
| <ul style="list-style-type: none"> • If patient is less than 15 years in age contact parent or guardian regarding treatment plan. • If patient is 15 years old or greater offer parent or guardian contact regarding treatment plan. • If tooth pain is of unknown cause, assist patient in accessing dental appointment and obtaining information from dentist regarding interim care of the problem • Initiate standing order <p>Teaching: Acetaminophen</p> <ul style="list-style-type: none"> • Do not exceed 5 doses in 24 hours <p>Follow up</p> <ul style="list-style-type: none"> • Instruct patient to keep dental appointment even if the discomfort improves | <p>Refer to provider</p> |
|---|--------------------------|

STANDING ORDER FOR Acetaminophen for treatment of tooth pain

1. CHN will administer in the medical director's name:
 - Acetaminophen
 - Tablets
 - Ages 6-11 325mg
 - Ages 12 and over 650mg
 - Stat dose
2. CHN will document treatment in medical record and write "per standing order of (insert name of current medical director, MD)" CHN will write medication on medication sheet with " (Insert medical director's initials)/ CHN's initials"

Last review date: December 2002