CLINICAL JUDGMENT MUST ALWAYS

SUPERCEDE PROTOCOL DETAILS

PROTOCOL: INFECTION CONTROL

If a resident's temperature is 100.5 (T), 101 (R) or above or any symptoms (example: nasal discharge, productive cough, etc.), then attempt to confine resident in bed or wheelchair in room until temperature returns to normal and no symptoms present for 24 hours.

When there is reason to believe that a resident has an infectious or communicable disease, the Attending Physician will be notified for appropriate precautions. Precautions shall remain in effect until discontinued by the Attending Physician.

If diagnosed with urinary tract infection or otitis media, only standard precautions are necessary.

Use gloves and full standard precautions for any contact with:

-blood
-body fluids visibly contaminated with blood
-purulent nasal discharge or tracheal secretions
-wound drainage or secretions
-diarrhea
-discharge from eyes or ears
-secretions from any area

Strict hand washing ENFORCED when resident has elevated temperature or any symptom.

Medical Director's Signature:

PROTOCOL: **RESPIRATORY DISTRESS**

Initiate the following if resident is having respiratory distress (rapid, shallow respirations and/or cyanosis):

-Check and record respiratory rate and quality, with O_2 saturation every one hour until improved.

-Check and record apical pulse, blood pressure and temperature every hour until stable.

-If O_2 saturation $\leq$ 90%, start O_2 by mask or nasal cannula, 3 liters per minute;
- -adjust O_2 flow rate to raise O_2 saturation above 90% up to 5 liters / min.
- -monitor O_2 saturation every 15 min until stable
- -once stable, monitor vital signs and O_2 saturation every 2 hrs while receiving O_2

-Elevate head of bed 15^o.

-Suction if indicated.

-Auscultate chest.

-If rales, rhonchi or diminished breath sounds are noted, then:
- -initiate chest physical therapy TID to promote cough
- -start postural drainage if not contraindicated
- -suction as necessary

-For wheezing, administer nebulizer treatment as per order sheet for the resident.

-Notify Attending Physician with above information.

Medical Director's Signature:

PROTOCOL: **FEVER**

When a resident spikes a fever, temperature ≥ 100.5 (T), 101 (R) or 99.5 (A):

Obtain full set of vital signs and oxygen saturation

Note presence or absence of:

-vomiting
-abdominal distension
-diarrhea
-cough
-purulent (yellow / green) nasal discharge
-purulent (yellow / green) pulmonary discharge
-conjunctivitis
-arousability
-irritability
-increased seizures

Check for:

-rash or sores
-eardrums for redness or discharge (use otoscope)
-throat redness, white patches
-nuchal rigidity (stiff neck)
-chest (auscultate)
-abdomen (for bowel sounds, tenderness, distension and impaction--if impacted, remove stool; see Protocol: Emesis)
-swollen anterior cervical nodes

If any abnormalities noted, notify Attending Physician for further orders.

Give acetaminophen or ibuprofen according to order sheet for that resident, PRN.

If resident is vomiting, may substitute acetaminophen suppositories mg / mg and administer rectally.

Give additional fluids (10 cc / kg per day) of Pedialyte or clear liquids for fever ≥ 101 (T) or 101.5 (R)

(see Protocol: Fluid Calculations for routine fluid requirements).

Monitor temperature every 1 hour until ≤ 101 (T) or 101.5 (R) and then every 4 hours until normal for 24 hours.

For a temperature ≥ 103.5 (T) or 104 (R), may use a tepid bath for 30 minutes.

Notify Attending Physician if:

resident's temperature is above 101 (T) or 101.5 (R) for 24 hours, if there are no other symptoms;

resident's temperature is above 102.5 (T);

there is no response to antibiotic treatment after 72 hours.

Medical Director's Signature:

PROTOCOL: ACUTE EMESIS

Note color and quantity of emesis:

if bloody or coffee ground, call Attending Physician.

Obtain full vital signs.

Vent G-tube and check for residual.

Check for:
-bowel sounds
-abdominal tenderness
-abdominal distension
-palpable abdominal masses
-impaction (note when last bowel movement occurred)

Notify Attending Physician if:
-bowel sounds absent
-abdominal tenderness present
-abdominal masses present

If impacted, may use bisacodyl / glycerin suppository or phosphate enema; may digitally remove impaction. If these procedures are not successful, proceed to a Fleet's enema.

Make NPO at time of next feeding.

Change diet to pedialyte or sick tray diet as tolerated for next 24 hours (see Protocol: Fluid Calculations).

Increase to normal diet as tolerated, if no further emesis.

For resident who has G-tube residual of greater than 50% of previous feeding, and is otherwise healthy, discard the residual and substitute next feeding with pedialyte (only one feeding should be substituted).

Notify Attending Physician of persistent emesis for further orders.

Medical Director's Signature:

PROTOCOL: DIARRHEA

Diarrhea: 2 or more loose or watery stools in 24 hours

Note color of stool:
if bloody or tar-black, call Attending Physician.

Obtain full vital signs.

Note whether there is nausea, vomiting, gagging.

Vent G-tube and check for residual.

Check for:
- -bowel sounds
- -abdominal tenderness
- -abdominal distension
- -palpable abdominal masses
- -impaction (note when last bowel movement had occurred)

Notify Attending Physician if:
- -bowel sounds absent
- -abdominal tenderness present
- -abdominal masses present

If impacted, may use bisacodyl/glycerin suppository or phosphate enema; may digitally remove impaction. If these procedures are not successful, proceed to a soap suds enema.

After two watery stools in a 24 hour period:
- -place resident on electrolyte solution for 24 hours (see protocol for fluid calculation);
- -hold Colace, Pericolace, mineral oil, prune juice, or any other laxatives.

If diarrhea continues place on sick tray diet until NO loose stools for 24 hours.

Resume regular diet after 24 hours if diarrhea cleared.

If diarrhea persists notify Attending Physician for further orders.

Medical Director's Signature:

PROTOCOL: DIARRHEA FROM THE USE OF ANTIBIOTICS

When resident is placed on antibiotic therapy, due to illness, and the resident starts having loose stools, start the resident on a Yogurt supplement.

Along with the resident's regular diet, (or altered diet, due to the illness) the resident will be placed on a Yogurt supplement twice a day:

For 10 to 20 kg. Resident: plain or flavored yogurt (live culture) 4 ozs. twice daily

For 20+ kg. Resident: yogurt (live culture) 6-8 ozs. twice daily

Medical Director's Signature:

PROTOCOL: HOLDING A MEDICATION

PURPOSE: Document and report when a nursing judgement is made that the resident does not require a certain medication at the time it is normally ordered.

PROCEDURE:

Nurse to make decision to hold medication based on good judgement.

Chart on medication sheet. Initial appropriate box and circle initials.

Chart in nurses notes and / or on the back of the medication administration record (MAR) the reason medication was held.

Attending Physician will be informed at time of weekly visit that medication was held.

IF IMPORTANT MEDICATION HELD, SUCH AS ANTICONVULSANT, ANTIBIOTICS, CARDIAC OR DIABETIC MEDICATION, THE ATTENDING PHYSICIAN MUST BE NOTIFIED IMMEDIATELY.

Medical Director's Signature:

PROTOCOL: CALLING FAMILY / GUARDIAN

The nurse is to notify the resident's family/guardian by telephone for the following situations:

- -The resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
- -There is a significant change is the resident's physical, mental or psychosocial status.
- -There is a need to alter the resident's treatment significantly.
- -A medication change has taken place.
- -It is necessary to transfer the resident to a hospital.

EXAMPLES WOULD INCLUDE:

-Cardiac or respiratory arrest
-Presence of significant respiratory distress that requires oxygen
-Presence of yellow or green pulmonary or nasal secretions that requires treatment and medication
-Presence of an infectious disease
-Started on a new medication or antibiotic
-Temperature of > 100.5 (T), 99.5 (A) or 101 (R) for greater than 24 hours with or without symptoms
-Lack of response of fever to antibiotics after 72 hours
-Status epilepticus
-Purulent drainage from ears, eyes or wound that requires treatment and medication

Medical Director's Signature:

PROTOCOL: CHICKEN POX

Notify Medical Director when first case of chicken pox is noted.

Initiate droplet precautions. Precautions shall remain in effect until discontinued by the medical director.

Notify Attending Physician immediately if a resident develops complications such as pneumonia or an elevated temperature that is not controlled by acetaminophen / ibuprofen. Also notify Attending Physician if purulent drainage develops from the skin lessions.

Treatment:

Confine resident from other residents or cohort residents with chicken pox.

Apply Calomine lotion to lesions to alleviate itching.

May give baking soda, oatmeal or Aveno baths to keep resident comfortable.

For severe itching or discomfort call physician for antihistamine order.

Give acetaminophen / ibuprofen for fever and discomfort as per resident's PRN orders.

Medical Director's Signature:

PROTOCOL: CALLING ATTENDING PHYSICIAN

The nurse is to notify the attending physician by phone for the following:

-accident or incident that results in injury

-an incident report is filled out for a serious event

-a decision has been made to transfer or discharge the resident from the facility

-an important medicine is held (such as anticonvulsant, antibiotic, cardiac or diabetic medications)

-suspicion of an infectious or communicable disease that would require precautions

-occurrence of chicken pox

-there is a significant change in a resident's physical, mental, or psychosocial condition.

Examples would include:

-cardiac or respiratory arrest
-presence of significant respiratory distress that requires oxygen
-presence of an infectious disease
-fever $\geq$100.5 (T) for greater than 24 hours without explanation
-lack of response of fever to antibiotics after 72 hours
-persistence of emesis
-emesis of blood or coffee ground material
-absence of bowel sounds or abdominal tenderness
-persistence of diarrhea $\geq$ 24 hours
-bloody or tarry stools
-increased lethargy
-status epilepticus
-purulent discharge from ears, eyes or wound

Medical Director's Signature:

PROTOCOL: FLUID CALCULATION

The following is a fluid requirement formula that is followed if a resident has an emesis and/or diarrhea:

Note: weight in pounds divided by 2.2 = weight in kilograms

Fluid requirements / 24 hours:

0 – 10 kg	=	100 cc / kg / 24 hrs
+ 10 – 20 kg	=	50 cc / kg / 24 hrs
+ over 20 kg	=	20 cc / kg / 24 hrs

Example: 25 kg resident

first 10 kg (10 x 100)	=	1000 cc
second 10 kg (10 x 50)	=	500 cc
over 20 kg (5 x 20)	=	100 cc
		1600 cc / 24hrs.

Medical Director's Signature:

PROTOCOL: SICK TRAY DIET FOR ORAL FEEDERS

Breakfast

1/2 cup clear juice
1/2 cup clear gelatin
toast with very little margarine
scrambled egg
pedialyte or, if resident prefers, soda pop

Lunch/Dinner

1/2 cup clear juice
6 oz. broth or light soup with crackers
1/2 cup clear gelatin
toast with very little margarine
scrambled egg or plain meat
pedialyte or, if resident prefers, soda pop

Medical Director's Signature:_____

PROTOCOL: CALLING THE MEDICAL DIRECTOR

All long-term residents have their own attending physician.

All respite residents have their own pediatrician / family doctor.

This pediatrician / family doctor is the attending physician during the respite stay.

This pediatrician / family doctor must sign all of the admission and medication orders.

For acute medical problems, if it is impossible for the nursing staff to reach the attending physician, then the nursing staff must:

-call the medical director for instructions and / or orders;

-make a fully detailed notation in the nurses' progress notes concerning the inability to reach the attending physician and that the medical director had to be called;

-ensure that during the next visit by the medical director to the facility, the medical director has an opportunity to write a progress note in the clinical chart concerning the event.

Medical Director's Signature:

PROTOCOL: HEAD INJURY

Definition: Any trauma to the head mild to severe, with or without immediate signs of injury.

Assess for the following:

Injury to the head
- -bleeding
- -laceration
- -bump
- -indentation

Vital signs
- -slow, irregular or shallow respiratory rate
- -irregular or rapid pulse

Pupilary abnormality
Vomitting
Loss of consciencousness
Bleeding from nose or ears
Leakage of liquid (CSF) from nose or ears
Agitation or restlessness
Change in affect
Diminished response to stimuli

Notify the attending physician with all of the above information

Continued assessments:

Vital signs and Neuro checks:
q 1 hour for 2 hours,
q 2 hours for 4 hours,
q 4 hours for 24 hours,
q shift for 48 hours.

Neuro checks are to include level of consciousness, pupil reaction, movement of four extremities, and response to stimuli.

Vital signs are to include P, R, BP and oxygen saturation.

Monitor for increased seizure activity, vomiting and leakage of CSF.

Medical Director's Signature:_____

PROTOCOL: REFUSAL TO EAT / DRINK

When an orally fed resident refuses 50%, or more, of required liquid volume, within a 24 hour period:

Obtain full set of vital signs and oxygen saturation

Note presence or absence of:

-sore throat
-vomiting
-abdominal distension
-diarrhea
-cough
-purulent (yellow / green) nasal discharge
-purulent (yellow / green) pulmonary discharge
-arousability
-irritability
-increased seizures

Check for:

-throat redness, white patches
-swollen anterior cervical nodes
-rash or sores
-eardrums for redness or discharge (use otoscope)
-nuchal rigidity (stiff neck)
-chest (auscultate)
-abdomen (for bowel sounds, tenderness, distension and impaction--if impacted, remove stool; see Protocol: Emesis)

If any abnormalities noted, notify Attending Physician for further orders.

Start monitoring and documenting all input and output.

Obtain daily weights.

Notify Attending Physician if there is a 5% or more weight loss.

Medical Director's Signature:_____

PROTOCOL: CRITICAL LABORATORY VALUES

TO BE CALLED TO ATTENDING PHYSICIAN

NOTE: OTHER LABORATORY VALUES ARE NOT TO BE CALLED

HEMATOLOGY

WBC	< 2.0	> 20.0
Hgb	< 8.0	> 25.0
Hct	< 24	> 60.0
Platelets	< 50	> 900

CHEMISTRY

BUN		> 69
Calcium	< 6.1	> 13
Glucose	< 40	> 200
Potassium	< 3.0	> 5.9
Sodium	< 120	> 158
SGOT		> 80

MEDICATION LEVELS

Carbamazepine (Tegretol)	> 15
Digoxin	> 2
Diphenylhydantoin (Dilantin)	> 30
Lithium	> 1.6
Phenobarbital	> 40
Theophylline	> 20
Valproic Acid (Depakene, Depakote)	> 150

MICROBIOLOGY (Cultures)

MRSA
VRE
All positive blood cultures
All positive C. Difficule toxins

Medical Director's Signature: _____