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ABSTRACT

Developed as the first of a two-part supplement to Technical Supplement Q for Standing Orders (TS-Q), this handbook of standing orders was designed to help health personnel at Comprehensive Employment and Training Act (CETA) Job Corps health centers meet the federal requirement that each center have a set of written standing orders on how to provide health services to corpsmembers. This working document begins with a brief introduction to its use followed by personal authorization forms and orders regarding their use for both health and non-health personnel. The next four standing orders are administrative ones covering the management of an emergency, the operation of a dispensary and an infirmary, and the referral of corpsmembers to emergency room and/or consultant or for hospital admission. Each of these administrative orders includes one or all of the following: flow chart of activities, pertinent content, and instructions regarding the procedures to follow. The remainder of this handbook is comprised of twenty-five technical standing orders and each one includes the activities in flow chart format followed by brief notes on relevant content. Some of the technical orders included are for the management of burns, lacerations, infected wounds, upper respiratory symptoms, abdominal pain, vaginal discharge, suspect acne, oral bleeding, depression, and anxiety. (EM)

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# COMPREHENSIVE EMPLOYMENT AND TRAINING ACT OF 1973

# JOB CORPS HEALTH PROGRAM

## A WORKING DOCUMENT FOR STANDING ORDERS

## PART I

## STANDING ORDERS FOR HEALTH PERSONNEL



U. S. DEPARTMENT OF LABOR
EMPLOYMENT AND TRAINING ADMINISTRATION
WASHINGTON, D. C. 20213

NOVEMBER 1977

# FOREWORD

## SCOPE

This document offers specific recommendations to assist center personnel in fulfilling the requirements of Title 29 Code of federal regulations (CFR) sections 97a.61 and 97a.62 as they appeared in the *Federal Register*. These portions of the regulations require that each center have a set of written standing orders on how to provide health services to corpsmembers.

## PURPOSE

ET Handbook 330-D has been designed to supplement the guidelines and logical framework in Technical Supplement Q for Standing Orders (TS-Q). This purpose is accomplished by providing:

1. A preliminary mechanism for evaluating health staff members' abilities and for designating those patient care activities each individual is expected to perform and not perform.

2. Administrative orders for the provision of health care at Job Corbs centers.

3. Specific technical recommendations for triage and treatment, based on the signs and symptoms presented by patients.

## IMPLEMENTATION

ET Handbook 330-D is effective for use upon receipt. Instructions for use are detailed in ET Handbook 330 (TS-Q).

## FURTHER INFORMATION

For further information contact:

Medical Director
Job Corps
Employment and Training Administration
Department of Labor
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## INTRODUCTION

This *Working Document for Standing Orders (ETH 330-D)* is designed to support "Technical Supplement Q for Standing Orders (TS-Q)." ETH 330-D provides the recommended individual standing orders written by the Job Corps national health staff. It is a looseleaf document that allows easy addition of new pages and deletion of revised or modified pages. ETH 330-D is separated into two parts; Part I provides orders primarily for health personnel and Part II is designed for non-health personnel.

ETH 330-D is expected to form the beginning of each center's comprehensive *Book of Standing Orders* for health care delivery. One blank authorization, four administrative orders, and a number of technical orders are included in this document (ETH 330-D, Part I). After discussion, the responsible personnel may want to adopt as written or tailor any or all of the standing orders.

The responsible personnel include: the center director (CD); the administrative officer or staff person responsible for health services (AO); the center physician (MD) who may be a doctor of medicine or osteopathy, the center dentist, or the center mental health consultant, as appropriate; and the center's health staff. After discussing, adapting, and adopting specific standing orders, the responsible personnel should sign and date the orders. Once the orders have been signed by the responsible personnel, the orders are incorporated as part of the center's *Book of Standing Orders* and should be followed by the center's personnel.

When the orders have been tailored to meet a center's unique needs and the responsible personnel have signed the orders, two "review packages" should be assembled. A review package consists of a cover memo that tells which orders have been adopted without any changes and which orders have been changed. Copies of the orders that have been modified should be attached to the cover memo. The administrative orders on the management of the dispensary and infirmary (H/NH 3 and H/NH 4) are orders that require completion and should be attached. Finally, the package must include a personal authorization for each member of the health staff (H 1).

In regions served by a nurse consultant, one of the review packages should be sent to him/her in care of the regional office. The nurse consultant will in turn send the various orders to the appropriate regional health consultants. The other review package should be sent to the Job Corps national health office. In regions that are not served by a nurse consultant, both review packages should be sent to the national health office. The national health staff will send the various orders to the appropriate regional health consultants. The other review package will be retained in the national health office for reference.

TS-Q further defines and outlines the concepts and policies involved in the review and implementation process for developing a viable set of standing orders, i e., a center's *Book of Standing Orders*. If there are any questions, TS-Q should be consulted first. The regional health consultants are also available to answer questions or offer advice regarding difficulties.

STANDING ORDER NH 1

_____ JCC

**PERSONAL AUTHORIZATION FOR NON-HEALTH STAFF**

Name of Non-Health Staff Member: _____

Title of Non-Health Staff Member: _____

| Functions in Absence of Health Staff Member: | YES | NO |
|---|---|---|
| 1. Open the dispensary | | |
| 2. Dispense over-the-counter medications: (e.g., aspirin, Maalox, Desenex) | | |
| a. | | |
| b. | | |
| 3. Take and record vital signs including: a. temperature | | |
| b. pulse | | |
| c. respiration | | |
| 4. Give first aid for minor problems including: a. sprains | | |
| b. contusions | | |
| c. abrasions | | |
| 5. Give basic first aid for major problems by: a. artificial respiration | | |
| b. external cardiac massage | | |
| c. treatment for shock | | |
| d. control of bleeding | | |
| e. splinting or stabilizing of fractures | | |
| 6. Evaluate illness or injury according to standing orders for the following conditions: a. burns | | |
| b. fractures, dislocations and sprains | | |
| c. lacerations | | |
| d. upper respiratory symptoms | | |

| | YES | NO |
|---|---|---|
| e. earache | | |
| f. abdominal symptoms | | |
| g. vaginal discharge | | |
| h. painful urination in females | | |
| i. painful urination in males | | |
| j. menstrual problems | | |
| k. rashes and skin problems | | |
| l. dental problems | | |
| m.headache | | |
| n. mental health problems | | |
| 7. Call the MD directly | | |
| 8. Send patient to ER directly | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |

DATE SIGNATURE

_____ _____, M.D.

_____ _____, AO.

_____ _____,

_____ _____,

Standing Order H 1

## PERSONAL AUTHORIZATION FOR HEALTH STAFF

This is a list of activities for patient care that may be performed by members of a Job Corps health staff. It is not meant to be all-inclusive. There should be a Personal Authorization List for each member of the center health staff. The MD will be asked to indicate which tasks can be delegated to each member of the health staff by checking either the YES or NO column.

The national health staff realizes that the level of delegation will be determined not only by the education, experience, and training of the nurse* in question, but also by the preferences of the MD responsible for the center.

To simplify the list, the health care functions are given in order of increasing complexity, beginning with the simpler tasks that most health personnel should be able to perform, and ending with the more complex tasks that only certified physician's extenders should be expected to perform.

This is a recommended list. The MD should feel free to make additions or revisions to this list of authorizations if necessary.

*Nurse as used here refers to physician's extenders (physician assistants or nurse practitioners), registered nurses, medical technicians (medics), and/or licensed practical or vocational nurses.

STANDING ORDER H 1

_____ JCC

# PERSONAL AUTHORIZATION FOR HEALTH STAFF

Name of Health Staff Member: _____

Title of Health Staff Member: _____

| Functions: | YES | NO |
|---|---|---|
| 1. Dispense over-the-counter medications | | |
| 2. Take and record vital signs including: a. temperature | | |
| b. pulse | | |
| c. respiration | | |
| d. blood pressure | | |
| 3. Complete the structured "Report of Medical History," SF-93, Technical Supplement-C, Revised May, 1976 | | |
| 4. Review health questionnaire, Form ETA 6-53 | | |
| 5. Conduct cursory medical inspection as outlined in Technical Supplement-C, including: a. vision and hearing tests (gross) | | |
| b. vital signs (temperature, pulse, respiration. blood pressure) | | |
| c. mouth | | |
| d. skin | | |
| e. genitalia | | |
| 6. Take specimen for throat culture | | |
| 7. Give oral polio vaccine | | |
| 8. Administer and read tine test for tuberculosis | | |
| 9. Give first aid for minor problems including: a. sprains | | |
| b. contusions | | |
| c. abrasions | | |
| 10. Maintain health records on SF-88 (Report of Medical Examination) and SF-600 (Chronological Record of Medical Care) | | |
| 11. Give basic first aid for major problems by: a. artificial respiration | | |
| b. external cardiac massage | | |
| c. treatment for shock | | |
| d. control of bleeding | | |
| e. splinting or stabilizing of fractures | | |
| 12. Conduct sick call, evaluate and treat illness or injury according to standing orders for the following conditions: a. burns | | |
| b. fractures, dislocations and sprains | | |
| c. lacerations | | |
| d. infected wounds | | |
| e. upper respiratory symptoms | | |
| f. earache | | |
| g. abdominal symptoms | | |
| h. vaginal discharge | | |
| i. painful urination in females | | |
| j. painful urination in males | | |
| k. menstrual problems | | |
| l. rashes and skin problems | | |
| m. dental problems | | |
| n. headache | | |
| o. mental health problems | | |
| 13. Do the following lab studies on-center: a. hemoglobin | | |
| b. hematocrit | | |
| c. urinalysis (dip stick type of screening for sugar and albumin) | | |
| d. pregnancy test | | |
| e. guaiac | | |
| 14. Decide whether commonly-performed lab studies are needed and, if so, initiate requests for: a. sickle cell | | |
| b. gonococcal culture | | |
| c. throat culture | | |
| d. Pap smear | | |
| e. serological test for syphilis | | |
| f. complete blood count | | |
| g. microscopic urinalysis | | |
| h. venipuncture to collect blood specimens | | |
| 15. Conduct entrance physical examinations as outlined in Technical Supplement-C, except for ophthalmoscopy, auscultation, pelvic and rectal exams | | |
| 16. Order full-size chest X-ray if tine test is positive | | |
| 17. Summarize patient problems to the physician | | |
| 18. Take unstructured patient history | | |
| 19. Dispense non-narcotic medications as outlined in standing orders or as ordered by the center physician(MD)(in writing or over the telephone) | | |
| 20. Sort out normal from abnormal lab test results | | |
| 21. Provide counseling on patient problems | | |
| 22. Evaluate patient progress or deterioration | | |
| 23. Take an EKG (does not mean interpret) | | |
| 24. Audiometry (does not mean interpret) | | |
| 25. Remove casts | | |
| 26. Administer parenteral medications as ordered by physician or as outlined in standing orders | | |
| 27. Administer tetanus toxoid and flu shots | | |
| 28. Suture minor lacerations | | |
| 29. Start intravenous infusions | | |
| 30. Conduct complete physical examinations including: a. ear, nose, throat exams | | |
| b. auscultation of heart and lungs | | |
| c. rectal | | |
| d. pelvic (including taking specimens for GC culture and Pap tests) | | |
| e. neurological | | |
| f. ophthalmoscopy | | |
| 31. Dispense or administer narcotics as ordered by the physician | | |
| 32. Remove foreign bodies from eye | | |
| 33. Manage the following chronic diseases after initial evaluation by physician: a. hypertension | | |
| b. diabetes | | |
| c. obesity | | |
| d. epilepsy | | |
| 34. Change dressings | | |
| 35. Teach patients how to use crutches | | |
| 36. Manage normal pregnancy | | |
| 37. Keep problem-oriented medical records | | |
| 38. | | |
| 39. | | |
| 40. | | |
| 41. | | |

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Standing Order NH 1

## PERSONAL AUTHORIZATION FOR NON-HEALTH STAFF

This is a list of activities for patient care that may be performed by members of a Job Corps staff other than health staff. It is not meant to be all-inclusive. There should be a Personal Authorization List for each center staff member who may be called on regularly to help sick or injured corpsmembers. The AO, with the assistance of the health staff and the MD, will be asked to indicate which tasks can be delegated to such members of the staff by checking either the YES or NO column.

The national health staff realizes that the level of delegation will be determined not only by the education, experience, and training of the staff member in question, but also by the preferences of the AO and MD.

To simplify the list, the health care functions are given in order of increasing complexity, beginning with the simpler tasks and ending with the more complex tasks.

This is a recommended listing. The AO or MD should feel free to make additions or revisions to this list of authorizations if necessary.

_____ JCC

# ADMINISTRATIVE ORDER FOR THE MANAGEMENT OF AN EMERGENCY OR URGENCY

Is a member of the health staff available?

## YES

Arrange for care by the most skilled health person available.

Does a life-threatening emergency exist according to the responsible health person? (a)

### YES

**Disposition I**

This patient should be rushed to the hospital as soon as possible. Health personnel should be able to provide the following basic emergency measures should it be necessary to take action until a physician assumes responsibility for the patient: (b)

a. Maintain airway.
b. Administer cardiac massage and artificial respiration.
c. Control bleeding.
d. Monitor vital signs.
e. Prevent shock.
f. Replace fluid loss with intravenous infusion, if authorized.

DATE SIGNATURE

_____ _____, M.D.
_____ _____,
_____ _____,
_____ _____,

### NO

But there is an urgency. (c)

Is the patient . . .

#### A corpsmember?

**Disposition II**

a. If needed, provide basic first aid (see Red Cross manual).
b. Summarize the patient's problem to the MD as soon as possible.
c. Follow MD's referral and/or treatment plan.
d. If no referral is necessary, health personnel should treat condition as specified in technical orders.
e. Complete appropriate records and incident reports.

#### Staff, family, visitor?

**Disposition III**

a. If needed, provide basic first aid (see Red Cross manual). (d)
b. Refer patient to private physician or emergency room. (d)
c. Call an ambulance for the patient should condition deteriorate while still on-center.
d. Complete appropriate records and incident reports.

## NO

Arrange for care by most experienced personnel on-center and contact a senior staff member.

Does an emergency exist according to the senior staff person?

### YES

**Disposition IV**

If needed, provide the following basic first aid measures: (e)

a. Give mouth to mouth resuscitation.
b. Keep patient warm.
c. Stop bleeding by applying pressure on wound.
d. Call local rescue squad or ambulance if no health personnel are available.

Names and telephone numbers of physicians accepting referrals;

1. _____
2. _____
3. _____

Telephone number of
Hospital emergency room _____
Physician _____
Ambulance/rescue squad _____

### NO

But there is an urgency. (f)

Is the patient . . .

#### A corpsmember?

**Disposition V**

a. If needed, provide basic first aid (see Red Cross manual). (f)
b. Summarize the patient's problem to the MD or health staff member.
c. Follow MD's referral plan.
d. Complete appropriate records and incident reports.

#### Staff, family, visitor?

**Disposition III**

a. If needed, provide basic first aid (see Red Cross manual). (d)
b. Refer patient to private physician or emergency room. (d)
c. Call an ambulance for the patient should condition deteriorate while still on-center.
d. Complete appropriate records and incident reports.

Notes to Standing Order H/NH 2

## THE MANAGEMENT OF AN EMERGENCY OR URGENCY

This administrative order provides instructions regarding procedures to be used when confronted with an emergency or a health problem urgent enough to warrant examination by the MD as soon as possible. Since some of the problems are more serious than others, and since other Job Corps staff members may have to respond to a problem in the health staff's absence at night and on weekends, there are five optional dispositions.

(a) Life-threatening emergencies are those that can cause death in minutes. They include the inability to breathe, inability of the heart to pump, uncontrolled bleeding, and the following:

- Severe allergic reaction (anaphylaxis).
- Choking on food.
- Attempted suicide.
- Poisoning (such as cyanide).
- Gunshot wounds (chest, abdomen).
- Shock.
- Drowning.
- Uncontrollable convulsions.

(b) Disposition I describes what to do with any patient who presents with a life-threatening emergency condition. It is assumed that all health personnel have knowledge of basic first aid (see American National Red Cross Manual, Standard First Aid & Personal Safety, Doubleday and Co., Garden City, New York, 1973)* and that some health staff members have more advanced skills. The health staff members should discuss with the MD his/her expectations regarding how emergencies should be handled and what skills and equipment are necessary and available. All health staff members should familiarize themselves with the following lifesaving measures as listed in Disposition I:

- Maintenance of airway
- Administration of cardiac massage and artificial respiration

*Another good text on first aid is First Aid Instructions, published by MESA (Mine Engineering Safety Administration).

Notes to Standing Order H/NH 2
The Management of an Emergency or Urgency (Cont.)

- Bleeding is controlled by applying pressure to the wound or by using a tourniquet. The use of a tourniquet is dangerous, and the tourniquet should be used only for a severe, life-threatening hemorrhage that cannot be controlled by other means. Tourniquets are used far too often and are rarely required; they should not be used except in critical emergencies when direct pressure on appropriate pressure points fails to stop bleeding. The decision to apply a tourniquet is in reality a decision to risk sacrifice of a limb in order to save life. For additional information, see American National Red Cross Manual, Standard First Aid & Personal Safety, Doubleday and Co., Garden City, New York, 1973, pp. 28-30. Nearly all external bleeding can be controlled by putting pressure over the affected vessels. Even minor lacerations (e.g., scalp lacerations) can cause significant blood loss if unattended.

- Vital signs should be monitored every five minutes. Any change can help the MD in his/her evaluation. The blood pressure, pulse, and respiratory rate should be taken to determine whether the patient is going into shock.

- The prevention and treatment of shock, which includes: laying the patient flat on his/her back and elevating the patient's legs; establishing an airway and making sure the patient is breathing; if authorized, placing a large bore catheter (#18 or above) into a vein and initiating fluid therapy with Ringer's lactate or isotonic saline. Shock is defined as collapse with low blood pressure. If it progresses, there will be a loss of consciousness, rapid heart rate, and clammy skin. Shock may occur in the following cases: blood loss, fluid loss secondary to diarrhea, massive infection, and severe allergic reactions.

- Fluid can be lost due to bleeding, burns, or diarrhea; and it is this loss that causes shock in the cases described above. This bleeding may be internal and not immediately obvious. To prevent or reverse shock, fluid therapy may be necessary. A health staff member who is trained and authorized should administer the infusion and remain with the patient on-center while awaiting transportation to the hospital. If there is no health staff member trained and authorized to administer an I.V., then the health staff should continue other anti-shock measures until the ambulance or rescue squad arrives.

Notes to Standing Order H/NH 2
The Management of an Emergency or Urgency (Cont.)

(c) Urgencies are health problems that need evaluation by the MD within a few hours, as they may soon result in a life-threatening situation or may produce permanent damage. Disposition II describes what to do with any patient who presents with an urgent condition. Only health personnel should follow Disposition II. Urgencies may include:

- Third degree burns.
- Fractures.
- Serious lacerations.
- Diarrhea and vomiting lasting over 24 hours.
- Abdominal pain.
- Threatened abortion.
- Severe depression or anxiety.
- Foreign body in the eye (metal, wood).

(d) In Disposition III, for urgent conditions, health staff and other Job Corps staff members (in case there is no health staff member available) should make the patient comfortable and provide first aid measures only; however, the patient is then to be referred to a private physician or to an emergency room.

(e) Non-health staff should follow Disposition IV for an emergency until a health staff member can take over or until the patient is seen by the MD. If the person using this disposition is unable to administer first aid, then that person should try to locate someone with first aid training to administer basic care. (See American National Red Cross Manual, Standard First Aid & Personal Safety, Doubleday and Co., Garden City, New York, 1973).

(f) When non-health staff (residential living advisors, counselors, etc.) are confronted with what they think may be an urgent health problem, they should follow the instructions in Disposition V. The CD should see that non-health staff have some first aid skills and have available the phone numbers of the MD, nurse, medic, hospital emergency room, and ambulance service.

Standing Order H/NH 3

## ADMINISTRATIVE ORDER FOR THE OPERATION OF THE DISPENSARY*

_____, Job Corps Center

Date: Signature:

_____ _____, C.D.

_____ _____, A.O.

_____ _____, M.D.

_____ _____,

1. HOURS OF OPERATION AND SERVICES PROVIDED

The dispensary will be used as follows:

a. Sick call

Sick call will be conducted every weekday from _____ to _____ and from _____ to _____. During this time, corpsmembers with any medical problem may obtain assistance. No appointment is necessary.

b. Drop-in visits to the dispensary

Corpsmembers are urged to report to sick call for routine medical problems. Accidents and rapid-onset illnesses will be treated as needed.

*The dispensary is always open for emergencies, but the casual use of the dispensary as an excuse for avoiding responsibilities can cause serious disruption of the center's educational activities. Therefore, use of drop-in visits as a routine should be discouraged.*

Drop-in patients must obtain a pass from their teacher or counselor.

2. APPOINTMENTS

Appointments are scheduled for corpsmembers according to the urgency of the situation and the schedule of staff members who are providing services. These appointments may be made for the following types of services:

*Fill in the blanks to fit the situation at your center. Make any changes you consider necessary. The completed order should be approved by the regional office.

Standing Order H/NH 3
Administrative Order for the Operation of the Dispensary (Cont.)

a. Immunizations and allergy shots

These are scheduled to be administered by the _____. Immunizations will be scheduled by the _____ as needed.

*A specific time may be scheduled for immunizations and allergy shots to maximize efficiency and decrease waste of materials prepared for injection.*

b. Cursory physical exams

Every corpsmember will be examined within 24 hours after arrival on-center by _____.

c. Entrance physical exams

These are scheduled for _____. They will be performed by the _____.

d. Physician visits on-center

These will be held every _____. Patients needing medical evaluation will be scheduled for visits (____ minutes each) on the above-mentioned days.

e. Dentist visits

These are held at _____ every _____; routine dental visits should be scheduled then. Emergency dental services may be obtained by calling the dentist at his/her office (telephone number _____). Be prepared to give the dentist a brief description of the problem when you call.

f. Mental health visits

These are scheduled on-center every _____. About one-half of the consultant's time will be allocated for seeing patients, the other one-half for conferences with members of the staff and for staff training activities. Appointments to see the mental health consultant can be made for the time when he/she is on-center. The consultant should be called for any mental health emergency at (telephone number _____). Be prepared to give a brief description of the problem when you call.

Standing Order H/NH 3
Administrative Order for the Operation of the Dispensary (Cont.)

3. STAFF

The basic staff in the dispensary is _____, _____, and _____. The MD is in charge of the dispensary. In his/her absence, the _____ is in charge. If none of these people are available, call the other persons on the Emergency Call List posted _____ _____. For more information see Section 8 below.

4. TRIAGE

Triage, the sorting and classification of patients during sick call, will be done by the _____.

Although clerical personnel at the centers will often see the patient first, they will not make any triage or clinical decisions. They will refer all patients to the _____ for disposition.

5. DISPENSING MEDICATIONS

Medications will be dispensed in the dispensary by each health staff member as checked on the authorization list by the MD.

6. TREATMENT OF STAFF, VISITORS AND FAMILY

*The dispensary and the health facilities exist to provide services to corpsmembers. They should not be used as a convenience facility by members of the staff, their families, or visitors.* However, since they do have resources for the treatment of emergencies, they should provide care to persons regardless of their identity or their relationship to Job Corps, if the need arises. Patients who are not corpmembers who require non-emergency care will be referred to their physician. If the person does not have a private physician or if the physician cannot be reached, refer the person to the emergency room of _____ Hospital (telephone number _____). If necessary, single doses of analgesics or sedatives may be provided by an authorized staff member.

7. RECORDS

The following clinical records, as found in Technical Supplement-C, revised July 2, 1976, must be maintained on all dispensary visits: Report of Medical History, SF-93; Report of Medical Examinations, SF-88; and Chronological Record of Medical Care, SF-600. *Other forms are shown in ETH 334, the Forms Preparation Handbook.*

Standing Order H/NH 3
Administrative Order for the Operation of the Dispensary (Cont.)

A clinical note should be placed in the patient's chart for each visit. The note should specify the nature of the visit (e.g., sick call, eye check-up), what was found, and what disposition was made of the patient's problem. If medications were ordered, the name, dose, frequency, and duration should be indicated. The nature of the proposed follow-up should be described. The notes should be legible, dated, and signed.

*A recommended format is the SOAP note which stands for the following types of information: subjective, objective, assessment, plan. The information for a SOAP note is obtained easily by following the algorithm and will indicate that the appropriate technical order has been consulted and followed.*

8. DISPOSITION OF EMERGENCIES

a. Working day emergencies

An emergency, as defined by the health staff, will ordinarily interrupt all other activities (except another, more severe emergency), including breaks, lunches, and conferences. The most skilled health staff member available will be in charge of the disposition of the emergency.

b. Off-hour emergencies

Emergency services are available at the dispensary at all times--24 hours a day and seven days a week. If no health care staff member is actually on-center, follow the posted instruction to: open the dispensary if authorized, call for assistance, or obtain assistance at alternate facilities (first aid supplies are located in _____).

*The CD, after discussion with the AO and the health staff, should design an Emergency Call List which should be posted _____. The List should set out, in order of priority, whom to call first, second, etc., in case of an emergency. Telephone numbers, of course, should accompany the persons' names as well as any restrictions if necessary. For example, John Doe may be on call on Tuesday nights only; if it is Wednesday, Mary Brown should be called first.*

Standing Order H/NH 3
Administrative Order for the Operation of the Dispensary (Cont.)

Personnel should be summoned in the following sequence for emergency patients: _____, _____, _____, _____, and then _____. If none of these people can be contacted, call the other persons on the Emergency Call List in the order their names appear.

If an ambulance is needed and the center ambulance is not available, ambulance service may be obtained by calling the _____ (telephone number _____) or the private ambulance service (telephone number _____). The local hospital's emergency room staff should be called to notify them of the pending arrival and the nature of the problem (telephone number _____).

Refer to Standing Order H/NH 2, Administrative Order on the Management of an Emergency or Urgency, for more information.

9. DISPOSITION OF URGENT PROBLEMS

a. Problems which are urgent (those which require care before the next sick call or before the next routinely scheduled visit) should be resolved as soon as possible. If the problem can be managed by available personnel (that is, if the standing authorizations allow them to manage the problem), it may be resolved without further consideration.

If the patient must be seen by the MD and the MD will not be on-center within two to six hours, arrangements should be made to transport the patient to the MD's office (or emergency room) at the earliest possible time. The MD's office should be called (telephone number _____) to make an appointment for the patient. Patients should not be sent to his/her office without a prior telephone call and, if possible, an appointment. Be prepared to give a brief description of the problem when the call is made.

b. Refer to Standing Orders H/NH 2, H 5, and NH 5 for more information.

**Standing Order H/NH 3**
**Administrative Order for the Operation of the Dispensary (Cont.)**

10. *In order to assist the health staff in the performance of their duties, the CD, with the AO and the health personnel, should set a guideline of priority responsibilities and duties. Naturally, responding to an emergency should be the first priority on the list. Other duties that should be included on the list are:*

*a. Holding sick call.*

*b. Performing cursory physicals.*

*c. Assisting in initial physical examinations.*

*d. Providing infirmary care.*

*e. Maintaining and completing records and reports.*

*f. Driving patients.*

*g. Counseling patients.*

*h. Teaching, e.g., in-service training HEP, etc.*

*Organizing this list of duties in order of their importance by the days of the week may be a useful format. There are other duties which demand the time and efforts of the health staff, and they should also be considered when designing this list.*

STANDING ORDER H/NH 4

# ADMINISTRATIVE ORDER FOR THE OPERATION OF THE INFIRMARY

_____ Job Corps Center

Date: Signature:

____ _____, Center Director

____ _____, Administrative Officer

____ _____, Center Physician

____ _____,

## 1. DIFFERENT USES FOR THE INFIRMARY

A number of different types of patients may be housed in the infirmary. Somewhat different rules apply to the care of each type of patient. In general, however, corpsmembers who are housed in the infirmary should have stable or improving vital signs unless they are waiting for transportation to a hospital or a physician.

### a. Medical Isolation

Medical isolation is used to prevent the spread of an infectious disease, or a suspected infectious disease, to other corpsmembers and staff from a patient who:

- is awaiting diagnosis or hospitalization;
- has a mild infectious disease which does not require hospitalization; or
- is recovering from an infectious disease that required hospitalization that is no longer necessary.

Not all corpsmembers with infectious diseases should be kept in isolation and not all those who need isolation should be kept in the infirmary. Table I is a guide to the use of isolation facilities. Questions regarding medical isolation should be resolved by the center physician.

### b. Isolation for Mental Health Reasons

The following types of patients may require isolation for mental health or emotional reasons:

- agitated, psychotic, delusional, or irrational patients;

TABLE I

A GUIDE FOR ON-CENTER ISOLATION OF PATIENTS
WITH SUSPECT OR DIAGNOSED INFECTIOUS DISEASES

| TYPE OF DISEASE | CAUSATIVE AGENT | HOW SPREAD? | IS ISOLATION NEEDED? | PRECAUTIONS |
|---|---|---|---|---|
| RESPIRATORY<br>Colds, Flu<br>Sore Throat<br>Pneumonia | Virus<br>Bacteria (Strep)<br>Virus and Bacteria | All these respiratory diseases are spread by sneezing or coughing infected droplets into the air | NO, not effective | Proper hygiene to avoid spreading of infected droplets |
| VOMITING, DIARRHEA<br>Gastroenteritis | Virus | Spread by sneezing or coughing infected droplets into the air and by fecal/oral infection | NO | None known |
| Dysentery<br>(Bloody Diarrhea) | Bacteria < Shigella, Salmonella<br>Protozoan-Amebiasis | Spread by fecal/oral infection: drinking infected water; or through direct contact with an infected person | YES | Hands should be washed after all contact |
| RASHES<br>Measles | Virus | Spread by sneezing or coughing infected droplets into the air | YES | None besides isolation |
| German Measles | Virus | Same as measles | YES | No contact with pregnant women |
| Chicken Pox | Virus | Same as measles | YES | None besides isolation |
| Scabies | Parasite | Spreads from clothing, bed sheets, or direct contact with an infected person | YES, until treated | Treat clothing |
| Impetigo | Bacteria | Spread by direct contact with an infected person | NO | Proper hygiene |
| HEPATITIS | Virus | Spread by fecal/oral infection or drinking infected water | YES | Proper handwashing; sterilize eating utensils |
| MENINGITIS | Virus<br>Bacteria | Spread by sneezing or coughing infected droplets into the air | YES, inside hospital | Masks and gowns |
| TUBERCULOSIS | Bacteria | Spread by sneezing or coughing infected droplets into the air | YES, inside hospital | Masks and gowns |

**Standing Order H/NH 4**
**Administrative Order for the Operation of the Infirmary (Cont.)**

- those who are confused or disoriented and for whom contact with other corpsmembers would have an adverse effect;
- those who require isolation for their own protection or for the protection of others;
- suicidal patients (note that some suicidal patients should not be isolated); and
- patients who are under the influence of alcohol or other drugs.

Questions regarding isolation for psychiatric or emotional reasons should be resolved by the center health consultant or the center physician.

c. Use of the Infirmary for a Minor Illness

Patients with minor illnesses, who cannot be expected to continue their usual training activities, may be housed in the infirmary. The determination of their capacity to maintain usual activities is left to the discretion of the health staff.

d. Use of the Infirmary for Post-Hospital or Minor Surgery Recovery

Patients may be housed in the infirmary during their post-hospital recovery period. If the infirmary is used following hospitalization, the cost savings and convenience should not deprive the patient of needed care.

The infirmary also may be used to house patients following minor out-patient surgical procedures such as tooth extraction and abscess drainage.

e. Use of the Infirmary for Observation

Certain types of patients require more careful observation than their regular living facility can provide. For example, a corpsmember with a head injury may be housed in the infirmary for a few hours to facilitate early detection of complications.

2. LIMITATIONS ON THE USE OF THE INFIRMARY

a. The infirmary is not a disciplinary facility. Patients will not be kept in isolation as a form of punishment.

b. Patients who are violent and cannot be controlled by reassurance, by medication that the infirmary staff is authorized to administer, or with minimal restraints as outlined in Section 6, may not be housed in the infirmary.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

c. Patients requiring more than 12 hours of intravenous fluids and patients with worsening vital signs should generally not be housed in the infirmary.

3. DEFINITION OF TERMS

a. The term center physician (MD) includes center dentists, doctors of osteopathy, and center medical health consultants when appropriate.

b. Health staff includes all other employees of the center health unit, such as medics, nurses, and clerks.

c. Non-health personnel or non-health staff include all employees of the center not assigned to the health unit.

d. Staff includes health and non-health center personnel.

4. INFIRMARY COVERAGE

a. Physicians

Patients in the infirmary must be seen regularly by center physicians. It is not necessary for each one to be seen each day; patients recovering from illness or surgery may be visited by physicians less frequently. Telephone consultation may be satisfactory for many patients.

b. Emergency Calls

An emergency call list identifying the physicians and staff members who should be called and the sequence in which they should be called, will be posted _____. In the event no one on the list can be reached during an emergency, Standing Order H/NH 2, "Administrative Order for the Management of an Emergency or Urgency" should be referred to.

c. The following specifications apply at all times to the infirmary:

1) The infirmary must be supervised by _____* for at least one shift during each workday. Other shifts may be supervised by non-health personnel.

*A physician assistant, nurse practitioner, registered nurse, medic or licensed practical nurse.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

*Individuals responsible for the infirmary must be capable of obtaining and recording vital signs, administering oral medications, recarding appropriate notes in a clinical record, and following physicians' orders. When the infirmary is supervised by non-health personnel, particular attention should be given to assure that only patients who have minor or uncomplicated problems are housed in the infirmary. Patients requiring special care, those in isolation, those requiring special medications that cannot be administered by non-health personnel, and those requiring intravenous fluids should only be supervised by health staff. Alternate arrangements such as hospitalization should be made for those patients if health staff is not available.*

2) Supervision of the infirmary implies that the staff member is actually present in the infirmary or in close proximity. This implies that the staff member can hear a call for assistance or can be reached by phone and that he/she will make regular rounds of the infirmary every ____ hour.

3) Staff members who are supervising the infirmary may conduct other appropriate activities if they can respond quickly to the needs of corpsmembers housed in the infirmary. For example, a medic can conduct sick call in an adjacent area.

4) Supervision of the occupied infirmary must be maintained 24 hours a day, seven days a week. If the appropriate staff members are not available, non-infirmary arrangements must be made; i.e., patients could be hospitalized, medically terminated, or returned to their regular living quarters, depending on the particular situation.

5) Staff members assigned to supervise the infirmary at night and on weekends may be required to perform other activities consistent with their job descriptions such as filing charts, arranging follow-up appointments, restocking supplies, and maintaining technical equipment. They are not expected to perform unrelated activities such as routine cleaning and food preparation.

5. INFECTIOUS DISEASE ISOLATION

a. The extent of isolation needed and specific isolation procedures are specified in two standard publications. The recommendations of either of the two should be followed for all corpsmembers with infectious diseases. Copies of these books can be found on the bookshelf in the office of _____.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

- Control of Communicable Diseases in Man, A.S. Berenson (editor), 12th edition, 1975. *This book is published by the American Public Health Association, 1015 18th Street, N.W., Washington, D.C. 20036; price is $4.00.*

- Report of the Committee on Infectious Disease, American Academy of Pediatrics, 17th edition, 1974. *This report is published by the American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204; price is $3.00.*

b. The types of problems requiring isolation for infectious diseases have been outlined in Section 1 of this administrative order. For any case, however, decisions about isolation in the infirmary depend upon consideration of handwashing techniques and facilities, handling of eating utensils and dishes of corpsmembers, the disposal of waste, the washing of linens, and toilet facilities.

c. If the infirmary is used for infectious disease isolation, the center physician or his designee must make sure staff training is provided for proper isolation techniques and that compliance with these techniques is maintained.

d. If a corpsmember's infectious disease cannot be handled in the infirmary in a manner consistent with the recommendations set forth in either of the two references cited; or if the infirmary and/or staff is not adequate for reasons of physical facilities or size of staff, hospital care must be arranged.

6. SPECIAL CONSIDERATIONS FOR PSYCHIATRIC PROBLEMS

a. Restraints

1) No restraints will be used without approval from the senior member of the health staff available and, if possible, from the center physician. No patient will be kept in restraint longer than one hour without examination by and approval of the center physician or mental health consultant. *This requirement is specified in Title 29, Code of Federal Regulations, Part 97a, 68c.*

2) When restraints are used, a notation of the reason and the approval should be recorded in the patient's chart. The time when restraint was applied must also be noted.

3) Restraints will never be used for more than 12 hours. Patients needing restraints for longer periods will be hospitalized.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

4) Strait jackets will not be used. Soft, well-padded limb restraints, applied as loosely as possible to as few limbs as possible, are the only restraints permitted. Patients should never be restrained in a spread-eagle position.

5) Efforts must be made to calm patients by friendly, supportive, and non-threatening activities. If possible, the reasons for the restraints should be explained to the patient. The patient's family or friends may be helpful in providing this assistance and should be utilized if available. Talking with the patient generally is more effective than restraints or medication.

It is rarely necessary to use restraints on a patient. Restraints are frequently used because of the staff's failure to calm the patient by non-physical means rather than because of the severity of the patient's problems. Restraints are more likely to increase, rather than decrease, a patient's agitation.

b. Medication

1) Particular care must be taken with patient's request for assistance. Even the suspicion of suicide in a patient should elicit the concern of staff. Attention should be given to depressed persons, to those who express feelings of hopelessness or doom.

2) Suicidal patients will not necessarily be kept in isolation. Isolation may increase the tension of an agitated patient.

3) Suicide precautions involve two elements:

- removal of objects that could be used by the patient to commit suicide such as belts, neckties, and sharp instruments;
- continual observation of the patient (conservation and reassurance should be part of the patient's therapy).

c. Isolation

Psychiatric patients should not be isolated needlessly. Isolation may cause a deterioration in their emotional state and complicate therapy.

Hospitalization must be considered for psychiatric patients who require isolation for longer than 12 hours, and for whom specific written approval from the center physician or mental health consultant cannot be obtained immediately.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

7. INFIRMARY RECORDS AND ORDERS

a. A complete clinical record must be kept for each corpsmember housed in the infirmary. The clinical record should be incorporated into the patient's center health record.

b. Clinical records must include the following:

- vital signs;
- nurse's notes (signed or initialed);
- medications administered, including a notation of the time, and initialed;
- physician's and consultant's progress notes (signed or initialed);
- laboratory records, hospital and clinic summaries.

c. Telephone orders from physicians should be recorded by the infirmary staff in the doctor's orders section of the chart. They should be noted as telephone orders and countersigned by the physicians at the earliest opportunity. The Federal Government and some states have specific laws or regulations about dispensing drugs such as narcotics. Each center should consider these factors in establishing its procedures for telephone orders.

d. Progress notes should be recorded by the physician, dentist, or mental health consultant at each visit. These progress notes must be legible and must reflect an assessment of the corpsmember's current clinical status and plans for his or her disposition or continuing care. A note that merely recounts nursing information, such as the patient's temperature, is not satisfactory. The responsible physician should provide a brief summary of the infirmary stay in the patient's chart. If the patient was in the infirmary for a minor illness and was not seen by a physician, the summary may be written by the senior member of the health staff. This summary should include at least the following:

- reason for the infirmary stay (the nature of the illness of diagnosis);
- nature of the treatment or care given;
- outcome of the treatment rendered;
- anticipated disposition, including plans for evaluation or follow-up care.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

8. MEDICATIONS

a. Medication may be dispensed only as outlined on each staff member's personal authorization list. To the extent possible, infirmary medication requirements for nights and weekends should be anticipated so that infirmary staff will not have difficulty in obtaining medication during off-hours.

b. No prescription medications may be dispensed without an order or written prescription. Orders may be specifically written for the patient, telephoned to the infirmary by the center physician, or set forth in a standing order.

c. It is the responsibility of _____, who is in charge of the infirmary, to be sure adequate supplies of drugs are maintained, accessible, stored properly, and replaced as they are used or become outdated.

9. NOTIFICATION OF FAMILY

a. When a corpsmember is admitted to the infirmary for other than a minor problem, his/her family must be notified. The senior health staff member present or the center physician should notify the family.

b. If the circumstances are of an urgent or emergency nature, the patient's family should be notified as soon as possible. Should hospitalization be necessary, the patient's family must be notified immediately.

c. If the circumstances are not of an urgent or emergency nature, this notification may be done by telephone during the next working day following admission or may be left to the discretion of the corpsmember and the infirmary supervisor.

10. VISITORS TO THE INFIRMARY

a. Patients in medical isolation may be visited by family members only. Depending on the condition, visitors may be required to use caps, masks, and gowns, and observe washing procedures.

b. Patients in isolation for mental health reasons may be visited only if specified by the center physician or the mental health consultant.

c. No visitors less than ____ years old are permitted to visit an infirmary patient.

d. Parents, guardians, spouses, and certain other members of a patient's family may visit at any time, if authorized to visit by the center physician or mental health consultant.

Standing Order H/NH 4
Administrative Order for the Operation of the Infirmary (Cont.)

e. For non-family members, visiting hours for non-isolation patients are ____ P.M. to ____ P.M., daily. No more than two visitors are permitted for any patient at any time. All visitors are limited to _____ minutes.

STANDING ORDER H 5

_____ JCC

# ADMINISTRATIVE ORDER FOR REFERRAL OF CORPSMEMBERS TO EMERGENCY ROOM AND/OR CONSULTANT, OR FOR HOSPITAL ADMISSION

## An emergency. (a)

Is it life-threatening?

NO → ● Give first aid as needed.

YES

If the facilities of a hospital emergency room are obviously needed:
- Call ambulance or rescue squad (tel. no._____).
- Give basic first aid.
- Maintain airway.
- Begin cardiopulmonary resuscitation if necessary (CPR).
- Take anti-shock measures.
- Control bleeding if any.

## An urgency. (a)

● Give first aid as needed.

Can you reach MD on duty or by phone?

YES → ● Follow instructions.

NO → ● Send patient to hospital emergency room.

Have previous arrangements been made? (b)

NO →
- Notify emergency room.
- Arrange transportation. If center is not equipped to transfer patient, call tel. no._____).
- Give first aid and comfort during transportation.
- Notify senior staff member on duty.
- Notify MD unless referred by MD.

YES →
- Follow previous instructions. (c)
- Notify MD. (d)
- Notify senior staff on duty.

## A non-urgent problem. (a)

Has MD authorized referral without his having to see the patient?

NO → ● Refer to MD. ● Follow instructions.

YES → Have previous oral or written arrangements been made between center director and/or MD and consultants (e.g., opthalmologist, gynecologist, orthopedist, (etc.)? (b)

NO →
- Call MD.
- Follow his/her verbal instructions.
- Arrange for transportation.

YES → ● Follow previous instructions. (c)

In case of hospital admission:
- Have staff member stay with patient until admission is completed.
- Note bed and room numbers.
- Notify next of kin.
- Notify MD of any results and file reports and/or discharge summary.

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 5

## REFERRAL OF CORPSMEMBERS TO EMERGENCY ROOM AND/OR CONSULTANT OR FOR HOSPITAL ADMISSION

(a) Refer to Standing Order H/NH 2. This standing order complements Standing Order H/NH 2 and has been designed because most emergencies and urgent problems are referred to hospitals. If a patient's problem appears to be non-urgent, then he/she should be referred to the physician's or consultant's office rather than to the hospital.

(b) Written rather than verbal agreements between centers and consultants or hospitals are recommended.

(c) Prior arrangements between the center and consultants or hospitals should include arrangements for fees and charges; consent for care; authorization for payment by the center; and written reports back to the physician for the center health staff.

(d) Whenever a patient is sent to the emergency room, the physician must be notified within 24 hours so that follow-up can occur. Most physicians have an answering service where a message can be left.

**STANDING ORDER H 6**

_____ JCC

**TECHNICAL ORDER FOR THE MANAGEMENT OF BURNS**

Patient comes in with a burn.

- Administer first aid. (a)
- Evaluate

Is the burn a full thickness third degree burn? (b) — YES → Does burn cover more than 10% of the skin surface? — YES →

Anticipate shock and, if necessary, take the following preventive measures for a life-threatening condition (as in Disposition I of Standing Order H/NH 2):

- Establish an airway if there is respiratory difficulty.
- Monitor vital signs for shock.
- If authorized, start an I.V. with Ringer's Lactate or 0.9% saline solution.
- Call an ambulance for immediate transfer to a hospital emergency room.
- Contact MD and summarize patient's condition and reasons for transfer.

NO ↓ Does burn cover more than 10% of the skin surface?

NO ↓ Treat as an urgent condition:

- Protect the burn wound with a clean bandage.
- Summarize patient's problem to the MD as soon as possible.
- Follow MD's treatment and/or referral plan.

NO ↓ Is there a second degree burn covering more than 20% of the skin surface? (c) — YES →

NO ↓ Is there . . .

A second degree burn covering more than 5% of the body?
A second degree burn involving eyelids, face, hands or feet? (d)
Epilepsy or diabetes? (e)

YES (to any question) →

- Call MD for evaluation and treatment plan.
- Treat according to MD's instructions.
- If authorized, administer tetanus toxoid as needed. (f)
- Complete records and incident reports; have records transferred with patient if patient is sent to emergency room.
- Get to emergency room as soon as possible.

NO ↓ Is there a minor second degree burn involving less than 5% of other parts of the body? — YES →

- Cleanse the wound with soap and water.
- Apply gauze dressings as explained in note. (g)
- Administer tetanus toxoid if authorized. (f)
- Do not rupture blisters.
- Treat pain with 2 tablets of aspirin every 4 hours or, if authorized, with codeine 15 mg. every 4 hours.
- Recheck patient every 24 hours and change dressings; if pain continues or if there are any signs of infection, refer patient to MD. (h)

NO ↓

- Treat any first degree burn with wet dressings and cold packs.
- Two tablets of aspirin every four hours will relieve pain in most cases.
- Do not rupture blisters if they develop.
- See note on sunburn. (i)

| DATE | SIGNATURE |
|---|---|
| _____ | _____, M.D. |
| _____ | _____, |
| _____ | _____, |
| _____ | _____, |

## GENERAL NOTES FOR THE USE OF TECHNICAL ORDERS

1. Trade names are often used in the technical orders to aid in the identification of medications that can be given to treat a condition. When a trade name is mentioned, it should not be considered an endorsement of a particular company's product. Whenever possible, the generic drug, i.e., non-proprietary drug, should be used. Non-proprietary drugs are not protected by the trade name or brand name of a particular company. The generic drug is usually less expensive. For example, Miltown (made by Wallace) and Equanil (made by Wyeth) are different companies' brand names for the generic drug meprobamate, a tranquilizer used in the treatment of anxiety and tension.

2. Algorithms provide a set of questions requiring binary decision-making: that is a "yes" or a "no" answer is required. If a situation arises where there is no clear "yes" or "no" answer, then the more cautious route should be chosen. The answer that directs you to call the center MD (or to refer the patient to the emergency room if the center MD cannot be reached within a specified number of hours) should be chosen. *In general*, the "yes" answers indicate a more serious situation and call for more conservative or cautious action.

3. Before administering any medication, the patient should be asked if he/she is allergic to that medication and if possible, the corpsmember's health record should be checked. If the patient is allergic, a substitute medication should be used. For example, if a corpsmember is allergic to Betadine, a hexachlorophene soap such as pHisoHex can be used instead.

Notes to Standing Order H 6

## THE MANAGEMENT OF BURNS

(a) No clothing should be removed unless it is burning. Jewelry and rings must be carefully removed. No grease ointment or antiseptic should be applied. The burned limb(s) should be immersed in cold water or cold wet towels should be applied. This will limit the severity of the burn and provide pain relief. The cold water process should be stopped in ten minutes, however; it does no good to continue and and may even do harm by chilling the patient. After the water immersion, the burn should be covered to minimize bacterial contamination and decrease pain by preventing air from coming into contact with the injured surface.

For a chemical burn, the first priority is to remove the agent from the skin by washing with running water. All clothing should be taken off. It is necessary to use a continuous stream of water because plunging the injured part into a bucket of water merely dilutes and diffuses the chemical.

If the patient is in shock, Standing Order H/NH 2, Disposition I should be followed.

This algorithm asks the user to determine the percentage of skin surface affected by a burn. To estimate this percentage, the "rule of ten" may be used:

10% head and neck

20% chest and abdomen

20% back

10% each arm

20% each leg

(b) Burns are classified as first, second and third degree according to the depth of the burn. Third degree burns destroy all layers of the skin and extend into the deeper tissues. They are sometimes painless if the nerve endings have been destroyed. Sensation, or lack of it, can be tested using a sterile needle. If there is no sensation when skin is pinpricked, then one can assume that there has been a third degree burn. These full-thickness burns result in scarring and may present problems with infection and fluid loss. If the third degree burn involves more than 10 percent of the body or there are deep burns of the face, or hands, this should be considered a medical emergency, since shock can occur rapidly. Smaller third degree burns can result in severe scarring and require grafts. Patients with third degree burns must be referred to a

Notes to Standing Order H 6
The Management of Burns (Cont.)

hospital or physician for urgent treatment; delay increases the likelihood of infection. Third degree (full thickness) burns must be suspected in electrical, chemical, or grease burns.

(c) Second degree burns show up as blisters caused by fluid exuding through the injured skin. If about 20 percent of the skin surface blisters, the result can be severe fluid loss. It is therefore important to check pulse, blood pressure, temperature, and respiration every 15 mintues. An intravenous infusion of normal saline should be started by an authorized person as an emergency measure to treat shock. In general, patients with 10-20 percent second degree (partial thickness) burns are hospitalized; those between 5 and 10 percent may be hospitalized depending on the location of the burn.

(d) Burns involving the eyes, face, hands and fingers should be treated by the physician to avoid potential disfigurement, infection or functional impairment.

(e) Burns can trigger severe disorders; diabetics are prone to infection and epileptics may have seizures.

(f) All but superficial burns should be treated as tetanus prone. The current status of tetanus immunization of the patient should be checked. In general, persons who have received active immunization within the past ten years, have not had a booster in the past five years, should receive 0.5 ml of tetanus-diphtheria toxoid. (See Technical Supplement B, Table II). If immunization requirements have been met, the patient will not need additional tetanus toxoid.

(g) These directions are to be used when dressing burns:

1. The primary layer of bandages should be nonadherent, made from sterile, fine-mesh gauze lightly impregnated with petroleum jelly to prevent the gauze from sticking to the wound surface and to allow fluid to flow freely through the gauze, thus avoiding tissue breakdown.

2. The intermediate layer of bandages should be an absorbent layer of pile-up gauze--never loose cotton or paper because these tend to adhere. This intermediate layer acts as a wick drawing and storing fluid away from the burn to further guard against tissue breakdown. This layer should be applied loosely to accommodate swelling if it occurs.

3. The outer layer should be a supportive gauze roller bandage that anchors the primary and intermediate bandages and lightly limits movement. Elastic or other expandable bandages that tighten after application are not appropriate. Should swelling develop, a restrictive

Notes to Standing Order H 6
The Management of Burns (Cont.)

outer layer would compromise circulation. By leaving tips of fingers or toes exposed, circulation can be observed.

4. Care should be taken to prevent body surfaces from touching (i.e., fingers and toes), and to maintain proper position and function of limbs that are dressed.

(h) Inflamed wound edges, new blisters and/or a bad odor are signs of infection. The patient should be referred to the physician if any sign of infection develops or if the pain continues for 24 hours. Even if infection does not develop, the physician should check any patient treated on-center for burns within one week.

(i) For sunburn:

1. Wash burned area gently with soap and tepid water.

2. Apply a water soluble anesthetic agent (e.g., Solarcaine).

3. Give large quantities of water by mouth.

4. Give aspirin to relieve general discomfort.

STANDING ORDER H 7

_____ JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF POSSIBLE FRACTURES, DISLOCATIONS, AND SPRAINS

Patient comes in with suspected fracture, dislocation, or sprain. (a)

Are there multiple severe fractures?
Is the patient sweaty, pale, dizzy or thirsty?
Is blood pressure below 90/60, pulse over 100?
Is there a possible fracture of the skull, neck, spine, pelvis or thigh? (b)

YES (to any question) →

**EMERGENCY**

Shock is imminent. (c)

- Give first aid.
- Do not move patient.

Is MD available?

YES, ON DUTY →
- Have MD attend to patient.

YES, ON CALL →
- Follow instructions.

NO →
- Call an ambulance.
- Provide the following emergency measures until the MD assumes responsibility for the patient:
  Maintain airway
  Control bleeding.
  Monitor vital signs.
  Replace fluid loss with 1000cc lactated Ringer's intravenous infusion, if authorized.
  Keep patient lying down.
  If necessary, administer cardiac massage and artificial respiration.
- Notify emergency room and MD as soon as possible.

NO ↓

Has the bone broken through the skin? (d)
Is the injured limb cold or blue? (e)
Does the patient complain of lack of sensation?
Is the pulse below the fracture absent?

YES (to any question) →

**URGENCY**

Complications caused by fracture.
Unless surgical treatment is received within 4 hours, permanent damage or loss of limb can occur.

- Administer first aid.

Is MD available?

YES, ON DUTY →
- Have MD attend to patient.

YES, ON CALL →
- Obtain instructions.

NO →
- Control bleeding.
- Splint the injured limb. (f)
- Do not give anything by mouth.
- Transport patient to the emergency room immediately.
- Notify emergency room.
- Notify MD as soon as possible.

NO ↓

Is the injured limb deformed?
Is injury result of severe blow?
Is there pain, swelling or discoloration of the limb or joint?
Does the pain prevent regular motion or use of the injured part?

YES (to any question) →

Suspect fracture. (g)

- Splint injured part.
- Do not correct a suspected dislocation. (h)
- Refer for x-ray within 4 hours. (i)

Does x-ray reveal a fracture or dislocation?

NO →

These instructions should be followed for the management of severe sprains, bruised muscles and pulled ligaments.

- Rest affected part. Elevate injured limb for the first 24 hours to reduce swelling.
- Apply ice packs to painful areas 10 minutes on/10 minutes off for the first 12 hours after the injury. (j)
- After 12 hours, apply heat with a hot water bottle or heating pad. (k)
- Apply an elastic bandage to injured knee, ankle, elbow or wrist. (l)
- Apply a sling for an arm injury.
- Instruct patient in the use of crutches if the leg is injured. (m)
- Give 2 tablets of aspirin or acetaminophen (Tylenol) every 4 hours for pain.
- If there is still pain after 72 hours which prevents use of an extremity, refer patient to the MD or the emergency room for further evaluation and treatment. (n)

YES ↓

Can you reach the MD by phone immediately?

YES →
- Follow instructions.

NO →
- Have the patient treated at the hospital emergency room.

DATE _____ SIGNATURE _____, M.D.

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Notes to Standing Order H 7

## THE MANAGEMENT OF POSSIBLE FRACTURES, DISLOCATIONS AND SPRAINS

(a) A fracture is a break or crack in a bone. A dislocation is a separation of two bones normally held together by a joint (the shoulder, elbow, fingers or thumb). In other words, dislocation occurs when the connective tissue holding the joint together is stretched or torn away from the bone. A sprain is an injury to the ligaments, tendons or muscles which provide stability to the joint and allow it to move.

(b) When a patient has many fractures (as in a car accident) or when there is a fracture in the pelvic or thigh area, the patient may go into shock from internal bleeding. Bleeding from the rectum or bladder, or the inability to sit or stand up are signs of a fractured pelvis.

If the fracture of the neck or spine is suspected, avoid moving the patient until the ambulance comes. To prevent damage to the spinal cord:

- Do not allow the patient's head to bend in any direction.
- Do not put a pillow under the head.
- Place pillow, sandbags or any available support around shoulders, neck and head to prevent movement.
- When you are ready to move him/her, move the body as a unit; do not twist or turn any part separately.

(c) In shock the body turns cold and moist, and the skin appears pale or bluish. The pulse is fast and weak, the respiration quick and shallow, and the blood pressure below 90/60. The person in shock may be anxious, extremely thirsty or may lose consciousness.

Steps for preventing shock include:

1. Keeping the victim lying down.
2. Covering only enough to keep victim from losing body heat.
3. Getting medical help as soon as possible.

(Further details are given in Standing Order H/NH 2: Emergencies)

Notes to Standing Order H 7
The Management of Possible Fractures, Dislocations and Sprains (Cont.)

Body Position

The position for a victim must be based on the injuries. Generally, the most satisfactory position for the injured person will be lying down to improve the circulation of blood.

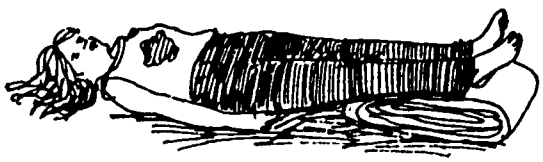
A victim with severe wounds of the lower part of the face and jaw, or who is unconscious, should be placed on his/her side to allow drainage of fluids and to avoid blockage of the airway by vomit and blood (Fig. 1). Extreme care must be taken to ensure an open airway and to prevent asphyxia. When there is no danger of aspiration of fluids, a victim who is having difficult in breathing may be placed on his/her back with head and shoulders raised (Fig. 2).

Victims in shock may improve if the feet (or foot of the stretcher) are raised from 8 to 12 inches (Fig. 3). If the victim has increased difficulty in breathing or experiences additional pain after his/her feet are raised, the feet should be lowered.

Figure 1

Figure 2

Figure 3



Notes to Standing Order H 7
The Management of Possible Fractures, Dislocations and Sprains (Cont.)

(d) Compound fractures are caused by broken bone puncturing the skin. The bone usually slips back beneath the skin, but the patient needs immediate surgical attention due to tissue damage and bleeding and to prevent infection. A large sterile dressing should be applied loosely around the wound and the limb splinted. No attempt should be made to clean the would at this time. Bleeding can usually be controlled by direct continuous pressure over the wound for five to ten minutes.

(e) If an extremity is cold, blue, and/or the pulse is absent, it is possible that the nerves and arteries were damaged at the time of the fracture or dislocation. The staff member must feel for the wrist pulse for a suspected fracture of the forearm or feel for a pulse in the foot in case of leg injury. Muscle tissue can die if its blood supply is cut off for four hours, resulting in permanent injury or loss of a limb.

(f) The injured limb should be put in a splint to reduce pain and to prevent further injury to muscles, arteries and nerves from broken bones. Splints are available commercially or may be made from rolled-up newspapers, blankets or magazines. A simple technique that can be used is to place padding between the injured and the uninjured parts and then tape or tie them together. An injured arm can be taped to the chest if the elbow is bent or taped to the side if the elbow is straight. Splints may be held in place by strips of cloth, large handkerchiefs, neckties or similar material. The splinted limb should be checked every half hour for color changes or swelling. If the patient complains of numbness, tingling sensations or the inability to move the fingers or toes, the splint should be loosened or reapplied. In applying a splint it should be remembered that:

- The splint must be long enough to extend past the joints on either side of a suspected fracture.
- There should be adequate padding between the splint and the skin, especially over bony areas.

Specific fractures can be splinted according to the instructions and illustrations in the American National Red Cross Manual, Standard First Aid & Personal Safety, Doubleday and Co., Garden City, New York, 1973, pp. 200-217.

Notes to Standing Order H 7
The Management of Possible Fractures, Dislocations and Sprains (Cont.)

(g) X-rays are needed to distinguish between a sprain and a fracture; both may cause pain, bleeding, swelling or discoloration to the injured part. An X-ray is needed any time there is reasonable suspicion of fracture since it is not always possible to tell by examination alone whether there is a fracture. If a limb is crooked or there is pain that prevents use of the injured limb, there is an obvious reason to suspect fracture. Although large bruises under the skin may be caused by soft tissue injury alone, fracture should be suspected.

(h) A dislocation should never be corrected by a health staff member because this may aggravate injury to the joint capsule. Inexpert handling can tear supporting structures and damage blood vessels and nerves in the area.

(i) In most instances, patients will have to be taken to the hospital emergency department for X-rays of long bones.

(j) Ice packs can relieve pain and reduce bleeding and swelling. They should never be placed directly on the skin, but rather on a thin towel or cloth placed over the skin. The limb should never be packed in ice since this may cause the tissue to freeze and interfere with blood circulation in the area.

(k) Heat increases circulation in tissue, aids in healing and relieves the pain and discomfort, but should not be instituted until at least 12 hours after injury.

(l) Elastic bandages provide support and help to reduce swelling while the injury is healing. When applying the bandage, the wrapping should begin at the point farthest from the injury and work toward the body, each loop should be made a little looser than the one before: the ankle should be wrapped from the base of the toes to the mid-calf; the knee should be wrapped from mid-calf to mid-thigh; the elbow should be wrapped firmly but not tightly from mid-forearm to mid-arm. It should not cause the limb to swell or hurt; and it should not cut off the blood circulation. After four hours, the limb should be checked to make sure that it is not blue or purple.

(m) Crutches are used to help the patient walk while not bearing full weight on an injured limb. It is essential that crutches be exactly the right length for the individual. Crutches that are too long can cause pressure on the nerves in the armpit which can lead to impairment of the functioning of the hand. Crutches that are too short cause the

Notes to Standing Order H 7
The Management of Possible Fractures, Dislocations and Sprains (Cont.)

user to crouch and they prevent adequate leverage. Crutches should be adjusted so that the shoulder support is an inch or two from the armpit. The patient should be thoroughly instructed in the use of crutches. The body weight should be on the hand bar rather than on the top of the crutch. In cases where the injured leg is not to be used at all, the weight should be borne on the uninjured leg.

(n) Torn ligaments in the knee or ankle joint seldom heal well without surgery. Sprains follow a typical healing pattern: swelling for 72 hours, decreasing symptoms for ten days and full structural healing in six to eight weeks. The patient should be warned not to expect a fully strong joint for six weeks or longer and to protect it.

STANDING ORDER H 8a

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# TECHNICAL ORDER FOR THE MANAGEMENT OF LACERATIONS

Patient comes in with a laceration.

Does the laceration involve the lips, nose, ears or eyelids? (a)
Is the wound likely to cause disfigurement? (a)
Does the laceration involve tendons, muscles or nerves? (b)
Does bleeding continue after pressure is applied? (b)
Is the wound contaminated with foreign bodies such as a piece of glass imbedded in the wound? (c)
Is there any associated or significant trauma? (d)
Is the patient suffering from a relevant disease, such as diabetes? (Check health record.)
Is there skin missing requiring a graft?
Is the laceration complicated, infected or jagged?
Does the patient have keloid scars from previous lacerations? (a)

YES (to any question) → Is the MD available by phone?

YES → • Follow instructions.

NO →
- Give first aid.
- Refer to hospital within 2 hours.

NO → Are sutures needed? (e)

YES → Are you authorized to place sutures? Do you have adequate equipment and assistance for suturing?

YES (to both questions) →
- Cleanse wound with soap and water and flush with sterile saline; then suture wound with 3-0 or 4-0 Ethicon. (c)
- Apply sterile dressing as needed. (f)
- If authorized, administer tetanus toxoid. (g)
- Arrange for recheck for infection within 48 hours.
- Arrange for future removal of sutures in 5-7 days.
- Instruct patient on care of wound and sutures and make notation in the chart of the instruction given.

NO (to either question) →
- Administer first aid.
- Call MD and arrange for examination to be done as soon as possible.

NO →
- Cleanse thoroughly with soap and water. (c)
- Apply sterile dressings, including butterfly band-aids or steri strips, as needed. (e)
- If authorized, administer tetanus toxoid, as needed. (g)

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Notes to Standing Order H 8a

## THE MANAGEMENT OF LACERATIONS

(a) Minor lacerations of the eyelids, nose, ears and lips should be sutured by MDs, since they are prone to cause disfigurement. Patients with this type of laceration are often referred to specialists in ophthalmology or plastic surgery. Also, any patient with keloid scars from previous lacerations should be referred for suturing.

(b) Any laceration should be carefully examined to determine if it involves more than subcutaneous tissue or muscle coverings. Injury to internal structures, such as muscles, tendons, ligaments, blood vessels, or nerves, presents the possibility of permanent damage. Numbness, blood pumping vigorously from the wound despite pressure, tingling or weakness in the affected limb, all call for urgent examination by an MD.

(c) The wound should be thoroughly cleansed and examined. Cleansing can be done with soap and water for at least ten minutes and the wound irrigated with sterile saline under pressure to remove foreign matter (dirt, slivers, glass). This cleansing removes the potential for infection if thoroughly and vigorously done. The skin may be shaved if necessary.

(d) There is the possibility of fracture if the laceration resulted from a blow (for example, the examiner must rule out the possibility of fracture in scalp lacerations).

(e) The edges of a clean, minor cut can usually be held together by "steri-strips" tape. A deep wound involving the subcutaneous layer and exposing fat, or one over two cm long (about one inch) will require sutures. A wound over a joint which opens when the joint is flexed may require sutures. A wound which continues to bleed after bandaging will probably need sutures. If a wound cannot be closed without trapping fat, stitching must take place within eight hours of the injury since, after that time, bacteria begin to grow and fester in the wound and can be trapped under the skin. If there is doubt as to whether or not a patient needs sutures, the patient should always be referred to the MD or the emergency room.

(f) Most lacerations will stop bleeding if pressure is applied directly to the wound. This process is as effective as tourniquets and is a safer method. Bulky, sterile dressings are sufficient if tightly applied.

(g) The current status of tetanus immunization of patients should be checked. In general, persons who have received active immunization within the past ten years, but have not had a booster in the past five years, should receive 0.5 ml of tetanus-diphtheria toxoid. (See Technical Supplement B, Table II.) If immunization requirements have been met, patients will not need additional toxoid.

STANDING ORDER H 8b

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF INFECTED WOUNDS

Patient complains of pain, swelling or pus in a wound several days following a laceration.

Are there red streaks running up from a wounded extremity?
Are the lymph nodes closest to the wound, enlarged and tender? (a)
Is there fever greater than 100°F - 38° C accompanied by chills? (b)
Is there pus around or under the wound? (c)

YES (to any question) → This is an urgent problem. Is MD available?

- YES → • Refer to MD.
- NO → • Refer to emergency room within 4 hours.

NO → Has the wound been sutured?

- YES → Are you authorized to remove sutures?
  - NO → • Refer to MD or emergency room within 8 hours.
  - YES → • Remove sutures.
    • Cleanse the wound with soap and water.
    • Dress the wound and refer to MD within 24 hours.
- NO →
  - Cleanse wound with soap and water.
  - Give instructions to patient on keeping wound clean.
  - Give tetanus toxoid booster, if necessary.

Notes to Standing Order H 8b
The Management of Infected Wounds

(a) This condition is known as lymphangitis. The red streaks indicate drainage of infection to the lymph glands which become enlarged and tender.

(b) A wound infection can spread to the bloodstream causing chills and fever.

(c) It takes at least 2 days for pus to form in a wound. Any discharge prior to 48 hours is probably not due to infection.

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STANDING ORDER H 9

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# TECHNICAL ORDER FOR THE MANAGEMENT OF UPPER RESPIRATORY SYMPTOMS

Patient may complain of one or more of the following: a cold, congestion, a sore throat, runny nose, stuffiness, a sinus problem, sneezing, allergies, and sometimes joint aches and pain. (a)

Has the patient had chills or fever over 100°F - 38°C for several days?
Is respiratory rate more than 32 per minute?
Does the patient experience pain on taking a deep breath?
Is the patient short of breath?

YES (to any question) → Suspect an urgent problem such as pneumonia or pleurisy. (b)
Can you reach the MD by phone immediately?
NO → • Send patient to emergency room immediately.
YES → • Follow instructions.

NO

Is the patient wheezing? (c)
Is there a history of asthma on the chart? (d)

YES (to either question) → Suspect asthma from infection or allergies. (d)
Can you reach the MD by phone?
NO → • Refer to emergency room within 24 hours.
YES → • Follow instructions.

NO

Since having a cold or flu, has the patient been coughing up a green sputum?

YES → Suspect bronchitis. (e)
- Instruct patient to:
  Stop smoking.
  Get plenty of rest.
  Drink plenty of fluids.
  Inhale steam from vaporizer.
- Give cough medicine, 1 teaspoon every 4 hours as needed.
- Also give tetracycline, 2 tablets (500 mg) every 6 hours for 5 days.
- If there is no improvement within 5 days, refer patient to the MD.

NO

Does the patient complain of sinus pain by pointing to the forehead or cheek areas?
Does the patient wince or draw back when pressure is applied to forehead or cheek?
Is there a thick discharge of pus coming from the nose?

YES (to any question) → Suspect acute sinusitis. (f)
- Give an antihistamine such as chlorpheniramine, 2 mg every 6 hours as needed, and steam inhalations.
- Arrange to have a culture done on the nasal discharge at the MD's office or at hospital lab.
- Begin treatment with ampicillin, 2 tablets (500 mg) every 6 hours, or if allergic to it treat with tetracycline, 2 tablets (500 mg) every 6 hours for 7 days.
- If there is no improvement within 3 days, refer patient to MD.

NO

Does the patient have an earache?

YES → • Refer to Standing Order H 10, The Management of Earache.

NO

Does the patient have a sore throat?

YES →
- Obtain a throat culture. If one cannot be done on-center, refer patient to the MD's. office or hospital lab.

Is patient allergic to penicillin? (Check patient's health record if necessary.)

NO →
- Give patient an adequate supply of penicillin G. tablets, 250 mg 4 times daily, to last until he/she returns for throat culture results.

YES →
- Give patient an adequate supply of erythromycin tablets, 250 mg 4 times daily, to last until he/she returns for throat culture results.

- Have patient return when throat culture results are expected.

Culture negative for betahemolytic strep.
- Treat with hot salt water gargles.

Culture positive for betahemolytic strep.

No penicillin allergy
- If patient is reliable, give him/her an adequate dose of oral penicillin G, 250 mg 4 times daily to complete a 10-day course.
- If patient is not reliable, administer in one dose benzathine penicillin G, 1.2 million units intramuscularly.

Penicillin allergy
- Provide an adequate supply of erythromycin, 250 mg, to complete a 10-day course of therapy.

NO → Consider this an uncomplicated upper respiratory problem such as a cold or an allergy. Treat as follows:
- Diet as tolerated. Encourage nutritional fluids.
- If there is fever or aches and pains, give aspirin, 2 tablets 4 times daily as needed or acetaminophen (e.g., Tylenol or Tempra), 2 tablets 4 times daily as needed.

If dominant symptom is . . .

Stuffy or runny nose or allergy (a), give:
Nose drops or nose spray, e.g., Neosynephrine, ¼ percent 4 times daily as needed (limit 4 days).

and

Chlorpheniramine (e.g., Chlor-Trimeton or other antihistamine) 4 mg 4 times daily as needed.
Caution: drowsiness may result.

cough. give:
Cough medicine with codeine, 1 teaspoon 4 times daily as needed.

- Advise patient to return if:
  Symptoms become more severe.
  No improvement is noted within 48 hours.
  New symptoms develop.

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Notes to Standing Order H 9

## THE MANAGEMENT OF UPPER RESPIRATORY SYMPTOMS

(a) About one half of the visits to any clinic are for upper respiratory symptoms, which are most commonly due to viral infections (colds, flu) and less commonly due to allergies. Though most of these symptoms last only a few days, the patient should be followed closely for the following complications that occur in 10 percent of the cases: pneumonia, acute bronchitis, flaring up of latent asthma, acute sinus infection, and acute middle ear infection. A viral infection can pave the way for a more serious bacterial infection of the sinuses, the tonsils, the ears, the bronchi or the lung tissue.

The questions in this algorithm are designed to enable the health staff member to detect and to refer for treatment the above-mentioned disorders. It is important that anyone with a cold or the flu have follow-up visits if complications arise.

(b) In late adolescence, pneumonia is usually due to the pneumococcus bacteria, which may infect one or more lobes of the lung. It begins rapidly and is accompanied by high fever and sometimes by a shivering attack. If pneumonia is suspected, the patient should be referred to the physician or to the hospital for a chest examination. The diagnosis will be immediately confirmed by an x-ray and Gram-stained sputum.

(c) A dry cough and wheezing are characteristic of upper respiratory infection in many asthma cases. Epinephrine, 0.1-0.5 cc, given subcutaneously, will usually provide relief.

(d) When a patient has lower respiratory symptoms such as wheezing, and difficulty of expiration associated with a history of asthma, the patient should be referred to the MD to determine if antibiotic treatment is necessary.

(e) Inflammation of the trachea causes a sore, scratchy feeling behind the breastbone, and usually occurs along with an irritating cough. If the bronchi are affected, the patient may experience a tightness in the chest along with a shortness of breath, with the major complaint being a cough. At first there is only a sticky sputum that may be difficult to bring up. As the infection progresses, fever may develop and sputum consisting of mucus and pus forms. The cough is easily controlled by steam inhalation, cough medicine and by tetracycline. (Tetracyline should not be given to pregnant women.) If health personnel suspect pneumonia as well (see note b), the patient should be immediately sent to the MD or to the hospital.

Notes to Standing Order H 9
The Management of Upper Respiratory Symptoms (Cont.)

(f) Sinusitis is an infection of the sinuses (air spaces) in the bones of the face or the bones above the eyes (see figure below). When the infection is bacterial, it is often accompanied by fever and headache.

Ephedrine tablets (30-60 mg), administered orally, have proven to be an effective treatment in opening the sinuses in the nose (see Figure 1 below). This medication also prevents wheezing by opening the bronchi in the lungs.

Some examples of antihistamines are Ornade, Triaminic, Novahistine and Coricidin. These drugs reduce the effects of histamine production (chemical released at the onset of an allergy or a cold).

The frontal and maxillary sinuses.

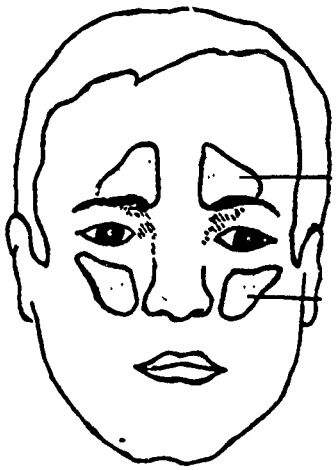


Figure 1

STANDING ORDER H 10

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# TECHNICAL ORDER FOR THE MANAGEMENT OF EARACHE

Patient complains of discomfort in the ear with or without hearing difficulty.

Is there a temperature over 102°F - 39°C with severe pain in the ear? (a)
Is there increasing pain and hearing loss? (a)
Is there neck stiffness? (b)
Is there pain over the mastoid bone behind an ear? (b)

YES (to any question) → Suspect a serious infection in the middle ear or surrounding structures requiring treatment within 4 hours. (b)

- Call MD; follow his/her treatment and referral plan. If not available, send patient to emergency room.

NO

Is there a discharge of pus coming from the ear after an earache? (c)

YES → Suspect ruptured eardrum.

- Insert a cotton wick into external ear canal after removing the pus with a cotton swab.
- Refer patient to MD or emergency room for examination and treatment within 12 hours.

NO

Has the patient had upper respiratory symptoms recently, such as a runny nose, sneezing or cough from a cold, flu or allergies?
Does the patient have hearing loss associated with a hollow-headed or congested feeling?

YES (to either question) → Suspect serous otitis media. (d)

- If authorized, examine the eardrum with otoscope.
- If diagnosis is confirmed, instruct patient to use a nasal decongestant spray, such as Afrin up to 4 times a day, for 3 days.
- If not authorized to use otoscope, arrange for patient to see MD within 24 hours.

NO

Does the patient complain of intense itching in the ear canal(s)?
Has the patient had water in the ear(s) recently from swimming, shampooing hair, or bathing?

YES (to either question) → Suspect external otitis. (e)

- If authorized, examine the ear canal with otoscope; a swollen, tender ear canal confirms the diagnosis. There may also be pain when the external ear is moved.
- Give Cortisporin eardrops 3 times a day for one week.
- If no improvement is seen in 2 days, send patient to MD.
- If not authorized to use otoscope, send patient to MD within 24 hours.

NO

Does the patient have reduced hearing in one ear associated with a discharge and, has this occurred on and off without pain since childhood?

YES → Suspect chronic otitis media. (f)

- If authorized, examine the eardrum with otoscope. If a perforation is visible, the diagnosis is confirmed.
- A flare-up of this condition can be controlled with 1 ampicillin capsule (500 mg) every 6 hours by mouth. If possible, take a culture of any discharge before starting treatment.
- Arrange for patient to see MD within 3 days for ear, nose, and throat examination and a treatment plan.
- If not authorized to use otoscope, arrange for patient to see MD within 24 hours.

NO

The patient probably has impacted earwax in the external ear canal.

- If authorized: examine the ear canal with otoscope; use hydrogen peroxide eardrops to soften the earwax for 24 to 48 hours; irrigate the ear with warm water to remove the plug.
- If not authorized to do any of the above, send patient to MD within 24 hours.

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Notes to Standing Order H 10

## THE MANAGEMENT OF EARACHE

(a) A severe earache is usually due to bacterial infection in the middle ear. Bacteria get into the middle ear via the Eustachian tube which serves as a passage between the middle ear and throat.

When the back of the throat is inflamed from colds or allergies, the Eustachian tube can become blocked. Bacteria trapped in the middle ear grow and cause ACUTE OTITIS MEDIA. As pus develops, pressure intensifies and pain results as the eardrum stretches. For this condition, pain killer should be given as ordered by the physician.

(b) Ear infections are potentially dangerous and can spread into the skull, causing MENINGITIS, an infection of the membranes covering the brain and spinal cord. When the infection enters the mastoid bone behind the ear, this condition is called MASTOIDITIS. Both conditions cause neck stiffness.

(c) If a middle ear infection is not treated, the eardrum may perforate within 48 hours (develop a small hole through which pus flows). This often results in relief of pain and fever. The patient will have a temporary discharge and a scar on the drum when the perforation heals. Repeated infections can cause a permanent opening in the drum.

(d) SEROUS OTITIS MEDIA occurs when, as a result of Eustachian tube blockage, there is a collection of fluid in the middle ear. The condition will sometimes correct itself spontaneously and responds well to decongestant and antihistamine therapy.

(e) CHRONIC OTITIS EXTERNA is caused by a low grade inflammation of the ear canal skin. It is a kind of eczema or allergic skin disorder. A flare-up of the condition is due to infection and is referred to as ACUTE OTITIS EXTERNA. The diagnostic symptom in the chronic condition is itching rather than pain. This condition can be brought on by getting water in the ears during swimming or showering.

The patient should tilt the head with the affected side up to instill the drops, and keep it tilted for five minutes so the medicine can penetrate deeply into the canal. Acute otitis externa responds well to broad-spectrum antibiotic therapy such as ampicillin (500 mg) administered every six hours for seven to ten days.

(f) CHRONIC OTITIS MEDIA - repeated middle ear infections in childhood can result in a permanent opening in or destruction of the eardrum. This may result in loss of hearing and a recurrent discharge. Such persons may need to have the drum reconstructed by an ENT (ear, nose, and throat) specialist, after termination.

STANDING ORDER H 11a

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# TECHNICAL ORDER FOR THE MANAGEMENT OF DIARRHEA

Patient complains of frequent bowel movements. (a)

Is there a fever over 102°F - 39°C?
Is there severe steady abdominal pain?

YES (to either question) →

- There may be an inflammation or other disorder requiring surgery. Give nothing by mouth and refer immediately to MD or hospital emergency room. (b)

NO ↓

Have there been more than 8 bowel movements in the last 24 hours?
Is the diarrhea accompanied by more than 3 episodes of vomiting in the past 24 hours?
Has the patient been unable to drink within the last 12 hours?

YES (to any question) →

- To prevent dehydration, refer to the MD or emergency room within 4 hours. Until patient is seen, give as much water by mouth as the patient will tolerate. (c)

NO ↓

Do you suspect food poisoning? — YES → Was there fever within past 12 hours?

YES → Suspect more serious food poisoning than due to staphylococcus. (d)

- Refer to MD within 8 hours for diagnosis and treatment.

NO → Suspect staphylococcus food poisoning. (e)

- Treat in the same way as viral gastroenteritis. (See below.)

NO ↓

Does the patient have blood or mucus in his/her bowel movements? — YES → Suspect bacillary or amebic dysentery (f)

- Refer patient to MD or hospital emergency room for stool culture and examination to determine proper antibiotic therapy.

NO ↓

Are cramps absent?
Is the patient tense and anxious?
Does diarrhea occur during times of tension?

YES (to any question) → Suspect psychosomatic disease. (g)

- Be supportive and discuss emotional problems with patient.
- Refer patient to MD and/or mental health consultant for evaluation.

NO ↓

Has diarrhea recurred 3 or 4 times in the past 2 months?
Does patient have lactase deficiency?
Has the patient lost over 10 lbs. since diarrhea began?

YES (to any question) → Suspect chronic diarrhea (h)

- Give Lomotil, 2 tablets 4 times per day until next possible appointment with MD.

NO →

Suspect viral gastroenteritis.

- Advise the patient to:
  - Avoid solid food until diarrhea stops.
  - Drink plenty of water.
  - Take 4 to 8 tablespoons of Kaopectate after each bowel movement.
  - If no improvement within 8 hours administer a paregoric-containing preparation, one tablespoon every 6 hours as necessary.
  - Bed rest for 24 hours if necessary.
- If symptoms continue after 48 hours, refer the patient to the MD or hospital emergency room. (a)

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Notes to Standing Order H 11a

## THE MANAGEMENT OF DIARRHEA

(a) When the bowels are irritated, there is a speeding up of movements in the bowels because muscle contractions increase. Diarrhea results -- and may be caused by infections from viruses, bacteria and parasites, nervous tension, food allergy, inflammation, or food poisoning. Ninety percent of the cases seen on-center will be caused by simple virus infections (gastroenteritis) and will clear up in a day or two.

(b) Fever and steady pain, rather than cramps, may indicate that the patient has an acute surgical condition of the abdomen, such as appendicitis.

(c) Diarrhea and vomiting prevent water re-absorption from the bowel, and cause a loss of body fluids and salts. If this loss is not counteracted by replacement fluids, the patient will become dehydrated.

Signs and symptoms of dehydration are:

- Extreme thirst.
- Dryness of the mouth.
- Sunken eyes.
- Failure of the skin to spring back into place when picked up between finger and thumb.
- Pulse above 100, blood pressure below 90/60.

Fever increases the body's need for fluids. A person with a fever who has diarrhea is in greater danger of becoming dehydrated than one who does not have fever.

(d) Diarrhea that lasts for more than two days and is accompanied by a low grade fever ($100^0$ - $102^0$F, $38^0$ - $39^0$C) may be caused by Salmonella. In cases of food infection, often the patient will have headache, chills, and foul-smelling diarrhea.

(e) SUSPECT FOOD POISONING WHEN SEVERAL PEOPLE GET DIARRHEA AT THE SAME TIME AFTER A COMMON MEAL.
Most cases of food poisoning that will be seen on-center will be caused by Staphylococcus germs that get into food when foodhandlers have infections in their noses or their fingers. The germs grow best in milk or

Notes to Standing Order H 11a
The Management of Diarrhea (Cont.)

cream products, such as pastry fillings and custards. While growing, these bacteria multiply and produce a poison which causes nausea and vomiting within a few hours of eating. Symptoms clear up in 24 hours.

(f) Bacillary dysentery is caused by the Shigella germ and can be distinguished by fever and bloody diarrhea containing mucus and pus. About 15 percent of corpsmembers will have amebic cysts in their stools also. This means that they carry an asymptomatic infection. These infections rarely become active or result in bloody diarrhea. The diagnosis is confirmed when trophozoites are found during the microscopic examination of fresh stools. Because of the potential complications of amebiasis, if cysts are detected in a patient's stools, the patient should be referred to the physician for treatment.

(g) The most common cause of non-infectious diarrhea is nervous tension that appears in individuals prone to anxiety. Physicians call this the "irritable bowel syndrome." Psychosomatic diseases are those caused by nervous tension. The diarrhea can usually be controlled with Lomotil during times of stress (cause of nervous tension) and with counseling from the examiner or the mental health consultant.

(h) There are many possible causes of chronic diarrhea, such as tension, chronic infection, food allergies and chronic inflammatory bowel diseases. Lactase deficiency should be suspected in patients of African or American Indian origin who have diarrhea.

STANDING ORDER H 11b

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF NAUSEA AND VOMITING (a)

Patient complains of nausea, and/or vomiting.

Has patient vomited 4 or more times in the past 24 hours?
Has patient been unable to take fluids in past 12 hours due to nausea or vomiting?
Has patient had more than 8 bowel movements in the last 24 hours?

YES (to any question) →
- Observe patient for signs of dehydration. (b)
- If dehydration present, refer to MD or emergency room in 4 hours.
- If authorized, start to administer 500cc normal saline intravenously before transferring patient.
- Encourage clear liquids by mouth.

NO ↓

Has patient had a head injury or concussion in the past 48 hours? — YES → The possibility of bleeding in the head should be considered. (c)
- Refer immediately for neurological examination.

NO ↓

Is there severe, steady abdominal pain?
Is there a fever over 102°F - 39°C?

YES (to either question) →
- Refer to MD or emergency department to eliminate possibility of a surgical problem within 4 hours. (d)

NO ↓

Is the patient in first trimester of pregnancy?
Is there early morning nausea? (e)

YES (to either question) →
- Be supportive.
- Instruct patient to eat 2 or 3 crackers on awakening and remain in bed 15 minutes.
  Eat small meals up to 6 per day.
- For difficult cases, give Bendectin, 2 tablets at bedtime. If oral route is not practical, use Dramamine, 100 mg suppository.
- If above treatment is unsuccessful, refer to MD within 48 hours.

NO ↓

Have any new drugs or medications been taken? (f) — YES →
- Call the MD to determine if medication should be continued.

NO ↓

Is the patient emotionally upset?
Does the patient have many physical complaints of psychological origin? (g)

YES (to either question) →
- Be supportive and show concern towards the patient by discussing the problem(s).
- Give Dramamine, one tablet 50 mg or 100 mg suppository, or 50 mg intramuscular injection 3-4 times a day, as needed for 24 hours.
- Refer patient to mental health consultant or MD within 24 hours.

NO ↓

Has the patient had a recent viral illness?
Is there a whirling or spinning sensation?

YES (to either question) → Suspect vertigo from labyrinthitis.
- Give Dramamine, 50 mg oral or 100 mg suppository, 3-4 times per day as necessary.
- Refer to MD within 48 hours for ENT exam.

NO ↓

Treat for a simple viral gastroenteritis.
- Patient should:
  Drink only clear liquids.
  Rest in bed if necessary.
- Give Dramamine, one tablet 50 mg or 100 mg suppository or 50 mg intramuscular injection 3-4 times a day, as needed. (h)
- For headache, give Tylenol, 2 tablets 4 times a day.
- If no improvement in 48 hours, refer patient to MD.

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Notes to Standing Order H 11b

## THE MANAGEMENT OF NAUSEA AND VOMITING

(a) Nausea and vomiting seldom last long and are usually caused by viral infections of the gastrointestinal tract. Excess food, alcohol, and emotional stress also may cause nausea and vomiting. Forty percent of pregnant women have this complaint. Occasionally a more serious problem is causative such as a head injury, bleeding ulcer, or gall bladder disease.

(b) Vomiting causes the loss of important fluids and chemicals essential to the proper functioning of the body. If the patient vomited large amounts for more than 24 hours and has not been drinking fluids, dehydration may be present. (See dehydration in the standing order on diarrhea.) The body reacts by showing one or more of the following signs or symptoms:

- Pulse rate over 100.
- Blood pressure under 90/60.
- Respiratory rate over 25.
- Extreme thirst.
- Sunken eyeballs.
- Dry tongue.
- Failure of the skin to spring back into place when picked up between finger and thumb.

(c) Projectile vomiting or vomiting with great force suggests increased pressure on the brain. This pressure can be caused by an intracranial mass such as a pocket of blood pressing the brain against the inside of the skull. While headache is often associated with viral gastroenteritis, headache and vomiting may be due to intracranial disease such as meningitis or bleeding. These patients should always be referred if the cause is in doubt.

(d) Severe abdominal pain accompanied by nausea and vomiting could mean that the patient has an acute abdominal disorder such as appendicitis, an obstructed intestine, or a perforated ulcer. Viral infections cause crampy rather than steady pain.

(e) Morning nausea and/or vomiting in the first 12 weeks of pregnancy is common. Bendectin is a safe drug to use in pregnancy.

Notes to Standing Order H 11b
The Management of Nausea and Vomiting (Cont.)

(f) Certain drugs can irritate the stomach or intestine or stimulate the brain's vomiting center. These drugs include aspirin, Dilantin, oral contraceptives, iron, antibiotics, asthma medications (Theophylline), narcotics, cocaine, amphetamines, and anti-migraine medications.

The most common cause seen will be alcohol abuse.

(g) Sometimes, in cases of anxiety or during psychiatric disorder, vomiting will occur soon after meals without prior nausea. The patient may resume eating after vomiting. The physician or mental health consultant may have to do a psychiatric evaluation to determine the patient's personality make-up and psychological needs before treatment can be effected.

(h) When the patient is vomiting, oral medication cannot be given. Dramamine inhibits vomiting and can be administered intramuscularly. It may cause drowsiness, therefore the patient should not drive or operate machinery while under the influence of Dramamine. Possible substitutes for Dramamine are: Antivert, Compazine, Phenergan, Emetrol, Tigan.

STANDING ORDER H 11c

_____ JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF CONSTIPATION

Patient complains of constipation or irregular bowel movements. (a)

**Is there abdominal pain?**
**Is the patient dehydrated?**
**Is the patient taking narcotics?**

YES (to any question) → Suspect a serious problem.
- Refer the patient to the MD within 4 hours.

NO ↓

Are the bowel movements thin and pencil-like?

YES → Suspect a partial intestinal obstruction. (b)
- Refer patient to the MD within 24 hours.

NO ↓

Is there rectal pain, and/or bleeding caused by bowel movements?

YES → Are you authorized to examine the patient's anus and rectum?

NO → Refer to MD or emergency room within 6 hours.

YES → Are hemorrhoids obvious? (c)

YES →
- Prescribe Xylocaine suppositories, one every 4 hours. (d)
- If hemorrhoids do not resolve spontaneously within 48 hours, refer to MD.

NO →
- The patient may have some other conditions.
- Refer to MD within 6 hours.

NO ↓

Is the patient taking medication that may be causing constipation? (e)

YES →
- Reach the MD who prescribed the drug by phone within 24 hours to discuss a plan for managing the problem.

NO ↓

Is the patient depressed? (f)

YES →
- Be supportive and show concern for the patient by discussing emotional problems.
- If problem persists for 7 days, refer patient to MD or mental health consultant.

NO ↓

Is the constipation brought on by pregnancy? (g)

YES →
- Increase fluid intake to 6 glasses of water/day.
- Increase bulk in diet.
- Mineral oil, one tablespoon at night.
  or
  Milk of Magnesia, 1 tablespoon at night.

NO ↓

Treat constipation as follows:
- Advise patient to drink 6 glasses of liquid a day. (h)
- Increase food bulk in diet or add a bulk-producing agent to the diet. (i)
- If no relief in 3 days, add a stool softener.
- If constipation continues after one week, refer patient to MD.

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Notes to Standing Order H 11c

## THE MANAGEMENT OF CONSTIPATION

(a) Constipation, rarely a serious medical problem, is a common complaint from patients who have had a slowing down of bowel habits or whose stools are hard, dry, and difficult to eliminate. Many persons have been conditioned by their families to think that a daily bowel movement is necessary. This is a common misconception. A bowel movement once a week is sufficient for some healthy people. Constipation can result from variations in diet, weather, mood, and level of activity. Regularity and daily elimination are not essential to good health, so when a patient is not having daily stools, he/she is not necessarily constipated.

(b) Thin, pencil-like bowel movements suggest the presence of an abscess, an inflammation, or cancer in the lower part of the intestine, causing a partial blockage. This condition is rare in this age group. A digital rectal examination may be performed by an authorized person and may detect a mass located in the rectum.

(c) Hemorrhoids are among the commonest afflictions known to man. They are varicose veins around the anus and flare up intermittently.

(d) If pain is severe, it may inhibit the patient from moving his/her bowels, thereby aggravating the problem further as the stools harden. Treatment consists of:

- A high bulk diet and stool softeners to prevent flare-ups.
- Hot sitz baths when a flare-up occurs, accompanied by analgesic (painkilling) suppositories.

(e) Certain medications depress the nerves and muscles of the intestine and cause constipation. Some examples of these drugs are narcotics, iron, some antacids such as Maalox, and overdosage with anti-diarrheal medications such as Lomotil.

(f) Persons who are severely depressed often do not eat, drink, or move their bowels, and as a result can become extremely constipated.

(g) Constipation occurs in pregnancy because of pressure of the growing fetus on the bowels, the need for more fluid than normal, and because the bowel slows down as a physiological response to pregnancy. Laxatives and enemas should be avoided and preventive measures should be followed such as those listed in the algorithm.

(h) When bowels fail to move for a couple of days, the patient should drink a glass of hot water or a cup of tea or coffee half an hour before breakfast and a glass of prune juice with breakfast.

Notes to Standing Order H 11c
The Management of Constipation (Cont.)

(i) If increasing food bulk is impractical on-center, a bulk producing agent such as Metamucil, Mucilose, Effersylium or Collagel combined with water should be administered. Examples of stool softeners are Surfak, Bu-Lax, Maltsupex, Comofolax and Colace. They promote water absorption, which causes the breakup of hard stools and facilitates evacuation.

STANDING ORDER H 11d

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# TECHNICAL ORDER FOR THE MANAGEMENT OF HEARTBURN

Patient complains of burning epigastric pain or indigestion. (a)

Is there vomiting of blood or coffee ground-like material? (b)
Is the patient pale and sweaty?
Is the blood pressure below 90/60 or is the pulse over 100? (b)
Is the patient passing black or bloody bowel movements? (c)

YES (to any question) → Suspect a hemorrhage in the upper gastrointestinal tract.

Shock may be caused by the bleeding.

- Prevent shock by:
  Keeping patient lying down and warm.
  Raising feet 8-12 inches.
  If authorized, administering 1 liter normal saline IV.

Can you reach MD by phone?

YES → • Follow instructions.

NO → • Get patient to hospital emergency room immediately.

NO

Is there a history of gastric or duodenal ulcers? (d) (Check the patient's record.)
Does burning epigastric pain awaken the patient? (e)
Does eating lessen the pain? (e)

YES (to any question) → Suspect an ulcer.

- Give antacid medication, such as Gelusil or Maalox, 1-2 tablespoons every 2 hours as needed.
- Refer patient to MD within 24 hours for diagnosis and treatment plan.

Does indigestion occur after consumption of milk or milk products?

YES → Suspect lactase deficiency. (f)

- Advise patient to avoid milk and milk products.

NO

Is the patient taking medication which may be causing heartburn? (g)

YES → • Call MD to discuss alternative medication or ways to control the problem.

NO

Is the patient pregnant?

YES → • Be supportive. Advise patient to:
  Take a prescribed antacid.
  Avoid fatty and fried food.

NO

Hot spices in diet?
Does the patient smoke heavily? (h)
Has the patient been drinking alcohol heavily or large amounts of coffee or tea? (i)

YES (to any question) → Irritation of the esophagus or stomach (j)

- Advise patient to:
  Follow a bland diet and eat smaller meals.
  Stop smoking.
  Reduce alcohol intake.
  Take 2 tablespoons of antacid medication every 2 hours or when necessary.

NO

Is the patient anxious and under constant emotional stress? (k)

YES → Nervous indigestion. (l)

- Be supportive and show concern towards the patient by discussing emotional problems.
- Reassure patient and refer to counselor.
- Give 2 tablespoons of antacid every hour when necessary.
- If authorized, administer Librax 1 capsule 4 times a day for 1 day.
- If heartburn is still present after 5 or 7 days, refer to MD or mental health consultant.

NO

- If the problem is flatulence (gas), advise patient to: (m)
  Eat more slowly.
  Avoid carbonated beverages.
- Administer:
  Mylicon 40 mg, 4 times a day or as needed, for 1 week.
  Activated charcoal 2 capsules 4 times daily as needed for one week.
- If no improvement refer to MD after 1 week.

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Notes to Standing Order H 11d

## THE MANAGEMENT OF HEARTBURN

(a) Heartburn is caused by acid from the stomach irritating the lining of the wall of the stomach and esophagus. Patients suffering from heartburn experience a burning or gnawing sensation just below the breastbone and ribs, which physicians refer to as the epigastric area.

(b) Bleeding in the upper part of the digestive tract can cause vomiting of blood or coffee ground-like material. If the bleeding is heavy enough, the patient may go into shock with low blood pressure and rapid pulse.

(c) Bleeding ulcers may cause the bowel movements to look black and tarry, and to be more frequent.

(d) Ulcers tend to recur.

(e) Burning epigastric pain which awakens a person is usually severe and is often caused by duodenal ulcers. Ulcer pain is increased when acid accumulates after three or four hours, such as at night when the stomach is empty.

(f) Many patients lack the enzyme, lactase, necessary to digest milk. Common symptoms are heartburn, cramps, distention and ind.gestion. It may be necessary to eliminate milk products from the diet to prevent symptoms.

(g) Drugs such as aspirin, prednisone and antibiotics can irritate the stomach lining, thus causing heartburn.

(h) Heavy smoking means more than 30 cigarettes (1 1/2 packs) a day.

(i) Heavy drinking means more than three cans (36 oz) of beer, three drinks (4 1/2 oz) of hard liquor (whiskey, gin, etc.) or three glasses (9 oz) of wine. Large amounts of coffee or tea means more than five cups a day.

(j) These substances cause both direct irritation of the esophagus, stomach and duodenum and increased production of acid. The physician can prescribe a bland diet for the patient in accordance with the food available at the center. Antacids such as Maalox or Gelusil taken alternately with milk -- every one or two hours -- will relieve most pain symptoms.

(k) Stress or emotional ten n can also cause heartburn or indigestion by stimulating an overproduc of digestive acids. Consultation with the center's counselor may be helpful.

Notes to Standing Order H 11d
The Management of Heartburn (Cont.)

(l) Ulcers and heartburn are common psychosomatic conditions caused by stress. Many individuals find Job Corps an anxiety-provoking experience due to demands being made, peer pressure and separation from the home or familiar environment. Patients who develop diseases from psychological causes need the examiner's skill, patience, time, and referral to the physician and or mental health consultant. Difficult cases can be temporarily managed with Librax, a combination tranquilizer and anti-spasmodic agent.

(m) Air swallowing is the usual cause, but a patient with a persistent problem should be sent to the physician who can screen the patient for underlying gastrointestinal disease.

STANDING ORDER H 11e

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# TECHNICAL ORDER FOR THE MANAGEMENT OF ABDOMINAL PAIN

Patient complains of a belly ache or cramps. (a)

Has there been severe abdominal pain for more than 6 hours? (b)
Is the pain localized in a specific area of the abdomen? (c)
Is there severe cramping? (e)
Is there a temperature over 102° F - 39° C? (f)
Is the patient pregnant? (g)
Has there been an abdominal injury within the past 24 hours? (h)
Is the abdominal pain worse during urination? (i)

- If you are authorized, examine the patient while he/she is lying down. (j)

Are the abdominal muscles rigid?
Are there any obvious swellings?
Are there any areas of tenderness?

YES (to any question) → Suspect an "acute abdomen."

- Nothing to be taken by mouth.
- Do not give any medication for the pain. (d)
- Consider this an urgent health problem.

Can you reach the MD by phone?

NO → Refer patient to hospital emergency room immediately.

YES → Follow instructions.

NO

Is the pain associated with:

diarrhea? YES → Refer to Standing Order H 11a.
nausea and vomiting? YES → Refer to Standing Order H 11b.
constipation? YES → Refer to Standing Order H 11c.
heartburn? YES → Refer to Standing Order H 11d.

NO

Does the patient have a history of anxiety or depression?
Does the patient appear emotionally upset? (k)

YES (to either question)

NO → Suspect a viral infection or gas.

- Instruct patient to:
  Drink plenty of clear liquids.
  Rest in bed, if necessary.
  Take an antacid, such as Gelusil or Maalox, 1-2 tbsp. every hour when necessary.
- Advise patient to return if:
  The abdominal pain persists over 48 hours.
  New abdominal problems develop such as vomiting, diarrhea or constipation.

Suspect a nervous or psychological problem.

- Reassure the patient.
- Give antacid medication, such as Gelusil or Maalox, 1-2 tbsp. every 2 hours when necessary.
- Give an antispasmodic such as Donnatal, 2 tablets 3 times daily as necessary for 24 hours. (l)
- If pain recurs or persists after MD's examination, refer patient to counselor or mental health consultant. (m)
- If pain increases, if pain is not relieved after another 24 hours, or if any of the above urgent signs develop, send patient to MD or emergency room.

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Notes to Standing Order H 11e

## THE MANAGEMENT OF ABDOMINAL PAIN

(a) The most common causes of abdominal pain are gas, viral infections, anxiety and depression.

(b) Severe abdominal pain lasting longer than six hours may be due to a problem requiring immediate surgery such as the following abdominal emergencies:

- Appendicitis.
- Gallstones.
- Kidney stones.
- Kidney infection.
- Tubal pregnancy.
- Complications of abdominal injuries.
- Cholecystitis (inflamed gallbladder).
- Perforated peptic ulcer.
- Complicated hernia.
- Intestinal obstruction.

The health staff must decide within an hour after the patient's arrival at the dispensary whether examination by the physician or referral to the emergency room is needed.

(c) Each of the numerous diseases that can cause abdominal pain has its own characteristic signs and symptoms. By determining where in the abdomen the pain is located, a physician can sort out which organ is affected. Patients with nervous problems often cannot pinpoint an exact pain location, e.g., "it hurts all over" could be a type of complaint from a patient with nervous or emotional problems.

(d) If an abdominal emergency is suspected, no pain medication should be given because it may interfere with the physician's diagnosis.

(e) Severe cramping is usually caused by violent contractions of the stomach and intestine, liver and bile ducts, the pancreatic ducts, the ureter (tube leading from the kidney to the bladder) or the womb. This

Notes to Standing Order H 11e
The Management of Abdominal Pain (Cont.)

kind of cramping is called "colic" by physicians. Biliary colic is cramping caused by gall stones passed in the bile ducts; ureteral colic is cramping caused by kidney stones passed in the ureter.

(f) Fever with abdominal pain can mean the presence of infection in one of the abdominal organs (kidney, gallbladder, appendix). All patients with a fever and abdominal pain should have a white blood cell count done. An elevated white blood cell count usually indicates a bacterial infection in the abdomen and not a viral illness. It must be stressed here that colds, flu and other viral infections also can cause abdominal pain and account for most cases you will see. Serious problems such as appendicitis are unlikely if fever precedes or is present at the onset of pain.

(g) The possibility of an ectopic pregnancy must be eliminated by a physician.

(h) Most serious problems from an abdominal injury will become evident immediately. Abdominal injuries can cause internal bleeding by a rupture or laceration of any of the abdominal organs. These injuries can cause death unless the bleeding is stopped. Signs of internal bleeding are: blood pressure below 90/60; cold, clammy skin; and rapid, shallow respiration.

(i) Abdominal pain during urination can be caused by a kidney infection, a stone in the ureter, a pelvic abscess or appendicitis.

(j) For the examination, the patient should lie down flat on his/her back and be made as comfortable as possible. The general appearance of the abdomen should be observed first for any abnormal distension or swelling. The patient should be asked to point to the painful area. The examination should begin in the area farthest away from the most painful point. Light palpation, gentle fingertip pressure to a depth of 1 to 2 cm, should be applied over the entire abdomen. Inflammation of an organ in the peritoneum (the sac lining in the abdominal cavity which covers most of the organs within) causes the abdominal muscles to become rigid. This can indicate a disorder such as appendicitis, peritonitis or a perforated ulcer.

Tenderness is the sensation of pain when a particular part of the abdomen is pressed.

(k) Emotional problems can show up as abdominal pain. Worry and anxiety can cause the digestive organs to go into spasm, causing pain of a crampy nature.

Notes to Standing Order H 11e
The Management of Abdominal Pain (Cont.)

(l) Other antispasmodic medications besides Donnatal are: Barbidonna, Atropine Sulfate, Librax and Probital.

(m) The patient should be referred to the counselor or mental health consultant only after a physician's examination has ruled out physical disease as the cause of pain.

STANDING ORDER H 12

_____ JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF VAGINAL DISCHARGE

Patient complains of a discharge from the vagina, vaginal itching, venereal disease, painful intercourse and/or bladder symptoms.

Screening for gonorrhea should be done as part of every pelvic examination.

Is the discharge associated with a temperature over 101°F - 38.5°C? (a)
Is there pain in the lower abdomen or is there pain when pressure is applied in that area? (b)

YES (to either question) → Suspect a pelvic infection. (c)

- Refer the patient immediately to the MD or the emergency room for further investigation.

NO

Are you authorized to take specimens from the vagina, cervix and the urethra for cultures and lab examinations? (d)

NO →

- Refer these patients to the MD within the next 24-48 hours.

YES

Is the problem mainly frequency and pain on urination?
Do you think the patient may have had sexual intercourse during the past 3 to 10 days with a partner possibly infected with gonorrhea?

YES (to either question) →

- Refer to Standing Order H 13a, The Management of Painful Urination in Females.
- Screen for gonococcal urethritis by milking the urethra for secretions and taking a culture. (e)
- If positive, treat with procaine penicillin as in gonococcal cervicitis.

NO

Is the discharge white and does it look like cottage cheese?
Is there intense itching in the genital area?
Has the patient recently been taking antibiotics?
Is the patient pregnant? (f)
Is the patient on birth control pills?

YES (to any question) → Suspect a vaginal fungus or yeast infection.

- Have a potassium hydroxide (KOH) preparation or culture done on a specimen of the discharge at the lab.
- If lab tests are positive for Candida albicans, treat with 1 Mycostatin vaginal suppository each night for 2 weeks.

NO

Is there a foul odor associated with the discharge?
Is the discharge greenish, bubbly and itchy?
According to her chart, has the patient been treated previously for trichomoniasis?

YES (to any question) → Suspect trichomonal vaginitis.

- Order a wet mount to be done at the lab on the vaginal discharge to check for Trichomonas vaginalis.
- If the wet mount test is positive:
  Treat patient with 1 Flagyl tablet 250 mg, 3 times a day for 7 days. (Do not give to pregnant women.)

NO

Is there a grayish discharge that is frothy without itching? YES →

- Have a wet mount prepared.
- If there are "clue" cells and no Trichomonas, suspect Hemophilus vaginalis infection. (g)
- Order a Gram stain. (h)
- Treat with Furacin, one vaginal tablet in the evening for 10 nights.
- Refer the patient to the MD for an examination and additional therapy if there is no improvement within 10 days.
- Treat sexual partner(s).

NO

Is the patient on sequential type birth control pills? YES →

Suspect increased vaginal secretion due to hormonal stimulation.

- If authorized, change oral contraceptive to a non-sequential type, with a low estrogen dose. (i)

NO

Are you authorized to use a speculum to examine the cervix? NO →

- Refer these patients to the MD within 24-48 hours.

YES

Is there pus discharging from the cervix?
Is the cervix red and tender to touch? YES →

Suspect acute cervicitis.
Suspect a vaginal infection due to gonorrhea.

- Take a cervical swab and send the specimens to the MD's office or to the hospital lab for a Thayer-Martin culture. (e)
- Upon positive confirmation of the diagnosis, consult first with the MD, then treat the patient as follows:

Is there a penicillin allergy?

NO →

- Administer 1 gram of Probenecid orally one hour before the injections of procaine penicillin, 4.8 million units, one half in each buttock.

YES →

- Administer 1.5 grams of tetracycline hydrochloride orally in a single dose.
- The MD should examine patient within 72 hours if complications arise.

NO

Is there an erosion on the cervix?
Is the patient pregnant or on birth control pills?

YES (to either question) → Suspect chronic cervicitis.

- Refer to MD at the next possible appointment.

NO

Some females naturally have a heavy, non-irritating, odorless discharge. (j)

- Reassure the patient that there is no abnormality.

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Notes to Standing Order H 12

## THE MANAGEMENT OF VAGINAL DISCHARGE

(a) A history of vaginal discharge associated with lower abdominal pain and fever signals a possible infection of the female organs (uterus and fallopian tubes).

(b) Severe infection and inflammation of the pelvic organs cause pain in the lower abdomen due to irritation of the peritoneum (the sac that lines the abdominal cavity and surrounds all the organs within it). In such cases, the lining of the fallopian tubes and the ovaries has become inflamed as a result of infection. (The fallopian tubes are a pair of trumpet-shaped tubes that connect the uterus, or womb, to the ovaries--which are the reproductive glands containing the eggs.) When this happens, the patient experiences pain when the examiner presses on the abdomen, causing the inflamed surfaces to rub together.

(c) An infection (inflammation of the mucous membrane transmitted chiefly by sexual intercourse) can spread from the vagina, to the lining of the uterus, and then infect the fallopian tubes and the ovaries. If pus pockets form in the fallopian tubes, the result is abdominal pain and occasionally fever. At times, when pain is on the right side of the abdomen, it is difficult even for physicians to differentiate between an infection of the fallopian tubes and an appendicitis. The fluid which is sometimes discharged from the vagina must be cultured to ensure the proper diagnosis and treatment. Infection which spreads from the vagina to the pelvic organs must be carefully treated by a physician to ensure against complications, such as sterility. These complications can arise if the fallopian tubes become permanently scarred and closed off, preventing egg movement from ovary to the womb.

(d) The cause of vaginal discharge is accurately determined only by lab studies, such as a Thayer-Martin culture or wet mount. The physician may authorize certain health personnel to take specimens, order tests and relay the results. This would save him/her time since the necessary information to make a diagnosis would be at hand when the pelvic exam is done.

If lab equipment is available on center, one of the easiest examinations to perform is microscopic examination of a wet mount of the discharge as follows:

(1) A drop of discharge is placed at each end of the slide.

(2) One drop is mixed with saline and the other with a 20 percent potassium hydroxide solution (a few drops of each).

Notes to Standing Order H 12
The Management of Vaginal Discharge (Cont.)

(3) A cover slip should be placed over both suspensions and then examined. The Trichomonas can be seen swimming in the saline, and the spores and hyphae, if present, can be seen in the potassium hydroxide solution.

(e) Due to the shortness of the female urethra, the canal conveying urine from the bladder to the exterior of the body, many women suffer from bladder infections characterized by painful, burning, and frequent urination. Health staff should always consider gonorrhea as a possible cause of urethritis and take a culture sample from the urethral opening. Painful urination is experienced three days after sexual contact, but symptoms resolve in a day or two. Compression of the urethra and its glands should be done on examination to squeeze out pus for the culture. Further information can be found in Technical Supplement B, Immunization (Section F, Venereal Diseases, pp. 18-24).

(f) There is a normal increase of vaginal fluids during pregnancy and when a patient is on birth control pills. However, there is also a tendency toward monilial (yeast) infections due to a change in vaginal acidity. Yeast infections can occur as a result of previous antibiotic therapy, especially from ampicillin or tetracycline which kill normal vaginal bacteria and set the stage for yeast infection.

(g) Many patients with vaginitis have two or more causes. Twenty-five percent of women with trichomoniasis also have Hemophilus vaginitis caused by a bacterium transmitted sexually. It may be necessary to refer these patients to the physician for combined therapy.

(h) A Gram-stain will often show a predominance of short, Gram negative rods (bacilli) when inflammation of the vagina is due to Hemophilus vaginalis.

(i) Ovral, Ovulen 21, Ortho-Novum 2 mg, Norinyl 2 mg and Norquen 21 are examples of non-sequential oral contraceptives with a low estrogen dosage.

(j) Some women have an increase in vaginal fluids at the time of ovulation (the middle of the cycle, approximately 14 days after menstruation).

STANDING ORDER H 13a

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# TECHNICAL ORDER FOR THE MANAGEMENT OF PAINFUL URINATION IN FEMALES

Patient has one or more of the following complaints: (a)
- Frequent urination (day and/or night),
- Cannot wait to urinate when the urge comes on.
- A feeling of burning when passing urine.
- Lower abdominal pain on urination.

Does the patient have a history of any of the following:
- Diabetes or hypertension?
- Kidney or bladder infection?
- Kidney or bladder surgery?

Is the patient pregnant? (b)

Does the patient have any of the following signs or symptoms:
- Pain over the kidney region of the back?
- Aching and pain in the joints?
- Pain over the back muscles?
- Sore and rigid muscles of the abdomen?
- Chills and fever over 101°F- 38.5°C?
- A pulse rate over 100?
- Blood pressure over 140/90?

YES (to any question) → Suspect kidney infection. (c)

- Send patient to MD or emergency room within 8 hours for lab tests and exam. (d)

NO

Does the patient have vaginal itching or discharge? (e) YES → Suspect urethral inflammation due to vaginal infection.

- Refer to Standing Order H 12, The Management of Vaginal Discharge.

NO

If the patient has only painful and frequent urination, suspect a bladder infection or urethritis.

- Send patient to clinic or hospital for a midstream urinalysis, culture and sensitivity test. (f)

→ Does the urinalysis reveal pus or a bacterial count over 100,000?

NO → Suspect urethral syndrome. (g)

- Reassure the patient; limit intake of alcohol, coffee and tea and force other fluids.
- If symptoms continue for 48 hours, repeat the urinalysis and refer the patient to the MD.

YES

- The bladder infection or urethritis is confirmed. Review results with MD and follow his/her instructions for antibiotic therapy.
- When results of urine culture and sensitivity tests arrive, review them with MD for possible changes in treatment.

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Notes to Standing Order H 13a

## THE MANAGEMENT OF PAINFUL URINATION IN FEMALES

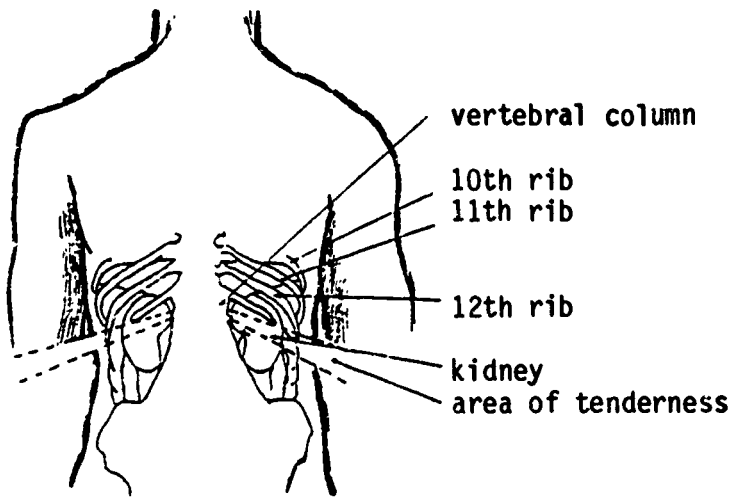
(a) Due to the shortness of the female urethra, the canal conveying urine from the bladder to the exterior of the body, many women suffer from bladder infections, characterized by painful, burning, and frequent urination.

(b) In the first trimester, the pregnant female commonly develops a bladder infection due to pressure on the bladder and increased susceptibility to infection.

(c) The health staff must learn to sort out the more common case of bladder infection, from kidney infection. The latter occurs when infection spreads from the bladder into the kidneys causing a potentially life-threatening problem. Acute kidney infection (pyelonephritis) typically manifests itself as severe illness with chills, fever, vomiting, pain in the upper abdomen as well as in the back, and tenderness over the kidney on the affected side. (See illustration below.)

Figure 1:

The costovertebral area, or the back over the kidney which may feel tender if kidney is infected.



Notes to Standing Order H 13a
The Management of Painful Urination in Females (Cont.)

(d) Urine samples are examined under a microscope to detect bacteria or pus cells (white blood cells). It is generally accepted that bacterial contamination should not exceed 100,000 bacteria per milliliter. If the bacteria exceed this limit, this should be considered a definite sign of infection in the urinary tract and the physician should be notified. He/she will decide which antibiotic to initiate. The most commonly prescribed antibiotics are ampicillin, sulfonamide and kanamycin. The examiner should make sure that a culture and sensitivity test are done also to assure use of the correct antibiotic. These tests will take several days and the physician should be contacted as soon as the results are returned from the lab, since the treatment may need to be changed.

(e) All patients with vaginal discharge should be sent to the physician for pelvic examination. In adolescents, diseases that most commonly cause discharge from the vagina and bladder or that cause urethral irritation are gonorrhea and trichomoniasis.

(f) Strict attention must be paid to the techniques of collecting a mid-stream urine sample. The examiner must make sure the patient understands and follows instructions. To collect an uncontaminated urine specimen, the patient must be instructed to clean the urethral opening with an antiseptic, such as Betadine solution (see Figure 2). Then she should discard the first of the stream because the outer part of the urethra is usually overgrown with bacteria, which will contaminate the first few drops of urine. Next, she should be told to spread the vulva (see Figure 3) and void into a sterile container. Finally, the patient should discard the end of the stream since it is expelled with less force and may dribble over the surrounding skin, causing contamination.

(g) Many patients have symptoms even though there is no evidence of infection. This is due to inflammation for reasons other than bacterial infection, such as trauma from sexual intercourse, heavy coffee or tea drinking or nervousness.

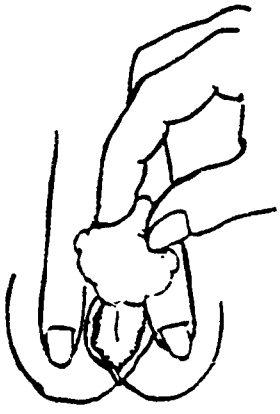


Figure 2

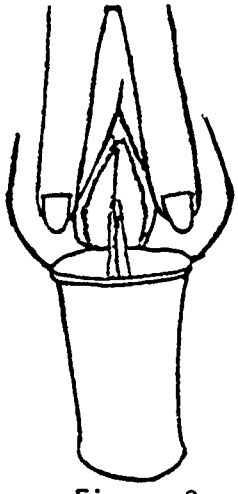


Figure 3

STANDING ORDER H 13b

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# TECHNICAL ORDER FOR THE MANAGEMENT OF PENILE DISCHARGE AND PAINFUL URINATION IN MALES

Patient complains of increased frequency of urination and/or a burning sensation upon voiding. (a)

Are there shaking chills and a fever over 101°F (38.5°C?
Does the urine look bloody or dark?
Is there a foul odor to the urine?
Is there flank pain or abdominal pain?
Is there a history of urinary tract infection?

YES (to any question) → Suspect obstruction or infection in the urinary tract. (b)
- Refer to MD within 4 hours.

NO

Is there swelling in the testicles? (c)
Is there pain and swelling in any of the joints? (d)

YES (to either question) → Suspect gonorrhea that has spread into the epididymis or the blood stream.
- Refer to the MD within 12 hours after initiating treatment.

NO

Is there a discharge coming from the opening of the penis?

NO → If there is no discharge but a history of contact or symptoms, do a culture. (e)

YES

Are you authorized to do a Gram stain of the discharge?

YES → Do a Gram stain of the discharge to determine presence of gonococcal bacteria.

NO → Send patient to lab at referral clinic or hospital for a Gram stain and culture. (e)

Is there a positive result for gonorrhea?

NO → Suspect non-gonococcal urethritis. (f)
- Refer to MD within 24 hours.

YES → Order a serological test for syphilis. (g)

Is there a penicillin allergy? (h)

NO →
- Administer aqueous procaine penicillin G., 2.4 million units intramuscularly in each buttock.
- Also administer Probenecid 1 gram by mouth.

YES →
- Administer spectinomycin hydrochloride, 2 grams, intramuscularly.

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Notes to Standing Order H 13b

## THE MANAGEMENT OF PENILE DISCHARGE AND PAINFUL URINATION IN MALES

(a) A discharge from the penis is one of the most common complaints of young males. It may be thick and creamy or clear and watery. Most often it is accompanied by a feeling of burning pain experienced when the individual passes urine. About 50 percent of patients with these complaints have gonorrhea and the other 50 percent have what is referred to as non-specific or non-gonococcal urethritis. The organism in gonorrhea, called Neisseria gonorrhoeae, is easily recognized under the microscope when a Gram-stain is done. Non-specific urethritis is caused by other organisms which cannot be easily detected. Both conditions are spread by sexual intercourse and have a two- to seven-day incubation period.

(b) Pain, burning, and frequent urination also are caused by kidney and bladder infections, which are rare for males between 16 and 21. Acute kidney infection (pyelonephritis) typically manifests itself as severe illness with chills, fever, vomiting, pain in the upper abdomen as well as in the back and tenderness over the kidney on the affected side.

Urinary tract infections above the urethra are rare in young males. Any male complaining of pain, increased frequency, or urinating at night more than once (nocturia), should have the following organs checked:

1. The prostate and other parts of the male sexual glands.
2. The bladder.
3. The kidneys.

Untreated gonorrhea can spread from the urethra and infect other parts of the urinary tract. A mid-stream or a two-glass urinalysis should be done. If white blood cells and bacteria are detected, the patient should be sent to the physician for a complete urological investigation.

(c) Ten to 20 percent of untreated gonococcal urethritis cases develop an epididymitis. Since the epididymis is located next to the testicles, the scrotum should be examined for swelling.

(d) One to 3 percent of untreated cases of gonorrhea result in a gonococcemia (blood infection) which can result in joint infections.

(e) Twenty percent of cases of gonorrhea are asymptomatic. It is important to differentiate between the two kinds of urethritis since penicillin does not work in non-specific urethritis. Therefore, it is imperative that a Gram-stain be done.

Notes to Standing Order H 13b
The Management of Penile Discharge and
Painful Urination in Males (Cont.)

(f) Many men continue to have symptoms for up to three weeks after successful treatment for gonorrhea. Antibiotics only cure the infection and not the accompanying inflammation. The unhealed lining of the urethra needs time to regenerate. Resistance or true relapses are rare in gonorrhea. Often the real problem is further sexual contact.

(g) Anyone with gonorrhea will have an increased probability of having come in contact with syphilis. Therefore, it is conventional medical practice to order a serological test for syphilis on all individuals with gonorrhea. (Note that since the test does not become positive until three weeks to three months after exposure, any negative test must be repeated when three months have elapsed. For further details on venereal diseases, see Technical Supplement B, pp. 17-24).

(h) The patient's health record should be checked and the patient should be asked if he/she is allergic to penicillin.

STANDING ORDER H 14

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# TECHNICAL ORDER FOR THE MANAGEMENT OF MENSTRUAL PROBLEMS

Patient complains of painful periods, severe abdominal cramps or lower backache.

Is there a fever over 100°F - 38°C?
Has the patient recently had gonorrhea or a pelvic infection? (a)

YES (to either question) → Suspect pelvic inflammatory disease.

NO

Is the pain steady rather than crampy?
Are there other signs and symptoms of an abdominal problem? (b)
Did the patient miss her last period?

YES (to any question) → Suspect an acute surgical problem.

NO

Is the patient bleeding more than normal (over 10 soaked pads or tampons a day)? (c)

YES → Excessive bleeding.

NO

Is this the patient's first painful period? (d)
Was a pelvic mass found on the entrance physical exam? (Check health record.) (e)
Does the patient have an IUD?

YES (to any question) → Suspect painful menstruation due to pelvic disease.

NO

Painful menstruation only? (f)

NO → Does the patient complain of headache just before her period? (g)

YES →
- If the headache is severe, refer to Standing Order H 17, The Management of Headache.
- If not severe, treat with aspirin, 2 tablets every 4 hours as necessary.

NO

Does the patient complain of swelling in the abdomen and legs, depression and irritability just before her period?

YES → Premenstrual tension. (h)
- Place on low salt diet, if possible.
- Be supportive and prevent psychological incapacitation.

YES → Consider the patient's complaint normal for women in the 16 through 21 age group.
- Treat with aspirin, 2 tablets every 4 hours, or acetaminophen (e.g., Tempra, Tylenol), 2 tablets every 4 hours.
- Reassure the patient and place her on bed rest until the discomfort passes.
- Use hot water bottle on abdomen or lower back.
- If pain continues or becomes worse after 12 hours, refer the patient to the MD or to the hospital emergency room for a pelvic examination.

- Consider this an urgent problem and refer patient to MD or to hospital emergency room within 4 hours.

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Notes to Standing Order H 14

## THE MANAGEMENT OF MENSTRUAL PROBLEMS

(a) The presence of fever indicates a possible pelvic infection. Gonorrhea is the most common pelvic infection in this age group. If the pain began several days after the onset of the period and is steady rather than crampy, infection is likely. Gonorrhea can flare up at the end of a period because blood provides an excellent climate for growth of bacteria. The patient's health record should be checked to see if she was treated for gonorrhea in the past two months. The patient could also be having a relapse or could have been re-infected.

(b) On history, if the pain is associated with nausea, vomiting, fever and tenderness in the abdomen, the possibility of salpingitis (inflammation of the fallopian tubes) or appendicitis should be considered. This kind of pain is steady rather than crampy.

(c) An excess of ten soaked pads or tampons a day indicates heavier bleeding than normal. The volume of menstrual flow can be assessed since a soaked tampon contains 25ml of blood and a soaked pad, 50ml. The most common causes of heavy bleeding in this age group are miscarriage, insufficient production of thyroid hormone, and the presence of IUDs or tumors in the uterus. Patients should be examined by the physician as soon as possible to rule out bleeding from these causes.

(d) Nearly all females with menstrual cramps have had cramps frequently in the past. If the patient has had menstrual cramps for years, and the pain is not different from her usual discomfort, this should be considered uncomplicated painful menstruation. But when a patient who has had normal periods complains of extreme discomfort for the first time, it may mean there is a disease of the pelvic organs such as an infection or tumor. This patient should have a pelvic examination.

(e) Diseases such as endometriosis (formation of blood-containing cysts in the pelvis), fibroids (lumps on the womb), and other tumors can cause painful menstruation. These problems are uncommon for this age group (16 through 21 years old). If the patient's entrance examination was over six months ago and she is having new symptoms, she should be rechecked to make sure none of the above-mentioned conditions has developed.

(f) Painful menstruation is one of the most common conditions health staff members will be called upon to treat. Up to 80 percent of women have menstrual discomfort and ten percent are incapacitated enough to lose time from school and work.

Notes to Standing Order H 14
The Management of Menstrual Problems (Cont.)

The pain is greatest about 12 hours after the onset of flow when the lining of the uterus is shedding at the fastest rate. Pain is crampy, usually abdominal, but can be felt in the thighs and the back. The physiological cause of pain is due to the muscles of the uterus contracting to expel blood and tissue through the cervix. It is important to realize that tolerance of pain depends on the emotional make-up of an individual. Basic psychotherapy and support can do much to relieve symptoms. Patient should be encouraged to be normally active. Mild physical exercise rather than bed rest may be helpful. In severe cases, the physician may wish to dilate the cervix and/or prescribe birth control pills which cause less endometrium to be formed, therefore less pain.

(g) Premenstrual headaches occur during the time of bloating (or edema formation) and usually vanish after the first day of vaginal bleeding. If a headache is severe and incapacitating, it should be treated as a migraine. (See Standing Order H 17)

(h) The term "premenstrual tension" is used to describe the discomfort felt in the week before menstruation. These symptoms are caused by the wide fluctuations in female hormone levels that occur during a normal cycle. These fluctuations, which affect salt and water metabolism, trigger changes in all tissues. The most frequent complaints are abdominal bloating, breast tenderness, headache, irritability, mental depression and swollen ankles. There is no known effective treatment. Often a supportive relationship with a health staff member, allowing a patient to talk freely about herself, may be the only therapy needed.

STANDING ORDER H 15a

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# TECHNICAL ORDER FOR THE MANAGEMENT OF SUSPECT ACNE

Patient complains of pimples, whiteheads or blackheads. (a)

Have the lesions recently appeared?
Does the affected area itch?
Are there lesions on the hands or lower extremities?
Has the patient contacted chemicals on-center which may have caused this skin condition?

YES (to any question) → Suspect an allergic reaction or skin rash resembling acne. (b)

- Give an antihistamine, as needed for itching.
- Refer the patient to MD within 24 hours.

NO ↓

Is the patient taking drug(s) which may be causing or aggravating the condition? (c)

YES → Suspect a drug side-effect. (c)

- Refer the patient to MD within 24 hours.

NO ↓

- Examine the patient's face, back, chest, and neck; evaluate the severity by the number and type of lesions and the presence of scarring.

→ Are there cysts, severely inflamed pustules, nodules and pitting or scarring?

YES → Grade IV or very severe acne. (d)

- If an abscess has formed, refer to MD for I&D within 12 hours.
- If no abscess has formed, refer to MD within 48 hours.

NO ↓

Are there pimples, pustules, nodules that are inflamed covering the face, neck and/or shoulders and back?

YES → Grade III severe acne. (e)

- Treat with a topical sulfur soap and sulfur drying lotion and refer to MD within 1 week. (f)

NO ↓

Are there pimples and pustules scattered on the face, neck and back which are not very inflamed?

YES → Grade II moderate acne. (g)

- Treat with a mild abrasive topical soap and benzoyl peroxide drying agent. (f)
- Refer the patient to MD within 1-2 weeks if not improved.

NO ↓

Are there a moderate number of comedones of recent onset with occasional pimples?

YES → Grade I acne. (h)

(1) Wash with an abrasive soap 1-2 times daily. (f)
(2) Use a benzoyl peroxide drying lotion day and/or night until skin is dry but not painful; if no improvement after 4 weeks, advance to step (3).
(3) Apply Tretinoin cream 0.05% once every 2-3 days. Avoid face washing two hours before and several hours after the application. Wash with a mild soap and avoid excessive exposure to sun. Continue 3 to 6 weeks.
(4) Instruct in hygiene.
(5) Refer to MD if acne becomes worse, otherwise continue treatment (3) as needed.

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Notes to Standing Order H 15a

## THE MANAGEMENT OF SUSPECT ACNE

(a) Acne is a superficial skin eruption caused by a combination of factors. It is the most common skin problem that appears during adolescence because more skin oils are secreted during this period. Comedones (Keratin plugs commonly called blackheads) in the openings of hair follicles and sweat glands cause these skin oils to accumulate. Bacteria grow in these secretions, the surrounding skin becomes inflamed, and pimples develop.

Acne can be a psychological and emotional tragedy for adolescents. By showing understanding and sympathy, staff can prevent the patient's withdrawal from social life and encourage the patient to view acne as a condition that can be controlled and frequently cured. Treatment or control of acne to prevent or reduce scarring may involve the use of antibiotics. External measures such as removal of comedones and incision and drainage may also be used in certain cases.

(b) Allergic reactions sometimes cause acne-like lesions. However, these pustular rashes will occur in areas of the body such as the hands and feet where acne is never seen. These rashes appear within a few days of contact. Some cosmetics used on the face aggravate already existing acne by increasing inflammation.

(c) Iodides, bromides, steroids and Dilantin (used in the treatment of epilepsy) are examples of drugs which may cause acne. No drug should be discontinued without the approval of the physician.

(d) Pitting, scarring, irregularly-shaped bumps, hard nodules or soft cysts characterize Grade IV severe acne. These bumps are often painful and filled with pus.

To prevent scarring, a physician may decide to treat these large lesions with steroid injections or incise them to aid drainage of pus. The physician will determine the necessary antibiotic measures.

(e) Grade III acne is usually treated orally with tetracycline--250 mg four times daily and externally with drying agents. This treatment may last up to one or two years, but due to the risk of such side effects as Candida infections of the mouth and genitalia or liver damage, the MD should prescribe the tetracycline and monitor the patient regularly for side effects. The dose should be increased or decreased, as necessary, to control the acne.

Notes to Standing Order H 15a
The Management of Suspect Acne (Cont.)

(f) Topical agents useful in the treatment of acne:

Sulfur Based Drying Soaps (useful for skin cleansing in Grades III and IV).
Fostex
Acnedome Cleanser

Sulfur Drying Lotions (useful for skin drying in Grades III and IV acne).
Acnedome Cream and Lotion
Acnomel Cream and Cake
Fostril
Komed Acne Lotion

Abrasive Soaps (useful for skin cleansing in Grades I and II acne).
Pernox
Brade-A-Foam
Brasivol
Komed Scrub

Benzoyl Peroxide Topical Drying Lotions (useful for skin drying and desquamation in Grades I and II acne).
Persadox
Panoxyl 5
Panoxyl 10
Benzagel 5
Benzagel 10

Tretinoin Cream (Vitamin A acid) useful in Grade I acne.
Retin A
Aberel

Cosmetic Substitute.
Liquimat

The following is a descriptive list of topical agents used in the treatment of acne:

Acnedome Cleanser is a salicylic acid and sulfur topical cleanser, effective in degreasing and peeling away dead skin. Acnedome cleanser should be massaged onto the affected areas twice daily and rinsed off. It can

Notes to Standing Order H 15a
The Management of Suspect Acne (Cont.)

be used in all grades of acne. Very useful in the treatment of Grades III and IV acne.

Acnedome Creme and Lotion is a sulfur and resorcinol topical drying and peeling agent. Acnedome creme and lotion should be applied sparingly to affected areas twice daily. Effective in all grades of acne, especially good in Grades III and IV.

Acnomel Cream and Cake, a sulfur and alcohol based, mild topical peeling and degreasing cream, comes also in cake form. Acnomel should not be applied to diffuse, acutely inflamed areas. One application daily is usually sufficient.

Benzagel 5 and 10 - 5 percent or 10 percent benzoyl peroxide is compounded in an astringent gel. Provides drying, desquamative and antiseptic activity. Wash affected areas prior to application. Keep away from eyes and mucosae. Fair individuals should begin with a single application at bedtime.

Brade-A-Foam, an abrasive soap is composed of a topical pumice in a cleansing foam. It is indicated for the treatment of mild acne conditions. Brade-A-Foam should not be used when nodular cystic acne or acute inflammation is present. Good for Grades I and II acne.

Fostex, a penetrating sulfur cleanser, decreases the oiliness of skin and should be used instead of soap. It is a good topical soap for Grades III and IV acne. It can be used with all grades of acne.

Fostril is a topical sulfur drying and peeling agent. Daily use should result in a desirable degree of dryness and peeling in about seven days. It also helps prevent epithelial closure of pores and formation of new lesions. Good in Grades II, III and IV acne.

Komed Acne Lotion, a salicylic acid and alcohol based keratolytic lotion. Komed Lotion is greaseless and dries to an almost invisible film.

Komed Scrub, is an abrasive cleanser useful as an aid in reducing oily skin in the treatment of mild acne. Use in place of soap. Do not use on inflamed skin.

Liquimat is a lipid-free, drying, make-up type lotion useful in the topical treatment of all grades of acne. Available in nine different shades. Its masking properties render acne lesions less noticeable. Good substitute for make-up.

Notes to Standing Order H 15a
The Management of Suspect Acne (Cont.)

Panoxyl, Panoxyl 5 contains 5% Benzoyl peroxide. Panoxyl 10 contains 10% Benzoyl peroxide. Provides therapeutic control of acne through drying and desquamative action, as well as providing antiseptic activity.

Pernox, an abrasive substance which scrapes off the top layer of skin, helps loosen blackheads and degrease the skin. Pernox should be massaged one to two times daily, then rinsed off. It should not be used when nodules are present as in Grade III and IV acne. Replaces soap. Useful in the treatment of Grades I and II acne.

Persadox is a 5% benzoyl peroxide topical lotion specifically indicated for patients with fair or normal skin. When in contact with living tissue, benzoyl peroxide slowly but continuously liberates active oxygen, producing antiseptic, drying and keratolytic actions. The degree of dryness, scaling and desquamation produced depends upon the skin type and the frequency, amount and strength used. This product should not be used on highly inflamed, denuded or thin, highly sensitive skin.

Tretinoin Cream (Retin-A or Aberel) (Vitamin A acid) causes the skin to peel which results in an unblocking of the pores. Tretinoin works best on non-inflammatory acne and should not be used on patients with other skin problems such as eczema, abrasions, psoriasis or other rashes. All contact with the mouth, nose, eyes or mucous membranes must be avoided. Sun exposure should be kept to a minimum. It is not effective in most cases of severe pustular and deep cystic nodular acne. It is also advisable to "rest" a patient's skin until the effects of peeling agents subside before using this cream. Therapeutic results should be noticed after two to three weeks, but more than six weeks of therapy may be required before definite beneficial effects are seen. Most effective in Grade I acne.

(g) Most Grade II acne is best treated with drying or peeling agents such as Benzoyl peroxide, also known as Panoxyl-5, Persa-Gel-5, or 5-Benzagel. It is an effective drying agent that causes redness and peeling. The lotion or gel is applied for 15 minutes the first evening and then removed with soap and water. Exposure is increased by 15 minutes each evening until the preparation is tolerated for two hours. If there is no improvement or there is inflammation or a rash after one-two weeks, refer the patient to the MD for evaluation. Benzoyl peroxide should not be used when inflammation is present.

(h) Grade I acne patients usually respond well to long-term treatment with topical agents.

STANDING ORDER H 15b

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# TECHNICAL ORDER FOR THE MANAGEMENT OF ECZEMA

Patient complains of an itchy rash. (a)

Is there redness, swelling, blisters or oozing?
Are the hands mainly involved?
Is there severe itching?

YES (to all questions) → **Probably acute eczema. (b)**

**If the patient is incapacitated due to complete involvement of the hands:**

- Refer to MD or to hospital emergency room.

**If the patient is not incapacitated:**

- When first seen, have the patient soak hands in lukewarm water for 15 minutes to control itching.
- For an hour 3 times a day, until the rash subsides, wrap hands with cloths soaked in Burow's solution.
- Apply 1 percent hydrocortisone lotion 3 times daily over the affected area for 2 days. (c)
- If no improvement within 2 days, refer to MD.
- If improvement after 2 days, discontinue soaks, and begin using hydrocortosine cream 1 percent 3 times daily.
- Instruct patient to eliminate sensitizing agents. (d)

NO

Are there areas of itching, oozing, and redness on the body such as behind the ears, the neck, or on the front part of the elbows, or back of knees?
Is there a history of asthma, hay fever, or hives since infancy?
Does the rash tend to occur during periods of stress or during particular seasons?

YES (to all questions) → **Suspect atopic dermatitis (chronic eczema).**

- Instruct patient to protect skin by avoiding irritants such as soaps, chemicals and drying agents and wool clothing. (e)
- Use Cetaphil lotion as a cleansing agent.
- During flare-ups of the condition, use hydrocortisone 1 percent cream, 3 times daily until condition subsides.
- If infection occurs, refer to MD within 24 hours. (f)
- Advise the patient to keep fingernails short to prevent scratching.
- If no improvement within 1 week, refer to MD.

NO

Has patient come into contact with poison ivy or poison oak?
Are there lines, streaks, vesicles or blisters on the skin?

YES (to either question) → Is the area affected more than 10 percent of the body surface? (See rule of 10's under algorithm for the Management of Burns) (e)

YES →

- If severe reaction over large body surface, refer to MD for possible oral steroid therapy.

NO →

- Use wet soaks as above for first 24 hours.
- If small areas affected, treat with Calamine lotion 3 times daily. (e)
- Give Benadryl 25 mg 3 times daily to control the itching, for 3 days.
- If no improvement, refer to MD after 3 days.

NO

Are there hives or itchy red blotches? (g) → YES → **Probably urticaria.**

- Give subcutaneous epinephrine 0.2 to 0.5 cc. stat.
- Repeat in 15 minutes if necessary.
- Give Benadryl 50 mg stat.
- If signs of shock or respiratory difficulty exist, such as wheezing, treat as an urgent problem and refer to the emergency room immediately after administering the above treatment.

NO

Suspect problem other than eczema or allergic skin rash.

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 15b

## THE MANAGEMENT OF ECZEMA

(a) About 5 percent of the population has what is known medically as atopic dermatitis, or eczema. This problem lasts until early adulthood, and most affected people have had the problem since infancy. It is commonly associated with other disorders such as asthma, hay fever, urticaria, etc.

(b) Patients with chronic eczema will have an acute flare-up in response to stimuli such as itchy clothing, harsh detergents or body sweat. The oozing, swollen lesions can be soothed with wet compresses. After a few days, the skin may return to normal. If the lesions are not improved, the patient should be referred to the physician.

(c) The major drug used for the management of eczema is hydrocortisone, applied in a lotion or cream. Lotion is usually required only during flare-ups and cream is used when the condition is resolving. The amount and strength of the drug should be prescribed by the physician.

(d) Patients with atopic dermatitis react badly to the repeated application of materials with a high sensitizing potential. Allergic complications may occur. It is therefore prudent for the atopic patient not to use well-known sensitizers on the skin. This includes the caine group of medications, antihistamines, antibiotics (especially neomycin), compounds containing mercury, and cosmetics (especially nail polish, which contains formaldehyde, and lipstick, which has sensitizing dyes as ingredients). Sometimes the atopic patient is sensitive to the base of a medication, e.g., lanolin, and this sensitivity may explain a patient's failure to respond to treatment.

(e) Atopic patients are peculiarly intolerant to alkalis applied to the skin, so generally they should not use soap. If necessary, oil-free cleanser (Cetaphil) or (BP) may be added to the tub water. Sometimes, if center facilities permit, "oilated" colloidal oatmeal (Aveeno) added to the bath water is soothing; four tablespoons are placed in a strainer and water is run through it into the tub. In general, bath oils should not be used, because they are potential sensitizers and any beneficial effect they may possess is temporary.

Calamine lotion is an inexpensive way to relieve itching. Burow's solution compresses also add relief during the first two days. Anyone who has over 10 percent of the body surface affected should be referred to the physician who may decide to use Decadron injections to control the symptoms. The "rule of ten" from the algorithm, The Management of Burns, may be used to determine the extent of the rash.

Notes to Standing Order H 15b
The Management of Eczema (Cont.)

(f) In managing infections, remember that atopic dermatitis is associated with an increased susceptibility to anaphylactic shock. In general, it is wise for these patients not to receive penicillin (in any form) unless it is absolutely essential.

(g) Hives are a sign of an allergic reaction, usually to a drug or chemical. Many people react to insect stings with hives. Drugs to be suspected as causing hives are penicillin and horse serum vaccines used for prevention of tetanus. Many persons also react to certain fruits and plants with hives. Whatever the cause, the treatment to be used is the same.

STANDING ORDER H 15c

_____ JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF SUPERFICIAL FUNGAL INFECTIONS

Patient complains of itching in localized area or patches on skin.

Is there a possible fungal infection of the scalp or nails? (a)

YES → • Refer patient to MD within 48 hours, for possible antibiotic therapy.

NO ↓

Are there ring-shaped, scaly, itchy patches on the skin? (b)

YES → Suspect ringworm (tinea corporis).

- Apply hydrocortisone lotion 1% 3 times a day for 2 days.
- If no improvement in 2 days, refer patient to MD within 48 hours.

NO ↓

Are there many small, scaly, pink or white patches on the chest and back? (c)

YES → Suspect pityriasis versicolor (tinea versicolor).

- Apply a sulfur-based lotion such as Selsun or Sebulex once a week; leave on 12 hours then rinse skin thoroughly.

NO ↓

Are there itchy, red, scaled lesions involving the groin and the inner side of the thighs?

Are the lesions clearly defined and symmetrical? (d)

YES (to either question) → Suspect jock itch (tinea cruris).

- Apply hydrocortisone lotion or cream 3 times daily for 48 hours.
- Refer patient to MD within 48 hours.

NO ↓

Is there redness and scaling between the toes and on the soles of the feet?

Is there itching in the affected area? (e)

YES (to either question) → Treat as athlete's foot. (tinea pedis).

- Advise patient to:
  - Wash between the toes with a cloth, soap and water, twice daily.
  - Dry between the toes completely.
  - Wear clean cotton socks (avoid nylon or wool).
  - Wear well-ventilated shoes or sandals.
  - Apply Calamine lotion for the first 7 days.
  - Use foot powder after bathing. (f)

↓

Is there improvement after 7 days?

YES → • Advise patient to continue treatment using above measures until skin is completely clear.

NO → • Refer patient to MD within 48 hours.

NO ↓

Suspect the lesions to be caused by something other than a fungal infection.

- Refer patient to MD within 48 hours.

DATE _____ SIGNATURE _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 15c

## THE MANAGEMENT OF SUPERFICIAL FUNGAL INFECTIONS

(a) If the center has a lab, specimens of hair or nails should be examined in a potassium hydroxide solution under a microscope to determine the presence of a fungal infection. A patient with a positive diagnosis should be referred to the MD for possible oral therapy with griseofulvin (e.g., Grifulvin V, Gris-Peg, Fulvicin-U/F, etc.).

(b) Ringworm (tinea corporis) begins as a small red spot which gradually enlarges, becomes ring-like and has a well-defined red border. Later, the central part of the lesion loses color and may itch. If the complaint is scaly patches on the trunk, it could be a fungus, pityriasis rosea, erythema multiforme, nummular eczema or early psoriasis. If the examiner is unsure of the diagnosis, a bland medication such as Calamine lotion or a corticosteroid cream or lotion may be applied. An antifungal ointment applied to conditions such as eczema can irritate and harm.

(c) Pityriasis versicolor (tinea versicolor) is a fungal infection rarely seen other than on the chest and back. The lesions in black-skinned people may be more scaly than those found in light-skinned people. The scales cover patches approximately one cm (about half an inch) in diameter and can be easily scratche off. The patches do not tan and are more obvious in warm weather.

(d) Jock itch (tinea cruris) is most commonly found in males 18-25 years old, and is aggravated by humidity, perspiration, obesity and chafing. In this age group, a fungal infection is the most likely diagnosis; however, a variety of atopic dermatitis may be causing the rash. Since an antifungal agent may cause irritation if the problem is dermatitis, it is best to refer the patient to the physician within 48 hours. While waiting, the lesions should be treated with a bland drug such as hydrocortisone lotion. The physician can make the diagnosis by scraping the skin and doing a culture. The specific needed therapy can then be prescribed.

(e) Athlete's foot (tinea pedis) is caused by a fungus. It is most often spread in such public facilities as showers or locker rooms. Athlete's foot usually occurs between the toes and on the soles of the feet causing itching, blisters, cracking and scaling. Susceptibility to athlete's foot is increased by tight footwear and foot perspiration.

Lesions found on the top of the foot may not be caused by fungi, but by an allergic reaction to shoes and patients with these lesions should be referred to the physician.

Notes to Standing Order H 15c
The Management of Superficial Fungal Infections (Cont.)

(f) Examples of antifungal foot powder that may be used to treat athlete's foot are Desenex and Tinactin (tolnaftate). Sulfur and salicylic acid can be combined in an effective, non-irritating ointment (Fostex, for example) that kills the fungus causing athlete's foot.

STANDING ORDER H16a

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF PAIN IN TEETH OR JAWS

Patient complains of pain. (a)

- Review patient's history and medical records. (b)

Is pain present now?

## NO

Is swelling present? (c)

### NO

Is temperature over 101°F - 38.5°C? (d)

#### NO

**Disposition I**

a. Dispense analgesic with instructions for use if needed for pain.

b. Set up an appointment with dentist within 5 days.

#### YES

**Disposition III**

a. Call the dentist within 24 hours to summarize findings; then follow instructions for treatment and medications. (e)

b. Dispense the analgesic, with instructions for use if pain recurs.

### YES

Is temperature over 101°F - 38.5°C? (d)

#### NO

**Disposition II**

a. Call the dentist as soon as possible, summarize findings and follow instructions.

b. If dentist is not available in 4 hours, follow the plan established to reach another dentist or call MD.

#### YES

**Disposition III**

a. Call the dentist within 24 hours to summarize findings; then follow instructions for treatment and medications. (e)

b. Dispense the analgesic, with instructions for use if pain recurs.

## YES

Is swelling present? (c)

### YES

**Disposition II**

a. Call the dentist as soon as possible, summarize findings and follow instructions.

b. If dentist is not available in 4 hours, follow the plan established to reach another dentist or call MD.

### NO

Is temperature over 101°F - 38.5°C? (d)

#### YES

**Disposition II**

a. Call the dentist as soon as possible, summarize findings and follow instructions.

b. If dentist is not available in 4 hours, follow the plan established to reach another dentist or call MD.

#### NO

Is there a sore in the mouth? (g)

##### NO

**Disposition I**

a. Dispense analgesic with instructions for use if needed for pain.

b. Set up an appointment with dentist within 5 days.

Is it still painful after 24 hours? (f)

##### YES

**Disposition IV**

a. Dispense an analgesic mouthwash, such as Chloraseptic for use every 2 hours and/or dispense a topical anesthetic ointment or gel every 2 hours.

b. Set up an appointment with the dentist within 5 days.

YES

DATE SIGNATURE

_____ _____, Center Dentist

_____ _____,

_____ _____,

_____ _____,

## Notes to Standing Order H 16a

## THE MANAGEMENT OF PAIN IN TEETH OR JAWS

(a) In response to a complaint of pain in the teeth or jaw area, the immediate services or treatment rendered (by someone other than the dentist) is directed toward the pain rather than the cause of the pain. This standing order, consequently, is directed toward pain rather than a differential diagnosis as to the cause of the pain. The degree or amount of pain may vary between individuals from any given cause. What may be described as a mild sensitivity by some, could be interpreted as acute pain by others. Treatment for this complaint should not be based solely on whether the patient complains a lot or a little.

Pain can be present even though the patient has received recent dental treatment. An exposed pulp or nerve irritation could have resulted from a previous dental visit. If bleeding is also present, refer to Standing Order H 16b for The Management of Oral Bleeding.

(b) Review medical history and previous treatment; note allergic reaction and present medications before administering other drugs.

(c) Swelling:

1. A number of conditions can lead to facial swelling, including trauma or an abscess. Swelling is due to edematous tissue (tissue containing an excess of fluid). The examiner should also suspect inflammation of the parotid gland, particularly mumps.

2. If the swelling is due to a dental abscess, the pain may be relieved if the abscess starts to drain. The swelling may subside also. Sometimes a dental abscess will drain its contents inside the mouth. This results in blood and pus coming out of the gums or other teeth. To examine inside the mouth, use a flashlight and a tongue depressor. On some occasions, an abscess will drain outside the mouth, usually along the lower jaw line. An outside drainage will look like an oozing, open sore.

3. A localized abscess is usually the cause of tenderness in the area around the root of a tooth; however, in some cases involving the upper teeth, a sinus infection will cause the same response. In the latter case, the patient may have a history of recent upper respiratory infection and should be referred to the physician for appropriate diagnosis and treatment.

Notes to Standing Order H 16a
The Management of Pain in Teeth or Jaws (Cont.)

4. Regardless of whether there was swelling previously (yesterday or last week), the procedure recommended for swelling currently present should be followed:

(d) Temperature:

A fever associated with pain most often signifies bacterial infection. Often the first sign of a dental abscess is an increase in temperature. Occasionally a dental abscess can become a generalized infection by spreading through the bloodstream or sinuses. If temperature is between 100-101$^{0}$F, 38-38.5$^{0}$C, the patient should return to the infirmary the next day to have his/her temperature rechecked and any increase noted.

(e) In some cases, a dentist may wish to start medication before seeing a patient. Specific instructions in the standing order must be included to cover this eventuality. Because a patient may have an allergy to one drug, an alternate drug should be included in the standing order.

(f) For very severe toothaches, it is helpful if something can be done to obtain temporary relief. There is no single procedure that will guarantee relief; consequently, a number of methods can be tried. If the pain seems to be localized around a tooth that has a large cavity, then two drops of oil of cloves or commercial "toothache" medicine in the cavity may ease the pain. If no large cavity is apparent, sometimes holding warm water in the mouth will help. If not, cold water or an ice pack may be tried. Do not use hot water bottles or heating pads. Heat will increase the swelling potential and usually will make matters worse.

(g) Whatever the nature of the sore, should it be an aphthous ulcer, canker sore, or irritation from foods such as cheese, rough toast, etc.; these sores heal readily after a limited period of time although they may be extremely sensitive in the process. The treatment indicated will help the patient to be comfortable until this natural healing takes place. It is necessary to schedule the patient for a dental appointment so that an accurate diagnosis can be made.

STANDING ORDER H 16b

JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF ORAL BLEEDING

Patient complains of bleeding in the mouth.

- Review patient's history and medical records. (a)

Is it bleeding now? (b)

**NO**

Is there an obstructive clot? (c)

**NO**

Disposition I
a. Make appointment with dentist.
b. Give instructions to follow if bleeding recurs. (d)
c. Dispense sterile gauze pads.

**YES**

Does removal of clot start any bleeding?

**NO**

Disposition I

**YES**

**YES**

- Apply pressure. (d)

Does bleeding continue after pressure is released.

**YES**

Disposition II
a. Call the dentist as soon as possible, summarize findings and follow instructions.
b. If dentist is not available in 2 hours, follow the plan established to reach another dentist or call MD.

or

Does bleeding continue if obstructive clot (c) is removed and pressure is applied and then released?

**NO**

Disposition I

DATE SIGNATURE

_____ _____, Center Dentist

_____ _____,

_____ _____,

_____ _____,

## Notes to Standing Order H 16b

## THE MANAGEMENT OF ORAL BLEEDING

(a) Patient's health record should be reviewed and previous dental problems, dates of treatment and evidence in the medical history of the presence of hemophilia or other blood conditions should all be noted.

(b) It is important to note the type of bleeding that is occurring--slow oozing, pulsating, or profuse bleeding. Profuse bleeding usually is secondary bleeding that follows oral surgery or trauma. It is the most dangerous type of bleeding and can result in large blood loss. Inability to stop profuse bleeding demands immediate attention by the dentist. If pain is also present, Standing Order H 16a for the management of pain in teeth or jaws should be referred to.

A complaint of bleeding may be accompanied by a complaint of nausea, stomach upset, and a foul taste. This condition may result from swallowing a lot of blood and may be alleviated by dispensing an antacid such as Gelusil or Mylanta and instructing the patient not to swallow the blood.

(c) An obstructive clot is a large mass of clotting blood mixed with saliva that obstructs or hinders swallowing, chewing, breathing or eating. This type of clot may protrude excessively from the socket of a recently extracted tooth, or from a wound or trauma, or follow a gum problem. The portion of the clot which is obstructing vital processes must be removed. The patient's mouth should be rinsed with cold water and emptied. If necessary, tweezers or a hemostat may be used to remove a clot from the mouth. If bleeding starts again, the instructions in (d) below should be followed.

(d) The technique for applying pressure to stop bleeding in the mouth is effective because the upper and lower jaws exert great pressure when they bite. If the following technique is to be effective, the point of bleeding must be between the jaws. To use this technique:

1. Make a pad with gauze sponges small enough to fit into the bleeding area but large enough to guarantee pressure during the bite.

2. Place the pad in the mouth over the bleeding area.

3. Have patient close the jaws and maintain pressure for at least 20 minutes.

Notes to Standing Order H 16b
The Management of Oral Bleeding (Cont.)

4. Recheck the area for bleeding with a flashlight after a period of time (approximately 30 minutes). If bleeding seems to have stopped, the patient may be dismissed after a clean gauze pad has been placed in the mouth. The patient should be given instructions to maintain the pressure for an additional hour. Extra gauze may be given to the patient to use to repeat the entire process if bleeding recurs. A moistened tea bag may be substituted for part of the gauze that is in contact with the bleeding area. The tannic acid in tea will help stop the bleeding.

If the bleeding area is not between the jaws but is located on the outside of the gums (cheek, tongue, etc.), an attempt should be made to stop the bleeding by placing a gauze pad over the bleeding area and instructing the patient to maintain pressure with his/her hand from the outside. Direct finger pressure on the bleeding area may also be used to stop the bleeding.

STANDING ORDER H 17

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF HEADACHE.

Patient complains of a headache. (a)

Is there fever over 102°F - 39°C without upper respiratory signs or symptoms? (b)
Has there been a head injury within 2-3 days? (c)
Is there a stiff neck? (d)

YES (to any question) → Suspect an emergency or urgency. Can you reach the MD by phone?

- YES → • Follow instructions.
- NO → • Send patient to hospital emergency room immediately.

NO ↓

Has the patient had a fit (seizure)? (e)
Is headache aggravated by coughing or changing position? (f)

YES (to either question) → • If you can't reach MD in 12 hours, and patient has not improved, send to hospital emergency room.

NO ↓

Is there fever between 100°F - 102°F, 38°C - 39°C? (b)
Does the patient have U.R.I.?

YES (to either question) →
- Administer aspirin, 2 tablets 4 times daily.
- Place on bed rest if patient feels very sick.
- Examine patient at next sick call.

NO ↓

Does the patient have migraine? (Ask and check health record.) (g)

YES →
- Have patient rest in a dark room.
- Give Cafergot. (g)

→ Is headache relieved in 2 hours?

- NO → Can you reach the MD by phone?
  - NO → • Send patient to hospital emergency room immediately.
  - YES → • Follow instructions.
- YES → No further treatment necessary.

NO ↓

Does patient have a hangover (from alcohol or other drugs)?

YES →
- Administer aspirin, 2 tablets 4 times daily.
- Place on bed rest if obviously very sick.

NO ↓

Is pain on both sides, pressing or vise-like?
Are muscles of the neck sore?
Is patient depressed or anxious? (h)

YES (to any question) →
- Suspect tension headache.
- Reassure patient.
- Administer aspirin, 2 tablets every 4 hours.

↓

- If the headache is not relieved within 24 hours and if there are still no signs or symptoms of an upper respiratory infection or no stiff neck, call the counselor. If the counselor is not available, call mental health consultant.

↓

Can you reach counselor or mental health consultant by phone?

- NO → • Send patient to MD or to emergency room for examinatior
- YES → • Follow instructions.

DATE SIGNATURE

_____ _____,M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 17

## THE MANAGEMENT OF HEADACHE

(a) Few headaches (approximately 2 percent) are due to serious diseases or injuries. This algorithm is constructed to separate the serious ones from the 98 percent due to migraine, tension or nerves.

(b) Fever shows infection, most commonly U.R.I. (upper respiratory infections), but might be caused by many other conditions such as flare-up of sinusitis or flu.

(c) The patient may have a concussion or worse - don't delay.

(d) If the patient cannot touch chin to chest, meningitis (inflammation of the coverings of the brain) must be suspected, especially if the patient has been vomiting. Death may occur within 24 hours if treatment is delayed.

(e) Staff and other corpsmembers will probably have seen the fit (seizure) and the health record may show history and medication taken. If this is the first attack, exam by an MD is imperative.

(f) Headache may be caused by a tumor in the head. A tumor is uncommon in this age group, but if present, it may also be causing difficulty with speech, double vision, bad balance, one-sided weakness and unequal pupils.

(g) Migraine usually begins early in life, although the patient may not have admitted it on the health questionnaire or medical history. It often starts with blackout in vision of one eye or bright flashes of light a few minutes before the headache begins. This is caused by spasms of one artery, therefore headache is usually on one side.

Cafergot constricts the arteries (reduces their size) in the brain and body. This prevents or stops the headache. Cafergot should be given immediately. Two tablets should be given orally; one tablet may be repeated at half-hour intervals, not to exceed six in a 24-hour period. Or one suppository may be given rectally and repeated in one hour, not to exceed two in one attack or four in a one-week period. Pregnant women must not be given Cafergot because it will restrict the nutritive blood supply to the fetus, possibly causing abortion. Tylenol--two tablets, or aspirin--two tablets, also can be given for the pain. If the headache is not relieved in two hours, the patient should be sent to the physician.

Notes to Standing Order H 17
The Management of Headache (Cont.)

(h) Tension headaches account for 90 percent of those occurring in patients. They are symptoms of emotional reactions to homesickness, change of life style, frustration, boredom and similar problems and situations.

In tension headaches, muscles of the back of the neck are often sore and massage often helps. Many patients respond well to support from counselors and other staff (health and non-health), also to aspirin and Tylenol. Counseling is more important than pills. The more tense patient may need a mild relaxant such as Valium.

STANDING ORDER H 18a

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF DEPRESSION

Patient attempts suicide or seems depressed. (a)

Has patient attempted suicide? (b) — YES → Psychiatric emergency.

- Do not leave patient alone.
- Call police or security.
- If patient has been seriously injured, administer emergency care as in Standing Order H/NH 2 and call an ambulance.
- Notify center director, MD and emergency room about the problem.

NO

Has patient expressed self-destructive thoughts?
Has patient lost sense of identity, time or location?
Is patient severely withdrawn?
Is patient hallucinating?

YES (to any question) → Psychiatric evaluation is necessary within 4 hours. (c)

- Keep patient in dispensary and make sure someone stays with him/her.

Is MD available by telephone?

YES → • Follow instructions.

NO → Is center mental health consultant available by phone?

YES → • Follow instructions.

NO →

- Alert emergency room that you are sending or bringing a patient for evaluation.
- Arrange for transportation.
- Notify center director.

NO

Does patient visit the dispensary frequently with trivial or chronic complaints that do not respond to treatment?
Does patient complain of insomnia?
Does patient complain of weight loss and loss of appetite?
Does patient complain of feelings of guilt and worthlessness?
Have other staff reported poor performance or self-destructive behavior such as drunkenness or drug-taking?
Does patient weep frequently?

YES (to any question) → Symptoms of chronic depression. (d)

- Give or refer for daily counseling for one week.

Any improvement?

NO →

- Refer to mental health consultant for evaluation.

YES →

- Continue to develop rapport with patient.

NO

Has patient lost someone close to him/her?
Has patient come to center within 30-60 days?
Has patient lost self-esteem?

YES (to any question) → Adjustment reaction. (e)

- Give or refer for daily counseling.

Any improvement after one week?

NO →

- If you are unable to identify a problem, but you suspect mental disorder, refer to the MD to determine whether the help of a psychiatrist is necessary. (f)

YES →

- Continue counseling as necessary.

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 18a

## THE MANAGEMENT OF DEPRESSION

(a) Depression can be described as a mood disorder in which a patient feels very negative about himself/herself, and often includes a loss of self-esteem or self-worth, a disinterest in surroundings, and guilt, and inadequacy. If these feelings are not verbalized, they may be acted out in the form of suicidal behavior or by taking drugs and alcohol to excess.

(b) One of the commonest causes of death in adolescents is suicide. Males tend to choose violent methods--gunshot, jumping, hanging--while females tend to choose drug overdose. A serious attempt at suicide becomes grounds for medical termination from the program. Suicidal patients must be referred immediately to a facility able to provide emergency psychiatric services. Each center should have a referral agreement with a mental health facility.

(c) Psychiatric decompensation or nervous breakdown should be suspected if a patient keeps threatening to kill himself/herself, does not know the date (day, month, year), where or who he/she is, or if inappropriate answers are given to questions concerning time, space, or person. If a patient ceases to be in contact with reality or claims to be having auditory hallucinations --"voices,"--rapid psychiatric evaluation should be provided. This evaluation will result in a referral or treatment plan, as necessary. Some patients may respond well to medication and therapy if a problem is detected soon enough.

(d) Chronically unhappy people often complain a great deal, particularly about their health. They seldom respond to treatment or will develop new complaints or problems as a reason to visit the dispensary. Complaints are often of a vague nature. The more severely depressed often complain of sleeplessness or early morning waking (3-4 a.m.). Loss of appetite and interest in food may lead to weight loss. The patient may be referred by other staff members who may report habitual drunkenness or poor performance in the program.

(e) All persons react with sadness if a loved one is lost through separation, sickness or death. Most patients in this situation will respond well to counseling.

Approval by their peers is particularly important to adolescents. A perceived loss of approval may lead to a grief reaction. Corpsmembers who are adjusting to center life may become despondent and withdrawn due to separation from their family and friends. They are also confronted with the necessity to win approval from a new peer group. All centers can minimize stress reactions, longliness, and alienation by providing orientation, group rap sessions, and supportive counseling at an early stage before problems become full-blown.

Notes to Standing Order H 18a
The Management of Depression (Cont.)

(f) Causes of abnormal behavior are not by any means limited to mental disorders. Patients with diabetes, high blood pressure and epilepsy may show abnormal behavior when their disorders are not adequately controlled. Severe infections may cause patients to become delirious, or "out of their heads" from the fever. Patients with brain tumors or head injuries may develop changes in personality. Head injuries may result in personality change due to small scars left on the brain and blood clots around the brain.

STANDING ORDER H 18b

_____JCC

# TECHNICAL ORDER FOR THE MANAGEMENT OF ANXIETY

Patient appears worried, uptight, and/or angry. (a)

Has the patient become withdrawn, quiet and disinterested?
Is the patient disoriented in time and place?
Is the patient fearful without apparent cause?
Is the patient careless in appearance?
Has the patient frequently been absent from classes recently?
Has the patient greatly increased his/her use of alcohol, drugs or tobacco?
Has the patient developed a hostile, belligerent or aggressive attitude?

YES (to any question) → Suspect emotional decompensation (falling apart). (b)

- Refer patient to MD or psychiatrist for psychiatric evaluation within 24 hours.

NO ↓

Is the patient depressed?

YES → 

- Refer to Standing Order H 18a, The Management of Depression.

NO ↓

Does the patient have multiple bodily complaints? (c)
Is the patient frequently at sick call for minor complaints that never improve? (d)
Has the patient been suffering from insomnia for a week or more? (e)

YES (to any question) → Suspect a chronic anxiety state.

- Discuss problem with patient and refer to center counselor.
- If no improvement within 2 weeks, consult with center counselor and jointly refer to mental health consultant for psychiatric evaluation.

NO ↓

Is anxiety the result of a specific crisis?
Does the patient fear the loss of a loved one?
Is there fear of failure?
Is there fear of losing approval from or status among other corpsmembers?

YES (to any question) → Consider this a stress reaction. (f)

- Reassure the patient by:
  - Being kind but not overly sympathetic.
  - Listening attentively.
  - Asking the patient about work, family, and how he/she gets along with other corpsmembers.
  - Discussing the things that may cause worry or anxiety
  - With the patient, developing solutions to overcome the problem.
  - Emphasizing the number of things that can be done to resolve the problem.
- If no improvement within 48 hours, consult with counselor and jointly refer patient to mental health counsultant or MD.

NO ↓

The patient may be malingering (faking illness). (g)

- Refer back to regular training schedule.

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 18b

## THE MANAGEMENT OF ANXIETY

(a) Anxiety is defined as a state of apprehension, tension and uneasiness. Mild anxiety is a necessary part of life and may help motivate an individual to achieve goals. But when anxiety is severe, it is a symptom of mental illness. Though regarded as a symptom, anxiety can generate a wide variety of other symptoms (e.g., drinking, drug abuse, insomnia, or aggressive behavior).

(b) Anxiety can be explained as a person's attempt to cope with changing life situations that require an ability to adapt. Emotional decompensation (falling apart) is a mental disorder that occurs when a person is unable to cope, expressed in different ways by different persons. However, there are definite clues that indicate decompensation: disorientation (loss of one's sense of direction or location), withdrawal, aggression, chronic intoxication, self-neglect, and/or tardiness. If counseling by center staff does not relieve the problem, the patient should be referred to the mental health consultant or MD for psychiatric evaluation.

(c) Anxiety can be difficult to cope with. Rather than suffer distress, some people unconsciously change anxiety into bodily (somatic) symptoms. The examiner should always remember that, to the patient, the problems are very real. The nurse should always listen and try to show understanding to the patient.

Possible reasons for converting anxiety into bodily symptoms are:

- Patients are less willing to admit "mental" causes rather than "physical" causes for their discomfort.
- Patients feel that health personnel are less interested in mental complaints than in physical ones.
- The bodily complaint is a ticket of admission into the dispensary.

Common bodily reactions to anxiety are:

- Fatigue, headaches, dizziness.
- Difficulty swallowing.
- Rapid heartbeat.
- Heartburn.

Notes to Standing Order H 18b
The Management of Anxiety (Cont.)

- Bowel spasms.
- Diarrhea, vomiting.
- Hyperventilating (fast, shallow breathing).
- Urinary frequency (cystitis symptoms).
- Sweating palms.
- Shaking hands (tremor).
- Painful menstruation
- Low backache.

(d) Most ailments due to anxiety do not improve until the cause of the anxiety is dealt with. Once the patient has insight into the underlying problems, anxiety levels can be significantly reduced. The mental health consultant may be able to identify the cause by taking a detailed medical history of the patient.

(e) Insomnia is a frequent complaint heard during sick call. Chronic insomnia (one week or more) may be a clue to an underlying disorder. Rather than give these patients a sleeping medication, they should be referred to their counselor. The examiner should discuss with the patient the wisdom of consulting the mental health consultant or MD for an evaluation of the problem.

(f) Most people have experienced anxiety or have gone through a crisis of some sort in their lives. Because sharing one's distress with another person offers relief from anxiety, health practitioners and counselors are often called upon to give reassurance and support.

(g) Malingering (faking illness) is a common occurrence in organizations where persons obtain some benefit by being excused from regular duties. The nurse can become skilled at detecting malingerers by knowing the corpsmembers on-center, by working closely with other staff members and by having an effective system for taking medical histories and examinations to rapidly detect true physical or psychiatric disease. Any corpsmember who comes to the dispensary must be treated as if there were an underlying problem until it is clear that he/she is malingering.

STANDING ORDER H19a

_____JCC

# TECHNICAL ORDER FOR THE SCREENING AND EVALUATION OF HYPERTENSION

Patient comes in for physical examination or with a major illness or injury.

- Check patient's blood pressure. (a)

On first reading, is diastolic ≥120? (b)

**YES**

- Refer patient to physician (M.D.) for examination and treatment, if possible, within 24 hours.

**NO**

On first reading, is systolic ≥138 or diastolic ≥90 and <98?

**YES**

- Recheck patient's blood pressure on 3 separate days.

On 2 out of 3 recheck readings:
is systolic ≥130 and <138 and diastolic ≥80 and <88
OR
is systolic ≥140 or diastolic ≥90 and <98;
OR
is systolic ≥140 and diastolic <90?

**YES**

Consider patient "borderline hypertensive."

- Reassure the patient that he/she does not have hypertension but only a slightly unusual blood pressure reading that should be checked again in 6 months. (c)

**NO**

On 2 out of 3 recheck readings:
is systolic ≥140 and diastolic ≥90?
OR
is systolic <140 but diastolic ≥100?

**YES**

Consider patient "hypertensive suspect."

- Refer him/her to physician (M.D.) for further evaluation. (d)

**NO**

On first reading, is systolic ≥130 and <138 and is diastolic ≥80 and <88?

**YES**

**NO**

Then systolic must be <130 and diastolic <80.

- Advise patient that his/her blood pressure is within normal limits, but that an annual check-up is recommended.

**NO**

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

Notes to Standing Order H 19a

## THE SCREENING AND EVALUATION OF HYPERTENSION

(a) When reading a corpsmember's blood pressure, numbers should be rounded up to the nearest even digit. For screening and subsequent checks, blood pressure should be taken while the corpsmember is in a sitting position. An average normal reading is considered to be 128/78. The 128 and 78 represent systolic and diastolic pressures of the heart, respectively. In general, the diastolic blood pressure is the point where all sounds disappear. When this point cannot be determined, the point at which the sounds abruptly become mufflied (phase IV) should be recorded. The first time blood pressure is taken after a corpsmember arrives on-center should be considered the screening blood pressure.

(b) If a patient is ever found to have a diastolic reading of 120 mm Hg or above, he/she should be sent to the physician for immediate evaluation. The symbol > means greater than; < means less than. When either symbol appears with a line below it, as $\geq$ and $\leq$, then the symbol takes on the additional meaning of "greater than or equal to," or "less than or equal to," respectively.

(c) A file of "borderline hypertensive" patients should be kept so that they can be rechecked in six months or reminded to have a recheck before they terminate from Job Corps.

(d) When a patient is referred for suspected hypertension, the physician must assess the severity of the hypertension; assess whether damage is already present due to hypertension, including the extent of any associated heart and blood vessel disease; and screen for a correctable cause of the hypertension. The physician's assessment should include a detailed personal and family history, including related treatment and outcome of hypertension, heart and kidney disease, and stroke. It should also include a physical examination that is concentrated on the target organs (heart, blood vessels, eyes, brain, and kidneys). Finally, the physician should do a laboratory work-up for those patients referred who have two diastolic readings greater than 100 or who have clinical evidence of organ damage.

These patients should be counseled about the changes that should be made in their lifestyles such as less ingestion of salt, modification of smoking and drinking habits, and shedding of extra pounds. Advice concerning exercise must be followed and medication must be taken as prescribed. Once the condition is diagnosed by the physician as hypertension, the patient should be warned that it is his/her own responsibility to follow the doctor's advice. If left untreated, hypertension can accelerate the disintegration of bodily functions and organs, even though there may be no outward signs of illness.

STANDING ORDER H 19b
_____ JCC

# TECHNICAL ORDER FOR THE TREATMENT AND MONITORING OF HYPERTENSION *

Patient comes in as "hypertensive suspect."

Is there target organ damage or is diastolic ⩾100 on 2 of 3 blood pressure readings? (a)

YES

- Obtain laboratory work-up and counsel patient.(b)

- Administer hydrochlorothiazide 50 mg per day for 2 weeks. (c)

After 2 weeks, is diastolic ⩽90?

YES

- Maintain treatment and monitor every 3 months.

NO

- Increase hydrochlorothiazide to 50 mg twice a day for 2 weeks.

After 2 weeks is diastolic ⩽90?

NO

- Administer reserpine, 0.25 mg once a day for 4 weeks, in addition to the 50 mg hydrochlorothiazide twice a day for 4 weeks.

YES

- Maintain treatment and monitor every 3 months.

After 4 weeks, is diastolic ⩽90?

YES

- Maintain treatment for 1 more month.

After 1 month is diastolic ⩽90?

NO

- Consider administering hydralazine, in addition to the 0.25 mg per day reserpine and the 100 mg per day hydrochlorothiazide;
- Or consider administering methyldopa instead of the reserpine.

YES

- Maintain treatment and monitor every 3 months.

On 2 of 3 readings, is diastolic ⩾100?

YES

NO

- Recheck blood pressure monthly. Advise patient to make life-style changes to keep pressure at normal level.

NO

- Recheck patient's blood pressure monthly. If "hypertensive suspect," counsel patient on potential problems and advise life-style changes.

- On subsequent monthly readings, if diastolic is ⩾100, recheck on 3 spearate days.

DATE SIGNATURE

_____ _____, M.D.

_____ _____,

_____ _____,

_____ _____,

*This order is written for physicians.

Notes to Standing Order H 19b

## THE TREATMENT AND MONITORING OF HYPERTENSION

(a) The symbol > means "greater than"; < means "less than." When these symbols appear as ≥ or ≤ , they take on additional meaning of "equal to or greater than" or "equal to or less than", respectively.

(b) Once a patient's condition is diagnosed as hypertension by the physician, the patient should be told that it is his/her responsibility to follow the physician's advice about modification of smoking and drinking habits; about shedding extra pounds; about ingesting less salt; and about exercising more. Patient education and cooperation are elements essential to the management of hypertension. Because adolescents are more prone to deny that they differ from their peers (i.e., that they must take daily medication or that they must restrict their diet), they are more prone to "postpone," consciously or unconsciously, the necessity of participation in follow-up treatment when hypertension is diagnosed. The physician should, therefore, make a special effort to explain that the patient does not have to drastically alter his/her life-style to control high blood pressure.

(c) A patient whose diastolic blood pressure is 100 or more on two out of three readings should be given 50 mg of hydrochlorothiazide daily. If his/her blood pressure is not lowered significantly in two weeks, the dosage should be increased to 100 mg a day, as indicated on the algorithm. As an alternative therapy, a "no-added salt" or a "two gram sodium" diet may be considered for those who experience side effects as a result of the medication.

When a patient is referred for suspected hypertension, the physician should screen for correctable cause; assess whether damage is already present due to the hypertension and the extent of heart and blood vessel disease; and assess the severity of hypertension. The physician's assessment should include a detailed personal and family history and a thorough physical examination. A laboratory work-up should be obtained on those patients who have two diastolic readings equal to or greater than 100 or who have clinical evidence of organ damage.