



Division Directive Number
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Title: Management of Acute Illness/Injuries

Application: Division of Developmental Disabilities State Operated Waiver Programs and Habilitation Center Campuses

Purpose: Prescribes procedures and guidelines for State Operated Programs staff to ensure successful medical management of an Acute Illness or Injury upon prompt identification of the problem and initiation of rapid and appropriate treatment by the staff.

Successful medical management of an Acute Illness or Injury depends upon the prompt identification of the problem and the initiation of rapid and appropriate treatment by the staff.

In a life-threatening situation, 911 should be called immediately and life sustaining interventions (e.g., cardiopulmonary resuscitation / CPR) initiated by the staff immediately.

Conditions that will likely require Emergency Care include (but are not limited to):

1. Chest Pain
2. Coma/Unresponsiveness
3. Sudden changes in mental status or ability to move
4. Symptoms of heat exhaustion or stroke
5. Uncontrolled bleeding
6. Vomiting blood
7. Broken Bone
8. Cerebrovascular Accident (CVA): sudden numbness or weakness of face, arm, or leg, especially on one side of the body; sudden confusion or trouble speaking or understanding speech; sudden trouble seeing in one or both eyes; sudden trouble walking, dizziness, or loss of balance or coordination; sudden severe headache with no known cause
9. Anaphylaxis-shock (severe allergic reactions, such as difficulty breathing, swelling of tongue /mouth, hives over much of body)
10. Unexplained seizure activity/or seizures lasting longer than 5 minutes in duration or coming in rapid succession without full recovery between
11. Injury to the head
12. Laceration requiring suturing
13. Acute changes in condition relating to the heart, breathing, brain, bleeding or vomiting/diarrhea
14. Deep Vein Thrombosis (DVT) Swelling of the leg or along the vein of leg, ankle or foot; pain, increased warmth, tenderness in leg (may increase with standing or walking); redness or discoloration of area, calf cramping
15. Temperature greater than 104 degrees F or less than 96 degrees F

16. Serious burns

- a. 1st degree if it affects a substantial portion of hands, feet, face, groin/ buttock, or covers a major joint
 - b. 2nd degree if it is larger than 3 inches in diameter or if it affects hands, feet, face, groin/buttock, or covers a major joint
 - c. All 3rd degree burns
- In a situation which is ***NON*** life-threatening, the licensed nurse will perform an assessment for signs and symptoms of potential illness/injury, or exacerbation of a chronic illness.
 - The licensed nurse will notify the Primary Care Provider (PCP) within 30 minutes of identifying problems that may require medical evaluation and intervention. When informing the PCP, the following information should be communicated:
 1. Complete set of vital signs, including pulse oximetry;
 2. Other subjective and objective data (e.g., what the client and the staff are verbalizing, measures of the injury, laboratory test results, x-ray reports, etc.)
 3. Current medications and treatments, noting any changes within the past 72 hours;
 4. Any allergies and all injuries new or old noted within the last 72 hours; and
 5. A brief summary of the individual's medical history.
 - If the PCP is unavailable, the licensed nurse will determine whether the individual requires medical evaluation and treatment at the Emergency Room (ER).
 - In the event that the licensed nurse determines the client requires medical evaluation and treatment in the ER, he/she will proceed to arrange to send the individual to the ER.
 - The nurse will continue to attempt to reach the PCP for notification of the situation and document the event.

GUIDELINES

The following are guidelines for conducting follow-up evaluations for common acute illness or injuries.

1. **Head Injuries:**

- Regardless of the severity of the head injury, the licensed nurse and/or physician will conduct an initial comprehensive neurological assessment.
- A licensed nurse will conduct follow-up Neurological Checks every hour for 4 hours and then every 2 hours for 4 hours and then every 4 hours for 72 hours unless otherwise specified by the PCP.
- Assessment findings will be recorded on the "Neurological Examination Record" and will include identification of common neurological symptoms (e.g., headache, dizziness, vision changes, nausea vomiting, etc.), an assessment of the level of consciousness and response to stimuli, papillary size and response, and a complete set of vital signs.

2. **Temperature Elevations:**

- Complete vital signs, including temperature, will be monitored every four hours by a licensed nurse for an individual with a temperature elevation of 101° orally or greater until the individual is afebrile for 48 hours.

- The route of the temperature should always be recorded and conversions made if needed.
- The licensed nurse will evaluate and document evaluation on the individual each shift until the individual has been afebrile for 48 hours.
- The licensed nurse will ensure that nursing interventions to prevent dehydration and provide comfort are implemented.

Note: An individual with a fever of unknown origin should be thoroughly assessed to identify the nature of the infection.

3. **Antibiotic Therapy:**

- A comprehensive assessment including vital signs, will be completed by the licensed nurse specific to the presenting condition or diagnosis will occur at least every shift during the timeframe when the individual is receiving antibiotic drug therapy for an acute illness and for 48 hours after therapy is completed.
- The evaluation should address the efficacy of the treatment and reflect monitoring for any potential side effects the individual may develop.

4. **Fracture and/or if a Cast is in Place:**

- The licensed nurse will inspect the cast and conduct an assessment of the affected area using the “Orthopedic Check Sheet”:
 - Checking for swelling and circulation every four hours until the cast is dry;
 - Every shift until the cast is removed;
- The Registered Nurse will be notified of any significant findings.
- Follow-up plans of care after the cast is removed will be developed if necessary.

5. **Vomiting or Diarrhea:**

- The individual will be monitored by a licensed nurse at least every shift until the individual is symptom free for 24 hours.
- The licensed nurse will monitor the individual holistically including performing an abdominal assessment, a respiratory assessment and the cardiovascular system, analyzing of intake and output and obtaining vital signs. Individuals at risk of or with a history of constipation will have their “Bowel Movement Record” reviewed and a rectal exam performed, if clinically indicated, to rule out impaction.
- Documentation will include a description and measurement of vomitus or fecal matter and the results of a hem occult test, if clinically indicated.
- Laboratory values will be monitored, especially electrolytes, and abnormal results will be reported to the PCP as soon as they are received.
- Antiemetic or anti-diarrheal medications, if administered, will be monitored specifically for efficacy and side effects.
- Nothing by mouth (NPO) or clear liquid diet will be ordered as appropriate.

6. **Major Choking Episode:**

- The Registered Nurse or PCP will evaluate the individual after each choking episode.
- Documentation will include the item the individual choked on, any diet orders on the client, any client supervision orders and the circumstances surrounding the choking incident.
- A licensed nurse will monitor the individual at least daily for 72 hours, for repeat episodes and/or secondary complications e.g., aspiration and notify the PCP/Registered Nurse, as appropriate.
- Dietary and dysphasia specialists (Occupational Therapist and/or Speech Language Pathologist) will be notified immediately and will conduct appropriate mealtime/swallowing evaluations within 24 hours of notification.

7. **Suturing:**

- A licensed nurse will assess the suture line each shift until the sutures are removed to monitor for signs of infection and evidence of wound closure and initiation of the healing process.
- Vital signs shall be obtained every shift throughout the period that the sutures are in place and for 48 hours after the sutures are removed.

8. **Human Bite:**

- Both involved individuals and their medical records will be assessed by a licensed nurse to determine their tetanus status, hepatitis status, and potential for other high-risk infections. The guardians will be contacted for consent to draw blood for HIV, Hepatitis B and Hepatitis C, if indicated.
- A licensed nurse will monitor the individual who is bitten at least daily for 72 hours or until the potential for disease and/or infection has been eliminated.
- The PCP/Registered Nurse will ensure wound management is initiated, if necessary with special management when the bite affects the facial area, is over a joint, or if there is documented bleeding due to the increased risk of complications in these areas.
- The licensed nurse will notify the Infection Control Nurse as appropriate.
- Prophylactic antibiotics will be considered by the PCP for human bites with broken skin.

9. **Insect/Animal Bite:**

- The licensed nurse will report and treat where appropriate.
- The licensed nurse will review tetanus vaccination status.
- Animal bites are usually reportable and the identification and quarantining of the animal for ten days is recommended, if possible.
- Tick bites: Lyme disease titers will be done if the tick is identified as a Lyme disease carrier. The individual will be treated if they become symptomatic or have positive titers. The tick should be saved and identified, whenever possible.

10. **Signs and Symptoms of Respiratory Distress:**

- A licensed nurse will evaluate an individual with respiratory distress based on the frequency established in the Health Care Plan or more frequently if warranted by the individual's status.
- This evaluation will include at a minimum:
 - Assessing for airway problems;
 - Evaluating positioning;
 - Assessing breath sounds by auscultation;
 - Observing the individual's color;
 - Measuring of oxygen saturation level using a pulse oximeter;
 - Obtaining a complete set of vital signs.
- A Registered Nurse will verify assessments conducted by a Licensed Practical Nurse (LPN). Findings will be reported to the Registered Nurse (RN) who will perform a thorough evaluation of the respiratory system at least once per shift or more frequently based on clinical judgment and/or the individual's status.
- The PCP will immediately be notified when an individual's oxygen saturation level is less than 95%, unless otherwise indicated.
- If the level for oxygen saturation is 90% or less, oxygen will be administered by nasal cannula or mask to support respirations in accordance with the facility protocol (see below) while 911 is called, the PCP is notified, and the individual's transfer to a hospital is being arranged.

- In the event the person stops breathing or has no pulse, staff will immediately initiate CPR and continue necessary life sustaining interventions until the individual's pulse and/or respirations return, they are relieved by emergency medical services personnel, or instructed to cease CPR by the PCP.

PROTOCOL FOR EMERGENCY ADMINISTRATION OF OXYGEN

1. **Only licensed nurses may administer oxygen in an emergency without obtaining a PCPs order utilizing the following guidelines:**

- For individuals with chronic lung problems (i.e., asthma or emphysema), a history of being a heavy smoker, and for those at risk of vomiting, aspiration or refusing to use a mask for oxygen delivery, **administer oxygen via nasal cannula at 2 liters/minutes while awaiting Emergency Medical Services or instructions from the PCP.**

Note: Giving oxygen at too high a concentration to an individual with chronic lung disease could cause them to stop breathing because they are dependent on hypoxia and hypercapnia to stimulate their respirations.

- For all other individuals, administer oxygen via nasal cannula as tolerated, at between 0.25 and 6 liters/minute, rates of greater than 4 liters/minutes should be used with caution as these cause increased irritation to the nasal passage and often call for oxygen humidification. And by simple mask at between 6-10 liters /minute, this eliminates carbon dioxide build up inside the mask
- Conduct frequent assessments to determine the effectiveness of treatments and the individual's response to oxygen therapy, conduct every-15-minutes oxygen saturation checks.
- Assess the individual's response to treatment by monitoring vital signs, color, and level of consciousness, respiratory pattern and pulse oximetry.
- Document in the Individual Observation Notes: assessment findings, time oxygen was started, method of administration (e.g., nasal cannula or mask), number of liters/minute administered, condition of the individual and the response to therapy.

Authority

Lippincott Manual of Nursing Practices