

# CARDIAC EMERGENCIES

## SUBJECTIVE

Symptoms may include:

Chest pain (may or may not radiate to the left arm, neck, back or jaw), pressure in chest and/or shortness of breath

Apprehension

History of coronary artery disease

Currently taking cardiac medicines

## OBJECTIVE

Weak, irregular, rapid pulse, or no pulse

Cyanosis (nail beds, lips, etc)

Cold clammy skin

Fall in blood pressure, or no pressure

Labored respirations

May or may not have distended neck veins when patient is at 45° angle

## ASSESSMENT

Coronary Artery Disease/Angina

## PLAN

Initiate emergency response system

Check vital signs

Administer CPR if indicated

Use automatic external defibrillator (AED) if available and indicated

Give oxygen 4-6 liters/minute via mask, or nasal cannula

After determining that patient is not allergic to aspirin, give 325 mg non-enteric coated aspirin, crushing tablet and adding to water. **DO NOT ADMINISTER UNLESS PATIENT IS FULLY CONSCIOUS**

Observe closely for signs of continued decrease in blood pressure, arrhythmias, tachycardia or bradycardia

If patient has nitroglycerin medication, instruct to take prescribed dosage sublingually; one tablet q 5 minutes x 3; hold if systolic blood pressure is less than 100

Transport via ambulance as soon as possible and send report of care give

## REFERENCES:

GIVING EMERGENCY CARE COMPETENTLY, Nursing Skills Books

“Cardiac arrest: When minutes count,” Romaine Hart, RN

“Myocardial Infarction: How to alleviate pain and anxiety: Catherine C. Manzi, RN  
TDH, Division of Emergency Medical Services, PARAMEDICAL PROTOCOL,

“Symptomatic Chest Pain”, H. Lynn Massingale, M.D., Oct. 1, 1991

Conn's Current Therapy, Edited by Robert E. Rakel, MD. W.B. Sanders Co.,  
Philadelphia 1999. "Acute Myocardial Infarction" pp 324-329

American Heart Association Guidelines CPR ECC, 2010, September 2011

<http://www.heart.org/idc/groups/heart->

[public/@wcm/@ecc/documents/downloadable/ucm\\_317350.pdf](http://www.heart.org/idc/groups/heart-public/@wcm/@ecc/documents/downloadable/ucm_317350.pdf)

# DIAPER DERMATITIS (DIAPER RASH)

## Subjective

Caretaker reports diaper rash  
Irritability

## Objective

*Contact dermatitis:* Chafed, reddened, non-raised areas over genital and buttocks area

*Infected dermatitis:* Inflamed, bright red, indurated and tender skin; parched area  
With satellite lesions; thick white plaques with an erythematous base may be present on oral mucus membrane (thrush), especially during or following antibiotic therapy (see also oral candidiasis/moniliasis)

## Assessment

Contact or Infected Diaper Dermatitis

## Plan

For Contact Diaper Dermatitis:

Change diaper as soon as possible after it becomes wet or soiled; check diaper every hour in newborn

Dry diaper area gently and expose to air to dry completely after urination. Clean diaper area with warm water and mild soap (ie. Dove or Basis) after each bowel movement and dry gently but thoroughly

Leave diaper off during nap time to allow drying of the area

A thin layer of protective ointment or cream or medicated powder may be applied to skin with each diaper change.

Do not overdress infant

Discourage use of waterproof pants, plastic covered diapers, tightly pinned or double diapers, scented diapers, and diaper wipes as many contain perfume or alcohol

DO NOT USE TALCUM POWDER, BAKING SODA, OIL, OR PETROLEUM JELLY

Provide laundry instructions for cloth diapers, if applicable:

Suggest laundering diapers in mild detergent ( i.e. Dreft) and rinse thoroughly

Discourage use of fabric softener

**Referral Indicators:**

- Infected diaper dermatitis
- Suspicion of burn
- No response to treatment within 2-3 days
- Presence of systemic involvement (e.g., fever)

**Follow up:**

Parent will be asked to contact health provider in 48-72 hours if not improved

**Reference:**

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006  
Uphold and Graham, Fourth Edition 2003  
American Academy of Pediatrics, Healthy Children  
<http://www.healthychildren.org/English/ages-stages/baby/diapers-clothing/Pages/Diaper-Rash-Solution.aspx>

# **PEDICULOSIS CAPITIS (1320) (Head Lice)**

## **POLICY STATEMENT**

The following policy was adopted by the Medical Services Evaluation Committee July 22, 1998:

**Local school authorities have the sole authority to implement a no-nit policy in a school. However, the Tennessee Department of Health encourages school officials to consult with the Regional Health Officer and the local health department prior to implementing such a policy. Scientific evidence for or against a no-nit policy is not available. Educational efforts directed toward local medical professionals, school officials, teachers, and parents should be at the center of control measures. The Health Department feels that only in special cases should any no-nit policy be attempted, and then for a limited period of time. In these cases, the problems accompanying the implementation of the policy should be understood and reviewed with all concerned.**

## **SUBJECTIVE**

Severe itching of scalp  
Bugs on head or nits (eggs) on hair  
Contact with infected individual  
Rule out allergies to drug components

## **OBJECTIVE**

Light, tan, or dark eggs firmly attached to hair shaft  
May see lice in hair, especially at the back of the head in occipital region  
Excoriation of scalp  
Enlargement of occipital and cervical nodes

## **ASSESSMENT**

Pediculosis Capitis (head lice)

## **PLAN**

### **Advise Parents Regarding Appropriate Treatment:**

Issue and/or advise to treat with OTC pediculocide shampoo or crème rinse according to specific product instructions  
Nits should be removed with a fine tooth comb or fingernails  
Treat all family members and other close contacts

### **Advise Parents How to Clean the Environment:**

- Soak all combs and brushes in hot water for 5 – 10 minutes.
- Launder all washable clothing and bed linens used within previous 48 hours with hot water (130 degrees) and detergent, and dry at high heat for at least 20 minutes; dry clean clothing that is not washable, or place items that cannot be washed, including stuffed animals, in a heavy duty plastic bag, and securely seal for 10-14 days
- Vacuum carpet, furniture, and car upholstery (throw away vacuum cleaner bag); if vacuum is not available use a pediculocide spray on such areas

### **Advise Parents How to Prevent Spread and Re-infestation:**

- Report** case of head lice to school, day care, camp, church, and social groups so that other children in the facility can be checked

### **Strategy Regarding Persistent Infestation:**

- Question** to assess reason for continued infestation (misdiagnosis, non-compliance, new infestation); have patient describe process used
  - Tell me step-by-step how you used the product*
  - Tell me step-by-step how you cleaned the environment*
  - How did you remove the nits? (assess for adequate eyesight/lighting and use of comb and fingernail)*
- Retreat all household members and close contacts if live lice are noted 7-10 days after initial treatment using OTC pediculocide shampoo or crème rinse or alternatively use a non-toxic, pesticide-free product.
- Repeat questions to assess correct use of product and compliance with cleaning the environment
- Retreat using a different OTC pediculocide shampoo or crème rinse in accordance with package instructions, if live lice are noted 7-10 days after second treatment, (a maximum of three treatments may be advised)

### **Health Teaching** (in accordance with “Lice Advice” in the appendices):

#### **Instruct parents to check child’s head daily for lice (this catches head lice early and thus prevents it from spreading in school/daycare and keeps child from missing school and parents from missing work)**

- Teach mode of transmission and prevention of spread (e.g., headphones in school, stuffed toys, auto upholstery, car seats, sharing of hats, hair scrunches, combs, and helmets)
- Teach children to avoid sharing hats, sports headgear, combs and brushes, or borrowing clothing or other personal objects
- Teach use and side effects of medications, and caution against overuse
- Advise that rinsing the hair with a 1:1 vinegar/water rinse before treatment may help to loosen the nits. Advise that oil treatment (e.g., vegetable oil, olive oil) may be used as a last resort or as an interim treatment if live lice are noted prior to 7 days following a traditional treatment with pediculocide shampoo or

crème rinse; the family should be told that there is no guarantee that this will work and that mechanical removal of the nits should still be performed

*Massage oil into the child's head and scalp*

*Cover with shower cap or plastic wrap for 30 to 60 minutes*

*Shampoo with liquid dish detergent (will require repeated shampooing)*

*Remove nits*

*Clean environment using traditional methods*

Teach mother to wear gloves if they are shampooing the child's hair and especially if she is pregnant

Teach patients to shampoo their hair in the sink to prevent over absorption of medication due to contact on other body surfaces

Advise do not use conditioner or shampoo that contains conditioner when washing hair before treatment.

Advise to avoid shampooing the hair for 2 days after treatment and then to shampoo as infrequently as possible for the next two weeks using a mild shampoo.

### **Referral Indicators:**

Children 2 years and under, refer to specific product instructions on the package insert for age appropriate use.

Pregnant women in their first trimester, or lactating women

Secondary bacterial infection

Those with a known sensitivity to pediculocide shampoo, crème rinse or chrysanthemums/ragweed sensitized persons

Nits present in eyelashes

Repeat infestations (greater than 3)

Neurological disorders

Raw or inflamed scalp

### **Follow-up:**

Assessment after treatment

## **REFERENCE**

Centers for Disease Control. <http://www.cdc.gov/parasites/lice/head/treatment.html>