OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

MSRM 140117.01.11.2
(R-2/20)

RUNNY NOSE / CONGESTION / UPPER RESPIRATORY INFECTION / INFLAMMATION OF SINUS MUCOSA

(Example - seasonal/Allergic Rhinitis/Common Cold/Sinusitis)

Subjective Data: **Allergies:** _____

Chief complaint: _____

Onset:_____ ❑ New Onset ❑ Chronic ❑ Recurrence

History:

❑ Asthma ❑ Sinus infection ❑ Upper respiratory infection
❑ Smoke ❑ Packs per day:_____ Number of years smoking: _____

Associated Symptoms:

❑ Nasal itching ❑ Stuffy nose ❑ Runny nose ❑ Headache ❑ Non-productive cough ❑ Sore throat
❑ Sneezing ❑ Watery eyes ❑ Red eyes ❑ Itchy eyes ❑ Clear nasal discharge
❑ COPD ❑ Past Positive PPD ❑ Weight loss ❑ Night Sweats ❑ Fever ❑ Hoarseness
❑ Headache ❑ Toothache like pain ❑ Ear pain ❑ Malaise ❑ Nasal discharge/post nasal drip
❑ Productive cough? Describe:_____
❑ Known allergen exposure? Describe:_____
❑ Pain elicited with pressure on forehead/cheek? ❑ Yes ❑ No

Objective Data: (clinically indicated VS)

BP_____ Pulse_____Resp. _____Temp. _____Wt._____

Throat:	❑ Normal	❑ Red / inflamed	❑ White / patchy	❑ Pustules	❑ Clear drainage
Nasal Mucosa:	❑ Normal	❑ Red / inflamed	❑ Swollen	❑ Tonsils	❑ Yellow/green drainage
Lungs (right):	❑ Clear	❑ Crackles	❑ Wheezing	❑ Rhonchi	❑ Diminished
Lungs (left):	❑ Clear	❑ Crackles	❑ Wheezing	❑ Rhonchi	❑ Diminished
Neck Glands:	❑ Normal	❑ Swollen	❑ Tender to palpitation		
Swelling:	❑ None	❑ Throat	❑ Nasal	❑ Eyes	❑ Facial
Ears:	❑ Normal	❑ Red	❑ Drainage	Describe:_____	
Appearance:	❑ No distress	❑ Mild distress	❑ Moderate distress	❑ Severe distress	

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: *Health care provider must be called if not on site or if after clinic hours.*

❑ Fever greater than 101 degree F or other signs of infection
❑ Symptoms of TB: night sweats, weight loss, productive cough, fever
❑ Inmate returns with complications
❑ Swelling or redness around eyes
❑ Swollen, red, white patchy throat
❑ Marked lymphadenopathy present
❑ There is history of severe COPD
❑ Double vision or other visual changes
❑ Severe headache
❑ Stiff neck
❑ There are symptoms or concerns of secondary bacterial infection: green or yellow purulent sputum or drainage from nose, ear pain, dyspnea

REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Severe exacerbation ❑ Yellow/green/blood tinged sputum/nasal drainage ❑ Unresponsive to treatment ❑ Abnormal lung sounds
❑ Purulent drainage ❑ Severe pain over eyes/cheeks ❑ Cough lasting more than 2 weeks

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** ❑ Yes ❑ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: Do not use antihistamines with HTN and /or COPD

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ Apply warm wet compresses to sinus area for 20 minutes followed by cold compress for 20 minutes.
❑ Saline nose spray 2 squirts every 2 hours a day for 7 days PRN.
❑ Salt water gargles for throat discomfort.
❑ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN. **OR** ❑ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days PRN.
❑ Chlorpheniramine (CTM) 4 mg p.o. three times daily for 8 days PRN. **OR** ❑ Loratidine (Claritin) 10 mg p.o. once daily for 10 days PRN.
❑ Guaifensin cough syrup 2 TEAspoon three times a day for 4 days PRN. **OR** ❑ Guaifensin 400 mg 1 tablet three times a day for 10 days PRN.
❑ Halls cough drops 1 lozenge every 4 hours for 4 days PRN.
❑ Education/Intervention: Instructed to increase fluids, medication use, avoid smoking, avoid vigorous nose blowing, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/Credentials: _____ **Date:** _____ **Time:** _____

Inmate Name (Last, First) DOC #