

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
EARACHE / EXCESS EAR WAX

MSRM 140117.01.20
(R-8/11)

Subjective Data:

Allergies: _____

Chief complaint: _____
 Location: Right ear Left ear Both ears
 Onset: New Onset Constant Intermittent

History:

| | | | |
|--|----------------------------------|--|---|
| <input type="checkbox"/> Recent trauma | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Sinus problem | <input type="checkbox"/> Recent respiratory problem |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea | <input type="checkbox"/> Recent foreign body |

Associated symptoms:

| | | | | | | |
|-----------------------------------|----------------------------------|--------------------------------|--|---|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Cough | <input type="checkbox"/> Fever | <input type="checkbox"/> Running nose | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Ringing | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Popping | <input type="checkbox"/> Cough | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Pain: Pain scale: (0-10) _____ | | |

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____

| | | | | | | |
|-----------------------|--------------------------------------|--|--|--|---------------------------------------|--|
| Ear drum/canal | <input type="checkbox"/> Normal | <input type="checkbox"/> Bulging | <input type="checkbox"/> Redness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Dull | <input type="checkbox"/> Fluid behind ear drum |
| Drainage | <input type="checkbox"/> None | <input type="checkbox"/> Blood | <input type="checkbox"/> Purulent | <input type="checkbox"/> Clear | <input type="checkbox"/> Other: _____ | |
| Throat | <input type="checkbox"/> Normal | <input type="checkbox"/> Redness | <input type="checkbox"/> Swollen | <input type="checkbox"/> White patches | | |
| Gait | <input type="checkbox"/> Steady | <input type="checkbox"/> Unsteady | <input type="checkbox"/> Unable to stand | | | |
| Glands | <input type="checkbox"/> Normal | <input type="checkbox"/> Swollen | <input type="checkbox"/> Enlarged tonsils | | | |
| Wax | <input type="checkbox"/> None | <input type="checkbox"/> Present | | | | |
| Appearance: | <input type="checkbox"/> No distress | <input type="checkbox"/> Mild distress | <input type="checkbox"/> Moderate distress | <input type="checkbox"/> Severe distress | | |

HEARING LOSS EMERGENCY:

Contact Medical Provider /RN **IMMEDIATELY** if abrupt hearing loss accompanied by pain, drainage, dizziness, bloody discharge, fever or stiff neck

Refer to Medical Provider If:

- | | |
|--|--|
| <p align="center"><u>Earache</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Temp 101 <input type="checkbox"/> Stiff neck or pain/swelling behind ear <input type="checkbox"/> Otitis medica / Otitis externa <input type="checkbox"/> Popping sensation or lethargy <input type="checkbox"/> Unable to visualize ear anatomy <input type="checkbox"/> Decreased appetite with or without fever | <p align="center"><u>Excess Ear Wax</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding or drainage from ear canal (see Ear ache Protocol) <input type="checkbox"/> Inability to directly observe earwax accumulation or other signs <input type="checkbox"/> Symptoms unrelieved by intervention <input type="checkbox"/> Possible foreign body |
|--|--|

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alteration in comfort (hearing) related to ear pain.

Plan:

Nursing Intervention Routine:

| | |
|---|--|
| <p align="center">Earache</p> <ul style="list-style-type: none"> <input type="checkbox"/> If wax present refer to protocol for excess wax <input type="checkbox"/> Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days <li align="center">or <input type="checkbox"/> Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days <input type="checkbox"/> Chlorpheniramine (CTM) 4 mg p.o. three times daily for 8 days | <p align="center">Excess Ear Wax</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days <li align="center">or <input type="checkbox"/> Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days <input type="checkbox"/> Irrigate affected ear(s) gently with room temperature water, till clear <input type="checkbox"/> If above ineffective, instill Debrox (Carbamide Peroxide 6.5% in Anhydrous glycerol), 3-5 drops in affected ear(s) twice a day for 2 days, then repeat irrigation as above. (This will require an order from the medical provider) |
|---|--|

Progress Note: _____

Offender Education:

Instructed not to insert Q-tips or other objects into ear, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

DOC #