

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

MSRM 140117.01.20
(R-12/15)

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		

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

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:

Earache

- Temp 101
- Stiff neck or pain/swelling behind ear
- Otitis medica / Otitis externa
- Popping sensation or lethargy
- Unable to visualize ear anatomy
- Decreased appetite with or without fever

Excess Ear Wax

- Bleeding or drainage from ear canal (see Ear ache Protocol)
- Inability to directly observe earwax accumulation or other signs
- Symptoms unrelieved by intervention
- Possible foreign body

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

Assessment:

Alteration in comfort (hearing) related to ear pain.

Plan: Nursing Intervention Routine: (check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.

<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 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 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)
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Education/Intervention: 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.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/Credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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