RN Protocol: Headache

I. POLICY

A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients presenting with a complaint of headache.

B. Circumstances under which the RN may perform the function:
   1. Setting: Outpatient clinic.
   2. Supervision: No direct supervision required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients presenting with a complaint of headache. Headache is a symptom and while the vast majority of headaches are not related to a specific cause, a small percentage of headaches occur secondary to underlying disease. The most common headache disorders are tension-type headache, migraine headache, and cluster headache.

Tension-type headache is characterized by constant, dull, non-pulsating, band-like pain, usually more intense in the occipital region and upper neck, but may also occur in the frontal and parietal areas. Tension headaches tend to occur more frequently and become more severe during periods of emotional conflict or stress. Chronic tension headaches may be a manifestation of anger, chronic anxiety, or depression.

Migraine headache is characterized by throbbing pain on one or both sides of the head, often accompanied by nausea, vomiting, and sensitivity to light (photophobia) and noise. Migraine headaches are often preceded by an aura, usually hallucinations of flashing lights or geometric shapes. The pain frequently begins in the early morning and lasts from two to 72 hours.

Cluster headache is a rare condition that predominantly affects older men. The headaches usually occur in groups or "clusters" with individual attacks lasting anywhere from 15 minutes to four hours. Cluster headaches are characterized by abrupt onset of excruciating, unilateral orbital and/or temporal pain. Cluster headaches typically occur at night and the pain is often so severe that patients are awakened from sleep. Other symptoms associated with cluster headache include swollen eyelids, red watery eyes, small pupils, facial flushing, drooping of the eyelid on the affected side of the face, and nasal congestion. Patients may have several attacks a day and attacks may go on for several weeks or months at a time.

Headaches secondary to underlying disease may result from cerebrovascular disease, meningeal irritation (e.g., meningitis), neoplasms, sinusitis, glaucoma, systemic infection, hypertension, food allergies, exposure to toxins, reaction to drugs (e.g., cocaine) or alcohol, head trauma, and intracranial bleeding. A thorough history and neurologic

examination is essential to ensure that patients are appropriately diagnosed and referred to a physician as needed.

B. Subjective:
   1. Chief complaint (document in the patient's own words).
   2. Date and time of onset.
   3. Location of the pain (frontal, temporal, occipital; left, right, bilateral).
   4. Description of the pain (dull, aching, sharp, throbbing, constant, intermittent). Does the pain radiate to other parts of the body?
   5. Rate pain on a scale of 0-10 (0 = no pain, 10 = worst pain).
   6. What makes the pain better? What makes the pain worse?
   7. Degree of incapacity caused by the headache (i.e., does the headache interfere with sleep or other activities?).
   8. Assess for accompanying symptoms (nausea, vomiting, photophobia, fever, chills, blurred vision, double vision, flashing lights, blind spots, stiff neck, dizziness/vertigo, focal weakness, loss of consciousness). **NOTE: focal weakness must be reported to a physician STAT.**
   9. Past medical history of headaches (type) depression, hypertension, recent trauma, recent upper respiratory infection.
   10. Chronic illness (e.g., diabetes, hypertension).
   11. Allergies.
   12. Current medications.

C. Objective:
   1. Vital signs.
   2. General appearance.
   3. Neurologic status (alert, oriented, lethargic, confused).
   4. HEENT examination. Observe and document the following:
      a. Facial flushing
      b. Red, watery eyes and/or droopy eyelids
      c. Pupil size, shape, equality, and reactivity to light
      d. Photophobia
      e. Extraocular eye movements
      f. Palpate scalp for tenderness, masses, skull defects, hematomas, and bruises
      g. Palpate frontal or maxillary sinus for tenderness
   5. Neck/shoulder range of motion
   6. Deep tendon reflexes (note any asymmetrical, absent, or hyperactive responses)
   7. Gait (normal, abnormal)
   8. Signs of stroke (slurred speech, facial drooping, focal or asymmetric weakness, generalized symmetric weakness).

D. Assessment:
   - Pain evidenced by/related to:
   - Neurological deficits as evidenced by/related:

E. Plan:
   1. If headache is accompanied by any of the following signs and symptoms contact the physician **STAT** and transport patient to the emergency treatment area:
      - Recent head trauma
      - Confusion or loss of consciouness
      - Facial flushing or sweating on the same side as the pain
      - Facial or eyelid drooping
      - Visual deficit, double vision, abnormal eye movements or pupil responses
      - Inability to touch chin to chest
      - Focal weakness
      - Abnormal gait
      - Vomiting
      - Fever > 101.5 F
      - Systolic blood pressure > 180 mm Hg or diastolic blood pressure > 110 mm Hg
   2. If physical exam is negative for above, proceed as follows:
      a. Acetaminophen 325 2 tabs PO Q4-6 hours PRN pain while symptoms persist; not to exceed 12 tabs in 24 hours. **or**
      b. Ibuprofen 200mg 1-2 tabs PO Q4-6hrs PRN pain while symptoms persist; not to exceed 6 tabs in 24 hrs
      c. Follow-up in RN clinic in 72 hours if headache persists.

F. Patient Education:
   1. Assess patient's potential for understanding the health information to be provided.
   2. Provide patient education consistent with the assessment of the condition.
   3. Document the education provided and the patient's level of understanding on the nursing protocol encounter form.
   4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.
   5. Follow-up in RN clinic in 72 hours if headache persists.

G. Documentation:
   All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with headache and achieve a minimum score of 80% on the written posttest examination.
B. Experience: None.
C. Certification: None.

D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstration. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

   A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____ REVISION DATE: _____
_____ _____
_____ _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

_____ DATE:_____
Chief Nursing Executive/Director of Nursing

_____ DATE:_____
Chief Medical Executive