

PROTOCOL FOR: Headache (Acute): Nursing Management of the Patient with

DESIRED
PATIENT OUTCOME: Patient will receive adequate pain control during Emergency Department visit and for management of pain after discharge.

CLINICAL
ASSESSMENT

- AND CARE:
1. Etiology of headache (trauma, past hx, associated illness, etc).
 2. Pain scale assessment and reassessment after medication.
 3. Vital signs include neurological vital signs for history of trauma, sudden onset, for presence of fever, or presence of other symptoms (i.e. weakness, dizziness, numbness).
 4. Sudden severe headache with no known cause within past 2 hours consider acute stroke.
 5. Allergies
 6. Current medications
 7. Past medical history
 8. Prior effective treatment
 9. Assess for presence of associated nausea, vomiting
 10. Provide calm, dark environment
 11. Establish IV site and administer IV fluid per MD order
 12. Medicate for pain/nausea/vomiting per MD order
 13. Assist with further diagnostic procedures

REFERENCES: Emergency Department Unit Review
Nursing Standards Committee
Emergency Department QA Representatives

EFFECTIVE DATE: 8/93

REVISION DATES: 10/99, 11/02, 9/08

REVIEW DATE: 2/06