

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
BACK PAIN (Acute / Chronic)

MSRM 140117.01.33
(R-6/11)

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Onset Recurrence Constant

Location of pain: _____

Type of pain:

Dull Intermittent Constant Throbbing Achy Sharp Pressure Worse at night
 Pain scale: (0-10) _____ Radiation Describe: _____

History:

Known cancer Known osteoporosis

Associated symptoms:

Pain on urination Change in urine color Increase urination frequency Penile discharge
 Pain with coughing Pain with breathing Unexplained weight loss ROM impaired
 Numbness : Describe _____ Tingling : Describe _____

Objective Data: (clinically indicated VS)

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

Able to bend side to side Able to bend posteriorly Able to touch toes Walks on heels
 Vomiting Abrasion Bruising Walks on toes
 Normal gait Abnormal gait Muscle spasm Moves all extremities
 Edema Tender to touch Redness
 Weakness in one or more extremities (Describe) _____

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

****** RED FLAGS ******

Abnormal vital signs Awakens offender from sleep History of cancer
 Edema, Discoloration Worse at night Bowel or bladder symptoms
 Weakness Temp > 101 Abnormal gait
 Loss of sensation in perineal area, legs and feet Unexplained weight loss
 Numbness/severe pain
 Temp > 101

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

Assessment:

Alteration in comfort related to back pain

Plan:

Nursing Intervention Routine:

Cool compresses/ ice pack to back for 24 hours (on 45 minutes / off 15minutes)
 Dipstick UA
 Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4days
OR
 Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days
 Analgesic balm to affected area 4 times a day for 7 days
 Temporary lay – in / restrictions (if indicated)

Progress Note: _____

Offender Education:

Instructed to avoid heavy lifting, strenuous work/activity until problem resolved, 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)

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