

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
MUSCLE STRAIN / OVERUSE / SPRAIN

MSRM 140117.01.35
(R-6/11)

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Onset Recurrence Activity at onset: _____

Type of pain:

<input type="checkbox"/> Dull	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Constant	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Achy	<input type="checkbox"/> Sharp	<input type="checkbox"/> Pressure
<input type="checkbox"/> Pain with wt. bearing		<input type="checkbox"/> Pain without wt. Bearing		Pain scale: (0-10) _____		

Associated symptoms:

<input type="checkbox"/> Bruising	<input type="checkbox"/> Swelling	<input type="checkbox"/> Deformity	<input type="checkbox"/> Tender to touch	<input type="checkbox"/> Able to walk immediately after injury	<input type="checkbox"/> Able to walk when examined
<input type="checkbox"/> Numbness : Describe _____			<input type="checkbox"/> Tingling : Describe _____		

Objective Data: (clinically indicated VS)

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

Pulses (distal to injury)	Skin temp (distal to injury)	Appearance of injury	Range of Motion	Appearance
<input type="checkbox"/> Present	<input type="checkbox"/> Normal	<input type="checkbox"/> Deformity	<input type="checkbox"/> Full	<input type="checkbox"/> No distress
<input type="checkbox"/> Absent	<input type="checkbox"/> Warm	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Slightly decreased	<input type="checkbox"/> Mild distress
	<input type="checkbox"/> Cool	<input type="checkbox"/> Edema	<input type="checkbox"/> Greatly decreased	<input type="checkbox"/> Moderate distress
		<input type="checkbox"/> Bruising	<input type="checkbox"/> Crepitus with motion	<input type="checkbox"/> Severe distress

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IN ALL CASES OF SPRAIN FOLLOWING FIRST AID TREATMENT:

Injuries are present that suggest need for x-ray or further assessment (i.e. joints)

Refer to Medical Provider If:

Injuries are present that suggest need for x-ray or further assessment (i.e. joints)

No response to interventions

Meets Ottawa criteria for x-ray

Tenderness at posterior edge of lateral malleolus

Tenderness at lateral edge of mid foot

Inability to walk immediately and when examined (regardless of limping)

No response to interventions

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

Assessment:

Alteration in comfort related to joint trauma

Plan:

Nursing Intervention Routine:

Apply cold compresses/ice packs for 20 minutes every 3 hours while awake for first 24 hours and then either cold or warm compresses for additional 24 hours

Local heat after acute phase resolution - compresses

Analgesic Balm to affected area QID for 7 days – issue one tube

Immobilization of area for no longer than 3 days, crutches as needed for ambulation for no longer than 3 days

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

Activity restrictions may be indicated for a period of time until the offender can be evaluated by the medical provider

Splint, sling, ace wrap, crutches should be considered where appropriate

Rest and elevation for 3 days (medical lay-in / restrictions if indicated)

Medical lay-in / restrictions

Progress Note: _____

Offender Education:

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