

ABRASIONS

Subjective Data:

Allergies: _____

Chief complaint: _____

Associated Symptoms:

Active bleeding Numbness Pain Pain Scale: (0-10) _____

Objective Data: (clinically indicated VS)

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

Size and location of injury: _____

Character of wound:

Clean Dirty Dry Weeping Crusted Redness/ Swelling Imbedded or foreign material present

Drainage: Yes No If "Yes" describe _____

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

NOTIFY MEDICAL PROVIDER IMMEDIATELY IF:

- Wound is severe /deep / requires sutures
- Signs of infection present (redness, tenderness, exudate, etc.)
- Bleeding is uncontrolled

Refer to Medical Provider If:

- Daily dressing changes are indicated
- Last tetanus diphtheria injection more than 5 years
- Orders needed for treatment
- Wound has imbedded debris not easily irrigated out

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

Assessment:

- Alteration in skin integrity related to injury

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.
- Stop bleeding with pressure
- Wash well with antiseptic soap, sterile water or sterile normal saline, remove all ingrained dirt.
- "Polysporin" ointment and dressing, if wound location subject to irritation or dirt – issue one tube
- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days

OR

- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days.
- Education/Intervention: Instructed to keep wound clean and dry, signs and symptoms of infection, condition worsens or fever, 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:** _____

Name
(Last, First)

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