

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
INDIGESTION

MSRM 140117.01.26
(R-12/15)

Subjective Data:

Allergies: _____

Chief complaint: _____
Onset: _____ New Onset Chronic Pain scale: (0-10) _____

History:

Last bowel movement: _____	Color/Consistency: _____
Dietary habits: _____	
Fluid intake/restriction: _____	
Recent wt. change: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____ Amount loss/gain _____
Gallbladder disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Recent Abd. surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Appendicitis: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____
Ulcers: <input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____

Current medications: _____

Associated symptoms:

Burning Belching Gas Flatulence Bloating Discomfort in upper stomach / chest

Objective Data: (clinically indicated VS)

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

Abdomen	<input type="checkbox"/> Soft	<input type="checkbox"/> Firm	<input type="checkbox"/> Tender to	<input type="checkbox"/> Distended	
Bowel sounds	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Hypoactive	<input type="checkbox"/> Sluggish	<input type="checkbox"/> Absent

(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:

- Onset is sudden and abnormal vital signs or problem exists or recurrence
- Symptoms suggesting cardiac origin
- Symptoms unrelieved by nursing interventions

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

Assessment:

- Alteration in comfort related to ingestion

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.
- Aluminum / Magnesium Hydroxide (i.e. Alamag, Mylanta, Maalox); chew 2 tablets four times a day (between meals and at bedtime) for 3 days as needed for indigestion **OR**
- Calcium Carbonate (i.e. Alcalak, Tums): chew 2 tablets four times a day (after meals and at bedtime) for 3 days as needed for indigestion
- Education/Intervention: Instructed to avoid spicy foods, foods that increase symptoms: caffeine, nicotine, ASA eat small meals, chew slowly and thoroughly, increase water intake to 8 glasses daily/fibrous foods, not to lie down at least 2 hours after eating, medication use, 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:** _____

Offender Name
(Last, First)

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