

OKLAHOMA DEPARTMENT OF CORRECTIONS  
NURSING PRACTICE PROTOCOLS  
**NAUSEA / VOMITING**

MSRM 140117.01.27  
(R-12/15)

**Subjective Data:**

**Allergies:** \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Onset: \_\_\_\_\_  New Onset  Chronic  Last emesis: \_\_\_\_\_

**History:**

Last bowel movement: \_\_\_\_\_ Color/Consistency: \_\_\_\_\_

Dietary habits: \_\_\_\_\_

Fluid intake/restriction: \_\_\_\_\_

Recent wt. change:  Yes  No When: \_\_\_\_\_ Amount loss/gain \_\_\_\_\_

Gallbladder disease:  Yes  No When: \_\_\_\_\_

Recent Abd. surgery:  Yes  No When: \_\_\_\_\_

Appendicitis:  Yes  No When: \_\_\_\_\_

Ulcers:  Yes  No When: \_\_\_\_\_

Current medications: \_\_\_\_\_

**Associated symptoms:**

Vertigo  Fever  Cramping  Flatulence  Chills  Diarrhea  Generalized muscle aches

Dyspnea Pain:  Yes  No scale: (0-10) \_\_\_\_\_ Location: \_\_\_\_\_ (if chest pain refer to Chest Pain protocol)

**Objective Data:** (clinically indicated VS)

BP (sitting) \_\_\_\_\_ (lying) \_\_\_\_\_ (standing) \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_

<b>Abdomen</b>	<input type="checkbox"/> Soft	<input type="checkbox"/> Firm	<input type="checkbox"/> Distended	<input type="checkbox"/> Tender to palpation
<b>Bowel sounds</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Hypoactive	<input type="checkbox"/> Absent
<b>Mucus membrane</b>	<input type="checkbox"/> Moist	<input type="checkbox"/> Dry	<input type="checkbox"/> Parched	
<b>Skin</b>	<input type="checkbox"/> Warm	<input type="checkbox"/> Cool	<input type="checkbox"/> Pale	<input type="checkbox"/> Clammy <input type="checkbox"/> Diaphoretic
<b>Turgor</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased		
<b>Skin</b>	<input type="checkbox"/> Warm	<input type="checkbox"/> Dry	<input type="checkbox"/> Cool	<input type="checkbox"/> Moist <input type="checkbox"/> Clammy
<b>Skin color</b>	<input type="checkbox"/> Pink	<input type="checkbox"/> Pale	<input type="checkbox"/> Flushed	<input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice
<b>Character of emesis</b>	<input type="checkbox"/> Clear	<input type="checkbox"/> Bright red	<input type="checkbox"/> Gastric	<input type="checkbox"/> Coffee grounds <input type="checkbox"/> Undigested food
	<input type="checkbox"/> Intact medication	<input type="checkbox"/> All fragments of medication		

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

**Hematemesis Emergency: Immediate Emergency Care transfer without delay:**

Emesis of gross blood with unstable vital signs

**NOTIFY MEDICAL PROVIDER IMMEDIATELY:**

Intractable vomiting, or dehydration appears probable, or Temp > 101F, or offender is known diabetic

Vomitus is bloody or contains fecal material, known cancer or chemotherapy

**Refer to Medical Provider If:**

Bowel sounds are absent, symptoms continue more than 24-36 hours after protocol

Associated with persistent abdominal pain

**Emergency department notification time:** \_\_\_\_\_ **Transport time:** \_\_\_\_\_

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

**Assessment:**

Alteration in comfort related to gastro-intestinal upset

**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.

Clear liquid diet and activity restriction for 24 hours only

Bismuth tablets: chew 2 tablets 4 times a day (before meals and at bedtime) for 3 days (DO NOT GIVE IF HX BLEEDING, ASTHMA OR ALLERGY TO ASA)

Education/ Intervention: Instructed to avoid spicy foods, increase water intake, clear liquid diet, 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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