

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

MSRM 140117.01.33
(R-12/15)

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) _____

(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:

Abnormal vital signs
 Edema, Discoloration
 Weakness
 Loss of sensation in perineal area, legs and feet
 Numbness/severe pain
 Temp > 101

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

Awakens offender from sleep
 Worse at night
 Temp > 101
 Unexplained weight loss
 History of cancer
 Bowel or bladder symptoms
 Abnormal gait

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

Assessment:

Alteration in comfort related to back pain

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.
 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)
 Education/Intervention: Instructed to avoid heavy lifting, strenuous work/activity until problem resolved, 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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