

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

MSRM 140117.01.35
(R-12/15)

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

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

Assessment:

Alteration in comfort related to joint trauma

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.
- 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
- Education/Intervention: 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.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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