

OKLAHOMA DEPARTMENT OF CORRECTIONS
 NURSING PRACTICE PROTOCOLS
PEPPER SPRAY (OC) / TEAR GAS (CN)
 (Oleoresin-Capsaicin) (Omega -chlorobenzylidene)

MSRM 140117.01.44
(R-12/15)

Subjective Data: _____ **Allergies:** _____

Chief complaint: _____

History of Event (by offender or bystander)

Type of exposure: _____ Time of exposure: _____ Area exposed: _____

History of COPD: Yes No History of Asthma: Yes No

Associated symptoms:

<input type="checkbox"/> Burning	<input type="checkbox"/> Coughing	<input type="checkbox"/> Gagging	<input type="checkbox"/> Running nose	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Increased salivation
<input type="checkbox"/> Pain	scale (0-10) _____	<input type="checkbox"/> Shortness of breath			

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ O₂ sats. _____

Respiration	Lung Sounds	Skin	Neurological	EYES	Appearance
<input type="checkbox"/> Even	<input type="checkbox"/> Clear	<input type="checkbox"/> Pink	<input type="checkbox"/> Awake	<input type="checkbox"/> Redness	<input type="checkbox"/> No distress
<input type="checkbox"/> Uneven	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Alert	<input type="checkbox"/> Tearing	<input type="checkbox"/> Mild distress
<input type="checkbox"/> Labored	<input type="checkbox"/> Wheezes	<input type="checkbox"/> Mottled	<input type="checkbox"/> Oriented X _____	<input type="checkbox"/> Swelling	<input type="checkbox"/> Moderate distress
<input type="checkbox"/> Unlabored	<input type="checkbox"/> Diminished	<input type="checkbox"/> Jaundiced	<input type="checkbox"/> Confused	<input type="checkbox"/> Visual disturbances	<input type="checkbox"/> Severe distress
<input type="checkbox"/> Shallow	<input type="checkbox"/> Rales	<input type="checkbox"/> Pale	<input type="checkbox"/> Lethargic		
<input type="checkbox"/> Deep	<input type="checkbox"/> Airway obstructed	<input type="checkbox"/> Blistering	<input type="checkbox"/> Comatose		
		<input type="checkbox"/> Redness	<input type="checkbox"/> Pupils equal		
		<input type="checkbox"/> Swelling	<input type="checkbox"/> Pupils unequal		

(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:

- Respiratory or cardiovascular problems, unconsciousness occurs
- Blistering of skin
- Ocular problems that do not resolve within 15-30 minutes
- Emergency Room notification time: _____ Transport time: _____

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

Assessment:

- Alterations in comfort related to exposure to chemicals.

Plan: Nursing Intervention Routine: (check all that apply)

- Check in assessment only for medical providers visit.
- Calm offender and move the offender to fresh air and /or provide adequate ventilation
- Do not rub the face as this will aggravate the pain already being experienced
- Check for acute pulmonary or cardiac complications arising from aggravation of pre-existing conditions, or from trauma. If present call 911 and prepare offender for transport to emergency room.
- Flush affected areas with copious amounts of cool water. Irrigate eyes with sterile normal saline. Skin should be washed with oil-based or cold cream based soap. **Note: If offender sprayed with CS, irrigation can result in temporarily increasing burning sensation but still should be attempted.**
- Remove contaminated clothing and contact lenses (rigid contacts)
- Monitor offender. Significant improvement should be noted within 15-30 minutes after exposure. If symptoms persist or are severe, the offender should be evaluated by the medical provider
- Bag offender clothing and send to laundry to be decontaminated.
- Remember the offender will likely recover even if no first aid is provided
- Education/Intervention: Instructed to keep hands off the affected area and put on clean clothes, proper hygiene, procedure(s) and care provided, follow-up sick call after emergency room / hospitalization. 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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