OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
FALL

Subjective Data: **Allergies:** _____

Chief complaint: _____

Date of fall: _____ **Time of fall:** _____ ❑ **AM** ❑ **PM**

Location of fall: _____ **Activity at time of fall:** _____

Reason for fall: ❑ Loss of balance ❑ Slipped ❑ Tripped ❑ Lost strength/weakness ❑ Lost consciousness

Risk Assessment:

❑ History of falls	❑ Poor vision	❑ Medication	❑ Foot wear
❑ Orthostatic Hypotension	❑ Impaired mobility	❑ Mental status changes	❑ Weakness/fatigue

Current Problems: _____

Current medication(s): _____

Objective Data: (clinically indicated VS)

BP (sitting) _____ (lying) _____ (standing)_____ Pulse _____ Resp. _____ Temp. _____ Wt.____O_2 sats._____ FSBS: ____

Respiration	LOC	Neurologic		Appearance
❑ Even	❑ Awake	❑ Gait steady	❑ Gait unsteady	❑ No distress
❑ Uneven	❑ Alert	❑ Grips equal	❑ Grips unequal	❑ Mild distress
❑ Labored	❑ Oriented X_____	❑ Speech normal	❑ Speech slurred	❑ Moderate distress
❑ Unlabored	❑ Confused	❑ Pupils equal	❑ Pupils unequal	❑ Severe distress
❑ Shallow	❑ Lethargic			
❑ Deep	❑ Follows commands			
❑ Rapid	❑ Unable to follow command			

Severity Level:

❑ No injury
❑ Minor injury/first aid only (ex: bruise, abrasion, skin tear) Location: _____
❑ Major injury (ex: laceration with sutures, closed head injury, fracture): Location: _____
❑ Death

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: *Health care provider must be called if not on site or if after clinic hours.*

❑ Wound is severe/deep/requires sutures
❑ Bleeding is uncontrolled
❑ Laceration to the face, ear, nose, eyelid or over joint
❑ Decreased level of consciousness
❑ Neurological deficits: unequal pupils, difficulty walking/abnormal gait, weakness, numbness, facial asymmetry, disorientation

REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Daily dressing changes are indicated
❑ Last Tetanus/Diphtheria injection more than 5 years

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** ❑ **Yes** ❑ **No**

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ Bruise - refer to MSRM 140117.01.2.6 “Contusion”
❑ Skin Tear - refer to MSRM 140117.01.2.16 “Skin Tear”
❑ Abrasion or Laceration - refer to MSRM 140117.01.2.1 “Abrasion/Laceration/Puncture”
❑ Closed Head Injury - refer to MSRM 140117.01.10.2 “Head Trauma”
❑ Fracture - refer to MSRM 140117.01.9.6 “Skeletal Injury”
❑ Education/Intervention: Instructed to sit when feeling dizzy to avoid injury, methods to decrease sensation of vertigo, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/Credentials: _____ **Date:** _____ **Time:** _____

Inmate Name (Last, First) DOC #