OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
Swelling
(Peripheral and Pulmonary Edema)

MSRM 140117.01.1.4
(R-4/19)

Subjective Data: **Allergies:** _____

Chief complaint: _____

Location: _____ Size: _____ Pain Scale: (0-10) _____

Objective Data: (clinically indicated VS)

BP_____ Pulse_____Res_____Temp. _____Wt_____ O2 sats: _____ FSBS _____

Inmate on anticoagulants (warfarin, aspirin, heparin etc.), diuretic, cardiac medication. ☐ Yes ☐ No

Heart Rhythm	Respiration	Lung Sounds	Skin	Swelling	Pulse
❑ Sinus rhythm ❑ Tachycardia ❑ Bradycardia ❑ Arrhythmia	❑ Even ❑ Uneven ❑ Labored ❑ Unlabored ❑ Shallow ❑ Rapid ❑ Dyspnea ❑ Air Hunger ❑ Use of accessory muscles	❑ Clear ❑ Rhonchi ❑ Diminished ❑ Rales	❑ Warm ❑ Pink ❑ Diaphoretic ❑ Cool ❑ Moist ❑ Cyanotic ❑ Mottled ❑ Erthema	❑ Tongue ❑ Throat ❑ Extremities ❑ Abdomen ❑ Generalized	Location: _____ ❑ Able to palpate ❑ Unable to palpate

Capillary Refill	Edema	Neurological (sensation)	Movement	Appearance
❑ Brisk - < 2 seconds ❑ Sluggish - > 2 seconds	❑ Non - Pitting ❑ Pitting (scale) ☐ +1 ☐ +2 ☐ +3 ☐ +4 Location: _____	❑ Sensation Present ❑ Sensation Absent Location: _____ ❑ Lethargy ❑ Disoriented	❑ No Limitation ❑ Limit Movement Describe: _____	❑ No distress ❑ Mild distress ❑ Moderate distress ❑ Severe distress

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

- ❑ Shortness of breath, abnormal breaths sounds and/or tachycardia
- ❑ Impaired neurological (lethargy, disorientation)/vascular status
- ❑ Edema is accompanied by blurry vision, severe headache, tingling or numbness
- ❑ Active infection – if suspect cellulitis
- ❑ Leg size discrepancies

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.*

- ❑ Marked edema is present
- ❑ Condition not responding to intervention

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.

Peripheral Edema	Pulmonary Edema
❑ Protect the affected area. ❑ Raise the legs several times per day to improve circulation. Elevate head if facial. ❑ Apply ice to the affected area to reduce swelling 24 to 48 hours ❑ Elevate the affected area anytime sitting or lying down. ❑ Cut down salt consumption. ❑ Avoid sitting for long periods of time. ❑ Monitor I & O ❑ Assess fit of shoes and slippers to avoid risk of pressure and skin breakdown. ❑ Consider crutches if lower extremity. ❑ Medical lay-in/Restrictions. ❑ Circumference: Lt: _____Rt: _____	❑ Place inmate in semi-fowler position or reclining position ❑ Place pulse oximeter ❑ Administer Oxygen at 2L minute via nasal cannula to maintain oxygen saturation above 90% (requires health care provider order) ❑ Monitor blood pressure, cardiac rate and rhythm ❑ Monitor breath sounds and be alert for crackles (Rales), heart tones and peripheral pulses ❑ Monitor skin color, moisture, temperature and capillary refill time ❑ Monitor for a new non-productive cough ❑ Monitor for signs of hypoxia: restlessness, confusion, headache ❑ Assess for distended neck and peripheral vessels ❑ Schedule inmate for daily weights ❑ Monitor I & O

❑ Education/Intervention: Instructed signs and symptoms to warrant further treatment (loss of sensation, increase swelling, decrease ROM, 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 #