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

MSRM 140117.01.9.3
(R-2/20)

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._____O_2 sats._____ FSBS: _____

❑ 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)_____

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

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

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

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

Health Care Provider Notified: Date: _____ **Time:** _____ **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.
❑ Cool compresses/ ice pack to back for 24 hours (on 45 minutes / off 15 minutes). Alternate with warm moist compress.
❑ Dipstick UA
❑ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN **OR** ❑ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days PRN.
❑ Analgesic balm to affected area 4 times a day for 7 days PRN.
❑ Temporary lay – in / restrictions (if indicated)
❑ Education/Intervention: Instructed to avoid heavy lifting, strenuous work/activity until problem resolved, and 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 #