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

MSRM 140117.01.9.5
(R-2/20)

Subjective Data: **Allergies:** _____

Chief complaint: _____

Onset:_____ ❑ New Onset ❑ Recurrence Activity at onset: _____

Type of pain:

❑ Dull ❑ Intermittent ❑ Constant ❑ Throbbing ❑ Achy ❑ Sharp ❑ Pressure
❑ Pain with wt. bearing ❑ Pain without wt. Bearing Pain scale: (0-10) _____

Associated symptoms:

❑ Bruising ❑ Swelling ❑ Deformity ❑ Tender to touch
❑ Able to walk immediately after injury ❑ Able to walk when examined
❑ Numbness : Describe_____ ❑ Tingling : Describe_____

Objective Data: (clinically indicated VS)

BP _____Pulse _____ Resp. _____ Temp. _____ Wt._____O_2 sats._____ FSBS: _____

Pulses (distal to injury)	**Skin temp** (distal to injury)	**Capillary Refill**	**Appearance of injury**	**Range of Motion**	**Appearance**
❑ Present ❑ Absent	❑ Normal ❑ Warm ❑ Cool	❑ Brisk - < 2 seconds ❑ Sluggish - > 2 seconds	❑ Deformity ❑ Discoloration ❑ Edema ❑ Bruising	❑ Full ❑ Slightly decreased ❑ Greatly decreased ❑ Crepitus with motion	❑ No distress ❑ Mild distress ❑ Moderate distress ❑ Severe distress

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IN ALL CASES OF SPRAIN FOLLOWING FIRST AID TREATMENT: *Health care provider must be called if not on site or if after clinic hours.*

❑ Injuries are present that suggest need for x-ray or further assessment (i.e. joints)

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.*

❑ No response to interventions

Meets Ottowa 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

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.
❑ 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.
❑ Immobilization of area for no longer than 3 days, crutches as needed for ambulation for no longer than 3 days.
❑ Local heat after acute phase resolution – compresses.
❑ Analgesic Balm to affected area QID for 7 days PRN.
❑ 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.
❑ Activity restrictions may be indicated for a period of time until the inmate can be evaluated by the health care provider.
❑ Crutches issued. Aides to Impairment Appliance Record completed and signed by inmate.
❑ 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. 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 #