

**SKELETAL INJURY**  
(example – Fractures / Dislocations)

**Subjective Data:**

**Allergies:** \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Onset: \_\_\_\_\_ Location: \_\_\_\_\_ Mechanism of injury: \_\_\_\_\_

**Type of pain:**

<input type="checkbox"/> Dull	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Constant	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Achy	<input type="checkbox"/> Sharp	<input type="checkbox"/> Pressure
<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Pain	Pain scale: (0-10) _____			

**Objective Data:** (clinically indicated VA)

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_ O<sub>2</sub> sats. \_\_\_\_\_ FSBS: \_\_\_\_\_

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

**ORTHOPEDIC EMERGENCY: IMMEDIATE EMERGENCY CARE WITHOUT DELAY AND CONTACT HEALTH CARE PROVIDER**

- If suspected fracture of the cervical spine, evaluate respiratory function continuously, call 911, do not attempt to move inmate
- Impaired circulation, shock, hemorrhage, open fracture, loss of consciousness

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

- Obvious deformity, loss of sensation
- Mechanism of injury suggesting hidden trauma
- Numbness/severe pain, absent distal pulses
- Takes anticoagulants, over age 50

**REFER HEALTH CARE PROVIDER FOR:** *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.*

- X-rays
- Tetanus booster

**Meets Ottawa 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

**Emergency department notification time:** \_\_\_\_\_ **Transport time:** \_\_\_\_\_ **Transported by:** \_\_\_\_\_

**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: (No traction should be applied to a compound fracture)** (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.
- Immobilize affected limb prior to moving.
- Elevate affected limb.
- Cover open wound with sterile dressing.
- Splint joint above and below injury.
- Sling for upper extremity.
- Ice to closed injury site.
- Crutches (if indicated)
- 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
- Medical lay-in / restrictions.
- Education/Intervention: Instructed on RICE (rest, ice, compression bandage, elevate part), 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)

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