

RN Protocol: Musculoskeletal Complaints (Non-Traumatic)

I. POLICY

- A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients presenting with non-traumatic musculoskeletal complaints.
- B. Circumstances under which the RN may perform the function:
 - 1. Setting: Outpatient.
 - 2. Supervision: No direct supervision required.

II. PROTOCOL

- A. Definition: This protocol covers the assessment and treatment of patients presenting with muscle, joint, extremity, or back pain; joint swelling, stiffness and/or effusion, not related to a traumatic injury.
- B. Subjective:
 - 1. Chief complaint (document in the patient's own words).
 - 2. Date and time of onset.
 - 3. Location and description of the problem.
 - 4. Assess for pain including flank pain.
 - 5. If pain is present rate on a scale of 0-10 (0 = no pain, 10 = worst pain).
 - 6. Quality of the pain (dull, sharp, aching, throbbing, spasm).
 - 7. History of prior pain and duration.
 - 8. If low back pain or flank pain assess for urinary symptoms (e.g. urinary frequency, dysuria, and/or burning on urination, hematuria).
 - 9. What makes the pain better? What makes the pain worse?
 - 10. Accompanying symptoms (e.g., muscle spasms, numbness, tingling).
 - 11. History of fever, chills, headache, nausea, vomiting, diarrhea, or fatigue.
 - 12. History of recent trauma.
 - 13. History of chronic illness (e.g., arthritis, cancer, diabetes, blood dyscrasias, or renal disease).
 - 14. Allergies.
 - 15. Current medications.
- C. Objective:
 - 1. Vital signs and weight.
 - 2. Observe and document the following:
 - a. Color, warmth, tenderness, deformity or swelling of affected area.
 - b. Circulation and sensation.
 - c. Muscle atrophy, hypertrophy, weakness, tremors.

- d. Range of motion to affected extremity (limited- for example bending at waist).
 - e. Pain or discomfort with or without movement.
 - f. For back pain observe curvature, gait, and stance; test for straight leg raising.
3. Dipstick urine if current symptoms or history of flank pain, urinary frequency, dysuria, and /or burning on urination and hematuria.

D. Assessment:

- Impaired physical mobility related to/evidenced by:
- Pain related to/evidenced by:

E. Plan:**Extremity pain or stiffness:**

1. If alteration in circulation or sensation, new deformity or discoloration, or patient appears ill or has history of fever, chills, headache, nausea, vomiting, or diarrhea notify physician **STAT**.
2. If none of the above signs and symptoms are present:
 - a. Apply ice or heat as deemed appropriate.
 - b. Ibuprofen 200mg 1-2 tabs PO Q4-6 hours PRN pain while symptoms persist; not to exceed 6 tabs in 24 hours or
 - d. Naproxen 220mg 2 tabs PO 1st hour; 1 tab Q8-12 hours PRN pain while symptoms persist; not to exceed 3 tabs in 24hours
 - e. Activity as tolerated.
 - f. Instruct patient to follow-up in RN clinic in 72 hours if symptoms persist.

Muscle cramps:

1. Severe muscle cramps; muscle weakness with or without fever: Refer **STAT** to physician.
2. Mild to moderate muscle pain or cramps, without weakness or fever:
 - a. Advise patient to rest.
 - b. Acetaminophen 325mg 2 tabs PO Q4-6 hours PRN pain while symptoms persist; not to exceed 12 tabs in 24 hours; **or**
 - c. Ibuprofen 200mg 1-2 tabs PO Q4-6hours PRN pain while symptoms persist; not to exceed 6 tabs in 24 hours; **or**
 - e. Naproxen 220mg 2 tabs PO 1st hour; 1 tab Q8-12 hours PRN pain while symptoms persist; not to exceed 3 tabs in 24hours
 - f. Instruct patient to follow-up in RN clinic in 72 hours if symptoms persist.

Joint pain:

1. Warm or acutely swollen, joints: Refer patient to physician **STAT** for evaluation.
2. Joint pain without redness, swelling, or deformity:
 - a. Naproxen 220mg PO 2 tabs 1st hour; 1 tab Q8-12 hours PRN pain while symptoms persist; not to exceed 3 tabs in 24 hours; **or**
 - b. Ibuprofen 200mg 1-2 tabs PO Q4-6hours PRN pain while symptoms persist; not to exceed 6 tabs in 24 hours;

- b. Instruct patient to follow-up in RN clinic in 72 hours if symptoms persist.

Low back pain:

1. Acute low back pain: Refer patient to physician on a **STAT**, **Urgent**, or **Routine** basis as appropriate.
2. If urine dipstick is positive or patient has signs and symptoms consistent with a urinary tract infection (UTI) refer the patient to the physician **STAT**.
3. Chronic low back pain with documented diagnosis:
 - a. Review unit health record to confirm diagnosis and treatment.
 - b. Continue recommended exercises and provide patient with instruction sheet.
 - c. Review proper body mechanics with the patient.
 - d. Activity as tolerated. Advise patient to avoid prolonged sitting.
 - e. Acetaminophen 325mg 2 tabs PO Q4-6 hours PRN pain while symptoms persist; not to exceed 12 tabs in 24 hours. **or**
 - f. Ibuprofen 200mg 1-2 tabs PO Q4-6hours PRN pain while symptoms persist; not to exceed 6 tabs in 24 hours; **or**
 - g. Naproxen 220mg 2 tabs PO 1st hour; 1 tab Q8-12 hours PRN pain while symptoms persist; not to exceed 3 tabs in 24hours; **or**
 - h. Instruct patient to follow-up in RN clinic in 72 hours if symptoms persist.

F. Patient Education:

1. Assess patient's potential for understanding the health information to be provided.
2. Provide patient education consistent with the assessment of the condition.
3. Document the education provided and the patient's level of understanding on the nursing protocol encounter form.
4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.
5. Advise patient to resubmit a Health Care Request Form (CDC 7362) if symptoms persist.

G. Documentation:

All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

- A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with non-traumatic musculoskeletal complaints and achieve a minimum score of 80% on the written posttest examination.
- B. Experience: None.
- C. Certification: None.
- D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstrations. The Registered Nurse must

satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

- E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____

REVISION DATE: _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

Chief Nurse Executive/Director of Nursing

DATE: _____

Chief Medical Executive

DATE: _____