OKLAHOMA DEPARTMENT OF CORRECTIONS  
NURSING PRACTICE PROTOCOLS  

Movinole Deficit  
(Ischemic Attack, CVA, Bell’s Palsy)  

Subjective Data:  
Allergies: ____________________________  
Chief complaint: ________________________  
Onset of Symptoms: ____________________ Duration of Symptoms: ______ Activity at Onset: ____________________  

Associated symptoms:  
☐ Generalized weakness/paralysis  ☐ Disturbance of speech  ☐ Loss of balance  ☐ Excessive tearing of eye  
☐ Neck ache  ☐ Pain behind ear  ☐ Visual disturbances  ☐ Confusion  ☐ Loss of consciousness  
☐ Loss of bladder and/or bowel  ☐ Facial drooping  ☐ Loss of taste  ☐ Facial drooping  ☐ Drooling  

Stroke-THINK F.A.S.T  
Bell’s Palsy – COWS  
Face - weakness on one side of the face and ask person to smile  
C – close your eyes  
Arm- weakness or numbness in one arm ask the person to raise both arms  
O – open your eyes  
Speech – slurred speech or trouble getting words out, ask the person to speak a simple sentence  
W – wrinkle your forehead, raise your eyebrows  
Time – note time when signals were first observed  
S – smile  

Objective Data:  
BP ___________ Pulse ___________ Resp. ___________ Temp. ___________ Wt. ________ O2 sats. ________ FSBS: ___________  

Respiration  
☐ Even  ☐ Uneven  ☐ Labored  ☐ Unlabored  ☐ Shallow  ☐ Deep  ☐ Rapid  
LOC  
☐ Awake  ☐ Alert  ☐ Oriented X_____  ☐ Confused  ☐ Lethargic  ☐ Comatose  ☐ Follows commands  ☐ Unable to follow commands  ☐ Knows month & age  ☐ Does not know month & age  
Neurologic  
☐ Gait steady  ☐ Gait unsteady  ☐ Grips equal  ☐ Grips unequal  ☐ Speech normal  ☐ Speech slurred  ☐ Pupils equal  ☐ Pupils unequal  ☐ Smile symmetrical  ☐ Smile asymmetrical  ☐ Facial drooping  ☐ Pain behind the ear  ☐ Able to wrinkle forehead and close eyes  ☐ Unable to wrinkle forehead and close eyes  ☐ Loss of sense of taste  
Mental Status  
☐ Oriented to place  ☐ Oriented to date & time  ☐ Can repeat “ball, flag, tree”  ☐ Can name a pen and watch  ☐ Can repeat “no ifs and or buts”  ☐ Can draw a clock set to 2:30  

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IN ALL CASES OF NEUROLOGIC ADNORMALITIES: In cases of emergency call EMS.  
Health care provider must be called if not on site or if after clinic hours.  
☐ Facial drooping  ☐ Decreased level of consciousness  ☐ Paralysis  ☐ Weakness/numbness/paralysis  ☐ Blood Pressure elevation  
☐ Loss of consciousness  ☐ Unable to speak/slurred speech  
☐ (Systolic ≥ 185 mmHg or Diastolic ≥ 110 mmHg)  

Emergency department notification time: ________ Transport time: ________ Transported by: ____________________  
Health Care Provider: ____________________ Time Notified: ________ Orders Received for Treatment: ☐ Yes ☐ No  

Plan: Interventions:  
☐ 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.  
☐ Call EMS for altered state of consciousness, facial drooping and/or can’t speak.  
☐ Obtain VS, including FSBS, paying special attention to an elevated blood pressure.  
☐ Assess inmate’s coordination of movement and ability to move upper and lower extremities.  
☐ Check pupil size and reaction to light.  
☐ Assess facial symmetry. Look for differences between features of right and left side of face (e.g. smile/frown, raise eyebrows) and presence/absence of eyelid drooping.  
☐ Assess inmate’s ability to walk, observing gait and balance.  
☐ Do not give inmate anything to eat or drink.  
☐ Have inmate rest quietly on their weakened side so secretions can drain from the mouth.  
☐ Education/Intervention: Instructed on treatment provided, follow-up sick call with health care provider after ER / hospitalization. Inmate verbalizes understanding of instructions.  

Progress Note: ____________________  

Health Care Provider Signature/Credentials: ____________________ Date: ________ Time: ________  
RN/LPN Signature/Credentials: ____________________ Date: ________ Time: ________  

Inmate Name: ____________________  
Doc #: ____________________  
(Last, First)