

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
NOSEBLEED (EPISTAXIS)

MSRM 140117.01.3.4
(R-4/19)

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ New Onset Chronic Spontaneous

History:

Upper Resp. Infection:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
High blood pressure:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Trauma / foreign object:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Nasal surgery:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Hemophilia:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Aspirin:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Bleeding disorder:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____
Blood thinners:	<input type="checkbox"/> Yes <input type="checkbox"/>	When: _____ Are you still on blood thinners: <input type="checkbox"/> Yes <input type="checkbox"/>
Last PT/INR: _____		Last platelet count: _____

Associated symptoms:

Runny nose Cold Cough Sneezing Fever
Pain: Yes No Pain scale: (0-10) _____

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____

Right nare:	<input type="checkbox"/> Normal	<input type="checkbox"/> Red	<input type="checkbox"/> Swollen	<input type="checkbox"/> Drainage / bleeding
Left nare:	<input type="checkbox"/> Normal	<input type="checkbox"/> Red	<input type="checkbox"/> Swollen	<input type="checkbox"/> Drainage / bleeding
Trauma:	<input type="checkbox"/> Laceration	<input type="checkbox"/> Bruising	<input type="checkbox"/> Deformity	<input type="checkbox"/> External swelling
Amount of bleeding:	<input type="checkbox"/> Constant	<input type="checkbox"/> Spurting	<input type="checkbox"/> Trickle	<input type="checkbox"/> Frequent swallowing

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

- Bleeding not controlled by 15-20 minutes of compression (by the clock compression); may be repeated once
- Recurrent bleed within one hour-no new trauma
- Inmate report of bleeding disorder, clotting disorder or on anticoagulants, Plavix or long term ASA use
- Second episode within one week
- Blood pressure greater than 100 mm Hg diastolic

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.

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.
- Place inmate in sitting position with head tilted forward to prevent aspiration and swallowing of blood
- Hold nose firmly and continuously for 15-20 minutes with 4x4 – Apply continuous external pressure to both sides of nose with thumb and forefinger.
- Have inmate breathe and spit through mouth
- Cold packs to bridge of nose or back of neck
- Observe for 45-60 minutes after bleeding stops
- Education/Intervention: Instructed not to insert Q-tip or other object into nose, do not pick or blow nose, 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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