RN Protocol: Epistaxis

I. POLICY

A. Function: To facilitate and guide the Registered Nurse in the assessment and treatment of patients presenting with epistaxis (nosebleed).

B. Circumstances under which the RN may perform the function:
1. Setting: Outpatient clinic.
2. Supervision: No direct supervision required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients presenting with epistaxis. Epistaxis is defined as acute or sudden onset of hemorrhage of the nasal mucosa from the traumatic or spontaneous rupture of superficial vessels and/or arteries located most often in the anterior portion of the nasal septum. Trauma to the nasal mucosa is the most common cause of epistaxis and may occur as a result of picking the nose or direct blunt trauma. Spontaneous rupture of superficial veins in the nasal cavity may occur as a result of acute or chronic sinusitis or upper respiratory infection. In addition, epistaxis may be secondary to local or systemic infections, excessive drying of the nasal mucus membranes, arteriosclerosis, hypertension, and bleeding tendencies associated with aplastic anemia, leukemia, thrombocytopenia, liver disease and hereditary coagulopathies.

B. Subjective:
1. Chief complaint (document in the patient's own words).
2. Date and time of onset.
3. Nosebleed occurred as a result of: (blunt trauma, nose picking, foreign body, recent upper respiratory infection, other).
4. Estimated blood loss (number of tissues, ounces, cups).
5. History of epistaxis.
6. History of chronic illness (specifically liver disease, hemophilia or other inherited or acquired coagulopathy, leukemia, multiple myeloma, COPD, heart disease, and hypertension).
7. Allergies.
8. Current medications (specifically coumadin, aspirin, and platelet aggregation inhibitors such as Ticlid).

C. Objective:
1. Vital signs and weight. Postural pulse and blood pressure for significant blood loss.
2. General appearance.
3. Nostril involved (left, right, both).
4. Observe for facial injury, deformity, swelling, and blood in posterior oropharynx.
5. Note amount and extent of bleeding, and whether blood is fresh or dried.

D. Assessment:
- Impaired tissue integrity evidenced by/related to:
- Risk for fluid volume deficit by/related to:

E. Plan:
1. If the patient has a traumatic injury, or is on anticoagulants refer patient to a physician **STAT**.

2. If systolic blood pressure < 90 or > 180; diastolic blood pressure > 110; pulse >110 or postural pulse change > 20 beats per minute refer patient to a physician **STAT**.
3. If bleeding from posterior oropharynx refer patient to a physician **STAT**.
4. If none of the above conditions are present and the patient is actively bleeding, ask patient to sit up, lean forward and gently blow nose to remove clots. Then firmly pinch nostrils between the thumb and index fingers X 15 minutes. If bleeding persists after 15 minutes transport to Triage Treatment Area for evaluation by a physician.
5. If bleeding stops after 15 minutes examine the patient to make sure there is no active bleeding and no clots. Observe patient for at least 30 minutes before discharging from treatment. Prior to discharge advise patient not to blow nose and avoid sneezing for at least 12 hours. If patient must sneeze advise to open mouth so that air escapes through the mouth instead of the nose. Patient may "snuff up" as needed. After 12 hours patient may apply a thin layer of Petrolatum/Lanolin Skin Protectant Ointment to nostrils B.I.D. while dryness of the nasal mucosa persists.

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. Evaluate the patient's level of understanding and document all patient education on the encounter form or a progress note.
   4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.
   5. Advise the patient to resubmit a Health Care Request Form (CDC 7362) if symptoms recur.

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 epistaxis, 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 demonstration. 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:

_____ DATE: _____
Chief Nurse Executive/Director of Nursing

_____ DATE: _____
Chief Medical Executive