

OKLAHOMA DEPARTMENT OF CORRECTIONS  
NURSING PRACTICE PROTOCOLS  
**NOSEBLEED (EPISTAXIS)**

MSRM 140117.01.21  
(R-12/15)

**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:**

<input type="checkbox"/> Runny nose	<input type="checkbox"/> Cold	<input type="checkbox"/> Cough	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Fever
Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Pain scale: (0-10) _____				

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

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_

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

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

**NOTIFY MEDICAL PROVIDER IMMEDIATELY IF:**

- 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
- Offender 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

**Medical Provider Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Alteration in comfort related to epistaxis

**Plan: Nursing Intervention Routine:** (check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- Place offender 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 offender 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. Offender verbalizes understanding of instructions.

**Progress Note:** \_\_\_\_\_

**Medical Provider Signature/Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**QHCP Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Offender Name  
(Last, First)

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