## Gastrointestinal Bleeding, Acute and Chronic – Clinical Protocol

### Assessment and Recognition

1. As part of the initial assessment, the physician will help the staff identify individuals with a history of gastrointestinal (GI) bleeding and those who are at significant risk for having gastrointestinal bleeding; for example, individuals taking Prednisone or nonsteroidal anti-inflammatory drugs (NSAIDs), those with a recent severe acute illness, or those with a history of gastrointestinal disorders association with bleeding such as peptic ulcer disease or ulcerative colitis.

2. The physician and staff will identify individuals with active gastrointestinal bleeding, including details such as general location (upper or lower GI), association with meals, related pain, presence of clots, tarry or black stools, orthostatic (postural) hypotension, dizziness, tachycardia, etc.
   a. For example, check stool or vomitus for occult blood, check for orthostasis in suspected GI bleeding, check bowel sounds and rectal tenderness in cases of lower gastrointestinal bleeding.

### Cause Identification

1. The physician will try to identify causes of GI bleeding by ordering pertinent diagnostic tests and/or consultations; for example, stool for enteric pathogens, abdominal x-ray, endoscopy or colonoscopy, etc.
   a. Alternatively, the physician will document why investigation of causes is not warranted; for example, the resident cannot cooperate with endoscopy, advance directives decline additional testing, or identification of causes is unlikely to change the treatment or the outcome.

2. The staff and physician will look for complications of gastrointestinal bleeding such as lethargy, activity intolerance, and anemia.

### Treatment/Management

1. The physician will address treatable causes and complications of gastrointestinal bleeding.
   a. This might include fluid replacement (if needed) to maintain adequate circulating volume, treating colitis, or stopping medications associated with esophageal or gastric irritation or erosion; for example, aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), chemotherapy agents, corticosteroids, medications used to treat osteoporosis, etc.
   b. Alternatively, the physician should explain why the medication is needed despite apparent gastrointestinal complications and institute pertinent prophylaxis.
   c. Proton pump inhibitors (PPIs) protect against some causes of gastric or esophageal erosion, but do not necessarily prevent bleeding from other diverse causes.

2. The physician will help characterize the severity and urgency of the situation, based on vital signs, amount of bleeding, resident distress, etc.

3. The physician will help identify individuals who need transfer to the hospital for additional evaluation or treatment based on the severity, urgency, and likely causes of symptoms.

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Monitoring and Follow-Up

1. The staff and physician will monitor the individual with gastrointestinal bleeding, including response to intervention, status of bleeding, and progress in resolving underlying causes.
2. The physician will adjust interventions based on the resident response and other factors.

References

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<td>Survey Tag Numbers</td>
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Related Documents

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