**Aim:**
- Early identification and treatment of life threatening causes of gastrointestinal bleeding, escalation of care for patients at risk.
- Early initiation of treatment / clinical care and symptom management within benchmark time.

**Assessment Criteria:** On assessment the patient should have one or more of the following signs / symptoms:
- Haematemesis
- Abdominal pain
- Dizziness
- Melena
- Nausea
- Lightheadedness

**Escalation Criteria:** Immediate life -threatening presentations that require escalation and referral to a Senior Medical Officer (SMO):
- Altered mental status
- Chest pain
- Respiratory failure
- Elderly > 65 years
- Pregnant
- Trauma Call Criteria*

**Primary Survey:**
- Airway: patency
- Breathing: resp rate, accessory muscle use, air entry, SpO₂
- Circulation: perfusion, BP, heart rate, temperature
- Disability: GCS, pupils, limb strength

Notify CNUM and SMO if any of the following red flags is identified from Primary Survey and Between the Flags criteria

<table>
<thead>
<tr>
<th>Airway – at risk</th>
<th>Breathing – respiratory distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial / full obstruction</td>
<td>RR &lt; 5 or &gt;30 /min</td>
</tr>
<tr>
<td>Disability – decreased LOC</td>
<td>SpO₂ &lt; 90%</td>
</tr>
<tr>
<td>GCS ≤ 14 or a fall in GCS by 2 points</td>
<td>Exposure</td>
</tr>
<tr>
<td></td>
<td>Temperature &lt;35.5°C or &gt;38.5°C</td>
</tr>
<tr>
<td></td>
<td>BGL &lt; 3mmol/L or &gt; 20mmol/L</td>
</tr>
<tr>
<td></td>
<td>Circulation – shock / altered perfusion</td>
</tr>
<tr>
<td></td>
<td>RR &lt; 40bpm or &gt; 140bpm</td>
</tr>
<tr>
<td></td>
<td>BP &lt; 90mmHg or &gt; 200 mmHg</td>
</tr>
<tr>
<td></td>
<td>Postural drop &gt; 20mmHg</td>
</tr>
<tr>
<td></td>
<td>Capillary return &gt; 2 sec</td>
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</tbody>
</table>

**History:**
- Presenting complaint
- Allergies
- Medications: and any recent change to medications.
  - Is the patient currently taking anti-inflammatory medication, or aspirin?
  - Are they on anticoagulant medications?
  - Are they taking iron with can turn stool black?
- Past medical past surgical history relevant: Alcohol intake; liver disease; abdominal aortic aneurysm; angiodysplasia; diverticulosis; GORD; hemorrhoids; peptic ulcer disease; varices or portal hypertension.
- Last ate / drank & last menstrual period (LMP)
- Events and environment leading to presentation: duration of onset
- Pain Assessment / Score: PQRST (Palliating/ provoking factors, Quality, Region/radiation, Severity, Time onset)
- Associated signs / symptoms: history, frequency and quality of vomiting

**System Assessment:**
- Inspection: Skin colour, bruising and distension; vomiting / melena (e.g. bright red or coffee ground granules) and amount; pulsating masses; scars indicating previous operations
- Auscultation: Bowel sounds - absent or hyperactive
- Percussion: Tympani over all filled organs; dullness over fluid fill organs and bone
- Palpation: Pain on light palpation or deep palpation of the abdomen; radial pulses: strong or weak; central capillary refill time; abdominal masses.

Notify CNUM and Senior Medical Officer (SMO) if any of following red flags is identified from History or Systems Assessment.
- Rebound / localised tenderness
- Involuntary guarding
- Absent bowel sounds
- Renal disease or heart failure
- Pulsating abdominal mass
- Hypotension
- Blood transfusion refusal
- Capillary refill >3 seconds
- Tachycardia / Bradycardia

**Investigations / Diagnostics:**

<table>
<thead>
<tr>
<th>Bedside:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BGL: If &lt; 3 or &gt; 20mmol/L notify SMO</td>
</tr>
<tr>
<td>ECG: look for Arrhythmia, AMI</td>
</tr>
<tr>
<td>Postural Blood Pressure</td>
</tr>
<tr>
<td>Urinalysis / MSU (if urinary symptoms)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory / Radiology:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology: Refer to local nurse initiated STOP</td>
</tr>
<tr>
<td>FBC, UEC, COAGS</td>
</tr>
<tr>
<td>Group and Hold (if bleeding suspected)</td>
</tr>
<tr>
<td>Blood Cultures (if Temp &lt; 35 or &gt;38.5°C)</td>
</tr>
<tr>
<td>Radiology: Discuss with SMO</td>
</tr>
</tbody>
</table>
Nursing Interventions / Management Plan:

### Resuscitation / Stabilisation:
- Oxygen therapy & cardiac monitor
- IV Cannulation (consider large bore i.e. 16-18gauge)
- IV Fluids: Sodium Chloride 0.9% 1 litre stat (discuss with SMO)
- Packed red blood cells (PRBC) (discuss with SMO)

### Symptomatic Treatment:
- **Antiemetic:** as per district standing order
- **Analgesia:** as per district standing order
- **IV Fluids:** as per district standing order
- **Proton pump inhibitors:** (discuss with SMO)
- **Fresh Frozen Plasma, Vitamin K or prothrombinex:** (discuss with SMO)

### Supportive Treatment:
- **Nil By Mouth (NBM)**
- Monitor vital signs as clinically indicated (BP, HR, RR, T, SpO₂)
- Monitor neurological status GCS as clinically indicated
- Monitor pain assessment / score
- **Good oral hygiene**
- **Fluid Balance Chart (FBC)**
- Consider nasogastric tube and indwelling catheter.
- Faecal occult testing
- Faecal culture
- Stool Chart

### Practice Tips / Hints:
- **Always** have adequate suction available
- Upper GI bleeding is more common in males and lower GI Bleeding in females.
- Oxygen saturation readings become unreliable in patients with significant blood loss.

### Further Reading / References:

1. SSELHD Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating Adult and Maternity Inpatient

### Acknowledgements:
- SESLHD Adult Emergency Nurse Protocols were developed & adapted with permission from:
  - Murphy, M (2007) Emergency Department Toolkits. Westmead Hospital, SWAHS
  - Hodge, A (2011) Emergency Department, Clinical Pathways. Prince of Wales Hospital SESLHD.

### Revision & Approval History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
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<tbody>
<tr>
<td>September 2014</td>
<td>0</td>
<td>Developed by – Ray Hunt Clinical Nurse Educator, Emergency Sutherland Hospital.</td>
</tr>
<tr>
<td>December 2014</td>
<td>1</td>
<td>Edited by Wayne Varndell, ED CNC &amp; Leanne Horvat - Clinical Stream Nurse Manager, Emergency / Critical Care &amp; Emergency Stream CNC / NE Working Group SESLHD</td>
</tr>
<tr>
<td>February 2015</td>
<td>2</td>
<td>Endorsed by: SESLHD Emergency Clinical Stream Committee on 27 February 2015</td>
</tr>
<tr>
<td>March 2015</td>
<td>3</td>
<td>Endorsed by: SESLHD District Drug &amp; QUM Committee meeting on 12 March 2015</td>
</tr>
<tr>
<td>April 2015</td>
<td>3</td>
<td>Endorsed by: SESLHD Clinical and Quality Council on 15 April 2015 (T15/14555)</td>
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