Outreach Services of Indiana
FSSA – State of Indiana

GERD PROTOCOL
(Gastro-esophageal reflux disease)

Name_____

The following is intended as a guideline. This protocol does not supersede facility policy, nursing judgment or physician orders.

Call 911

- If the person vomits blood
- If the person appears gravely ill or you are concerned about their immediate health
- The person is having trouble swallowing and /or has food lodged in their throat
- Is having trouble breathing or is wheezing, especially after eating

Symptoms of GERD

- Heartburn- Burning pain in the Middle of the Chest
- Regurgitation-Appearance of refluxed food or liquid in the mouth
- Nausea
- Acid smell when burps, burps frequently
- Chronic irritation and sore throat, laryngitis, hoarseness
- Inflammation of the gums, loss of tooth enamel
- Frequent upper respiratory infections or bronchitis
- PICA, (eating non-edibles, putting hands in mouth or down throat)
- SIB – Self injurious behavior
- Sudden salivation or excessive drooling
- Difficulty swallowing/dysphagia or Repeated swallowing
- Coughing ,wheezing
- Discomfort or symptoms after eating, after medications or when lies down
- Unplanned weight loss
- Blood in stools or black tarry stools
- Vomiting blood or coffee ground substance
- Restlessness, crying ,irritability
- Anemia &/or Low Albumin on blood tests
- Persons own way of letting you know they may be uncomfortable from GERD:_____

_____

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If symptoms are noted: Notify Nurse_____ Supervisor_____ Other_____
Document noted symptoms on Daily Notes_____ Flow Sheet___ Other_____
Documentation Reviewed by:_____ Frequency of Review_____

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Prevention

Elevate the head of the bed ___degrees: Yes___ No___ How elevation is marked:___
Elevate at all times including personal care and dressing: Yes___ No___
Keep upright ___hour/minutes after a meal: Yes ___ No___
Keep upright ___hours/minutes after medications: Yes___ No___
Special positioning during meal: Yes___ No___ See Dining Plan___
Describe_____

_____

Special Positioning after meals: Yes___ No___ See Positioning Schedule____
Describe _____

_____

Avoid clothes that fit tight around the abdomen: Yes___ No___
Eat 6 small meals: Yes___ No____
Smoke cigarettes: Yes___ No___ **If yes**-Consider smoking cessation program Yes___ No___
Foods or Beverages that aggravate GERD symptoms: Please specify (May include-greasy or spicy Foods, carbonated drinks, alcohol, tomato or citrus, mint or anything specific to the person):

_____

_____

Medications

Routine Medications: Yes ___ No____ See MAR/TAR _____
Describe:_____

_____

PRN Medications: Yes___ No___ See MAR/TAR_____
Describe when to use, how long to wait for results, and who to notify if not effective:

_____

_____

_____

PRN use reviewed by:_____ Frequency of Review:_____

Outreach Services of Indiana
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