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

- Persons own way of letting you know they may be uncomfortable from GERD:_________________
  ______________________________________________________________
  ______________________________________________________________
  ______________________________________________________________

If symptoms are noted: Notify Nurse______ Supervisor______ Other______
Document noted symptoms on Daily Notes______ Flow Sheet____ Other______
Documentation Reviewed by:_________________ Frequency of Review_________________
## 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:________________________