

## RN Protocol: Hemorrhoids

---

### I. POLICY

- A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients with hemorrhoids.
- B. Circumstances under which the RN may perform the function:
  - 1. Setting: Outpatient clinic.
  - 2. Supervision: No direct supervision required.

### II. PROTOCOL

- A. Definition: This protocol covers the assessment and treatment of patients presenting with hemorrhoids. Hemorrhoid is defined as an enlarged vein in the mucous membrane inside or outside the rectum. Hemorrhoids are usually caused by straining to evacuate hard, dry stools. Symptoms include mild to moderate pain, itching, bleeding, and discomfort aggravated by defecation and prolonged sitting or standing. A hemorrhoid covered with rectal mucosa, whether inside the rectum or protruding outside the rectum is an *internal* hemorrhoid. Internal hemorrhoids frequently are found in patients with severe liver disease as a result of increased portal hypertension. A hemorrhoid covered with skin is an *external* hemorrhoid.

Acute internal hemorrhoids are only visible if prolapse (i.e., hemorrhoids protrude from the anus) occurs. Painless bleeding may be the only symptom, and usually occurs at the end of defecation.

Acute external hemorrhoids appear as bluish, firm varices covered with skin, protruding around the anus. Bleeding is present only if the varices rupture.

- B. Subjective:
  - 1. Chief complaint (document in the patient's own words).
  - 2. Date and time of onset.
  - 3. Describe symptoms (e.g., itching, burning, bleeding, irritation).
  - 4. If pain present rate on scale of 0-10 and describe characteristics.
  - 5. Prior history of hemorrhoids, constipation, diarrhea, GI illness (including liver disease), anal sex or instrumentation, other.
  - 6. Chronic illness.
  - 7. Allergies.
  - 8. Current medications.
- C. Objective:
  - 1. Vital signs.
  - 2. Visually inspect the anal area for: trauma, rash, papules, redness, edema, visible skin tags, hemorrhoids, and warts, abscess, fissures, fistula.

3. Note any signs of bleeding or drainage.
4. Note any open wounds or lesions.

D. Assessment:

- Impaired tissue integrity evidenced by/related to:
- Pain evidence by/related to:

E. Plan:

1. For moderate to severe pain, discharge, bleeding, abscess, open lesions, condylomata, evidence of trauma, or history of anal sex or instrumentation: refer patient to a physician **STAT**.
2. For rectal itching, erythema and/or mild discomfort with or without hemorrhoids or open lesions:
  - a. Sitz bath 20 min. TID PRN pain/itching while symptoms persist.
  - b. Warm compresses to area QID PRN pain/itching while symptoms persist.
  - c. Hydrocortisone Hemorrhoidal Cream 2.5%: apply to affected area no more than 3-4 times/day while symptoms persist.
3. External hemorrhoids accompanied by mild bleeding with bowel movements:
  - a. Warm compress to area QID PRN while symptoms persist.
  - b. Anucort HC 25mg suppository PRN per rectum itching/burning/pain after each BM while symptoms persist; not to exceed 4 times/day.
  - c. Sitz bath 20 min. TID while symptoms persist.
  - d. Docusate Sodium 100mg 1-3 softgels PO QD x 14 days and while hemorrhoids persist.
  - e. Calcium Polycarbophil 625mg PO QD x 30 days and while symptoms persist
4. All other symptoms: Refer patient to a physician on a **STAT, Urgent, or Routine** basis as appropriate.

F. Patient Education:

1. Assess patient's potential for understanding the health information to be provided.
2. Provide patient education consistent with the assessment of the condition.
3. Document the education provided and the patient's level of understanding on the nursing protocol encounter form.
4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.
5. Advise the patient to resubmit a Health Care Request Form (CDC 7362) if symptoms persist.

G. Documentation:

All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

**III. REQUIREMENTS FOR RN**

- A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with rectal/perianal complaints consistent with hemorrhoids, and achieve a minimum score of 80% on the written posttest examination.
- B. Experience: None.
- C. Certification: None.
- D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstration. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

- E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis.

**IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE**

A current list of all Registered Nurse authorize to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

**V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE**

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REVISION DATE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THE PROTOCOL WAS APPROVED BY:

\_\_\_\_\_  
Chief Nurse Executive/Director of Nursing

DATE: \_\_\_\_\_

\_\_\_\_\_  
Chief Medical Officer

DATE: \_\_\_\_\_