EMERGENCY GUIDELINES, POLICIES, PROCEDURES AND PROTOCOLS

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2014-2015 EMERGENCY CLINICAL REVIEW TEAM

Jennifer Burkholder, RN, MSN, MPH,
Deputy Chief Nurse of Emergency
Preparedness, Office of Nursing
Department of Public Health

David Westfall, MD
District 2
District Health Director

Angela Griffin, RN, BSN
County Nurse Manager
District 9-2
Appling County Health Department

Christi W. Dixon, RN
County Nurse Manager
Southwest Public Health District (8-2)
Mitchell County Health Department

Carolyn Simmons, RN, BSN
County Nurse Manager
District 8-2
Thomas County Health Department

Patrick O'Neal, MD
Medical Consultant
Office of Emergency Preparedness
and Response

Debbie York, RN, MSN, APRN
Clinical Nurse Supervisor
Medical Access Clinic
District 1 -2
Whitfield County Health Department

Heather Holloway, RN, BSN
Public Health Nursing Supervisor
District 5-2
Houston County Health Department

Tonia Parrott, Ph.D, MT (ASCP)
Clinical Microbiology Services Director
Georgia Public Health Laboratory
Georgia Department of Public Health
Atlanta, GA

Jeffrey McGhee, RPh
Director of Pharmacy Services
Cobb and Douglass Board of Health
District 3-1

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GUIDELINES FOR EMERGENCY KITS/CARTS IN PUBLIC HEALTH CLINIC SITES

A. GENERAL POLICY

Local factors such as anticipated EMS response time, the availability of a physician and the ability of trained personnel to initiate an emergency procedure in the event of vasovagal syncope, and/or an acute anaphylaxis/allergic reaction will determine the need for supplies beyond the minimum and expanded protocol/procedure for some clinics. Emergency plans and procedures should be coordinated with the local Emergency Medical System (EMS).

All emergency drugs and supplies should be kept together in a secured kit or cart that is easily moveable and readily accessible/visible during clinic service hours. Inventory should be checked monthly with careful attention to medication expiration dates and the working condition of equipment.

B. DEFINITION OF EMERGENCY KIT/CART

Emergency kits/carts are those drugs and supplies which may be required to meet the immediate therapeutic needs of patients and which are not available from other authorized sources in sufficient time to prevent risk or harm to patients. Medications may be provided for use by authorized health care personnel in emergency kits/carts, provided such kits/carts meet the following requirements:

1. Storage

Emergency kits/carts shall be stored in limited-access areas and sealed with a disposable plastic lock to prevent unauthorized access and to insure a proper environment for preservation of the medications in them.

2. Labeling - Exterior

The exterior of emergency kits/carts shall be labeled so as to clearly and unmistakably indicate that it is an emergency drug kit/cart and is for use in emergencies only.

3. Labeling – Interior

All medications contained in emergency kits/carts shall be labeled in accordance with the name of the medication, strength, quantity, and lot # and expiration date.

4. Removal of Medications

Medications shall be removed from emergency kits/carts only pursuant to nurse protocol/procedure, by authorized clinic personnel or by a pharmacist.

5. Inspections

Each emergency kit/cart shall be opened and its contents inspected by RN/APRN/Pharmacist/MD monthly with the exception of oxygen (every 6 months). The monthly inspection shall be documented on an Emergency Check-Off Log sheet which includes:

a. the listing of all emergency supplies and equipment,
b. the name of the medication(s), its strength, quantity, lot # and expiration date,
c. the staff member's name who performed the inspection and
d. the inspection date.

Upon completion of the inspection, the emergency kit/cart shall be resealed with the appropriate disposable plastic key.

6. Minimum Medication(s)

a. Epinephrine 1:1000, 1 ml (2 ampules)
b. Diphenhydramine 50 mg/mL (2 ampules)
c. Diphenhydramine elixir/solution 12.5 mg/5 mL (1 bottle)
d. Diphenhydramine HCl 25 mg caps (1 bottle)
e. Portable oxygen (by nasal cannula at 5 L/ min unless patient has history of emphysema or chronic lung disease when it should be administered at 2L/min).

7. Minimum Supplies

a. Blood pressure cuffs (adult and child)
b. Stethoscope
c. Flashlight/extra batteries
d. Copy of emergency protocols/procedures
e. Allergic Reaction/Acute Anaphylaxis Record
f. Bag-valve-mask (AMBU) for resuscitation (Infant/Child/Adult)
g. Copy of initialed current Monthly Checklist of Drugs and Supplies
h. Nasal cannula for oxygen administration
i. Needles and syringes
j. Filter needles, 5 micron, for use when aspirating a medication from a glass ampule, to reduce contamination

8. Recommended Additional Supplies and Medications

(For use where additional protocol/procedures and trained personnel are available)

a. Pulse-oximeter
b. Automated external defibrillator (AED)
c. Epinephrine Auto-injector 0.15 mg (3 doses)
d. Epinephrine Auto-injector 0.3 mg (3 doses)

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GUIDELINES FOR ALTERED LEVEL OF CONSCIOUSNESS/SYNCOPE (FAINTING)/SEIZURE ACTIVITY

DEFINITION

Syncope (fainting) is a transient loss of consciousness accompanied by loss of postural tone due to decreased blood supply to the brain. Syncope is commonly a benign vasovagal event; however, it may represent a serious medical event, particularly in the elderly. Typical vasovagal syncope occurs in a person in upright position with appropriate stimulus (e.g., fear or pain from blood draw or injection). By definition, vasovagal symptoms resolve when recumbent position restores blood flow to the brain. The main goal of evaluation of patients who faint, are dizzy or have altered LOC is to identify those who are at risk for or are experiencing acute medical emergencies such as volume depletion, cardiac, metabolic or neurologic event.

ETIOLOGY

Vasovagal syncope is usually due to emotional stress related to fear or pain (e.g., having blood drawn or an injection).

OBJECTIVE

1. Fall in blood pressure
2. Dizziness.
3. Nausea.
4. Diminished vision.
5. Slow pulse.
6. Pallor, perspiration.
7. May progress to loss of postural tone and consciousness.
8. Seizure Activity.

ASSESSMENT

Loss of postural tone and consciousness, etiology to be determined

PLAN

1. Protect patient from fall injury. Position the patient in the recumbent position with legs elevated. Loosen tight clothing at the neck and waist. If the patient does not immediately regain consciousness, call 911 for EMS support and consider lateral decubitus position to prevent aspiration or airway obstruction. Consider initiating oxygen. If sitting, do not lower head by bending at waist (may further compromise venous return to heart).

2 Monitor blood pressure and pulse. If these return to baseline normal for that patient and the patient regains consciousness and has no persistent complaints or abnormal signs/symptoms, observe the patient for at least 20 minutes.

3. Do not give anything by mouth or allow the patient to resume an upright position until feeling of weakness has passed.

4. Patient may leave the clinic (ideally accompanied) when able to take oral fluids and ambulate (unless- non-ambulatory as baseline), and has no complaints or symptoms.

5. If patient does not stabilize, call 911 for EMS transport to closest appropriate hospital Emergency Department.

6. Signs and symptoms of instability requiring hospital evaluation:
   a. Persistent hypotension.
   b. Cardiac arrhythmia (including bradycardia or tachycardia).
   c. Persistent altered level of consciousness.
   d. Persistent complaints (e.g., dizziness, chest pain, difficulty breathing, abdominal pain).
   e. Any injury sustained during episode.
   f. Seizure Activity

PATIENT EDUCATION/COUNSELING

1. Emphasize the importance of staying well hydrated.

2. Advise patient to resume normal activity.

3. Advise patient to call 911 for any chest or abdominal pain, difficulty breathing, dizziness or weakness or any recurrence of “fainting”.

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PROCEDURES FOR ALLERGIC REACTIONS, INCLUDING ACUTE ANAPHYLAXIS IN ADULTS, INFANTS AND CHILDREN

DEFINITIONS

Allergic reactions that are potentially life-threatening (anaphylactic) reactions, after exposure to an antigen which has been injected, ingested or inhaled.

Reactions range from mild, self-limited symptoms to rapid death:

1. Mild to moderate allergic reactions involve signs and symptoms of the gastrointestinal tract and skin. Observing the patient for rapid increase in severity of signs and symptoms is important, as the sequence of itching, cough, dyspnea and cardiopulmonary arrest can lead quickly to death.

2. Severe/anaphylactic reactions involve signs and symptoms of the respiratory and/or cardiovascular systems. These may initially appear minor (i.e., coughing**,** hoarseness, dizziness, mild wheeze) but any involvement of the respiratory tract or circulatory system has the potential to rapidly become severe. Death can occur within minutes. Therefore, prompt and effective treatment is mandatory if the patient's life is to be saved.

ETIOLOGY

Agents commonly associated with allergic reactions/anaphylaxis, include:

1. Medications:
   a. Over the counter, especially non-steroidal anti-inflammatory drugs.
   b. Prescribed medication, especially antibiotics; may occur with vaccines.
   c. Illicit or illegal drugs.
   d. Herbal or home remedies.

2. Food:
   a. Especially tree nuts, peanuts, shellfish and eggs.

3. Environmental:
   a. Stings (e.g., bee, wasp, yellow jacket, hornet, fire ants).
   b. Pollens, grass, molds, smoke, animal dander.
   c. Iodinated contrast media.

SUBJECTIVE &

OBJECTIVE

Allergic reaction may affect one or more organ systems:

1. Skin:
   a. Itching and hives or welts (localized or generalized).
   b. Flushing or skin edema.
   c. Tingling.
   d. Itching.
2. Gastrointestinal:
   a. Abdominal pain.
   b. Nausea, vomiting.
   c. Diarrhea.
3. Cardiac:
   a. Dizziness or fainting (hypotension).
   b. Palpitations.
   c. Chest pain.
4. Respiratory:
   a. Difficulty breathing.
   b. Bronchospasm, wheezing.
   c. Upper airway swelling (including lips and tongue).

.

ASSESSMENT

Severe Reactions (anaphylaxis): Reactions involving more than one organ system or causing difficulty breathing or hypotension/shock are by definition severe and may progress rapidly to death. Most severe reactions occur soon after exposure. The faster a reaction develops, the more severe it is likely to be.

PLAN

THERAPEUTIC

1. Cutaneous symptoms only (mild)

   Step 1 Diphenhydramine PO or IM:

   NOTE: Children younger than 2 years of age should receive diphenhydramine only after consulting with a physician **(consultation may be by phone)**.

   Diphenhydramine PO:
   Pediatric:
   2 to 5 years: 6.25 mg every 4-6 hours; maximum: 37.5 mg/day.

   6 to 11 years: 12.5-25 mg every 4-6 hours; maximum: 150 mg/day.

   12 years or older: 25-50 mg every 4-6 hours; maximum: 300 mg/day.

Adults: 25-50 mg every 6-8 hours.
OR

Diphenhydramine IM:

Diphenhydramine IM Dosing (The standard dose is 1 mg/kg body weight, up to 100 mg) May repeat dose every 6 – 8 hours; Adult not to exceed 400 mg/day. Child not to exceed 300 mg/day.*	
Weight lbs (kg)	Diphenhydramine Dose (Injection: 50 mg/mL)
24-37 (11-17)	15 mg / 0.3 mL
37-51 (17-23)	20 mg / 0.4 mL
51-77 (23-35)	30 mg / 0.6 mL
77-99 (35-45)	40 mg / 0.8 mL
>99 (>45)	50 mg / 1 mL
***Note: Children younger than 2 years of age should receive diphenhydramine only after consulting with a physician (consultation may be by phone).**	

Step 2 Complete Allergic Reaction Record.
Step 3 Observe for 60 minutes.
Step 4 If any respiratory or circulatory signs develop, proceed to #2 below (Severe Reactions).
Step 5 If, after 60 minutes, the patient's symptoms are still limited to the skin and the patient is comfortable, then:

a. Advise adult patient to take diphenhydramine orally every 6 to 8 hours if symptoms persist. Advise that if anytime the patient experiences dizziness, difficulty breathing or chest pain to call 911.
b. Advise parent to give pediatric patient diphenhydramine orally every 4 - 6 hours, if symptoms persist. Advise that if anytime the child experiences dizziness, difficulty breathing or chest pain to call 911.
c. Inform the patient that he/she has an apparent allergy to the causative agent and advise that this information should be provided to all healthcare givers in the future.

d. If the causative agent was a medication being dispensed for additional use at home, then this plan should be reconsidered and an alternative medication should be used that is in a different chemical family that is not regarded as having "cross-reactivity" with the causative agent.

2. Severe Reactions (anaphylaxis) Reactions involving more than one organ system or causing difficulty breathing or hypotension/shock are by definition severe and may progress rapidly to death. Early recognition and early treatment with epinephrine are essential in preventing this outcome.

Step 1 Call for HELP

a. Have someone call EMS/911 and/or the physician.
b. Do not leave the patient unattended!
c. Assure open airway; begin CPR if indicated.
d. Assign one person to keep the anaphylaxis record and be the timekeeper.
e. Administer epinephrine:

NOTE: Administer into thigh (more effective at achieving peak blood levels than into deltoid area).

Epinephrine IM Dosing
(Dosing by body weight is preferred;
the standard dose is 0.01 mg/kg body weight, up to 0.5 mg.)

Weight lbs (kg)	Epinephrine IM Dose (1mg/ml=1:1,000 wt/volume)
<9 (<4)	Weigh baby and calculate appropriate dose
9-15 (4-7)	0.06 mg/0.06 mL
15-24 (7-11)	0.10 mg/0.10 mL
24-31 (11-14)	0.12 mg/0.12 mL
31-37 (14-17)	0.16 mg/0.16 mL
37-42 (17-19)	0.18 mg/0.18 mL
42-51 (19-23)	0.20 mg/0.20 mL
51-77 (23-35)	0.30 mg/0.30 mL
77-99 (35-45)	0.40 mg/0.40 mL
>99 (>45)	0.50 mg/0.50 mL

May repeat every **5 to 15** minutes PRN for a total of 3 doses
(≤1.5 mL [1.5 mg] total)

OR

If at least 33 bs (15 kg)

Epinephrine Auto Injector may repeat using an additional Epinephrine Auto Injector every 5 to 15 minutes as needed for a total of 3 doses			
Weight lbs (kg)		Dose	Auto Injection
33-66 lbs (15-29 kg)	Epinephrine Auto Injector	0.15 mg	Delivers 0.15 mg per injection
66 lbs (30 kg) or greater	Epinephrine Auto Injector	0.3 mg	Delivers 0.3 mg per injection

Note: There are several brands of Epinephrine Auto Injectors available. Please read the package insert prior to administration.

f. Apply oxygen at 5 L/minute by nasal cannula or at 2L/min if patient has history of emphysema or chronic lung disease.

Step 2 Place patient in supine position, legs elevated, if tolerated.

Step 3 Begin monitoring Vital Signs with BP every 5 minutes.

Step 4 Any patient who has received epinephrine must be transported by EMS to closest appropriate hospital emergency department; copy of anaphylaxis record must go with patient to hospital.

PAITENT EDUCATION/COUNSELING

1. When a patient is given an agent (e.g., antibiotic or vaccine) capable of inducing anaphylaxis, he/she should be advised or encouraged to remain in the clinic for at least 15 minutes.

2. Inform patient that he/she has an apparent allergy to the causative agent and advise that this information should be provided to all healthcare givers in the future.

3. Advise the patient to call 911 if any difficulty breathing, dizziness or chest pain occurs.

4. Advise the adult patient that cutaneous symptoms may be treated with diphenhydramine every 6 - 8 hours. Advise the pediatric patient that cutaneous symptoms may be treated with diphenhydramine every 4 – 6 hours. Persistent or worsening symptoms should be evaluated by the patient's primary care provider.

REFERRAL

1. Immediately refer patients with wheezing, laryngeal edema, hypotension, shock or cardiovascular collapse to ER via EMS.

2. Refer to primary care provider for further evaluation those patients with itching, redness welts/hives.

FOLLOW-UP

1. Place an allergy label on the front cover of the patient's medical record.

2. Educate the patient/caretaker about medical alert bracelets for anaphylactic reactions.

3. If the allergic reaction is immunization-induced, complete a vaccine adverse event record (VAERS).

ALLERGIC REACTION / ANAPHYLAXIS RECORD – page 1

District/Clinic Site _____ Date _____

Patient Demographic Information:

Name: _____

DOB _____/_____/_____ AGE _____ months / years

Estimated/Actual Weight *(please circle one)* Infant / Child / Adult _____lbs/kg

Event which preceded reaction:

_____ Immunization
_____ Medication administered
_____ Biologicals administered
_____**Food ingested**
_____**Exposure to Environmental Hazard(s)**
_____ Other: (please explain) _____

TIME OF REACTION: _____ AM / PM TIME EMS CALLED: _____ AM / PM

Signs and Symptoms: (please check)

_____ Apprehension
_____ Flushing and/or skin edema
_____ Palpitations
_____ Numbness and tingling
_____ Itching
_____ Localized or generalized urticaria (rash, welts)
_____ Seizure Activity
_____ Choking sensation
_____ Coughing/hoarseness/wheezing
_____ Difficulty breathing
_____ Nausea and vomiting
_____ Severe hypotension
_____ Vasomotor collapse
_____ Loss of consciousness

Other (e.g., dizziness**)**: _____

OTHER OBSERVATIONS / COMMENTS: _____

_____

_____

SIGNATURE OF RN/APRN:
_____

DISPOSITION: _____

REVIEWER: _____

NOTE: *Send copies of both pages of this record with patient referred to a physician's office or hospital*

ALLERGIC REACTION / ANAPHYLAXIS RECORD – page 2

1. Call for HELP.
   Assign timekeeper/recorder.

2. Assure AIRWAY.
   Check VITAL SIGNS q 5 minutes.
   CPR if necessary.

   Call EMS if indicated.

3. For cutaneous symptoms only (mild):

Diphenhydramine IM Dosing (The standard dose is 1 mg/kg body weight, up to 100 mg) May repeat dose every 6 – 8 hours; Adult not to exceed 400 mg/day. Child not to exceed 300 mg/day.*	
Weight lbs (kg)	Diphenhydramine Dose (Injection: 50 mg/mL)
24-37 (11-17)	15 mg / 0.3 mL
37-51 (17-23)	20 mg / 0.4 mL
51-77 (23-35)	30 mg / 0.6 mL
77-99 (35-45)	40 mg / 0.8 mL
>99 (>45)	50 mg / 1 mL
***Note: Children younger than 2 years of age should receive diphenhydramine only after consulting with a physician.**	

4. For Severe Reactions (anaphylaxis) involving more than one organ system or causing difficulty breathing or hypotension/shock:

Epinephrine IM Dosing (Dosing by body weight is preferred; the standard dose is 0.01 mg/kg body weight, up to 0.5 mg.)	
Weight lbs (kg)	Epinephrine IM Dose (1mg/ml=1:1,000 wt/volume)
<9 (<4)	Weigh baby and calculate appropriate dose
9-15 (4-7)	0.06 mg/0.06 mL
15-24 (7-11)	0.10 mg/0.10 mL
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77-99 (35-45)	0.40 mg/0.40 mL
>99 (>45)	0.50 mg/0.50 mL
May repeat every **5 to 15** minutes PRN for a total of 3 doses (≤1.5 mL [1.5 mg] total) **NOTE:** Administer into thigh (more effective at achieving peak blood levels than into deltoid area).	

OR

Epinephrine Auto Injector may repeat using an additional Epinephrine Auto Injector every 5 to 15 minutes as needed for a total of 3 doses			
Weight lbs (kg)	***If at least 33 kg***	Dose	Auto Injection
33-66 lbs (15-29 kg)	Epinephrine Auto Injector	0.15 mg	Delivers 0.15 mg per injection
66 lbs (30 kg) or greater	Epinephrine Auto Injector	0.3 mg	Delivers 0.3 mg per injection

PATIENT NAME:_____
PATIENT WEIGHT**:**_____
PATIENT DOB/AGE:_____

TIME EMS CALLED:_____AM/PM
TIME EMS ARRIVED:_____AM/PM

VITAL SIGNS (monitor every 5 minutes)

Time	B/P	Pulse	Resp
_____	___/___	_____	___
_____	___/___	_____	___
_____	___/___	_____	___
_____	___/___	_____	___
_____	___/___	_____	___
_____	___/___	_____	___
_____	___/___	_____	___

CPR Indicated: _____YES _____NO
TIME CPR started:_____AM / PM
TIME CPR ended: _____AM / PM

Oxygen started: _____YES _____NO

TIME	**DOSE**	**ROUTE**
_____	_____	_____

Epinephrine 1:1000 w/v ampule

TIME	DOSE	ROUTE	SITE
_____	_____	IM	____
_____	_____	IM	____
_____	_____	IM	____

Epinephrine Auto-Injector

TIME	DOSE/TYPE	ROUTE	SITE
_____	_____	IM	____
_____	_____	IM	____
_____	_____	IM	____

IM Diphenhydramine 50 mg/mL vial

TIME	DOSE	ROUTE	SITE
_____	_____	IM	_____

Oral Diphenhydramine 12.5 mg/5 mL (Elixir/Solution)
OR 25 mg, 50 mg (Capsules)

TIME	DOSE	ROUTE
_____	_____	PO

TIME EMS DEPARTED TO HOSPITAL: _____AM/PM
HOSPITAL'S NAME:_____
Patient's status when transported to hospital:
_____
If not transported, Patient's status when leaving clinic:
_____

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POLICY FOR REVIEWING EMERGENCY PROTOCOLS/ PROCEDURES IN PUBLIC HEALTH CLINIC SITES

A review of emergency protocol/procedures shall be completed at least once annually at each clinic site. The Nursing Supervisor shall arrange for the annual review and completion of the attached checklist.

Staff member(s) listed below participated in training updates for all age ranges and performed in a mock emergency drill on _____.
(Date)

District Health Director:

Printed Name_____

Signature_____ Date_____

District Public Health Nursing and Clinical Director:

Printed Name_____

Signature_____ Date_____

Name(s) of Staff Member(s)

_____

_____

_____

_____

_____

EMERGENCY CHECKLIST
FOR PUBLIC HEALTH CLINIC SITES

PURPOSE

To assure that each site is equipped and prepared to handle emergencies that may occur. The Nursing Supervisor and District Public Health Nursing & Clinical Director will assure that this checklist is completed annually for each site and that follow-up occurs for any inadequacies/incomplete areas.

#	EMERGENCY ITEM	Complete/ Adequate	Incomplete/ Inadequate	Comments
1.	Emergency numbers posted on each phone.			
2.	Exits clear.			
3.	Hallways clear.			
4.	Staff able to describe action to take in case of emergency.			
5.	Staff demonstrates use of anaphylaxis equipment.			
6.	Emergency kit/cart stored in secured area except during clinic hours.			
7.	Emergency kit/cart stocked according to district protocol for anaphylaxis **and has been checked monthly, as required.**			
8.	All staff trained in emergency procedures and certified in CPR (every 2 years).			
9.	Practice emergency drill(s) conducted and documented at least annually. **NOTE:** Drills should include age-group variations (i.e., adults, infants and children).			

County_____

Nursing Supervisor: Printed Name _____

Signature _____

Date of Review: _____ Date Corrected: _____

District Public Health Nursing
& Clinical Director: Printed Name _____

Signature _____

EVALUATION TOOL FOR PRACTICE DRILL

		Yes	No
A.	Response Team		
1.	Team effort utilized and well-coordinated.	_____	_____
2.	Response team timely.	_____	_____
3.	Patient assessment complete.	_____	_____
4.	Code Blue* called.	_____	_____
5.	Emergency Medical Services/ Physician notified.	_____	_____
6.	Emotional support provided to significant others, if applicable.	_____	_____
B.	Patient Outcome		
1.	Level of consciousness assessed.	_____	_____
2.	Vital signs monitored.	_____	_____
3.	Appropriate drugs given.	_____	_____
4.	CPR instituted, if applicable.	_____	_____
5.	EMS/physician responded.	_____	_____
6.	Documentation complete.	_____	_____

C. Recommendations/Comments:

_____
_____
_____

Site_____ Date_____

Evaluator: Printed Name_____

Signature _____

**Although Code Blue is not specified in the anaphylaxis protocol/procedures, it should be used to signal the emergency.*

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STANDARD NURSE PROTOCOL FOR SHOCK/ HEMORRHAGE

DEFINITION

Shock is a critical condition brought on by a sudden drop in blood flow (and thus oxygen delivery) through the body. Shock that is unrecognized and untreated can lead to permanent organ damage or death.

ETIOLOGY

Shock may result from blood loss, dehydration, allergic reaction, infection, pulmonary embolism, or myocardial infarction/heart failure. Common causes of shock in females with reproductive capacity include 1) ruptured ectopic pregnancy, 2) pulmonary embolism (especially smokers on birth control pills), 3) ruptured ovarian cyst, 4) placental abruption, 5) severe, chronic untreated dysfunctional bleeding, and 6) severe PID.

SUBJECTIVE

Symptoms: dizziness, nausea, weakness, sweating, agitation and/or confusion

OBJECTIVE

1. Cardiac: rapid weak pulse; low blood pressure;
2. Skin: pale or ashen; cool; sweaty;
3. Neuro: altered level of consciousness (agitated, confused, or somnolent)

ASSESSMENT

Shock, etiology to be determined, requiring urgent evaluation and treatment

PROCEDURE

1. Call 911 or your local emergency number.
2. If patient is unresponsive, not breathing and/or has no pulse, begin CPR.
3. Stop visible bleeding by applying direct pressure to bleeding site.
4. Administer oxygen. If only nasal cannula is available, administer oxygen at 5 L/ minute unless patient has history of emphysema or chronic lung disease when the administration rate should be limited to 2L/minute.
5. Monitor with pulse-oximeter, if available.
6. Have the person lie down on his or her back with feet higher than the head, if the patient can tolerate this position (some patients with respiratory distress cannot tolerate supine position.
7. Keep the person warm and comfortable. Loosen belt and tightly fitted clothing and cover the person with a blanket. Even if the person complains of thirst, give nothing by mouth.

8. Turn the person on his or her side to prevent choking if the person vomits or bleeds from the mouth.
9. Patient should be transported by EMS to closest appropriate hospital emergency department.

REFERENCES

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3. "Shock"; American College of Emergency Physicians; accessed May 19, 2015. http://www.emergencycareforyou.org/EmergencyManual/WhatToDoInMedicalEmergency/Default.aspx?id=270
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