TABLE OF CONTENTS

CODE BLUE EMERGENCY MEDICAL RESPONSE PLAN ......................................................... 3
EMERGENCY CALL TAKER’S CHECKLIST .......................................................................... 5
CARDIAC ARREST – ADULT CPR/AED TREATMENT GUIDELINE ........................................ 6
CARDIAC ARREST – CHILDREN AND INFANT CPR/AED TREATMENT GUIDELINE .............. 7
CARDIAC ARREST TREATMENT GUIDELINE (OPERATING ROOM) .................................. 10
ANAPHYLAXIS TREATMENT GUIDELINE (ADULT) ............................................................ 11
CARDIAC CHEST PAIN TREATMENT GUIDELINE (ADULT) ................................................ 12
DIABETIC HYPOGLYCEMIC TREATMENT GUIDELINE (ADULT) ........................................ 13
HYPOTENSIVE/HYPOVOLEMIC TREATMENT GUIDELINE (ADULT) .................................. 14
SEIZURE TREATMENT GUIDELINE (ADULT) ................................................................ 15
SEVERE SHORTNESS OF BREATH WITH A HISTORY OF ASTHMA/COPD TREATMENT GUIDELINE ........................................................................................................... 16
SYNCOPE TREATMENT GUIDELINE ............................................................................ 17
UNRESPONSIVE NOT YET DIAGNOSED (NYD) TREATMENT GUIDELINE ...................... 18
MALIGNANT HYPERTHERMIA TREATMENT GUIDELINE ................................................ 19
SAMPLE TRANSPORT TREATMENT GUIDELINE (FOR OPERATING ROOM FACILITY) ............ 20
FIRE RESPONSE PLAN .................................................................................................. 21
EARTHQUAKE RESPONSE PLAN .................................................................................... 23
EMERGENCY & MEDICAL TREATMENT GUIDELINES

CODE BLUE EMERGENCY MEDICAL RESPONSE PLAN

Preamble

The goal of this plan is to quickly identify and respond to any patient, visitor or staff member that suffers from a potential life threatening medical emergency. The following procedure outlines the roles and responsibilities of staff who respond to a medical emergency on-site.

1. Types of Medical Emergencies

The following types of Medical Emergencies identified by employees will activate the Emergency Medical Response Team. These types of emergencies are to be considered Code Blue calls.

- Unresponsive person / person with a decreased level of responsiveness
- Unexpected fainting / collapse
- Severe chest pain
- Shortness of breath including choking
- Seizure
- Severe allergic reaction (anaphylaxis)

2. Activation

All staff working at this facility should be made aware that whenever a potential Code Blue medical emergency is identified, they must activate a medical emergency response. Go to the nearest telephone (or designate someone to go) OR call out to initiate a Code Blue broadcast.

If activating by telephone, speak slowly and clearly. State:

“May I have your attention. Code Blue. Location _______. Code Blue. Location _______.“

All staff should provide first aid / assistance to the level they are trained while they await the arrival of the medical response team.
3. **Employees’ Roles and Responsibilities**

**Reception**

When a Code Blue broadcast is made, the Receptionist is to follow the Call Taker’s Checklist (see page 5) to guide the response as follows:

- Call 911
- Ensure the Emergency Medical Response Team (includes the physician staff) have been notified
- Designate someone to meet Emergency Health Services (fire/ambulance) outside the facility and ensure that a clear pathway is available for access to the patient (including elevators).
- Assist at the scene and report any further information to 911 as required.
- Record sequence of events.

**Team Leader (Physician or designate)**

- The Team Leader will be responsible for providing direct patient care.
- Responsibilities include patient management, airway management, ordering and administration of medications, and transfer of care to paramedics.

**Medical Emergency Response Team Members**

- Respond to the scene of the medical emergency quickly and safely and ensure defibrillator and medications are brought to the scene.
- Provide initial and ongoing care to their level of training under the direction of the Team Leader.

**Facility Manager/Support Staff**

- Assist as required including bringing emergency equipment (defibrillator & medications) to the scene.
- Assist with crowd control and ongoing patient flow.
EMERGENCY CALL TAKER’S CHECKLIST

[INSERT FACILITY ADDRESS]

Follow the steps below when you hear a Code Blue broadcast.

1. **Go to the incident scene** and gather the following information:
   - Incident location in clinic:_____________________________________
   - Number of Patients: _____ Approx. Age:________   Sex:_____
   - Nature of the medical emergency (what’s wrong?):__________________________

2. **Call 911** and tell the dispatcher you need an Ambulance. Provide the information above including the Clinic address. Answer any other questions the 911 operator may have.

3. **Record**: Time 911 call made: ______________

4. **Designate someone** to meet the ambulance outside of the clinic. Tell her/him to ensure that all furniture has been moved out of the path the Paramedics/Fire Fighters will take.

5. **Stay at the scene** to report any further information to 911 as required.

6. **Record**: Time of EHS arrival: _____________________
CARDIAC ARREST – ADULT CPR/AED TREATMENT GUIDELINE

**Indications: Adult** Patient in Cardiac Arrest

**Contraindications:**
- Verifiable Do Not Resuscitate (DNR) or No CPR orders

**No Delay to AED**
- Position AED, attach pads\(^2\), power on AED while CPR continues, follow AED prompts
- Analyze as soon as possible

**If Shock Advised:**
- Provide shock
- 2 minutes of CPR \(^1\)
- Analyze
- Repeat Defibrillation - CPR - Analysis cycle \(^3\)

**No Shock Advised:**
- Immediately start 2 minutes of CPR \(^1\)
- Analyze
- Repeat CPR - Analysis cycle \(^3\)

**Continue CPR/AED until:**
- You transfer patient care over to more advanced care providers or;
- There are signs of life (e.g. patient movement, coughing, or breathing) \(^3\)

**Determine if patient is in cardiac arrest:**
- Unresponsive and not breathing or not breathing normally (gasping)
  - Begin CPR
  - Call for help and AED

**Footnotes**

1. Initiate chest compressions before ventilations (C-A-B). CPR ratio: 1 or 2 rescuers - 30:2 with a compression rate of 100/minute. If airway is secure, compressions/ventilations may be done at a ratio of 10:1.
2. Place electrode pad at least 2.5 cm (1 inch) away from any implanted pacemaker or cardioverter/defibrillator.
3. Only check pulse if there is any sign of life (i.e. patient movement, coughing, or breathing). If there is a pulse the rescuer should maintain airway, breathing and facilitate prompt transport.
CARDIAC ARREST – CHILDREN AND INFANT
CPR/AED TREATMENT GUIDELINE

**Indications:** Child or infant in cardiac arrest or infant’s pulse <60 and signs of poor perfusion¹

**Contraindication:**
- Verifiable Do Not Resuscitate (DNR) or No CPR orders

**No Delay to AED:**
- Position AED, attach pads and power on AED as CPR continues³,⁴
- Analyze as soon as possible

**If Shock Advised:**
- Defibrillate
- 2 minutes of CPR²
- Analyze
- Repeat Defibrillation - CPR - Analysis cycle⁴

**Determine if patient is in cardiac arrest:**
- Unresponsive and not breathing or not breathing normally (gasp). In infants also pulse <60 and signs of poor perfusion¹
  - Begin CPR
  - Call for help and AED
- Maintain C - Spine precaution if indicated

**No Shock Advised:**
- Immediately start 2 minutes of CPR²
- Analyze
- Repeat CPR - Analysis cycle⁴

**Continue CPR/AED until:**
- You transfer patient care over to more advanced care providers or;
- There are signs of life (e.g. patient movement, coughing, or breathing)⁴

**Footnotes**
1. Signs of poor perfusion may include any or all of the following: pale skin color or severe mottling, cyanosis, usually accompanied by a decreased or falling level of consciousness and extremely unwell or toxic appearance, often with a history suggestive of respiratory illness or sepsis.
2. Initiate chest compressions before ventilations (C-A-B). CPR ratio: 1 rescuer - 30:2 or 2 rescuers - 15:2 with a compression rate of 100/min.
3. Place electrode pad at least 2.5 cm (1 inch) away from any implanted pacemaker or cardioverter/defibrillator. For a small child, the AED pads may have to be positioned anterior/posterior if they are closer than 2.5 cm (1 inch) together. Use pediatric pads and dosage if available, otherwise use adult pads and dosage.
4. Only check pulse if there is any sign of life (i.e. patient movement, coughing, or breathing). If there is a pulse the rescuer should maintain airway and breathing.

**CPR/AED Information**
Basic concepts:

- Early CPR is an essential component to successful outcome from cardiac arrest.
- CPR should be provided with as few interruptions as possible (keep interruptions to less than 10 seconds).
- Full decompression (i.e. un-weighting hands from the chest between compressions) is a significant component in effective CPR.
- Change operators every 2 minutes (where possible) to maintain maximum efficiency.
- No pulse checks after your initial assessment, until directed by advanced care providers or the patient begins to move (e.g. spontaneous breaths, cough, eyelid movement, and vocalization).
- CPR is more effective while you are stationary (i.e. trying to move the patient while performing CPR results in a deterioration of effective CPR).
- Move a victim early in your management while performing CPR only if the victim is in a dangerous environment or if you believe you cannot perform CPR effectively because of the victim’s position or location.
- Early defibrillation is an essential component to successful outcome from cardiac arrhythmias that are responsive to defibrillation.
- The concepts of early CPR and early defibrillation should co-exist and one should not impede the other.
- Avoid hyperventilation (i.e. aim for 8 - 10 breaths per minute).

Adult CPR/AED Basics

- Immediately activate the emergency response system (if appropriate) and get an AED (if available).
- Optimum chest compression rate is 100 per minute with a depth of 5.0 cm (2 inches) in a normal adult (adjust to ⅓ to ½ the chest diameter for smaller and bigger patients).
- Ratio is 30 compressions to 2 breaths (one or two rescuers).
- Apply and use the AED as soon as possible.
- Resume CPR immediately following delivery of any shock.
- No Shock Advised - resume CPR immediately.
- Continue resuscitation efforts on-scene as long as one is capable until the patient recovers, advanced care providers take over (e.g. BC Ambulance Service, physician) or you are presented with a valid “Do Not Resuscitate” order.
Child (1 year to puberty) CPR/AED Basics

- If alone, immediately start CPR for 5 cycles (about 2 minutes) before activating the emergency response system (if appropriate) and applying the AED (NOTE: for a witnessed sudden collapse - alone or not, immediately activate the emergency response system [if appropriate] and get an AED [if available]).
- Start CPR if there is no pulse or if the heart rate is less than 60 beats per minute with signs of poor perfusion (e.g. pale skin color or severe mottling, cyanosis, usually accompanied by a decreased or falling level of consciousness and extremely unwell or toxic appearance, often with a history suggestive of respiratory illness or sepsis).
- If not injured, carry the child, if possible, to the telephone so that you can continue CPR or resume CPR more quickly after the call.
- Optimum chest compression rate is 100 per minute with a depth of \( \frac{1}{3} \) the chest diameter.
- Ratio is 30:2 for one rescuer and 15:2 for two rescuers.
- Resume CPR immediately following delivery of any shock.
- No Shock Advised - resume CPR immediately.
- Use pediatric AED pads (if available) and follow the AED instructions to select a lower (child) shock dose (if available). If not available you may use the adult pads and deliver the adult dose.
- If the defibrillator pads, when placed in the normal anterior/lateral chest position, are within 2.5 cm (1 inch) of each other, they should be shifted to an anterior/posterior configuration.

Infant (less than 1 year of age) CPR Basics

- Due to the size of an infant’s head in relation to its body, use a pad (if available) under the shoulders to facilitate the head tilt-chin-lift maneuver.
- Effective ventilation/oxygenation is very important for optimal CPR.
- Assess for pulse using the brachial rather than the carotid artery.
- If alone, immediately start CPR for 5 cycles (about 2 minutes) before activating the emergency response system (if appropriate). (NOTE: for a witnessed sudden collapse - alone or not, immediately activate the emergency response system [if appropriate]).
- If not injured, carry the infant to the telephone so that you can continue CPR or resume CPR more quickly after the call.
- Start CPR if there is no pulse or if the heart rate is less than 60 beats per minute with signs of poor perfusion (e.g. pale skin color or severe mottling, cyanosis, usually accompanied by a decreased or falling level of consciousness and extremely unwell or toxic appearance, often with a history suggestive of respiratory illness or sepsis).
- Optimum chest compression rate is 100 per minute with a depth of \( \frac{1}{3} \) the chest diameter.
- Ratio is 30:2 for one rescuer and 15:2 for two rescuers.
- For two rescuers, perform chest compressions with the 2 thumb-encircling hands technique if hands can fit around the front and back of the infant.
- **2010 guidelines for resuscitation of an infant (< 1 year of age now include the use of an Automated External Defibrillator (AED).**
- Use pediatric AED pads (if available) and follow the AED instructions to select a lower (child) shock dose (if available). If not available you may use the adult pads and deliver the adult dose.
- If the defibrillator pads, when placed in the normal anterior/lateral chest position, are within 2.5 cm (1 inch) of each other, they should be shifted to an anterior/posterior configuration.
CARDIAC ARREST TREATMENT GUIDELINE (OPERATING ROOM)

Ensure 911 called and Code Blue Response Activated

A. Roles and Responsibilities Once No Signs of Life Confirmed

1. Surgeon
   - End procedure
   - Assist with evaluation and treatment as per ACLS algorithms
   - Assist with management and resuscitation as required
   - Establish and maintain IV access when able

2. Anesthesiologist
   - Diagnose and manage patient as per ACLS algorithms
   - Establish and maintain airway and ventilations
   - Establish and maintain IV access

3. Nurse 1 (Scrub Nurse)
   - Begin CPR 30:2 compressions to ventilations ratio

4. Nurse 2 (PAR Nurse)
   - Assist with airway and IV establishment and maintenance
   - Bring crash cart to side of patient and have available emergency drugs including epinephrine, atropine, and other drugs as necessary
   - Draw up and administer medications as directed
   - Charge defibrillator under direction of anesthesiologist

5. Nurse 1 (Circulating Nurse)
   - Relieve Scrub nurse

B. Monitoring and Follow-up

   - Monitor ABC’s, vital signs, pulse oximetry and ETCO2 (if available)
   - Maintain O2Sat > 95% with high flow oxygen as necessary
   - Maintain circulation using IV fluid and medications as necessary
   - Ensure code summary provided and transfer procedure completed

Date: ___________________________ Medical Director Signature: ______________________________
ANAPHYLAXIS TREATMENT GUIDELINE (ADULT)

Ensure 911 called and Code Blue Response Activated

1) Perform Primary Survey
   - Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, Oral Airway, Bag Valve Mask, supine position, etc.)
   - Oxygen 15 L/min by mask (non rebreather)
   - Confirm pulse / signs of life present
     
     P:____   BP:____/_____
     RR:____   T:____
     O₂ Sat:____Glu:____ GCS____

2) Perform Secondary Survey
   - Obtain a history relevant to an anaphylactic reaction
   - Record initial vital signs
   - Attach cardiac monitor, pulse oximeter, and initiate IV (if able)
   - Perform focused physical exam

3) Indications for Interventions (both indications must be present)
   - Patient has had a recent exposure to a probable allergen
   - Patient is unstable demonstrated by at least one of the following
     - Respiratory distress (wheezing, stridor or shortness of breath)
     - Generalized edema, urticaria, or significant localized edema of face, tongue or throat
     - Systolic blood pressure < 90 mm Hg

4) Interventions*
   - Epinephrine 0.3 mg IM (0.3 cc of 1:1000 Epinephrine) OR use Epi-pen (0.3 ml IM)
   - IF SEVERE SHOCK (MAP < 65 mm Hg may use 0.1 - 0.3 mg IV (1 - 3 cc of 1:10,000 Epi pre-load)
   - IV NS 500 cc bolus Normal Saline (repeat bolus as necessary up to 2 liters)
   - Benadryl 25 - 50 mg IV/PO
   - Record vital signs after administration of epinephrine
   - Repeat dose of Epinephrine in 5 - 10 minutes if no improvement
   - If patient has significant wheezing: Salbutamol - titrate to response:
     - Salbutamol 400 - 800 µg (4 - 8 puffs) by puffer (MDI) with spacer
     - If no improvement Salbutamol 100 µg (1 puff) every 30 - 60s (to max 20 puffs)
     - Decrease frequency as symptoms improve
   - Consider: Hydrocortisone 100 mg IV or Methylprednisolone 125 mg IV
   - Consider: Ranitidine 50 mg IV
   - Glucagon 5 mg IV over 1 min initially then 5 mg IV in 10-15 min if no improvement in BP (if patient on beta-blocker)

5) Monitoring and Follow-up
   - Monitor ABC's, vital signs and pulse oximetry
   - Maintain O₂Sat > 95% with high flow oxygen
   - Transfer to acute care hospital as all anaphylaxis patients require prolonged monitoring

*Adult medication doses provided; use Broselow Tape or equivalent for pediatric medication dosages

Date: __________________________ Medical Director Signature: __________________________

IRIDIUMEDICAL
CARDIAC CHEST PAIN TREATMENT GUIDELINE (ADULT)

Ensure 911 called and Code Blue Response Activated

1) Perform Primary Survey
- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)
- Oxygen 15 L/min by mask (non rebreather)
- Place patient in position of comfort
- Confirm pulse / signs of life present

| P:_____ | BP:___/____ |
| RR:_____ | T:_____ |
| O2 Sat:____ | Glu:____ | GCS____ |

2) Perform Secondary Survey
- Obtain a history sufficient to suggest that the pain is cardiac in nature
- Record initial vital signs
- Attach cardiac monitor, pulse oximeter, and initiate IV if able
- Perform focused physical exam

3) Indications for Interventions (all must be present)
- Patient is alert
- History suggests pain is cardiac in origin
- Systolic BP > 100 mm Hg
- Heart rate > 60 bpm and < 150 bpm

4) Interventions
- ASA 325 mg PO (chewed) if no allergy and no contraindications
- If considering Nitro use ensure patient has not taken Viagra or Levitra within the last 24 hours or Cialis within the last 48 hours
- Record vital signs, establish IV as potential for hypotension exists and only administer Nitroglycerin if BP > 100 and HR > 60
- Nitroglycerin 0.4 mg spray sublingually, then every 5 minutes as needed for chest pain, to a maximum of 3 doses
- Record vitals signs after each dose of Nitroglycerin

5) Monitoring and Follow-up
- Monitor ABC’s, vital signs and pulse oximetry
- Maintain O2Sat > 95% with high flow oxygen
- Transfer to acute care hospital

Date: ______________________ Medical Director Signature: ______________________
DIABETIC HYPOGLYCEMIC TREATMENT GUIDELINE (ADULT)

Ensure 911 called and Code Blue Response Activated

<table>
<thead>
<tr>
<th>1) Perform Primary Survey</th>
<th>P:____ BP:_<strong>/</strong>__</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)</td>
<td></td>
</tr>
<tr>
<td>- Oxygen 15 L/min by mask (non rebreather)</td>
<td></td>
</tr>
<tr>
<td>- Confirm pulse / signs of life present</td>
<td></td>
</tr>
<tr>
<td>RR:____ T:____</td>
<td></td>
</tr>
<tr>
<td>$O_2$ Sat:____ Glu:____ GCS____</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Perform Secondary Survey</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Obtain a history of diabetes and/or use of insulin/oral hypoglycemic agent</td>
<td></td>
</tr>
<tr>
<td>- Record initial vital signs</td>
<td></td>
</tr>
<tr>
<td>- Obtain glucometer reading: _________mmol/L</td>
<td></td>
</tr>
<tr>
<td>- Attach cardiac monitor, pulse oximeter, and initiate IV if able</td>
<td></td>
</tr>
<tr>
<td>- Perform focused physical exam</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Indications for Interventions (all indications must be present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Glucometer reading of &lt; 4.0 mmol/L or “Low”</td>
</tr>
<tr>
<td>- Patient is symptomatic with one or more of the following signs of hypoglycemia (altered LOC, confusion, tachycardia, sweaty)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If airway is not compromised, 1 package of glucogel OR fruit juice/regular soda PO</td>
</tr>
<tr>
<td>- If airway or LOC is compromised, then</td>
</tr>
<tr>
<td>- D50W IV 0.5 - 1.0 ml/kg OR</td>
</tr>
<tr>
<td>- If unable to establish, Glucagon 1 mg SC/IM</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5) Monitoring and Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Monitor ABC’s, vital signs and pulse oximetry</td>
</tr>
<tr>
<td>- Repeat glucometer 10 minutes after intervention</td>
</tr>
<tr>
<td>- Maintain $O_2$Sat &gt; 95% with high flow oxygen</td>
</tr>
<tr>
<td>- If patient awakens give the patient 200 ml sweetened orange juice or similar and follow with some form of carbohydrate (crackers, etc)</td>
</tr>
<tr>
<td>- Transfer patient to acute care hospital as necessary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6) Nursing Standing Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>- D50W IV 0.5 - 1.0 ml/kg q5min PRN if glucometer &lt; 4.0 mmol/L or “Low”</td>
</tr>
</tbody>
</table>

Date: __________________________ Medical Director Signature: __________________________
# Hypotensive/Hypovolemic Treatment Guideline (Adult)

**Ensure 911 called and Code Blue Response Activated**

## 1) Perform Primary Survey
- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)
- Oxygen 15 L/min by mask (non-rebreather)
- Confirm pulse / signs of life present

| P:____ | BP:____/____ |
| RR:____ | T:____ |
| 0₂ Sat:____ | Glu:____ | GCS____ |

## 2) Perform Secondary Survey
- Obtain a history relevant to hypovolemia
- Record initial vital signs
- Assess signs of blood loss and/or shock
- Attach cardiac monitor, pulse oximeter, and initiate IV (two large bore IV ≥ 16 gauge if possible)
- Perform focused physical exam

## 3) Indications for Interventions
- Patient has evidence of significant loss of blood or body fluids to support a diagnosis of hypovolemia evidenced by:
  - Systolic BP < 90 mm Hg
  - Significant signs of shock (e.g. dizziness, diaphoresis, HR > 120)

## 4) Interventions
- Maintain continuous direct pressure on bleeding wound if present
- Position patient supine, and elevate affected area if possible
- Normal Saline IV 500 ml bolus (flow rate wide open)
- Reassess vital signs after initial bolus
- If no improvement, repeat Normal Saline IV 500 ml bolus (flow rate wide open)
- Reassess vital signs
- If no improvement, repeat Normal Saline IV 500 ml boluses to a max of 2 liters
- Reassess vital signs after each Normal Saline IV 500 ml bolus

## 5) Monitoring and Follow-up
- Monitor ABC’s, vital signs and pulse oximetry
- Maintain 0₂ Sat > 95% with high flow oxygen
- Transfer patient to acute care hospital

## 6) Nursing Standing Order
- Normal Saline IV 500 ml boluses q15min PRN for systolic BP < 90 mm Hg or signs of shock to maximum of 2 liters

Date: __________________________ Medical Director Signature: __________________________
SEIZURE TREATMENT GUIDELINE (ADULT)

Ensure 911 called and Code Blue Response Activated

1) Perform Primary Survey
- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)
- Oxygen 15 L/min by mask (non rebreather)
- Confirm pulse / signs of life present

2) Perform Secondary Survey
- Obtain a history relevant to seizure if possible
- Record initial vital signs, including glucometer
- Attach cardiac monitor, pulse oximeter, and initiate IV if able
- Perform focused physical exam

3) Indications for Interventions
- Patient who displays symptoms consistent with a generalized seizure

4) Interventions*
- If glucometer reads < 4mmol/L or “Low” see Hypoglycemic Treatment Guideline
- If seizure continues, Diazepam (Valium) 5 - 10 mg IV at 2 mg/min up to 15 mg max OR Lorazepam (Ativan) 2 - 4 mg IV at 2 mg/min up to 6 mg max
- If no IV, Midazolam (Versed) 5 - 8 mg IM
- Record vital signs after each medication dose and maintain patient O2 sat > 95% with use of jaw thrust, oxygen and BVM if necessary

5) Monitoring and Follow-up
- Monitor ABC’s, vital signs and pulse oximetry
- Maintain O2Sat > 95% with high flow oxygen
- Obtain a set of vital signs when seizure activity has stopped
- Transfer patient to acute care hospital

6) Nursing Standing Order
- Diazepam (Valium) 5 mg IV at 2 mg/min q5min PRN Seizure to a max of 15 mg
- Lorazepam (Ativan) 2 mg IV at 2 mg/min q5min PRN Seizure to a max of 6 mg

*Adult medication doses provided, use Broselow Tape or equivalent for pediatric medication dosages

Date: ____________________ Medical Director Signature: ____________________
**SEVERE SHORTNESS OF BREATH WITH A HISTORY OF ASTHMA/COPD TREATMENT GUIDELINE**

*Ensure 911 called and Code Blue Response Activated*

| 1) Perform Primary Survey | P: ____  BP: ____/____  
|---------------------------|--------------------------|
| 1. Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.) | RR: ____  T: ____  
| 2. Oxygen 15 L/min by mask (non rebreather) | 0₂ Sat: ____  Glu: ____  GCS ____  
| 3. Confirm pulse / signs of life present | |

| 2) Perform Secondary Survey |  
|-----------------------------|--------------------------|
| 1. Obtain a history to indicate asthma/COPD |  
| 2. Record initial vital signs |  
| 3. Attach cardiac monitor, pulse oximeter, and initiate IV if able |  
| 4. Perform focused physical exam, including auscultating the chest to assess for wheezing |  

| 3) Indications for Interventions |  
|---------------------------------|--------------------------|
| 1. Patient exhibits signs and symptoms consistent with severe bronchospasm and/or asthma |  

| 4) Interventions |  
|------------------|--------------------------|
| 1. Salbutamol inhaler- titrate to response: |  
| - Salbutamol 400 - 800 µg (4 - 8 puffs) by inhaler (MDI) with spacer |  
| - If no improvement 100 µg (1 puff) every 30 - 60s (to max 20 puffs) |  
| - Decrease frequency as symptoms improve |  

| 5) Monitoring and Follow-up |  
|-----------------------------|--------------------------|
| 1. Monitor ABC’s, vital signs |  
| 2. Maintain 0₂Sat > 95% with high flow oxygen |  
| 3. Transfer patient to acute care hospital |  

| 6) Nursing Standing Order |  
|---------------------------|--------------------------|
| 1. Salbutamol 400 - 800 µg (4 - 8 puffs) q20min PRN by puffer (MDI) with spacer for wheezing secondary to asthma or COPD |  

Date: ________________________  Medical Director Signature: __________________________
# SYNCOPE TREATMENT GUIDELINE

*Ensure 911 called and Code Blue Response Activated*

## 1) Perform Primary Survey
- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)
- Maintain C - spine if indicated
- Oxygen 15 L/min by mask (non rebreather)
- Confirm pulse / signs of life present

| P:____ | BP:____/_____ |
| RR:____ | T:____ |
| O₂ Sat:____ | Glu:____ | GCS____ |

## 2) Perform Secondary Survey
- Obtain a history if available
- Record initial vital signs including glucometer
- Attach cardiac monitor, pulse oximeter, and initiate IV if able
- Perform focused physical exam

## 3) Indications for Interventions
- Patient displays symptoms consistent with syncope

## 4) Interventions
- If patient alert, awake, oriented;
  - Record cardiac rhythm; document with rhythm strip
  - Check glucometer. If < 4.0 mmol/L refer to Hypoglycemic Treatment Guideline
  - Assess orthostatic vital signs (supine, sitting, standing) if no cervical spine injury
- If patient not responsive, treat as per Unresponsive Not Yet Diagnosed Treatment Guideline

## 5) Monitoring and Follow-up
- Monitor ABC’s, vital signs
- Maintain O₂ Sat > 95% with high flow oxygen
- Transfer patient to acute care hospital if remains unstable

## 6) Nursing Standing Order
- D50W IV 0.5 - 1.0 ml/kg if glucometer < 4.0 mmol/L or “Low”

Date: _____________________________  Medical Director Signature: _____________________________
## UNRESPONSIVE NOT YET DIAGNOSED (NYD) TREATMENT GUIDELINE

**Ensure 911 called and Code Blue Response Activated**

<table>
<thead>
<tr>
<th>1) Perform Primary Survey</th>
<th>P: ____  BP: <strong><strong>/</strong></strong>  RR: ____  T: ____  0₂ Sat: ____  Glu: ____  GCS ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Support Airway, Breathing and Circulation as required (including critical interventions, e.g. use of jaw thrust, OPA, BVM, supine position, etc.)</td>
<td></td>
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<tr>
<td>- Oxygen 15 L/min by non rebreather mask</td>
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<tr>
<td>- Confirm pulse / signs of life present</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Perform Secondary Survey</th>
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<tbody>
<tr>
<td>- Obtain a history to determine possible causes of unresponsiveness</td>
<td></td>
</tr>
<tr>
<td>- Record initial vital signs, including Glucometer</td>
<td></td>
</tr>
<tr>
<td>- Attach cardiac monitor, pulse oximeter, and initiate IV if able</td>
<td></td>
</tr>
<tr>
<td>- Perform focused physical exam</td>
<td></td>
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<thead>
<tr>
<th>3) Indications for Interventions (both must be present)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient is unresponsive</td>
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<tr>
<td>- Cause unclear</td>
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<table>
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<tr>
<th>4) Interventions</th>
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<tbody>
<tr>
<td>- If Glucometer &lt; 4.0 mmol/L and unresponsive:</td>
<td></td>
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<tr>
<td>- refer to Hypoglycemic Treatment Guideline</td>
<td></td>
</tr>
<tr>
<td>- If potential for narcotic overdose (pinpoint pupils, history of opiates)</td>
<td></td>
</tr>
<tr>
<td>- Naloxone SC/IM/IV 0.4 mg repeat q 60 sec to max 2 mg</td>
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<th>5) Monitoring and Follow-up</th>
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<tr>
<td>- Monitor ABC’s, vital signs</td>
<td></td>
</tr>
<tr>
<td>- Maintain 02Sat &gt; 95% with high flow oxygen</td>
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<td>- Transfer patient to acute care hospital</td>
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<tr>
<th>6) Nursing Standing Order</th>
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<tr>
<td>- D50W IV 0.5 - 1.0 ml/kg if glucometer &lt; 4.0 mmol/L or “Low” as per Hypoglycemia Treatment Guideline</td>
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</tr>
<tr>
<td>- Naloxone SC/IM/IV 0.4 mg q 60 sec to max 2mg for suspected narcotic overdose</td>
<td></td>
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</table>

Date: ___________________________ Medical Director Signature: ___________________________
MALIGNANT HYPERTHERMIA TREATMENT GUIDELINE

Ensure 911 called and Code Blue Response Activated

1) Signs & Symptoms of an Acute Malignant Hypertension Reaction:
   - Hypercarbia
   - Tachypnea
   - Tachycardia
   - Cardiac arrhythmias
   - Rigidity
   - Cyanosis/mottling
   - Unstable/increasing blood pressure
   - Fever

2) Interventions
   - Ensure 911 activated for transport, call for extra staff assistance and dantrolene
   - Stop volatile anesthetics and succinylcholine
   - Hyperventilate with 100% oxygen at high flow (> 10 L/min)
   - End procedure as soon as possible
   - Large bore IV access X 2/Insert Foley Catheter
   - Begin dantrolene sodium 2.5 mg/kg IV (for 70 kg patient will need to mix 9 vials of dantrolene)
     - Dissolve each vial in 60 ml sterile preservative-free water
     - Each vial contains 20 mg dantrolene and 3 grams mannitol
   - Transfer patient to acute care hospital
   - Sodium bicarbonate for acidosis
     - Consider 1 - 2 mEq/kg IV
   - If hyperthermic (core temp > 39 °C):
     - Initiate surface cooling with mist, fans, cool packs to groin and axillae
     - Avoid overcooling; stop if temp < 38 °C
   - For malignant dysrhythmias including cardiac arrest:
     - Consider hyperkalemia immediately and if a possible etiology treat with:
       - Calcium chloride IV (10 ml of 10% solution over 5 - 10 minutes)
       - Short-acting Insulin 5 - 10 units plus 50 ml D50W IV
       - Salbutamol 400 - 800 µg (4 - 8 puffs) by MDI/spacer if spontaneous breathing
       - Most arrhythmias respond to correction of hyperkalemia and acidosis by hyperventilation, dantrolene and sodium bicarbonate
     - Avoid Calcium Channel Blockers - in presence of dantrolene, may cause hyperkalemia or cardiac arrest

Date: __________________________ Medical Director Signature: ________________________
SAMPLE TRANSPORT TREATMENT GUIDELINE  
(FOR OPERATING ROOM FACILITY)

Goal of Transport
- To provide patients the safest and most expeditious transport to the most appropriate facility.

Receiving Facilities
- The receiving facilities for patients are:
  1) Insert facility name and ED phone number

Level of Transport Service
- The British Columbia Ambulance Service (BCAS) will be activated by the 911 system.
- The 911 caller should provide known details of the situation (e.g. patient collapse).
- The level of transport service will be determined by the 911 dispatch. NOTE: for a potential life threatening emergency, the current dispatch protocol could include a:
  1) First Responder Fire Rescue Unit
  2) Basic Life Support ambulance
  3) Advanced Life Support ambulance

Role of the Surgeon
- End surgery or procedure
- Assist with evaluation and treatment plan per treatment guidelines and/or ACLS algorithms.
- The surgeon will supply information regarding current status of the patient as well as any treatments given to the receiving emergency department.
- Following transport the surgeon will contact the College of Physicians and Surgeons by telephone to report the event and follow up with a written report.

Role of the Anesthesiologist
- Diagnosis and implementation of treatment guidelines to stabilize the patient for transport.
- Will accompany the patient to the hospital unless the patient is stable and no physician escort is required.
- Will maintain responsibility for the patient’s care until responsibility is transferred to a physician at the receiving hospital.
- Will oversee the protocols provided by the BCAS paramedics during transport.

Role of the PAR Nurse
- Will assist the surgeon and anesthesiologist as required.
- Will ensure that a copy of the chart and any available records accompany the patient to the receiving hospital.

Quality Improvement Activities
- Each transport event will be reviewed by the clinic Medical Director. Recommendations and feedback should be provided to ensure optimal response is obtained.
FIRE RESPONSE PLAN

IF YOU DISCOVER A FIRE IN THE BUILDING:

- **Activate** the nearest fire pull station.
  - There are _____(#) - each one is located ___________________________
  - The emergency exits are marked by illuminated red signs
- **Warn others** in the area and help them to exit as quickly and safely as possible.
- Do not delay evacuation to gather personal items.
- **Call 911** and advise the dispatcher that there is a fire; provide information such as:
  - Facility Address - e.g. 123 Bishop Avenue cross street Birch, Surrey
  - The nature/particulars of the fire
  - Any known injuries
- **Walk to a pre-established Assembly Area:** e.g. located in the East Parking Lot beside the Bishop Professional Centre.
- **Take attendance,** and inform fire officials of any missing employees.
- Liaise with building management/fire officials to report your area was clear, or to report any missing persons and to determine when it is safe to re-enter the building.

**If you hear a fire alarm in the building:**

**Floor Wardens: Names ________________________________**

- **Check-in** with each other immediately to ensure key tasks will be carried out.
- **Assign** others to help as needed.

**Staff and Patients/Guests:**

- **Take** jackets/purses etc. and **move** to the Reception Area.
- **Await** evacuation directions from the Floor Wardens.

**Primary Floor Wardens - General Manager**

- **Check** the primary evacuation route (out the front entrance) to determine if it is safe (look for signs of fire or smoke).
- **If determined safe,** **direct** all employees, patients, and visitors to exit and report to the **Assembly Area.**
- Meet with staff at the Assembly Area to ensure everyone is present.
- **Take attendance,** and inform fire officials of any missing persons.
- Liaise with building management/fire officials to report the facility was clear, to report any missing persons and to determine when it is safe to re-enter the building.

**Secondary Floor Wardens - Reception**

- **Check** washrooms, offices and patient rooms to ensure occupants are aware and ready to go.
- Once confirmed that the exit route is safe, **lead** staff and occupants (walk, don’t run) to the Assembly Area.
- The Primary Fire Warden will do a **final sweep of the entire space** to ensure everyone is out of the building and will close but not lock doors while exiting.
All Other Staff

- Upon hearing a fire alarm, move to the Reception Area and ensure someone is checking the exit routes and all rooms.
- Exit the building when instructed to do so in a calm, organized manner.
- Assist patients and guests as directed by the Primary and Secondary Floor Wardens.
- Do not delay evacuation to gather personal items.
- Once evacuated, meet at the designated Assembly Area to await further instruction.
EARTHQUAKE RESPONSE PLAN

During Shaking:

- **Duck** – Duck or drop down to the floor.
- **Cover** – Take cover under something if possible or seek cover next to an interior wall and protect your head and neck with your arms.
- **Hold** – If you have taken cover under something – hold on to it – hold your position until the shaking has stopped.

STAY CALM, NEVER RUN OUT OF THE BUILDING

After the shaking has stopped:

- **Look up** and around you to ensure there are no hazards before you leave your cover.

- **Assess** yourself and others in your area. Do not attempt to move anyone with serious injuries unless in danger of further injury (falling debris etc).

- **Do not evacuate** unless there is extensive damage to the building as it may be more dangerous outside.

- **If damage is not extensive inside**, assign someone to check the exterior of the building to look for exposed rebar, bent window frames or other hazards which will indicate that you should evacuate the building.

- **Assign someone to check** your evacuation route to make sure it is safe (falling debris, power lines, large cracks in ground surfaces) before instructing others to exit, and then evacuate with extreme caution.

- **Evacuation should not be an automatic policy.** The evacuation route and assembly area must be checked for hazards first. It may also be safer to stay indoors, depending on the magnitude of the tremors/shaking and the damage to the building as well as outdoor weather conditions.