

New Mexico Department of Health (NMDOH)
Public Health Division (PHD)

EMERGENCY MEDICAL RESPONSE PROTOCOL - 2023
Updated: February 2023

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Note: Blue highlighting indicates additions or edits from prior version.

INTRODUCTION

Although rare, adverse events may occur after vaccine or drug administration, or during/after a medical procedure. Medical emergencies for clients and staff may also occur coincidentally (i.e., not directly related to their reason for being in the Local Public Health Office (LPHO)) that still need to be managed appropriately.

This protocol outlines BASIC readiness and response for medical incidents/urgencies/emergencies encountered (e.g., loss of respiration/circulation, loss of consciousness, severe allergic reaction) to enable recovery or ensure stabilization, especially until Emergency Medical Services (EMS) arrives.

READINESS

- Each LPHO must conduct biannual reviews of this protocol to ensure that an appropriate emergency medical response to any serious incident is provided. Newly hired health services staff are also required to review this protocol as part of their orientation.
- Emergency telephone numbers (including Emergency Medical Services/law enforcement through 911, poison control, etc.) should be prominently placed on or near easily accessible telephones. All staff should know where these numbers are posted and to which medical facilities patients should be transported.
- All *licensed medical professionals* (nurses, physician assistants, nurse practitioners, and physicians) will maintain a current CPR/AED certification (American Red Cross standard course or equivalent that includes hands-on skill component). All staff members are highly encouraged to maintain a current CPR/AED certification. The local Safety Officer for any PHD office with an Automated External Defibrillator (AED) unit must ensure that annual training in operation and maintenance of the AED unit is scheduled and attended by staff.
- Assignments for emergency response duties will be maintained for each public health clinic. Each clinic location will perform an emergency medical response drill for training and evaluation purposes at least twice per year. These drills, coordinated by the local Safety Officer (or designee), will include the use of medical equipment (oxygen, Emergency Kit, and AED, if available).
- Pre-stocked Emergency Medical Kits containing appropriate supplies and medications (Attachment B) should be available in every local health office providing clinical care. The Emergency Kit should be secured with a numbered seal. These kits should only be opened for routine monthly inspection, response drills/exercises, or emergencies. A nurse will be assigned responsibility by the Nurse Manager to perform a monthly check to ensure that the Emergency Kit is complete and fully stocked, that the medications have not expired, and that the AED, if available on site, and oxygen equipment are working properly. After each equipment check, the nurse will complete and sign the Medical Emergency Equipment Maintenance Log (Attachment E).

All LPHO personnel must know where the Emergency Medical Kit is located (i.e., the health office drug room). If available in the health office, AED units will be stored in a high-traffic area that is easily accessible and convenient – AEDs must be used consistent with manufacturer’s recommendations and Regional protocols (if applicable).

- Pre-stocked Opioid Overdose Emergency Response Kits containing appropriate supplies and medications (Attachment C) may be available in local health offices, whether or not Emergency Medical Kits are available, as per the PHD Protocol for Overdose Prevention and Naloxone Distribution Appendix A (http://intranet/PHD/clinical_protocols.html). These kits may be kept in a secure, but readily accessible location for non-clinical staff access. They should only be opened for routine monthly inspection, response drills/exercises, or emergencies.

The Nurse Manager, or designee, will perform a monthly check to ensure that the kit is complete and fully stocked, and that the medication (naloxone) has not expired – if within 90 days of expiration, it

should be rotated out with medication being distributed or returned to the Pharmacy Warehouse for exchange. After each equipment check, the nurse will complete and sign the Medical Emergency Equipment Maintenance Log (Attachment F).

RESPONSE

Medical incidents in health offices may occur as a result of a procedure/medication administration, or may be coincidental (e.g., a client slips on ice while coming to an appointment or has a heart attack while waiting for their influenza vaccine). Incidents should always be managed in as calm, safe, organized, and appropriate a manner as possible. Basic principles for management include:

1. **Ensure responder safety** – assess the situation, and act to prevent additional victims or worsening of injuries. Use appropriate personal protective equipment (e.g., gloves, face mask).
2. **Do not leave the patient.** Call for help and initiate an emergency medical response when necessary. **Activate EMS (call 911) as soon as possible when necessary.** Although staff may take into account the client's preferences regarding EMS activation, EMS should be activated in any situation where a condition may become serious or progress rapidly. If a client leaves before they can be evaluated by EMS, document this in the chart. Clients may choose to refuse evaluation and/or transport by EMS. Note that jurisdictions vary on whether the EMS service may bill the client for an evaluation (whether or not transportation occurs).
3. If necessary, **initiate Basic Life Support** according to training.
4. Position victim for comfort and safety (see Attachment A for details).
 - If a neck injury may be possible, maintain c-spine precautions.
 - If unconscious and aspiration is a risk (e.g., seizure, overdose) consider placing the client in a recovery position.
 - If conscious, place client flat on back (supine) – having the client with their head at or lower than level of heart, with elevated legs, may be indicated.
 - Lying on floor is acceptable in an emergency, and may be necessary for some situations (e.g., CPR).
5. Loosen clothing around neck, chest, and arms to assist taking vital signs and doing physical examination.
6. Monitor and record vital signs: blood pressure, pulse, respiratory rate initially and every 5 minutes.
7. If a clinician is not quickly available, do not delay first aid/treatment or activating EMS to call a clinician.

Minor Medical Incidents

Most medical incidents encountered by staff are minor. These generally require only basic first aid management. Staff should provide medical care to their level of training, comfort, and available resources - affected staff or clients should be referred to a medical provider for further evaluation if necessary. In the event that the affected person cannot transport themselves to a provider, their emergency contact should be notified or EMS activated. Staff should keep in mind that apparently minor incidents (e.g., pre-syncope, head injury without loss of consciousness) could evolve into medical urgencies/emergencies – **if in doubt, activate EMS.**

The more likely minor incidents, and some additional notes about their management, that occur include:

- Local reactions to vaccination/medication administration such as wheal and redness (erythema) caused by histamine release. Apply pressure and ice to swelling and redness. Analgesics and/or antihistamines may be appropriate medications to recommend to the client – see Standing Order for Management of Moderate-Severe Allergic Reaction.

Anyone who suddenly develops rash, itching, and/or coughing/wheezing must be closely observed for the development of signs of airway obstruction and hypoxia.

- Pre-syncope (light-headedness, dizziness) – the individual remains conscious, but may feel weak, nauseous, and that they may faint/pass-out. Stop the procedure (if applicable), position the client for comfort, loosen clothing, check vitals, and call for help if necessary. A cold, damp cloth or cold pack wrapped in cloth applied to the forehead and back of the neck may provide comfort. If vital signs are within normal limits and patient improves after 5 -10 minutes lying down, assist patient to sitting position.

Clients should recover from minor medical incidents quickly and completely, and may leave once they have fully recovered, appear stable, and all management has been completed. If possible and appropriate, they should be released to the care of an emergency contact. If stability/recovery is uncertain or prolonged, other causes should be considered, and they should not be allowed to leave until they have been assessed by EMS. Advise clients that they should seek medical help if symptoms re-occur.

Medical Urgencies

Medical urgencies are medical incidents that are not immediately life-threatening but may require more management to prevent worsening of the condition. Again, staff should provide medical care to their level of training, comfort, and available resources – but activation of EMS should be considered early.

Some potential medical urgencies, and additional notes about their management, that occur include:

- Syncope (Fainting): May occur from exposure to stressful or painful experiences. As with pre-syncope, position the client for safety/comfort, loosen clothing, check vitals, and call for help. If vital signs are abnormal, there are signs of distress, or the client does not regain consciousness within 1-2 minutes consider serious causes of loss of consciousness and EMS activation.

Causes of syncope that may actually be emergencies include heart rhythm problems, opioid overdose, low blood sugar/hypoglycemia, and hypovolemia (due to dehydration or bleeding). If suspected, see the appropriate specific emergency response.

- Needlestick Injuries (NSIs)

These may occur for either a client or a worker. Concerns around NSIs relate to trauma from the incident, as well as the need for prevention of possible blood-borne pathogen transmission.

- ‘Clean’ needlestick injuries require only first aid but must still be reported.
 - A contaminated needlestick injury of a staff person should be managed according to the [PHD Health and Safety Handbook \(2022\)](#) (pages 80-82).
 - A contaminated needlestick injury in a client should be extremely unlikely – if this occurs, provide first aid and contact the DNS and Regional Health Officer for post-exposure prophylaxis management.
- Slips/falls: May occur in many situations (e.g., on a wet floor, falling from a ladder, etc.) resulting in minor to significant trauma, including:
 - Bruising and fractures of the arms and legs
 - Injuries to the hip and the pelvic bones
 - Head and facial injuries
 - Neck and spinal injuries, including lower spine
 - Internal injuries

Individuals who recover from an urgent medical incident **should be monitored until** they have fully recovered, appear stable, and all management has been completed. If possible and appropriate, they should be released to the care of an emergency contact. **If stability/recovery is uncertain or prolonged, they should not be allowed to leave until they have been assessed by EMS.**

Medical Emergencies

Medical emergencies are incidents with a risk of substantial injury or death without immediate and significant care. These will generally require activation of the EMS system, management using basic life support methods (e.g., CPR/AEDs), and potentially more advanced life support (e.g., medications, including oxygen).

Although very rare in health offices, some potential medical emergencies and additional notes about their management include:

- Severe allergic reactions (anaphylaxis, urticaria, angioedema, bronchospasm)
 - If a severe allergic reaction is suspected, in addition to EMS activation and basic life support, see Standing Order for Management of Moderate-Severe Allergic Reaction.
- Chest pain/discomfort - angina (stable or unstable) or myocardial infarction (heart attack)
 - If angina or myocardial infarction is suspected, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen and Standing Order for Administration of Aspirin for Management of Suspected Myocardial Infarction.
 - If client has a supply of nitroglycerin (tablets or spray), assist in administering as prescribed by their provider. Repeat every 5 minutes until pain relieved or three (3) doses administered. **Do not use if the systolic BP is below 130. Do not use if the person provides a history of taking Viagra (or comparable medication used for erectile dysfunction).**
- Cardiac arrest
 - If cardiac arrest occurs, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen.
 - **Send someone for an AED, if available, especially if the client is unstable (e.g., hypotension, loss of consciousness). Administer AED according to training.**
- Suspected Cerebrovascular Accident (CVA)(Stroke)
 - If a stroke is suspected, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen.

Note that a person suffering from an overdose of opioids (e.g., heroin) or hypoglycemia may have signs/symptoms that may mimic a stroke (e.g., confusion, loss of coordination, slurred speech).

- Seizure (generalized/tonic-clonic)
 - **Activate EMS.**
 - **Provide basic life support and protect the person from harm (e.g., falling).**
 - **Provide supplemental oxygen, if available (see Standing Order for Administration of Oxygen)**
 - After the seizure ends the person may be tired, disoriented/confused and/or embarrassed (especially as loss of bowel or bladder control may have occurred). Find a quiet place for the client to rest and call a friend or relative to help the client home safely, if EMS activation was not necessary.

Note that in addition to epilepsy (recurrent, unprovoked seizures), a seizure could result from many medical conditions, such as a head injury, fever, hypoglycemia, severe hypertension, withdrawal from drugs or alcohol, or a stroke.

- Suspected hypoglycemia (low blood sugar)

- Meters for blood sugar testing are not available in local health offices, and staff are not trained in their use. Clients may use their own blood sugar testing meters, if available.
- If HYPOGLYCEMIA is suspected, give the patient sugar-containing food or drinks [e.g., packets of sugar - may be mixed with several ounces of water) **or** ½ cup of juice **or** 5-6 hard candies **or** three glucose tablets (if client is carrying them)] **or** glucose gel. Wait 15 minutes and check status. If symptoms have not improved, repeat the treatment.
- Activate EMS if symptoms worsen or do not improve.
- Drug (opioid) overdose
 - If a DRUG OVERDOSE is suspected, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen and Standing Order for Management of Opioid Overdose by Administration of Naloxone).
- Hypotension/Shock (cardiogenic, anaphylactic, hypovolemic, septic)

Hypotension is defined as a systolic blood pressure \leq 90mm/Hg for adults or less than the fifth percentile by age, for children younger than 16 years (see Attachment I – Normal Values for Vital Signs).

Note: Careful measurement of blood pressure is important; be certain that the cuff used is the correct width. The cuff width should be 20-25% wider than the diameter of the extremity used. A **cuff** that is too large will give falsely low readings; a cuff that is too small will give a falsely high reading.

- If hypotension is suspected, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen.

All clients who have an emergency medical incident, even those who appear stable, should be evaluated by EMS.

Standing Order for
Moderate to Severe Allergic Reactions (Including Anaphylaxis)

Purpose: To reduce the morbidity and mortality related to development of moderate-severe allergic reactions (including anaphylaxis) following administration of vaccines or medications.

Policy: Under these standing orders, **trained** nurses may administer intramuscular diphenhydramine and/or intramuscular epinephrine to individuals who are or may be affected by moderate-severe allergic reactions.

Procedure:

If following administration of a medication or vaccine a patient develops signs or symptoms consistent with a moderate to severe allergic reaction:

1. Call for help/support by other office staff.
2. Evaluate the severity of the reaction.
3. **Activate the emergency medical system (EMS).**
4. Provide initial treatment:
 - For severe symptoms (e.g., flushing, apprehension, syncope, tachycardia, thready or unobtainable pulse associated with a fall in blood pressure, convulsions, vomiting, diarrhea and abdominal cramps, involuntary voiding, dyspnea due to laryngeal spasm, lip/facial/tongue swelling, difficulty swallowing and breathing, wheezing/cough, dizziness) administer:

1) EPINEPHRINE

- Aqueous **epinephrine** 1:1,000 (1 mg/mL) dilution intramuscularly (lateral thigh preferred) as 0.01 mg/kg body weight (up to 0.5 mg maximum single dose).

OR

- 0.15 or 0.3 mg/dose by age-appropriate autoinjector.

There are NO contraindications to epinephrine with anaphylaxis.

Note: for people ≥ 100 lbs give max dose of 0.5 mg (vial) or 0.3 mg (autoinjector)

THEN,

- 2) Diphenhydramine intramuscularly as 1.5 mg/kg body weight (up to a maximum 50 mg dose). The adult dose is 50 mg.

Repeat epinephrine dose every 5-15 minutes x 2 as needed.

- For moderate symptoms (e.g., general itching, hives, or redness), administer:
 - Diphenhydramine intramuscularly as:
 - 1.5 mg/kg body weight up to a maximum 50 mg dose. The adult dose is 50 mg.
5. Monitor the patient closely until EMS arrives.
 - Keep patient in supine position (flat on back) unless he or she is having breathing difficulty. If breathing is difficult, patient's head may be elevated, provided blood pressure is adequate to prevent loss of consciousness. If blood pressure is low, elevate the legs.
 - Provide oxygen (see Standing Order).
 - Monitor level of consciousness, blood pressure, and pulse every 5 minutes.
 - Perform cardiopulmonary resuscitation (CPR) if necessary and maintain the airway.
 6. Notify the Regional Health Officer or other available physician. This should be done by a second person, while the primary nurse assesses the airway, breathing, circulation, and level of consciousness of the patient.
 7. **If EMS has not arrived and symptoms are still present, repeat the dose of epinephrine provided in (above) every 5-15 minutes for up to 3 doses (total), depending on patient's response.**
 8. Record all vital signs, medications administered to the patient, including the time, dosage, response and the name of the medical personnel who administered the medication, and other relevant clinical information.
 9. Notify the patient's primary care physician.

[Note: For mild allergy symptoms (e.g., local itching, local swelling), observe for 30 min. If symptoms do not progress, the patient may be released, but can be advised to apply cold compresses, take an over-the-counter analgesic, and/or an over-the-counter H1-receptor blocker (e.g., cetirizine 10 mg daily; other options are fexofenadine or loratadine) for 2-3 days.]

Quick Dosing Guides

First-Line Treatment Anaphylaxis: Epinephrine				Epinephrine Dose	
Recommended dose is 0.01 mg/kg body weight up to 0.5 mg maximum dose. May be repeated every 5-15 minutes for a total of 3 doses.		Age group	Range of weight (lb)	Range of weight (kg)*	1 mg/mL injectable (1:1,000 dilution); intramuscular Minimum dose: 0.05 mL
		Infants and children	1-6 months	6-19 lb	3-8.5 kg
	7-36 months		20-32 lb	9-14.5 kg	0.1 mL (or mg)
	37-59 months		33-39 lb	15-17.5 kg	0.15 mL (or mg)
	5-7 years		40-56 lb	18-25.5 kg	0.2-0.25 mL (or mg)
	8-10 years		57-76 lb	26-34.5 kg	0.25-0.3 mL (or mg)
	Teens and adults	11-12 years	77-99 lb	35-45 kg	0.35-0.4 mL (or mg)
		13 years & older	100+ lb	46+ kg	0.5 mL (or mg) – max. dose

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

*Rounded weight at the 50th percentile for each age range

Diphenhydramine				Diphenhydramine Dose	
commonly known as Benadryl		Age group	Range of weight (lb)	Range of weight (kg)*	Injectable: 50 mg/mL (IV or IM)
		Infants and children	1-6 months	6-19 lb	
7-36 months	20-32 lb		9-14.5 kg	0.2-0.3 ml (10-15 mg)	
37-59 months	33-39 lb		15-17.5 kg	0.3-0.4 ml (15-20 mg)	
5-7 years	40-56 lb		18-25.5 kg	0.4-0.5 ml (20-25 mg)	
8-10 years	57-99 lb		26-45 kg	0.5-1.0 ml (25-50 mg)	
Recommended dose is 1-2 mg/kg body weight every 4-6 hours	Teens and adults	13 years & older	100+ lb	46+ kg	1.0 ml (50 mg) – max. dose

Note: If body weight is known, then dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

*Rounded weight at the 50th percentile for each age range

Reference: adapted from Immunization Action Coalition - www.immunize.org/catg.d/p3082a.pdf - May 24, 2018.

Notes on epinephrine options:

Epinephrine may be available in emergency medical kits as ampules, vials, or auto-injector formulations.

1) Auto-injector:

An auto-injector may be best used for the initial dose due to the simplicity of administration for clients weighing >33 lbs:

One auto-injector pack contains two 0.15 mg or 0.3 mg auto-injectors.



The auto-injector should be used as follows:

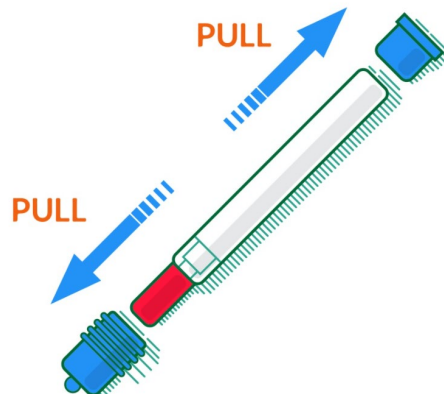
a. Select the correct epinephrine auto-injector based on weight:

- 0.15 mg for clients 33-66 lbs, OR
- 0.30 mg for clients >66 lbs

For clients <33 lbs, use the weight-appropriate epinephrine dosage obtained from an vial.

b. Prepare the epinephrine auto-injector:

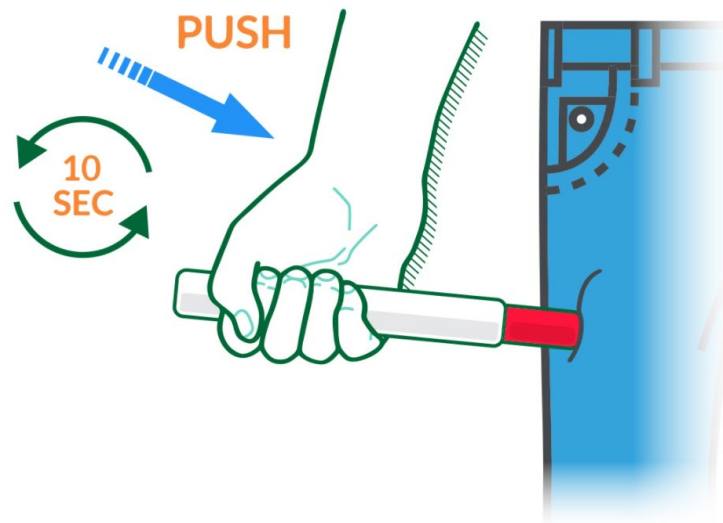
- Remove the auto-injector from the protective carrying case. Pull off blue end caps – grasp the auto-injector in a fist with the red tip pointing downward.



c. Administer epinephrine injection.

- Put the red tip against the middle of the outer thigh (upper leg) at a 90° angle (perpendicular) to the thigh.

- ii. Press down hard and hold firmly against the thigh for approximately 10 seconds to deliver the medicine – the auto-injector is designed to work through clothing.



- d. Remove the auto-injector from thigh area.
- e. Massage the area for 10 seconds.
- f. Check the red tip: the injection is complete if the needle is sticking out of the red tip. If the needle is not visible, administer as above (step 2) with same auto-injector or a new auto-injector if malfunction is suspected.
- g. Dispose of the auto-injector in a sharps container.

2) Vials

Single-use vials are managed as for other medications.

Note: although one vial provides sufficient medication for at least two doses, to ensure that excess medication is not administered accidentally, only a single dose per ampule should be drawn into a syringe. Per Board of Pharmacy regulations, remaining medication may not be drawn up in a second syringe – it must be discarded and a new ampule used.

Epinephrine in vials may be used for an initial dose if an auto-injector is not available or dosages less than or greater than 0.3 mg are needed.

This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded.

Signature of ordering provider(s)

PHD Medical Director  Date: 12/29/22

NE Region Health Officer Christine Ross, MD Date: 1/31/23

NW Region Health Officer  Date: 12/29/22

SE Region Health Officer Eugene Maricmink, MD. Date: 01/05/23

SW Region Health Officer Eugene Maricmink, MD. Date: 01/05/25

Standing Order for Naloxone for Suspected Opioid Overdose

Purpose: To reduce the morbidity and mortality related to opioid overdose by providing emergency intranasal naloxone.

Policy: Under these standing orders, eligible nurses may administer intranasal naloxone to individuals who are or may be affected by opioid overdose.

Note: additional policies/standing orders may govern administration of naloxone by other staff (see PHD Protocol for Overdose Prevention and Naloxone Distribution - http://intranet/PHD/clinical_protocols.html).

Procedure:

1. Identify indication(s) for administration of naloxone, including:
 - a. Opioid overdose is suspected, and
 - b. The individual has a respiratory rate less than 12 per minute.
2. The primary responder should assess the airway, breathing, circulation, and level of consciousness of the patient – provide rescue breathing +/- supplemental oxygen if indicated. A second person should activate the emergency medical services system and notify the regional health officer or other available physician.
3. Screen all patients, if possible, for contraindications and precautions to naloxone.
 - a. **Contraindications:** Allergy/sensitivity to naloxone.
 - b. **Precautions:** Use with caution in patients with cardiovascular, liver, or kidney disease, or seizure disorder.
4. With the individual or parent/guardian's consent if able to be provided, or with implied consent for unresponsive individuals, **administer naloxone** as:

Nasal Spray format, administer as follows:

- a. Place the patient in the supine position.
- b. Assess nostrils for obstructions (e.g., blood) that might impair drug absorption.
- c. Remove from packaging.
- d. Insert applicator end of the device within either nostril of the patient and provide support to the back of the neck to allow the head to tilt back. Do not prime or test the device prior to administration.
- e. Administer the entire dose (4 mg/0.1 ml) by briskly compressing firmly on the device plunger.
- f. Remove the device nozzle from the nostril after use.
- g. Turn patient on their side as shown in the Instructions for Use.





Additional doses of naloxone may be required until emergency medical assistance becomes available. Do not attempt to reuse – each applicator contains a single dose and cannot be reused.

5. If a comatose patient with suspected overdose fails to awaken with naloxone within 5 minutes, **administer a second dose of naloxone** (ampule or spray) as above. Consider alternate causes for the condition (e.g., MI, hypoglycemia).
6. Monitor as recurrence of respiratory depression may occur if the opioid involved is long-acting or a partial agonist (e.g., methadone, buprenorphine)

Warning: Naloxone reversal of an opioid overdose can be extremely rapid – following administration, the patient may regain consciousness quickly, but may be confused, agitated, irritable, and/or combative (due to precipitated withdrawal and possibly due to hypoxia). **Protect the client from harming themselves or others,** and provide a quiet place for the client to rest.

This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded.

Signature of ordering provider(s)

PHD Medical Director		Date: 12/29/22
NE Region Health Officer	Christine Ross, MD	Date: 1/31/23
NW Region Health Officer		Date: 12/29/22
SE Region Health Officer	Eugene Marimink, MD	Date: 01/05/23
SW Region Health Officer	Eugene Marimink, MD	Date: 01/05/23

Standing Order for Administration of Oxygen

Purpose: To reduce the morbidity and mortality related to medical incidents by providing supplemental oxygen (if available).

Procedure:

1. Oxygen may be administered to patients who may be affected by:
 - a. Severe allergic reactions
 - b. Chest pain/discomfort that may be angina or a myocardial infarction
 - c. Cardiac arrest
 - d. Stroke
 - e. Generalized seizure
 - f. Drug (opioid) overdose
2. Under these standing orders, eligible nurses may administer oxygen by mask at the highest flow rate available up to 10 liters/minute.
3. If necessary, provide assisted ventilations via Ambu-bag mask connected to oxygen supply per BLS protocols. Note: For infants/children use pediatric size face mask if available - if assisted ventilations are necessary do NOT over-inflate lungs.

Contraindications:

No absolute contraindications of oxygen therapy exist when indications are judged to be present.

Precautions:

1. A relative contraindication for oxygen therapy relates to patients with severe chronic obstructive pulmonary disease who may experience a decrease in the drive to breathe if given supplemental oxygen. Careful monitoring of these patients for hypoventilation is required during oxygen therapy.
2. Other issues related to oxygen therapy include:
 - a. Fire hazard
 - b. Potentially inadequate flow due to a high inspiratory demand or an inappropriate oxygen delivery device
 - c. Skin irritation from pressure exerted by the device or reactions to the materials from which the device is made
 - d. Aspiration of vomitus may be more likely when a mask is in place – this may occlude the valve of a mask and decrease oxygen delivery

This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded.

Signature of ordering provider(s)

PHD Medical Director  _____ Date: 12/29/22

NE Region Health Officer Christine Ross, MD _____ Date: 1/31/23

NW Region Health Officer  _____ Date: 12/29/22

SE Region Health Officer	<u>Eugene Marimatz, MD.</u>	Date:	<u>01/05/23</u>
SW Region Health Officer	<u>Eugene Marimatz, MD.</u>	Date:	<u>01/05/23</u>

Standing Order for Administration of Aspirin for Management of Suspected Myocardial Infarction

Purpose: To reduce the morbidity and mortality related to myocardial infarctions by providing emergency aspirin (acetylsalicylic acid).

Policy: Under these standing orders, eligible nurses may administer aspirin to individuals who are or may be affected by a suspected myocardial infarction (heart attack).

Procedure:

1. Identify indication(s) for administration of aspirin, including:
 - a. Uncomfortable **pressure, fullness, squeezing** or **pain** in the center of the chest that lasts more than a few minutes or goes away and comes back or is not relieved by nitroglycerin
 - b. **Pain that spreads to the shoulders, neck, or arms**
 - c. Chest discomfort with **lightheadedness, fainting, sweating, nausea** or **shortness of breath**
2. Aspirin may also be given to a patient who exhibits any TWO of the following signs or symptoms:
 - a. Atypical chest pain, stomach or abdominal pain. This may include discomfort that can be localized to a point, that is “sharp” in nature, that is reproducible by palpation, or that is in the “wrong” location (such as the upper abdomen).
 - b. Unexplained nausea (without vomiting) or lightheadedness (not vertigo) without chest pain
 - c. Shortness of breath and difficulty breathing (without chest pain)
 - d. Unexplained anxiety, weakness or fatigue
 - e. Palpitations, cold sweats, or paleness
3. Screen all patients for contraindications and precautions to aspirin.
 - a. **Contraindications:**
 - i. Allergy/sensitivity to aspirin, products containing aspirin, or aspirin-like products
 - ii. Patient is unable to chew or swallow
 - iii. History of active bleeding disorder
 - iv. Recent or current ulcer or gastrointestinal bleeding
 - v. Systolic blood pressure over **180** mmHg OR diastolic over 110 mmHg
 - vi. Patient prescribed anticoagulation therapy
 - vii. Possible aortic aneurysm
 - b. **Precautions:**
 - i. Avoid when possible during pregnancy
 - ii. Known hemophilia or glucose-6-phosphate dehydrogenase deficiency
 - iii. May trigger a response in people with aspirin-sensitive asthma

Note: regular or recent aspirin use is NOT a contraindication or precaution: an additional dose may be provided if an MI is suspected.

4. With the individual or parent/guardian’s consent, administer:
Aspirin 325 mg by mouth – chew the tablets until they are dissolved (do not swallow whole)
(as four (4) children’s chewable ASA (aspirin) tablets or equivalent)

This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded.

Signature of ordering provider(s)

PHD Medical Director  Date: 12/29/22

NE Region Health Officer  Date: 12/29/22

NW Region Health Officer Christine Ross, MD Date: 1/31/23

SE Region Health Officer Eugene Maximik, MD Date: 01/05/23

SW Region Health Officer Eugene Maximik, MD Date: 01/05/23

DOCUMENTATION OF INCIDENTS

The documentation of an adverse incident depends on the type, severity, and whether the victim is a client or an employee. The materials and guidance for documentation may come from multiple sources.

- The medical response to an emergency should be documented on the Event Record form (Attachment G). Blank Event Record forms are kept inside the Emergency Kit and adjacent to the AED unit (if applicable). Record the events, recommendations, decisions, and outcomes. Record the client's name, address, and phone numbers for follow-up, if needed.
- Post-event documentation may also be included in the client's medical chart (e.g., BEHR) if the event involves a PHD clinical services client (e.g., noting that syncope occurred with vaccination). The Event Record form for employee incidents should be stored in the employee's health record.
- A [PHD Incident Report](#) (with a copy of the Event Record) should be completed and submitted to the appropriate supervisor or local Safety Officer within one working day for any event that is **NOT** a Worker's Compensation incident. For details, see the [PHD Health and Safety Handbook](#).
- A Worker's Compensation report (Notice of Accident-NOA-1), available in the LPHO, is required if the affected person is an employee. For details, see the [PHD Health and Safety Handbook](#).
- Additional documentation that may need to be considered:
 - ◆ A [Vaccine Adverse Event Reaction \(VAERS\) report](#), if a vaccine is involved.
 - ◆ Employer's First Report of Accident form.
 - ◆ Occupational Exposure Event Bloodborne Pathogen Form in the [PHD Health and Safety Handbook](#) if the incident involves a PHD employee exposed to potentially infectious materials.
 - ◆ [PHD Sharps Injury Form Feb 2019](#) for a sharps injury.
 - ◆ Entry in the local Sharps Injury Log, if applicable.
 - ◆ Other documents related to a Worker's Compensation claim.

ATTACHMENTS

- Attachment A – C-Spine Precautions and Recovery Position
- Attachment B – Supply List for PHD Emergency Kit
- Attachment C – Supply List for PHD Opioid Overdose Emergency Response Kit
- Attachment D – Supply List for PHD AEDs
- Attachment E – PHD Medical Emergency Equipment Maintenance Log
- Attachment F – PHD Opioid Overdose Emergency Response Kit Maintenance Log
- Attachment G – PHD Event Record (for recording interventions)
- Attachment H – AED Usage Data Collection Form
- Attachment I – Normal Values for Vital Signs
- Attachment J – PHD Protocol Approval Sheet
- Attachment K – PHD Acknowledgement and Receipt of Protocol

Attachment A – C-Spine Precautions and Recovery Position

An injury to the cervical spinal (C-spine) vertebra in the neck due to trauma (e.g., fall) can result in significant spinal cord injury. The injury may not always be recognized immediately – for example, if the client is unconscious, has other distracting injuries, is intoxicated, etc. However, if not recognized and managed, movement of the unstable vertebra can result in (additional) spinal cord damage, leading to permanent disability or death.

Patients should be considered to have cervical spine injury if they present with any of the following:

- a. Blunt force trauma to head, neck or back, fall
- b. Loss of consciousness/unconscious, or altered mental status
- b. Neurologic deficits (weakness/paresthesia) in torso, legs, or arms not explained by peripheral nerve injuries
- c. Tenderness on palpation of the cervical spine
- d. Pain in the cervical spine or paraspinal muscles

The first priority is keeping the airway open - if breathing stops, regardless of potential for increased injury to the person, you must continue CABs: circulation, airway, breathing.

- If a spinal injury is possible:

The preferred position for the victim with known or suspected spinal injury is to stabilize the spine in the supine position (on their back) in neutral alignment with no rotation or bending of the spinal column.

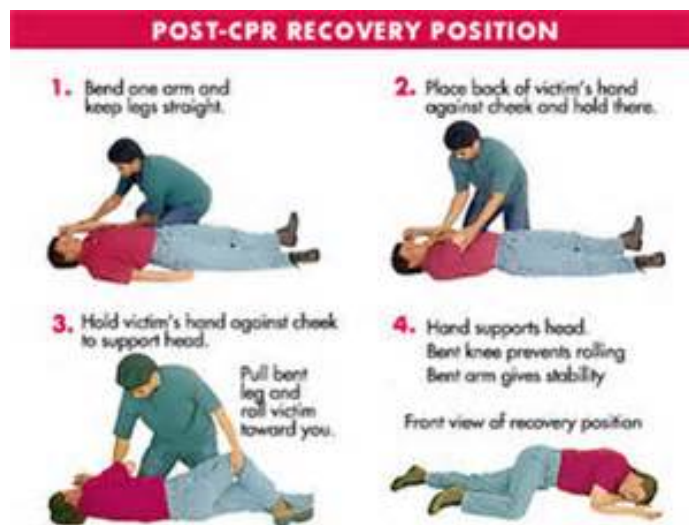
- Initially, a rescuer should place both hands on either side of the victim's head to steady it. Hold the victim's head gently but firmly to keep it from moving. Only release the head to help with the victim's airway, breathing, or circulation, or if the scene becomes unsafe.
- If the victim is conscious, instruct the client to remain calm and still. If the neck is not in the neutral position, an attempt may be made to achieve alignment: the patient may attempt to move their neck into line. If there is any pain, neurological deterioration, or resistance to movement the procedure should be abandoned and the neck held in the current position.
- If the victim is unconscious or unable to co-operate, and if the neck is not in the neutral position, maintain control of the victim's neck. If necessary, for example due to a compromised airway, an attempt can be made to passively achieve alignment (i.e., gently moving the victim's head). If there is any pain evident, neurological deterioration, or resistance to movement the procedure should be abandoned and the neck held in the current position.

If aspiration is a risk, a victim may be moved to the recovery position (see details below). However, practically speaking, safely moving a client with a possible C-spine injury can be hard without multiple trained staff – if attempted, one rescuer should be responsible for leading the movement AND maintaining control of the head and neck (in line with the body) while 1-2 others position the torso and legs. Place padding under the head to maintain neutral alignment – use of the HAINES position (a modified recovery position with the victim's arm above the head) is preferred.



Minimize movement of the victim until EMS arrives to take control of the client. Every effort should be made to ensure patient comfort. Consider placing extra padding to bony prominences (e.g., behind knees, to lumbar space (if lumbar spine negative) or occiput/behind the head).

- If a spinal injury is not suspected:
 - If the client is conscious, they may be placed in a comfortable position – usually supine (on the back). Elevating the legs may be helpful (e.g., for shock).
 - If unconscious, especially if aspiration is a risk (e.g., seizure, overdose), consider placing the client in a recovery position:



Caution: nerve and vessel injury can develop, particularly if the victim remains in this position for a long period of time.

Attachment B - Supply List for PHD Medical Emergency Kit

Drugs & Drug Administration

- Epinephrine
2 x 0.3 mg/0.3 ml epinephrine auto-injector

- AND/OR
- 2 x 0.15 mg/0.3 ml epinephrine auto-injector

- AND/OR

- 2 x 1 mL vials or ampules epinephrine 1:1000 (340B – for use only on patients of the clinic in or out of health office)
- AND
- 1 x 1 mL vial or ampule epinephrine 1:1000 (non-340B – for use on any response)
- 3 x 1 mL vials diphenhydramine (Benadryl) 50 mg/mL
- 2 packs Naloxone Nasal Spray devices (2 x 4 mg/device) – exchange >90 days prior to expiration
- 4 unit dose children’s chewable ASA (aspirin) (81 mg/tab)

- OR

- 1 bottle ASA tablets (81 mg/tab)

- Oxygen and regulator (to accompany Emergency Kit) – if available

Needles

- 10 x 22g x 1.5”
- 10 x 23g x 1”
- 5 x 19g x 1” 5-micron filter needles (for use with epinephrine ampules)

Syringes

- 6 x 1 cc syringes (graduated)
- 6 x 3 cc syringes (graduated)

Evaluation Equipment

- 1 stethoscope
- 1 adult BP cuff (sphygmomanometer)
- 1 pediatric BP cuff (sphygmomanometer)

Resuscitation Equipment

- 1 Adult and 1 pediatric non-rebreather mask
- Adult Ambu bag
- Pediatric Ambu bag (if available)

Treatment Equipment

- 10 alcohol swabs
- 10 band-aids
- 10 4X4 gauze pads
- 2 pen lights
- 1 roll adhesive tape

PPE

- Nitrile gloves (1 pair each S, M, L)
- 3 face-shields (optional)

Other Materials

- 1 copy of statewide Protocol for Emergency Medical Response
- 5 copies of Event Record (for documentation of emergency event)
- AED Use Record, if applicable
- 1 copy of Medical Emergency Kit supply list

Attachment C - Supply List for PHD Opioid Overdose Emergency Response Kit

Drugs & Drug Administration

- 2 packs Naloxone Nasal Spray devices (2 x 4 mg/device) - exchange >90 days prior to expiration

Resuscitation Equipment

- 1 adult size pocket mask with one-way valve

PPE

- Nitrile gloves (1 pair each S, M, L)
- 1 adult size pocket mask with one-way valve
- 1 pediatric size pocket mask with one-way valve
- 1 face-shield

Other Materials

- 1 copy of statewide Protocol for Emergency Medical Response - Standing Order for Naloxone for Suspected Opioid Overdose
- 1 copy of Event Record (for documentation of emergency event)
- 1 copy of Opioid Overdose Emergency Response Kit supply list

Attachment D - Supply List for PHD AEDs

AED Station*

AED and installed items include:

- AED case
- AED
- AED instructions
- Batteries (installed)
- 2 sets of adult pads
- 1 set of pediatric pads
- Accessories (e.g., CPR barrier mask, scissors, gloves, prep razor, towel and a moist towelette in a small zip-lock pouch)

*Does not include additional supplies (backup batteries, pads, etc.) maintained on-site or in the Regional Health Office

Attachment E - PHD Medical Emergency Equipment Maintenance Log

Year:	Expiration Date(s) or Check											
	J	F	M	A	M	J	J	A	S	O	N	D
Drugs & Drug Administration												
2 x 1 epinephrine auto-injector (0.3 mg each)												
2 x 1 epinephrine auto-injector (0.15 mg each)												
AND/OR												
2 x 1 mL vials epinephrine 1:1000 (340B – for use with clinic patients <u>in or out</u> of health office)												
AND												
1 x 1mL vial epinephrine 1:1000 (non-340B – for use on any response)												
3 x 1 mL vials diphenhydramine (Benadryl) 50 mg/mL												
2 packs Naloxone Nasal Spray devices (2 x 4 mg/device) – exchange >90 days prior to expiration												
4 unit dose children’s chewable ASA (aspirin) (81 mg/tab)												
OR												
1 unopened bottle ASA (81 mg/tab or 325 mg/tab)												
Needles												
10 x 22g x 1.5”												
10 x 23g x 1”												
Syringes												
6 x 1 cc syringes (graduated)												
6 x 3 cc syringes (graduated)												
Evaluation Equipment												
1 stethoscope												
1 adult BP cuff (sphygmomanometer)												
1 pediatric BP cuff (sphygmomanometer)												
Resuscitation Equipment												
1 Adult and 1 pediatric non-rebreather mask												
Adult Ambu bag and mask												
Oxygen and regulator (to accompany Emergency Kit)												
Treatment Equipment												
10 alcohol swabs												
10 band-aids												
10 4X4 gauze pads												
2 pen lights												
1 roll adhesive tape												
PPE												
Nitrile gloves (1 pair each S, M, L)												
3 face-shields (optional)												
Other Materials												
Protocol for Emergency Medical Response												
Event Record (for documentation) – 5 copies												
AED Use Record, if applicable												
Medical Emergency Kit supply list/Expiration Check												

Attachment F - PHD Opioid Overdose Emergency Response Kit Maintenance Log

Year 20__

Month	<i>Medications and Supplies Within Date*</i>	<i>Utilities Bag Present & Stocked</i>	<i>Signature/Comments</i>
Jan			
Feb			
Mar			
Apr			
May			
Jun			
Jul			
Aug			
Sep			
Oct			
Nov			
Dec			

*Exchange >90 days prior to expiration

Attachment G - PHD Event Record

Today's Date

Name of Local Health Office		Address	
Name of Patient	Phone Number	DOB / /	Age
Allergies:		or <input type="checkbox"/> NKDA	

Time	Action/Drugs/Oxygen	HR	BP	RR	Patient Condition	Initials

Narrative (i.e., Type of Drug Reaction, Diagnosis, Patient Status, Time of Departure, etc.):*

***If AED used, complete AED Usage Data Collection Form**

Patient Discharged to:		When:	
With Follow Up Care by:		When:	
Patient Transferred to:		When:	
Via:		When:	

Signature:	Title:
Date/Time:	

Attachment H - Sample AED Usage Data Collection Form

(Note: Use version in Regional AED Protocol, if available)

Victim's Name:				Date of Event:	
AED Responders:				Time of Event:	
				<input type="checkbox"/> Witnessed Event <input type="checkbox"/> Non-witnessed Event	
Location:	Address:				
	<input type="checkbox"/> Residential	<input type="checkbox"/> Commercial	<input type="checkbox"/> Industrial		
	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Agricultural	<input type="checkbox"/> Health Care Facility		
	<input type="checkbox"/> Mass gathering	<input type="checkbox"/> Recreation			

RESPONSE TIMES:	TIME
Estimated Collapse/Arrest	
1 st CPR	
AED Responder Scene Arrival	
1 st AED Defibrillation	
EMS Scene Arrival	
Transport from Scene	
Arrival at hospital (if obtainable from receiving hospital)	

Emergency Medical Response Plan Activated: Y / N

Was pulse taken at initial assessment?	<input type="checkbox"/> Y / <input type="checkbox"/> N
Was CPR given before the AED arrival?	<input type="checkbox"/> Y / <input type="checkbox"/> N
	If Yes, name of CPR rescuer(s):
Were shocks administered by AED?	<input type="checkbox"/> Y / <input type="checkbox"/> N
	Total number of shocks?
Did victim....	
Regain a pulse?	<input type="checkbox"/> Y / <input type="checkbox"/> N If Yes, pulse rate:
Resume breathing?	<input type="checkbox"/> Y / <input type="checkbox"/> N
Regain consciousness?	<input type="checkbox"/> Y / <input type="checkbox"/> N
Apparent cause of arrest:	
Estimated total time of event (time of collapse to transport time)?	
EMS Responding/Transporting Service(s):	

Receiving Hospital Information	
Name:	
Location (City/State):	
Hospital Record Number:	
On Admission:	Presenting Rhythm:
	Vital Signs:
ER Disposition:	<input type="checkbox"/> Discharge to Home <input type="checkbox"/> Hospital admission to (list Unit) <input type="checkbox"/> Transfer to: <input type="checkbox"/> Expired – Cause of death:
Diagnosed Cause of Arrest:	

Any problems encountered (device failure, injury)? Y / N

Comments:

Report completed by:		Date:	
----------------------	--	-------	--

Send completed report to the NMDOH Regional AED Program Director

Attachment I - Normal Values – Vital Signs

Heart Rate/Pulse (beats/min)	
Newborn	100-160
Infant (1-12 months)	90-160
Toddler (1-3 years)	80-150
Preschooler (3-5 years)	70-115
School age (6-12 years)	60-100
Adolescent (13-18 years)	60-100
Adults	60-100

Respiratory Rates (breaths/min)	
Newborn	30-60
Infant (1-12 months)	22-38
Toddler (1-3 years)	22-30
Preschooler (3-5 years)	20-30
School age (6-12 years)	16-22
Adolescent (13-18 years)	14-20
Adults	12-20

Systolic Blood Pressure (mmHg)	
Newborn	75-95
Infant (1-12 months)	80-100
Toddler (1-3 years)	80-110
Preschooler (3-5 years)	80-110
School age (6-12 years)	80-120
Adolescent (13-18 years)	110-120
Adults	100-120

Attachment J - Public Health Division Clinical Protocol/Manual Approval Sheet



PROGRAM/BUREAU: Public Health Division

CLINICAL PROTOCOL TITLE: Emergency Medical Response – 2023

Reviewed by: (Must have a signature from at least one clinical user of the Protocol)

Name:	<u>Dominique Martinez, BSN, RN</u>	Date:	01/31	/	/23
Name:	_____	Date:	/	/	
Name:	_____	Date:	/	/	

Approved by:

Program Manager	<u>Not Applicable</u>	Date:	/	/	
Bureau Chief	<u>Not Applicable</u>	Date:	/	/	
Bureau Medical Director	<u>Not Applicable</u>	Date:	/	/	
PHD Medical Director	<u></u>	Date:	12/29	/	22
Regional Health Officer	<u>Eugene Maximik, MD</u>	Date:	01/05/23		
PHD Chief Nurse	<u></u>	Date:	01/31	/	23
(Other)	_____	Date:	/	/	
(Other)	_____	Date:	/	/	

Attachment K - Public Health Division Acknowledgement and Receipt of New/Revised Clinical Protocol

PROGRAM/BUREAU: Public Health Division

CLINICAL PROTOCOL TITLE: Emergency Medical Response – 2023

I have reviewed the document listed above and I approve it for practice in ____ Region.

Regional Director	_____	Date:	/	/
Regional Health Officer	_____	Date:	/	/
Regional DNS	_____	Date:	/	/
Regional DNS	_____	Date:	/	/

I have received, reviewed, and will follow this Clinical Protocol and its Standing Orders.

Staff (Clinicians, PHNs, DPSs, etc.):

Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/
Name:	_____	Date:	/	/

Each clinician and PHN must review the document mentioned above and sign this sheet (use additional sheets as necessary). The Nurse Manager will retain the signed copy(ies) of this sheet at the clinic and submit the original(s) to the Director of Nursing Services.