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Objective

To ensure the consistent provision of care for patients requiring emergency interventions.

Scope

RNs with Critical Care skills and education related to this policy.

Policy

1. This clinical policy has been accepted as the Standard of Practice for the Detroit Medical Center to ensure the consistent provision of patient care. See CC 100 Critical Care Provisions of Care and CC 204 Cardioversion, Elective and Emergent.
2. If Progressive Care nurses have not taken Advance Cardiac Life Support (ACLS), the DMC Tier 2 PCD Emergency Protocol is followed.
3. House physicians/designee are paged STAT for all emergencies.

Provisions

1. In the absence of a physician, the RN initiates the following emergency interventions based on the American Heart Association (AHA), ACLS algorithms. See attached appendixes. The following AHA ACLS algorithms have been modified to include nursing interventions and settings related to Transcutaneous Pacing (TCP).
 - a. Universal algorithm
 - b. Ventricular fibrillation (VF) and Pulseless Ventricular tachycardia (VT)
 - c. Asystole
 - d. Pulseless Electrical Activity (PEA)
 - e. Bradycardia
 - f. Unstable Ventricular Tachycardia Overview
2. In the absence of a physician, the RN initiates the following interventions for patients in Acute Respiratory Distress.
 - A. For non-mechanically ventilated patients.
 - a. Open airway, using head tilt, chin lift method.
 - b. If patient is breathing, apply non-rebreather mask at 100%.
 - c. If patient is unresponsive and not breathing, ventilate patient with Manual Resuscitation Bag (MRB) with mask using 100% oxygen until anesthesia/physician arrives. Insert oral or nasal pharyngeal airway if needed. Assess for chest expansion during ventilation.
 - d. Page anesthesia, physician, and respiratory therapy STAT.
 - B. For mechanically ventilated patients.
 - a. Disconnect and manually ventilate with MRB using 100% oxygen.
 - b. Page respiratory therapy and anesthesia STAT if indicated.

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- c. Assess airway patency, breath sounds, chest expansion, endotracheal tube (ET) placement, tracheal position, ET balloon integrity, pulse oximetry, and arterial blood gases as needed.
- d. If inadequate ventilation occurs due to dislodged ET tube:
 - i. Page respiratory therapy, anesthesia, and physician STAT and ventilate using 100%.
 - ii. If patient stable, wait for anesthesia and / or physician.
 - iii. If patient unstable, and unable to ventilate with ET secondary to obstruction or ET tube in esophagus, remove ET and ventilate with MRB with mask using 100%.
- e. If inadequate ventilation occurs due to a suspected mucous plug:
 - i. Page respiratory therapy, anesthesia and physician STAT while suctioning patient.
 - ii. If patient continues to deteriorate, or becomes unstable, and unable to ventilate with ET, remove ET and ventilate with MRB with mask using 100%.
- f. If inadequate ventilation occurs due to loss of ET balloon integrity:
 - i. Page respiratory, anesthesia, and physician STAT.
 - ii. Attempt to maintain ventilation through ET with MRB using 100% oxygen.
 - iii. If patient decompensates despite attempts to ventilate through ET:
 1. Prepare for reintubation
 2. Consider obtaining ET tube exchanger (where available).
 3. Attempts to ventilate fail, remove ET tube and ventilate with MRB with mask using 100% oxygen.
 4. Insert oral pharyngeal airway if needed.
 5. Follow-up - obtain Arterial Blood Gases and pulse oximetry.

Documentation:

- Critical Care Flow Sheet, Code Blue form, and/or Progress Notes.
- Copies of code blue documentation form are sent to pharmacy and appropriate departments after completion.

EQUIPMENT:

HOSPITAL	DRH	SINAI-GRACE	HARPER	HUTZEL	HVSH	TOSH
Devices	HP CodeMaster XL	Physiocontrol Lifepak 9 & 12	HP CodeMaster XL	HP CodeMaster XL	HP CodeMaster XL	HP CodeMaster XL Lifepak
Crash Cart Availability	During transcutaneo us pacing (TCP),	Back up available on other Critical Care units.	During TCP contact 4 ICU and 9ICU for extra CodeMaster.	Back up CodeMaster available in ED	Back up available on unit.	Back up CodeMaster available in ED

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	contact another ICU for back up CodeMaster with pacing capability.		If in use or unavailable, call CPD and ask for Crash Cart back up with pacing capabilities.			
Progressive Level of Care		Progressive Level of Care Unit available				

APPENDIX
Appendix A-F

ADMINISTRATIVE RESPONSIBILITY

The Chief Nursing Officer/Senior Vice-President, Patient Care has overall authority and responsibility for the administration of all policies, procedures, and guidelines related to patient care.

Approval Signature

Iris Taylor, Ph.D., RN, Chief Nursing Officer

Date

REVIEW DATE:
03/31/2006

SUPERSEDES:
6/2001

References

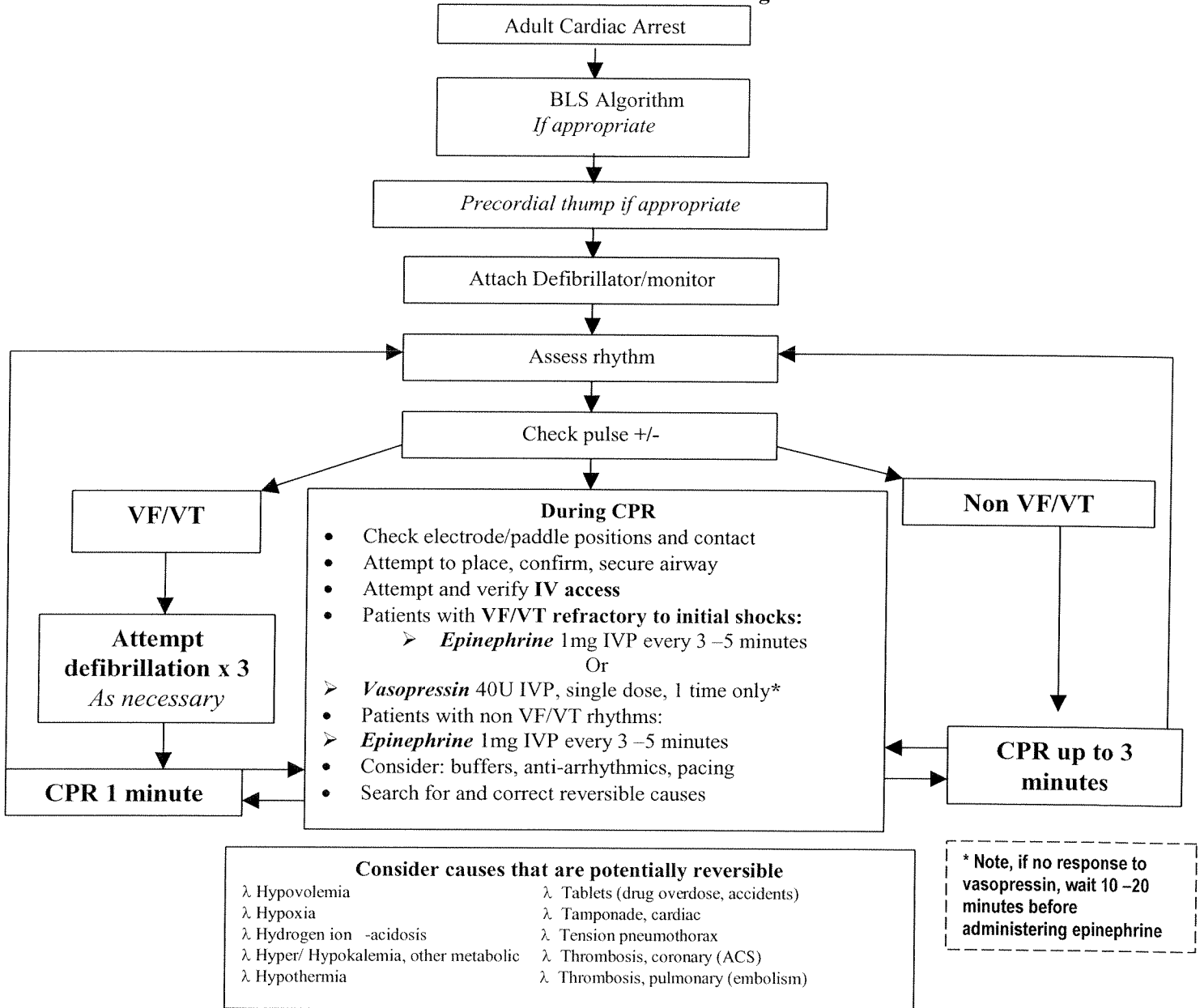
Lynn-McHale, D.J; Carlson, K.K. (2001). AACN Procedure Manual for Critical Care, 4th Ed. W.B. Saunders; Philadelphia, PA.

American Heart Association Advanced Cardiac Life Support, October 2000.
JAMA supplement.

See Appendix A through F
Algorithms courtesy of American Heart Association Advance Life Support Provider Manual 2000.

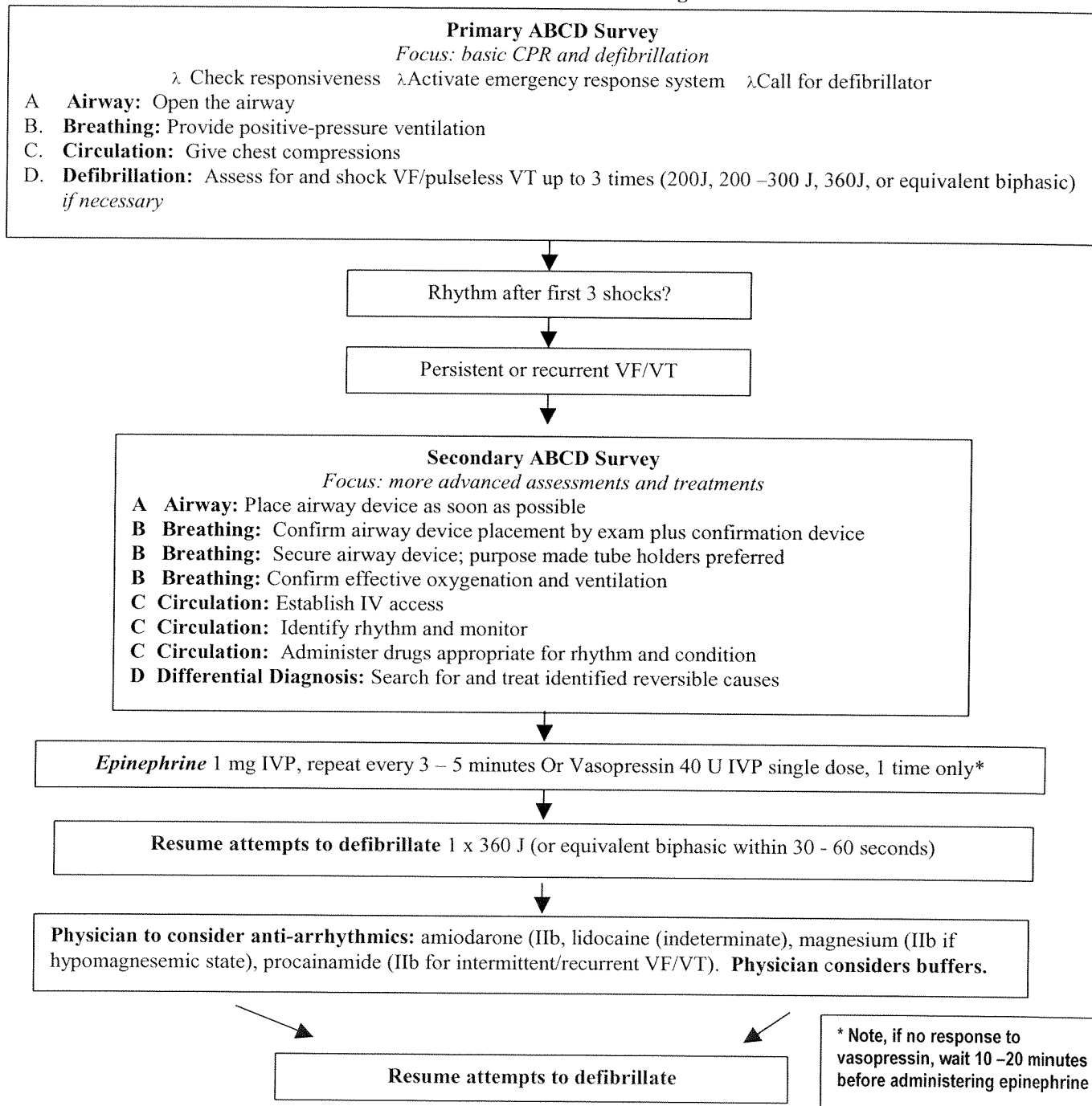
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Appendix A
ILCOR Universal/International ACLS Algorithm



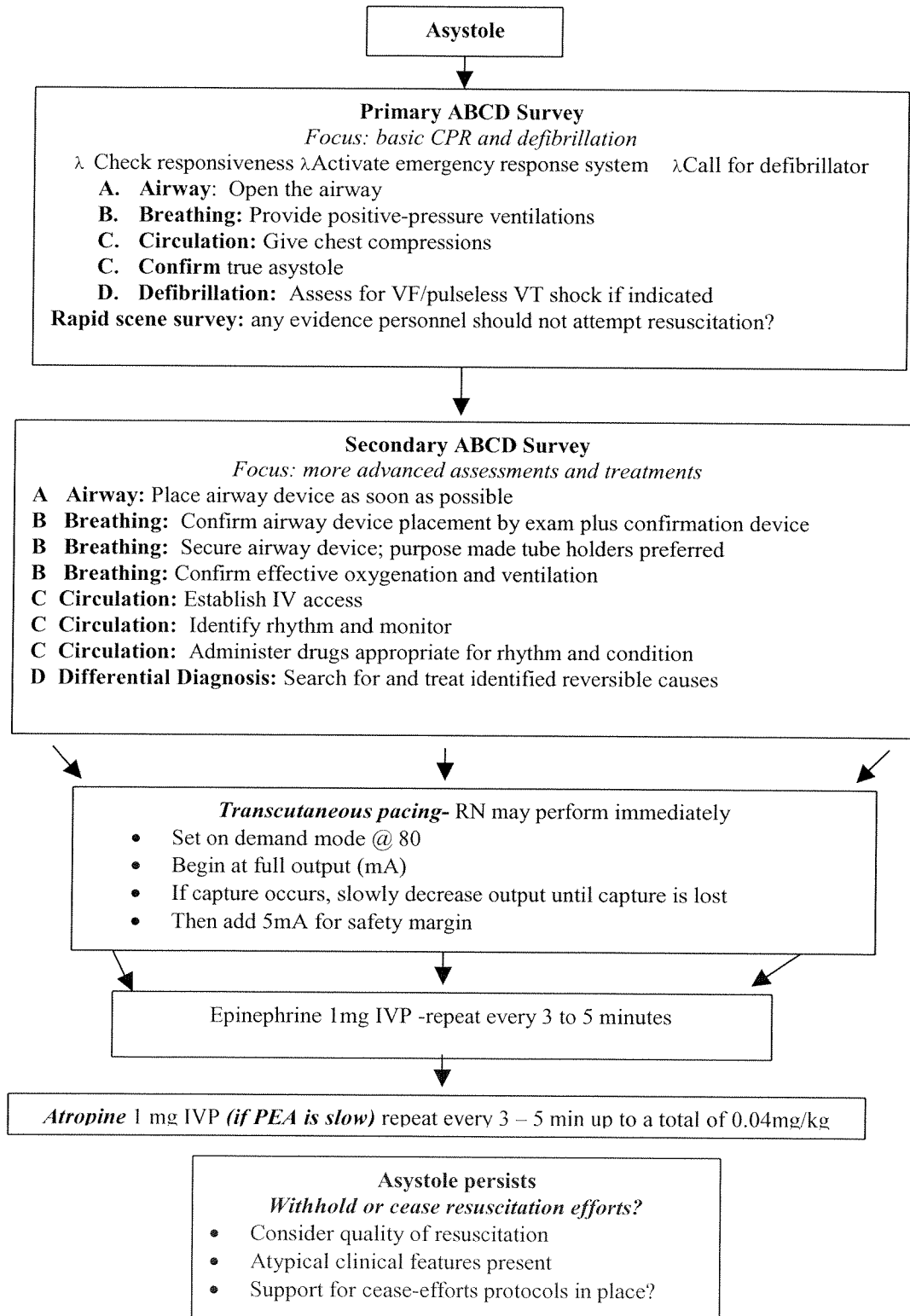
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Appendix B
Ventricular Fibrillation/Pulseless VT Algorithm



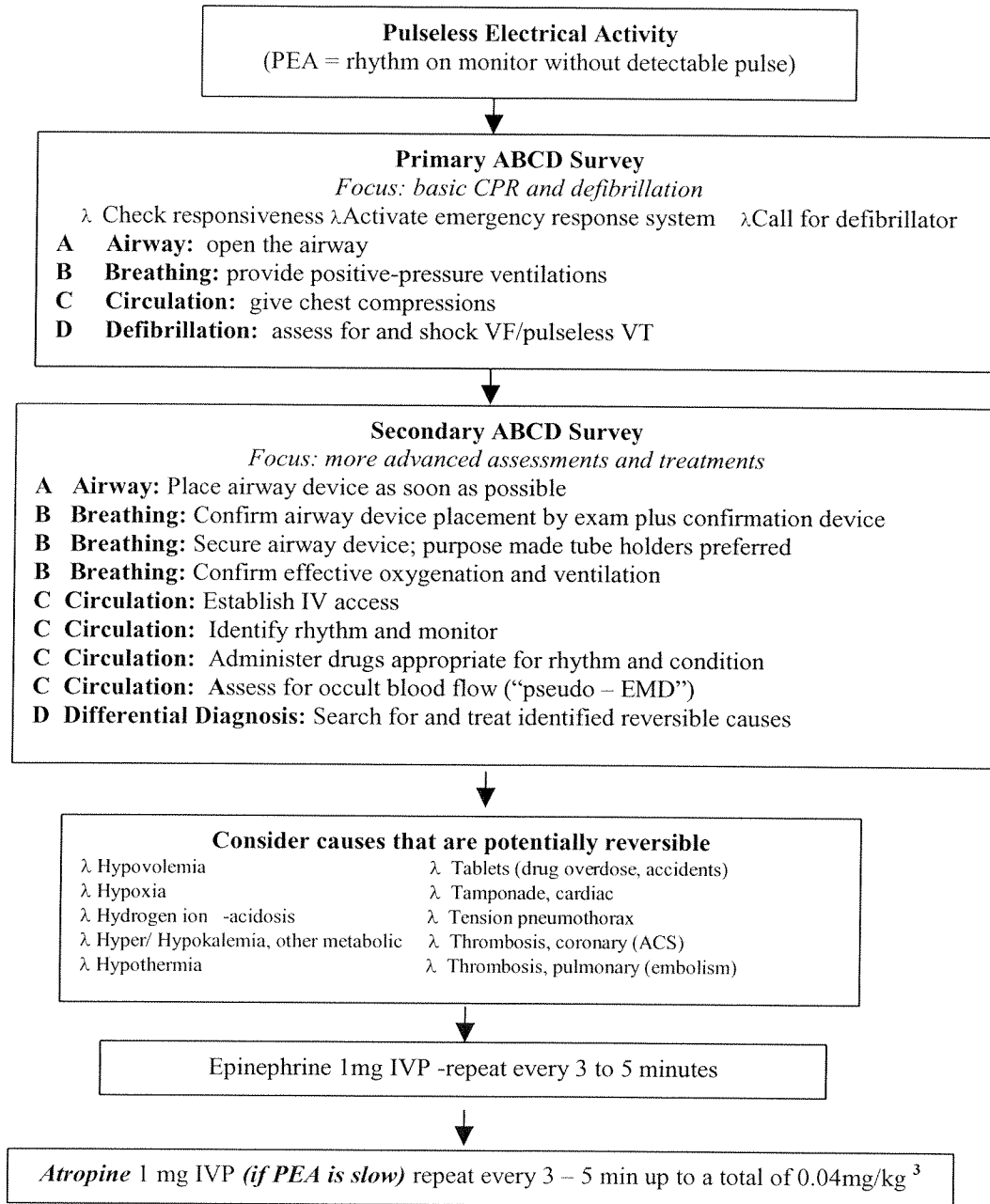
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Appendix C



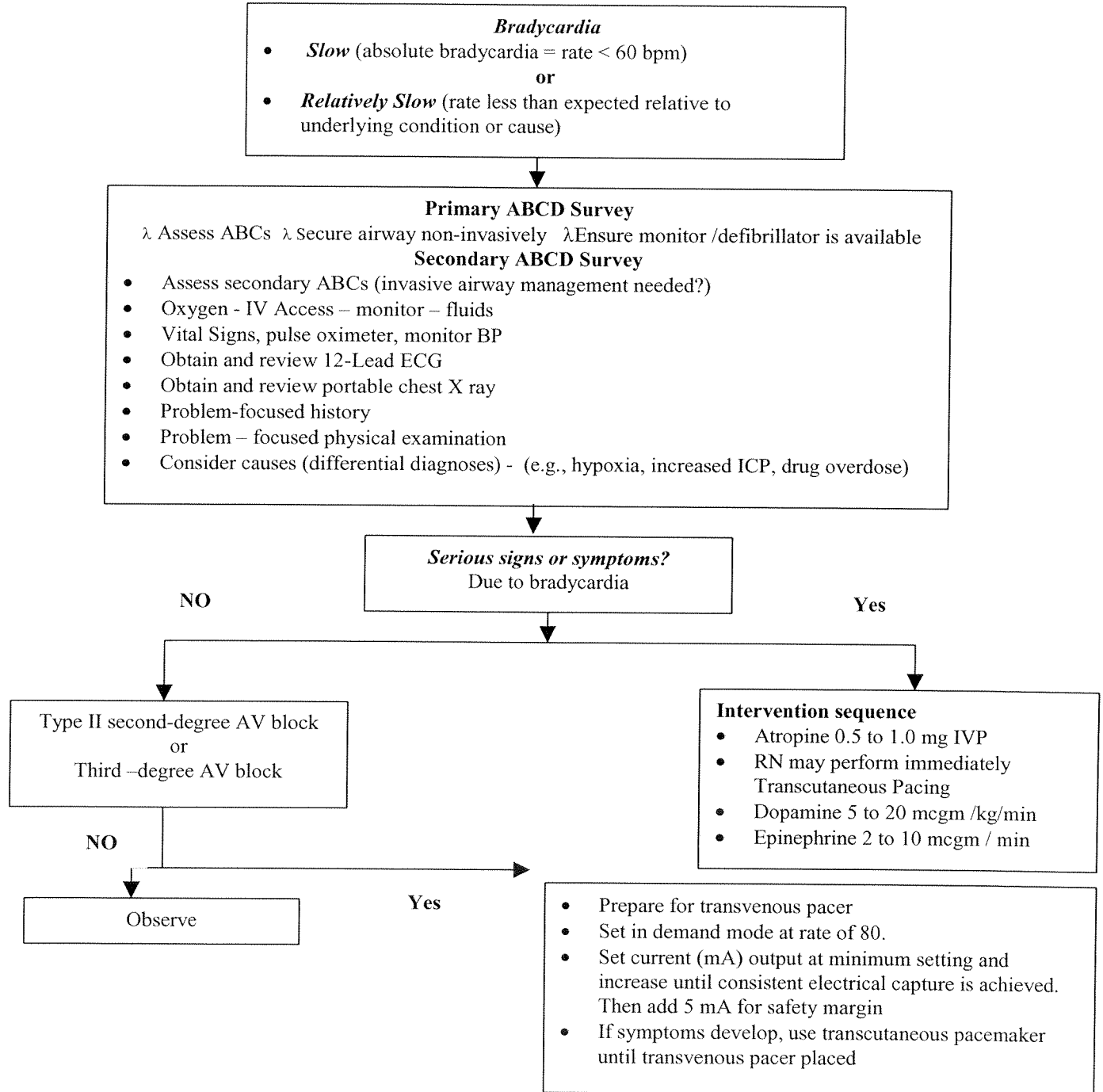
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Appendix D
Pulseless Electrical Activity Algorithm



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Appendix E
Bradycardia



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Appendix F
Unstable Ventricular Tachycardia Overview

UNSTABLE VENTRICULAR TACHYCARDIA

- Serious signs and symptoms:
 - ◆ Chest pain
 - ◆ Hypotension
 - ◆ Change in LOC
 - ◆ SOB
 - ◆ Symptoms of CHF
 - Establish that rapid heart rate is cause of symptoms
 - Rate related symptoms usually occur at rates > 150bpm
 - ***Immediately cardiovert @ 100J, 200J, 300J, 360J***
- Refer to policy CC 204 Cardioversion, Elective and Emergent**