# EMERGENCY MEDICAL RESPONSE  
**July 2018**

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INTRODUCTION
Although rare, reactions 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 (ambulance, police, fire, rescue, local emergency room, 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 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 Kit 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. A nurse will be assigned responsibility by the Nurse Manager to perform a monthly check to ensure that the kit is complete and fully stocked, and that the medication (naloxone) has not expired. 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, or may be coincidental (i.e., 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.**

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 (e.g., shock).
   - 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 medical treatment or activating EMS if symptoms are severe or progressing rapidly.**

**Minor Medical Incidents**

Most medical incidents encountered by staff are minor. These generally require only common sense and 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 to bleeding 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 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 NOT be allowed to leave unless** 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)**
  - If a generalized (tonic-clonic) seizure is suspected, in addition to EMS activation and basic life support, see Standing Order for Administration of Oxygen
  - **Activate EMS if:**
    - Person is pregnant;
    - Person is an infant or child;
    - Person has diabetes;
    - Person injures him/herself during the seizure;
    - Person is experiencing first seizure (or you think it might be first seizure);
    - Seizure lasts longer than 3 minutes;
    - Another seizure starts before the person regains consciousness; or
    - Person does not begin breathing again or does not return to consciousness after the seizure stops.

  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 safety, 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)**
  - If HYPOGLYCEMIA is suspected, assist the client in checking the blood sugar level (BSL), if a meter is available. Activate EMS for blood sugars <70 g/dl.
  - 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). Wait 15 minutes and check status. If symptoms have not improved, repeat the treatment.

- **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 ≤ 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.

Clients who recover from an emergency medical incident **SHOULD NOT be allowed to leave**, even if they appear stable, **until they have been assessed 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, eligible nurses may administer intramuscular diphenhydramine and/or intramuscular or subcutaneous 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. Provide initial treatment:
   - For severe symptoms (e.g., lip/facial/tongue swelling, difficulty swallowing and breathing, wheezing/cough, hypotension, dizziness) administer:
     1) 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). The adult dose is 0.5 mg/dose. There are NO contraindications to epinephrine with anaphylaxis. THEN,
     2) Diphenhydramine intramuscularly as 1.5 mg/kg body weight (up to a maximum 50 mg dose). The adult dose is 50 mg.
   - For moderate symptoms (e.g., urticaria/hives, general itching), administer:
     Diphenhydramine intramuscularly as:
     • 1.5 mg/kg body weight up to a maximum 50 mg dose. The adult dose is 50 mg.

4. Activate the emergency medical system.
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 1. (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.


[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.]

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**Quick Dosing Guides**

### First-Line Treatment Anaphylaxis: Epinephrine

<table>
<thead>
<tr>
<th>Age group</th>
<th>Range of weight (lb)</th>
<th>Range of weight (kg)*</th>
<th>Recommended dose</th>
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<tr>
<td>Infants and children</td>
<td>1-6 months</td>
<td>6-19 lb</td>
<td>3-8.5 kg</td>
</tr>
<tr>
<td></td>
<td>7-36 months</td>
<td>20-32 lb</td>
<td>9-14.5 kg</td>
</tr>
<tr>
<td></td>
<td>37-59 months</td>
<td>33-39 lb</td>
<td>15-17.5 kg</td>
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<tr>
<td></td>
<td>5-7 years</td>
<td>40-56 lb</td>
<td>18-25.5 kg</td>
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<tr>
<td></td>
<td>8-10 years</td>
<td>57-76 lb</td>
<td>26-34.5 kg</td>
</tr>
<tr>
<td>Teens and adults</td>
<td>11-12 years</td>
<td>77-99 lb</td>
<td>35-45 kg</td>
</tr>
<tr>
<td></td>
<td>13 years &amp; older</td>
<td>100+ lb</td>
<td>46+ kg</td>
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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.

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### Diphenhydramine

Commonly known as Benadryl

<table>
<thead>
<tr>
<th>Age group</th>
<th>Range of weight (lb)</th>
<th>Range of weight (kg)*</th>
<th>Injectable: 50 mg/mL (IV or IM)</th>
</tr>
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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.

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This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded or until July 1, 2019.

Signature of ordering provider(s)

PHD Medical Director ____________________ Date 06/15/18

NE Region Health Officer ____________________ Date 07/30/18

NW Region Health Officer ____________________ Date 06/15/18

SE Region Health Officer ____________________ Date 07/13/18

SW Region Health Officer ____________________ Date 07/05/18
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. 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:
   a. **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 form of naloxone 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) via one of the two intranasal forms 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). Safely restrain the patient and find 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 or until July 1, 2019.

Signature of ordering provider(s)

PHD Medical Director ___________________________ Date __06/15/18____

NE Region Health Officer ___________________________ Date __07/30/18____

NW Region Health Officer ___________________________ Date __06/15/18____

SE Region Health Officer ___________________________ Date __7/13/18____

SW Region Health Officer ___________________________ Date __7/10/18____
Standing Order for
Administration of Oxygen

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

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 may 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 or until July 1, 2019.

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<td>SW Region Health Officer</td>
<td>Date 07/05/18</td>
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NMDOH/PHD Emergency Medical Response Protocol
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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. Asthma may worsen with due to aspirin allergy

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 (81 mg) – four (4) children’s chewable ASA (aspirin) tablets by mouth - chew the tablets until they are dissolved (do not swallow whole)

This policy and procedure shall remain in effect for all staff covered by this standing order until rescinded or until July 1, 2019.

Signature of ordering provider(s)

PHD Medical Director _______________________________ Date _06/15/18_

NE Region Health Officer ___________________________________ Date _07/30/18_

NW Region Health Officer ___________________________________ Date _06/15/18_

SE Region Health Officer ___________________________________ Date _07/03/18_

SW Region Health Officer ___________________________________ Date _07/05/18_
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.
  ♦ Blood-borne Pathogen Exposure Event forms, if the incident involves a PHD employee exposed to potentially infectious materials (see PHD Infection Control for the Health Care Worker), AND entry in the local Sharps Injury Log.
  ♦ 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
  c. Neurologic deficits (weakness/paresthesia) in torso, legs, or arms not explained by peripheral nerve injuries
  d. Tenderness on palpitation of the cervical spine
  e. 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:

  ![POST-CPR RECOVERY POSITION](image)

  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
- 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 1mL 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)
- 4 unit dose children’s chewable ASA (aspirin) (81 mg/tab)
- Oxygen and regulator (to accompany Emergency Kit)

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 and mask

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)

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

<table>
<thead>
<tr>
<th>Year:</th>
<th>Expiration Date(s) or Check</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>J</td>
</tr>
</tbody>
</table>

#### Drugs & Drug Administration
- 2 x 1 mL vials or ampules epinephrine 1:1000 (340B – for use with clinic patients 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)
- 4 unit dose children’s chewable ASA (aspirin) (81 mg/tab)

#### 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 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 of emergency event) – 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__**

<table>
<thead>
<tr>
<th>Month</th>
<th>Medications and Supplies Within Date</th>
<th>Utilities Bag Present &amp; Stocked</th>
<th>Signature/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mar</td>
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<tr>
<td>Apr</td>
<td></td>
<td></td>
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<tr>
<td>May</td>
<td></td>
<td></td>
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<tr>
<td>Jun</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Jul</td>
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<td></td>
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<tr>
<td>Aug</td>
<td></td>
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<td></td>
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<tr>
<td>Sep</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Oct</td>
<td></td>
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<td></td>
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<tr>
<td>Nov</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Attachment G - PHD Event Record

**Name of Local Health Office**  
**Address**  
/  
/  

**Name of Patient**  
**Phone Number**  
**DOB**  
**Age**  

**Allergies:**  
[ ] or  
[ ] NKDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Action/Drugs/Oxygen</th>
<th>HR</th>
<th>BP</th>
<th>RR</th>
<th>Patient Condition</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>With Follow Up Care by:</th>
<th>When:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Transferred to:</th>
<th>When:</th>
</tr>
</thead>
</table>

| Via: | When: |

**Signature:**  
**Title:**  
**Date/Time:**
**Attachment H - Sample AED Usage Data Collection Form**
(Note: Use version in Regional AED Protocol, if available)

<table>
<thead>
<tr>
<th>Victim’s Name:</th>
<th>Date of Event:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AED Responders:</td>
<td>Time of Event:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Witnessed Event</td>
</tr>
<tr>
<td></td>
<td>Non-witnessed Event</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Residential</td>
<td>☐ Commercial</td>
</tr>
<tr>
<td>☐ Nursing Home</td>
<td>☐ Agricultural</td>
</tr>
<tr>
<td>☐ Mass gathering</td>
<td>☐ Recreation</td>
</tr>
</tbody>
</table>

**RESPONSE TIMES:**

<table>
<thead>
<tr>
<th>TIME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated Collapse/Arrest</td>
</tr>
<tr>
<td></td>
<td>1st CPR</td>
</tr>
<tr>
<td></td>
<td>AED Responder Scene Arrival</td>
</tr>
<tr>
<td></td>
<td>1st AED Defibrillation</td>
</tr>
<tr>
<td></td>
<td>EMS Scene Arrival</td>
</tr>
<tr>
<td></td>
<td>Transport from Scene</td>
</tr>
<tr>
<td></td>
<td>Arrival at hospital (if obtainable from receiving hospital)</td>
</tr>
</tbody>
</table>

Emergency Medical Response Plan Activated: ☐ Y / ☐ N

<table>
<thead>
<tr>
<th>Was pulse taken at initial assessment?</th>
<th>☐ Y / ☐ N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was CPR given before the AED arrival?</td>
<td>☐ Y / ☐ N</td>
</tr>
<tr>
<td></td>
<td>If Yes, name of CPR rescuer(s):</td>
</tr>
<tr>
<td>Were shocks administered by AED?</td>
<td>☐ Y / ☐ N</td>
</tr>
<tr>
<td>Did victim...</td>
<td>Total number of shocks?</td>
</tr>
<tr>
<td>Regain a pulse?</td>
<td>☐ Y / ☐ N</td>
</tr>
<tr>
<td></td>
<td>If Yes, pulse rate:</td>
</tr>
<tr>
<td>Resume breathing?</td>
<td>☐ Y / ☐ N</td>
</tr>
<tr>
<td>Regain consciousness?</td>
<td>☐ Y / ☐ N</td>
</tr>
</tbody>
</table>

Apparent cause of arrest:

<table>
<thead>
<tr>
<th>Estimated total time of event (time of collapse to transport time)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS Responding/Transporting Service(s):</td>
</tr>
<tr>
<td>Receiving Hospital Information</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Location (City/State):</td>
</tr>
<tr>
<td>Hospital Record Number:</td>
</tr>
<tr>
<td>On Admission:</td>
</tr>
<tr>
<td>Presenting Rhythm:</td>
</tr>
<tr>
<td>Vital Signs:</td>
</tr>
<tr>
<td>ER Disposition:</td>
</tr>
<tr>
<td>Discharge to Home</td>
</tr>
<tr>
<td>Hospital admission to (list Unit)</td>
</tr>
<tr>
<td>Transfer to:</td>
</tr>
<tr>
<td>Expired – Cause of death:</td>
</tr>
<tr>
<td>Diagnosed Cause of Arrest:</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Systolic Blood Pressure (mmHg)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>75-95</td>
</tr>
<tr>
<td>Infant (1-12 months)</td>
<td>80-100</td>
</tr>
<tr>
<td>Toddler (1-3 years)</td>
<td>80-110</td>
</tr>
<tr>
<td>Preschooler (3-5 years)</td>
<td>80-110</td>
</tr>
<tr>
<td>School age (6-12 years)</td>
<td>80-120</td>
</tr>
<tr>
<td>Adolescent (13-18 years)</td>
<td>110-120</td>
</tr>
<tr>
<td>Adults</td>
<td>100-120</td>
</tr>
</tbody>
</table>
Attachment J - Public Health Division Clinical Protocol/Manual Approval Sheet

Program/Bureau: Public Health Division

Clinical Protocol Title: Emergency Medical Response – 2018-2019

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

Name: ___________________ Date: / /

Name: ___________________ Date: / /

Name: ___________________ Date: 07/03/18

Approved by:

Program Manager: Not Applicable Date: / /

Bureau Chief: Not Applicable Date: / /

Bureau Medical Director: Not Applicable Date: / /

PHD Medical Director: ___________________ Date: 06/15/18

Regional Health Officer: ___________________ Date: 07/10/18

PHD Chief Nurse: ___________________ Date: 7/17/18

(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 – 2018-2019

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.