

Crashing Medical Patient - Pearls

General impression of crashing medical patient
New onset ALOC (motor GCS <6), airway issues, respiratory distress, signs of shock

Do not initiate movement of the patient
Consider calling for additional resources
Place NPA/OPA as indicated/tolerated
Apply monitors (including waveform capnography)

Assess respiratory status - Intervene ASAP, Goal SpO2 > 94%

Respiratory distress
Increased work of breathing
Inability to speak full sentences
Accessory muscle use
SpO2 <90 on room air

High flow oxygen by nonrebreather or CPAP
If asthma/wheezing/anaphylaxis/acute pulmonary edema - treat per appropriate AG

Respiratory failure
Poor respiratory effort
Unable to speak
Loss of muscle tone
Unable to sit up
SpO2 < 90 despite O2
Altered mental status
increasing EtCO2

Immediate PPV with BVM
2-person, elevate the head of bed, 100% O2
2 NPA +/- OPA

No Improvement or persistent hypoxia
Advanced airway measures
(SGA, ETI, surgical airway if unable to oxygenate / ventilate)

Assess circulatory status - Intervene ASAP, Goal SBP > 90 mmg Hg or initiation of vasopressors

BP <90 with signs of shock
OR hypoxia unresponsive to above airway interventions

Unstable bradycardia
Transcutaneous pacing

General medical /cardiogenic
Fluids per protocol

Unstable tachycardia
Cardioversion

Push dose epinephrine (14 years or older only) IV/IO
10-20 mcg boluses (1-2 mL) every 2 minutes
Preparation: mix 1 mL of 1 mg/10 mL (CARDIAC) epinephrine with 9 mL NS. This results in 10 mcg/mL concentration.
Titrate to effect, goal SBP 90 mmHg

Okay to initiate patient extrication and transport

Movement of the patient should be minimized until goals are met or treatment optimized
Trending vital signs is important - a single set does not verify stability
Patient movement increases risks of poor BVM