NURSE AND EMS WEEK

Nurse and EMS Week is a time to say “thank you” to our hospital and EMS partners who don’t hear it often enough. We are able to share our experiences and improve patient outcomes through our quality assurance process.

May is a great time to thank those we work with 24/365 and share how much we appreciate all they do. On a daily basis, we are caring for the health of patients who not only need and depend on us.

Thank you for ALL you do.

RURAL TRAUMA TEAM DEVELOPMENT COURSE

Tampa General Hospital Trauma team and Aeromed recently provided Winter Haven Hospital the Rural Trauma Team Development Course. This course developed by the American College of Surgeon’s Committee on Trauma teaches rural receiving facilities the fundamental elements of injury resuscitation. This course emphasizes a team approach to the initial evaluation and resuscitation of the trauma patient at a rural facility. With more than 60 percent of the country’s trauma deaths occurring in rural areas, the course assists health care professionals in determining the need to transfer the patient to a higher level of care. ("Rural Trauma Team Development Course," Key concepts of this course include organization of the trauma receiving area and utilization of available resources.

Naloxone

Scenario – you get called to a potential Drug OD. The patient is noted to be confused and not responsive to questions by you on arrival. They are noted to have pinpoint pupils with an empty used syringe nearby and a tourniquet wrapped around his left upper arm. Initial vital signs – HR 88, RR 18, BP 120/80, 98% on RA. You suspect an opiate overdose. Do you give Naloxone?

The answer is No. Not every patient who is suspected to have opiate ingestion needs Naloxone. Naloxone should be reserved for those patients who are hypo-ventilating (<10 breaths/min) and are starting to retain CO2. The patient in this scenario is maintaining his airway, has normal respirations with normal O2 saturation and thus needs to be monitored with the naloxone at standby for if/when the patient starts to develop hypoventilation and hypoxemia. So how much naloxone to give? Over time, the dose of naloxone has decreased. Localized protocols vary 0.4mg of naloxone, however, seems to be a good starting dose. Be aware that this dose may push patients into immediate withdrawal so smaller more frequent doses of 0.1mg may be adequate. However, in this era of fentanyl adulterated heroin or Car-fentanyl adulterated heroin, you may need more Naloxone and repeat dosing, so keep that in mind.

Remember, an opiate overdose isn’t an oxygenation problem; it’s a ventilation problem. Your goal for adequate dosing should be increased ventilation and improved end tidal CO2 measurement, and that’s it. Placing these patients on supplemental O2 without end-tidal CO2 is not best practice. Supplemental O2 will improve the O2 saturation. However, they may be retaining CO2, which would be missed without end-tidal CO2 monitoring.

What about the patient who was given 0.4 mg naloxone before arrival to the ED. He arrives on your EMS stretcher awake, alert and stating he wants to leave. What do you do? Naloxone’s half-life is about 30 minutes. Waiting at least 4 -5 half-lives ensures the naloxone is completely removed from the body.

If the patient continues to have normal VS and is AAOx3 after 2-3 hours, experts agree that they should be fine to be discharged. Remember, dose low, go slow, and don’t wake them up if you don’t need too. There is no standard/defined time to watch these patients, but experts state 2-3 hours is usually enough.

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