POLICY:
Patients will be assessed for current allergies and risk factors for allergic reactions and monitored for any reactions during the course of care.

Whenever possible, the patient should receive the first dose of an infusion medication in a controlled environment (e.g., hospital, ambulatory infusion center) with access to emergency medical equipment and medication.

CONSIDERATIONS:
1. Anaphylaxis is a severe allergic reaction that occurs rapidly and causes a potentially life threatening response.
2. Anaphylactic reactions generally occur within minutes of exposure but some reactions occur more than 30 minutes after exposure. Wait and observe patient for at least 30 minutes after parenteral drug administration.
3. Administer epinephrine hydrochloride cautiously to the elderly, pregnant, those with cardiovascular disease, hypertension, diabetes, hyperthyroidism and psychoneurosis. Epinephrine hydrochloride is contraindicated in narrow angle glaucoma, organic brain syndrome and cardiac insufficiency.
4. Advise patients with drug sensitivities to wear alert tags.
5. Advise patients with bee sting sensitivities to carry bee sting kits.

PREVENTION:
- Obtain a thorough allergy and drug history; note any cross-sensitivity
- Identify risk factors for anaphylaxis, including history of severe drug reactions and family history of same, and when administering blood/blood components and the first does of an infusion medication with a risk for severe allergic reactions/anaphylaxis
- Document allergy in the patient’s permanent medical record.

ASSESSMENT:
- Assess for changes in vital signs and for signs and symptoms of allergic reaction or anaphylaxis, including:
  - Neurological – dizziness, headache, weakness, syncope, seizures
  - Psychiatric – anxiety, feeling of impending doom
  - Respiratory – oropharyngeal or laryngeal edema, dyspnea, wheezing, bronchospasm, tachypnea, cyanosis, respiratory arrest
  - Cardiovascular – tachycardia, hypotension, arrhythmias, chest pain, infarction, or cardiac arrest
  - Cutaneous – flushing, erythema, pruritis, urticaria, angioedema
  - Gastrointestinal – nausea, vomiting, diarrhea, abdominal cramps.

EQUIPMENT:
- Gloves
- Alcohol swabs
- Epinephrine hydrochloride 1:1000
- Tuberculin syringes
- Blanket
- 500 ml bag 0.9% sodium chloride
- Administration set
- IV Benadryl: Adult – 50 mg
- IV push, children – 25 mg IV push
- Infant 12.5 mg IV push – all over 2-3 minutes

INTERVENTION:
1. Adhere to Standard Precautions.
2. Stop infusion immediately.
3. Discontinue any medication suspected of causing reaction.
4. Maintain vascular access for emergency supportive therapies.
5. Explain procedure to patient who may be conscious and very scared.
6. Quickly evaluate the patient and home situation. If required dial 911 to arrange for immediate emergency care and transportation.
7. Initiate basic life support as needed.
   - Call 911 (e.g., outpatient/physician office/home)
   - CPR
8. Notify licensed independent practitioner (IP) immediately.
9. Prepare 0.9% sodium chloride via administration set for immediate infusion.
10. Perform interventions and treatments as ordered.
    - Administer emergency medications such as epinephrine or steroids as ordered.
11. Monitor patient’s vital signs.
12. Administer epinephrine hydrochloride as directed (physician orders may vary slightly from suggested guidelines).
   a. Adults - 0.2-0.5 mL epinephrine hydrochloride 1:1000 subcutaneous or intramuscularly. Dose depends on size and musculature of patient. Safe dose is usually 0.3 or 0.4 mL.
   b. Children - Epinephrine hydrochloride 1:1000(1mg/1ml), 0.01 mL per kg of body weight subcutaneous (max 0.3 mg).
   c. Infants (birth to 10 kg/22 lbs.) - 0.01 mL epinephrine hydrochloride per kg of body weight. Usual range is 0.04 mL (4 kg/8.8 lb) to 0.1 mL (10 kg/22 lb.)
13. If patient does not require immediate emergency medical care and transportation to an emergency
facility, notify physician/patient's source of medical supervision and obtain further medical treatment orders.

14. Discard soiled supplies in appropriate containers.

AFTER CARE:

1. Document in patient's permanent medical record:
   a. Observations and patient assessment
   b. Licensed independent practitioner (LIP) notification
   c. Interventions taken and outcome
   d. Patient's condition and response to interventions

2. Complete an Unusual Occurrence or Sentinel Event Report according to organizational policy.

REFERENCES:

Purpose:
To recognize and treat autonomic dysreflexia.

Considerations:
1. Autonomic dysreflexia is a serious medical phenomenon that occurs in patients with a spinal cord injury with lesions above the area of the 6th thoracic segment (usually, loss of sensation below the nipple line or higher).

2. Pathology: A stimulus (i.e., distended bladder), initiates a reflex action of the sympathetic and parasympathetic systems that cannot be reversed by the action of vasomotor center because of the level of spinal cord lesion. Any ordinarily painful stimuli may trigger dysreflexia.

   a. Infection.
   b. Skin disorders: decubiti, cuts, bruises, ingrown toe nail, restrictive clothing.
   c. Bladder calculi, bladder infection, bladder distention, blocked catheter.
   d. Fecal impaction, bowel or anal manipulation such as rectal exams.
   e. Cystoscopy, catheterization.
   f. Menstrual cramps, in women.
   g. Skeletal fractures.

3. Precautionary Measures:
   a. Always be aware of the potential for autonomic dysreflexia in spinal cord injured patients at the T6 level of injury or above, including chronic patients.
   b. Reduce the possibilities of irritating stimuli (decubiti, plugged catheters, fecal impaction, hard stool in the anal sphincter, pressure from shoes and braces).
   c. Any newly admitted spinal cord injured patient should have blood pressure and pulse taken before and after first rectal exam to recognize this condition, if it exists.
   d. Any patient with plugged catheter, fecal impaction, etc., should have blood pressure and pulse taken before and after treatment.
   e. Any patient with hyperreflexia should have this noted on the front of the chart with a note stating, "Any rectal and/or urologic procedures may be accompanied by marked blood pressure rise."
   f. Diagnosis should always include location of spinal cord injury.
   g. Instruct the family in signs and symptoms and potential for occurrence.

4. Symptoms:
   a. Sweating of forehead and above level of injury.
   b. "Goose bumps" below level of injury.
   c. Pounding headache.
   d. Flushing.
   e. Anxiety.
   f. Nasal stuffiness.
   g. Paroxysmal hypertension as high as 300/160 mm Hg.
   h. Slow pulse (bradycardia).
   i. Nausea.

Equipment:
- Catheter supplies (if applicable)
- Gloves
- Personal Protective Equipment

Procedure:
1. Adhere to Standard Precautions.
2. Once the stimulus is identified, explain procedure to patient.
3. Place the patient in a sitting position.
4. Drain the bladder. Do not drain more than 600 mL at one time. If catheter is plugged, irrigate with no more than 30 mL of solution. If no results, replace the catheter.
5. If the marked elevated blood pressure does not decline within one minute, contact the physician. [Note: The "average" quadriplegic will have a blood pressure of 90/60 or lower in the sitting position.]
6. If the blood pressure declines after the bladder is emptied, continue to observe the patient closely, as the bladder can go into severe contractions, causing hypertension to recur.
7. Follow medical instruction and arrange for emergency transport, if indicated.
8. Discard soiled supplies in appropriate containers.

After Care:
1. Document in patient's record:
   a. Incident and vital signs.
   b. Treatment provided.
   d. Identity and location of emergency facility, if indicated.
   e. Condition of patient at time of transportation, if indicated.
PURPOSE:
To prevent infection or other complications from a human bite.

CONSIDERATIONS:
Human bites that break the skin may become seriously infected because the mouth is a source of bacteria.

EQUIPMENT:
Gloves – if available
Soap and water
Clean or sterile gauze
Tape

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Cleanse the wound with soap and cool water.
4. Control bleeding by direct pressure; elevate if possible.
5. Apply ice pack or ice wrapped in towel.
6. Cover with a non-medicated dressing.
7. Secure dressing with tape.
8. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Contact the physician to report the incident and obtain further orders.
2. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 2010
PURPOSE:
To prevent further damage and obtain medical treatment from animal bites and stings.

CONSIDERATIONS:
1. Infection, rabies and tetanus are all potential risks, depending on the animal involved.
2. A bite on the face or neck requires immediate medical attention.
3. For any signs of dizziness, fainting, shortness of breath, swelling of face, throat or tongue, and difficulty swallowing, 911 should be called.

EQUIPMENT:
Sterile or clean gauze
Tape
Soap and water
Gloves – if available

PROCEDURE:
(See Appendix for signs, symptoms and care of different bites and stings.)
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Hold wound under running water and wash thoroughly with soap. DO NOT use antiseptics.
4. Pat dry with gauze.
5. Cover with un-medicated dressing. Avoid movement of affected part. Control bleeding by direct pressure and elevate if possible.
6. Notify physician; transfer to emergency room if large or multiple areas involved (e.g., face, hands).
7. Call 911 if the patient has any signs of dizziness, fainting, shortness of breath, swelling of the face, throat, or tongue, or difficulty swallowing.
8. Call manager who will notify Department of Health. Be sure family understands importance of follow up with Health Department. (In some areas, incident is reportable to police, Public Health Department and Department of Agriculture.)
9. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Do not let anyone destroy or release the animal. Note color, kind of animal and other identifying information, especially name and address of animal’s owner.
2. Document in patient’s record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Notification of physician and Health Department.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 20
Emergencies – Blunt Trauma

Strength of Evidence Level: 3

PURPOSE:
Prevent further injury, swelling and pain from blunt trauma.

CONSIDERATIONS:
1. A hemophiliac or person on anticoagulant therapy who injures himself/herself should seek medical attention.
2. If trauma occurs to the eye area, the patient should see an eye specialist.

EQUIPMENT:
Cold compresses or ice pack
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Inspect affected body part for injuries, e.g., abrasions, cuts, fractures, dislocations, or swelling.
4. If extremity is affected, elevate above the level of the heart, if it does not cause more pain.
5. Apply cold compresses or ice pack for 30 minutes. Do not apply directly on skin.
6. If swelling or pain persists, reapply ice packs intermittently for comfort and refer to physician.
7. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Contact referring physician if other injuries are suspected or swelling continues to progress past one-half hour.
2. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 2010
PURPOSE:
To prevent further injury and promote healing of burned area.

CONSIDERATIONS:
1. Follow first aid instructions on the label of chemical container, if available.
2. In cases involving some powder or dry chemicals, it may not be appropriate to flush with water. If a dry chemical is involved, carefully brush the chemical off the skin with a gloved hand or a cloth, if possible, and check package or package insert for emergency information.
3. Water temperature should be cold to tepid. Washing should be done with gentle flow.

EQUIPMENT:
Water
Dry sterile dressing – clean if sterile is not available
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Chemical burns of skin:
   a. Wash away chemical with large amounts of water using a hose or shower, if possible, for at least 20 minutes.
   b. Remove victim's clothing from the involved area, but avoid spreading chemical to unaffected areas. Cover the burned area with clean, dry dressing.
   c. Refer to medical treatment.
4. Chemical burns of eye:
   a. Wash face, eyelid, and eye with large amounts of water for at least 20 minutes.
   b. Turn victim's head to the side, hold the eyelid open, pour water from the inner corner of the eye outward, making sure the chemical does not wash into the other eye.
   c. Cover affected eye with dry, sterile dressing and tape in place. DO NOT permit patient to rub his/her eyes.
   d. Refer to medical treatment.
5. Electrical Burns:
   a. Look for two burn sites – entry and exit. Tissues beneath may be severely damaged.
   b. Cover burn injuries with a dry, sterile or clean dressing. Give care to minimize shock.
   c. DO NOT cool burn(s) with water. Look for painful, swollen and deformed extremities.
   d. With burn victims of lightening, look and care for life-threatening conditions (i.e. respiratory or cardiac arrest). Victim may also have fractures, including spinal, so DO NOT move him or her.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Chemical which caused burn, if applicable.
   c. Treatment provided.
   e. Referral to medical care, if indicated.
2. Contact physician to report the incident and obtain further orders.

REFERENCES:
Lippincott Manual of Nursing Practice 9th edition 2010
PURPOSE:
To prevent further tissue damage and lessen pain from thermal burns.

CONSIDERATIONS:
1. DO NOT open blisters or remove burned tissue.
2. DO NOT apply antiseptic preparations, sprays, ointments or other home remedies to burns without a physician’s order.
3. Consider any second or third degree burn as serious and seek medical attention.
4. Second degree burns covering more than 15% of the body surface and those with third degree burns extending over more than 2% of their body surface will probably require hospitalization. Percentage of the body surface area involved can be roughly estimated using the "Rule of Nine." Head and neck = 9%, front of trunk = 18%, arm = 9%, leg = 18%, perineum = 1%.
5. Treat for shock as necessary.
6. Elevate burned feet or legs. Keep burned hands above heart level, if it does not increase pain.
7. If person has facial burns, sit or prop him up and observe for difficulty in breathing. Oxygen should be administered if it is available.
8. Soft tissue will continue to burn for minutes after source of heat has been removed. It is essential to cool any burned areas immediately with large amounts of cool water. DO NOT use ice or ice water on other than superficial burns. Ice or ice water can cause critical body heat loss and may also make the burn deeper.
9. If victim is conscious, not vomiting and medical help is more than one hour away, have him slowly sip one glass of water to which two pinches of salt and one pinch of baking soda have been added.

EQUIPMENT:
Cool water
Ice (only on superficial burns)
Dry sterile gauze or clean cloth
Blanket, sheet and towels
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. First-degree burn – Damage is limited to the epidermis, causing redness, discoloration, mild swelling or pain.
   a. Submerge the burned area in cold water for 2 to 10 minutes or apply ice. If pain is present, repeat up to 3 times.
   b. Blot dry gently with clean cloths or dry sterile gauze.
   c. Apply dry sterile gauze as a protective bandage, if needed.
4. Second-degree burn – The epidermis and part of the dermis is damaged producing redness, motting, blisters, pain, swelling, or wet appearance of skin.
   a. If skin is not broken, immerse in cool water for 2 to 10 minutes.
   b. Blot area dry gently and cover with dry sterile gauze or a clean cloth.
5. Third-degree burn – The entire epidermis and dermis is destroyed causing deep tissue destruction. The area is white or charred in appearance, no blisters and not painful.
   a. Protect burned area from the air with a thick, sterile, dry dressing or gauze or clean cloth.
   b. Immediately arrange for transportation to the hospital.
   c. Make no attempt to strip away clothing from charred areas.
   d. Apply cool pack to face, hands or feet after bandaging. DO NOT apply directly on skin.
6. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient’s record:
   a. Incident and degree of injury.
   b. Treatment provided.
2. Contact physician to report the incident and obtain further orders.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 2010
PURPOSE:
To provide immediate basic life support to the adult.
[Note: CPR Certification required.]

CONSIDERATIONS:
1. Possible indications for initiation of cardiopulmonary resuscitation (CPR) are drowning, suffocation, drug overdose, trauma, electrocution, heart attack, cardiac arrest and stroke.
2. The American Heart Association (AHA) believes a patient who is seen to collapse has probably suffered a cardiac event. The rescuer should shout to rally help from bystanders, phone to activate the emergency response system, and return to provide CPR.
3. If the patient is found unresponsive after an un-witnessed event, the lone healthcare provider should shout to alert bystanders and give five cycles of CPR prior to activating the Emergency Response System. The rescuer should then return to perform CPR.
4. CPR is stopped only when:
   a. Spontaneous return of pulse and respirations occurs.
   b. Another trained individual takes over.
   c. Physician assumes responsibility.
   d. Rescuer is exhausted and unable to continue resuscitation.
5. While performing CPR, utilize a one-way valve mask, e.g., Laerdal Pocket-Mask, if available.
6. An adult is identified as anyone who has reached puberty. This is indicated by breast development in females and growth of underarm hair in males.

EQUIPMENT:
One-way valve mask, if available
Gloves, if available
Personal protective equipment, if available

PROCEDURE:
Resuscitation (CPR) Adult
1. One rescuer CPR:
   a. Establish unresponsiveness by gently shaking the victim and asking, "Are you okay?" Avoid excessive shaking that may cause further damage to already present injuries. Check for breathing by leaning over the victim. Rescuer places his/her ear over victim’s nose and mouth looking toward victim’s chest for 5 to 10 seconds.
   b. Call for help. If help is unavailable, call 911 and get AED.
   c. Log roll victim into proper positioning for initiation of CPR.
   d. Check for presence of pulse by feeling for the carotid pulse on the side nearest rescuer. Take 5 to 10 seconds to feel for presence of pulse.
   [Note: If pulse is present, continue rescue breathing every 5 to 6 seconds until spontaneous breathing returns. Notify Emergency Medical System (EMS)/911.]
   e. If no pulse present, begin chest compressions. The AHA recommends a compression-to-ventilation ratio of 30:2 for all single rescuers to use for all victims from infants to adults. For effective chest compressions, the resusciter must have proper hand positioning.
      1. Place heel of hand on lower half of the sternum.
      2. Place other hand on top of the positioned hand. Interlock fingers.
      3. Lock elbows, lean over the victim with your shoulders directly over your hands and sternum of the victim.
      4. Using the weight of our upper body, depress the sternum 2 inches at a rate of 100 times per minutes.
      5. After each compression, relax the pressure completely and allow the chest to return to its normal position. This should be done without pausing. Never lift your hands off the chest or change their position as you may lose correct hand positioning, resulting in ineffective chest compressions.
      6. Perform 30 compressions in 18 seconds or less.
   f. Open the airway by tilting head and lifting chin.
      1. Place one hand on the victim’s forehead and apply firm, backward pressure with the palm.
      2. Place the tips of the fingers of the other hand under the lower jaw on the bony part near the chin, bringing the chin forward and tilting the head back.
      [Note: If case of neck injury, do not hyperextend the head by lifting the neck. Lift the jaw by grasping the angles of the mandible and lifting the jaw with both hands, one on each side, slightly tilt the head.]
      3. Ventilate victim by pinching nostrils closed. Make a seal over the patient’s mouth with your own. Give two full breaths. Each rescue breath should be given over 1 second. Each rescue breath should make the chest rise. Allow lungs to deflate between ventilations. All rescuers should take a normal breath (not a deep breath) before giving mouth-to-mouth or mouth-to-barrier device rescue breaths.
      [Note: If victim has tracheostomy, seal victim’s mouth and nose and blow into the tracheostomy to inflate lungs. When 2 rescuers, no longer are cycles used. Breaths are every 6-8 seconds,
compressions are 100 per minutes without pausing for ventilations.]
g. Repeat this cycle five times (approximately 2 minutes).
h. Check for a carotid pulse.
i. If breathing and pulse are still absent, resume single rescuer CPR of 30 compressions, alternating with two ventilations.
   [Note: Stop and check for return of spontaneous breathing and pulse every 4 to 5 minutes.]
j. If a second person trained in CPR becomes available for CPR, that person can relieve the first rescuer.
   (1) Second rescuer assumes position for compressions.
   (2) Initial rescuer moves to the head and opens airway and checks carotid pulse.

2. Two rescuer CPR
   a. Second rescuer identifies him/herself as, “I know CPR. Have you called for help?” If first rescuer has not called for help, second rescuer will activate the EMS.
   b. Second rescuer positions him/herself on opposite side of victim as first rescuer and begins compressions.
   c. When more than one rescuer is present, rescuers should change “compressor” roles approximately every 2 minutes or five cycles of CPR (one cycle of CPR = 30 compressions and two rescue breaths).
   d. Rescuers should try to complete the switch in 5 seconds or less.

3. Use of AED/Automated External Defibrillator
   a. Place AED near head of patient and turn it on.
   [Note: The American Heart Association does not recommend for or against the use of an AED on infants.]
   b. Peel off pads and place on patient using the diagram – one on right upper chest and one on left lower chest below arm pit.
   c. Connect pads to AED and follow the directions given. [Note: Continue CPR until pads are attached and connected to AED.]
   d. Pause CPR to allow AED to analyze the heart rate with no one touching the patient.
   e. When AED voice says “Shock Advised,” shout “Clear” being sure no one touches the patient and press the shock button.
   f. Resume CPR starting with compressions when advised by AED.
   g. When the team of First Aid arrives, disconnect the pads from the AED and allow team to care for patient.

Key Points before applying AED:
1. Dry patient quickly if wet.
2. Remove medication patch if present and dry area.
3. If jewelry on chest, remove quickly.

4. Shave area where pads are to be placed as needed when razor is available.

4. Airway Obstruction in Adults
   a. Ask person, “Are you choking?”
   b. Call for help and have someone call 911.
   c. Step behind person putting your leg between theirs for support.
   d. Encircle person with your arms, locating the umbilicus and bottom of breast bone/sternum, then place one hand in a fist in between with thumb knuckle against the space and place other hand over first hand.
   e. Perform Heimlich maneuver with upward thrust of hands until obstruction is expelled or person becomes unconscious.
   1. If person becomes unconscious, slide person to floor on back protecting the head.
   2. Perform CPR with one exception:
      Open mouth to look for obstruction and sweep mouth only if visible. [Note: No blind finger sweep to be done on anyone.]

AFTER CARE:
1. Document in patient’s record:
   a. Incident, including date and time.
   b. Treatment provided, including duration.
   d. Notification of emergency medical personnel and physician.

REFERENCES:
American Heart Association
PURPOSE:
To provide immediate basic life support to infant or child. [Note: CPR Certification required.]

CONSIDERATIONS:
1. Possible indications for initiation of CPR are drowning, suffocation, drug overdose, trauma, electrocution and stroke.
2. The American Heart Association (AHA) believes a patient of any age who is seen to collapse has probably suffered a cardiac event. The rescuer should shout to rally help from bystanders, phone to activate the emergency response system, and return to provide CPR.
3. For any child not seen to collapse, the healthcare provider should shout to summons help, give five cycles of CPR and then call to activate Emergency Medical System (EMS).
4. Artificial ventilation frequently causes gastric distention in the infant or child. The incidence of gastric distention can be minimized by limiting ventilation volume to the point that the chest rises. Attempts to relieve gastric distention should be avoided because of the danger of aspiration.
5. Hyper-extending the neck when opening the infant’s airway can cause obstruction of the airway.
6. Accuracy of the finger position for external cardiac compressions will avoid damage to internal organs.
7. CPR is stopped only when:
   a. Spontaneous return of pulse and respirations occurs.
   b. Another trained individual takes over.
   c. Physician assumes responsibility.
   d. Rescuer is exhausted and unable to continue resuscitation.

EQUIPMENT:
One-way valve mask
Gloves, if available
Personal Protective Equipment

PROCEDURE:
1. One rescuer CPR of the infant (up to 1 year of age):
   a. Establish unresponsiveness
      (1) Observe for movement.
      (2) Turn on back and place on hard surface.
      (3) Tap feet or gently shake shoulders and shout.
      (4) If not responsive, shout for help.
   b. Establish breathlessness or gasping up to 10 seconds.
   c. Circulation
      (1) Feel for brachial pulse for 5 to 10 seconds.
      (2) If there is a pulse, continue rescue breathing one breath every 3 to 5 seconds. Notify EMS.
      (3) If no pulse, assume the position for chest compressions. Draw an imaginary line between nipples. One finger breadth below imaginary line, place two to three fingers on sternum. Fingers must be parallel to sternum.
      (4) Compress sternum to depth of one-third the depth of the chest at a rate of at least 100 compressions per minute. Each cycle delivered in 18 seconds or less. 30 compressions to 2 breaths=cycle.
   d. Open the airway
      (1) Use chin-lift maneuver to open airway.
      (2) DO NOT hyper-extend neck.
   e. Breathing
      (1) Seal mouth and nose of infant or child with rescuer's mouth.
      (2) Give two small puffs of air at 1 to 1.5 seconds per inflation.
      (3) Observe chest rise with inflation and allow for chest deflation after each breath.
      (4) If the chest does not rise and no air enters, reposition the head in an attempt to open the airway. If this does not work after several attempts, consider foreign body airway obstruction.
   f. If a second rescuer becomes available, the technique is changed to the “two thumb-encircling hands” method. One rescuer will maintain the airway. The second rescuer will find the landmark on the sternum in the standard way. Then, compressions will be given with both thumbs together as the fingers encircle the chest and support the infants back. You will now give 15 compressions and then 2 breaths. [Note: If an infant or child is unresponsive with a pulse rate less than 60 beats per minute, the healthcare provider should provide chest compressions in the manner described above.]
      (5) Give two puffs of air after every 30 compressions (except on newborns).
      (6) If a second rescuer becomes available, the technique is changed to the “two thumb-encircling hands” method. One rescuer will maintain the airway. The second rescuer will find the landmark on the sternum in the standard way. Then, compressions will be given with both thumbs together as the fingers encircle the chest and support the infants back. You will now give 15 compressions and then one breath. [Note: If an infant or child is unresponsive with a pulse rate less than 60 beats per minute, the healthcare provider should provide chest compressions in the manner described above.]
g. Continue CPR for 2 minutes and then if no one has called 911, do so now.
   (1) Maintain open airway and check for pulse.
   (2) If victim still has no pulse, continue CPR beginning with 30 compressions.
   (3) If pulse returns without breathing, continue rescue breathing every 3 to 5 seconds.
   (4) Reassess every few minutes.

2. One rescuer CPR of the child:
   A child is considered to be greater than 1 year in age but not yet to the onset of puberty. The visual cues of an adult are: breast development in females and growth of under-arm hair in males
   a. Establish unresponsiveness
      (1) Tap or gently shake shoulder and shout.
      (2) Shout “Are you okay?”
      (3) If not responsive, shout for help.
   b. Establish breathlessness, gasping for no more than 10 seconds.
   c. Circulation
      (1) Feel carotid pulse closest to rescuer for 5 to 10 seconds.
      (2) If there is a pulse, continue rescue breathing one breath every 3 to 5 seconds. Notify EMS.
      (3) If no pulse, assume the position for chest compressions. Kneel by victim's shoulder. Rescuers should use the heel of one or two hands to compress the lower half of the sternum to a depth of one-third of the chest diameter. If two hands are used, hand placement is the same as that used for compression of adult victims.
      (4) Apply chest compressions at a rate of 100 compressions per minute. 30 to 2 breaths.
   d. Breathing
      (1) Seal mouth with rescuer's mouth and use fingers to pinch nose.
      (2) Give two slow breaths at 1 second per inflation.
      (3) Observe chest rise with inflation and allow for chest deflation after each breath. If the chest does not rise and air does not enter, reposition the head in an attempt to open the airway. If this is unsuccessful after several attempts, consider foreign body airway obstruction.
      (4) Give two breaths after every 30 compressions.
      [Note: If a second rescuer becomes available, the technique remains the same. The compression-to-ventilation ratio becomes 15:2.]
   f. Continue CPR for 2 minutes. If no one has called 911, do so now.
      (1) Maintain open airway and check for pulse.
      (2) If victim still has no pulse, continue CPR beginning with two full breaths followed by 30 compressions.
      (3) If pulse returns without breathing, continue rescue breathing every 3 seconds.
      (4) Reassess every few minutes.

3. Airway obstruction in child
   a. Ask child, “Are you choking?”
   b. Call for help and have someone call 911.
   c. Step behind child and bend down on one knee having child straddle the other knee.
   d. Perform Heimlich maneuver by encircling child with your arms, locating the umbilicus and the bottom of the breastbone/sternum. Place one hand with thumb in a fist against the space inbetween and place other hand over first hand with upward thrust of hands until obstruction is expelled or child becomes unconscious.
      (1.) If child becomes unconscious, slide child to floor on back protecting the head.
      (2.) Perform CPR with one exception: open mouth to look for obstruction and sweep mouth only if visible. [Note: No blind finger sweep.]

4. Airway obstruction in infant
   a. Observe for signs of poor perfusion or attempts to breathe.
   b. Call for help, have someone call 911.
   c. Place infant over one arm facing down supporting the head with the head lower than the hips. [Note: Gravity may assist in dislodging obstruction.]
   d. Perform back blows at the shoulder blades, harder than that of a burp, for five times.
   e. Place hand over infant supporting the head switch/flip infant to that arm facing up with head lower than hips.
   f. Perform chest thrusts with 2 fingers on sternum and parallel to it at the nipple line for five times.
   g. Repeat until obstruction is expelled or infant becomes unconscious.
      (1) If infant becomes unconscious place infant on a hard surface.
      (2) Perform CPR with one exception: open mouth to look for obstruction and sweep mouth only if visible. [Note: No blind finger sweep.]

AFTER CARE:
1. Document in patient's record:
   a. Incident, including date and time.
   b. Treatment provided, including duration.
   d. Notification of emergency medical personnel and physician
**PURPOSE:**
To provide prompt treatment to prevent hemorrhage, relieve shock, prevent infection and avoid potential for tetanus.

**CONSIDERATIONS:**
1. Wounds may vary from minor lacerations to severe injuries.
2. Seek medical help for:
   a. Gaping wounds.
   b. Wounds with extensive tissue damage.
   c. Puncture wounds.
   d. Wounds that continue to bleed.
3. An objective of bandaging is mobilization. The stability of the wound helps natural clotting mechanisms as well as reduces patient discomfort.

**EQUIPMENT:**
- Sterile gauze or clean cloth
- Tape
- Blanket
- Gloves, if available
- Antibiotic ointment or cream

**PROCEDURE:**
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Wash wound with clean running water for 5 minutes or longer. Wash the wound or abrasion until there is no sign of foreign matter. If running water is not available, you can use any source of clean water.
4. Apply sterile dressing. Use pressure if bleeding is uncontrolled by placing the palm of your hand on the dressing directly over the entire area of the wound. Reinforce dressing with additional layers of gauze or cloth, continuing direct hand pressure. [Note: Do not disturb blood clots formed on dressing. If the wound is an abrasion or is superficial, the first aid provider can apply an antibiotic ointment or cream.]
5. Apply pressure bandage.
6. Elevate affected extremity above the level of the heart.
7. If direct pressure and elevation of the part do not stop the bleeding, pressure should also be applied to the artery supplying blood to the area, e.g., femoral or brachial.
8. Treat for shock. Keep victim lying down and keep warm. Cover with blanket and slightly elevate the legs if possible.
9. Discard soiled supplies in appropriate containers.

**AFTER CARE:**
1. Document in patient's record:
   a. Incident and degree of injury and wound location and size.
   b. Treatment provided.
2. Check when patient last received tetanus and diphtheria (Td) or tetanus immunization.
3. Contact physician to report incident and obtain further orders.

**REFERENCE:**
Lippincott Manual of Nursing Practice 9th edition 2010
Emergencies – Cuts and Punctures of Eye or Eyelid

Strength of Evidence Level: 3

PURPOSE:
To provide prompt attention to prevent further injury and development of infection.

CONSIDERATIONS:
1. Avoid touching the eye. Use very light pressure while applying dressing to prevent further injury.
2. Penetrating (puncture) injuries of the eye are extremely serious and can result in blindness.

EQUIPMENT:
Sterile water or tepid water
Sterile gauze or clean dressing
Tape
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient. With loss of eyesight or bandaging both eyes, the patient can become anxious.
3. If contacts are observed and patient is able, contacts should be removed.
4. Puncture of eye:
   a. Make no attempt to remove object or wash the eyes.
   b. Cover both eyes loosely with sterile or clean dressing secured with tape. Avoid pressure on the eyes. Coverage of both eyes is necessary to prevent movement of affected eye.
   c. Keep victim quiet and lying on his/her back.
   d. Arrange immediate transfer to emergency treatment center.
5. Injury of eyelid:
   a. Stop hemorrhaging by gently applying direct pressure.
   b. Gently rinse wound with sterile water (if available) or tepid tap water, and apply sterile or clean dressing. Tape dressing in place or hold snugly by bandage that encircles the head. Seek medical care immediately.
   c. Bruises above and below the eye should be treated by immediate cold applications to lessen bleeding and swelling.
   d. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Whether or not contacts were in place.
2. Contact physician to report incident and obtain further orders.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 2010
Emergencies – Discharge from Ears

Strength of Evidence Level: 3

PURPOSE:
To assess cause of discharge from ears for proper treatment and prevention of further injury.

CONSIDERATIONS:
1. Discharge from ears may be a result of perforation of the tympanic membrane due to:
   a. Otitis media: may be purulent, bloody or blood tinged.
   b. Skull fracture: may be clear or blood tinged.
   c. Other trauma: may be clear or blood tinged.
2. DO NOT allow victim to hit himself/herself on the side of his/her head in an effort to restore hearing.
3. DO NOT insert instruments or any kind of liquid into the ear canal.

EQUIPMENT:
Gloves – if available
Gauze or cotton

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Obtain history and assess victim for cause of discharge. Skull fracture may be indicated by loss of consciousness, headache, nausea, vomiting and obvious deformity from skull depression.
4. Discharge caused by rupture of eardrum:
   a. Place small pledget of gauze or cotton loosely in the outer ear canal for protection.
   b. Obtain medical care.
5. Discharge caused by skull fracture:
   a. DO NOT clean the ear.
   b. DO NOT stop the flow of cerebrospinal fluid from the ear.
   c. Turn victim on his/her side with affected ear down (unless contraindicated, i.e., spinal cord injury), with head and shoulders propped up on a small pillow to allow fluid to drain away.
   d. Obtain medical care.
6. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Incident, type and amount of discharge.
   b. Treatment provided.
2. Contact physician to report incident and obtain further orders.

REFERENCE:
Lippincott Manual of Nursing Practice 9th edition 2010
PURPOSE:
To prevent further injury from drug overdose by obtaining prompt medical assistance.

CONSIDERATIONS:
1. Depending on the drug, the patient may have respiratory depression, cold and clammy skin, lethargy, dilated or constricted pupils, weak and rapid pulse, decreased or increased tendon reflexes, coma, agitation, arrhythmias or hallucinations.
2. Some types of overdose stimulate the central nervous system and can cause tinnitus, vomiting, hyperventilation, fever and hyperactivity. Severe cases may cause convulsions, dehydration, decreased sensorium, respiratory failure and cardiovascular collapse.

EQUIPMENT:
None

PROCEDURE:
1. Adhere to Standard Precautions.
2. Assess patient's general condition and treat the patient for respiratory distress.
3. Obtain medical assistance.
4. Note patient's age and estimated weight.
5. Ask the patient or caregiver what medication, amount and dosage ingested.
6. If you don't know what substance was ingested, look for burns in and around the mouth, smell the breath for any unusual odors and examine hands and clothing for stains or residue. If there is vomit, place some in clean plastic container for analysis by hospital lab.
7. If patient cannot immediately be transported to emergency room, call Poison Control Center for further information for care at 1-800-222-1222.

AFTER CARE:
1. Send the suspected drug medication container with the patient, if available.
2. Record and send with patient:
   a. Patient's age and estimated weight.
   b. Suspected drug information.
   c. Treatment provided.
   e. Document the above information in patient's record.
Emergencies – Fainting

Strength of Evidence Level: 3

PURPOSE:
To prevent injury and aspiration from fainting.

CONSIDERATIONS:
1. An unconscious person should not be given anything orally.
2. Fainting is usually accompanied by pallor, diaphoresis, coldness of skin, dizziness, numbness and tingling of hands and feet, nausea and possible visual disturbance.
3. Patient should be observed carefully after fainting, as this might be a symptom of a serious condition.

EQUIPMENT:
Washcloth
Gauze, tissues or handkerchief

PROCEDURE:
1. Adhere to Standard Precautions.
2. If patient feels weak or dizzy, assist to lying position or lower head to knee level.
3. Loosen tight clothing.
4. If patient vomits, roll to side or turn head to the side, wiping vomit from mouth.
5. Maintain an open airway by tilting the patient's head back. If neck injury is suspected, use jaw thrust method of opening the airway.
6. Examine the patient to determine if any other injury was sustained from falling.
7. Keep patient warm.

AFTER CARE:
1. Document in patient's record:
   a. Incident and any injury.
   b. Treatment provided.
2. Contact physician to report incident and obtain further orders.

REFERENCE:
Illinois Emergency Medical Services Manual for Children
PURPOSE:
To expel food or foreign objects lodged in the throat, blocking the airway.

CONSIDERATIONS:
1. Patient education of common causes of airway obstruction and precautions to avoid airway obstruction is very important.
   a. Take small pieces of food, chew slowly and thoroughly.
   b. Avoid laughing and talking during meals.
   c. Avoid excessive alcohol intake before and during meals.
   d. Instruct children to avoid walking, running, or playing with food or small objects in their mouths.
   e. Keep small objects (beads, marbles, etc.) away from infants and small children.
2. Early recognition of airway obstruction is important for successful management.
   a. Partial airway obstruction with good air exchange.
      (1) Symptoms: Forceful cough and good air exchange.
      (2) Treatment: Encourage victim to continue coughing and breathing efforts. Do not interfere with victim's efforts to expel the obstruction at this time.
   b. Partial airway obstruction with poor air exchange.
      (1) Symptoms: Weak, ineffective, high-pitched noises while inhaling, increased respiratory difficulty, possible cyanosis of mucous membranes and nailbeds.
      (2) Treatment: Manage as obstructed airway.
   c. Complete airway obstruction.
      (1) Symptoms: Victim unable to speak, breathe or cough; may clutch his/her neck (universal distress signal).
      (2) Treatment: Immediate effort to relieve obstruction is necessary as no air exchange can occur. Victim will lapse into unconsciousness and death will follow.
3. Attempt to calm victim by identifying yourself as knowledgeable in management of airway obstruction, reassuring victim you will assist him/her.
4. Two maneuvers for relieving airway obstruction are manual thrusts and finger sweep.

EQUIPMENT:
Personal Protective Equipment

PROCEDURE:
Adhere to Standard Precautions.

Victim Standing or Sitting
1. Identify airway obstruction by asking victim, “Are you choking?” If person is coughing weakly or making high-pitched noises or is not able to speak, breathe or cough forcefully, tell the victim that you are trained in first aid and offer to help.
2. If you are alone shout for help. If there is a bystander, have that person phone the Emergency Medical System (EMS).
3. Do abdominal thrusts as follows:
   a. Stand behind victim, wrapping arms around his/her waist.
   b. Grasp one fist with your other hand, placing thumb side of fist against victim's abdomen between waist and rib cage.
   c. Grasp your fist with your other hand. Press your fist into the victim's abdomen with a quick upward thrust. Be sure your fist is directly on the midline of the victim's abdomen when you press. DO NOT direct the thrusts to the right or left.
4. Repeat the thrusts until the obstruction is cleared or until the person becomes unconscious.

Victim Lying (Known Choking)
1. Check victim for unresponsiveness.
2. Shout for help. If help unavailable, call 911.
3. Roll victim onto his/her back.
4. Open the airway. Look, listen and feel for breathing. Remove the object if you see it and begin CPR. [Note: If the foreign body is seen in the mouth, it should be removed by performing a tongue-jaw lift and sweeping finger through the mouth. If object is not seen, do not attempt to dislodge with finger as the object may be pushed further into the throat.]

Obese or Pregnant Victim - Standing or Sitting (Known Choking)
1. If the victim is too large to wrap your arms around to perform abdominal thrust or if pressure to the abdomen will cause complications as in pregnancy, an alternative technique to use is chest thrusts.
2. Stand behind the victim encircling his/her chest, placing your arms directly under the victim's armpits.
3. Form a fist and place the thumb side of your fist on the middle of breastbone (avoid the xiphoid process or margins of the rib cage).
4. Grasp your fist with your other hand and exert 5 quick backward thrusts. Continue the series of chest thrusts until the obstruction is relieved.
Obese or Pregnant Victim - Lying (Known Choking)
1. Kneel facing the victim.
2. Position victim on his/her back, place the heel of your hand on the lower half of the victim’s sternum, (avoid the xiphoid process or margins of the cage).
3. Administer quick downward thrusts that will compress the chest cavity 1-1/2 (one and one-half) to 2 inches. Continue the series of chest thrusts until the obstruction is relieved.

Choking Victim Who Becomes Unconscious
Victim with obstructed airway becomes unconscious:
1. Additional Assessment:
   a. Position the victim, turning on back as a unit; place face up with arms by sides.
   b. Call for help or, if others respond, activate EMS system.
2. Foreign Body Check - Finger Sweep:
   a. Keep victim's face up.
   b. Use tongue-jaw lift to open mouth.
   c. Attempt to remove foreign body, if you see it.
3. Breathing Attempt:
   a. Open airway with head tilt/chin lift.
   b. Seal mouth and nose properly.
   c. Attempt to ventilate.
4. Administer 30 chest compressions that will compress the chest cavity 1-1/2 (one and one-half) to 2 inches at a rate.
5. Sequencing: Repeat Steps 2-4 until airway obstruction is removed.
6. After airway obstruction is removed: Check for breathing and pulse. If pulse is absent, ventilate a second time and restart cycles of compressions and ventilations. If pulse is present, open airway and check for spontaneous breathing. If breathing is present, monitor breathing and pulse closely; maintain open airway. If breathing is absent, perform rescue breathing at 12 times/minute and monitor pulse.
7. Place in recovery position (also called fetal position.)

Unconscious Victim and Cause Is Not Known
1. Call for help. Open airway by head tilt chin lift. Establish absence of breathing; attempt to ventilate.
2. If unsuccessful, reposition head and try to ventilate again.
3. If still unable to open airway, start CPR.
4. Finger sweep only if object is seen.

AFTER CARE:
1. Document in patient's record:
   a. Incident.
   b. Treatment provided.
2. Notify physician, if applicable. Document any subsequent orders, if indicated.

REFERENCE:
PURPOSE:
To remove foreign body from the eye and prevent further injury.

CONSIDERATIONS:
1. It is important to assess what the object is, e.g., metal, wood, lint, as object may be embedded or may result in infection. DO NOT attempt to remove any object embedded in the eye.
2. Keep patient from rubbing eye.
3. DO NOT insert any instrument into eye in an attempt to remove a foreign body.
4. Refer patient to physician or emergency room (ER) if object is embedded in eye or something is thought to be embedded but cannot be located. Use protective dressing to bandage both eyes.
5. If patient has contacts, have the patient remove them, if possible. If the patient is unable to remove them, inform the next healthcare provider that the patient is wearing contacts.

EQUIPMENT:
Dry sterile gauze, handkerchief or clean tissue
Cotton-tipped applicator
Sterile water or tepid tap water
Gloves – if available
Paper cup

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Pull down lower lid to determine if object is on inner surface. If object does lie on inner surface, gently remove it with corner of sterile gauze, clean handkerchief or paper tissues dipped in water. Never use dry cotton around the eye.
4. If object has not been located, it may be lodged beneath the upper lid.
   a. While patient looks down, grasp lashes or upper lid gently.
   b. Pull upper lid forward and down over lower lid. Tears may dislodge the foreign object.
   c. If foreign object is still in eye, depress upper lid with a cotton-tipped applicator placed horizontally on top of the cartilage and avert the lid by pulling upward on the lashes against the applicator. Remove the foreign body with the corner of the gauze or clean handkerchief and replace the lid by pulling downward gently on the lashes.
   d. Flush the eye with sterile water or tepid tap water. Apply protective dressing.
5. If embedded in eye, stabilize as best you can and place a sterile dressing around the object or use a paper cup to support the object – Secure in place with tape or a bandage.
6. Refer for medical assistance.
7. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient’s record:
   a. Incident and degree of injury.
   b. Treatment provided.
2. Refer to medical assistance, if indicated.

REFERENCE:
Emergencies – Foreign Body in Nose

Strength of Evidence Level: 3

PURPOSE:
To remove foreign body from nose and prevent further injury.

CONSIDERATIONS:
1. Bloody, excessive nasal discharge, odor or pain may indicate a foreign body in the nostril.
2. Only remove object if it is easily accessible and if attempting to remove it will not push object further into nostril.

EQUIPMENT:
Flashlight
Forceps or tweezers
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Have patient blow nose while occluding unobstructed nostril.
4. Using flashlight, observe type of object and location.
5. Remove object with forceps or tweezers, if readily accessible. During extraction occlude nostril superior to object so it cannot be pushed further in.
6. If object is not easily removed, have patient seek medical attention.
7. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
2. Refer to medical care, if indicated.

REFERENCE:
PURPOSE:
To render first aid to the person suffering a fracture.

CONSIDERATIONS:
1. The person suffering a fracture may have suffered additional injuries, which require immediate emergency treatment before initiating care for the obvious injury.
2. Signs and symptoms of a fracture are:
   a. Pain continues with increasing severity until bone fragments are immobilized.
   b. Loss of functions; inability to use part.
   c. False motion; abnormal mobility.
   d. Deformity (visible or palpable).
   e. Localized swelling and discoloration of the skin from the trauma and/or from the hemorrhage that follows.
   f. Crepitation, grating sensation due to rubbing together of the bone fragments.
3. Fractures are classified as:
   a. Open: when skin integrity has been broken, creating the risk of infection.
   b. Closed: when the fracture does not break the skin integrity.
4. Fractures may impair circulation requiring immediate medical attention. Signs of circulatory impairment include coolness, blanching, decreased sensation and diminished or absent pulses.
5. Splints to immobilize fractures may be provided with household items such as pillows, magazines, blanket rolls, newspapers or boards.

EQUIPMENT:
Splinting material
Sterile or clean dressing
Gloves, if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Give immediate attention to the patient's respiratory and circulatory condition:
   a. Evaluate for airway and breathing difficulties. Initiate the steps for Cardiopulmonary Resuscitation (CPR), if necessary.
   b. Control hemorrhage:
      (1) Control bleeding by direct pressure.
      (2) If not effective, apply digital pressure over the artery closest to the bleeding area.
   c. Treat for shock:
      (1) Assess for signs and symptoms of shock, including falling blood pressure, cold and clammy skin, and rapid, thready pulse.
      (2) Keep the patient warm and slightly elevate the legs, if possible.
4. Observe the entire body using methodical head to toe system to assess for angulation, shortening or asymmetry to indicate a fracture.
5. Cut away clothing, if necessary, to inspect fractured part.
6. Assess the neurovascular status of the extremity.
7. Cover open fracture with sterile or clean dressing.
8. Immobilize the joint above and below the fracture site.
9. Assess the neurovascular status of the extremity again after splinting.
10. Arrange for immediate medical attention.
11. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Medical treatment obtained.
   e. Home safety deficits.
   f. Equipment needs.
PURPOSE:
To evaluate and monitor patient sustaining head injury until medical attention received.
To prevent further injury and complications.

CONSIDERATIONS:
1. It is necessary to observe the symptoms common with head injuries, which are reportable to the emergency medical caregivers. Clinical manifestations indicative of a head injury are:
   a. Unconsciousness.
   b. Headaches.
   c. Dizziness.
   d. Confusion or delirium.
   e. Respiratory irregularities.
   f. Symptoms of shock.
   g. Changes in body temperature.
   h. Pupillary abnormalities.
   i. Visual disturbances.
   j. Nausea and vomiting.
   k. Clear or blood-tinged fluid draining from nose or ears.
   l. Bleeding from nose, ear canal or mouth.
   m. Paralysis of muscles of extremities of side opposite injury and paralysis of muscles on face on same side of injury.
   n. Disturbance of speech.
   o. Convulsions, twitching of muscles.
   p. Pale or flushed face.
   q. Weak and rapid pulse.
   r. Loss of bowel and bladder control.
2. If examination of scalp wound indicates cranial fracture, DO NOT cleanse because of the danger of contamination of brain and increased bleeding.

EQUIPMENT:
Pillow or rolled blanket
Gauze dressing
Blood pressure cuff
Stethoscope
Gloves, if available

PROCEDURE:
1. Adhere to Standard Precautions.
3. Evaluate for hemorrhage.
4. Arrange for immediate medical attention.
5. Determine patient's baseline condition. Report to physician:
   a. Level of responsiveness, orientation.
   b. Presence of headache, double vision, nausea or vomiting.
   c. Pupil size and reaction to light.
   d. Blood pressure, pulse and respirations.
   e. Movement and strength of extremities.
   f. Other injuries and open wounds.
6. Obtain as much specific information about the injury as possible from the patient or witness. Report to physician or paramedics:
   a. Cause of injury.
   b. Force and direction of the blow.
   c. Loss of consciousness and length of time.
   d. Bleeding from eyes, ears, nose or mouth.
   e. Paralysis or flaccidity of the extremities.
   f. Seizure activity.
7. Treatment:
   a. Keep patient lying down. Treat for shock. (See Emergencies – Shock) Immobilize neck. If necessary, open airway by chin lift/jaw thrust. If vomiting occurs, log roll patient to side while maintaining cervical spine (C-spine) traction. Never position patient so that head is lower than rest of body.
   b. Control hemorrhage.
   c. DO NOT give fluids by mouth.
   d. DO NOT give sedatives.
   e. If scalp wound is present, apply a large dressing over injury and wrap it in place with a full-head bandage.
   f. Treat other injuries.
   g. Maintain quiet restful environment and continue to evaluate patient for any changes in condition.
8. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. How injury occurred.
   b. Description of wound.
   c. Symptoms.
   d. Treatment administered and patient's response.
2. Transfer recorded data to person assuming medical responsibility for patient.
Emergencies – Heat Exposure

PURPOSE:
To stabilize patient's condition until crisis passes or patient is transported to emergency facility.

CONSIDERATIONS:
1. It is important to instruct patients and caregivers to maintain adequate fluid and salt intake, wear loose fitting clothing and rest frequently during hot weather.
2. Persons who are hot and perspiring a lot should avoid drinking ice cold water/drinks too quickly or in too large quantity as this may result in muscle cramps of the abdomen.
3. Persons who experience heat cramps, exhaustion or stroke should avoid immediate re-exposure to high temperatures. This person may remain hypersensitive to increased temperatures for a considerable length of time.
4. Persons most vulnerable to heat cramps, exhaustion or stroke are the elderly, alcoholics, athletes, those who have cardiovascular disease and persons working in a hot environment who perspire a lot.
5. Stimulants such as coffee or tea should not be given to patients with symptoms of heat stroke.

EQUIPMENT:
Cool water
Salt
Thermometer
Ice packs (optional)

PROCEDURE:
1. Adhere to Standard Precautions.
2. For heat cramps and muscular spasms in legs and abdomen with faintness and profuse perspiration:
   a. Move patient to cool place and loosen clothing.
   b. Administer sips of cool drinking water.
   c. Massage gently to relieve muscle spasms.
   d. Restrict further activity until cool and well-rested.
3. Heat exhaustion is manifested by weak pulse, rapid/shallow breathing, generalized weakness, paleness, clammy skin, profuse perspiration, dizziness and/or unconsciousness.
   a. Treat for shock and arrange transportation to hospital.
   b. Move patient to cool place.
   c. Remove as much clothing as possible.
   d. Administer sips of cool drinking water if fully conscious.
   e. Fan body to cool, but do NOT chill.
4. Heat stroke is manifested by temperature of 104 degrees Fahrenheit (40 degrees Celsius) or higher; central nervous system dysfunction (delirium, psychosis, stupor, convulsions, coma); weak, rapid, irregular pulse; dry, hot, flushed skin and/or dilated pupils.
   a. Obtain medical assistance.
   b. Move patient to cool place.
   c. Remove clothing, assure open airway.
   d. Cool body temperature promptly by sponging continuously with ice water or wrap in wet sheets.
   [Note: If ice packs are available, place around neck, under arms and at the ankles. Do NOT apply rubbing (isopropyl) alcohol; it may cause poisoning, either through the skin or through inhalation.]
   e. Monitor vital signs and level of responsiveness.

AFTER CARE:
1. Document in patient's record:
   a. Symptoms present.
   b. Treatment provided.
   d. Medical assistance obtained.
PURPOSE:
To stop bleeding as soon as possible while arranging for emergency care.

CONSIDERATIONS:
1. The presence of hemorrhage may be obvious (external hemorrhage) or subtle (internal hemorrhage).
2. Internal hemorrhage usually presents signs and symptoms based on the anatomical site where the bleeding occurs, e.g., change in mental status, pain, acute shortness of breath or massive extremity swelling.
3. Hemorrhage unchecked will lead to hypovolemic shock.
4. Because of the diverse causes of hemorrhage, it may not be possible to locate the source of the bleeding and/or the site to apply direct pressure.
5. Because infants and children have less blood volume than adults, they may experience physiologic changes with less blood volume loss.

EQUIPMENT:
Tape
Clean or sterile gauze
Blanket
Blood pressure cuff
Stethoscope
Gloves
Tourniquet (please see note at end of procedure)

PROCEDURE:
1. Adhere to Standard Precautions.
2. Quickly evaluate the patient to determine the possible source of the bleeding. Monitor respirations, pulse and blood pressure.
3. If blood loss is significant, bleeding will not stop. If patient presents symptoms of shock, arrange for emergency medical treatment.
4. Control external bleeding by applying direct, firm pressure to the site of the bleeding or wound using a compress or gauze. If the compress becomes blood-soaked, apply additional cloth layers, while continuing to apply direct, firm pressure. Do NOT remove original compress.
5. Unless there is evidence of fracture, elevate the injured extremity above the level of the heart. Immobilize the injured extremity.
6. If direct pressure fails to stop the bleeding or cannot be applied directly because of a fracture, apply digital pressure to the arterial pressure point nearest the wound or bleeding. Apply pressure with the heel of the hand to cover the area where the pressure point is located. If hand placement is correct, there will be an absence of the pulse below the pressure point, and the patient may feel local tingling or numbness.
7. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Identity and location of emergency facility, if indicated.
   e. Condition of patient at time of transport, if indicated.

[Note: A tourniquet is rarely used as part of emergency care. It most often does more harm than good. ONLY use as a last resort to control bleeding/save a life as it may result in the loss of the limb below the injury.]
Emergencies – Nosebleed (Epistaxis)

Strength of Evidence Level: 3

PURPOSE:
To control bleeding and prevent hemorrhage during a nosebleed.

CONSIDERATIONS:
1. Nosebleed may indicate an underlying disease, e.g., hypertension, a blood dyscrasia, anticoagulant therapy, coronary artery disease, alcoholism or recent upper respiratory tract infection.
2. Most nose bleeds stop when direct pressure is applied.
3. Assess for symptoms of hypovolemic shock caused by severe blood loss.
4. Check for Medic-Alert bracelet, which may indicate that patient has a blood dyscrasia.
5. A patient with a nosebleed should remain quiet, sitting up and leaning slightly forward. If it is necessary to lie down, the head and shoulders should be elevated.

EQUIPMENT:
4 x 4 gauze pads (optional)
Cold compress or ice pack (optional)
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Place patient in a seated position with head slightly forward.
4. Have patient pinch the nostrils together for a minimum of 10 minutes using a 4 x 4 gauze pad if desired. (The nurse may have to do this for the patient).
5. An ice pack may be applied to the bridge of the nose.
6. Obtain medical history and current medications.
7. Take vital signs and observe patient's general condition.
8. Contact the physician if bleeding is not controlled or transfer to ER.
9. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Document in patient's record:
   a. Severity and duration of bleeding.
   b. Treatment provided.
2. Contact physician to report incident and obtain further orders.
PURPOSE:
To prevent death or permanent disability related to ingestion of poisonous or toxic substances.

CONSIDERATIONS:
1. Much information printed in professional literature regarding emergency treatment of poisoning is inaccurate and may prove harmful to the patient if followed. Many poison charts distributed to patients are based on outdated information that has now been largely disproved. Therefore, when faced with a poisoning in the home, it is essential that the nurse contact the nearest regional Poison Control Center for instructions before instigating treatment.
2. Remember that the nurse will have to consider the impact and interaction of all substances that the patient has ingested with the toxic substance.
3. Toxic substance exposure may result from exposure to any one or a combination of the following:
   a. Prescription and non-prescription drugs.
   b. Poisonous plants and mushrooms.
   c. Household products.
   d. Cosmetics.
   e. Industrial chemicals.
   f. Pesticides.
   g. Venomous insect bites and stings.
   h. Snake bite.
   i. Food poisoning.
4. Nursing personnel should assess the patient/caregiver environment for potential exposure to toxic substances and should provide appropriate patient teaching to prevent such occurrences.
5. Product labels are often wrong, may not have been updated in years, and may contain erroneous antidote instructions. DO NOT rely on these labels for instructions.
6. DO NOT give victim anything to drink or eat unless so advised by medical professionals. If poison is unknown and the victim vomits, save some of the vomit in a clean container for the hospital to identify the poison. Look for pieces of plant, pill fragments, or blood in the vomit and report any such findings to the EMT or emergency room personnel.

EQUIPMENT:
Poison Control Center (PCC) number by phone
1-800-222-1222
Ipecac Syrup (15 - 30 mL) – only use if recommended by PCC or physician.
Activated Charcoal – only use if recommended by PCC or physician (25-50 grams for adult, 1/4-1/2 (one-fourth to one-half) of adult dosage for child)

PROCEDURE:
1. Adhere to Standard Precautions.
2. Assess the victim's status.
3. Determine the cause of toxic substance poisoning.
4. Call the nearest Poison Control Center, and be prepared to provide the following information.
   a. Patient data: name, age, gender.
   b. Name of toxic substance.
   c. Read and/or spell name of all ingredients on label.
   d. Estimate amount of exposure or amount ingested.
   e. Time of ingestion or exposure.
   f. Symptoms manifested by victim, e.g., vomiting, burns to mouth, pain, drowsiness.
   g. Weight of victim -- this information will be especially important in such poisonings as acetaminophen, aspirin and iron. The amount of many substances ingested relative to the weight of the patient determines toxicity. In addition, protocols for clinical management will depend on mg/kg ingestion or exposure.
5. Follow instructions given by Poison Control Center or appropriately qualified physician with knowledge of toxicology.
6. General emergency procedures for major categories of poisoning:
   a. Inhaled Poison:
      (1) Get victim to fresh air, evidence is insufficient to recommend for or against the use of oxygen for first aid.
      (2) Avoid inhaling fumes.
      (3) Open doors and windows to increase ventilation of environment and dissipate fumes.
      (4) If victim is unconscious, assess for initiation of CPR.
   b. Topical Poison:
      (1) Remove clothing contaminated with toxic substance.
      (2) Flood skin with large amounts of water for 10 minutes.
      (3) Assess skin for integrity. Seek further medical treatment, if indicated.
   c. Poison in the Eye:
      (1) Flood the eye with lukewarm water poured 2 to 3 inches from the eye.
      (2) Repeat irrigation for 15 minutes.
      (3) Instruct victim to blink frequently while eye is being irrigated.
      (4) If eyelid is shut, do not force eyelid open.
      (5) Refer victim for medical treatment.
   d. Ingested Poison:
      (1) Medicine - DO NOT administer anything until instructions have been obtained from the Poison Control Center.
      (2) Chemical in Household Products - If instructed by the Poison Control Center to induce vomiting use the dose of Ipecac
Syrup prescribed by the physician (usually 15 mL). Follow administration of Ipecac by 8 ounces of water. Instruct victim to drink as much water as possible. If vomiting has not occurred within 20 minutes, repeat preceding procedure. If vomiting still does not occur, call physician. Physician may prescribe liquid charcoal.

(3) Victims should not drink anything (including milk or water) after ingesting a poison.

AFTER CARE:

1. Refer to physician for further examination and treatment, if necessary.
2. Document in patient's record:
   a. Incident.
   b. Type of poison and amount.
   c. Treatment provided.
   d. Patient's response to treatment
Emergencies – Postpartum Hemorrhage

SECTION: 13.30

Strength of Evidence Level: 3

PURPOSE:
To prevent excessive bleeding and resulting shock.

CONSIDERATIONS:
1. Most postpartum hemorrhage occurs within the first 24 hours after delivery. It can also occur a week or more after a delivery due to retained placental fragments.
2. Blood loss greater than 500 mL is considered hemorrhage. Six fully saturated obstetrical sanitary pads are equivalent to 500 mL blood loss.
3. If fundus requires massaging, press uterus against symphysis pubis and vigorously massage.
4. Breast feeding stimulates uterine contractions to reduce bleeding.

EQUIPMENT:
- Pillow/rolled towel
- Disposable bed pads
- Plastic sheet
- Newspapers (optional)
- Ice bag (optional)
- Gloves, if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Palpate uterus for firmness. If atonic, massage fundus until firm. Continue monitoring uterus until medical assistance is obtained. Have patient breastfeed infant.
4. Take vital signs, noting patient's color and general condition.
5. Elevate the patient's pelvic area at least 4 inches, using pillow or rolled towel.
6. Obtain medical assistance.
7. Place disposable bed pads and/or plastic sheet/newspapers under patient.
8. Ice bag may be applied to vaginal area if patient is experiencing pain or bleeding from lacerations.
9. Save all pads, clots, saturated bedding in order to estimate amount of blood loss.

AFTER CARE:
1. Document in patient's record:
   a. Onset of bleeding.
   b. Estimated amount of blood loss.
   c. Vital signs, color and condition.
   d. Treatment provided.
   e. Patient's response to treatment.
   f. Medical care obtained.
Emergencies – Seizures
SECTION: 13.31
Strength of Evidence Level: 3

PURPOSE:
To provide a safe environment, protect patient from injury and keep airway open.

CONSIDERATIONS:
1. DO NOT place blunt object between patient's teeth.
2. DO NOT restrain patient.
3. DO NOT pour liquid into patient's mouth.
4. DO NOT place patient in a tub of water.
5. In most cases, a seizure will last 2 to 5 minutes.
6. With a generalized seizure (tonic-clonic) respirations may be disrupted temporarily with cyanosis noted. Once respirations resume, copious amounts of oral secretions may be present.
7. Expect patient to be confused or agitated in the postictal phase.

EQUIPMENT:
Gloves – if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Prevent injury by removing sharp or other dangerous objects from patient's vicinity.
3. Place pillow under head and turn patient to one side to prevent aspiration of saliva or vomitus.
4. Loosen tight clothing.
5. Initiate Cardiopulmonary Resuscitation (CPR), if indicated. (See Emergencies - CPR Adult or CPR Infant/Child.)

AFTER CARE:
1. After seizure, allow patient to sleep or rest.
2. If seizure was precipitated by a high fever, give a tepid water sponge bath continuously until fever is reduced.
3. Document in patient's record:
   a. Length, type and characteristics of seizure, in particular, note level of consciousness and continence.
   b. Treatment provided.
4. Contact physician to report incident and obtain further orders.
5. Emergency care may be necessary if:
   a. Seizure lasts more than a few minutes.
   b. Patient has repeated seizures.
   c. Patient appears to be injured.
   d. Uncertain about cause of seizure.
   e. Patient is pregnant.
   f. Patient is known diabetic.
   g. Patient is infant or child.
   i. Patient fails to regain consciousness after the seizure.
PURPOSE:
To provide first-aid treatment for shock while arranging for emergency medical care.

CONSIDERATIONS:
1. Signs and symptoms of shock are:
   a. Falling arterial pressure and decreasing pulse pressure.
   b. Increasing pulse rate and respirations rate.
   c. Thready, weak pulse.
   d. Cold, clammy skin.
   e. Pallor and circumoral pallor.
   f. Changes in mental status, e.g., anxiety and/or restlessness.
   g. Reduced urine output.
   h. Thirst.
   i. Nausea and vomiting.
   j. Drowsiness or loss of consciousness.
2. Despite the cause of shock, the first-aid remains the same.
3. Shock may be accompanied by other problems, e.g., hemorrhage or sepsis.

EQUIPMENT:
Stethoscope
Blood pressure cuff
Blanket (optional)

PROCEDURE:
1. Adhere to Standard Precautions.
2. Quickly evaluate the patient and home situation. If possible, arrange for immediate emergency care and transportation, while implementing procedure.
3. Place patient in Trendelenburg position or place several blankets/items under the feet and maintain open airway. Monitor blood pressure, pulse and respirations.
4. Initiate cardiopulmonary resuscitation, if needed.
5. Use blanket, if available, to insulate around the patient, to maintain the patient's body heat.

AFTER CARE:
1. Document in patient's record:
   a. Incident and vital signs.
   b. Treatment provided.
   d. Identity and location of emergency facility, if indicated.
   e. Condition of patient at time of transportation, if indicated.

<table>
<thead>
<tr>
<th>Type</th>
<th>Types of Shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylactic</td>
<td>Life-threatening allergic reaction to a substance; can occur from insect stings or from foods and drugs.</td>
</tr>
<tr>
<td>Cardiogenic</td>
<td>Failure of the heart to effectively pump blood to all parts of the body; occurs with heart attack or cardiac arrest.</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>Severe bleeding or loss of blood plasma; occurs with internal or external wounds or burns.</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Loss of body fluid; occurs after severe diarrhea or vomiting or heat illness.</td>
</tr>
<tr>
<td>Neurogenic</td>
<td>Failure of nervous system to control size of blood vessels, causing them to dilate; occurs with brain or nerve injuries.</td>
</tr>
<tr>
<td>Psychogenic</td>
<td>Factor, such as emotional stress, causes blood to pool in the body in areas away from the brain, resulting in fainting.</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Failure of the lungs to transfer sufficient oxygen into the bloodstream; occurs with respiratory distress or arrest.</td>
</tr>
<tr>
<td>Septic</td>
<td>Poisons caused by severe infections that cause blood vessels to dilate.</td>
</tr>
</tbody>
</table>
PURPOSE:
To prevent further injury of a patient with spinal or neck injuries.

CONSIDERATIONS:
1. Patient may demonstrate impairment or absence of adequate respirations due to spinal shock (a sudden neurovascular shutdown in response to trauma). Rescuers should use the jaw thrust method to open the airway.
2. Utmost care in immediately immobilizing the spine is absolutely necessary to prevent further injury. If you suspect a spine injury, it is best not to move the patient. If you are alone and must leave the unresponsive patient to get help, extend one of the patient’s arms above the head. Then, roll the patient’s body to that side so that the patient’s head rests on the extended arm. Bend the legs to stabilize the patient.
3. Check for spinal fluid leakage from nose or ears.

EQUIPMENT:
- Stethoscope
- Manometer
- Board (optional)
- Sandbags (optional)
- Towels or sheets
- Gloves, if available

PROCEDURE:
1. Adhere to Standard Precautions.
2. Establish patent airway, keeping neck immobilized. Use rolled, firm towel or sandbag, if available, to prevent flexing or hyperextending the neck.
3. Arrange for immediate emergency care and transportation, if appropriate. Determine patient’s level of consciousness. If alert, instruct patient to not change position in any way. First aid providers should use manual spine stabilization (i.e. stabilization with hands rather than devices) and should avoid using immobilizing devices. DO NOT move unless absolutely necessary. If necessary to move, avoid flexing of neck or back. Apply manual traction to neck while moving patient.
4. Monitor blood pressure.
5. If spinal fluid is draining from nose, remove gently with soft gauze. Instruct patient to not blow nose.
6. If ear is draining, cover with sterile gauze. DO NOT pack.
7. Remain in home; provide support to family until emergency medical assistance arrives and/or patient is transported.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Identity and location of emergency facility, if indicated.
   e. Condition of patient at time of transportation, if indicated.
Emergencies – Splinting for Transporting the Patient with a Fracture or Dislocation

SECTION: 13.34

Strength of Evidence Level: 3

PURPOSE:
To immobilize the affected body parts when a fracture or dislocation is suspected.

CONSIDERATIONS:
1. Unless there is threat of life or loss of limb, there is usually time to splint the affected body part.
2. When placing the patient in a position of comfort, consider the fracture site and length of time until emergency care and transportation are to be provided.
3. Avoid twisting, turning or pulling the spine when moving or transporting the patient.

EQUIPMENT:
Gloves, if available
Splinting materials – boards, blankets, newspapers, gauze, strips of cloth, tape, sling

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Arrange for immediate emergency care and transportation
4. Place patient in position appropriate for site of fracture/dislocation.
5. Remove jewelry from affected extremity.
6. Check the vascular status of the extremity before splinting; check color, temperature, pulse and blanching of nail beds.
7. Immobilize the joint above and below the fracture. Place one hand distal to the fracture and apply some traction by placing the other hand underneath the fracture for support.
8. DO NOT manipulate a dislocation. Splint it in the position found.
9. Extend the splints well beyond the joints adjacent to the fracture. The patient's opposite leg, board, etc., may be used for a splint if necessary. Splint joints in functional position.
10. Check the vascular status of the extremity after splinting; check color, temperature, pulse and blanching of nail beds.

AFTER CARE:
1. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Identity and location of emergency facility.
   e. Condition of patient at time of transportation.
PURPOSE:
To render first aid to a person suffering from a sprain and strain.

CONSIDERATIONS:
1. A sprain usually occurs by forcing a joint beyond the normal range of motion. This motion causes injury to the soft tissue surrounding the joints by stretching or tearing ligaments, muscles, tendons and blood vessels.
2. The signs and symptoms of a sprain are: rapid swelling, bruising, discoloration of the skin and pain upon movement of the joint.
3. It is usually impossible to tell a sprain from a closed fracture without an X-ray.

EQUIPMENT:
Cold compresses or ice bag
Compression wrap (elastic bandage)

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Elevate and rest the affected part above the level of the heart, if possible, for at least 12 hours.
4. Apply cold compresses or ice bag intermittently (15 minutes on, 15 minutes off during waking hours) for the first 12 to 48 hours in order to reduce swelling and pain. DO NOT apply directly on skin.
5. Ambulate as tolerated.

AFTER CARE:
1. If the sprain is severe with instability of the joint or if the swelling and pain persists, refer for medical assistance.
2. Document in patient's record:
   a. Incident and degree of injury.
   b. Treatment provided.
   d. Referral to medical assistance.
PURPOSE:
To identify signs/symptoms of stroke and take appropriate action in order to maintain life.

CONSIDERATIONS:
1. Signs and symptoms of stroke are:
   a. Partial/total paralysis (unilateral or bilateral).
   b. Loss of consciousness.
   c. Aphasia.
   d. Headache.
   e. Hyper or hypotonia.
   f. Sensory impairment (touch, visual).
   g. Seizure activity.
   h. Dysarthria.
   i. Facial drooping.
   j. Incoordination.
   k. Incontinence.
   l. Lethargy.
   m. Nausea and/or vomiting.

EQUIPMENT:
Manometer
Stethoscope
Otoscope (optional)

PROCEDURE:
1. Adhere to Standard Precautions.
2. Check for patent airway—initiate cardiopulmonary resuscitation, if indicated. (See Emergencies-Cardiopulmonary Resuscitation.) If there is fluid or vomit in victim's mouth, position on side to allow fluids to drain out. "Finger sweep" may be necessary to clear material from mouth.
3. Keep patient in left lateral recumbent position if there is difficulty maintaining an airway.
4. Determine level of consciousness.
5. Protect paralyzed extremities.
6. Measure and assess patient's response to commands. Determine loss of impaired vision, speech and motor ability.
7. Obtain vital signs.
8. Call for immediate medical direction/emergency care, as indicated.
9. Reassure and calm the patient and family.

AFTER CARE:
1. Document in patient's record:
   a. Incident, signs and symptoms of stroke present and vital signs.
   b. Treatment provided.
   d. Identity and location of emergency facility, if indicated.
   e. Condition of patient at time of transportation, if indicated.
## INSECT BITES AND STINGS

**SIGNS AND SYMPTOMS:**
- Stinger may be present
- Pain
- Local Swelling
- Hives or rash
- Nausea and vomiting
- Breathing difficulty

**CARE:**
- Remove stinger; scrape it away with card or knife
- Wash wound
- Cover wound
- Apply a cold pack
- Watch for signs and symptoms of allergic reactions; take steps to minimize shock if they occur

## TICK BITES

**SIGNS AND SYMPTOMS:**
- Bull’s eye, spotted, or black and blue rash around bite or on other body parts
- Fever and chills
- Flu-like aches

**CARE:**
- Remove tick with tweezers
- Apply antiseptic and antibiotic ointment to wound
- Watch for signs of infection
- Get medical attention if necessary

## SPIDER BITES

**SIGNS AND SYMPTOMS:**
- Bite mark or blister
- Pain or cramping
- Nausea and vomiting
- Difficulties breathing and swallowing
- Irregular heartbeat

**CARE:**
- If black widow or brown recluse:
  - Call EMS personnel immediately to receive antivenin and have wound cleaned

## SCORPION STINGS

**SIGNS AND SYMPTOMS:**
- Bite mark
- Local Swelling
- Pain or cramping
- Nausea and vomiting
- Profuse sweating or salivation
- Irregular heartbeat

**CARE:**
- Wash wound
- Apply a cold pack
- Get medical care to receive antivenom
- Call EMS personnel or local emergency number

## SNAKE BITES

**SIGNS AND SYMPTOMS:**
- Bite Mark
- Severe pain and burning
- Local swelling and discoloration

**CARE:**
- Wash wound
- Keep bitten part still and lower than heart
- Call EMS personnel or local emergency number

## MARINE LIFE & WILD ANIMAL BITES

**SIGNS AND SYMPTOMS:**
- Possible marks
- Pain
- Local swelling

**CARE:**
- If jellyfish – soak area in vinegar, alcohol or baking soda paste
- If stingray – soak area in non-scalding hot water until pain goes away - clean bandage wound
- Call EMS personnel or local emergency number if necessary

## DOMESTIC BITES

**SIGNS AND SYMPTOMS:**
- Bite mark
- Bleeding
- Pain

**CARE:**
- If wound is minor, wash wound, control bleeding, apply a dressing, and get medical attention as soon as possible
- If wound is severe, call EMS personnel or local emergency number, control bleeding, and DO NOT wash wound

## HUMAN BITES

**SIGNS AND SYMPTOMS:**
- Bite mark
- Pain

**CARE:**
- If wound is minor, wash wound, control bleeding, apply a dressing, and get medical attention as soon as possible
- If wound is severe, call EMS personnel or local emergency number, control bleeding, and DO NOT wash wound
## List of Common Toxic Substances

### Household Products
- Alcoholic beverages
- Ammonia
- Antifreeze
- Ant syrup or paste
- Automotive products
- Bathroom bowl cleaner
- Bleach
- Boric Acid
- Camphophenique
- Charcoal lighter fluid
- Cleaning fluid
- Clinistest tablets
- Copper and brass cleaners
- Corn and wart remover
- Deodorizers
- Detergents
- Dishwasher detergents
- Disinfectants
- Drain cleaners
- Epoxy glue kit
- Furniture polish
- Garden sprays
- Gasoline
- Gun cleaners
- Hair dyes
- Iodine
- Iron medications
- Kerosene
- Lighter fluid
- Model cement
- Muratic acid
- Mushrooms
- Nail polish
- Nail polish remover
- Oven cleaner
- Paint
- Paint remover
- Paint thinner
- Perfume
- Permanent wave solutions
- Pesticides
- Plants

### Prescription and non-prescription medicines

### Rat killers

### Rubbing alcohol

### Shaving lotion

### Silver polish

### Snail bait

### Spot removers

### Strychnine

### Sulfuric acid

### Super glue

### Turpentine

### Veterinary products

### Weed killers

### Window wash solvent

### Plants
- Anemone
- Angel trumpet tree
- Apricot kernels
- Arrowhead
- Avocado - leaves
- Betel nut palm
- Bittersweet
- Buckeye
- Buttercups
- Caladium
- Calla lily
- Caster bean
- Cherries - wild and cultivated
- Crocus, Autumn
- Daffodil
- Daphne
- Delphinium
- Devil's Ivy
- Dieffenbachia (Dumb Cane)
- Elderberry
- Elephant Ear
- English Ivy
- Four O'Clock
- Holly berries
- Foxglove
- Horsetail reed
- Hyacinth
- Hydrangea
- Iris
- Ivy (Boston, English and others)
- Jack-in-the-pulpit
- Jequirity Bean
- Jerusalem Cherry
- Jessamine (Jasmine)
- Jimpson weed (Thorn apple)
- Jonquil
- Lantana Camara (Red sage)
- Larkspur
- Laurels
- Lily-of-the-Valley
- Lobelia
- Marijuana
- Mayapple
- Mistletoe
- Moonseed
- Monkshood
- Morning Glory
- Mother-in-Law plant
- Mushroom
- Narcissus
- Nightshade
- Oleander
- Periwinkle
- Peyote (mescal)
- Philodendron
- Poison Ivy
- Poison Oak
- Poppy (California Poppy excepted)
- Pokeweed
- Primrose
- Potato sprouts
- Ranunculus
- Rhododendron
- Rhubarb - blade
- Rosary Pea
- Star-of-Bethlehem
- Tobacco
- Tomato vines
- Tulip
- Water Hemlock
- Wisteria
- Yew
REFERENCES


