

**LOOKS CRITICALLY ILL
(Don't Know Why)**

30 Second Review Looks Critically Ill
RN, LPN if RN not available on-site
DEF: Illness or injury that within minutes to hours may cause irreversible CNS damage, loss of limb, or death.
S/S: Signs and symptoms dependent on underlying condition.
RX: Initiate transport to emergency facility if patient appears critically ill. Maintain airway and breathing, Oxygen 2-8L (NP or mask). High flow oxygen by Ambu-bag if LOC depressed. Start IV with large bore needle TKO while awaiting transport.

SKILL LEVEL: RN, LPN if RN not available on-site

DEFINITION: Critically ill or traumatized patient. Any condition where grave consequences may ensue rapidly. Any condition where a threat to loss of life, limb, or non-reversible CNS damage may occur within minutes to hours. These are often complex, critical problems. Specific therapy needs to be quickly initiated to alter its natural progression to irreversible loss. These patients all need intensive hospital based care.

Cause of illness may be due to any condition or disease process such as:

- Trauma
- Respiratory Distress
- Cardiovascular Distress
- Sepsis
- GI
- GU
- Neuropsychiatric
- Metabolic
- Poisons

DATA BASE:

Subjective:

Patient presents with one of the conditions defined above and/or situation may include gross bleeding, major trauma/laceration/avulsion, possible history of drug ingestion, foreign substance ingestion, unconsciousness, semi-consciousness, hypotension, extreme tachycardia, asthmatic attack, dyspnea, or any condition where grave consequences may ensue.

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Objective:

Symptoms dependent upon underlying condition but any and/or all of the following may be present:

1. Cardiovascular: Pulse weak, thready or absent. Apical pulse under 40. Systolic Blood Pressure < 90. and hypotensive symptoms.
2. Skin: cool, clammy with or without profuse diaphoresis.
3. Respiratory: Respirations under 6 or greater than 30 per minute. Presence of any of the following: Dyspnea, wheezing, stridor, use of accessory muscles for respirations, tachypnea, respiratory arrest.
4. Neurological: anxious, confused, stuporous, comatose, semi-comatose. Waxing and waning sensorium.

Assessment: Nurse concern about patient acute illness or clinical deterioration. Patient needs emergency treatment. Critically ill or traumatized patient who requires immediate attention by on-site physician or transport to Emergency Room.

Plan:

1. Prepare patient for transport to an emergency facility.
2. If patient is unconscious or semi-conscious, check Blood Sugar and treat if it's low. Administer Narcan 0.4 mg IV, IM or SC as an initial dose. A repeat dose may be given in 3-5 minutes prn
Maximum total dose: 2 mg
3. Maintain breathing: Oxygen 2-8L (NP or mask) or high flow Oxygen by Ambu-bag if LOC is depressed.
4. Start a (preferably) large bore IV and run fluids while awaiting transport.

If Systolic BP < 85 start 1 Liter Lactated Ringers or similar solution wide open

If Systolic BP > 85 start 1 Liter Lactated Ringers or similar solution @ 200cc hour

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Note: Please refer to specific protocol for definitive therapy if possible. Use this protocol if no other emergency protocol fits the clinical situation or if you aren't sure what specifically is causing this patient to be critically ill.

APPROVED:

Medical Services Manager

Date

Chief Medical Officer

Date

Steve Shelton MD.

Medical Director

2/24/2015

Date

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