Adult and Pediatric Anaphylaxis Kit

Contents

Epinephrine 1:1000 (3 vials)
Filter needles (3)
22G needles (3)
23G needles (3)
1ml syringe (3)

Benadryl 50mg/ml (1)
3cc syringe (1)

Pepcid 20mg/2ml (2)
5cc syringe (1)
18g needle (1)

Solumedrol 125mg vial (1)
3cc syringe (1)

Albuterol 2.5mg/0.5ml (1)
3cc saline bullet (1)

Alcohol wipes (5)
Gauze pads

Source: Gifford Medical Center, Randolph, VT.

Adult Medication Administration Guidelines for Anaphylaxis Treatment *See IV medication book for full recommendations*			
Medication	**Dose**	**Route**	**Administration**
Epinephrine	0.3mg-0.5mg of 1:1000 (1mg/ml). Repeat every 3-5 minutes as needed.	IM	Best absorbed if given mid-anterolateral thigh
Benadryl	25-50mg	IV Push	Give undiluted 25mg/minute
Solumedrol	125mg	IV Push	Give over 2 minutes
Pepcid	40mg	IV Infusion	Dilute in 10cc normal saline Give 20mg/minute
Albuterol Nebulizer	2.5mg-5mg in 3ml of saline. Repeat as needed.	Nebulizer	Nebulizer
Epinephrine Infusion	2-10mcg/minute titrated to effect *For patients with inadequate response to IM epinephrine. *Continuous IV infusion is preferred over an IV bolus of epinephrine	IV infusion	Mix 1mg of 1:1000 (1mg/ml) in 500cc of D5W *See IV book for drip chart *Supplies in adult code cart

Pediatric Medication Administration Guidelines for Anaphylaxis Treatment *See IV medication book for full recommendations*			
Medication	**Dose**	**Route**	**Administration**
Epinephrine	0.01 mg per kg of 1:1000 (1mg/ml). Repeat every 3-5 minutes as needed. Maximum dose 0.5mg.	IM	Best absorbed if given mid-anterolateral thigh
Benadryl	1-2mg/kg. Maximum dose 50mg. *Can give IM if symptoms not severe	IV Push	Give undiluted 25mg/minute
Solumedrol	2mg/kg. Maximum dose125mg.	IV Push	Give over 2 minutes
Pepcid	0.25mg/kg *Can give IM if symptoms not severe	IV Infusion	Dilute in 10cc normal saline Give 20mg/minute
Albuterol Nebulizer	0.15mg/kg in 3ml of saline. Minimum dose 2.5mg. Repeat as needed.	Nebulizer	Nebulizer
Epinephrine Infusion	0.1-1mcg/kg/minute titrated to effect *for patients with inadequate response to IM epinephrine. *continuous IV infusion is preferred over an IV bolus of epinephrine	IV infusion	*See Braslow IV medication guideline book for preparation and drip chart *Supplies in pediatric code cart

Source: Gifford Medical Center, Randolph, VT.

Gifford Medical Center

Addressograph

Emergency Department
Acute ST Elevation Myocardial Infarction Order Set

**orders must be timed and signed by MD to activate*
Pt.'s Weight in KG_____ Allergies:

Time	Medication/Intervention	MD signature	Time/ RN Initials	Time/ RN Initials	Time/ RN Initials	Time/ RN Initials
	Baby Aspirin 81mg tabs 4 tabs (324mg) p.o. chewed x1	standing order				
	Continuous Oxygen via nasal cannula at 4L/min to maintain SaO2>90%	standing order				
	Nitroglycerin 0.4mg SL q5min x3 for chest discomfort Hold and notify MD if SBP <100					
	Nitroglycerin Ointment 1 inch topically Notify MD if SBP <100					
	Morphine Sulfate 2-4mg IV p.r.n. for chest pain unrelieved by nitroglycerin. Notify MD if SBP< 100.					
	Plavix 75 mg tables 8 tabs (600mg) p.o.					
	Heparin IV Bolus 60 units/Kg (max 4000U) _____Kg x60units/kg=_____ units					
	TNKase administered as single injection over 5 seconds in dose based on patient's weight See tenecteplase (TNKase) protocol					

Time Initials	Other Orders	MD Signature	RN
	12-lead EKG within 10 minutes of pt's arrival to ED. Right sided EKG for inferior wall MI. Repeat 12- lead EKG when patient is chest pain free or significant change in patient status	standing order	
	Labs: CBC/Comprehensive/Troponin/CKMB/PT/PTT Radiology: Portable CXR	standing order	
	IV access: #18 Saline Lock; Place 2 #18 Saline locks prior to anticoagulation	standing order	

Provider Signature_____Date_____Time_____

Source: Gifford Medical Center, Randolph, VT

GIFFORD MEDICAL CENTER **CONFIDENTIAL**

Title:	TPA (Altepase) for Acute Ischemic Stroke	***Effective Date:**	2007-07-15	**Policy #:**	PH-224
Applies to:	☒ Hospital ☐ Nursing Home ☐ GMC Employees (HR Policy) ☐ Provider Practice ☐ Medical Staff				
Policy Type:	Protocol				
Contact:	Director of Pharmacy				

* **Policy Statement:**	To safely administer TPA to an adult in the event of an acute ischemic stroke

A. Inclusion Criteria: Acute ischemic stroke with onset of symptoms within 3 hours of initiation of treatment.

B. Absolute Contraindications

1. Evidence of intracranial hemorrhage on pretreatment evaluation.
2. Suspicion of subarachnoid hemorrhage
3. Intracranial surgery, serious head trauma or previous stroke within past 3 mos.
4. Major surgery (CABG, organ biopsy, puncture at noncompressible vessel) within preceding 14 days.
5. History of intracranial hemorrhage
6. Recent myocardial infarction
7. Uncontrolled hypertension at time of treatment: SBP>185 mm Hg or DBP>110 mmHg that cannot be decreased by labetalol 10 to 20 mg IV over 1 to 2 minutes, may repeat x1; or Nitropaste 1 to 2 inches.
8. Seizure at onset of stroke
9. Internal bleeding (GI / Urinary) within preceding 21 days
10. Intracranial neoplasm, arteriovenous malformation, or aneurysm
11. Current use of anticoagulants or PT> 15 sec.(INR>1.7), or use of heparin within previous 48 hr. or elevated PTT, platelet count< 100,000.
12. Minor neurologic deficit (e.g. isolated ataxia, sensory loss, dysarthria, or minimal weakness.
13. Rapidly improving signs prior to initiation of treatment.
14. Early signs of infarction on pretreatment CT scan (substantial edema, mass effect, or midline shift).
15. Blood glucose < 50 or > 400 mg/dl.

C. Relative Contraindications include, but are not limited to:

1. Recent trauma
2. High likelihood of left heart thrombus
3. Acute pericarditis
4. Subacute bacterial endocarditis
5. Hemostatic defects including those secondary to severe hepatic or renal disease.
6. Significant hepatic dysfunction
7. Pregnancy
8. Diabetic hemorrhagic retinopathy, or other hemorrhagic ophthalmologic conditions.
9. Septic thrombophlebitis or occluded AV cannula at seriously infected site.
10. Advanced age (e.g. over 75 years old).
11. Severe deficits (e.g. global aphasia, hemiparesis, and forced eye deviation, NIH SS > 22).

D. Procedure

1. The emergency room physician or attending physician determines that the patient meets the above criteria and that there are no contraindications.

2. A CT scan of the head is reviewed by the Gifford Medical Center radiologist or by a radiologist at another hospital.

3. Routine labs including PT/PTT, CBC with platelet count, comprehensive, and ESR are obtained and reviewed by the emergency room or attending physician. Use stool guaic and urinalysis to check for occult blood.

4. A telephone consultation is obtained with the on-call neurologist at the Dartmouth-Hitchcock Medical Center or FAHC. The patient's history, physical, neurologic exam, CT scan, and lab results will be presented. Confirmation to proceed with t-PA thrombolysis will be obtained with consultation from the on-call neurologist. **Clearly document the consultation in the patient's record including the name of the consulting physician/neurologist.**

5. Informed consent should be obtained whenever feasible. If the patient is aphasic or confused, consent should be obtained from the family members. The patient and/or family should understand that thrombolytic therapy carries a 6.4% risk of intracerebral hemorrhage. **It is recommended that this potential risk be written on the consent form.**

6. Patient is weighed.

7. **Do not** administer any aspirin, heparin, warfarin, ticlopidine, or other antithrombolytic or antiplatelet agent within the first 24 hours of treatment.

8. Administer t-PA (0.9 mg/kg, maximum 90 mg) with 10% of the total dose administered as a bolus over 1 minute followed by an infusion lasting 60 minutes.

9. A cranial CT should be repeated within 24 hours routinely and immediately with any change in severity or character of the neurologic deficit.

E. Ancillary Management Practices

1. Admit patient to ICU/SCU
2. Central venous access and arterial punctures are restricted during the first 24 hours.
3. Placement of an indwelling bladder catheter should be avoided during the period of drug infusion and for at least 30 minutes following the end of the infusion.
4. Insertion of a nasogastric tube should be avoided, if possible, during the first 24 hours after treatment.
5. Careful management of blood pressure is critical during the administration of TPA and the ensuing 24 hours. Monitor blood pressure during the first 24 hours after starting treatment as follows. Every 15 minutes for 2 hours after starting the infusion then, every 30 minutes for the next 6 hours, then, every 60 minutes until 24 hours after starting treatment. Initially treat with labetalol 10 mg IV over 1 to 2 minutes, may repeat every 10 to 20 minutes, maximum dose of 300 mg[1]. If BP is still not controlled, consider sodium nitroprusside (0.5-10 mcg/kg/min). Sodium nitroprusside is only kept in the main pharmacy. Dosing and administration guidelines are kept with the drug.

F. <u>TPA dosing table</u> (drug has a concentration of 1 mg/ml once reconstituted)

Weight (lbs)	Weight (kg)	Bolus (over 1 min)	1 hour infusion rate	Total dose
90-94	41	3.7 ml	33 ml/hr	36.7 mg
95-97	43	3.9 ml	35 ml/hr	38.9 mg
98-104	45	4.1 ml	36 ml/hr	40.1 mg
105-109	48	4.3 ml	39 ml/hr	43.2 mg
110-114	50	4.5 ml	41 ml/hr	44.5 mg
115-119	52	4.7 ml	42 ml/hr	46.7 mg
120-124	55	5 ml	44 ml/hr	49 mg
125-129	57	5.1 ml	46 ml/hr	51.1 mg
130-134	59	5.3 ml	48 ml/hr	53.3 mg
135-139	61	5.5 ml	49 ml/hr	54.5 mg
140-144	64	5.8 ml	52 ml/hr	57.8 mg
145-149	66	5.9 ml	54 ml/hr	59.9 mg
150-154	68	6.1 ml	55 ml/hr	61.1 mg
155-159	70	6.3 ml	57 ml/hr	63.3 mg
160-164	73	6.6 ml	59 ml/hr	65.6 mg
165-169	75	6.8 ml	61 ml/hr	67.8 mg
170-174	78	7.0 ml	63 ml/hr	70 mg
175-179	80	7.2 ml	65 ml/hr	72.2 mg
180-184	83	7.5 ml	67 ml/hr	74.5 mg
185-189	85	7.7 ml	69 ml/hr	76.7 mg
190-194	88	7.9 ml	71 ml/hr	78.9 mg
195-199	90	8.1 ml	73 ml/hr	81.1 mg
200-204	92	8.3 ml	74 ml/hr	82.3 mg
205-209	94	8.5 ml	76 ml/hr	84.5 mg
210-214	96	8.6 ml	78 ml/hr	86.6 mg
215-219	98	8.8 ml	79 ml/hr	87.8 mg
220 or more	100 or more	9 ml	81 ml/hr	90 mg

Reference:
1. *Stroke.* 2007;38:1655.

Key Words: CVA, Stroke, TPA, alteplase, ICH, thrombolytic

Standard or Statute:	N/A	**Standard or Statute Details:**	
Date Created:	1997-12-01		
Last Review:	2008-07-15	**Revised:**	Yes

Source: Gifford Medical Center, Randolph, VT

GIFFORD MEDICAL CENTER **CONFIDENTIAL**

Title:	Treatment of ST-Segment Elevation Myocardial Infarction	***Effective Date:**	2010-02-10	**Policy #:**	NUR-675
Applies to:	☒ Hospital ☐ Nursing Home ☐ GMC Employees (HR Policy) ☐ Provider Practice ☐ Medical Staff				
Policy Type:	Procedure				
Contact:	Emergency Department Nurse Manager				

***** **Policy Statement:**	The following guidelines are to assist practitioners with the American Heart Associations/American College of Cardiology recommendations for the treatment of patients who present to the Emergency Department with symptoms consistent with an ST-segment elevation MI

A. Patient Inclusion Criteria

1. Patients presenting to the ED with symptoms consistent with an Acute MI.
   AND
2. EKG demonstrates ST elevation greater or equal to1mm in two or more adjacent leads **or** new LBBB.

B. Procedure

1. Front desk staff will notify the ED nurse or the ED provider **immediately** when a patient arrives with complaints of chest pain.

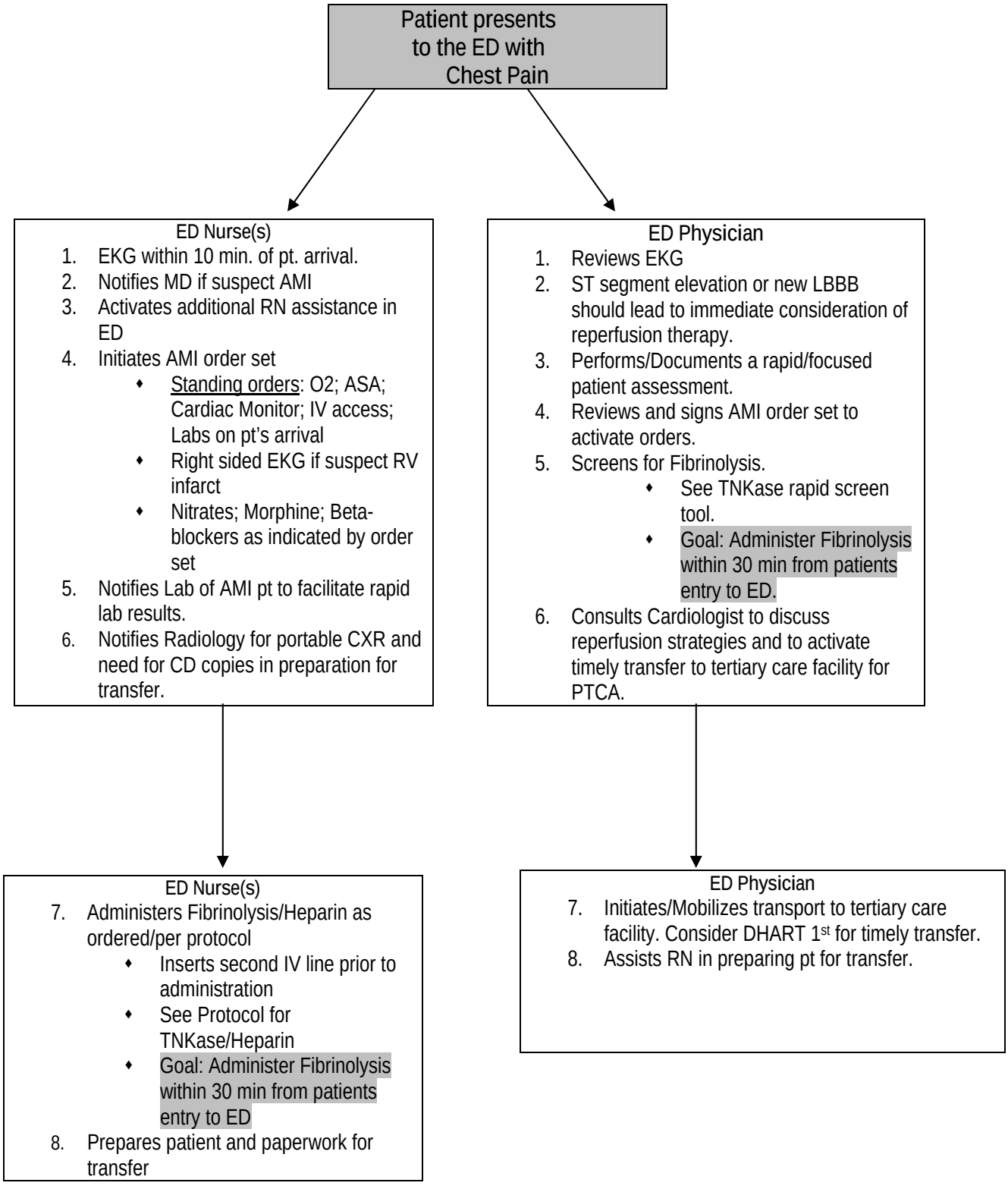
2. The ED nurse and/or provider will evaluate the patient immediately and bring him/her to the treatment area for an EKG, cardiac monitoring, and rapid assessment. Our objective is to have an EKG within 10 minutes of patient's arrival to the ED.

3. The ED nurse will notify the ED provider if symptoms and EKG are consistent with an Acute ST-segment elevation MI and will initiate AMI algorithm and AMI order set to expedite care. AMI algorithm is attached and AMI order set is available in the ED or CPSI. If indicated, our objective is to administer Fibrinolysis within 30 minutes of the patient's arrival to the ED.

C. The following additional policies may be relevant to the care of the patient with an AMI:

1. Fibrinolysis/Tenecteplace (TNKase) Administration
2. Heparin Administration
3. Nitroglycerin Administration
4. **Transport/transfer via DHART or ambulance**

Guideline: Algorithm for Acute ST Segment Elevation MI Assessment and Treatment



Key Words: Acute Myocardial Infarction, ST elevation, Chest Pain, Thrombolytics

Standard or Statute:	Other	**Standard or Statute Details:**	American Heart Association and American College of Cardiology
Date Created:	2006-12-15		
Last Review:	2009-09-30	**Revised:**	Yes

Source: Gifford Medical Center, Randolph, VT