

AEROMED OUTREACH

NURSE AND EMS WEEK

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

May is a great time to thank those we work

with 24/365 and share how much we appreciate all they do. On a daily basis, we are caring for the health of patients who not only

need and depend on us.

Thank you for ALL you do.



RURAL TRAUMA TEAM DEVELOPMENT COURSE

Tampa General Hospital Trauma team and Aeromed recently provided Winter Haven Hospital the Rural Trauma Team Development Course. This course developed by the American College of Surgeon's Committee on Trauma teaches rural receiving facilities the fundamental elements of injury resuscitation. This course emphasizes a team approach to the

initial evaluation and resuscitation of the trauma patient at a rural facility. With more than 60 percent of the country’s trauma deaths occurring in rural areas, the course assists health care professionals in determining the need to transfer the patient to a higher level of care. ("Rural Trauma Team Development Course," Key concepts of this

course include organization of the trauma receiving area and utilization of available resources.

American college of surgeons. Retrieved from <https://www.facs.org/quality-programs/trauma/education/rttdc>



UPCOMING OUTREACH ACTIVITIES

- **Stop The Bleed Class** offered at TGH the 2nd Thursday each month at 10am and the 4th Thursday each month at 5:30pm April-June. Contact Jennifer Mefford at jmefford@tgh.org for additional information

PHYSICIAN'S ARTICLE

Naloxone

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

The answer is No. Not every patient who is suspected to have opiate ingestion needs Naloxone. Naloxone should be reserved for those patients who are hypo-ventilating (<10 breaths/min) and are starting to retain CO₂. The patient in this scenario is maintaining his airway, has normal respirations with nor-

mal O₂ saturation and thus needs to be monitored with the naloxone at standby for if/when the patient starts to develop hypoventilation and hypoxemia.

So how much naloxone to give? Over time, the dose of naloxone has decreased. Localized protocols vary 0.4mg of naloxone, however, seems to be a good starting dose. Be aware that this dose may push patients into immediate withdrawal so smaller more frequent doses of 0.1mg may be adequate. However, in this era of fentanyl adulterated heroin or Car-fentanyl adulterated heroin, you may need more Naloxone and repeat dosing, so keep that in mind.

Remember, an opiate overdose isn't an oxy-

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

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

If the patient continues to have normal VS and is AAOx3 after 2-3 hours, experts agree that they should be fine to be discharged.

Remember, dose low, go slow, and don't wake them up if you don't need too. There is no standard/defined time to watch these patients, but experts state 2- 3 hours is usually enough.

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