LOOKS CRITICALLY ILL
(Don’t Know Why)

30 Second Review
Looks Critically ILL (Don’t know why)
RN, LPN if RN not available on-site

DEF: Illness or injury/trauma that within minutes to hours may cause irreversible CNS damage, loss of limb, and have a concern for possible organ damage or death.

S/S: Signs and symptoms dependent on underlying condition and the location/depth of injury/trauma.

RX:
1. Assess and support airway, breathing and circulation. Consider patient responsiveness and implement C-Spine precautions if indicated or suspected.
2. Start CPR/AED if patient is determined to not be breathing and is pulseless.
3. Activate EMS, keep oxygen SATs >94%, may use supplemental Oxygen to reach this goal. Use high flow oxygen with ambu-bag @ 10-15 liters if LOC depressed.
4. Control bleeding by covering with sterile dressing by applying direct pressure if indicated, do not remove any impaled object if present (only stabilize impaled object).
5. Start IV with large bore needle. May run IV fluid wide open, unless exhibiting signs and symptoms of fluid overload. Continue to monitor airway and vitals closely.

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.

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.

Objective:
Symptoms dependent upon underlying condition but any and/or all of the following may be present:
2. Respiratory: Respirations under 6 or greater than 30 per minute. Presence of any of the following: Dyspnea, wheezing, strider, use of accessory muscles for respirations, tachypnea, respiratory arrest.
4. Skin: cool, clammy with or without profuse diaphoresis.

5. Loss of limb or presents with disfigurement of a joint or extremity.

6. Presents with signs and symptoms of uncontrolled bleeding, external or internal.

**Assessment:**

Nurse has a concern that the patient is presenting with an acute illness or injury/trauma or may be presenting with signs and symptoms of rapid clinical deterioration.

**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 naltrexone/naloxone HC1 0.4 mg IM as an initial dose. A repeat dose may be given in 3-5 minutes as needed. Maximum total dose: 2 mg

3. Maintain breathing: Maintain pulse ox above 94% may use supplemental Oxygen to reach this goal. High flow oxygen by Ambu-bag if LOC depressed. high flow Oxygen by Ambu-bag 10-15 L if LOC is depressed.

4. Start a (preferably) large bore IV with normal saline solution. May run IV fluids wide open, unless patient exhibiting signs or symptoms of fluid overload. Continue to monitor airway and vitals closely.

**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

Clinical Medical Director ___________________________  Date

Effective Date: ________________
Revised: March 2018
Supersedes: February 2015