

Medical Emergency Equipment Policy and Procedures

Purpose:

To provide appropriate evaluation and management of patients in emergency situations so as to optimize the patient's health and well being and to have equipment available to meet the needs of the patients in the event of a medical emergency.

During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site **until** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to:

- 1) establish and maintain a patent/open airway, and
- 2) manage anaphylactic reaction.

Emergency medical equipment: Emergency equipment and medication, appropriate to patient population, are available in an accessible location. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s).

Emergency phone number list: Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), appropriate State, County, City and local agencies (e.g., local poison control number). List should be dated, and updated annually.

Airway management: Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. Portable oxygen tanks are maintained at least $\frac{3}{4}$ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than $\frac{3}{4}$ full at time of site visit, site has a back up method for supplying oxygen if needed **and** a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. Health care personnel at the site must demonstrate that they can turn on the oxygen tank.

Anaphylactic reaction management: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), Benadryl 25 mg. (oral), or Benadryl 50 mg/ml (injectable), tuberculin syringes, alcohol wipes. There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc).

Site Specific Emergency procedures: Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). It is **not sufficient** for provider/staff to state "we call 911". If a site does not have basic medical equipment and medication for handling airway and anaphylactic medical emergencies, there is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene and has taken over care/treatment. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment.

Note: An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy, 2) serious impairment to bodily functions, and 3) serious dysfunction of any bodily organ or part. "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

Evacuation Plans and Procedures eTool

Employee Alarm Systems » Alarm Systems Checklist

GENERAL REQUIREMENTS	YES	NO
1. Does your plan include a way to alert employees, including disabled workers, to evacuate or take other action, and how to report emergencies?	<input type="radio"/>	<input type="radio"/>
2. Have you established an employee alarm system that complies with [29 CFR 1910.165]? [29 CFR 1910.38(d)]	<input type="radio"/>	<input type="radio"/>
3. If the employee alarm system is used for alerting fire brigade members, or for other purposes, is a distinctive signal used for each purpose? [29 CFR 1910.38(d)]	<input type="radio"/>	<input type="radio"/>
4. Does the employee alarm system provide warning for necessary emergency action as called for in the emergency action plan, or for reaction time for safe escape of employees from the workplace or the immediate work area, or both? [29 CFR 1910.165(b)(1)]	<input type="radio"/>	<input type="radio"/>
5. Can alarms be heard, seen, or otherwise perceived by everyone in the workplace? [29 CFR 1910.165(b)(2)]	<input type="radio"/>	<input type="radio"/>
6. Do you provide an auxiliary power supply if electricity is shut off? [29 CFR 1910.165(b)(2)]	<input type="radio"/>	<input type="radio"/>
7. Do you ensure that alarms are distinctive and recognized by all employees as a signal to evacuate the work area or perform actions identified in your plan? [29 CFR 1910.165(b)(3)]	<input type="radio"/>	<input type="radio"/>
8. Have you made available an emergency communications system such as a public address system, portable radio unit, or other means to notify employees of the emergency and to contact local law enforcement, the fire department, and others? [29 CFR 1910.165(b)(4)]	<input type="radio"/>	<input type="radio"/>
9. Have you established procedures for sounding emergency alarms in the workplace? [29 CFR 1910.165(b)(5)]	<input type="radio"/>	<input type="radio"/>
INSTALLATION AND RESTORATION	YES	NO

INSTALLATION AND RESTORATION**YES NO**

1. Are only approved devices, components, combinations of devices, or systems used? Steam whistles, air horns, strobe lights or similar lighting devices, or tactile devices meeting the requirements of this section are considered to meet this requirement for approval. [29 CFR 1910.165(c)(1)]

2. Are all employee alarm systems restored to normal operating condition as soon as possible after each test or alarm? Spare alarm devices and components must be readily available. [29 CFR 1910.165(c)(2)]

 MAINTENANCE AND TESTING**YES NO**

1. Are all employee alarm systems in proper working condition, except when undergoing repairs or maintenance? [29 CFR 1910.165(d)(1)]

2. Is the reliability and adequacy of non-supervised employee alarm systems tested every two months? Use a different actuation device in each test of a multi-actuation device system. [29 CFR 1910.165(d)(2)]

3. Are power supplies maintained or replaced as often as is necessary to assure a fully operational condition? Provide back-up alarms when systems are out of service. [29 CFR 1910.165(d)(3)]

4. Is employee alarm circuitry installed after January 1, 1981 supervised and does it provide positive notification to assigned personnel whenever a deficiency exists in the system? [29 CFR 1910.165(d)(4)]

5. Are the servicing, maintenance and testing of employee alarms done by properly trained persons? [29 CFR 1910.165(d)(5)]

 MANUAL OPERATION**YES NO**

1. Are manually activated alarms unobstructed, conspicuous and readily accessible? [29 CFR 1910.165(e)]

UNITED STATES DEPARTMENT OF LABOR

Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210
☎ 800-321-6742 (OSHA)

EMERGENCY PROTOCOL & CONTACT LIST

TYPES / SERVICE

CONTACT INFORMATION

ALL EMERGENCIES:

911

POISON CONTROL:

(800) 411-8080

CHILD ABUSE HOTLINE:

ELDER ABUSE HOTLINE:

(877) 477-3646

DOMESTIC VIOLENCE HOTLINE:

(800) 799-7233

LOCAL POLICE DEPARTMENT:

LOCAL FIRE DEPARTMENT:

MANAGER/SUPERVISOR NUMBER:

Type of emergency employee alert system used on site: _____

Back-up system: _____

(If 10 or less employees, direct verbal communication is acceptable and does not require a back-up system)

The MEDICAL EMERGENCY KIT is located at _____

The INVENTORY LIST of emergency drugs and their DOSAGE CHARTS are stored with the MEDICAL EMERGENCY KIT.

The OXYGEN TANK is located at _____ and is FULL; secured; has a flow meter and a regulator; and has a mask/cannula attached.

In the event of a MEDICAL EMERGENCY, the following personnel are responsible for:

_____ shall call 911

_____ shall start CPR

_____ shall retrieve the MEDICAL EMERGENCY KIT

_____ shall retrieve the OXYGEN TANK

_____ shall remain with family and/or other patients

Approved by: _____ Date: _____

Dates of Annual Review (for updates): _____

OFFICE EMERGENCY PROTOCOL

IN CASE OF EMERGENCY:

FRONT OFFICE RECEPTIONIST

In charge of communication:

- a. Make phone call to paramedics
- b. Make phone call to ambulance
- c. Make phone call to poison control (if applicable)
- d. Make phone call to Emergency Room (If applicable)
- e. Make phone call to a Specialist (if applicable)

BACK OFFICE MANAGER

In charge of coordination:

- a. Get oxygen, blanket, and IV supplies
- b. Get crash cart
- c. Emergency medication standby (e.g. Epinephrine)
- d. Communicate with patients family if necessary
- e. Monitor vital signs and stay with patient

BACK OFFICE ASSISTANT

In charge of assisting physician:

- a. Perform EKG
- b. Assist in CPR
- c. Assist with other procedures as necessary

Crash Cart, IV Supplies, Oxygen, ETC, are stored together in an easily accessible location.

INFORMATION FOR PRACTITIONER OFFICES

Poison Emergency in the U.S. call	(800) 222-1222
Child Abuse Hotline	Los Angeles County (800) 540-4000 within CA (213) 639-4500 outside CA (800) 272-6699 TDD
	Riverside County (800) 442-4918 or (877) 922-4453
	San Bernardino County (800) 827-8724 or (909) 384-9233
Elder Abuse Hotline	Los Angeles County (877) 477-3646 or (877) 4-R-Seniors (213) 351 -5401 outside California
	Riverside County (800) 491-7123 or (951) 358-6998
	San Bernardino County (877) 565-2020

Vaccine Information Sheets www.immunize.org

Interpreter Services

- SCAN Health Plan
 - TDD (Telecommunication Device for the Deaf)
 - Language Line Services
- (800) 559-3500 Mon-Fri 7:00 am to 6:00 pm
(877) 486-2048
(800) 752-6096 (fee for service)

DHCS Medical Emergency Response Guidelines for PCP Clinic

Emergency health care services are available and accessible 24 hours a day, 7 days a week (Facility Site Review, I. Access/Safety Guidelines, D.)

PROCEDURES:

- Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS).
- There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene
- When the MD or NPMP is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed.
- Non-CPR-certified staff may only call 911 and stay with the patient until help arrives.
- Emergency equipment and medication, appropriate to patient population, are available in an accessible location and is ready for use.
- For emergency “Crash” cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal.
- Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work.

- Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s).

EMERGENCY MEDICAL EQUIPMENT:

Minimum emergency equipment is available on site to:

- Establish and maintain a patent/open airway.
- Manage emergency medical conditions.

EMERGENCY PHONE NUMBER LIST:

- Post emergency phone number list that is dated with telephone numbers updated annually and as changes occur
 - Local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors)
 - Appropriate State, County, City and local agencies (e.g., local poison control number)
- List must include:

AIRWAY MANAGEMENT:

Clinic must have minimum airway control equipment, to include:

- Wall oxygen delivery system or portable oxygen tank (Portable oxygen tanks are maintained at least ¾ full)
 - There is a method/system in place for oxygen tank replacement
- If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed **and** a scheduled plan for tank replacement.
- Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank.
- Health care personnel at the site must demonstrate that they can turn on the oxygen tank.
- Nasal cannula or mask, oropharyngeal airways,
- Bulb syringe
- Ambu Bag as appropriate to patient population. (Mask should be replaced when they can no longer make a solid seal)
- Various sizes of airway devices appropriate to patient population within the practice are on site.

EMERGENCY MEDICATION/ANAPHYLACTIC REACTION MANAGEMENT:

DHCS Medical Emergency Response Guidelines for PCP Clinic – 2019

COMMUNICATION		PHASE	EMERGENCY RESPONSE	
ACTION	RESPONSIBILITY		ACTION	RESPONSIBILITY
Call 911, activate Emergency Medical Services (EMS); Provide address, clinic name, phone# Describe situation Vital Signs Level of consciousness Degree of urgency	Clinic Staff with health information provided by Primary Care Provider	TRIAGE	Check ABCS • airway, breathing, circulation • vital signs • check blood sugar, if indicated • check for medic alert	Primary Care Provider
Establish Leadership and direct activities	Primary Care Provider	MANAGEMENT	Complete brief history and P.E. Maintain a safe environment for staff and client	Primary Care Provider Clinic Staff
Obtain immediate assistance within the office	Primary Care Provider		Obtain required equipment as per emergency protocol Move client as required	Clinic Staff Primary Care Provider
Use Emergency documentation to note treatments and progress	Primary Care Provider		Do secondary survey, detailed physical examination	Primary Care Provider
Obtain history from next of kin and update them on situation	Primary Care Provider		Assess need for immediate treatment	Primary Care Provider
Communicate with and relocate other clients as needed	Clinic Staff	TRANSFER	Initiate treatment according to appropriate protocol with available equipment and medication	Primary Care Provider
Provide patient information and medication sheet for EMS	Clinic Staff		Reevaluate status and response to therapy	Primary Care Provider
Direct staff member to meet EMS team in parking lot, hold elevator, etc.	Clinic Staff		Transfer for definitive care to EMS	Primary Care Provider
Most responsible primary care provider to sign patient over to EMS	Primary Care Provider			
Provide written copy of documentation & medication sheet to EMS	Clinic Staff	FOLLOW-UP		
MD, PA, NP, or RN to call hospital emergency dept. & update status. Note on documentation.	Primary Care Provider		Restock Emergency Cart & re-order medication as required	Clinic Staff
MD, PA, NP, or RN to update next of kin. Permission from pt., if possible	Primary Care Provider		Provide medical follow-up in acute case setting as required	Primary Care Provider
Identify opportunities for improvement and implement changes accordingly	Primary Care Team Manager in collaboration with Primary Care Team		If critical incident, complete appropriate paperwork and steps for reporting. Debrief staff	Team Manager

*** Please confirm all dosages with manufacturer of actual medications on site***

Emergency medications dosage chart – sample

Rx name	Adults	Pediatrics										
<p>Albuterol sulfate¹ inhalation solution (0.0836% - 2.5 mg/ 3 ml)</p> <p>Albuterol sulfate¹ inhalation aerosol metered dose (90 mcg/actuation)</p>	<p>2.5mg to 5mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN.</p> <p>4 to 8 inhalations every 20 minutes for up to 4 hours, then 1 to 4 hours PRN.</p>	<p>Children: 2.5 mg to 5 mg every 20 minutes for 3 doses, then 2.5 mg to 10 mg every 1 to 4 hours PRN.</p> <p>Infant: 2.5 mg every 20 minutes for the first hour PRN; if there is rapid response, can change to every 3 to 4 hours PRN.</p> <p>Children: 2 to 10 inhalations every 20 minutes for 2 to 3 doses; if rapid response, can change to every 3 to 4 hours PRN.</p> <p>Infant: 2 to 6 inhalations every 20 minutes for 2 to 3 doses; if there is rapid response, can change to every 3 to 4 hours PRN.</p>										
<p>Chewable aspirin 81 mg (not enteric coated)</p>	<p>For myocardial infarction (MI): Chew 2 to 4 tablets upon presentation or within 48 hours of stroke.</p>	<p>For myocardial infarction (MI): Chew 2 to 4 tablets upon presentation or within 48 hours of stroke. *Aspirin is not recommended for patients less than 18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye syndrome.</p>										
<p>Benadryl¹ HCL injection, USP (50 mg/ml)</p>	<p>10 mg to 50 mg IV/IM (not to exceed 400 mg/day) If IV route, IV push at a rate of ≤25 mg/min.</p>	<p>Children: 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose). If IV route, IV push at a rate of ≤25 mg/min.</p> <p>Infant: 1 to 2 mg/kg/dose IV/IM (not to exceed 50 mg/dose).</p>										
<p>Benadryl² liquid 12.5 mg/5 ml</p>	<p>25 to 50 mg every 4 to 6 hours; max 300 mg/day.</p>	<p>Child weight (pound):</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;">lbs</td> <td style="padding: 2px;">20 to 24</td> <td style="padding: 2px;">25 to 37</td> <td style="padding: 2px;">38 to 49</td> <td style="padding: 2px;">50 to 99</td> </tr> <tr> <td style="padding: 2px;">ml</td> <td style="padding: 2px;">4</td> <td style="padding: 2px;">5</td> <td style="padding: 2px;">7.5</td> <td style="padding: 2px;">10</td> </tr> </table>	lbs	20 to 24	25 to 37	38 to 49	50 to 99	ml	4	5	7.5	10
lbs	20 to 24	25 to 37	38 to 49	50 to 99								
ml	4	5	7.5	10								
<p>Benadryl¹ chewable 12.5 mg</p>	<p>2 to 4 chewable tablets every 4 to 6 hours.</p>	<p>Child weight (pound):</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;">lbs</td> <td style="padding: 2px;">20 to 24</td> <td style="padding: 2px;">25 to 37</td> <td style="padding: 2px;">38 to 49</td> <td style="padding: 2px;">50 to 99</td> </tr> <tr> <td style="padding: 2px;">tablet</td> <td style="padding: 2px;">N/A</td> <td style="padding: 2px;">1</td> <td style="padding: 2px;">1 ½</td> <td style="padding: 2px;">2</td> </tr> </table>	lbs	20 to 24	25 to 37	38 to 49	50 to 99	tablet	N/A	1	1 ½	2
lbs	20 to 24	25 to 37	38 to 49	50 to 99								
tablet	N/A	1	1 ½	2								
<p>Benadryl¹ tablet 25 mg (Oral)</p>	<p>Take 25 mg to 50mg by mouth.</p>	<p>Not preferred. Refer to parenteral route or oral solution.</p>										
<p>Epinephrine¹ injection, 1:1,000 (1 mg/ml)</p>	<p>0.3 to 0.5 mg IM may repeat every 5 to 10 minutes.</p>	<p>0.01 mg/kg IM (up to maximum of 0.3 mg). May repeat every 5 to 10 minutes as needed.</p>										

Rx name	Adults	Pediatrics
Epinephrine² injection, 1:10,000 (0.1 mg/ml)	0.1 to 0.25 mg IV (1 to 2.5 ml of 1:10,000 solution) injected slowly once.	Infant: 0.05 mg IV slowly once, may repeat at 20 to 30 minute intervals as needed. Neonates: 0.01 mg/kg of body weight IV slowly once.
Epinephrine¹ Injection, USP auto-injector: Epipen Jr (Epinephrine 0.15 mg) Epipen (Epinephrine 0.3 mg) Auvi Q (Epinephrine 0.1 mg, 0.15 mg, 0.3 mg)	> 66 lbs: 0.3 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh. > 66 lbs: 0.3mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.	33 to 66 lbs: 0.15 mg/dose IM or subcutaneous into the anterolateral aspect of the thigh. < 33 lbs: Not recommended. 33 to 66 lbs: 0.15mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary. 16.5 - 33 lbs: 0.1mg IM or subcutaneous into anterolateral aspect of the thigh, through clothing if necessary.
Naloxone (Narcan)¹ injection solution injection (0.4, or 1 mg/mL): Naloxone auto injector (Evzio) (2 mg in 0.4 ml) Naloxone nasal spray (4 mg/actuation)	0.4 mg to 2 mg IV, IM, or subcutaneous up to a total dose of 10 mg, may repeat every 2 to 3 minutes as needed. 2 mg IM or subcutaneous into the anterolateral aspect of the thigh, may repeat same dose after 2 to 3 minutes. Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.	0.01 mg/kg IV, IM or subcutaneous, may repeat dose every 2 to 3 minutes as needed. 2 mg IM or subcutaneous into the anterolateral aspect of the thigh, may repeat same dose after 2 to 3 minutes. (Under 1 year old, thigh muscle should be pinched while administering injection). Spray 4 mg into 1 nostril. If desired response is not achieved after 2 to 3 minutes, give a second dose intranasally into alternate nostril.
Nitrostat (Nitroglycerin) SL tablets (0.3 mg or 0.4 mg) Nitroglycerin spray (0.4 mg)	0.3 mg to 0.4 mg sublingually or in buccal pouch at onset, may repeat in 5 minutes; max 3 tabs in 15 minutes. Prophylaxis: 5 to 10 minutes before activity. Spray 0.4 mg (1 spray) sublingually every 5 minutes up to 3 doses.	Not recommended.
Glucagon for injection (emergency medication for low blood sugar) 1 mg (1 unit)	< 20kg: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous. > 20 kg: 1 mg IM, IV or subcutaneous.	< 20 kg: 0.5 mg or 20 to 30 mcg/kg IM, IV or subcutaneous > 20 kg: 1 mg IM, IV or subcutaneous (If the patient does not respond in 15 minutes, may give 1 to 2 more doses).

Rx name	Adults	Pediatrics
Glucose tablet	<p>If the patient does not respond in 15 minutes, may give 1 to 2 more doses.</p> <p>15 gm (3 to 4 tablets) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve.</p>	<p>Children: 10 gm to 20 gm (0.3gm/kg) by mouth, may repeat in 15 minutes if hypoglycemic symptoms do not resolve.</p> <p>Infant: Not preferred. Parenteral route recommended (IV dextrose or IM glucagon).</p>
Ammonia² inhalants	Crack open one (1) capsule.	Same as adult.
Lidocaine² 1% HCL Inj. USP 10 mg/ml (50 ml MDK)	Use only the 10% solution for IM injection. 300 mg in deltoid or thigh muscle.	Individualize.
Sodium chloride² 0.9% Injection USP (1000 mL)	125 drops / minute	<p>Depends on age:</p> <p>1 to 4 years old: 40 drops/minute</p> <p>5 to 10 years old: 60 drops/minute</p>
Solu-Medrol² 125 mg/ml injection, USP 2 ml single dose vial	Initial dosage: 10 to 40 mg IV, IM	Initial dosage: 0.11 to 1.6 mg/kg/day in 3 to 4 divided doses IV,IM
Oxygen delivery system – tank at least three-quarters full	Can consider any oxygen delivery systems if appropriate.	<p>Children: Nasal prongs or nasal catheters preferred; can consider face mask, bead box, or incubator for older children.</p> <p>Infant: Nasal prongs or nasal catheters preferred.</p>
Oxygen delivered 6 to 8 L/minute	6 to 8 L/minute	<p>Children: 1 to 4 L/minute</p> <p>Infant: 1 to 2 L/minute</p>

¹ Only one emergency medication strength or route required.

² Not required; optional emergency medications only.

The material in this document is a knowledge-sharing tool provided by the FSR team to enhance compliance with Facility Site Review requirements. All content is for informational purposes and may be used and/or modified according to site-specific practices. Ensure appropriate review and approval by site management prior to adoption.

Management of Anaphylaxis

(EXTREMELY RARE REACTION TO IMMUNIZATIONS)

Anaphylaxis, a potentially life-threatening acute systemic allergic reaction to a foreign substance, is extremely uncommon after immunization. Nonetheless, immunization clinic staff should have basic knowledge on how to recognize and initiate "first-aid" treatment of this reaction.

Anaphylaxis must be distinguished from simple fainting (vasovagal syncope) which can occur before, during or shortly after injection. Persons experiencing this reaction may become pale and feel faint, or they may suddenly collapse unconscious but with a steady pulse and normal respiration.

- Persons feeling faint should lie flat or sit in the head-down position for several minutes.
- Person who faint completely should be placed flat with the feet (not the head) somewhat elevated. After they regain consciousness, they should be allowed to rest in a quiet area for 10 minutes.

Anaphylaxis usually begins at least several minutes after injection of an offending substance. Initial symptoms typically include several of the follow: sneezing, coughing, itching, "pins and needles" sensation of the skin, flushing, facial edema, urticaria ("hives"), and anxiety. In severe cases, these symptoms may be followed by progressive dyspnea (with or without audible wheezing or stridor due to lower and/or upper airway narrowing) and/or hypotension which may progress to shock and collapse, with a weak and fast or irregular pulse.

The following is a guideline for IMMEDIATE "first aid" medical treatment of anaphylaxis that should be given in immunization clinics where more sophisticated medical attention and equipment (oxygen, intravenous medication, etc....) are not immediately available.

Nurses can legally initiate these emergency treatment measures (Business and Professions Code 2725d):

1. Call emergency medical / paramedic staff.
2. Apply tourniquet lightly (not so tight as to stop arterial pulse) above injection site, unless this is impossible (as in deltoid or gluteal area injection).
3. Inject intramuscularly into the deltoid (not in the same are as the vaccine injection) **aqueous 1:1000 epinephrine (adrenaline)** according to the following approximate dosage:

< 12 months	0.05 ml
1-4 years old	0.15 ml
5-9 years old	0.3 ml
>10 years old	0.5 ml

If no improvement occurs within 3-4 minutes, repeat this intramuscular dose. Monitor respiration, pulse, and (if a sphygmomanometer is available) blood pressure. The same epinephrine dose can be repeated every 10-15 minutes, if needed.

4. As an adjunct to epinephrine (but not a replacement), **Benadryl (diphenhydramine hydrochloride), 50 mg/ml**, can be given once intramuscularly (at a different site than the epinephrine) in the following approximate dosage:

Under age 2 years	0.25 ml
Ages 2-4 years	0.5 ml
Ages 5-11 years	1.0 ml
>Age 12 years and Adults	2.0 ml

SECTION	Approval date:	
Access/Safety	Approved by:	
POLICY AND PROCEDURE	Effective date:	
Emergency Medical Procedures	Revision date:	

POLICY:

Emergency health care services shall be available and accessible twenty-four hours a day, seven days a week.

PROCEDURE:

I. EMERGENCY MEDICAL EQUIPMENT

Minimum emergency medical supplies/equipment, sufficient to establish and maintain a patent/open airway and manage anaphylactic reactions, shall be maintained in the facility. The equipment will include:

- A. A wall oxygen delivery system or secured portable oxygen tank maintained at least $\frac{3}{4}$ full. An oxygen delivery system which includes population-appropriate size (pediatric and adult): ambu-bag with face mask that creates proper seal, nasal cannula or oxygen mask, tubing, and bulb syringe.
 - Providers may NOT use small oxygen tanks where the liter flow cannot be adjusted. There is no size requirement for the tank, however, it must reflect the content balance in increments of $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$, and full. The oxygen should last long enough to handle an emergency until the arrival of the emergency medical response team.
 - Office staff will know how to turn on and regulate the oxygen flow.
- B. Benadryl 25 mg (oral) or Benadryl 50 mg/ml (injectable), Epinephrine 1:1000 (injectable), Naloxone, chewable aspirin 81 mg (at least 4 tablets), nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), glucose, appropriate sizes of ESIP syringes and alcohol wipes.
- C. Emergency medication dosage chart (see attached).

The supplies/equipment will be located “together” in an accessible location allowing for retrieval by all staff members without the use of assistive devices.

The supplies and equipment shall be checked for expiration and operating status at least monthly. Staff responsible for checking the equipment/supplies shall document:

- The date the supplies/equipment were checked, and
- His/her initials verifying that equipment is in working order, the oxygen tank is at least $\frac{3}{4}$ full, the supplies are within expiration date and the medication dosage chart is present.

Replacing/restocking supplies:

- An extra oxygen tank will be maintained onsite -OR- each time the oxygen tank is used, the remaining supply will be checked. If the tank is $\frac{3}{4}$ or less full, the supplier will be called to replace the used tank with a full tank.
- The month prior to the noted expiration date, the supplies/medication will be ordered to ensure delivery before the supplies actually expire.
- The medication and supplies will be ordered and or replaced immediately after use.

II. **EMERGENCY SERVICES TRAINING**

All staff members will be trained on the emergency medical protocol. Staff will be able to:

- Describe facility-specific actions, and
- Locate written emergency procedures and information.

Training shall be completed upon hire and when updates to policy are made.

Training shall be documented.

III. **EMERGENCY INFORMATION**

Emergency phone numbers will be posted in an accessible and prominent location (e.g., front and back office). Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City, and local agencies (e.g., local poison control number).

Emergency phone number list shall be dated, and telephone numbers updated annually and as changes occur.

IV. **EMPLOYEE ALARM/ALERT SYSTEM**

In the event of a fire or other emergency, employees are notified as soon as possible using the employee alarm/alert system (e.g., manual pull box alarms, public address systems, radio, telephones). Back-up means of alarm/alert (e.g., employee runners, air horns) shall be provided when systems are out of service. For those with 10 or fewer employees, direct voice communication is acceptable (provided all employees can hear the alarm or alert) and do not need a back-up system.

Type of Emergency Employee Alarm/Alert System used on site: _____
Back-up system: _____