



# Crashing Medical Patient

## History

- Blood loss - vaginal or gastrointestinal bleeding, AAA, ectopic
- Fluid loss - vomiting, diarrhea, fever
- Infection
- Cardiac ischemia (MI, CHF)
- Medications
- Allergic reaction
- Pregnancy
- History of poor oral intake

## Signs and Symptoms

- Tachycardia out of proportion to temp
- Hypoxia (SpO2<90%)
- Bradypnea or tachypnea
- Respiratory distress requiring NIPPV
- SBP <90
- AMS
- Delayed capillary refill >2 sec
- Hypotension for age
- Cool / mottled or flushed/ruddy skin
- Tarry stool / GI bleed

## Differential







- Ectopic pregnancy
- Dysrhythmias
- Pulmonary embolus
- Tension pneumothorax
- Medication effect / overdose
- Vasovagal
- Physiologic (pregnancy)
- Sepsis

Assess symptom severity & identify a critical medical patient

Patient exhibits one or more abnormal vital sign(s) with signs/symptoms consistent with crashing patient

**DO NOT INITIATE PATIENT MOVEMENT**  
*Unless movement is necessary for safety or patient access*  
**INITIATE RESUSCITATIVE MEASURES AS SOON AS POSSIBLE**  
Consider the need for additional resources

Primary goal is to stabilize the crashing patient before moving

 Airway Adult / Pediatric
 Allergic Reaction / Anaphylaxis
 Adult Cardiac
 Hypotension / Shock
 Respiratory Distress
 Sepsis

 **Notify Destination or Contact Medical Control** 



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## Pearls

- This protocol pertains to critical *medical* patients. The mainstay of treatment for critical **trauma** patients is still safe rapid transport.
- The idea of rapid transport for “definitive care” in a paramedic system is a misnomer- the initial resuscitative measures provided by the emergency department are identical to those initial resuscitative measures provided by a paramedic.
- Identification of a critical patient should occur as soon as possible upon patient contact *prior* to initiation of movement to the ambulance. A full set of vital signs must be obtained as soon as possible upon patient contact (preferably within 5 minutes).
- Ensure all resuscitative equipment is brought to the patient side and available at initial evaluation (i.e. bring equipment to patient side).
- For hypotensive patients, *clinically meaningful access* is required- large-bore proximal IV, or IO access.
- In hypotensive patients where IV access fails, transition to IO access rapidly.

**GCS 15 DOES NOT EQUAL STABILITY.**

**HYPOTENSION REQUIRES TREATMENT REGARDLESS OF MENTAL STATUS.**

**IO ACCESS DOES NOT REQUIRE ALTERED MENTAL STATUS AND SHOULD BE CONSIDERED IN ALERT PATIENTS REQUIRING EMERGENT ACCESS IN WHICH IV ACCESS CANNOT BE OBTAINED.**

- For patients requiring a prolonged extrication time to the ambulance (i.e. down multiple flights of stairs), pre-determined stopping points should be established to allow for patient reassessment (i.e. confirming pulse, reassessing vital signs, and titrating pressors) at least every 5 minutes. **EXTRICATION TAKES MORE TIME THAN ESTIMATED.**
- The only exception for safe rapid movement of a critical medical patient is for instances where the patient requires intervention not available to the EMS crew:
  - Hypoxia or respiratory distress refractory to EMS measures and requiring RSI or other advanced airway procedure.
  - Patient requiring hemodynamic or airway interventions not in scope of practice of responding crew and safe rapid transport is needed to facilitate ED transport or rendezvous with more advanced clinicians.
  - Suspected hemorrhagic shock requiring safe rapid transport for administration of blood products (if not available to crew) or surgical intervention (i.e. unstable GI bleed, unstable vaginal hemorrhage, or suspected aortic catastrophe).
  - EMS resuscitative measures have failed to result in clinical improvement (i.e. unable to pace a patient requiring safe emergent transport for transvenous pacing, hypotension refractory to vasopressors and fluids).