

Standing Order

TITLE	CARDIOPULMONARY ARREST
LOCATION	LORNE COMMUNITY HOSPITAL – All Areas of the Facility
STANDING ORDER No:	1
VERSION	1
VARIATIONS FROM PREVIOUS VERSION	NIL

Governance

Enactment date	/ /		
Expiry: (maximum of 36 Months from date of original Approval)	13/8/07		
Drug and Therapeutics Committee Endorsement Date	/ /		
Chairperson, Drug and Therapeutic Committee (Clinical Services)	Signature	Name	Date
Completion of Process for removal of previous version of Standing Order	Signature	Authority	Date
Approved Standing Order Distributed	Signature	Authority	Date

Staff Requirements and Authorisation

AS PER LORNE COMMUNITY HOSPITALS “STANDING ORDER POLICY”

ALS endorsed Nurse have all undertaken education in the diagnosis and assessment of cardiac rhythms. This includes theoretical and practical sessions in:

- Assessment concerning the rhythms that are amenable to the use of atropine and adrenalin
- The Drugs, doses and side effects.

Application of the Standing Order

When use of this standing Order Is applicable	When a client has a severely reduced or absent Cardiac Output as a result of a life threatening arrhythmia.
Other Relevant Standing Orders	When arrest is associated with acute pulmonary oedema, anaphylaxis or asthma, refer to those standing orders when reversing possible causes of arrest,
Links	<ul style="list-style-type: none"> ❑ Adult Advance Life Support Algorithm - Aust Resus Guidelines 2002 ❑ Emergency Nursing Guidelines 2001 3rd Edn – DHS Vic

Basis for Standing Order

To allow for the treatment of clients suffering potentially fatal conditions by the Lorne Community Hospital nursing staff, despite a Doctor not being immediately available.

The immediate treatment of life threatening cardiac rhythms by defibrillation and drug therapy has been well documented, with early interventions producing the best possible outcomes for the patient.

References

1. The Advanced Life Support Committee of the Australian Resuscitation Council.
Policy Statement 11.7 July 1997
Policy Statement 11.4 February 2002
2. American Heart Association Emergency Cardiac Care. Guidelines for cardio-pulmonary resuscitation and emergency cardiac care.
3. Emergency Nursing Guidelines 2001 3rd Edition

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Administration of Atropine

Clinical Condition and Circumstances for use	<p>Bradycardia in adult patients where the heart rate is < 40 with a systolic blood pressure < 80 mm Hg</p> <p>PLUS</p> <p>Signs of decreased cardiac output threatening life (Shutdown, sweating, decreased GCS, central cyanosis, sense of impending doom etc)</p> <p>(ie idioventricular, heart blocks)</p>
Limitations	For use in adult patients only (18ys and above)
Area of application	<p>Hospital Inpatients</p> <p>UCS</p> <p>Residential Care</p> <p>District Nursing service</p>
Contra-indications	<ul style="list-style-type: none"> ❑ Known allergy to atropine ❑ Exemption from standing order ❑ Documented NFR order <p>Be cautious with Glaucoma, urinary retention, paralytic ileus, Unstable CV Status.</p>
Monitoring	Continuous cardiac monitoring, SAO2, pulse rate, NIBP.
Procedure	<ul style="list-style-type: none"> ❑ 100% O2 ❑ IV Access with IV Normal Saline running ❑ Administer by IV push ❑ Allow Saline flush ❑ Document change in monitored Heart Rate, Rhythm, pulse and clinical condition (print rhythm strip) ❑ Urgent consult with medical officer <p><i>As per ARC guidelines</i></p>
Documentation	<p>All drugs administered as part of resuscitation are recorded and signed on medication section of the UCS form or MR161. The Nurse who administers the drug is to write</p> <p>“Standing Order”</p> <p>in the section provided for Doctors signature</p>
Dosage	600 microg intravenously, this may be repeated at 3 minutely intervals to a maximum of 2 mg.
Adverse effects	Adverse effects are dose related and usually reversible when therapy ceased. (Blurred vision, photophobia, dry mouth, tachycardia, arrhythmias, hypertension, urinary retention, excitement, delirium, constipation, insomnia and hyperthermia)
Management of Complications	Commence appropriate ALS resuscitative measures and notify Medical Officer.

NB : Do not delay notification of the Medical Officer

Administration of Adrenaline

Clinical Condition and Circumstances for use	All pulseless patients (Ventricular Fibrillation, Pulseless Ventricular Tachycardia, Asystole, Pulseless electrical activity/EMD, Ventricular Standstill etc)
Limitations	For use in adult patients only (18ys and above)
Area of application	Hospital Inpatients UCS Residential Care District Nursing service
Contra-indications	<ul style="list-style-type: none"> ❑ A pulse ❑ Known allergy to Adrenaline ❑ Exemption from standing order ❑ Documented NFR order
Monitoring	Continuous cardiac monitoring, SAO2, pulse rate, NIBP.
Procedure	<ul style="list-style-type: none"> ❑ BLS & ALS <p>DO NOT DELAY EARLY DEFIBRILLATION IF INDICATED!</p> <ul style="list-style-type: none"> ❑ IV Access with IV Normal Saline running ❑ Administer by IV push ❑ Allow Saline flush ❑ Document change in clinical condition. ❑ Urgent consult with medical officer <p style="text-align: center;"><i>As per ARC ALS Algorithm</i></p>
Documentation	All drugs administered as part of resuscitation are recorded and signed on medication section of the A&E patient form. The Nurse who administers the drug is to write “Standing Order” in the section provided for Doctors signature
Dosage	1mg intravenously @ 3 minutely intervals until <ul style="list-style-type: none"> ❑ Return of pulse ❑ CPR ceased as patient deceased ❑ Instructed differently by the Doctor (1ml of 1:1000 or 10ml of 1:10,000)
Adverse effects	Severe Hypertension = Cerebral vascular accident, tremor, nervousness, tachycardia, sweating, headache, dizziness, angina pain, nausea & vomiting.
Management of Complications	Commence appropriate ALS resuscitative measures and notify Medical Officer.
NB : Do not delay notification of the Medical Officer	