

Appendix 10: Emergency Office Drills

Airway Obstruction: Foreign Body Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal command 2. Sudden cessation of respiratory sounds a. May have breath-holding b. May have paradoxical breathing efforts	Recognition of emergency a. If patient can breathe and exchange air, leave alone. Universal sign: hands on throat b. If patient is conscious, remove materials from mouth and perform Heimlich maneuver (chest thrusts in pregnant woman) to dislodge object until breathing restored or patients loses consciousness.	☐ Satisfactory ☐ Unsatisfactory
Patient unconscious with known or suspected foreign body	Place patient in supine position and activate EMS. a. Remove materials from mouth if not yet accomplished. b. If you can see the object, include attempts to remove object by finger sweep and/or improve airway by head tilt-chin lift, jaw thrust or tongue protrusion and may include ventilation attempts with 100% oxygen. c. Attempt to visualize hypopharynx with laryngoscope and remove object with Magill forceps. d. If vocal cords visualized and in spasm, move to Laryngospasm Algorithm.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	Perform series of abdominal thrusts (chest thrusts in pregnant woman) to dislodge object followed by attempts to remove object and ventilate with 100% oxygen. a. Assess vital signs when possible.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	Consider muscle relaxant. a. May use succinylcholine in a dose of 1.0 to 1.5 mg/kg IV or 4mg/kg IM if no IV access. b. May use nondepolarizing blocker in intubation dose if succinylcholine is contraindicated. Rocuronium 0.6-1.2 mg/kg. Consider laryngoscopy and intubation. Consider cricothyroidotomy/transtracheal ventilation.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Airway Obstruction: Laryngospasm Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient sedated or G/A 2. Sudden cessation of respiratory sounds a. May have breath-holding b. May have paradoxical breathing efforts 3. High-pitched crowing sounds	1. Recognition of emergency 2. Remove materials from mouth. 3. Control bleeding. 4. Place patient in the supine position. a. May include attempts to improve airway by head tilt, chin lift, jaw thrust, or tongue protraction and may include ventilation attempts with 100% oxygen. 5. Suction hypopharynx. 6. Positive pressure via full face mask.	☐ Satisfactory ☐ Unsatisfactory
Initial response fails to resolve problem.	Deepen anesthesia.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem.	7. Positive pressure ventilation with 100% oxygen a. May include airway adjuncts. b. Laryngeal mask airway placement if laryngospasm not suspected.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem.	8. Deepen sedation. a. Propofol 0.2–0.5 mg/kg 9. Consider laryngoscopy and intubation. a. Use succinylcholine in a dose of 1.0 to 1.5 mg/kg or 4 mg/kg IM if no IV access. Alternate paralytic is rocuronium 1.0 mg/kg IV. 10. Consider reversal agents for Rocuronium: Neostigmine—0.07 mg/kg and Robinul 0.01 mg/kg once 1 of TOF is regained. For rapid reversal, sugammadex (Bridion) can be used in a dose of 16 mg/kg for early reversal of paralysis. 11. Consider cricothyroidotomy/transtracheal ventilation. 12. Consider EMS.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Bronchospasm Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may be conscious or nonresponsive to verbal command. 2. Auscultation of patient: You hear the following: - Expiratory wheeze common - Inspiratory wheeze indicative of severe attack - Prolonged expirations - No sounds = very severe attack 3. Vital signs 4. Tachypnea, dyspnea, tachycardia	Recognition and Management Steps - Patient position: Conscious patient: Place in sitting position for patient comfort. - Additional airway support as needed - Unconscious patient: Airway maneuvers: Head tilt, chin lift, jaw thrust, pull out tongue. - Suction the mouth and pharynx. - Auscultate the chest. - Nasal oxygen for awake or sedated patient: Want SpO₂ > 95. - Vital signs: Monitor HR, BP, Rhythm, SpO₂, capnography	☐ Satisfactory ☐ Unsatisfactory
Initial response fails to resolve problem	- What is the first drug used: SABA agent is albuterol MDI inhaler - What is the dose: 4 to 10 puffs. - Explain how this is accomplished with patient under anesthesia. - Show equipment you use to accomplish this. - Do you use a spacer? - SABA agent: Albuterol nebulizer - What is the dose? 2.5 mg/3 mL. - How is this administered: Show the equipment. - Intubated cases: How do you administer albuterol? - Show the equipment. - How do you ventilate the patient? - Show the BVM. - Why is it sometimes difficult to bag? Decreased lung compliance. - Deepen the anesthesia. - Inhalation agents are best bronchodilator. - Propofol is better than ketamine.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	- Activate EMS. - Parenteral bronchodilator - What is the drug, the dose, and the route? - Epinephrine: IV access for anesthesia; use this route, not IM. - Dose: 5 to 20 mcg as needed (q 5 min) - Epinephrine 1:1000 1-mL vial = 1 mg 100-mL bag of NSS. - Inject 1 mL into bag. - Concentration is 10 mcg/mL. - Epinephrine 1:10,000, 1 mL = 100 mcg dilute 1 mL with 9cc's NS to 10 mcg/mL - IM epinephrine 100 to 300 mcg. Do not give IM dose as IV dose.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	- Consider laryngoscopy and intubation with endotracheal tube. - Consider reversal agents, termination of anesthesia.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Notes: Multiple alternative anti-asthmatic agents are available; review proper use of candidate's emergency anti-asthmatic drug(s) before emergency evaluation.

Emesis-Aspiration Algorithm

Scenario requirements	Interventions	Examinee responses
1. Evidence of active or passive regurgitation under sedation or G/A	1. Recognition of emergency. 2. Place the patient in the proper position. a. If patient undergoing conscious sedation, right lateral position. b. If patient undergoing general anesthesia, Trendelenburg position (also on right side if feasible). 3. Immediate removal of materials in mouth and use high-speed suction. 4. Immediate cricoid pressure (Sellick's maneuver). 5. 100% oxygen 6. Monitor blood pressure at least q 1-3 min; continuously monitor pulse oximetry, heart rate, end tidal CO ₂ 7. Auscultate lungs to detect altered breath sounds.	☐ Satisfactory ☐ Unsatisfactory
Response based on presenting symptoms	8. With no evidence of aspiration: a. Consider termination of procedure and discharge after further monitoring. 9. With evidence of aspiration: a. Activate EMS. b. Consider reversal agents, terminate procedure. c. Consider 100% oxygen. d. Consider going to Bronchospasm Algorithm. 10. With evidence or possibility of aspiration in the unconscious patient: a. Consider laryngoscopy and intubation. b. Hospitalization.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Notes: Administration of antibiotics and steroids is not recommended. Tracheal suction after irrigation with 10 mL of sterile irrigation fluid is permissible to help remove particulate matter.

Respiratory Depression Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Evidence of respiratory depression by low pulse oximetry, low respiration rate/volume, and/or high end-tidal carbon dioxide tension.	1. Recognition of emergency. 2. Place patient in comfortable position, supine position if unconscious. 3. 100% oxygen. 4. Remove materials from mouth.	☐ Satisfactory ☐ Unsatisfactory
Response based on presenting signs and symptoms	5. If patient conscious: a. Encourage increased breathing efforts and assess vital signs. 6. If patient unconscious: a. Attempt to improve airway by head tilt-chin lift, jaw thrust, tongue protraction. b. Check pulse and assess vital signs when possible. c. Supplemental O ₂ via nasal cannula at 2–4 L/min.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	7. Consider supraglottic airway. 8. Consider reversal agents (naloxone, flumazenil). 9. Consider laryngoscopy and intubation. 10. Consider EMS.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Hypertension Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Hypertensive urgency: When blood pressure above 220/120 and no signs or symptoms; Hypertensive crisis: With evidence of myocardial ischemia, neurological dysfunction, significant bradycardia, pulmonary edema or visual disturbances.	1. Recognition of emergency. 2. Place patient in comfortable position. 3. Remove materials from mouth. 4. 100% oxygen. 5. Monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry, heart rate and end-tidal CO ₂ .	☐ Satisfactory ☐ Unsatisfactory
Initial response fails to resolve problem	6. Look for specific cause of hypertension (e.g., anxiety, cardiovascular disease, drug interaction, full bladder, hypoxia, pain). 7. Treat specific cause (e.g., provide additional local anesthesia for pain control) – deepen anesthesia.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	8. Administer drugs to decrease cardiac output and/or peripheral resistance. a. To control intraoperative and postoperative tachycardia and hypertension: esmolol. i. Immediate control: 1 mg/kg bolus then 150 mcg/kg/min. ii. Gradual control: 500 mcg/kg over 1 min, then 50 mcg/kg/min. b. May administer esmolol 0.5 mg/kg q 5 min if tachycardic then 50–300 mcg/kg infusion; up to 1 mg/kg for hypertension or SVT. c. Labetalol: 5 to 20 mg q 2 min (not for asthmatics) then 40–80 mg IV q 10 min; total dose not to exceed 300 mg.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	9. EMS if hypertensive crisis. 10. Consider immediate physician referral if hypertensive urgency.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario	1. Target initial BP gradually 20%–30% initially. 2. SP < 185 and DBP < 110 is a general goal.	☐ Satisfactory ☐ Unsatisfactory

Notes: Nonemergency hypertension may be treated without terminating procedure. Multiple alternative antihypertensive agents are available; review proper use of candidate's emergency antihypertensive drug(s) before emergency evaluation.

Hypotension Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Blood pressure below two-thirds normal for patient or causing signs and symptoms of hypoperfusion (lightheadedness, chest pain, disorientation).	1. Recognition of emergency. 2. Place patient in supine position with legs elevated. 3. Remove materials from mouth. 4. 100% oxygen. 5. Monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry and heart rate.	☐ Satisfactory ☐ Unsatisfactory
Initial response fails to resolve problem	6. Look for specific cause of hypotension (e.g., anxiety, cardiovascular disease, drugs, pain, postural changes), 5 Hs (hypercarbia, hypoxia, hypovolemia, hydrogen ion [acidosis] hypo/hyperkalemia, hypothermia) and 5 Ts (toxins, tamponade, tension pneumothorax, thrombosis [(pulmonary) and thrombosis [(coronary)]). 7. Treat specific cause (e.g., IV fluid challenge for hypovolemia 20 mL/kg for pediatrics and 500 mL challenge adults), stop anesthesia; stimulate patient.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	8. Administer drug to increase cardiac output and/or peripheral resistance. a. May administer 0.01 mg/kg atropine IV up to 0.5 mg if bradycardia; may repeat dose q 5 min for total of 3 mg. b. Hypotensive with NSR or bradycardia may administer ephedrine 5–10 mg q 5 min. c. May administer phenylephrine 0.1 mg q 5 min if tachycardia; 10 mg/1 mL. d. How to dilute phenylephrine: double-syringe technique, or 10 mg/100 mL equals 0.1 mg/mL.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	9. Consider reversal agents and watch patient for 1 hour. 10. Consider EMS.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Notes: Non-emergent hypotension may be treated without terminating procedure. Multiple alternative anti-hypotensive agents are available; review proper use of candidate's emergency anti-hypotensive drug(s) before emergency evaluation.

Allergic Reaction Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient shows signs of acute allergic reaction. 2. Patient may or may not be responsive to verbal commands.	1. What are some of the signs of an acute allergic reaction? a. Mild reaction b. Moderate reaction c. Anaphylactic reaction 2. Is there a preferred patient position? a. Comfortable. b. If hypotensive or unconscious, what position? i. Supine. 3. Describe your initial steps. a. Remove allergen if possible. b. Oxygen 100%, nasal cannula or face mask depending on saturation. c. What vital signs would you monitor? i. BP, pulse, SpO ₂ , capnography and ECG. ii. Lungs: Wheezing. 4. What typical findings are seen in a severe allergic reaction? a. Hypotension, tachycardia and wheezing.	☐ Satisfactory ☐ Unsatisfactory
What interventions are employed for a mild allergic reaction? What interventions are employed for an anaphylactic reaction?	1. Mild allergic reaction. a. Diphenhydramine. i. Adults: 50 mg PO or IV. ii. Children ages 6 to 11: 12.5 to 25 mg PO or IV. b. Secondary medication: Famotidine. i. Adults: 20 mg PO or IV. c. Monitor for at least 1 hour before consider discharge to home. 2. Moderate reaction: What is the difference between mild and moderate? a. Presence of angioedema of extremities, chest and abdomen b. Diphenhydramine c. Consider famotidine. d. Epinephrine. Only medication listed that can reverse edema. e. IM dosing since it is not life-threatening. i. Adult: 0.3 mg IM. ii. Child: 0.15 mg IM. f. Call EMS for transfer. 3. Anaphylactic reactions. a. Activate EMS. b. Epinephrine is the primary agent. i. Adult: 0.3 mg IM q 5 mins as needed. ii. Child: 0.01 ml/kg of 1:1000 epinephrine IM q 5 mins. c. Epinephrine IV in adults. i. 50 mcg initially then increase dose as needed. d. IV fluids in second IV line with 18 G angiocath in adult. i. Adult: 1 to 2 L rapid infusion. ii. Child: 20 ml/kg.	☐ Satisfactory ☐ Unsatisfactory
Secondary agents	1. Albuterol inhaler for wheezing using bronchospasm guidelines. 2. Diphenhydramine. 3. Famotidine. 4. Steroids. 5. Hydrocortisone IV 1–2.5 mg/kg. 6. Decadron 6 mg IV. 7. Methylprednisolone 80 to 125 mg IV.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Notes: Multiple alternative antihistamines and corticosteroids are available; review proper use of candidate's emergency anti-allergy drug(s) before emergency evaluation.

Angina-Myocardial Infarction Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Evidence of myocardial ischemia. - May have chest pain/pressure that may radiate to left arm, jaw or back. - May have nausea, dyspnea, palpitation, dizziness, anxiety or diaphoresis. - May have ECG changes (e.g., ST-segment depression), arrhythmias.	1. Recognition of emergency. 2. Place patient in comfortable position, supine if hypotensive or unconscious. 3. Remove materials from mouth. 4. 100% oxygen. 5. Monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry, heart rate, ECG and end-tidal CO ₂ .	☐ Satisfactory ☐ Unsatisfactory
Initial response fails to resolve problem	6. Administer nitroglycerin 0.4 mg SL by tablet or spray if systolic BP > 90 mm Hg. How do you know it is working? - Burning under tongue. - Patient feels better (no more chest pain). - Headache. - Dizzy. 7. Repeat nitroglycerin every 5 min twice if pain unresolved. Caution: people using drugs for erectile dysfunction (24 hrs for sildenafil/ vardenafil, 48 hrs for Tadalafil [Cialis] or patients with HR < 50 or tachycardic). 8. Activate EMS if no history of angina, quality of pain different, or no relief after 3 doses.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	9. Administer aspirin (non-enteric coated): Two 325-mg tablets: 1 chewed, 1 swallowed with water. 10. Start IV; administer morphine 2 mg IV q 5 min until pain relieved. 11. Alternative: Fentanyl 25 mcg IV q 5 min until pain relieved.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Cardiac Arrest Algorithm

Scenario requirements	Interventions	Examinee responses
1. Initially, patient may or may not be responsive to verbal commands. 2. Sudden loss of consciousness, respiration if previously awake; sudden loss of pulse, sinus rhythm if previously unconscious. <u>Duties of Rescuers</u> 1. First on scene 2. Second on scene 3. Third on scene 4. Forth on scene 5. Fifth on scene	1. Recognition of emergency. a. Alert staff; call for defibrillator or AED and crash cart and help. 2. Activate EMS. 3. Place patient in supine position. 4. Remove materials from mouth. 5. If previously awake and unmonitored arrest, head tilt-chin lift and assess ventilation and pulse. 6. Check for pulse (< 10 seconds). a. Carotid pulse (if no pulse). 7. Start CPR at 100–120 compressions per min. 30:2 (5 rounds or 2 minutes, then switch). a. Evaluate ECG for rhythm or AED. b. Defib or AED ASAP then 2 min CPR 100–120 compressions/min.	☐ Satisfactory ☐ Unsatisfactory
Continue with primary survey	8. If VF/VT, continue with ACLS protocol. 9. If asystole or PEA, continue as per ACLS protocol.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem; continue with secondary survey	10. Attempt to place airway device if possible without interruption (endotracheal tube, laryngeal mask). 11. Confirm ventilation with 100% oxygen. 12. Administer 1 mg 1:10,000 epinephrine IV push (0.01 mg/kg in children); repeat q 3–5 min. 13. Defibrillate q 2 min after every drug administration for VF/VT. a. Biphasic 200J; Child 2J/kg then 4J/kg.	☐ Satisfactory ☐ Unsatisfactory
Response fails to resolve problem	14. Consider use of antiarrhythmic if VF/VT. a. May use magnesium sulfate 1 to 2 g if Torsades de Pointes. b. May use amiodarone 300 mg IV; then 150 mg IV in 3 - 5 min. c. Child: 5 mg/kg.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Stroke Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient awake and talking/responsive to verbal commands. 2. Patient starts slurring words.	1. Recognition of emergency. 2. Patient in chair. 3. "FAST" rule. a. F: Face i. Look at patient – ask them to smile. ii. Facial drooping on one side (abnormal). b. A: Arm i. Ask patient to hold both arms straight up with palms facing up with both eyes closed. ii. Arm drift if one arm drifts and one arm stays still (abnormal). c. S: Speech i. Ask patient to repeat simple phrase. ii. Slur words, cannot speak or uses wrong words (abnormal). d. T: Time i. Call 911 get to Stroke Center ASAP. 4. Time is of the essence. 5. Write down time patient was last known to be normal without symptoms of stroke. 6. If one of the above 3 signs is abnormal, then 72% chance of stroke. If all 3 signs abnormal then > 85% probability of stroke. 7. If giving patient fluids, give 0.9% NaCl. Do not use D5W. 8. Determine BS: hypoglycemic, give 50% dextrose; if hyperglycemic, give insulin.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Syncope Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient is initially awake/responsive to verbal commands. 2. Evidence of sudden loss of consciousness.	1. Recognition of emergency. 2. Call for defibrillator if loss of pulse identified. 3. Place patient in supine/Trendelenburg position. 4. Remove materials from mouth. 5. Head tilt-chin lift and assess ventilation; lift legs.	☐ Satisfactory ☐ Unsatisfactory
Response based on presenting signs and symptoms	1. If breathing, 100% oxygen and monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry, heart rate. 2. If not breathing, positive pressure ventilations with 100% oxygen and check carotid pulse. a. Evaluate ECG if available.	☐ Satisfactory ☐ Unsatisfactory
Continue emergency response	1. Search for cause of syncope (e.g., fear, hypotension, hypoxia, hypoglycemia, arrhythmia, stroke). 2. Treat underlying cause if possible. 3. Hypotensive fluid challenge 500 mL/bolus if IV in place (20 mL/kg for pediatric patient). If bradycardic, atropine 0.5 mg q 3–5min up to 3 mg. 4. EMS if underlying cause not treatable.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Notes: May administer ammonia inhalants so long as use does not interfere with defined emergency response.

Seizure Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Evidence of generalized tonic-clonic or clonic seizure.	1. Recognition of emergency. 2. Place patient in supine position; protect patient from physical injury. 3. Remove materials from mouth only if possible to do so safely without injury to rescuer or patient. 4. 100% oxygen.	☐ Satisfactory ☐ Unsatisfactory
Response based on subsequent signs and symptoms	5. Monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry and heart rate. 6. For self-terminating seizure: - Reassure patient. - Assess patient for injuries. - May continue with treatment based on patient history, sedative/anesthetic use, and operative need; otherwise monitor recovery. - Check finger stick glucose. 7. Activate EMS.	☐ Satisfactory ☐ Unsatisfactory
Continue emergency management	8. Administer anticonvulsant. 9. Midazolam initially 0.05–0.2 mg/kg IV. Max dose 10 mg. 10. Midazolam 0.1–0.2 mg/kg IM up to a total dose of 10 mg. IN 0.2 mg/kg. Total dose 10 mg (IN or IM use 5 mg/mL dilution). OR 11. Ativan (Lorazepam) 0.05–0.1 mg/kg IV at rate of 2 mg/min. Loading dose 4–8 mg. IN 0.1 mg/kg, max 4 mg. OR 12. Diazepam 5 mg initially, then 1 mg/min IV (0.2 mg/kg, then 0.05 mg/kg/min up to a total dose of 0.5 mg/kg in children).	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory

Hypoglycemia Algorithm

Scenario requirements	Interventions	Examinee responses
1. Patient may or may not be responsive to verbal commands. 2. Evidence of hypoglycemia risk (e.g., history of insulin dependent diabetes); signs include diaphoresis, confusion and eventual loss of consciousness.	1. Recognition of emergency. 2. Place patient in supine position. 3. Remove materials from mouth. 4. 100% oxygen. 5. Monitor blood pressure at least q 3–5 min; continuously monitor pulse oximetry and heart rate. 6. Measure blood glucose.	☐ Satisfactory ☐ Unsatisfactory
Patient hypoglycemic or high suspicion of hypoglycemia based on history and presenting signs	7. If awake, may administer oral fluids containing sugar. 8. If consciousness impaired or lost: a. Administer 50% dextrose 1 mL/kg IV up to 50 mL. OR b. May give D5W 10 mL/kg IV up to 500 mL. OR c. May give glucagon 0.025 to 0.1 mg/kg IV/IM/SC up to 1 mg. 9. Monitor blood glucose. 10. Activate EMS if consciousness not restored.	☐ Satisfactory ☐ Unsatisfactory
Overall response to emergency scenario		☐ Satisfactory ☐ Unsatisfactory