

Recognizing Deterioration

Early Warning Signs

- ✘ **Altered LOC:** sudden confusion or unresponsiveness → assess immediately
- ✘ **Rising HR:** without clear cause → hemorrhage, infection, PE, cardiac
- ✘ **Falling SpO₂:** downward trend despite O₂ → respiratory failure, PE
- ✘ **UO <30 mL/hr:** sustained → AKI, dehydration, shock

Sepsis — q-SOFA & Bundle

- **q-SOFA:** RR ≥22 + altered mentation + SBP ≤100 (2+ = possible sepsis)
- **1-hour bundle:** cultures ×2; lactate; broad-spectrum ABX; 30 mL/kg IVF

Emergency Procedures

BLS & ACLS Essentials

- ✔ **CPR:** 100–120/min; 2–2.4 inches deep; full recoil; 30:2 ratio
- **V-fib/pulseless V-tach:** defibrillate immediately; minimize CPR interruptions
- **Epinephrine:** 1mg IV Q3–5 min for all shockable and non-shockable rhythms
- **Amiodarone:** 300mg IV for refractory V-fib; may repeat 150mg

Respiratory Emergencies

- ✘ **Tension pneumothorax:** absent breath sounds + tracheal deviation → needle decompression
- ✘ **Pulmonary embolism:** sudden dyspnea + tachycardia + pleuritic pain → CT-PA; heparin

Evaluating Treatment & Escalation

Signs of Improvement

- ✔ **Sepsis:** ↓fever, ↑BP, ↓HR, ↓lactate, ↑urine output
- ✔ **Heart failure:** ↓weight, ↓edema, ↑SpO₂, ↑urine output
- ✔ **Post-op recovery:** pain controlled, tolerating diet, ambulating

When to Escalate

- ✘ **VS triggers:** SBP <90, HR <40 or >130, RR <8 or >28, SpO₂ <90%
- ✘ **Neuro change:** sudden confusion, unresponsiveness, new focal deficits
- ✘ **Gut feeling:** 'something is wrong' is a valid reason to call rapid response

Emergency Response in Practice — What the RN Does

Patient: sudden confusion, RR 24, BP 92/58, temp 39.2°C, no clear source

→ q-SOFA ≥2 = sepsis — blood cultures ×2; lactate; broad-spectrum ABX; 30 mL/kg IVF; notify provider

Patient's SpO₂ drops from 96% to 82% over 10 minutes; tachycardic and diaphoretic

→ Call rapid response — O₂; assess breath sounds; ECG; consider PE, pneumothorax, MI; crash cart nearby

Patient found unresponsive; monitor shows V-fib

→ Call code blue; CPR; charge defibrillator; deliver shock; minimize interruptions; epinephrine 1mg Q3–5 min

Post-op patient returns to floor: BP 84/50, HR 132, RR 26; anxious and pale

→ Hemorrhagic shock — rapid response; pressure to wound; O₂; large-bore IV ×2; notify provider STAT

After 2 hours of sepsis treatment: BP improving, lactate falling, UO 45 mL/hr

→ Positive response — document; continue bundle; reassess Q1–2h; maintain antibiotic and fluid plan

💡 **After every emergency: debrief the team, complete documentation, and support staff — critical events are traumatic.**

Quick-Fire Scenarios & NCLEX Tips

Q What is the compression rate and depth for adult CPR?

→ 100–120 compressions/min; 2–2.4 inches deep; allow full chest recoil between compressions

Q A patient develops tension pneumothorax. What is the emergency intervention?

→ Needle decompression — 2nd intercostal space, midclavicular line on the affected side

Q When should a nurse activate a rapid response team?

→ ANY time a patient shows sudden or progressive deterioration, including when the nurse has a gut feeling

Q When should antibiotics be given relative to blood cultures in sepsis?

→ After cultures are drawn but as soon as possible — within 1 hour of sepsis recognition; delay increases mortality

💡 **NCLEX: V-fib = defibrillate. Pulseless V-tach = defibrillate. A-fib with pulse = cardiovert. Sepsis = cultures THEN antibiotics within 1 hour.**