CHOCCOLOCCO PARK

Athletic Emergency Action Plan

954 Leon Smith Pkwy
Oxford, Al 36203

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Choccolocco Park Emergency Action Plan

Revised February 2026

Emergency situations can occur at any point during athletic events or practice. It is essential to respond quickly and effectively in order to provide optimal care for individuals experiencing life-threatening conditions. By creating, executing, and regularly assessing this Emergency Action Plan, we can ensure that emergency care is readily available when needed.

Preparation to implement this plan must include thorough understanding of each component of the plan by all of those persons who might be involved in an emergency situation. It is crucial to have adequate event coverage, access to emergency equipment and supplies, and knowledge of how to use them effectively. Proper planning and understanding of emergency medicine are key factors in ensuring the success of the plan.

The prevention of potential emergencies can be achieved through pre-participation screening, sufficient medical insurance, the use of safe practice and training methods, the maintenance of suitable equipment and facilities, as well as a secure practice and competition area. Nonetheless, accidents and injuries are bound to occur in sports, emphasizing the significance of thorough preparation by the medical staff and park personnel.

The Choccolocco Park full time staff is certified by the American Heart Association for the basic life support (BLS) for Healthcare Providers (CPR & AED) program every two years.

For specific events, an EMS Provider and a BOC Certified and Alabama Licensed Athletic Trainer are on site for official practices and competitions. Additionally, there is an Athletic Training room located on site and can be accessed by contacting the Athletic Trainer.

Components of the Emergency Plan

1. Emergency Personnel
2. Emergency Communication
3. Notification of specific individuals
4. Emergency Equipment
5. Roles
6. Venue directions with map
7. Emergency plan Check list for non- medical emergency
8. Review of incident and preparation of written incident report

CALL 9-1-1

Important Numbers and Addresses

Park Director
Billy Thompson
(256) 453-0084

Athletic Trainers
Katie Neece, MS, LAT, ATC
(256) 499-0338

Dr. Austin Goss, DAT, MS, LAT.ATC
(256) 499-4689

Orthopedic Physician
Dr. Andrew Morris, MD
(256) 236-4121

Urgent Care
C.A.R.E.S.
(256) 835-0076

Oxford Fire Department
(256) 831-3125

Oxford Health Systems Paramedics
If there is an emergency **CALL 9-1-1**
Non-emergent number (256) 474-7900

Oxford Police Department
(256) 831-6108

Medical Emergency Transport

Northeast Regional Medical Center

400 E 10th St, Anniston, AL 36207

(256)235-5121

Citizens Baptist Medical Center

604 Stone Ave Talladega, AL 35160

(256) 362-8111

UAB St. Vincent's St. Clair

7063 Veterans Pkwy, Pell City, Al 35125

(205) 338-3301

UAB Hospital (Trauma 1)

1802 6th Ave S Birmingham, AL 35233

(205) 934-3411

Directive of EMS Access for Specific Venues

Signature Baseball and Softball Fields

*The **red arrows** mark the emergency vehicle access to these fields.

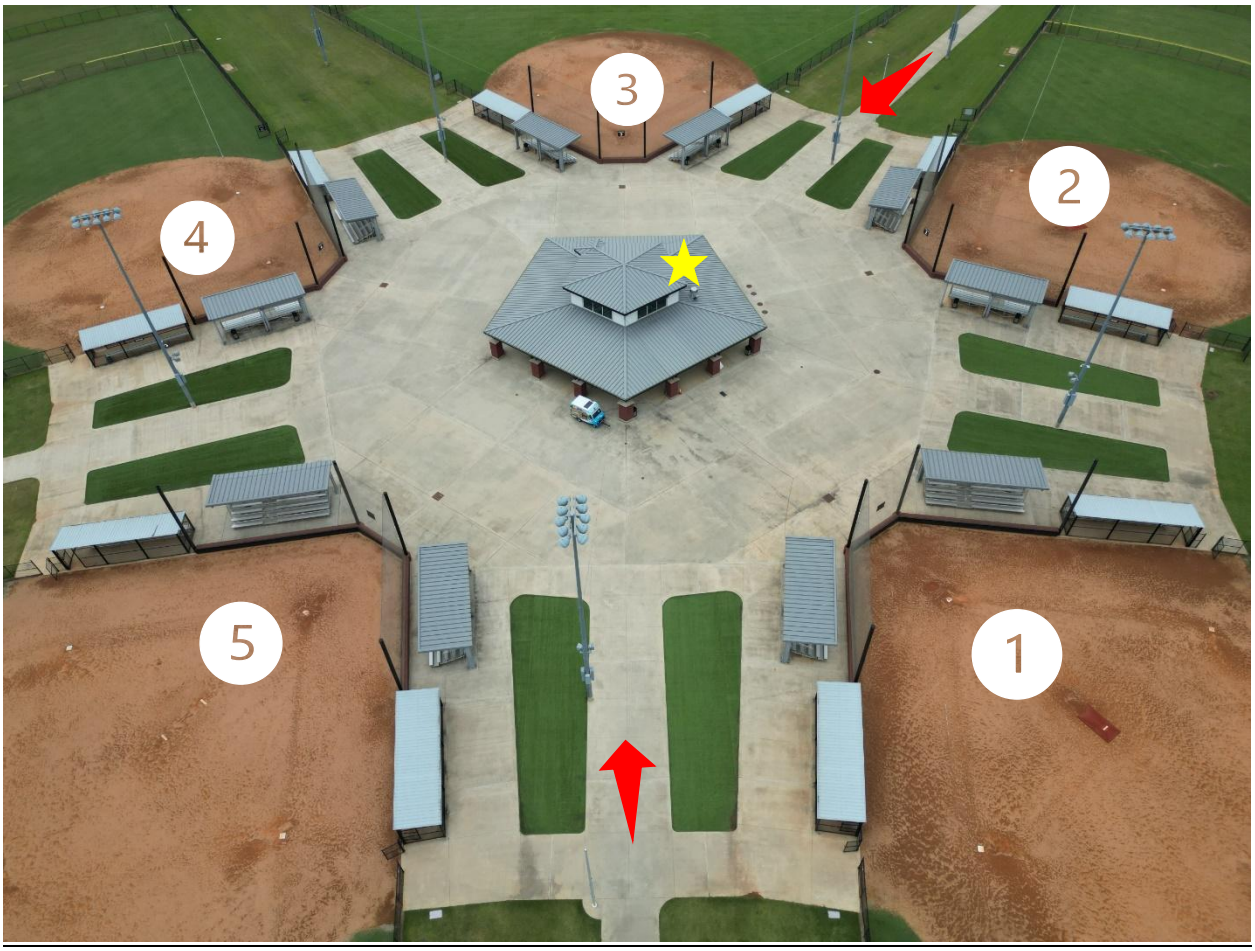
*The **yellow star** marks the AED location for these fields.

Track and Field

*The **red arrows** mark the emergency vehicle access to this facility.

*The **yellow star** marks the AED location for this facility.

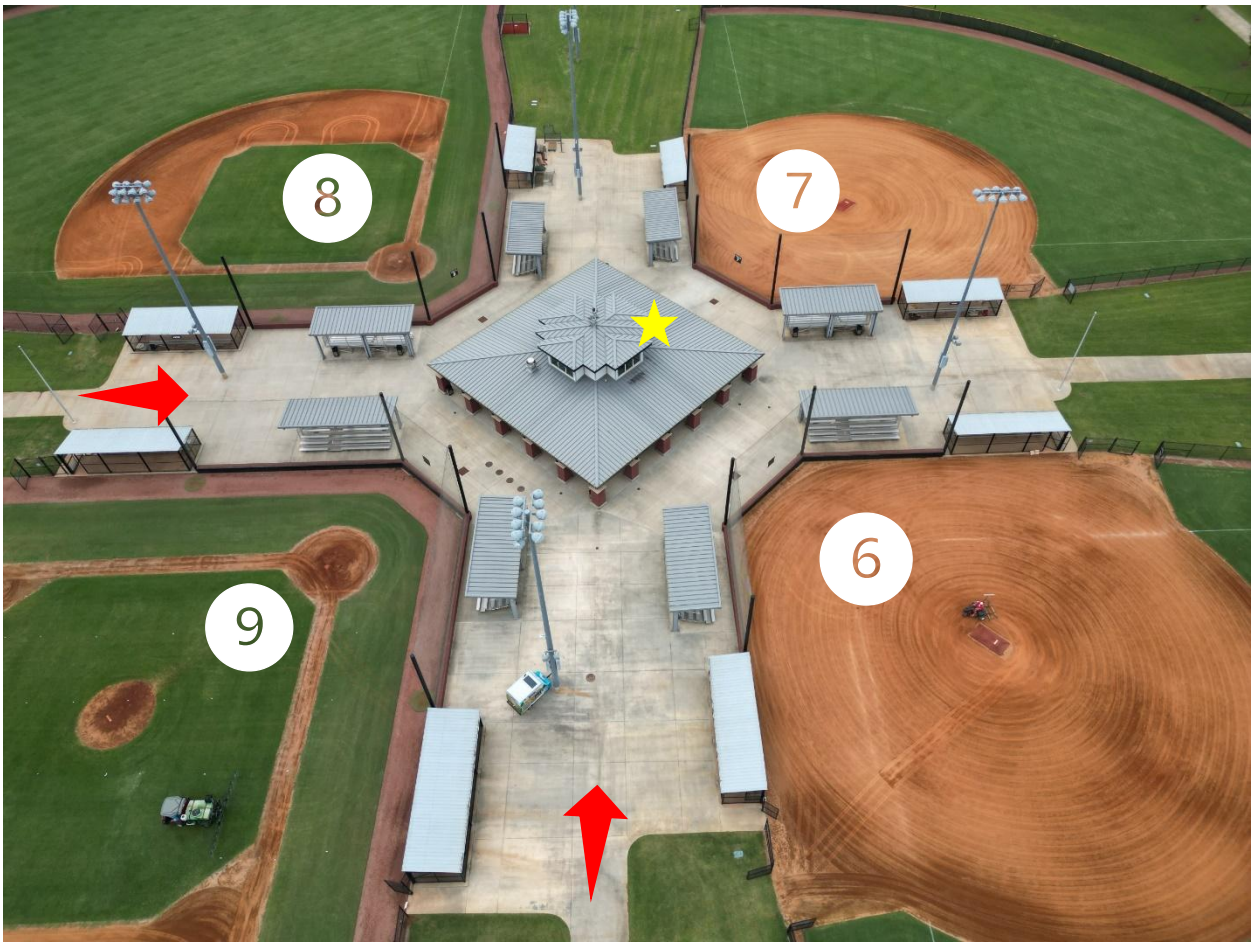
5 pod (Fields 1-5)



*The **red arrows** mark the emergency vehicle access to these fields. The **PRIMARY** access is located between fields 2 and 3. The **SECONDARY** access is between fields 1 and 5.

*The **yellow star** marks the AED location for these fields. The AED is located between Fields 2 and 3, inside the press box access door on the left.

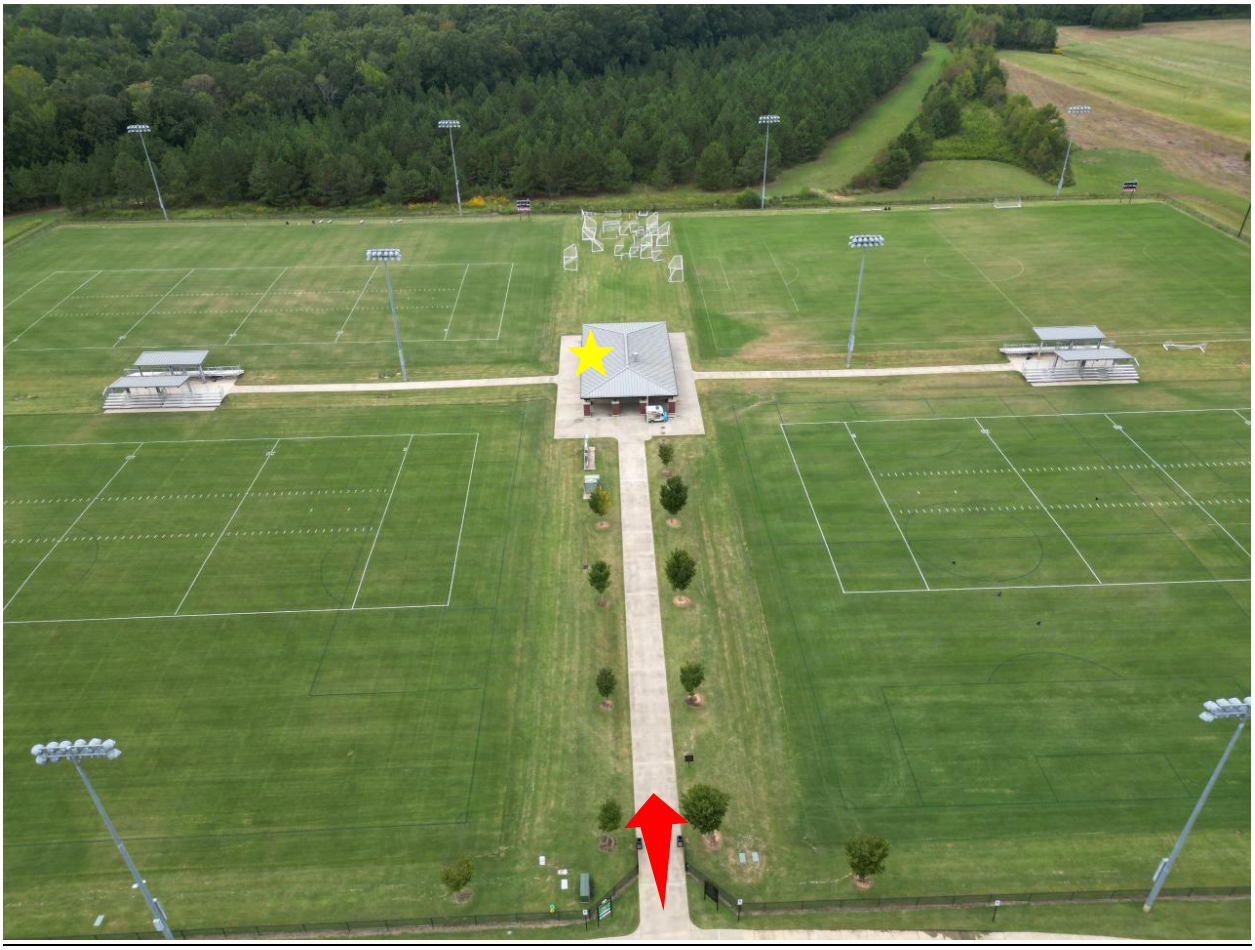
4- pod (Fields 6-9)



*The **red arrows** mark the emergency vehicle access to these fields. The **PRIMARY** access is located between fields 8 and 9. The **SECONDARY** access is located between fields 6 and 9.

*The **yellow star** marks the AED location for these fields. The AED is located between Fields 6 and 7, inside the press box access door on the left.

Soccer Fields



*The **red arrows** mark the emergency vehicle access to this facility.

*The **yellow star** marks the AED location for this facility.

Communication

Activate EAP

To Activate the EAP **Call 9-1-1.**

Providing Information:

- Name and Title of caller
- Location of Emergency
- Nature of emergency, whether medical or non- medical
- Condition of injured person(s)
- First aid treatment initiated
- Other information as requested by dispatcher

Notification of Specific individuals

- Parent/ Guardian
- Event Director
- Park Director

Emergency Equipment

An AED is located on site at all athletic practices and athletic events. All park personnel should be aware of the location and function of this device. Training and update on proper use for said equipment is conducted every two for all Full-Time Park personnel. Radio communication is used between park employees and medical staff (if applicable).

Medical Timeout

- A representative from each team or organization present should meet before start of each competition to review the emergency action plan. This meeting will include EMS providers (if applicable).
- Determine the role and location of each person present (i.e., ATC, EMS, MD)
- Establish how communication will occur (i.e., voice commands, radio, hand signals).
    - What is the primary means of communication?
    - What is the secondary or back-up method of communication?
- If an ambulance is present at the event:
    - Where is it physically located?
    - What is the planned route for entrance/exit and is the route unencumbered?
    - Is the ambulance a dedicated unit or on stand-by?
    - If an ambulance is not on site, what is the mechanism for calling one?
- In the event of emergency transport, what is the designated hospital? Consider the most appropriate facility for the injury/illness when selecting the hospital.
- What emergency equipment is present?
    - Where is it located?
    - Has it been checked to confirm it is in working order and fully ready for use?
- Are there any issues that could potentially impact the emergency action plan (i.e., construction, weather, crowd flow)?

Inclement Weather and Lightning Protocol

Choccolocco Park will provide recommendations and direction in the event of inclement weather to provide safe practice and competition environments for all student-athletes, coaches, and support personnel. This includes all environmental conditions including but not limited to heat, humidity, severe thunderstorms and lightning.

Choccolocco Park has available various resources to aid in the prevention of lightning injuries during practice sessions and competition. This protocol will also be in force during any camps, or any other activities hosted at Choccolocco Park

Perry Weather - Perry Weather is a weather technology company that provides organizations with real-time data that protects them from emergency weather. This system is available to Choccolocco Park employees and emergency personnel.

A weather alert will be issued when lightning is within 10 miles of Choccolocco Park, unless otherwise stated. At that time, a weather alert will sound notify the participants and spectators to relocate to a safe area. At that time, their activities should be suspended immediately, and all personnel should relocate to their designated safe areas.

Before resumption of athletic activities, Perry Weather will provide an additional weather alert allowing athletes to resume activity and spectators to re-enter the stands. The 30-minute “all clear” time period is the accepted standard lightning protocol.

LIGHTNING DANGER DURING COMPETITION: Game officials have become more conscious of the dangers of lighting and THEIR liability in the safe conduct of competitive activities. It is our plan to confer with game officials prior to and during contest when lighting might be a factor and when lighting becomes an imminent danger. It has been our recent experience that officials will welcome assistance in monitoring dangerous weather conditions so they will not be distracted from their duties during the contest.

Emergency Airway/ Oxygen Policies and Procedures

In any patient care situation, the first responder must immediately establish and maintain a patent airway. Various procedures and devices are available to assist in this all-important step. Once the airway is established, the first responder must determine whether the patient is breathing. If breathing is adequate, one must provide continued maintenance of the airway and administer supplemental oxygen. If breathing is inadequate, or absent, artificial respiration should be initiated.

Basic Airway Management and Oxygen Administration

In the absence of trauma, the preferred technique for opening the airway is the head-tilt/chin-lift maneuver. With suspected trauma and/or an unconscious patient, the modified jaw thrust technique should be utilized to open the airway.

In the unconscious patient without an intact gag reflex, an oropharyngeal (OP) airway may be inserted into the mouth to lift the base of the tongue forward. A properly sized OP airway will extend from the patient's mouth to the angle of the jaw or the earlobe.

The nasopharayngeal airway may be inserted into the patient's nostril to relieve soft-tissue upper airway obstruction in cases where use of an OP airway is not advised (presence of gag reflex, injury to oral cavity, patient's teeth clenched). A properly sized nasopharyngeal airway is slightly smaller than the diameter of the patient's nostril and is equal to or slightly longer than the distance from the patient's nose to earlobe. The nasopharyngeal airway should be lubricated with a water-soluable gel and inserted into the right nostril.

In the field, an airway may be compromised by a number of elements. Suctioning will remove vomitus, blood, and other fluids and secretions from the airway. Since suctioning reduces a patient's access to oxygen, each attempt should be limited to ten-fifteen seconds. If possible, hyperventilate the patient with oxygen prior to and following each suctioning effort.

Trauma patients should be supplied oxygen at 15 liters per minute through a non-rebreather mask. Patients in respiratory distress or arrest should be given positive-pressure ventilation with a BVM with 100 percent oxygen at 15 liters per minute. If available, utilize continuous cardiac monitoring and O2 sat with pulse oximetry with all airway emergencies.

Suspected Spinal Injury

General Guidelines

• Any athlete suspected of having a spinal injury should not be moved until a medical professional arrives and should be managed as though a spinal injury exists. C-spine in-line stabilization should be maintained.

• The athlete's airway, breathing, circulation, level of consciousness (AVPU/Glasgow Coma Scale) and neurological status should be assessed. If airway is impaired, maintain c-spine in-line stabilization simultaneously with airway using a modified jaw thrust maneuver. If the athletes breathing is inadequate, assist ventilations with bag-valve-mask and supplemental oxygen.

• EMS should be activated.

• In a situation where it may not be appropriate for on-site medical personnel to transfer the athlete to a long spine board prior to EMS arrival (lack of enough qualified help or other factors), the rescuer(s) should maintain in-line stabilization, place a rigid cervical collar on (if possible), and continue to monitor baseline vital signs and complete secondary evaluation while awaiting EMS (if number of rescuers is adequate).

Spine Immobilization

• If possible, a correctly sized rigid cervical collar should be placed on athlete prior to moving.

• When moving a suspected spine-injured athlete, the head and trunk should be moved as a unit by securing the athlete to a long spine board. Either the log-roll or lift-and-slide maneuver should be used to place the athlete on the long spine board. It is ideal that at minimum three (3) rescuers with preferably five to six (5-6) be in place to perform the log roll procedure and that at minimum five (5) rescuers with preferably six to eight (6-8) be in place to perform the lift-and-slide procedure.

• The rescuer controlling c-spine stabilization will be in command of log roll maneuver and long spine board immobilization.

• Once positioned onto long spine board, the athlete's torso and legs should first be secured, using spider straps or speed clips (if speed clips are used, ideally 7 straps should be applied: 2 crossing chests from shoulder to opposite axilla, one across chest under axilla, 1 across the abdomen, 1 across the pelvis, 1 across the mid thighs and 1 across the mid tibias). Athlete's arms should be left free from long spine board straps to facilitate vital sign monitoring and IV access. Athlete's wrists may be secured together in front of the body with velcro strap or tape once secured to long spine board.

• Once torso and legs are secured, the head should be secured last. If necessary, padding should be applied under the athlete's head to fill any voids and maintain neutral in-line position. The head should be secured with lateral restraint pads and then secured to board with tape over forehead and at chin.

• Following securing athlete to board, neurological status should be reassessed.

• The secondary survey should be completed with baseline vital signs (reassessed every 5 minutes), head-to-toe survey, and SAMPLE history.

•Athlete should be transported to the most appropriate emergency medical facility and head team physician and appropriate subspecialist(s) notified.

Additional Guidelines for Care of Spine-Injured Athlete

• The facemask should be removed prior to transportation, regardless of current respiratory status. Tools for facemask removal (power screwdriver, FM Extractor, Anvil Pruners, Trainers Angels should be readily accessible.

• All loop straps of the facemask should be cut, and the facemask removed from the helmet, rather than being retracted.

• The helmet and chin strap should only be removed if:

1) the helmet and chin strap do not hold the head securely, such that immobilization of the helmet does not immobilize the head.

2) the design of the helmet and chin strap is such that, even after removal of the facemask, the airway cannot be controlled, nor ventilation provided.

3) the facemask cannot be removed after a reasonable period of time; or

4) the helmet prevents immobilization for transportation in an appropriate manner.

• If the helmet must be removed, spinal immobilization must be maintained while removing. In most circumstances, it may be helpful to remove cheek padding and/or deflate air padding prior to helmet removal.

• Shoulder pads do not necessarily have to be removed on site. The front of the shoulder pads can be opened to allow access for CPR and defibrillation.

• Should either the helmet or shoulder pads be removed – or if only one of these is present appropriate spinal alignment must be maintained.

Orthopedic Injury Protocol

Initial Evaluation

The primary goals of an initial orthopedic evaluation are to:

1. Determine whether or not a true orthopedic emergency is present
2. Begin appropriate treatment
3. Determine the mode of transport for emergencies or routine extremity trauma, if needed

Evaluation of neurovascular status is the first step in the initial evaluation. Distal pulse, motor, sensation, and capillary refill should be assessed with any deficiencies and/or changes noted. Visual inspection for deformity and palpation for deformity and point tenderness should be performed, followed by evaluation for gross joint instability. Clinical tests for suspected long bone fractures such as torque, compression and percussion may be utilized as appropriate by the athletic trainer. Application of splints for fracture or gross joint instability is the final step prior to transport. If splints are applied to an extremity injury, should be evaluated both before and after placement of splints.

Orthopedic Emergencies

The increased incidence of bleeding, neurovascular compromise, and treatment complications resulting from infection classify open fractures and/or dislocations as a true orthopedic emergency. Open fractures and dislocations should have a sterile, moist compressive dressing applied as rapidly as possible. The dressing should be soaked in Betadine or Saline and applied to the open wound. As with any open wound, direct pressure should be used to control major bleeding. If direct pressure does not stanch the flow of blood, arterial pressure points should be used. Tourniquets may be applied to control bleeding. Treatment should then be identical to that of a closed fracture with immediate transport to the closest appropriate emergency facility by ambulance.

The athletic trainer must also be aware of **internal hemorrhage**. Occult hemorrhage into the **pelvis or femur fracture** can account for significant blood loss.

Large joint dislocations (shoulder, elbow, hip, knee and ankle) constitute an orthopedic emergency. Special attention should be given to knee and elbow dislocations as well as

dislocations of the sternoclavicular joint. These most commonly result in neurovascular complications, necessitating emergency management.

Delay in treatment of fractures and dislocations with neurovascular compromise may lead to disastrous consequences including loss of limb and even death. Immediate reduction or realignment by a physician should be performed. If a physician or an emergency facility is not readily available, the athletic trainer may attempt these maneuvers to restore circulation as a part of emergency medical care in a potentially life- or limb-threatening situation. This procedure may be performed by athletic training staff who have **verbal orders from the ordering physician** in regard to joint reduction after consulting regarding patient's current signs and symptoms and medical history. If, however, in the clinical opinion of the ATC, the athlete is in a life-or limb-threatening situation that would benefit from joint reduction and a MD verbal order is not immediately available then the ATC should call 911 (if EMS is not onsite) and may attempt to reduce the dislocation. If unable to reduce, the athletic trainer should immobilize the joint in the position found, continue to monitor PMSC, and immediate transport to the closest appropriate emergency facility by ambulance.

Any emergency situations where there is neurovascular compromise should be considered a **"load and go"** situation and emphasis placed on rapid evaluation, treatment and transportation. In order to provide the best possible care for the athlete(s), transportation to one of the utilized medical facilities is based upon the strengths of each facility.

Splinting Guidelines

General rules to follow during the application of a splint include:

• Deformity, gross instability, or crepitus is an indication for immediate splinting, and prompt referral of an unstable joint to an orthopedic surgeon is necessary.

• Splinting is useful in emergency situations, for decreased pain, and to allow for easier transport.

• Assess neurovascular status (PMSC) prior to and after the application of a splint

• Cover all wounds with sterile compressive dressings prior to the application of a splint

• Pad the splint to prevent local pressure

• Immobilization of the joint above and below a fracture or dislocation will decrease movement at the injury site

• Splinting can be performed in the position of deformity but with experience limb alignment may be helpful

Exertional Heat Illness Protocol

Recognition of Heat Stroke

The ability to rapidly and accurately assess core body temperature and CNS functioning is critical to the proper evaluation of exertional heat stroke. Medical staff should be properly trained and equipped to assess core temperature via rectal thermometer when feasible.

Most critical criteria for determination are:

- hyperthermic (rectal temperature > 104F) immediately post-incident and
- CNS dysfunction (altered consciousness, coma, convulsions, disorientation, irrational behavior, decreased mental acuity, irritability, emotional instability, confusion, hysteria, apathy).

Other possible findings include nausea, vomiting, diarrhea, headache, dizziness, weakness, hot and wet or dry skin (important to note that skin may be wet or dry at time of incident), increased heart rate, decreased blood pressure, increased respiratory rate, dehydration, and combativeness.

Aggressive and immediate whole-body cooling is the key to optimizing treatment of exertional heat stroke. The duration and degree of hyperthermia may determine adverse outcomes. If untreated, hyperthermia-induced physiologic changes resulting in fatal consequences may occur within vital organ systems (e.g., muscle, heart, brain, etc.).

Emergency Treatment of Heat Stroke

Immediate whole-body cooling is the best treatment for exertional heat stroke and should be initiated within minutes post-incident. It is recommended to cool first and transport second if onsite rapid cooling is possible. Cooling can be successfully verified by measuring rectal temperature. If onsite cooling is not an option, the athlete should be immediately transferred to the nearest medical facility.

The following procedures are recommended if exertional heat stroke is suspected:

1) remove clothing and equipment

2) move athlete immediately to air-conditioned facility or shaded area

3) cool athlete immediately by:

• place ice bags or ice over as much of body as possible, cover body with cold towels (replace towels frequently), fan body or spray with cold water

or

• immerse athlete in tub of cold water

or

• place athlete in Emergency Cold Containment System (ECCS); ice bags or ice may additionally be used with this system

4) monitor ABCs, core temperature, and CNS (cognitive, convulsions, orientation, consciousness, etc.)

5) place an intravenous line using normal saline (if appropriate medical staff available)

6) cease aggressive cooling when core temperature reaches approximately 101F; continue to monitor

7) transport athlete to nearest emergency medical facility

Recognition of Heat Exhaustion

Most critical criteria for determination are

1) athlete has obvious difficulty continuing intense exercise in heat,

2) lack of severe hyperthermia (usually < 104F) and

3) lack of severe CNS dysfunction. If any CNS dysfunction is present, it will be mild, and symptoms will subside quickly with treatment and as activity is discontinued.

Other possible findings include physical fatigue/dizziness, dehydration and/or electrolyte depletion, ataxia and coordination problems, syncope, profuse sweating, pallor, headache, nausea, vomiting, diarrhea, stomach/intestinal cramps, persistent muscle cramps, and rapid recovery with treatment.

Emergency Treatment of Heat Exhaustion

The following procedures are recommended if heat exhaustion is suspected:

1) remove athlete from play and immediately move to an air-conditioned or shaded area

2) remove excess clothing and equipment

3) cool athlete

4) have athlete supine comfortably with legs propped above heart level

5) if athlete is not nauseated, vomiting, or experiencing any CNS dysfunction, rehydrate orally with chilled electrolyte drink or water. If athlete is unable to take oral fluids, implement intravenous line using normal saline (if appropriate medical staff is available).

6) Monitor heart rate, blood pressure, respiratory, core temperature, and CNS status

7) Transport to nearest emergency medical facility if rapid improvement is not noted with prescribed treatment.

Sickle Cell Crisis Emergency Action Plan

Sickle Cell Trait

During intense training sessions without adequate recovery time, red blood cells can change their shape, or sickle, and accumulate in the blood leading to exertional rhabdomyolysis that can be life-threatening. Student-athletes can begin to experience symptoms in only two to three minutes of high intensity exercise, or in any other all-out exertion of sustained effort, thus quickly increasing the risk of collapse. Unlike heat-related or cardiac conditions, sickling athletes present as being fatigued, can often talk but may be experiencing ischemic pain and weakness in their muscles rather than muscular cramping or "locking up."

Sickle cell trait is not a barrier to outstanding athletic performance as student-athletes and athletics staff can incorporate precautions into intense training regimes. Precautions can enable student-athletes with sickle cell trait to thrive in their sport. Student-athletes with sickle cell trait should be knowledgeable of these precautions and institutions should provide an environment in which these precautions may be activated. In general, student-athletes with sickle cell trait should:

- Set their own pace.
- Engage in a slow and gradual preseason conditioning regimen to be prepared for sports-specific performance testing and the rigors of competitive intercollegiate athletics.
- Build up their intensity slowly while training.
- Use adequate rest and recovery between repetitions, especially during high intensity/ anaerobic exercise.
- Not be urged to perform all-out exertion of any kind beyond two to three minutes without a breather.
- Be excused from performance tests such as serial sprints or timed mile runs, especially if these are not normal sport activities.
- Stop activity immediately upon struggling or experiencing symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Maintain proper asthma management (if necessary)
- Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.
- Access supplemental oxygen at altitude as needed.
- Seek prompt medical care when experiencing unusual distress.

What are the signs of sickling collapse?

Sickling collapse is a medical emergency. They may slump to the ground with weak muscles with the inability to continue exercise. Athletes may complain of leg pain, back pain, muscle cramping, fatigue and shortness of breath. This is not to say all athletes present exactly the same.

Emergency Treatment of Sickling Collapse

Check vital signs.

Cool the athlete, if necessary.

If the athlete is unresponsive or level of consciousness is deteriorating and/or as vital signs decline, alert EMS.

Epi- Pen Policies and Procedures

Epinephrine Auto-Injector Introduction Epinephrine is the drug of choice for the emergency treatment of severe allergic reactions to insect stings or bites, foods, drugs or other allergens and for basic life support treatment for severe asthma. Epinephrine mimics the responses of the sympathetic nervous system. It quickly constricts blood vessels to improve blood pressure, reduces the leakage from the blood vessels, relaxes smooth muscle in the bronchioles to improve breathing through bronchodilation and alleviate the wheezing and dyspnea, stimulates the heartbeat, and works to reverse the swelling and hives. The drug takes effect within seconds, but the duration of its effectiveness is short (about 10-20 minutes).

Athletes and trained emergency personnel at Choccolocco Park can utilize the Epi-Pen Auto-Injector, a disposable delivery system for self-administration. The Epi-Pen has a spring activated needle that is designed to deliver a single precise dose (0.3 mg of 1:1000 solution) of epinephrine to adults when activated. The Epi-Pen Jr. has a spring-activated needle that is designed to deliver a single precise dose (0.15 mg. of 1:1000 solution) of epinephrine to infants/children under 8 years old when activated. It may be necessary in very severe reactions to administer a second dose after five minutes if initial response is inadequate.

Emergency Care for Anaphylaxis and/or Severe Asthma with Epi-Pen

The Sports Medicine staff should:

• call for EMS (if not on-site or in-route)

• maintain a patient airway

• suction any secretions

• administer oxygen therapy at 15 liters/minute with non-rebreather device

• be prepared to assist ventilation with positive pressure ventilation with bag-valve-mask

• administer epinephrine by a prescribed auto-injector

• initiate early emergency transport

Indications/Contraindications for Epinephrine Administration

Epinephrine should be administered if the patient exhibits signs and symptoms of a severe allergic reaction (anaphylaxis), including respiratory distress and/or shock (hypoperfusion) or severe asthma. Patients who have progressed to severe asthma experience a combination of the following: shortness of breath (>30 respirations/min.), mental status changes (anxious, confused, combative, drowsy), inability to speak in sentences, sweaty and unable to lie down. There are no contraindications for the administration of epinephrine in a life-threatening allergic reaction or severe asthma; however, precautions should be taken with elderly patients or patients with heart disease or hypertension.

Administration of Epinephrine

• Check the Epi-Pen to ensure the medication has not expired, has not become discolored, and does not contain particulates or sediments.

• Remove the gray safety cap from the auto-injector

• Place the tip of the auto-injector against the lateral aspect of the patient's thigh midway between the waist and knee

• Push the injector firmly against the thigh until the spring-loaded needle is deployed and the medication is injected (at least 10 seconds)

• Dispose of the auto-injector in a biohazard container designed for sharp objects.

• Record that epinephrine was administered, the dose, and the time of administration

Side Effects

The patient may complain of side effects following the administration of epinephrine. Possible side effects include increased heart rate, pale skin (pallor), dizziness, chest pain, headache, nausea, vomiting, excitability and anxiousness.

Reassessment

Following the administration of epinephrine, it is necessary to reassess the patient. Reassessment should include continued evaluation of airway, breathing and circulatory status. Decreasing mental status, decreasing blood pressure and increasing difficulty in breathing indicate the allergic reaction or severe asthma is worsening. If the condition is worsening, consider the following interventions: injection of second dose of epinephrine if second auto-injector is available, provide emergency care for shock, be prepared to administer positive pressure ventilation with supplemental oxygen if breathing becomes inadequate, and be prepared to initiate CPR and apply AED if patient becomes pulseless.

If the patient's condition improves following administration of epinephrine, continue to perform ongoing assessments. Be aware patient may complain of side effects from the epinephrine. Conscious patients may also be administered 50 mg. diphenhydramine orally or sublingually for antihistamine effects. Continue oxygen therapy with a nonrebreather device and treat for shock if necessary. Any patient requiring epinephrine administration should be transported to the closest available medical facility for follow-up evaluation and treatment as soon as possible. Remember that epinephrine is short-acting (10-20 minutes), and signs and symptoms may return as drug wears off.

Asthma Medication Metered Dose Inhaler (MDI) Policies and Procedures

The majority of patients with asthma and patients with allergies will have exercise induced bronchospasm (EIB). EIB usually occurs during or minutes after vigorous activity, reaches its peak 5-10 minutes after stopping the activity, and usually resolves in another 20-30 minutes.

Asthma Medications

Depending on the severity of asthma, medications can be taken on an as-needed basis (prn) or regularly to prevent or decrease breathing difficulty. Most of the medications fall into two major groups: quick relief medications and long-term control medications.

Inhaled Medications

Inhaled medications are delivered directly to the airways, which is useful for lung disease. Aerosol devices for inhaled medications may include the metered-dose inhaler (MDI), MDI with spacer, breath activated MDI, dry powder inhaler or nebulizer. The most commonly used inhaled medications are delivered by the MDI, with or without the spacer. There are few side-effects because the medicine goes right to the lungs and not to other parts of the body.

It is critical that the patient use the prescribed MDI correctly to get the full dosage and benefit from the medication. Unless the inhaler is used in the right manner much of the medicine may end up on the patient's tongue, the back of their throat, or in the air. Use of a spacer or holding chamber helps significantly with this problem and their use is strongly recommended. A spacer is a device that attaches to an MDI and holds the medication in its chamber long enough for the patient to inhale it in one or two slow deep breaths. This eliminates the possibility of inadequate medicine delivery from poor patient technique.