

The On-Call Emergency Playbook

THE FIRST 15 MINUTES

Practical emergency medicine for the ward,
emergency department and remote clinic.

29 worked cases

Recognise. Stabilise. Reassess. Escalate.

SBAR scripts / Documentation templates

Printable cards / Linked navigation

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Find it fast

Start from what you are seeing. Each chip jumps to the worked case — the first is the most likely fit; the rest are differentials worth excluding.

BREATHING	
Wheeze	1. Asthma p.9 2. COPD p.11 6. Anaphylaxis p.19
Crackles, frothy sputum, orthopnoea	3. Pulmonary oedema p.13 12. Sepsis p.33
Sudden breathlessness or pleuritic pain	4. PE p.15 5. Pneumothorax p.17
Stridor, lip or tongue swelling	6. Anaphylaxis p.19 29. Sick child p.71
Falling SpO2 on the ward	5. Pneumothorax p.17 4. PE p.15 3. Pulmonary oedema p.13 2. COPD p.11
HEART & CHEST	
Central chest pain or pressure	7. STEMI p.22 8. NSTEMI-ACS p.24 9. Aortic dissection p.26 4. PE p.15
Tearing pain to the back	9. Aortic dissection p.26 26. Shocked abdomen p.65
Fast pulse or palpitations	10. Tachyarrhythmia p.28 12. Sepsis p.33 4. PE p.15
Slow pulse, dizziness, heart block	11. Bradycardia p.30 24. Hyperkalaemia p.60 25. Poisoning p.62
Collapse or syncope	10. Tachyarrhythmia p.28 11. Bradycardia p.30 4. PE p.15 9. Aortic dissection p.26 13. Upper GI bleed p.35 26. Shocked abdomen p.65
CIRCULATION	
Low blood pressure or shock	12. Sepsis p.33 13. Upper GI bleed p.35 14. Major trauma p.37 6. Anaphylaxis p.19 26. Shocked abdomen p.65 27. PPH p.67
Bleeding — vomit, stool, wounds, after birth	13. Upper GI bleed p.35 14. Major trauma p.37 27. PPH p.67 26. Shocked abdomen p.65
Fever with a fast pulse or confusion	12. Sepsis p.33 18. Meningitis / malaria p.46 29. Sick child p.71
BRAIN	
Unroutable or GCS falling	15. Unresponsive p.40 21. Head injury p.53 22. Hypoglycaemia p.56 25. Poisoning p.62
Confused or agitated	17. Delirium p.44 22. Hypoglycaemia p.56 18. Meningitis / malaria p.46 12. Sepsis p.33
Facial droop, weakness, speech change	16. Stroke p.42 22. Hypoglycaemia p.56
Seizure	19. Status epilepticus p.49 28. Eclampsia p.69 22. Hypoglycaemia p.56 18. Meningitis / malaria p.46
Sudden severe headache	20. Thunderclap headache p.51 18. Meningitis / malaria p.46 28. Eclampsia p.69
Head injury	21. Head injury p.53 14. Major trauma p.37
RESULTS & INGESTIONS	
Glucose below 4 mmol/L	22. Hypoglycaemia p.56
Glucose high with ketones or acidosis	23. DKA / HHS p.58
Potassium 6.0 mmol/L or above	24. Hyperkalaemia p.60
Lactate 2 mmol/L or above	12. Sepsis p.33 14. Major trauma p.37 26. Shocked abdomen p.65
Raised troponin	8. NSTEMI-ACS p.24 7. STEMI p.22 4. PE p.15
Overdose or poisoning	25. Poisoning p.62 15. Unresponsive p.40 11. Bradycardia p.30
SPECIAL PATIENTS	
Pregnant or recently delivered	27. PPH p.67 28. Eclampsia p.69 26. Shocked abdomen p.65 4. PE p.15
Child	29. Sick child p.71 6. Anaphylaxis p.19 19. Status epilepticus p.49 22. Hypoglycaemia p.56
Older, frail, possible end of life	17. Delirium p.44 2. COPD p.11 12. Sepsis p.33

CASE 1 • WARD • ED • REMOTE CLINIC

Breathless and wheezy

Acute severe and life-threatening asthma

THE CALL

"Bed 14, 23-year-old known asthmatic admitted this afternoon. Much worse in the last half hour — she can only say a few words. The nebuliser hasn't helped much."

RR 32

SpO2 91% air

HR 128

BP 124/78

PEF 180 L/min (best 450)

GCS 15

THE FIRST 15 MINUTES

0–2 min

ARRIVE

- Sit her up. Oxygen to keep SpO2 93–98%. Stay with her.
- Look for life-threatening features: SpO2 <92%, PEF <33%, silent chest, cyanosis, poor effort, exhaustion, confusion, hypotension, arrhythmia.
- Any life-threatening feature: call your senior and the anaesthetist/ICU now — don't wait for the second nebuliser.

2–5 min

STABILISE

- Salbutamol 5 mg nebulised, oxygen-driven; repeat every 15–30 min, or back-to-back if severe.
- Add ipratropium 0.5 mg to the nebuliser.
- Prednisolone 40–50 mg orally (hydrocortisone 100 mg IV if vomiting or too breathless to swallow).
- Continuous SpO2, HR and RR; PEF if she can manage it — never force it in life-threatening asthma.

5–10 min

TARGET

- Blood gas if SpO2 <92% or any life-threatening feature. A **normal or rising PaCO2 means she is tiring** — this is near-fatal asthma.
- Magnesium sulfate 2 g IV over 20 min if not responding to the first nebulisers or any life-threatening feature (after senior discussion).
- Chest X-ray only if you suspect pneumothorax or consolidation, or she fails to respond — never delay treatment for it.
- Quick history: triggers, previous ICU or intubation, recent admissions, oral steroid courses. These mark the high-risk patient.

10–15 min

DECIDE

- Reassess at 15 min: speech, RR, HR, SpO2, work of breathing, PEF.
- Improving (PEF >50%, full sentences) → nebulisers 4-hourly, steroids, observe on the ward.
- Not improving, or any life-threatening feature → ICU and anaesthetic review now. IV aminophylline or IV salbutamol only on senior advice.
- Hand over the time of each nebuliser and the trend, not just the latest numbers.

WHAT MATTERS FIRST

- **Bronchodilate and oxygenate first, investigate second.** Salbutamol and oxygen in the first two minutes change the outcome; the X-ray and blood tests do not.
- **The quiet patient is the dangerous one.** A falling respiratory rate, a silent chest and drowsiness mean exhaustion, not recovery.

WHAT CHANGES THE PLAN

IF Life-threatening features or a rising PaCO2	→ Senior, ICU and anaesthetist to the bedside now. Intubation, if needed, by the most experienced person available.
IF Wheeze plus urticaria, swelling or hypotension	→ Treat as anaphylaxis — IM adrenaline 0.5 mg (Case 6).
IF Sudden deterioration or one side quieter than the other	→ Think pneumothorax (Case 5). Ultrasound or X-ray; decompress if tension.
IF Improving at 15 minutes	→ Nebulisers 4-hourly, prednisolone for at least 5 days, PEF before and after each nebuliser.

ESCALATE NOW — CALL YOUR SENIOR IF

- Any life-threatening feature: SpO₂ <92%, PEF <33%, silent chest, cyanosis, exhaustion, confusion, hypotension, arrhythmia.
- PaCO₂ of 4.6 kPa or more in a breathless asthmatic.
- No improvement after two back-to-back nebulisers.
- Previous ICU admission or intubation for asthma.

TRAPS

- Calling a drowsy, quieter patient "settled".
- Waiting for the X-ray or gas before giving the second nebuliser.
- Sedating an anxious asthmatic — never, outside ICU.
- Missing anaphylaxis: wheeze plus rash or swelling needs adrenaline, not just salbutamol.
- Give oxygen to the prescribed target; avoid both hypoxaemia and unnecessary hyperoxia.

DOSES (ADULT UNLESS STATED)

DRUG	DOSE	NOTES
Salbutamol	5 mg nebulised, oxygen-driven; every 15–30 min or continuous	Tremor and tachycardia expected; check K ⁺ after repeated doses
Ipratropium bromide	0.5 mg nebulised, 4–6-hourly	Add to the first salbutamol nebuliser
Prednisolone	40–50 mg orally once daily, at least 5 days	Hydrocortisone 100 mg IV 6-hourly if unable to swallow
Magnesium sulfate	1.2–2 g IV over 20 min, single dose	Acute severe not responding, or life-threatening
Salbutamol by spacer	4–10 puffs of 100 micrograms, every 10–20 min	When no nebuliser — as effective in most adults

REMOTE & LOW-RESOURCE

- No nebuliser? Salbutamol inhaler through a spacer (or a cut plastic bottle) works for most patients.
- No peak flow meter? Grade severity by speech, RR, HR and SpO₂.
- Limited oxygen: run nebulisers on air with nasal oxygen alongside; a concentrator at 5 L/min may be enough.
- If evacuation is hours away, give IV magnesium and get telemedical advice before she tires.

WHO DOES WHAT

- RN** Start oxygen and the first salbutamol nebuliser under standing protocol; record PEF and SpO₂ before and after.
- CO** Grade severity, give steroids and repeat nebulisers, call early for any life-threatening feature.
- DR** Decide on magnesium, the gas and ICU referral; lead the airway plan with the anaesthetist.

MAKE THE CALL — SBAR

- S** This is Amina, the FY1 on Ward 6. I'm calling about Ms K, 23, with acute severe asthma who is not responding to treatment.
- B** Known asthmatic with one previous ICU admission. Admitted this afternoon. She's had two salbutamol nebulisers and prednisolone.
- A** Still speaking in words only, RR 30, SpO₂ 92% on 10 litres, PEF a third of her best. Venous CO₂ is 6.1 kPa and rising — I think she is tiring.
- R** I need you to come now. I'm giving IV magnesium and back-to-back nebulisers. Please can you also call ICU and the anaesthetist?

WRITE IT DOWN — YOUR NOTE MUST SHOW

- Severity features with times; PEF as % of best; SpO₂ and the oxygen she was on.
- Every nebuliser and drug with its time, and the response after each.
- Gas results with your interpretation; who you escalated to, and when.

PRACTISE IT IN THE APP

[Clinical Pathway — Asthma & COPD](#)
[Night Watch sessions](#)

Before the patient leaves

Use this with the receiving and retrieval teams. Stabilisation and transfer planning often proceed together; do not delay time-critical definitive care for non-essential tasks.

Accept and communicate

Named receiving clinician, destination and bed/pathway confirmed. Agree urgency, transport mode, escort competence and what to do if the patient deteriorates. Send a concise SBAR and contact numbers.

Prepare the patient

Reassess ABCDE; secure and label airway devices, vascular lines and drains. Record observations and the response to treatment. Address pain, temperature, glucose and foreseeable deterioration. Check identity and relevant treatment limits.

Prepare the journey

Check oxygen supply against expected consumption, duration, delays and a reserve. Check batteries, suction, monitor, defibrillator, medicines and required pumps. Confirm equipment works during movement and transfers between vehicles.

Send the record

History, allergies, medicines and times; trends, ECGs and relevant results; outstanding tests and who will act on them; receiving acceptance and handover. Use secure channels for patient information.

Close the loop

Bedside handover to a named clinician. Confirm the patient, equipment and records have been received. Document departure, arrival, treatment en route and any event needing follow-up.

Remote-care prompt: ask the retrieval team about altitude-sensitive problems, cabin pressure, oxygen endurance and restrictions for your transport platform. Use your organisation's transfer policy.