In-Office Non-Ocular Emergencies

Lynn E. Lawrence, CMSgt(ret), USAF, CPOT, ABOC, COA

Overview

• The likelihood of encountering an emergency
• Different types of emergencies
• The value of staff policies and training
• Ways to handle non-ocular emergencies
• Equipment recommendations

Disclaimer

• This course is designed to inform offices on the need for training and established protocols. The course will cover available options. This does not replace the need for offices to develop a local emergency training plan and established protocols for their specific office. This course comes with a recommendation that each office assign a staff education position that will track all required and suggested training.
Annual Staff Training

• Conduct annual staff Training
• Make it mandatory
• Document and save

The Likelihood

• You just never know:
• 2007 American Family Physicians reported that 62% family practice and pediatrics saw at least one patient requiring hospitalization
• How many life saving transport have you made?????


• Most primary care physicians report at least one emergency presenting to their office per year. Asthma, anaphylaxis, shock, seizures, and cardiac arrest are among the most common adult and childhood emergencies in the office setting. Most offices are not fully prepared for these medical emergencies. Practices can initiate a preparedness program by purchasing emergency equipment and medications that reflect the spectrum of anticipated emergencies in their patient populations, the practitioners' skills, and the distance to the nearest emergency department.
• Physicians and staff should make every effort to maintain current certification in basic or advanced lifesaving courses. Offices may also wish to create a written emergency protocol that outlines the steps to be followed in the event of a medical office emergency. By preparing for medical emergencies with the correct equipment, education, and protocols, offices can greatly decrease the risk of an unfavorable outcome.

All Ages

• In caring for patients of all ages and providing routine health maintenance and urgent care, family physicians should be prepared to encounter a range of emergencies, from stroke in older patients to meningitis in infants. Adult patients may misinterpret the urgency of their condition or purposefully avoid the emergency department. Parents of critically ill children are often unaware of the severity of their child’s illness.

Concerns For Every Office

• Medical emergencies that arise in the office are a great source of concern for doctors and office staff. Proper planning for the unexpected can help alleviate some of this anxiety and improve patient safety within the office. The recommendations throughout this article are based on the opinions of several experts; good evidence on the topic of emergency preparedness is lacking.
First Step

- Good first step in preparing for medical emergencies is the acquisition of emergency supplies. Doctors should choose emergency medicines and equipment that reflect the spectrum of their office's anticipated emergencies.

Most Common in Primary Care

- Common to both these settings are respiratory distress (asthma), diabetic distress, anaphylaxis, shock, seizure, and cardiac arrest.

Needed Equipment

- Equipment choice should also reflect each office's patient population. Offices that care for a large number of patients who are chronically ill or children with special needs may choose to have a more extensive stock of equipment and medication.
Equipment Continued

• Most importantly, the decision on how to equip the primary care office should depend on the physicians' and nurses' skills. For medical and legal reasons, no office should stock equipment that cannot be used safely by office staff.

On Hand

• Established Protocols
• Blood Pressure Kit
• Glucose Meter
• AED
• Trained staff

Distance To Next Level of Care

• The distance from the office to the nearest emergency department should also be considered in choosing office emergency supplies. As mentioned, rural offices especially need to consider the additional time patients will spend traveling to the closest emergency department. Physicians in such offices may feel it necessary to provide additional treatment in the office before the patient departs with the emergency services. Urban offices located only blocks away from a hospital should not be complacent about emergency equipment; it is well established that early treatment of cardiopulmonary distress greatly increases the chance of a more favorable long-term outcome for the patient.
What Is An Emergency?

• Life threatening situation requiring immediate care

• Threat to life, limb, eyesight, or choking hazard

Contact Dr. Eye Care @ 850-455-5555 for Eye related care.

For all other emergencies Send patient to the St. Mary’s emergency room Call ahead at 850-454-0999

• Code system is used to train staff on how to react to given situations

**UT Emergency Code Designations**

<table>
<thead>
<tr>
<th>Announced “Code”</th>
<th>Meaning and Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Blue</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Brown</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Copper</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Gray</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Green</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Orange</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Red</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Violet</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>White</td>
<td>Code: 9999</td>
</tr>
<tr>
<td>Yellow</td>
<td>Code: 9999</td>
</tr>
</tbody>
</table>

**vasovagal episode**

• A **vasovagal episode** or **vasovagal response** or **vasovagal attack** (also called neurocardiogenic syncope) is a malaise mediated by the vagus nerve. When it leads to syncope or “fainting”, it is called a **vasovagal syncope**, which is the most common type of fainting. Vasovagal syncope more commonly affects young adults.

• There are different syncope syndromes which all fall under the umbrella of vasovagal syncope. The common element among these conditions is the central mechanism leading to loss of consciousness. The differences among them are in the factors that trigger this mechanism.
Seizures

- A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain.
- The term "seizure" is often used interchangeably with "convulsion." Convulsions occur when a person's body shakes rapidly and uncontrollably. During convulsions, the person's muscles contract and relax repeatedly. There are many different types of seizures. Some have mild symptoms without shaking.

Seizure Symptoms

- Brief blackout followed by a period of confusion (the person cannot remember for a short time), Changes in behavior such as picking at one's clothing, Drooling or frothing at the mouth, Eye movements, Grunting and snorting, Loss of bladder or bowel control, Mood changes such as sudden anger, unexplainable fear, panic, joy, or laughter, Shaking of the entire body, Sudden falling, Tasting a bitter or metallic flavor, Teeth clenching, Temporary stop in breathing
- Uncontrollable muscle spasms with twitching and jerking limbs

Prior to Seizure

- Symptoms may stop after a few seconds or minutes, or continue for up to 15 minutes. They rarely continue longer.
- The person may have warning symptoms before the attack, such as:
  - Fear or anxiety
  - Nausea
  - Vertigo (feeling as if you are spinning or moving)
  - Visual symptoms (such as flashing bright lights, spots, or wavy lines before the eyes)
Causes of Seizures

1. Missed Medication
2. Sleep Deprivation
3. Hormones
4. Drugs, Alcohol, and Excessive use of stimulants
5. Extreme Emotional Stress/Anxiety
6. Low Blood Sugar
7. Bright Lights
8. Medical conditions

Heart Attack

- **Chest discomfort.** Most heart attacks involve discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. It can feel like uncomfortable pressure, squeezing, fullness or pain.
- **Discomfort in other areas of the upper body.** Symptoms can include pain or discomfort in one or both arms, the back, neck, jaw or stomach.
- **Shortness of breath with or without chest discomfort.**
- **Other signs** may include breaking out in a cold sweat, nausea or lightheadedness.
- **Signs are different in men and women**

Stroke

- **Face Drooping** Does one side of the face droop or is it numb? Ask the person to smile.
- **Physical Weakness** Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?
- **Speech Difficulty** Is speech slurred, are they unable to speak, or are they hard to understand? Ask the person to repeat a simple sentence, like “the sky is blue.” Is the sentence repeated correctly?
- **Confusion or disorientation**
- **Time to call 9-1-1** if the person shows any of these symptoms, even if the symptoms go away, call 9-1-1 and get them to the hospital immediately.

No eating/drinking until emergency team arrives
External Signs

Different Types of Emergencies

- Adult/child (volunteers)
- Unknown
- Unconscious
- No pulse/no response
- Fainting
- Violent
  - Abuse
  - Gun involved
  - Fight
  - Stabbing
- Diabetics
- Hypertension / strokes
- Chest grabbing
- Choking
- Abduction
- Impaled objects
- Hostage
- Fire
- Robbery
- Falls
- Siezures

Emergency: Dizziness, Fainting.

- You're sitting at a game, maybe in the airport. A guy says he doesn't feel well. "If he tells you -- a perfect stranger -- that he feels weak, ill, or dizzy, you should be dialing 911," says Walters. "He needs medical attention." There are many medical causes for these symptoms, like a heart condition, diabetes, low blood sugar, pregnancy, heart attack, or it could be heat-related.

http://www.webmd.com/heart-disease/features/5-emergencies-do-you-know-what-to-do
Emergency: Chest Pain

- If someone grabs their chest and says "my chest hurts," assume it's a heart attack. "Chest pain is a heart attack until proven otherwise," Ramirez tells WebMD. "That's how we look at it in the ER world. A 17-year-old can have a heart attack. Anyone can have a heart attack."
- Plan of action: Dial 911. Then check airway, breathing, circulation (ABC). Are they breathing? Do they have a pulse? If not, start CPR.

Emergency: Choking

- You're talking at the dinner table, and someone starts coughing. When does it become an emergency? "When they're coughing, it's OK, because there is air movement, they are breathing," Ramirez says. "If they're not making any noise whatsoever, their face is getting red, you need to do the Heimlich maneuver. At that point, they are not breathing."
- Caution: "If they're coughing, doing the Heimlich can make it worse," she adds. Also, hitting a choking person on the back can make the situation worse -- the food may go back into the windpipe. "They need to work it out themselves; leave them alone, until they reach a point where there's no airway noise."

Emergency: Bleeding

- Rule of thumb: "When something scares you, call 911 or go to the hospital," she says. "We can say whether it's an emergency or not."
- A cut tendon may be more problematic than the bleeding, she says. "It may need to be closed with sutures, or they may never be able to use that finger again. We hear it all the time, men who say, 'I'm fine, I'm fine.' They need to have that cut looked at."
- Apply direct pressure until emergency care arrives
Emergency: Seizure

• The symptoms of seizures vary. The person may fall down and/or make erratic movements. Or their head might jerk and eyes flutter. This can happen to children who have a high fever, to someone with epilepsy, or when someone is having a stroke.

• Any seizure warrants medical attention. Call 911. While waiting for paramedics, make sure the person does not hurt themselves. "If they fall down, get everyone away from them," says Ramirez. "Don't get near them; they could hurt you. Don't try to put something in the person's mouth (as used to be advised); it's too dangerous. Also, watch the clock -- how long the seizure lasts."


Staff Training

• The correct equipment for dealing with emergencies in the office is only useful in experienced hands. The lack of emergency preparedness found in offices extends to staff education. A study conducted in 1989 found that 86 percent of family physicians had received training in basic life support and 25 percent had advanced cardiovascular life support training. A more recent survey showed that only 19 percent of family physicians had been trained in pediatric advanced life support. Ideally, all office employees should be trained and regularly retrained in basic life support regardless of their office responsibilities.

Developing A Plan

• The next step in preparing the office for emergencies is planning. Family medicine offices should take time to create a written emergency protocol that outlines the steps to be followed in the event of an office emergency. The protocol should take into account the emergency skills of each employee and assign each employee specific responsibilities within the office and during the resuscitation.
2012 OSHA Requirement

- Workplace violence training
- Annual
- Documented
- Maintained after employment termination
- Things happen, planning helps

Code System

- Adam or Amber Alert (Code Pink)
- Silver Alert (Elderly)
- Prisoner Escapee
- Violent (Take Down)
- Health Risk (Code Blue)

<table>
<thead>
<tr>
<th>Code System for St. Joseph Mercy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Red</strong> – Fire or smoke</td>
</tr>
<tr>
<td><strong>Code Black</strong> – Tornado Warning</td>
</tr>
<tr>
<td><strong>Code White</strong> – workplace violence</td>
</tr>
<tr>
<td><strong>Code Blue</strong> – Cardiac Arrest or Respiratory</td>
</tr>
<tr>
<td><strong>Code Green</strong> – Medical Emergency but patient is still breathing</td>
</tr>
<tr>
<td><strong>Code Pink</strong> – Infant or children abduction</td>
</tr>
<tr>
<td><strong>Code Orange</strong> – Bomb Threat</td>
</tr>
<tr>
<td><strong>Code Silver</strong> – missing elderly person</td>
</tr>
</tbody>
</table>

Office Staff’s Responsibilities

- Who ya gonna call?
- Training engages 95% of the time
- What happens the other 5%
- Never operate outside of training or comfort level
- Know what to do and where to go
Ways to Handle Non-Ocular Emergencies

• Proper training
• Proper practice
  – Documented
  – Regularly scheduled
• Checklist
• Phone list

Staff Training

• Types
• Mandatory
• Training Frequency
• Documentation
• Incident Reporting
• Tracking and Follow-up
• Posted Checklist

Types of Training

• Non-English Speaking
• Non-speaking
• Infection Control
• CPR
  – Adult
  – Child
• AED
• Scene Assessment
  – Indoor / outdoor
• When to call 911
Training Frequency

- How often be given
  - Minimal annually
  - Every process change
- Who should attend
  - Entire staff
  - Follow up training
  - Practice / document
- New employees
  - Immediately

Documentation

- Good Samaritan Law
- Sign in sheet (5 yrs after employment terminates)
- Incident reporting
  - Time, date, everyone present, all statements
- Staff member personnel files (patient or caregiver)
- Document everything at every phase
- Document everything
- Protect the practice
- Document witnesses

Tracking and Follow-up

- Responsible for tracking and follow-up care
- Documentation
- Post event training and review (what we did right and what could we do better)
- Get a copy of the 911 report if possible, put in pt’s chart
Patient vs Non-Patient

• Patient
  – Make entry in patient’s chart
  – Document everything
  – Copy of incident report in patient’s chart

• Non-patient
  – Get all available info
  – Start a chart
  – Document everything
  – Follow up care

Recommended Non-Ocular Equipment

• Face Protector
• Gloves (different sizes)
• AED
• Blood Pressure Kit
• EPI Pen
• Glucagon
• Thermometer
• Fire Extinguisher
• Wheel Chair

Review

• What is an emergency
• Different Types of emergencies
• Office Staff’s responsibilities
• Ways to handle non-ocular emergencies
Thank you

martralyn@msn.com