Best Practices for Responding to Medical Emergencies

This toolkit was created to provide information and resources to support effective responses to medical emergencies involving vulnerable people receiving services at programs under the Justice Center’s jurisdiction.

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The Issue

People receiving services in programs under the jurisdiction of the Justice Center often have complex medical needs. As a result, staff may have to respond to medical emergencies. A timely and well-executed response to a medical emergency is critical to ensure immediate assistance is provided by first responders. A delay in accessing medical care can have potentially catastrophic consequences. People with special needs are living increasingly longer lives, and multiple studies have identified that people with special needs or disabilities are more likely to have co-occurring conditions including heart disease, diabetes, and epilepsy than the general population, making timely access to quality health care even more critical.

The Scope of the Problem

Reports to the Vulnerable Persons Central Register (VPCR) regarding incidents involving the death of a person receiving services often include details surrounding the circumstances of the person’s death. Often times, the lack of a timely and appropriate response to a medical emergency is identified as a contributing factor to the incident. Recognizing the many responsibilities of staff in these programs, this toolkit was developed to provide agencies with suggested resources to assist staff in recognizing and responding appropriately to medical crises.

This Toolkit contains:

- Recognizing Medical Emergencies
- Staff Actions
- Agency Best Practices
- Training Tips
- Could This Happen in Your Program?
- CALM Chart
- Medical Emergencies At-A-Glance
- Sample pain picture
- Resources
RECOGNIZING MEDICAL EMERGENCIES

The first step to ensuring medical emergencies requiring immediate intervention are handled appropriately is to educate staff and people receiving services on what constitutes a medical emergency.

AGENCY POLICIES SHOULD INSTRUCT STAFF TO ALWAYS CONTACT 911 FOR MEDICAL EMERGENCIES! Time is of the essence—don’t delay, call right away!

To ensure staff are fully prepared for recognizing medical emergencies, agencies should:

- Implement protocols and directives for staff to recognize and respond to potential medical emergencies such as breathing difficulties, falls and head injuries.
- Ensure policies empower direct support professionals and other staff to call 911 without first seeking approval from a manager, supervisor, or RN
- Provide initial and refresher training in First Aid, CPR, and recognizing signs and symptoms of illness
- Train staff to recognize signs of medical distress specific to the unique diagnoses or medical conditions of people receiving services. Consider using a “pain picture” to help staff recognize when someone is in pain and/or supplementing training with videos that provide a visual depiction of medical distress.

Types of medical emergencies requiring immediate medical intervention:

- Loss of consciousness
- Severe shortness of breath
- Facial drooping or weakness in an arm or leg
- Chest pain
- Head trauma
- Uncontrolled bleeding
- Poisoning
- Major broken bones
- Suicidal or homicidal feelings
- Falls
- Sudden blurry or double vision
- Suspected overdose
- Choking
Do not delay medical care! Call 911 for any concerns about the immediate health and safety of people receiving services. Remember; don’t delay, call right away!

If applicable, call an emergency code such as a Code Blue for an internal emergency response.

Try not to panic! Stay calm and follow the directions from the 911 dispatcher.

After contacting 911, immediately initiate CPR for people receiving services who are not breathing. If rescue breaths are not possible due to an airway obstruction or the presence of bodily fluids, initiate chest compressions.

Do not delay medical attention for people receiving services due to concerns regarding staffing. Contact 911 immediately for all medical emergencies then arrange for any necessary staffing additions.

Conduct chest compressions on a hard, flat service. Place a backboard under the person or move them to the floor if they are not already on a hard, flat surface.

Provide emotional support to people receiving services who witnessed the medical emergency and may be scared or worried for their peer.

Ensure policies and procedures clearly identify when staff should elevate medical concerns to 911 or primary care physicians and empower them to do so without first seeking permission for any life threatening situations.

Train staff to recognize signs and symptoms of illness, true medical emergencies and behavioral changes that could indicate an underlying medical issue and to contact primary care physicians or 911 as soon as there are concerns for the health and safety of people receiving services.

Train program managers, supervisors, and administrators who may provide after hours on-call supports to direct staff to contact 911 when receiving calls regarding medical concerns for people receiving services.

Consider providing all staff with CPR and First Aid training.
BEST PRACTICES FOR RESPONDING TO MEDICAL EMERGENCIES

Policies:

- Ensure agency policies instruct staff to first contact 911 for all emergencies.
- Emphasize the importance of not delaying emergency medical care by calling other staff, health care proxies or family members before first contacting 911.
- When directing staff to bring people receiving services to the Emergency Department, direct staff to contact 911 if immediate medical assistance is required. Consider adopting a protocol to direct staff to contact 911 for all Emergency Department visits to avoid delays in accessing medical care.
- Do not delay medical attention for people receiving services due to concerns regarding staffing. Contact 911 immediately for all medical emergencies, then arrange for any necessary staffing additions.
- Ensure policies identify time frames for RNs and other on-call supports to respond to staff, including nights, weekends, and holidays and also provide guidance for staff to elevate medical concerns if no response is received.
- Include staff training requirements in policies for medical care, including annual and refresher training requirements for CPR, First Aid and responding to medical emergencies.
- Train staff to use clear and consistent terminology to accurately relay medical concerns to 911 or nursing staff.
- Ensure policies include a process for debriefing with staff following medical emergencies to provide constructive feedback, positive reinforcement and/or emotional support as needed.

Environment:

- Create and post a quick reference guide for staff to follow during emergencies that includes a hierarchy of when to first contact 911 or when to first contact a nurse for emergent medical needs. Display the poster in heavily trafficked areas such as the medication room and the kitchen. Include guidance for staff to follow if a medical response is not received in a timely manner.
- Ensure breathing masks and gloves are readily available. Position emergency crash carts, if available, in locations that promote quick access. Ensure staff are aware of the locations of these items.
- Ensure all staff have easy access to Narcan for known or suspected opioid overdoses. Implement a system to monitor the expiration date and replace when expired.¹
- Ensure staff have immediate access to emergency medical information “grab and go” binders that include diagnoses, medications, allergies, primary care physician information and family or guardian contact information.

¹Expired Narcan can still be administered if it is the only thing available. However, the efficacy of Narcan may begin to decline past the expiration and should be replaced.
Training:

- Train staff in CPR, First Aid, Narcan administration.
- Stress the importance of contacting 911 for any emergencies….Don’t delay, call right away!
- Include training information and scenarios regarding people receiving services who may be unable to verbally communicate pain or discomfort and may communicate pain or discomfort through behavioral changes.
- Train staff not to move people after a fall and to first contact 911 or nursing for guidance.
- Train staff on DNRs/DNIs and MOLSTs and how this can impact the use of CPR in an emergency.2
- Clearly identify whose responsibility it is to train staff and ensure all staff are trained, including staff who are absent from initial trainings, and per diem or relief staff.
- Whenever possible, provide in-person, interactive training to promote staff understanding of training content.

Training Tips!

- Consider conducting mock drills for staff to practice responding to medical emergencies. Include a debriefing after drills and after incidents to provide constructive feedback and positive reinforcement to staff.
- Provide realistic training scenarios for staff. For CPR training, consider providing weighted dummies to move from the bed to the floor before beginning CPR, or have staff practice administering CPR using a backboard. Prepare staff that they may encounter blood, vomit, urine, or feces when responding to emergencies.
- Consider using a “pain picture” to help staff recognize when someone is in pain and/or supplementing training with videos that provide a visual depiction of medical distress.

2 DNR refers to Do Not Resuscitate, DNI refers to Do Not Intubate and MOLST refers to Medical Orders for Life Sustaining Treatment.
Case #1

After dinner one night, Barry started to pace back and forth in the living room of his group home. One of the staff, Janice, noticed Barry pacing and asked Barry if he was ok. Barry was mostly non-verbal but he could typically indicate when he was in pain, and pointed to his stomach while he continued to pace in the living room. Janice chuckled and said, “Yep, my stomach hurts a little bit too after that big dinner we had! Your body probably just needs some time to digest and then you’ll feel better.” Janice and the other staff continued with the evening routine, gave everyone their medications and got them ready for bed. Barry stopped pacing and went to lie down in his room earlier than was normal for him. When Janice checked on him at 9:00 p.m. he was lying quietly on his bed, facing away from Janice. At 11:00 p.m., Gregor, the overnight staff, arrived and started to do room checks while Janice gathered her belongings and got ready to leave for the evening. When Gregor checked on Barry he noticed that Barry was sleeping in an unusual position and went further into Barry’s room to check on him. He saw that that Barry had vomited and that Barry’s eyes were open and fixed. He called Barry’s name a few times and tried to find Barry’s pulse but Barry did not respond and did not appear to have a pulse. He called out to Janice, “I think something may be wrong with Barry! Can you come check?” Janice came into Barry’s room and also observed that Barry was not responsive and did not have a pulse. Janice called the house supervisor, Carol, to let her know that something was wrong with Barry. Carol told Janice to start CPR and call 911. Janice called 911 while Gregor began CPR on Barry while Barry was still lying in his bed.

Case Concerns:

- Janice did not identify changes in Barry’s behavior that indicated he was unwell and needed medical attention. She did not take his vital signs when he indicated his stomach hurt and did not notify a nurse that Barry was complaining of stomach pain.
- Although Janice checked on Barry at 9pm she did not check him for signs of life, even though he had complained earlier that he did not feel well.
- Gregor did not immediately contact 911 when he realized that Barry did not have a pulse.
- Janice called the house supervisor instead of contacting 911 when she realized Barry did not have a pulse.
- Janice and Gregor began CPR on Barry while he was lying in his bed rather than moving him to a hard, flat surface.
Case #2

James was complaining of stomach pain and pointing to his stomach. James’ blood pressure was regularly monitored and Laureen, a direct care staff, took his blood pressure and noted that it was high. Laureen called the RN regarding James’ blood pressure but did not tell the RN that James was also complaining of stomach pain. The RN directed Laureen to bring James to the Emergency Department. Instead of immediately bringing James to the Emergency Department, Laureen waited for her co-worker to come back from an outing with another person receiving services. While she was waiting she gave James a shower and a shave and changed him into clean clothing. When the other staff returned from the outing, Laureen brought the person outside to hail a taxi to take them to the Emergency Department. While waiting for the taxi, James collapsed on the sidewalk. Laureen called her supervisor to tell him that James had collapsed. While Laureen was on the phone with her supervisor, some bystanders administered CPR to James.

Case Concerns

◊ Laureen did not inform the RN that James was complaining of stomach pain.
◊ Laureen did not inform the RN that she was waiting for another staff to return from an outing before bringing James to the Emergency Department.
◊ The RN did not delineate a timeframe for when to bring James to the ER or direct Laureen to contact 911 to bring James to the ER.
◊ Laureen did not immediately bring the person to the ER and instead gave the person a shower and changed his clothing first.
◊ When James collapsed on the sidewalk, Laureen did not contact 911, or begin CPR.
◊ The agency policy did not provide explicit instructions for transporting people receiving services to the ER.
Case #3

Amelia, a person receiving services diagnosed with Bipolar Disorder and Opiate Use Disorder, was admitted to an inpatient substance abuse unit at a hospital for inpatient treatment after finishing four days in the hospital’s detox unit. While walking with staff from the detox unit to the inpatient unit, Amelia used the bathroom in the hallway and found a medication bottle with a week’s supply of hydrocodone. Amelia took the pills out of the bottle and put them in her pocket. When she arrived to the unit, inpatient staff did not conduct a search of her person since she came from another area in the hospital. Amelia settled into her room and shortly thereafter, crushed the pills and snorted them. When staff checked on her a few minutes later, they found her unconscious. Staff yelled for help and asked that someone bring a Narcan kit. Staff could not get to the Narcan quickly because it was in a locked cabinet and the shift supervisor had the only key to the cabinet. When they got the cabinet open they rushed it to Amelia’s room but discovered the Narcan was expired so they were unsure if they should administer it.

Case Concerns

- Staff did not check the hallway bathroom for contraband prior to Amelia entering the room.
- Inpatient staff did not complete a search of Amelia and her belongings upon admission to the inpatient unit.
- The Narcan kit was behind a locked cabinet and was expired.
- Staff did not administer the expired Narcan, causing a delay in a potentially life saving intervention.
- Staff did not call for a code for a medical response.
Case #4

Georgiana was admitted to an inpatient psychiatric unit for depression, stating that she did not want to live anymore. Georgiana had a specific plan for ending her life and was placed on 15 minute checks for safety following her admission. While on the inpatient unit, Georgiana’s doctor made changes to her medication regimen and Georgiana appeared to be less depressed and began to talk about plans for the future. Nancy, an LPN on the inpatient unit, was assigned to provide supervision and 15 minutes safety checks to Georgiana. However, Nancy had been having trouble at home and argued with her husband just before her shift started. Her husband called her while she was working and Nancy stepped into an empty stairwell to speak to him. Nancy was on the phone for approximately 20 minutes and when she came back onto the unit, she spent time at the nurse’s station reviewing shift reports and chart updates. When Nancy went to check on Georgiana, it had been 35 minutes since her last check. As Nancy walked down the hall to Georgiana’s room she saw that Georgiana’s door was closed and when she opened it she found that Georgiana had used the blanket from her bed to hang herself from her door. Nancy yelled out for someone to call 911 and then ran out of the room to try and find help. Another nurse contacted 911 and the dispatcher directed them to remove the blanket from Georgiana’s neck and lower her to the floor and begin CPR. When 911 arrived they took over CPR but could not revive Georgiana.

Case Concerns:

- There was a delay in staff lowering Georgiana to the floor and beginning CPR. Nancy did not call a Code Blue, or try to immediately assist Georgiana. Instead, she ran from the room to try and find help.
- Nancy did not provide the 15 minutes safety checks for Georgiana as required or transfer the responsibility to conduct the checks to another staff when she left the unit to take a phone call.
- Nancy did not let anyone know that she was experiencing difficulty at home that might impact her ability to provide supervision to people receiving services.
- The hospital did not have a policy or practice in place to monitor the completion of safety checks.
Case #5

After dinner one night in December, Allana took Ian and Steve out for a ride in the agency vehicle to look at holiday lights. They spent an hour driving around their neighborhood and nearby neighborhoods looking at lights and decorations and had a great time. On the way back home, Allana decided to go to the drive-thru window of a fast food restaurant to get everyone a hot chocolate and a snack. She ordered hot chocolates and cookies for everyone and as soon as she got them, she passed the hot chocolate and cookies to Ian and Steve in the back seat. She warned them that the drinks were hot and they needed to wait for them to cool down before drinking them. Ian and Steve placed their drinks in the cupholders of the backseat and though Ian decided to wait until they got home to eat his cookie, Steve started eating his right away. Allana turned the radio up loud to listen to a song she liked and laughed as Ian and Steve started to sing along. Steve stopped singing just long enough to take a bite of his cookie and started singing again. Suddenly he started coughing and sputtering and Ian patted him on the back and said, “Slow down Stevie!” Steve stopped coughing and went silent while Alanna continued singing along to the radio. When Alanna glanced in the rear view mirror she saw that Steve was slumped over in his seat with his hand on his throat. She yelled to Ian, “Is Steve okay?” while she continued to drive. Ian looked at Steve and shrugged his shoulders. Since they were close to their house, Alanna drove home as quickly as she could. When she pulled into the driveway, she hopped out of the van and ran around to open the passenger door where Steve was sitting. Steve had stopped breathing and was turning blue. Alanna ran into the house and called out for someone to help her then ran back to the car and began pounding on Steve’s back. Vaughan, another staff who was working that night, called 911 then ran outside to help Alanna with Steve. When the ambulance arrived, they took over resuscitation efforts and transported Steve to the hospital.

Case Concerns:

- Alanna gave food to Ian and Steve while they were still in the vehicle which was against agency policy.
- Alanna could not supervise Steve while he was eating since she was driving.
- Alanna did not immediately pull over as soon as she saw that Steve was in distress.
- Neither Alanna or Vaughan administered abdominal thrusts on Steve.
A coordinated response to a medical emergency is vital to ensuring care is received in a timely manner. By designating a staff person a CALM role, staff will know what their individual responsibility is during a medical emergency. If your program has less than four staff, discuss which tasks can be combined to ensure the safety of all people receiving services and staff in the program.

**Best Practices**

- Make staff aware of their CALM role upon arrival to shift. Consider including it on staff assignment sheets or other documentation that would delineate staff work assignments for a shift.
- Practice using CALM roles during mock code drills
CALL 911

- Abdominal pain, severe/constant
- Bleeding heavily
- Broken bones
- Breathing difficulty, shortness of breath
- Chest pain
- Choking
- Consciousness, loss of consciousness or fainting
- Fall: with severe head injury, if unable to get up, limbs appear deformed
- Overdose, suspected
- Poisoning
- Swelling, neck or face (suspected allergic reaction)
- Seizures, new onset or increased frequency
- Standing, unable to bear weight (normally able to do so)
- Stroke, suspected (one sided weakness/numbness, facial drooping, slurred speech)
- Suicidal or homicidal feelings
- Vision, sudden change or loss
- Vomiting (or diarrhea) bloody

GO TO EMERGENCY DEPARTMENT

- Burns[,] with skin damage or blisters
- Falls, gets up on own but complains of pain
- Vomiting, projectile lasting >6 hours, unable to hold down small sips of liquid
- Vomiting or diarrhea lasting >12 hours

CALL RN ON-CALL OR PHYSICIAN

- Bleeding, moderate that stops after 5 minutes of direct pressure
- Blood pressure (upper number 200 or above)
- Blood pressure (upper number below 90 when normally above 90)
- Burn, sunburn or mild burn (redness only)
- Chills, shaking with or without fever
- Confusion, of new onset
- Fall, no apparent injury
- Fever >100 degrees, or <95 degrees
- Incontinence, new onset
- Rash, new onset
- Vomiting or diarrhea lasting <12 hours and individual is alert
Recognizing pain for those with complex communication needs, such as people with intellectual and/or developmental disabilities can be challenging. A pain picture developed with feedback from family, friends or staff who are familiar with the person can help identify when the person is experiencing pain or discomfort that may indicate an underlying medical issue.

Sample pain chart is from nursingtimes.net

**Fig 1. Pain picture - known indicators of pain for Mohammed Abad**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Family observation - normal</th>
<th>Family observation - pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin colour</td>
<td>Flawless mid-brown with slight glow</td>
<td>Lacklustre and sometimes mottled. Eyes appear sunken with very dark shadows underneath</td>
</tr>
<tr>
<td>Sweating</td>
<td>Not particularly sweaty, even in warm conditions. Skin can be quite cool to touch</td>
<td>Excess perspiration, especially hands and neck</td>
</tr>
<tr>
<td>Absence of contentment/facial expression</td>
<td>Very contented, smiles and laughs a lot. Very sociable and likes people. Watches people and animals, and is generally happy</td>
<td>Very quiet and withdrawn. Looks sad and does not watch people. Limited attempts to relate to others and is unsociable</td>
</tr>
<tr>
<td>Aggression</td>
<td>Occasionally rocks and gently bangs his ear, but no injury caused</td>
<td>Ear banging increases if he is in pain or unwell, and can be quite frenzied and frequent, causing redness and bruising</td>
</tr>
<tr>
<td>Breathing</td>
<td>Normal breathing, but is sometimes a little wheezy and gurgly</td>
<td>Becomes breathless and distressed, making loud wheezing sounds</td>
</tr>
<tr>
<td>Facial expression</td>
<td>Very smiley, happy, good eye contact, engaging</td>
<td>Looks down and avoids eye contact. Appears sad and distant</td>
</tr>
<tr>
<td>Behaviour (for example, eating, sleeping, behaviour patterns)</td>
<td>Sleeps well, usually from around 10pm until 7am. Has postural care supports in bed to improve body posture and help with breathing. Does not usually sleep during the day</td>
<td>Wants to sleep all the time, but is restless. Closes eyes and drops off wherever he is. Wakeful and restless at night, and sometimes cries and moans</td>
</tr>
<tr>
<td>Body tension</td>
<td>Quite relaxed</td>
<td>Increased tension. Can stretch legs in a tense way, but all changes are quite subtle</td>
</tr>
<tr>
<td>Increased vocalisation</td>
<td>Can be quite noisy, shouting and laughing. Uses a range of sounds. Can be quite loud, protesting at movement of limbs when he is moved out of his chair or bed</td>
<td>Vocalisation increases, with crying and moaning. Responds to sudden pain by screaming</td>
</tr>
<tr>
<td>Crying</td>
<td>Not well and comfortable</td>
<td>Cries out, but usually no tears. Crying can be sustained for several minutes at a time, resulting in increased wheezing</td>
</tr>
<tr>
<td>Other</td>
<td>Likes to be in his wheelchair and able to engage with others</td>
<td>Does not like getting in wheelchair when unwell or in pain</td>
</tr>
</tbody>
</table>

**PAIN PROFILE**

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Little or no pain identified. No need for extra clinical intervention; maintain interventions that reduce likelihood of pain</td>
<td><strong>Interventions:</strong> general massage; rubbing of limbs and feet; likes lively music, especially the Kaiser Chiefs and Snow Patrol; enjoys being out and about with family and friends; hydrotherapy and physiotherapy</td>
</tr>
<tr>
<td>Yellow</td>
<td>Evidence of some pain. Consider pain relief, including therapeutic approaches known to be helpful (for example, massage, change of position, simple analgesia)</td>
<td><strong>Interventions:</strong> As for green, plus 1,000mg paracetamol (soluble, administered through PEG), which should also be given if grumpy or unwell</td>
</tr>
<tr>
<td>Red</td>
<td>Evidence of significant pain. Provide pain relief as appropriate for the person</td>
<td><strong>Interventions:</strong> as for green and amber. If vomiting or temperature raised administer 2 x 500mg paracetamol suppository (follow prescription guidelines for frequency, check dose against any soluble paracetamol already administered to ensure prescribed levels are not exceeded). Seek medical advice</td>
</tr>
</tbody>
</table>

1The patient’s name has been changed.
PEG = percutaneous endoscopic gastronomy.
RESOURCES

Justice Center Spotlights on Prevention:
https://www.justicecenter.ny.gov/prevent-abuse

OPWDD Health and Safety Alerts:
Bowel Management, Pica Safety Alert, Sepsis Alert, Aspiration Alert, Helmet Safety, Sedation and Anesthesia Risks and Safeguards, Mechanical Lifts
Safety Alerts | Office for People With Developmental Disabilities (ny.gov)

OPWDD: Telephone Triage:

OPWDD Nursing Resources:
https://opwdd.ny.gov/providers/nursing

Office of Addiction Services and Supports:
Learning Thursdays:
https://oasas.ny.gov/training/learning-thursdays

Office of Mental Health Clinical Advisories and Guidelines:
https://omh.ny.gov/omhweb/advisories/

Developmental Disabilities Administration:
Proactive Approaches to Protecting Health and Welfare:
DDA Beyond First Aid Toolkit.pdf (wa.gov)