PURPOSE
The purpose of this policy is to assure that a patient's needs are met in an emergency situation.

POLICY
It is the policy of OCDHC that any patient medical emergency be evaluated, managed and treated so as to optimize the patient's health and well being.

A. GENERAL INFORMATION
1. Each clinic will have at least one CPR-certified staff member on site during regular clinic hours of operation.
2. Basic emergency equipment and supplies shall be maintained in a portable box that is on site whenever services are rendered. The box shall be inspected monthly and documented in a log. Inspection and stocking of emergency equipment and supplies is the responsibility of the Nurse Coordinator.
3. A protocol for in-clinic treatment of common medical emergencies shall be approved by the medical director and maintained as part of this policy.
4. Emergency drugs (including oxygen) are to be administered only under the direction of a licensed medical practitioner.
5. Emergencies that occur in the clinic that are beyond the scope of the available staff shall be dealt with by calling 911 for assistance.

B. PROCEDURE – MEDICAL CLINIC
1. Each clinic will have at least one CPR-certified staff member on site during regular clinic hours of operation.
2. The employee who recognizes a potential medical emergency should immediately notify a physician, midlevel practitioner or nurse (or arrange for another employee to do so). The nature and location of the emergency should be communicated calmly, but quickly.
3. At least one employee should remain with the patient at all times.
4. Upon arrival, the physician, midlevel or nurse in charge will perform a physical assessment of the patient, carry out essential medical procedures, and request emergency equipment or the assistance of additional staff as needed. If the physician determines that a code should be called, the Code Blue procedure (page 2) should be implemented immediately.
5. If the physician, midlevel or nurse in charge determines that the patient's needs are beyond the scope of clinic personnel, he or she shall order that 911 be called.
6. If no licensed medical practitioner (physician, midlevel, RN) is available, 911 should be called.
7. Basic emergency protocols are given on pages 1 and 2 (Item D).
8. Code Blue protocol is given on pages 2, 3 and 4 (Item E).

C. PROCEDURE – DENTAL CLINIC
1. Staff assignments are as follows:
   - Receptionist: Call 911 and act as recorder;
   - Dentist: Direct Code; administer CPR or emergency first aid;
   - Dental Assistant: Locate emergency supplies and monitor blood pressure.
2. At least one employee should remain with the patient at all times.
3. Staff not specifically called to the emergency shall remain calm and continue their assigned activities.

D. IN-CLINIC EMERGENCY PROTOCOLS (To Be Implemented by Licensed Medical Staff Only)
1. Anaphylaxis (allergic response to antibiotic or allergy shots)
   - Call 911 if the patient is having a serious reaction;
   - Administer: Antihistamine Benadryl 50mg po or im;
     Epinephrine 1:1,000, 0.3-0.5mg sq (0.01 ml/kg in children);
     Oxygen;
   - For bronchospasm, administer Albuterol by nebulizer;
   - Consider IV start, NS or LR.
2. Vasovagal/Syncope
   - Place patient in a recumbent position and elevate legs;
   - Monitor vital signs;
   - Consider IV start, Atropine 0.5-1.0mg IV if pulse is less than 60 bpm and symptoms persist call 911.

3. Suspected Hypoglycemia
   - Begin oral glucose paste or glucole from lab;
   - Check chem BG;
   - If altered mental status, call 911 then establish IV access with D5W or D5LR and bolus with 50ml of D50.

4. SAB with heavy bleeding (inevitable SAB)
   - Triage to hospital when anticipated;
   - IV with 20 IU Pitocin/ht, 500 ml/hr and/or mephentermine 0.2mg IM.

5. Preterm Labor
   - Refer to hospital;
   - Consider Terbutaline 0.25 mg sq.

6. Seizures (if first seizure or unknown seizure disorder)
   - Call 911;
   - Position patient on floor, protect from sharp objects, table corners;
   - Consider nasopharyngeal airway, oxygen;
   - Establish IV access if able;
   - If diabetic, consider D50 bolus (with thiamine, if available). Consider chemstick or blood draw if it will not significantly delay therapy;
   - Administer Valium 5-10mg IV q 5 minutes if seizure is prolonged.

7. Severe Asthma
   - Call 911 if respiratory distress is severe;
   - Consider Terbutaline 0.25 mg sq or Epinephrine 1.1,000 0.3-0.5 ml sq if very severe (use with caution in older patients).

8. Chest Pain
   - Administer aspirin, chewed or swallowed, if not contraindicated;
   - Consider nitroglycerine if BP is adequate.

9. Hemorrhage
   - Call 911;
   - Determine bleeding source; if external, apply direct pressure;
   - Position patient in Trendelenburg position;
   - Start large bore IV.

10. Shock
    - Call 911;
    - Determine cause and treat;
    - Provide O2 and maintain airway;
    - Consider IV Start;
    - Consider Causes: septic, hypovolemic, cardiogenic, neurologic, etc.

E. CODE BLUE PROTOCOL

Purpose: A "code" is called for a cardiac arrest, respiratory arrest, massive hemorrhage or any acute life threatening situation at any time when a client's condition is deteriorating rapidly such that an emergency response may be needed.

Goals: ........................................ assess the situation accurately and immediately;
        ........................................ initiate needed life support and stabilize client;
        ........................................ prepare patient for transport.
Procedure:

1. Anyone finding a person in apparent "code" situation:
   a. Assess the situation;
   b. Communicate the emergency and location calmly to appropriate personnel;
   c. Never leave the client alone;
   d. Begin emergency treatment (CPR) and continue until help arrives.

2. Anyone hearing the call for assistance
   a. Notify practitioner and staff;
   b. Rush the defibrillator, crash box, oxygen, EKG, IV tray and IV pole to the area;
   c. Assist with positioning of the client;
   d. Prepare the room by removing any bystanders and any unnecessary furniture.

3. Physician (or most qualified medical person on site)
   a. Should be immediately summoned;
   b. Directs the code procedure;
   c. Assesses the client's status and determines if 911 should be called (upon practitioner instructions, the runner will notify a member of the reception staff to make the call).

4. Clinic Nurse or Medical Assistant
   a. Directs the code procedure until the practitioner arrives;
   b. Assigns personnel to each role;
   c. Attends and operates automatic defibrillator;
   d. Starts IV: NS or LR 1000cc TKO after defibrillation;
   e. After practitioner has assumed responsibility, stands by to assist and monitor vital signs;
   f. Administers medications as ordered;
   g. Calls out medications and amount given;
   h. After "code" is cleared, reviews medications as documented;
   i. Gloves report to EMT;
   j. Restocks crash box and IV tray.

5. Ventilator: Nurse #2 or Medical Assistant (two people if needed for good seal on mask)
   a. Ventilates client with Ambu bag connected to oxygen tank at maximum litres/min. In coordination with cardiac compressor (30 compressions per 2 breaths);
   b. Routinely checks carotid pulse, pupil status, and respiration; reports findings;
   c. Assists with intubation;
   d. Alternates with compressor, prn.

6. Cardiac Compressor: Medical Assistant
   a. Coordinates rhythm with ventilator (30 compressions/2 breaths);
   b. Places EKG lead on patient;
   c. Alternates with ventilator, prn.

7. Recorder: Medical Assistant or Receptionist
   a. Lists and observes out of the mainstream;
   b. Documents events, medications given (time and amount), patient response;
   c. Makes copy of records for EMT and ER.

8. Runner: Medical Assistant
   a. Lists and observes out of the mainstream;
   b. Assists as needed;
   c. Obtains supplies as needed;
d. Clears hallway of personnel and bystanders;
e. Directs phone operator or receptionist to call 911 if ordered by provider;
f. Directs receptionist to meet the ambulance personnel at the entrance of the clinic and directs EMS personnel to "code"

Approved:

Willard Hunter, MD
Chief Medical Officer

Acknowledged:

Cheyenne Spetzler
Chief Operations Officers

Attachments:
Crash Cart Medications Check Log (Form #338)
AHA, CPR Recommendations