DHCS Medical Emergency Response Guidelines for PCP Clinic – 2020

Emergency health care services are available and accessible 24 hours a day, 7 days a week (Facility Site Review, I. Access/Safety Guidelines, D.)

PROCEDURES:

- ☐ Staff can describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). (Pg. 5)
- ☐ There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene (See Ex. Pg. 6).
- ☐ When the MD or NPMP is not on site, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed.
- ☐ Non-CPR-certified staff may only call 911 and stay with the patient until help arrives.
- ☐ Emergency equipment and medication, appropriate to patient population, are available in an accessible location and is ready for use.
- ☐ For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal.
- ☐ Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. (See Ex. Pg. 4).
- ☐ Documented evidence that emergency medication and equipment is checked at least monthly may include a log, checklist or other appropriate method(s). (See Ex. Pg. 2)

EMERGENCY MEDICAL EQUIPMENT:

Minimum emergency equipment is available on site to:

- ☐ Establish and maintain a patent/open airway.
- ☐ Manage emergency medical conditions.

EMERGENCY PHONE NUMBER LIST:

- ☐ Post emergency phone number list that is dated with telephone numbers updated annually and as changes occur (See Ex. Pg. 4). List must include:
  - ☐ Local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors)
  - ☐ Appropriate State, County, City and local agencies (e.g., local poison control number)

AIRWAY MANAGEMENT:

Clinic must have minimum airway control equipment, to include:

- ☐ Wall oxygen delivery system or portable oxygen tank (Portable oxygen tanks are maintained at least ¾ full)
  - ☐ There is a method/system in place for oxygen tank replacement
  - ☐ If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement.
  - ☐ Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank.
  - ☐ Health care personnel at the site must demonstrate that they can turn on the oxygen tank**.**
- ☐ Nasal cannula or mask, oropharyngeal airways,
- ☐ Bulb syringe
- ☐ Ambu Bag as appropriate to patient population. (Mask should be replaced when they can no longer make a solid seal)
- ☐ Various sizes of airway devices appropriate to patient population within the practice are on site.

EMERGENCY MEDICATION/ANAPHYLACTICE REACTION MANAGEMENT: (See Page 2 and 3)

EMERGENCY MEDICATION/ANAPHYLACTICE REACTION MANAGEMENT:

There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). Package inserts are not acceptable as dosage charts. All emergency medications in the emergency kit/ crash cart must have dosage charts.

Anaphylaxis Kit*	Stock	Lot #	Exp. Date	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
A written emergency protocol for anaphylaxis treatment should be posted in a prominent place and rehearsed regularly. It should include drug dosages for adults, as well as telephone numbers and contact details for resuscitation team, emergency medical services, emergency department, etc.															
Epinephrine (Anaphylaxis) Anaphylaxis 1:1000															
(1) X 1 mL vial of injectable diphenhydramine (Benadryl) 50 mg/mL															
(2) X 1 tab of oral diphenhydramine (Benadryl) 25 mg (Oral)															
(3) X 1 mL syringes with safety engineered needles (ESIP). Suggest: Needle gauge: 25G, needle lengths: 3 x 1″; 3 x 5/8″; 3 x 1.5″															
Oxygen Delivery System – tank at least ¾ full Oxygen delivered 6-8 L/minute															
Oral Airways (various sizes)															
Nasal Cannula or Mask															
Ambu bag															
1 Pocket mask															
5 Alcohol swabs															
Other Emergency Medications	**Stock**	**Lot #**	**Exp. Date**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Asthma exacerbation, chest pain, hypoglycemia management per American Academy of Family Practice (AAFP) recommendations.															
Naloxone (Narcan®)															
Chewable aspirin															
Nitroglycerin spray/tablet															
Nebulizer or metered dose inhaler															
Glucose															

EXAMPLE - DOSAGE CHART

2019 Site Review DHCS Guidelines
Emergency Medication\Anaphylactic Reaction Management
Medication Administration Reference (e.g. Medication Dosage Chart)

Anaphylaxis Kit*	Adult	Pediatric	Infant
Epinephrine (Anaphylaxis) Anaphylaxis 1:1000 (injectable)	0.01mg/kg IM (up to maximum of 0.5mg)	0.01 mg/kg IM (up to maximum of 0.3mg)	0.01 mg/kg IM (up to maximum or 0.3mg)
(1) X 1 mL vial of injectable diphenhydramine (**Benadryl**) 50 mg/mL	10mg to 50mg IV/IM (NTE 400mg/day) *If IV route, IV push at a rate of ≤25mg/min	1 to 2 mg/kg/dose IV/IM (NTE 50mg/dose) *If IV route, IV push at a rate of ≤25mg/min	1 to 2 mg/kg/dose IV/IM (NTE 50mg/dose)
(2) X 1 tab of oral diphenhydramine (**Benadryl**) 25 mg (Oral)	Take 25mg to 50mg by mouth	Not preferred. Refer to parenteral route or oral solution	Not preferred. Refer to parenteral route or oral solution
Oxygen Delivery System – tank at least ¾ full	Can consider any oxygen delivery systems if appropriate	Nasal prongs or nasal catheters preferred; can consider face mask, bead box, or incubator for older children	Nasal prongs or nasal catheters preferred
Oxygen delivered 6-8 L/minute	6 to 8 L/minute	1 to 4 L/minute	1 to 2 L/minute
Other Emergency Medications	**Adult**	**Pediatric**	**Infant**
Naloxone (Narcan®)	**Nasal (Narcan)**: Spray 4mg (content of 1 nasal spray) in one nostril as a single dose; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio)**: Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection**: Inject 0.4mg to 2mg IM as a single dose; may repeat every 2-3 minutes up to 10 mg	**Nasal (Narcan):** 4mg (content of 1 nasal spray) as a single does in one nostril; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio)**: Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection** (age ≥5 years old or ≥20kg): 2mg/kg IM/SQ; may repeat every 2-3 minutes prn	**Nasal (Narcan)**: 4mg (content of 1 nasal spray) as a single does in one nostril; may repeat every 2-3 minutes in alternating nostrils **Auto-injector (Evzio):** Inject 2mg (content of 1 auto-injector) IM as a single dose; may repeat every 2-3 minutes with another Evzio auto-injector **Solution injection** (age <5 years old or ≤20kg): 0.1mg/kg IM/SQ; may repeat every 2-3 minutes prn
Chewable aspirin	Chew 160mg to 325mg nonenteric coated aspirin upon presentation or within 48 hours of stroke	Aspirin is not recommended for patients <18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye syndrome	Aspirin is not recommended for patients <18 years of age who are recovering from chickenpox or flu symptoms due to association with Reye's syndrome
Nitroglycerin spray/tablet	**Tablet:** 0.3mg to 0.4mg sublingually every 5 minutes up to 3 doses **Spray:** Spray 0.4mg (1 spray) sublingually every 5 minutes up to 3 doses	Safety and effectiveness of oral nitroglycerin in pediatric patients have not been established	Safety and effectiveness of oral nitroglycerin in pediatric patients have not been established
Nebulizer or metered dose inhaler (albuterol)	**Nebulizer:** 2.5mg to 5mg every 20 minutes for 3 doses, then 2.5mg to 10mg every 1 to 4 hours prn **MDI** (90mcg/actuation): 4 to 8 inhalations every 20 minutes for up to 4 hours, then 1 to 4 hours prn	**Nebulizer:** 2.5mg to 5mg every 20 minutes for 3 doses, then 2.5mg to 10mg every 1 to 4 hours prn **MDI** (90mcg/actuation)**:** 2 to 10 inhalations every 20 minutes for 2 to 3 doses; if rapid response, can change to every 3 to 4 hours prn	**Nebulizer:** 2.5mg every 20 minutes for the 1st hour prn; if there is rapid response, can change to every 3 to 4 hours prn **MDI** (90mcg/actuation)**:** 2 to 6 inhalations every 20 minutes for 2 to 3 doses; if there is rapid response, can change to every 3 to 4 hours prn
Glucose	15gm (3-4 tablets) by mouth	10gm to 20gm (0.3gm/kg) by mouth	Not preferred. Parenteral route recommended (IV dextrose or IM glucagon)

7.30.19 Jenny Nguyen, PharmD, SFHP Pharmacy

References:
1. Arnold, J. J., & Williams, P. M. Anaphylaxis: recognition and management. American family physician, 84(10). 2011.
2. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention (GINA). 2018.
3. National Asthma Education and Prevention Program (NAEPP), "Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma Update on Selected Topics - 2002," J Allergy Clin Immunol, 2002, 110(5 Suppl):141-219.
4. Organization WH. Oxygen Therapy for Children. 2017.
5. Sunehag A, Haymond MW (2017). Approach to hypoglycemia in infants and children. UpToDate Inc. https://www.uptodate.com (Accessed July 29, 2019)
6. UpToDate. Wolters Kluwer. https://www.uptodate.com (Accessed July 29, 2019)

Emergency Contact List [Emergency contact list prominently placed or demonstrated online as easily accessible.]

YOUR CLINIC INFORMATION

Name of Office:	
Street Address:	
City, Postal Code:	
Telephone Number:	
Fax Number:	
Email:	

OFFICE/NURSE MANAGER

Name:	Primary Contact #:	Alternate Contact #:

EMERGENCY NUMBERS

Fire Department	Police Department	Ambulance Service
Hospital	Poison Control	Alarm Company

Site Access/Safety Emergency phone number contacts are posted.

Local emergency response services, emergency contacts (e.g., responsible managers, supervisors), poison control; dated/updated annually.

EXAMPLE **CLINIC** _____ **YEAR** _____

Worksheet

	Anaphylaxis Management			Asthma Exacerbation			Chest Pain			Hypoglycemia Management			Opioid Overdose Management		
	Annual Verification	Staff Mock Training		Annual Verification	Staff Mock Training		Annual Verification	Staff Mock Training		Annual Verification	Staff Mock Training		Annual Verification	Staff Mock Training	
Written protocol for treatment		Jan			Jan			Jan			Jan			Jan	
Protocol prominently placed		Feb			Feb			Feb			Feb			Feb	
Adult drug dosage chart		Mar			Mar			Mar			Mar			Mar	
Pediatric drug dosage chart		Apr			Apr			Apr			Apr			Apr	
		May			May			May			May			May	
		Jun			Jun			Jun			Jun			Jun	
		Jul			Jul			Jul			Jul			Jul	
		Aug			Aug			Aug			Aug			Aug	
		Sep			Sep			Sep			Sep			Sep	
		Oct			Oct			Oct			Oct			Oct	
		Nov			Nov			Nov			Nov			Nov	
		Dec			Dec			Dec			Dec			Dec	

Instructions: Each year and as indicated, date and initial that the criteria are current and in practice. According to best practices, date and initial the regular occurrences of mock training with staff.

Rothkopf, L., & Wirshup, M. B. (2013). A practical guide to emergency preparedness for office-based family physicians. *Family practice management*, *20*(2), 13-18.

EXAMPLE: **Procedure for Providing Immediate Emergent Medical Care On Site Until the Local EMS is On the Scene.**

COMMUNICATION		PHASE	EMERGENCY RESPONSE	
ACTION	**RESPONSIBILITY**		**ACTION**	**RESPONSIBILITY**
Call 911, activate Emergency Medical Services (EMS): Provide address, clinic name, phone# Describe situation Vital Signs Level of consciousness Degree of urgency	Clinic Staff with health information provided by Primary Care Provider	**TRIAGE**	Check ABCs • airway, breathing, circulation • vital signs • check blood sugar, if indicated • check for medic alert	Primary Care Provider
			Complete brief history and P.E.	Primary Care Provider
			Maintain a safe environment for staff and client	Clinic Staff
Establish Leadership and direct activities	Primary Care Provider	**MANAGEMENT**	Obtain required equipment as per emergency protocol	Clinic Staff
Obtain immediate assistance within the office	Primary Care Provider		Move client as required	Primary Care Provider
Use Emergency documentation to note treatments and progress	Primary Care Provider		Do secondary survey, detailed physical examination	Primary Care Provider
Obtain history from next of kin and update them on situation	Primary Care Provider		Assess need for immediate treatment	Primary Care Provider
Communicate with and relocate other clients as needed	Clinic Staff		Initiate treatment according to appropriate protocol with available equipment and medication	Primary Care Provider
Provide patient information and medication sheet for EMS	Clinic Staff			Primary Care Provider
Direct staff member to meet EMS team in parking lot, hold elevator, etc.	Clinic Staff	**TRANSFER**	Reevaluate status and response to therapy	Primary Care Provider
Most responsible primary care provider to sign patient over to EMS	Primary Care Provider		Transfer for definitive care to EMS	Primary Care Provider
Provide written copy of documentation & medication sheet to EMS	Clinic Staff			
MD, PA, NP, or RN to call hospital emergency dept. & update status. Note on documentation.	Primary Care Provider			
MD, PA, NP, or RN to update next of kin. Permission from pt., if possible	Primary Care Provider	**FOLLOW-UP**	Restock Emergency Cart & re-order medication as required	Clinic Staff
Identify opportunities for improvement and implement changes accordingly	Primary Care Team Manager in collaboration with Primary Care Team		Provide medical follow-up in acute case setting as required	Primary Care Provider
			If critical incident, complete appropriate paperwork and steps for reporting. Debrief staff	Team Manager

References: Tip – Use Google Scholar to access articles

Department of Health Care Services (DHCS) All Plan Letter 20-004, Facility Site Reviews.

1. Arnold, J. J., & Williams, P. M. (2011). Anaphylaxis: recognition and management. American family physician, 84(10). https://www.aafp.org/afp/2011/1115/p1111.pdf
2. Ebell, M. H. (2011). Evaluation of chest pain in primary care patients. Am Fam Physician, 83(5), 603-5. https://www.aafp.org/afp/2011/0301/p603.pdf
3. Hauk, L. (2017). Management of Chronic Pain and Opioid Misuse: A Position Paper from the AAFP. American family physician, 95(7), 458-459. https://www.aafp.org/afp/2017/0401/p458.pdf
4. Pollart, S. M., Compton, R. M., & Elward, K. S. (2011). Management of acute asthma exacerbations. American family physician, 84(1). https://www.aafp.org/afp/2011/0701/p40.pdf
5. Rothkopf, L., & Wirshup, M. B. (2013). A practical guide to emergency preparedness for office-based family physicians. *Family practice management*, *20*(2), 13-18. https://www.aafp.org/fpm/2013/0300/p13.html?printable=fpm
6. Toback, S. L. (2007). Medical emergency preparedness in office practice. American family physician, 75(11). https://www.aafp.org/afp/2007/0601/p1679.html
7. US Department of Health and Human Services, National Institutes of Health, & Centers for Disease Control and Prevention. (2014). Guiding principles for the care of people with or at risk for diabetes. *National Diabetes Education Programme*. https://www.niddk.nih.gov/-/media/Files/Health-Information/Communication-Programs/NDEP/health-care-professionals/Guiding-Principles-Final_04-25-19.pdf?la=en&hash=52322889BA2325EEFD94CDA37339674D

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