



Publication of MEDICAL MUTUAL/Professionals Advocate®

# DOCTORS

Volume 19 No. 2

Winter 2011



## A Letter from the Chair of the Board

*Dear Colleague:*

*When a medical emergency occurs in the private office setting, it usually strikes without warning, affording the practice precious little time to respond.*

*This issue of Doctors RX discusses the importance of establishing a plan of action to address unexpected medical emergencies and provides information to consider when evaluating your practice's emergency preparedness.*

*George S. Malouf, Jr., M.D.  
Chair of the Board*

*MEDICAL MUTUAL Liability Insurance Society of Maryland  
Professionals Advocate Insurance Company*

## Medical Office 911: Expecting the Unexpected

**Consider this scenario:** A 68-year-old woman presented to her family Physician for her yearly physical exam. The woman approached the registration desk and advised she was not feeling well. Just prior to reaching the counter she collapsed. Although there was a defibrillator in the office and equipment for intubation, there was no crash cart with emergency drugs. The Physician immediately instructed the secretary to call 911. No emergency care was administered while awaiting EMS arrival other than the Physician placing the patient in the recovery position on the floor to diminish the chance of fluid aspiration. Despite aggressive resuscitation efforts by paramedics, the patient was pronounced dead shortly after arrival at the hospital. The subsequent lawsuit alleged that had the Physician used any of the modalities available to him and had the appropriate equipment been available, the patient would have survived.

While there are no statutory provisions that outline the requirements for responding to medical emergencies in the office setting, patients expect that a medical practice will be equipped and prepared to respond to potentially life-threatening medical emergencies should they occur. As the above scenario illustrates, failure of Physicians and staff members to respond appropriately to these kinds of situations may lead to a medical malpractice lawsuit.

*Continued on next page*

Suzanne Stone



Although not an everyday occurrence, medical emergencies in private medical offices do occur, possibly more often than expected. A study of rural general practitioners demonstrated a median of eight emergencies per year, with 95 percent seeing at least one emergency in the past year.<sup>1</sup> Emergencies are more common in primary care pediatric offices. One survey of 52 pediatric offices showed a median of 24 emergencies per year, with 82 percent of the offices reporting an average of at least one emergency per month.<sup>2</sup> In another study, 62 percent of pediatricians and family Physicians practicing in an urban setting reported assessing more than one patient per week who required emergency care or hospitalization.<sup>3</sup>

The most common types of emergencies in primary care offices include asthma complications, psychiatric-related issues, seizures, anaphylaxis and cardiac arrest.<sup>4</sup> In pediatric offices, common emergencies are respiratory-related problems, seizures, infections in infants and dehydration.<sup>5</sup> If you are a specialist, you are likely already prepared for an emergency that is within your scope of practice. However, you should consider whether you are ready to handle emergencies outside your scope, such as a patient who is having an anaphylactic reaction to latex gloves.

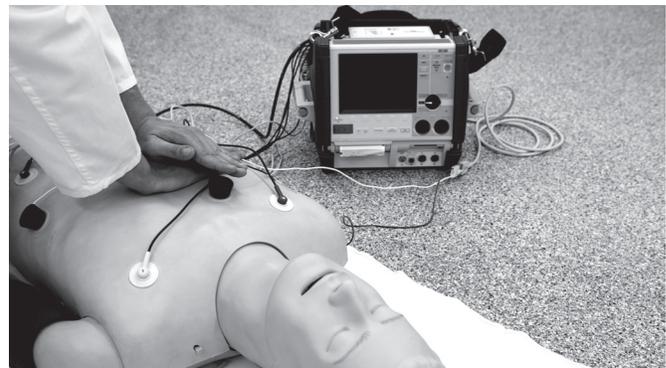
## Emergency Preparedness

Despite the fact that patient emergencies happen infrequently, even one can be too many if you are not adequately prepared. Emergency office preparedness begins with an evaluation of various aspects of your office and practice. This includes consideration of the following questions:

1. What types of emergencies have occurred in your office in the past year, and how often have you encountered such emergencies over the course of your medical career?
2. What type of patients do you treat? Do you treat a substantial number of patients who have special health needs or co-morbidities outside of your specialty? If so, what are the most common potential emergencies these patients might experience?
3. Is your office freestanding, or is it located in a large health center, a clinic or a hospital?

4. How far is your office from an emergency department or other emergent care facility?
5. How long does it take emergency services to respond to a 911 call from your office? Some articles indicate that average response times can be 11 to 16 minutes. If you are located in a rural area, the response time could be longer.<sup>6</sup>

The answers to these questions can be the first step in evaluating your office's response to a medical emergency and developing a plan for when a medical emergency occurs in your office. When developing an emergency response plan consider the items discussed below.



## Specialty Specific Emergency Guidelines

While there are no official regulations for adult emergencies, check with your specialty society to see if they have minimum recommendations for emergency medications and equipment.

For example, The American Academy of Pediatrics has issued guidelines to assist offices in establishing an emergency plan. The guidelines include a list of recommended supplies and are available at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;120/1/200.pdf>

Fortunately, medical emergencies are not something that most offices will experience on a regular basis. However, should the unexpected occur, having an emergency response plan in place and ensuring that staff is appropriately trained is the best way to reduce the potential for liability exposure and may ultimately save a life.



## CME Test Questions

### Instructions for CME Participation

*CME Accreditation Statement* – MEDICAL MUTUAL Liability Insurance Society of Maryland, which is affiliated with Professionals Advocate® Insurance Company, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians.

*CME Designation Statement* – MEDICAL MUTUAL Liability Insurance Society of Maryland designates this enduring material for a maximum of one (1) AMA PRA Category 1 Credits(s).™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Instructions – to receive credit, please follow these steps:

1. Read the articles contained in the newsletter and then answer the test questions.

2. Mail or fax your completed answers for grading:

Med•Lantic Management Services, Inc.

Fax: 410-785-2631

225 International Circle

P.O. Box 8016

Hunt Valley, Maryland 21030

Attention: Risk Management Services Dept.

3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the *Doctors RX*.

To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.

4. Completion Deadline: March 31, 2012

5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

1. According to a study published in the *American Family Physician*, the most common types of emergencies in primary care offices include asthma complications, psychiatric-related issues, seizures, anaphylaxis and cardiac arrest.  
A. True    B. False
2. A written emergency plan is necessary only if you determine that EMS response time is likely to take longer than 16 minutes and none of the staff are trained in basic life support.  
A. True    B. False
3. All staff should have a copy of the practice's medical emergency plan, however, there is no added benefit in having front office personnel participate in mock emergency drills, since generally they are not medically trained.  
A. True    B. False
4. One survey of 52 pediatric offices showed a median of 24 emergencies per year with 82 percent of the offices reporting an average of at least one emergency per month.  
A. True    B. False
5. All medical offices, even those that do not treat pediatric patients, are required to keep pediatric doses of common drugs such as epinephrine and Benadryl.  
A. True    B. False
6. Seizures, dehydration, infections and respiratory problems are common types of emergencies reported in pediatric settings.  
A. True    B. False
7. When rapid defibrillation is performed in a medically supervised environment, survival rates can be as high as 79 percent. Survival decreases by about 5 percent each minute until a defibrillator is applied to a patient experiencing cardiac arrest.  
A. True    B. False
8. As long as a thorough report of the emergency steps taken to treat the patient is transmitted to emergency service personnel there is no need to document the same information in the patient's medical record.  
A. True    B. False
9. Basic supplies that should be included in all emergency kits include an intravenous catheter, IV medication and an AED unit.  
A. True    B. False
10. Although there are no specific provisions in the law which outline exactly how Physician offices are required to respond to medical emergencies, every office should conduct an analysis of their practice to determine the most appropriate plan for emergency management.  
A. True    B. False





# CME Evaluation Form

## Statement of Educational Purpose

*Doctors RX* is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.<sup>®</sup> Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:

- 1) Gain information on topics of particular importance to them as Physicians,
- 2) Assess the newsletter's value to them as practicing Physicians, and
- 3) Assess how this information may influence their own practices.

## CME Objectives for "Medical Office 911: Expecting the Unexpected"

Educational Objectives: As a result of participating in this enduring material, participants should be better able to:

- 1) Consider the implications of failing to respond appropriately to an unanticipated medical emergency in the medical office practice.
- 2) Evaluate their own office's emergency preparedness.
- 3) Develop a practical and effective plan to respond to a potential medical emergency in the office setting.

<b>Strongly Agree</b>		<b>Strongly Disagree</b>
---------------------------	--	------------------------------

### ***Part 1. Educational Value:***

5 4 3 2 1

I learned something new that was important.

I verified some important information.

I plan to seek more information on this topic.

This information is likely to have an impact on my practice.

***Part 2. Commitment to Change:*** What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Part 3. Statement of Completion:*** I attest to having completed the CME activity.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Part 4. Identify Information:*** Please PRINT legibly or type the following:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Creating a “Crash Cart”

Although emergency supplies do not need to be maintained in a traditional “crash cart,” it is wise to keep all such supplies in one easily accessible location. You can assemble the supplies on your own or purchase a pre-assembled kit. The answers to the above evaluation of your patient population and the types of emergencies you may encounter will guide you in deciding what equipment, supplies and medication to have readily available.

You may want to consider purchasing an Automatic External Defibrillator (AED), which is standard equipment for many practices. If your office regularly treats patients who are at risk for cardiac events, this machine may be the difference between life and death. If you are in a rural location, where, as noted, emergency response time may be longer, an AED is a wise investment. When rapid defibrillation is performed in a medically supervised environment, survival rates can be as high as 90 percent. Survival decreases by about 10 percent each minute until a defibrillator is applied to a patient experiencing a cardiac event.<sup>7</sup>

Basic emergency supplies might include ambu-bags and masks, oxygen and tubing, a pulse oximeter, latex gloves, alcohol swabs and epinephrine auto injectors. Depending on your patient population, other supplies to consider include blood glucose monitors and nebulizers. If you treat many chronically ill or special needs patients, consider acquiring equipment and supplies appropriate for responding to specific emergencies that might occur in this population.

In selecting supplies, consider your skills and training and that of other Physicians in your office, as well as your medical staff. If no one in your office is proficient in advanced airway techniques, you will not need supplies for these procedures. However, at a minimum you should maintain proficiency in bag-valve-mask ventilation and stock the necessary supplies for this procedure. Similarly, if no one in your office is able to place an intravenous catheter, IV medication need not be stocked. Instead, consider parenteral medications, such as corticosteroids, glucagon and rectal diazepam.

Once you have set up an emergency kit, assign a staff member to check the equipment supplies and medication regularly. This assessment may include verifying that

equipment is in working order and that the kit is stocked with all necessary items. Medications will need to be checked periodically to ensure that they have not expired. Keep a list of required supplies and medications on the cart and have the staff member sign and date the maintenance form verifying that the supplies and medications have been checked. In addition to the regular checks, you may want to periodically assess the supplies and medications to determine whether additions are indicated.

## Training Your Staff

Just as important as having emergency medical equipment, supplies and medications available is ensuring appropriate members of your staff know how to use them. Begin by evaluating the size and structure of your staff and the knowledge and skills that are appropriate.

Consider whether Physicians, Physician assistants and nurse practitioners would benefit from advanced life support training. Such training includes the following:

- Identification and early management of peri-arrest conditions that may lead to cardiac arrest or complicated resuscitation outcomes;
- Management of cardiac arrest until spontaneous circulation returns, resuscitation is terminated or care of patient is transferred;
- Recognition of life-threatening clinical situations such as stroke;
- Identification and treatment of ischemic chest pain and sequence of care for patients with acute coronary syndromes;
- Team dynamics, including effective communication for both leaders and team members; and
- Basic life support (described below).

Training for nurses and medical assistants might include basic life support skills. Basic life support training typically includes the following:

- CPR for patients of all ages;
- Ventilation with barrier device, a bag-mask device



- Use of an AED; and
- Relief of foreign body airway obstruction.

Once initial training is completed, regular refresher courses are valuable to ensure that skill level remains up to date.

While front office staff is not directly involved in patient care, they generally are the first to see or speak with a patient or caregiver. This makes them key participants in identifying a situation that might be an emergency. Training for front office staff might include the following:

- Understanding signs or symptoms which indicate a potential emergency;
- Assessing potential telephone emergencies and determining whether the caller should be referred to an emergency room or told to come to the office immediately;
- Developing techniques for calming down an individual who calls about a potential medical emergency, and what information to gather to assist the medical staff in assessing the situation; and
- Identifying “buzzwords” that front office staff can use to communicate to medical personnel that a patient in the waiting room or on the telephone requires immediate attention (note: medical staff also will need to be familiar with the “buzzwords” that are identified)

If you think your staff would benefit, schedule mock drills. While mock drills are most effective when done without advance notice, drills may be scheduled before or after office hours to avoid disruption to your practice. If you notify staff of the drill, assign roles for each staff member and vary the roles and emergency scenarios. Some possible scenarios include drills for the most common types of emergencies including asthma complications, psychiatric-related issues, seizures, anaphylaxis and cardiac arrest.

Another item to consider when providing staff training is determining who will take notes during the emergency. Documentation during an emergency can present challenges because activity is occurring at a rapid pace. However, tracking activities during an emergency is

critical to the patient record. The notes should include patient status, specific actions taken, timeframe from onset of emergency to resolution or transfer to emergency personnel. Documentation should also indicate the medical information communicated to the emergency services personnel.

## The Emergency Plan

Planning for emergencies is the best way to be prepared and maximize the likelihood of a positive outcome. A written emergency plan can eliminate uncertainty and ensure that staff members understand their role. In addition to evaluating your practice, developing a “crash cart,” and providing staff training, you may also want to include the following in your final emergency plan:

- Summary of how to identify a patient in need of emergency care (e.g., what red flags indicate an emergency);
- Primary team leader and substitutes (usually Physicians);
- Designated assistants and the roles of each based on their training (nurses or other medical staff);
- Designated room for emergency treatment (if space allows);
- Location of emergency supplies;
- Treatment sequence (algorithms) for medical conditions your office is likely to encounter;
- Individual(s) responsible for documenting sequence of care during emergency;
- Individual(s) responsible for regularly checking emergency supplies;
- When to call 911 (e.g., immediately upon identification of emergency or after initial assessment by Physician);
- Individual(s) responsible for calling 911 when the order is given; and
- Frequency and design of mock drills



The basic treatment sequence will likely be the “airway, breathing, circulation” model that is taught in life support courses. Additional steps may be established for emergencies such as anaphylaxis, diabetes-related, psychiatric, asthma-related, seizures and other emergencies that might occur among your patient population.

Distribute a copy of the plan to all employees and post it in a location where staff will see it, such as a break room.

## Case Study

As the following scenario illustrates, an integral part of having an emergency plan is ensuring everyone in the office is aware of their role in an emergency and are adequately prepared to respond.

A 59-year-old female patient was seen in the office for an exam and fasting blood work. While checking out at the front desk the patient stated that her “sugar was low” and complained of being lightheaded, weak and shaky. The patient was brought back to the exam room and given a cup of soda and a few crackers. A few moments after eating the crackers, the patient began to exhibit symptoms of anaphylaxis, including nausea, tightness in her throat, difficulty breathing and swelling of her lips and tongue. The Physician called a code blue which signaled the medical assistant to call 911. Without hesitation, the medical assistant retrieved the medical emergency kit and oxygen tank. The Physician then administered 1mg/mL epinephrine followed by 50 mg/mL Benadryl and then a second ampule of epinephrine. The laryngeal spasm

appeared to subside, however the patient progressed to grand mal seizures. The patient was carefully repositioned to the floor to prevent injury. When the seizure subsided, the Physician began monitoring vitals. Her respirations were shallow and pulse was weak and thready. Oxygen was applied via mask. The pulse was lost and CPR was administered just prior to the arrival of the paramedics. Additional attempts at resuscitation both en-route and at the hospital were unsuccessful. The records of this situation were requested and reviewed by a plaintiff attorney; however, no suit was ever filed.

This scenario had a very different outcome for the Physician than the one presented at the beginning of this newsletter. In this scenario, all of the office staff responded appropriately to the patient’s medical emergency. Although the patient expired, the office worked as a team to handle the situation and provide emergency care. A well-crafted and practiced emergency plan can play an important role in preventing medical injury or death and potential future lawsuits.

## References

1,4,6,7 Medical Preparedness in Office Practice, American Family Physician, 2007 Jun 1;75(11):1679-1684. <http://www.aafp.org/afp/2007/0601/p1679.html>

2,3,5 Preparation for Emergencies in the Offices of Pediatricians and Pediatric Primary Care Providers, Pediatrics, 2007;120;200. <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;120/1/200.pdf>

## Doctors RX

Elizabeth A. Svoisky, J.D., *Editor*  
Assistant Vice President - Risk Management

Dr. George S. Malouf, Jr., M.D., *Chair of the Board*  
MEDICAL MUTUAL Liability Insurance Society of Maryland  
Professionals Advocate® Insurance Company

Copyright © 2011. All rights reserved.  
MEDICAL MUTUAL Liability Insurance Society of Maryland

Articles reprinted in this newsletter are used with permission. The information contained in this newsletter is obtained from sources generally considered to be reliable, however, accuracy and completeness are not guaranteed. The information is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this newsletter should be directed to your attorney.

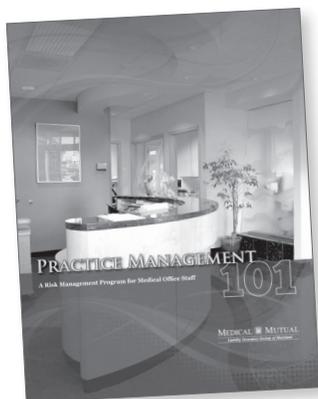
All faculty/authors participating in continuing medical education activities sponsored by MEDICAL MUTUAL are expected to disclose to the program participants any real or apparent conflict(s) of interest related to the content of her presentation(s). Suzanne Stone has indicated that she has nothing to disclose.

## Numbers you should know!

Home Office Switchboard	410-785-0050
Toll Free	800-492-0193
Incident/Claim/ Lawsuit Reporting	800-492-0193
Risk Management Seminar Info	ext. 215 or 204
Risk Management Questions	ext. 224 or 169
Main Fax	410-785-2631
Claims Department Fax	410-785-1670
Web Site	<a href="http://www.weinsuredocs.com">www.weinsuredocs.com</a>



## Free Office Staff Education Program Now Available



MEDICAL MUTUAL now offers a complimentary office staff educational program, *Practice Management 101*, designed to provide your employees with an overview of critical practice management issues.

This CD-based multimedia course covers topics such as staff-patient interaction, confidentiality, addressing patient concerns and complaints, workplace safety and more. The convenient format of the program makes it ideally suited for staff meetings, new employee orientations or as a general resource.

If you would like more information on how to obtain a copy of the program, please contact our Risk Management Services Department at 410-785-0050 or 800-492-0193.



Publication of MEDICAL MUTUAL/Professionals Advocate®

# DOCTORS



Volume 19 No. 2

Winter 2011

PRST STD  
U.S. POSTAGE  
PAID  
PERMIT NO. 5415  
BALTIMORE, MD

Home Office: Box 8016, 225 International Circle  
Hunt Valley, MD 21030 • 410-785-0050 • 800-492-0193

Professionals Advocate® Insurance Company

Medical Mutual Liability Insurance Society of Maryland 