NEW YORK STATE Corrections and Community Supervision **DIRECTIVE**	TITLE **Response to Health Care Emergencies**		NO. 4059 DATE 03/20/2023
SUPERSEDES DIR. #4059 Dtd. 04/06/21	DISTRIBUTION A	PAGES PAGE 1 OF 4	DATE LAST REVISED
REFERENCES (Include but are not limited to) See Section IV	APPROVING AUTHORITY Carol A. Moores, MD. [illegible]		

I. PURPOSE: To provide direction to staff on how to respond to a health care emergency and to establish a training standard to assist staff in meeting this responsibility.

II. BACKGROUND: All security and health care staff (Nurse, Physician, Physician Assistant, Nurse Practitioner) have been trained in basic first aid, including Cardiopulmonary Resuscitation (CPR), Narcan administration, and operation of an Automatic External Defibrillator (AED), in order to respond to health care emergencies.

III. POLICY: The Department of Corrections and Community Supervision (DOCCS) requires security staff and health care staff (Nurse, Physician, Physician Assistant, Nurse Practitioner) who encounter health care emergencies on the job to immediately provide necessary first aid, administer Narcan to unresponsive persons, and, in the event of cardiac or respiratory arrest, to immediately initiate CPR, and to use an AED, if indicated.

IV. REFERENCES

- ACA Expected Practice 5-ACI-6B-08
- Directive #2124, “Automatic External Defibrillators”
- Directive #4010, “Emergency Control Plans for Correctional Facilities”
- Directive #4058, “Narcan Administration by Uniformed Correctional Staff First Responders”
- Directive #4065, “Reporting Injuries and Occupational Illnesses”
- Directive #4069, “First Aid Kits”
- Directive #4101, “Incarcerated Individual Suicide Prevention”
- Health Services Policy Manual, Item 1.41, “Do Not Resuscitate Policy”
- Health Services Policy Manual, Item 1.35, “Emergency Medical Equipment”

V. DEFINITION

A. Health Care Emergency: For purposes of this directive, a “health care emergency” shall mean, but is not limited to, discovery of a person who is unconscious or unresponsive, without pulse, not breathing/having difficulty breathing, bleeding profusely, in a life-threatening position, suffering electrocution, suffering burns, or suffering a life-threatening injury or illness.

B. Response: For purposes of this directive, “response” refers only to the immediate or initial actions taken by security or health care staff which are intended as life-saving measures.

C. Cardiopulmonary Resuscitation (CPR): For the purposes of this directive, CPR shall mean chest compressions and assisted breathing with the use of a bag valve mask (BVM).

D. Primary Care Provider (PCP): A primary care provider (PCP) is a Clinical Physician, Nurse Practitioner, or Physician Assistant.

E. Narcan: Narcan is an opioid antagonist administered by first responders. Narcan is very specific and has essentially no side effects or drug interactions other than reversal of the effects of opioid medications.

NOTE: Facility staff may encounter a health care emergency, such as when an employee, incarcerated individual, or visitor suffers a heart attack, or when injuries occur during the restraint of a violent incarcerated individual. When such an event unfolds, staff are reminded of the responsibilities they have regarding their performance.

All Department facilities have stretchers, gurneys, or backboards (when medically necessary) strategically placed in various areas of the facility. Staff are expected to utilize this equipment to ensure prompt and safe transport of a person to the facility health services area unless exigent circumstances exist which would likely increase the risk to the lives or safety of staff and/or incarcerated individuals. Examples of such exigent circumstances are a fire, exposure to hazardous fumes, severity of injury, or if the incarcerated individual refuses. Staff are also reminded the person must be properly secured to the stretcher, gurney, or backboard prior to transport.

Further, all staff must be constantly aware that any incarcerated individual restrained in a prone position on their stomach, with their hands held or mechanically restrained behind their back may be susceptible to positional asphyxia in a relatively short time.

VI. PROCEDURE

A. Training: Initial and on-going training for all security and health care staff shall include instruction in the following:

1. Recognition of signs and symptoms, and knowledge of actions required in potential emergency situations.
2. Administration of first aid, CPR, and AED. (The Emergency Care & Safety Institute CPR/First-Aid Training Program has been approved as the Department's authorized training program.).
3. Administration of Narcan to unresponsive persons.
4. Methods of obtaining assistance.
5. Recognition of signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal.
6. Procedures for patient transfers to appropriate medical facilities or health care providers.
7. Suicide intervention.

B. Facility Policy & Procedures: The facility Superintendent, in collaboration with the facility Health Services Director, shall ensure that local procedures are developed and sufficient resources are provided to fulfill the training responsibilities specified in subsection VI-A.

Response time is a key component of operational readiness. Accordingly, security and health care staff are trained to respond immediately upon encountering a health care emergency, and all local procedures and resources shall be designed to ensure that an emergency response can be achieved anywhere in a facility **within three minutes**. Additionally, it is essential that staff responsible for contacting emergency medical services do so in an expeditious manner to ensure advanced cardiac life support is provided to the patient as soon as possible.

C. Annual Drill Requirement: To ensure that staff are able to respond to a health care emergency anywhere in a facility **within three minutes** of being notified, each facility shall conduct an annual emergency response drill on each tour. These annual emergency response drills should include facility areas such as Housing Units, Mess Halls, Programs, Restrictive Housing, etc. The facility Fire/Safety Officer and the Deputy Superintendent for Administration/Deputy Superintendent for Health will conduct the drill and shall document all activities related to the conduct of the drill, including response time, on Form #4059A, "Annual Emergency Response Drill." For facilities that do not have health care staff on duty for all shifts, the drills should be conducted with the staff available at the time.

The facility Superintendent and facility Health Services Director will schedule the drills and critique the results. Personnel conducting the drill shall record training credits on Form #RTF, "Report of Training Form."

D. Cardiopulmonary Resuscitation (CPR)

1. Initiation of CPR: Every person living in, working at, or visiting a correctional facility shall be presumed to consent to the administration of CPR in the event of cardiac or respiratory arrest, unless there is an applicable and written Do Not Resuscitate (DNR) order.

   Absent a DNR order, CPR is indicated and will be initiated in all cases of arrest (i.e., absence of a pulse in wrist or neck, no apparent heartbeat from the chest, and/or absence or minimal breathing). The only exception is in cases of decapitation or other traumatic injuries that are so extensive that they are incompatible with life.

2. Continuation of CPR: CPR, once initiated, is to be continuous through the care of the patient except when any ONE of the following criteria is met:

   a. Successful resuscitation with restoration of pulse and spontaneous respiration.
   b. AED analysis of the patient's heart rhythm requires a brief "hands-off" interval.
   c. An applicable (i.e., valid non-hospital) DNR is made available.
   d. Transfer of care to an appropriately trained individual in order to continue CPR (i.e., paramedic, ambulance personnel, back up health care staff, etc.).
   e. Care of the patient is transferred to hospital staff.
   f. Personnel performing CPR are not physically able to continue.
   g. Physician, Physician Assistant, or Nurse Practitioner assumes responsibility for the care of patient and gives an order to discontinue CPR. While a Physician Assistant or Nurse Practitioner must do this in person, a Physician can issue such an order by radio, telephone, or telemed.

NOTE: If there is any likelihood of successful resuscitation, the presumption is for continuing CPR until advanced cardiac life support can be provided. CPR ought to be initiated on location (e.g., housing area, program area, recreation area, etc.) as soon as possible and should not be delayed or discontinued for the purpose of being transported to a facility medical area. Most patients do not necessitate a move to a medical area, except under very rare circumstances (e.g., requires suctioning for aspiration), which must be identified by health care staff. Transporting a patient while still effectively performing CPR is extremely difficult and can even put staff at risk if they attempt to move a patient without sufficient support. Unless health care staff determines a patient must be moved or a security concern exists, CPR should continue, on location, until such time EMS, paramedics, ambulance personnel, etc. arrive at the facility. Upon arrival of such, the patient should be brought to the ambulance for transport to an outside hospital.

E. Treatment of Loss of Consciousness Nursing Algorithm: Nurses will follow the Unresponsiveness and/or Respiratory Depression Possibly Caused by Opioid Overdose Algorithm and the "Non-Patient Specific Standing Order for Unresponsiveness and/or Respiratory Depression Possibly Caused by Opioid Overdose," when encountering unconscious incarcerated individuals.

F. Uniformed correctional staff will follow Form #4058A, "Protocol for Narcan Administration by Uniformed Correctional Staff First Responders," outlined in Directive #4058.