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Common Medical Emergencies Health & Safety Alert

Introduction

Emergency situations can happen at any time anywhere to anyone. The best way to handle any emergency is to be prepared. Regular folks living and working in the community are the actual first responders in any emergency (8).

It is beneficial for everyone to learn how to handle various types of emergency situations, in order to save lives. Repetitive practicing, or drills, of emergency responses, has been shown to improve muscle memory and helps people to respond automatically in stressful circumstances (8).

This is especially true for caregivers of individuals with intellectual and developmental disabilities (DD). Many individuals with DD may be diagnosed with conditions which render them:

- Medically fragile.
- Non-ambulatory.
- Non-verbal.
- Medically complex – with multiple chronic health conditions.
- Mentally complex – with mental, emotional, or behavioral conditions which impact their ability to recognize danger, seek help, or save themselves independently (31).

Other individuals may be able to communicate verbally but may be unable to describe what they are feeling (chest pains, etc.). Due to this, they are wholly dependent on their caregivers in the community to maintain their safety and seek appropriate healthcare treatment for them, in a timely manner, when changes to their baseline occur (9).

Recognizing Medical Emergencies - Warning Signs and Symptoms

What constitutes an actual medical emergency? The answer is: *any* acute illness or injury which poses a threat to the life or well-being of an individual. Due to this, there is no definitive list or parameters. Below is a shortened list of medical emergency warning signs and symptoms from the American College of Emergency Physicians (for the general public):

- Bleeding which cannot be controlled.
- Shortness-of-breath, or respiratory distress.
- Changes in mental status or alertness.
- Chest pain.
- Choking.
- Loss of consciousness or dizziness.
- Head or spine injury.
- Severe vomiting.
- Sudden, acute/severe pain.
- Acute injury (motor vehicle accident, burns, near drowning, etc.).
- Accidental ingestion of poison.
- Suicidal or homicidal intention (4).

Potential Medical Emergencies Among Individuals with IDD

Licensed community provider agencies should strive to be prepared to respond to general medical emergencies and medical emergencies which tend to be more common among individuals with IDD.

Individuals who have a history of a specific type of medical emergency occurring repetitively should have an individualized, person-centered care protocol (signed by their PCP or medical specialist) with guidelines and parameters for that particular condition. It should include specific signs and symptoms, that would be considered an “emergency” for that specific individual. The care protocol should also include when and where (ER, PCP office, etc.) caregivers should seek treatment for the individual. All individualized, care-related protocols for medical conditions should be signed by the individual’s primary care provider (PCP) or medical specialist.

Individuals with DD are more prone to the following types of emergencies…

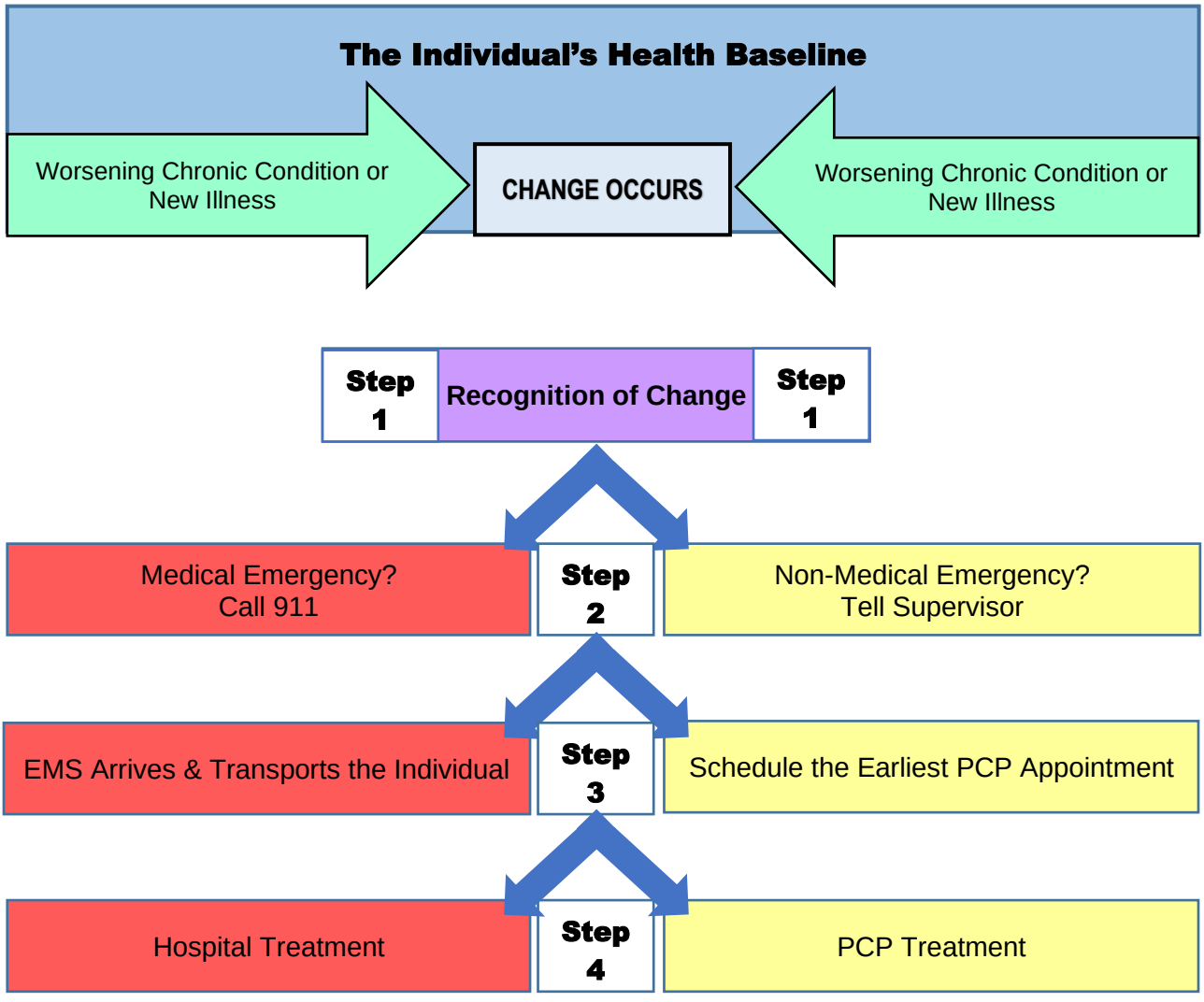
- Choking events.
- Seizures, individuals who are prescribed Diastat or those with ongoing seizures should have an individualized, person-centered care protocol signed by their PCP.
- Falls with and without injury.
- Sepsis signs and symptoms. Individuals with a history of sepsis should have an individualized, person-centered care protocol, which addresses signs and symptoms of sepsis signed by their PCP.

Health Changes Which Impact an Individual's Health Baseline

Worsening chronic health conditions or new illnesses which impact the individual's health baseline can lead to changes within the body. Changes within the body may be recognized by visual observations of an individual's general appearance, their behaviors, and/or their vital signs measurements.

Decision trees can assist caregivers in determining what should be done next and can help guide caregivers move through the process. The decision tree below starts with the observation of a change in the individual's baseline and walks you through the steps in obtaining help.

Recognition to Treat Decision Tree



Common Medical Emergencies Among Individuals with IDD

The following are common medical emergencies among individuals with IDD. Caregivers should be well-prepared to respond to them. Ongoing reviews and practice drills are also recommended to ensure staff have not forgotten how to respond to a particular emergency. Please see the Emergency Preparedness: Medical Emergency Policies, Plans and Drills Health & Safety Alert for detailed information on best practice actions caregivers should take to maintain individual's safety.

Choking

Dysphagia is the single greatest choking risk in adults with IDD. Choking is a leading cause of death for individuals with IDD (22) (16).

If a person can't cough, talk, cry, or laugh, give first aid to the person immediately.

Choking risk is increased by the following factors:

- Having a diagnosis of IDD.
- Having a genetic syndrome associated with IDD.
- Having a diagnosis of dysphagia.
- Having a diagnosis of GERD.
- Missing teeth
- Eating too quickly
- Stuffing too much food in the mouth while eating.
- Swallowing food whole.
- Talking while eating.
- Moving around while eating.
- Eating in isolation.

The American Red Cross recommends the following steps:

- Give five back blows.
  - Stand to the side and just behind a choking adult. Place your arm across the person's chest to support the person's body. Bend the person over at the waist to face the ground. Strike five separate times between the person's shoulder blades with the heel of your hand.
- Give five abdominal thrusts.
  - If back blows don't remove the stuck object, give five abdominal thrusts, also known as the Heimlich maneuver.

- Alternate between five blows and five thrusts until the blockage is dislodged.
- **If the individual continues to choke call 911 and prepare to do CPR until they arrive** (18).

A speech and language pathologist (SLP) can:

- Perform an assessment of the mouth for any structural anomalies.
- Observe for behaviors that increase the risk of choking.
- Recommend diet modifications for their mealtime protocol.
- Perform a swallow study to assess for dysphagia.

Seizures

Seizure disorders are more common and more serious in persons with IDD. There is a strong connection between IDD and seizure disorders, which are more resistant to treatment, than in the general population (23).

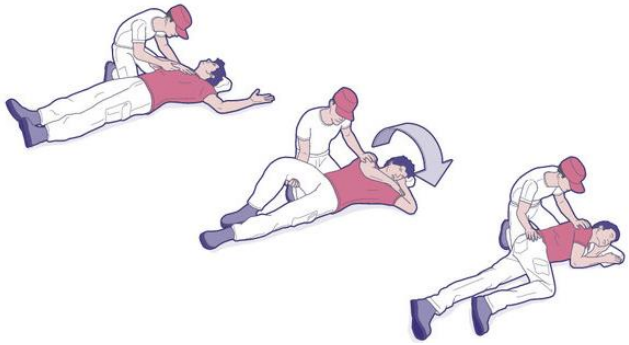
There are many different types of seizures. Medical attention is not always needed for every seizure. If one or more of the following is true, caregivers should call 911 and seek emergency medical help right away:

- If the individual has never had a seizure before.
- If the individual is having difficulty breathing or waking after the seizure.
- If the seizure lasts longer than 5 minutes. *Time all seizures*.
- If the individual has another seizure right after the first one.
- If the individual is hurt right before or during the seizure.
- If the seizure happens in water (10).

During a generalized tonic-clonic seizure, (what used to be called a grand mal seizure), a person may cry out, fall, shake, or jerk, and become unaware of what's going on around them (10).

To help an individual who is having a generalized tonic-clonic seizure:

- Assist or ease the individual down to the floor.
- Turn the person gently onto one side into the rescue position if possible. This will help the individual breathe.



- Clear the area around the individual of anything hard or sharp objects to prevent injury.
- Put something soft and flat under the individual's head.
- Remove eyeglasses if the individual is wearing them.
- Loosen any tight clothing from around the neck that may make it difficult for the individual to breathe.
- Time the seizure.
- Call 911 if the seizure lasts longer than 5 minutes and follow any seizure protocols signed by the individual's PCP (10).

What not to do when an individual is having a seizure:

- Do not hold an individual down or try to stop their movements.
- Do not put anything in the individual's mouth. This can injure their teeth or their jaw. (An individual having a seizure cannot swallow their tongue).
- Do not try to give mouth-to-mouth breaths (like CPR). People usually start breathing again on their own after a seizure.
- Do not offer the individual any water or food until they are sitting upright and fully alert (10).

Falls

If an individual has fallen once, it is likely they will fall again. It is estimated 50% of all falls experienced by individuals with DD result in injury requiring medical attention or hospitalization (7) (12).

Responding to someone who has fallen:

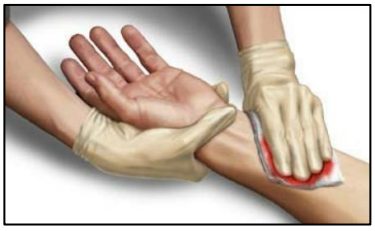
- Stay with the individual and call for help. Check the individual's respirations, and pulse (5).
- Take a set of vital signs if the person is conscious (when/if appropriate): temperature, respirations, pulse, oxygen saturation and blood pressure, and document them. These measurements may give the PCP medical-related clues which may have contributed to the fall. Check blood glucose if the individual is diabetic (1).
- If the patient is unconscious, not breathing, or does not have a pulse, call 911 start CPR, and continue until EMS arrives (5).
- Check the individual for injuries, such as cuts, scrapes, bruises, and broken bones (5).
- Ask others nearby if they saw what happened. If the individual is able to communicate, ask the individual what happened (5).
- If the individual struck their head during the fall on any object, the ground, etc., the individual should be transported to the emergency room or 911 should be called immediately (5).
- If there is a change to the individual's normal baseline vital signs, or if there is a visible injury after a fall, the individual should be transported to the emergency room or 911 should be called immediately (5).
- Individuals who have experienced a fall and have no outward signs of injury should be monitored closely for 72 hours after the fall occurred for any complaints of pain, and/or changes in behavior (1).
- Review the circumstances surrounding the fall as soon as possible after the fall occurred, to resolve any risks which may have contributed to the fall (1).
- When documenting a fall occurrence remember to include the following:
  - Date.
  - Day of week.
  - Time.
  - Location.
  - Type of fall.
  - Likely cause.
  - Activity at time of fall.
  - Staff present.
  - Type of footwear.
  - Walking aids, if in use (1).
- Follow all agency policies related to falls, making sure to notify the individual's primary care provider (PCP). All individuals who have been taken to the urgent

care or hospital emergency room should have a follow-up visit with their PCP within a week or two of discharge (1).

Bleeding

First aid is appropriate for external bleeding. If bleeding is severe, or if you think there is internal bleeding, call 911 and get emergency help immediately (4).

- Stay calm and reassure the person. The sight of blood can be very frightening for some individuals.
- If the wound affects just the top layers of skin (superficial), wash it with soap and warm water and pat dry. Bleeding from superficial wounds or scrapes (abrasions) are often described as oozing because the bleeding is slow (4).
- Help the individual to lie down, if possible. This reduces the chances of fainting or a fall by increasing blood flow to the brain. When possible, raise up the part of the body that is bleeding (4).
- It is safe to remove any loose debris or dirt that you can see from a wound, but do not remove objects such as a knife, or stick, that have penetrated the body and are stuck. Doing so may cause more damage and increase bleeding. Place pads and bandages around the object and gently tape the object in place so it cannot move about (4).
- Put pressure directly on an external wound with a sterile bandage, clean cloth, a clean towel, or even a piece of clothing. If nothing else is available, use your hand. Direct pressure is best for external bleeding, except for an eye injury (4).



- Maintain pressure until the bleeding stops. It takes approximately 5 minutes for blood to coagulate. When the injury has stopped bleeding, tightly wrap the wound dressing with adhesive tape or a piece of clean clothing. Do not peek to see if the bleeding has stopped (4).
- If bleeding continues and seeps through the material being held on the wound, do not remove it. Simply place another cloth over the first one. Only two additional gauze pads should be added over top the initial cloth in order to maintain good pressure on the wound (4).
- Keep the injured body part completely still. Lay the person flat, raise the feet about 12 inches and cover the person with a coat or blanket. If possible, do not move the person if there has been a head, neck, back, or leg injury, as doing so may make the injury worse (4).
- Call 911 and seek medical attention right away (4).

Loss of Consciousness

Major illness or injury such as a head injury, a stroke, seizures, epilepsy, or cardiac arrest (heart attack) can cause a loss of consciousness. Individuals can also lose consciousness due to dehydration, low blood sugar, temporary low blood pressure (syncope), and heart or nervous system problems. Individuals may also lose consciousness if they choke on an object, drink alcohol or use recreational/street drugs (4).

A brief loss of consciousness (fainting) can also be caused by breathing extremely fast (hyperventilating), coughing hard, or straining during a bowel movement (vasovagal syncope) (4).

Prior to fainting many people may feel light-headed or dizzy, may have ringing in their ears, may have an unsteady gait, or may look very pale or ashen. If an individual tells you they feel as if they might faint, help them to the floor or ground, to prevent injury from a fall. After an individual has fainted then becomes awake, but is less alert than usual, ask a few simple questions they should be capable of answering, such as:

- What is your name?
- How old are you?
- Where are you right now?

Wrong answers or not being able to answer the question as usual, might suggest a change in mental status. Non-verbal individuals should be monitored for any changes to their typical baseline or normal way of being for unusual behaviors (4).

If a person is unconscious or has a change in mental status, follow these first aid steps:

- Call or tell someone to call 911.
- Check the person's airway, breathing, and pulse. If necessary, begin CPR.
- If the person is breathing and lying on their back, and you do not think there is a spinal injury, place them in the recovery position by carefully rolling them onto their side. Bend the top leg so both hip and knee are at right angles. Gently tilt their head back to keep the airway open. If breathing or pulse stops at any time, roll the person onto their back, and begin CPR.
- If you think there is a spinal injury, leave the person where you found them (as long as breathing continues). If the person vomits, roll the entire body at one time to their side into the rescue position. Support their neck and back to keep the head and body in the same position while you roll.
- Keep the person warm until medical help arrives.
- If a person is acting as if they may faint, or says they feel faint, try to prevent a fall by helping the person to the floor and raising their feet about 12 inches.
- If fainting is likely due to low blood sugar, give the person something sweet to eat or drink when they become alert and fully conscious (4).

If the person is unconscious from choking:

- Begin CPR. Chest compressions may help dislodge the object.
- If you see something blocking their airway and it is loose, try to remove it. If the object is lodged in the person's throat, DO NOT try to grasp it. This can push the object farther into the airway.
- Continue CPR and keep checking to see if the object is dislodged until medical help arrives (4).

If a person is unconscious:

- DO NOT give them any food or drink.
- DO NOT leave them alone.
- DO NOT place a pillow under their head.
- DO NOT slap an unconscious person's face or splash water on their face to try to revive them (4).

Call 911 or the local emergency number if the person is unconscious and:

- Does not return to consciousness quickly (within a minute).
- Has fallen down or been injured, especially if they are bleeding.
- Has diabetes.
- Has seizures.
- Has lost bowel or bladder control.
- Is not breathing.
- Is over age 50.

Call 911 or the local emergency number if the person regains consciousness, but:

- Feels chest pain, pressure, or discomfort, or has a pounding or irregular heartbeat.
- Cannot speak, has vision problems, or cannot move their arms and legs.

Sepsis – Signs & Symptoms

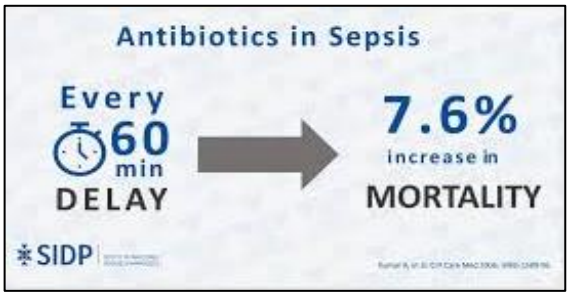
Sepsis is a severe inflammatory response to infection which can lead to death if not treated immediately. An infection can be anywhere in the body. An individual who is being treated with an antibiotic for an infection can still develop sepsis if the medication isn't working to resolve the infection (30). Pneumonia and Urinary Tract infections are the most common cause of sepsis among individuals with IDD (19).

When sepsis occurs in the body there is an extreme drop in blood pressure resulting in shock. Due to the reduced blood flow to the brain, kidneys, liver, lungs, and heart, all major organs may stop working and shutdown (30).

The first signs and symptoms of sepsis are typically: a very fast heart rate/pulse (greater than 100 beats per minute), low blood pressure (lower than 90/60), and fast

respirations (breathing) (greater than 20 breaths per minute), or a change in mental alertness (30). A vital signs care protocol, with parameters determined by the individual's PCP, is considered best practice.

If an individual has a history of sepsis, or multiple previous episodes of sepsis, they should have a sepsis care protocol, because they are at very high risk to develop sepsis again. Their care protocol should include guidelines for when (what symptoms and vital sign parameters) and where (ER/hospital, etc.) caregivers should seek help. Every 60-minute delay in the administration of intravenous (IV) antibiotics (after the first symptoms of sepsis), increases the mortality rate by 7.6% (17).



Symptoms of sepsis can include:

- Chills.
- Confusion or delirium.
- Fever or low body temperature (hypothermia).
- Lightheadedness due to low blood pressure.
- Rapid heartbeat.
- Skin rash or mottled skin.
- Warm skin.

When it comes to sepsis, remember It's About "**TIME**":

T – Temperature – higher or lower than normal.

I – Infection – may have signs or symptoms of infection.

M – Mental Decline – confused, sleepy, difficult to rouse.

E – Extremely ill – severe pain, discomfort, shortness of breath.

If you suspect sepsis or observe these symptoms, seek medical attention immediately, **CALL 911**, or go to a hospital and say, "I AM CONCERNED ABOUT SEPSIS" (Sepsis Alliance, 2023) or "THIS INDIVIDUAL HAS HAD SEPSIS IN THE PAST".

In 2023, the CDC launched a new program to strengthen survival and recovery rates for all sepsis patients (6). You can download their new Get Ahead of Sepsis Partner Toolkit here. Additional Get Ahead of Sepsis printable resources can be downloaded here.

Rescue/Recovery Position

1

- Lay the person down on their back with their legs stretched out.
- Kneel down beside them.
- Place the arm nearest to you on the floor next to their head in a bent position with their palm facing up.

2

- By taking the person's hand that is furthest away from you, pull their arm across their chest.
- Guide the back of their hand to their face so that it rests against the cheek closest to you. Hold it in place with one of your hands.

3

- Use your other hand to take hold of the thigh that is furthest away from you (for instance by touching their trousers – not at their knee joint).
- Pull the leg up so the knee is bent and the foot is on the ground.
- Gently roll their entire body towards you.

4

- The leg you pulled up should now rest on the ground in front of them, with the thigh at a right angle to their body.
- Gently tilt their head back a little and open their mouth slightly to make it easier for them to breathe.
- Keep their hand placed next to their head between their chin and the ground to stabilize the position of their head.

Additional Resources

American Red Cross First Aid Emergency App: https://www.redcross.org/get-help/how-to-prepare-for-emergencies/mobile-apps.html

CDC - Community Based Fall Prevention Program: https://www.cdc.gov/falls/programs/community_prevention.html

FEMA - Developing and Maintaining Emergency Operations Plans: https://www.fema.gov/sites/default/files/documents/fema_cpg-101-v3-developing-maintaining-eops.pdf

Mayo Clinic – Choking: First Aid – https://www.mayoclinic.org/first-aid/first-aid-choking/basics/art-20056637

Mayo Clinic – Severe Bleeding: First Aid: https://www.mayoclinic.org/first-aid/first-aid-severe-bleeding/basics/art-20056661

Mayo Clinic – Fainting: First Aid: https://www.mayoclinic.org/first-aid/first-aid-fainting/basics/art-20056606

Mayo Clinic - Cardiopulmonary resuscitation (CPR): First aid: https://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600

Sepsis Fact Sheet: https://www.sepsis.org/sepsis-basics/what-is-sepsis/

CDC – Seizure First Aid: https://www.cdc.gov/epilepsy/about/first-aid.htm

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To the best of the OIHSN Nursing Team's knowledge the information contained within this alert is current and accurate. If the reader discovers any broken or inactive hyperlinks, typographical errors, or out-of-date content please send email to communitynursing@dbhds.virginia.gov to include the title of the Health & Safety alert with specifics details of concern.

Case Scenario

Bleeding

You are with Alex in the kitchen preparing lunch. Alex has mild intellectual disability and is unable to communicate well using traditional language. He is able to communicate using facial expressions, sounds and gestures. Alex likes to help prepare food and has learned how to use a knife to spread condiments on bread, and rough-cut vegetables with assistance.

When Alex opens the refrigerator to get out the lunch meat and cheese a large glass jar of pickles falls out and breaks open on the kitchen floor. Before you can get to Alex he reaches down to pick up the glass and slices the palm of his hand. His hand starts bleeding onto the floor. You rush to take a look at his hand. You can tell immediately that it is a very deep cut.

1. What should you do next? Select the best option from the list below.
    a. Place his hand in a sink full of water to rinse all the blood off.
    b. Ask your coworker to call 911, put on gloves and immediately apply direct pressure to Alex's hand with a clean towel.
    c. Ask Alex why he picked a piece of glass up because he should know better.
    d. Try to apply a Band-Aid over the cut.

2. Alex's hand is bleeding very badly. He begins making very high-pitched noises and starts crying. What should you do until EMS arrives?
    a. Tell Alex to wait in his room while you clean up the broken glass.
    b. Tell Alex that crying is only going to make it worse.
    c. Help Alex sit down in a safe place away from the glass and continue to apply direct pressure without removing the original towel.
    d. Complain about what is taking EMS so long while you sit and wait with Alex.

When EMS arrives you provide them with Alex's My Care Passport and emergency information. EMS tells you that Alex will need sutures and they will be transporting him to the nearest ER. Alex begins to panic and cry even louder.

3. Staff do not need to provide reassurance to Alex when providing care because he is non-verbal.
    a. True
    b. False

4. One of the staff members says he has never had anyone cut themselves that bad. You want to make sure he knows what to do if something like this happens again. Which of his responses is incorrect and requires some feedback?

a. Call 911 or tell someone else to call 911.
b. Apply firm pressure directly over the cut or wound with a clean towel or bandage.
c. Avoid stacking multiple bandages as this weakens direct pressure.
d. Help the individual to sit or lie down and stay calm.
e. If you can see an object in the wound, pull it out with your hands or a pair of pliers.

Challenge questions for nurses or those who want to learn more:

5. As a nurse at the group home, you want staff to know some of the possible complications that can occur from bleeding and hemorrhaging. Which of the following is ***NOT*** a complication of excessive bleeding?
    a. Hypovolemic shock (Going into shock due to blood loss from the body.)
    b. Loss of consciousness or coma
    c. Diabetes
    d. Seizures
    e. Death

6. One of the staff asks how a nurse might know if a person has internal bleeding, since you can't see the blood. You explain that signs and symptoms of internal bleeding may include: *(Select all the apply)*
    a. Blood pressure rises and heart rate decreases.
    b. **Blood pressure decreases and heart rate rises.**
    c. **Dizziness and confusion.**
    d. **Shortness of breath.**
    e. Increased urination.

7. As the nurse, you explain to the staff that some individuals may be at higher risk for excessive bleeding due to other factors which may hinder coagulation (clotting of blood). Which of the following factors hinders coagulation (clotting of blood) and make it more difficult to stop bleeding?
    a. Anticoagulant medications (blood thinners)
    b. Alcohol consumption
    c. Blood clotting disorders
    d. Taking Advil (ibuprofen) daily
    e. All of the above

Case Scenario

Choking

You are a program manager in a group home, where a 45-year-old male named Chris resides. Chris has Prader Willi and mild intellectual disability (ID). Chris has boundless energy and is a joy to be around.

Chris is a big talker and at dinner he likes to tell everyone about all of the things he has done throughout the day. Chris wiggles and talks and is very animated, even while eating, which may have contributed to a few choking incidents in the past.

Chris also has some missing teeth due to dental extractions and will occasionally eat too fast, with minimal chewing. He is easily distracted from what he is doing and he also sometimes stuffs food in his mouth.

His last evaluation by an SLP (speech language pathologist) was five years ago. She ordered diet modifications which stipulate that his food is to be soft and cut up in bite size pieces.

Chris has had several choking episodes over the last year. Luckily, abdominal thrusts have always worked well, and staff have become experts at doing them. Chris has a list of foods that he should not be offered, or have on his plate, which seasoned staff are well aware of.

1) Which of the following actions would ***NOT*** lower risk of choking for Chris? *(Select all that apply)*

    a. Teach the individual and the DSP the universal sign for choking and have them redemonstrate, when possible.

    b. Help the individual focus more on eating and less on talking and moving around.

    c. **Encourage the individual to eat alone in their room to avoid distraction.**

    d. Remind the individual to slow down, take smaller bites, and chew the food thoroughly before swallowing.

    e. Complete a choking risk assessment screening tool to help identify difficulties the individual may have with swallowing, eating, or drinking that should be evaluated further by the individual's PCP (primary care provider), NP (nurse practitioner) or SLP (speech language pathologist).

    f. Ask Chris's PCP for a referral to an SLP (speech language pathologist) for a swallow study.

    g. **Do nothing since staff have already become experts at doing abdominal thrusts.**

Case Scenario

The nurse reminded Chris and the staff that he is scheduled to see the Speech Language Pathologist (SLP) for a swallow study next week. There is a new staff member that wants to know what a Speech Language Pathologist does.

2) All of the following information about what Speech Language Pathologists evaluate is correct except for:
    a. **Evaluate the individual's reading skills.**
    b. Perform an assessment of the mouth for any structural anomalies.
    c. Observe for behaviors that increase the risk of choking.
    d. Recommend diet modifications for their food, beverages and mealtime protocol.
    e. Perform a swallow study to assess for dysphagia.

After seeing the SLP, Chris's diet for soft bite size pieces was not changed, however the SLP provided an additional list of foods Chris should avoid and asked that staff be trained on the new modifications to his diet. To make sure the staff understand which foods Chris should avoid, you ask the staff to select the right meal for Chris.

3) Which of the following meals would be the safest choice for Chris or any other individual with a high risk for choking?
    a. Hot dogs with mustard, French fries, and popcorn.
    b. Peanut butter and jelly sandwich, grapes, and potato chips.
    c. **Scrambled eggs, yogurt, and oatmeal.**

4) The person orienting the new staff member asks her to choose which factors increase a person's risk for choking. Which of the following options is the correct response?
    a. Talking fast.
    b. Wearing prescription eyeglasses.
    c. **Having previous tooth extractions or missing teeth.**
    d. Not liking cats.
    e. Having curly hair.

5) The new staff member says she doesn't know which diagnoses and health-related factors might cause difficulty eating and swallowing, and/or increase risk for a choking episode. Which of the following responses are correct? *(Select all that apply)*
    a. **Having a diagnosis of Down syndrome.**
    b. Being 20 years old, single and male.
    c. **Having a diagnosis of intellectual and/or developmental disability.**
    d. Exercising daily.
    e. **Having a diagnosis of Prader Willi syndrome.**

Case Scenario

6) As program manager, you decide to make some changes to your agency's policy to help lower the risk of a fatal choking event. Select the correct options from the list below which may help lower an individual's choking risk. *(Select all that apply).*
    a. Each time there is a choking incident the DSP or nurse caring for the individual must pay a $100 fine to the provider.
    b. **Every 6 months have each staff member review and sign a Conscious Choking review sheet.**
    c. **Keep a copy of the American Red Cross Conscious Choking poster in a place where staff can easily access it when needed.**
    d. **Host a mandatory in-service for staff every 6 months in which everyone reviews and correctly demonstrates how to perform abdominal thrusts.**
    e. **Have a policy which requires one staff member to be seated at the table observing individuals during mealtimes as their specific assignment.**

7) You've asked an RNCC from DBHDS Office of Integrated Health to hold a training session about choking for the staff at a group home. Which of the following would you expect to be included in the training?
    a. Tips on how to cook heart healthy meals.
    b. Tips on the best blenders to buy for diet modifications.
    c. **A thorough review of signs and symptoms of swallowing difficulties.**
    d. **Signs, symptoms and other factors which should prompt caregivers to ask the individual's PCP for a referral to a Speech Language Pathologist for an evaluation.**
    e. Lots of tasty snacks to sample during the training.

The DBHDS OIH training session on Choking is finished, and you want to ensure all of your staff can accurately identify the signs and symptoms of someone choking.

8) Which symptom is ***NOT*** a sign or symptom of someone who is choking?
    a. Grabbing the throat.
    b. Shortness of breath.
    c. Coughing.
    d. Excessive laughing.
    e. Being unable to speak.
    f. Drooling.
    g. Turning pale, gray, or cyanotic (blueish).
    h. A look of panic or fear on the face.
    i. Smiling happily.

9) What are some possible complications of choking? Select the correct option(s) below *(Select all the apply)*:
    a. **Death.**
    b. **Aspiration (breathing foreign objects such as food into the lungs).**
    c. Hirsutism (excessive hair growth).
    d. **Pneumonia.**
    e. **Brain damage due to hypoxia (lack of oxygen).**

10) If choking episodes continue to be a problem at this group home, what are some action steps to take to help decrease choking risk?
    a. Call 911 for advice.
    b. **Contact the Community Nursing Team at the Office of Integrated Health at: communitynursing@dbhds.virginia.gov**
    c. **Go online to the COVLC website to view the available free trainings on choking, dysphagia and aspiration.**
    d. **Go to the Office of Integrated Health's webpage and download the following Health and Safety Alerts for caregiver tips to reduce choking risk:**
        - **Choking – April 2023**
        - **Nut Butters and Choking – September 2022 *Updated 10.2023***
        - **Dysphagia Health & Safety Alert – August 2021 *Updated 10.2023***
    e. Do nothing.

Case Scenario

Falls

Tasha is 60 years old and diagnosed with moderate ID. She wears glasses and walks without assistance. About six months ago, she fell while walking out to the van at her day program.

It is a beautiful afternoon, you and Tasha decided to go for a walk in the neighborhood after dinner. You grab the "go bag" containing a small first aid kit and emergency information for Tasha. The two of you are walking down the sidewalk when Tasha spots a brightly colored bird and points it out. You turn to look at the bird and then suddenly hear a thud on the ground. Tasha yells, "Ow!" When you turn around you see Tasha sprawled on the ground face down and is beginning to cry. The two of you are about a block away from home.

1. When someone falls, you should always check ***first*** for:
    a. Responsiveness.
    b. Breathing.
    c. Scrapes
    d. Broken bones.
    e. A & B.

Tasha is responsive and breathing, although she is very upset and crying. Tasha rolls over on her side and you see Tasha has a large bruise and a bump forming above her right eye as well as a large gash on her right cheek that is bleeding. You notice that her eyeglasses are also broken.

2. What should you do next?
    a. Call 911
    b. Put on gloves and apply a bandage to Tasha's cheek
    c. Provide reassurance to Tasha and check her for other injuries
    d. All of the above.

Tasha said she doesn't know what happened: "I just ended up on the ground!". You look around and notice an uneven surface on the sidewalk. You also notice that one of Tasha's favorite slip-on shoes has come off and is on the sidewalk. The ambulance arrives and begins providing care for Tasha.

3. What should you do next?
    a. Provide the emergency responders with Tasha's emergency medication information
    b. Call your supervisor and group home to alert them of the incident.
    c. If you are unable to ride with Tasha, ask the emergency responders where they are taking her.
    d. All of the above.

Case Scenario

You provide emergency responders with Tasha's My Care Passport and her emergency information. You reassure Tasha that you will meet her at the hospital, and you call your supervisor to alert them of the incident.

At the emergency department (ED), Tasha gets a CT scan of her head and stitches on her cheek. There does not appear to be a serious head injury, but the hospital doctor orders close monitoring of Tasha over the next several days for signs of a concussion. The ED nurse gives you a handout of symptoms to watch for. Tasha will also need to have an appointment scheduled with her PCP in the next week for a follow-up appointment.

All documentation is completed per agency policy regarding Tasha's fall and a review of the incident is done with the group home supervisor.

4. What risk factors may have contributed to the fall?
    a. Slip-on shoes.
    b. Uneven terrain.
    c. Changes in vision.
    d. All of the above

Case Scenario

Loss of Consciousness

You are a DSP in a day program. A group of individuals are meeting at the local park for a picnic and games to celebrate the 4th of July. The weather is sunny and hot. You are responsible for monitoring four individuals, Jan, Debbie, Tameka, and Lashana. Before leaving the day program you make sure everyone has had sun block lotion applied, and all have an extra bottle of water to drink.

It's mid-afternoon, and everyone has just finished playing kickball. Lashana tells you that she has a headache. Debbie is complaining about her sore feet. Jan seems is out of breath from running. Both of Tameka's water bottles are empty and she is saying she is still thirsty.

You let everyone know that it is time to head over to the pavilion for some shade, food and cold beverages after the game. On the way there, several people are gathering near a picnic table under a shade tree to take a short break when suddenly Lashana faints. Several DSPs rush over to her, you kneel down next to her, tap her shoulders and shout her name. After a few moments, she regains consciousness.

1. Although you are not a licensed healthcare professional you have taken numerous trainings through the Office of Integrated Health at DBHDS, and you know the following health-related conditions may have caused Lashana to faint: *(Select all that apply.)*

    a. Heat stroke (over-exposure to the sun or heat).
    b. Symptoms of diabetes.
    c. Hyperventilation (breathing too quickly).
    d. Low blood pressure (less than 90/60).
    e. All of the above
    f. None of the above

2. What is the first thing you should do to help Lashana?

    a. Give her a "High-5" for waking up.
    b. Force her to eat a cookie.
    c. Get her to stand up and walk it off.
    d. Ask someone to call 911.
    e. Offer her a Diet Coke

3. What are some other things you can do for Lashana while you are waiting for EMS to arrive? *(Select all that apply.)*

    a. Conduct a head to toe check looking for other signs of injury
    b. Provide reassurance that you are with her and help is on the way
    c. Cover her with a heavy blanket.
    d. Perform CPR.

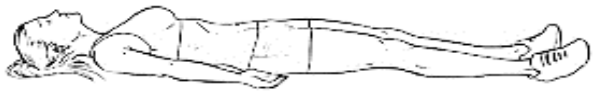
Case Scenario

4. Your check does not reveal any other signs of injury. You need to place Lashana in the recovery position. Which of the following is the correct position for the recovery position?

A.

B.

C.



5. Identify signs and symptoms a person may exhibit before fainting (losing consciousness). *(Select all that apply.)*

   a. They may have a sudden craving for chocolate.
   b. They may feel lightheaded, dizzy, and may have an unsteady gait.
   c. They may look very pale.
   d. They may be very angry.
   e. They may have restless leg syndrome (RLS).

Challenge questions for nurses and others who want to learn more:

1. What can DSPs and caregivers do to decrease the risk of fainting /loss of consciousness due to dehydration?

   a. **Develop and institute a guideline at your agency to offer individuals beverages every two hours on days in which the outdoor temperature is above 85 degrees.**
   b. Offer individuals caffeinated drinks.
   c. **Offer individuals water, flavored water, or electrolyte drinks.**
   d. **Offer individuals juicy fruits and veggies within their recommended diet modifications as applicable.**
   e. Nothing. If it's going to happen it will happen.

2. All of the following can cause someone to lose consciousness, except:
   a. Low blood pressure (less than 90/60).
   b. Stroke or cardiac arrest.
   c. Seizures or Epilepsy.
   d. Head injuries.
   e. **Watching television.**

3. Identify which option is **NOT** a symptom of **low** blood pressure:
   a. **Generalized swelling all over the body.**
   b. Dizziness.
   c. Blurry vision or seeing "stars"
   d. Feeling weak and shaky.

Case Scenario

Seizure

You are a DSP in a group home, where you provide care for a 25-year-old female named Rita. Rita has severe intellectual disability and is nonverbal. Rita has several chronic medical conditions, including epilepsy, a heart murmur, and frequent recurring urinary tract infections. Rita takes anti-seizure medication daily to control her seizures, which seems to work fairly well.

1. On average, Rita only has one break-through seizure each month. Even so, you know encouraging fluids to make sure Rita stays well-hydrated can lower her risk of having a seizure in the future.
    - **a. True**
    - b. False

A new DSP has been hired for the group home and will begin working later in the week. It is really important to share information about Rita with the new DSP, who has never witnessed one of Rita's seizures.

2. From the list below, please choose which pieces of information are important to share with the new DSP, in order to keep Rita safe and healthy.
    - a. Movies with bright, flashing lights and loud music have triggered Rita's seizures in the past.
    - b. A description of what Rita's seizures look like.
    - c. The length of time Rita's seizures usually last.
    - d. The frequency of Rita's seizures over the last year.
    - **e. All of the above.**

3. What other emergency situations is Rita at risk for experiencing while a having seizure?
    - a. Falls.
    - b. Choking.
    - c. Change in mental status or alertness.
    - d. Loss of consciousness or dizziness.
    - e. Head or spine injury.
    - f. Severe vomiting.
    - g. Acute injury (motor vehicle accident, burns, near drowning, etc.).
    - **h. All of the above.**

Case Scenario

Challenge questions for nurses and others who want to learn more:

1. The individual just had a three-minute seizure and is oriented to name, place, and time but is very lethargic and wants to sleep. What intervention should the nurse implement?
    a. Perform a complete neurological assessment.
    b. Awaken the individual every 30 minutes.
    c. Turn the individual to the side and allow them to sleep.
    d. Interview the individual to see if you can determine what caused the seizure.

2. You're educating a 25-year-old female about possible triggers for seizures. Which statement requires you to re-educate the patient about seizure triggers?
    a. "I'm at risk for seizure activity during my menstrual cycle."
    b. "I will limit my alcohol intake to 2 glasses of wine per day."
    c. "It's important I get plenty of sleep."
    d. "I will be sure to stay hydrated, especially during hot weather."

3. An individual has a history of epilepsy. While helping them to the restroom, they report having this feeling of déjà vu and seeing spots in their visual field. Your next nursing action is to?
    a. Continue assisting them to the restroom and let them sit down.
    b. Initiate the emergency response system.
    c. Lay them down on their side with a pillow underneath the head.
    d. Assess their medication history.

Case Scenario

Sepsis

You are a DSP in a supported residential home, where you provide care for a 35-year-old male named Billy. Billy has moderate to severe intellectual disability and a G-tube.

Billy has orders to be repositioned every two-hours. When you go into his room to reposition him at 10:00 pm you notice his breathing seems a little fast, but you can't be sure. Billy has an order from his PCP to have his vital signs checked every morning, and as needed (prn) to monitor for signs of sepsis, since he has been hospitalized with sepsis several times over the past few years.

Billy's PCP has signed a Sepsis Symptoms Protocol which is as follows:

Check vital signs every morning

Check vital signs as needed if changes in temperature or breathing are observed

Call 911 if Billy has a heart rate over 100

Call 911 if Billy's systolic blood pressure is less than 90 OR diastolic blood pressure is less than 60.

Billy's PCP has stressed the importance of calling 911 as quickly as possible for any signs of sepsis Billy might have, because survival rates are lower, when or if treatment is delayed.

You check Billy's vital signs because his breathing seems different and find the following:

Oral temperature is 99 degrees.

Blood pressure is 86/42.

Heart rate (pulse) is 130.

Respirations (breathing rate) are 15.

Oxygen saturation rate (taken with a pulse oximeter on his finger) is 97%

1. Which of Billy's vital signs prompt you to call 911? *(Select all the apply)*
    a. Oral temperature of 99.0 F
    b. Blood Pressure of 88/42.
    c. Heart Rate of 130
    d. Respirations are 15
    e. Oxygen saturation with a pulse oximeter is 97%

2. After checking his vital signs, which of the following is the next best step?
    a. See if Billy has a PRN (as needed) PCP order for Tylenol for fever.
    b. Call 911. Billy needs emergency medical care as quickly as possible.
    c. Call your supervisor, she will know what to do.
    d. Call your sister who has just started nursing school for advice.
    e. Do nothing. His vital signs are within normal limits.

3. An individual who has been diagnosed with sepsis in the past, has a very high risk of getting sepsis again in the future.
   - **a. True**
   - b. False

4. For every hour that IV antibiotic treatment is delayed after sepsis symptoms begin, the rate of survival for septic individuals drops by what percentage?
   - a. 1%
   - b. 5%
   - **c. 7.6%**
   - d. 100%
   - e. None of the above.

5. What factors contribute to an *increased risk* for sepsis among individuals with IDD? *(Select all that apply)*
   - a. Staying up-to-date on vaccinations.
   - **b. Having a compromised immune system due to a genetic syndrome.**
   - **c. Having communication difficulties.**
   - d. Eating healthy and exercising daily.
   - **e. Having a chronic health condition(s).**

6. Which infections are the most common causes of sepsis? *(Select all that apply)*
   - a. Sexually transmitted infections.
   - **b. Pneumonia (lung infections).**
   - **c. Urinary tract infections (UTIs).**
   - d. Ear infections
   - e. None of the above

7. All of the following are signs of sepsis except: *(Select all the apply)*
   - a. Very fast breathing (greater than 20 breaths per minute).
   - **b. Hyperactivity.**
   - c. Low blood pressure (lower than 90/60).
   - **d. High blood pressure.**
   - e. Very fast heart rate (pulse) (greater than 100 beats per minute).