Are You Ready for Emergency Medical Services in Your Oral and Maxillofacial Surgery Office?

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KEYWORDS

- EMS • Medicolegal • Emergency preparedness • Office-based anesthesia
- Crisis resource management

KEY POINTS

- Oral and maxillofacial surgery practices should be familiar with the functionality of their local emergency medical services system (response time, training/ability of responders, onsite hierarchy, and logistics of patient transport).
- Emergency medical services skills and response times can vary; the oral and maxillofacial surgery office should be prepared to stabilize the patient for at least 15 minutes.
- The office should be prepared to manage the patient until Emergency medical services arrives and to coordinate care among the various teams.
- Emergency medical services teams usually follow specific standing medical orders from their medical directors that can conflict with the wishes of the oral and maxillofacial surgeon.
- The oral and maxillofacial surgery office should be prepared to reassert management of the emergency should emergency medical services fail to successfully manage the situation.

INTRODUCTION

Emergency medical services (EMS) provide out-of-hospital acute medical care and transport to definitive care, among other services. Although the frequency of true medical or anesthetic emergencies are currently not tracked, it is likely, and perhaps inevitable, that all oral and maxillofacial surgery (OMS) offices will experience at least 1 emergent situation requiring EMS assistance or transport during their practice lifetime. Because the training, experience, and ability to identify and manage these emergencies are quite variable, the ongoing challenge of anticipation, preparation, and management of emergencies must be continually addressed. This article focuses on the mechanics, interplay, and outcomes once "activate EMS" is reached in any given algorithm.

THE CALL TO 911

The call to 911 provides access to police, fire, ambulance services and EMS via a Public Safety Answering Point (PSAP).[1,2]

The call to 911 is not a sign of weakness, inability, embarrassment, or failure. Rather, it reinforces the OMS's commitment to all patients

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to provide the best possible care, regardless of circumstance. It is both recognized and accepted that patient responses can be unpredictable, and there are established limits to both diagnostic and treatment modalities that are available in any OMS facility. Contacting EMS remains a judgment call on the part of the OMS. However, regardless of circumstance, if events occur that will prevent the patient from returning home for independent living, the call for (at minimum) transport to another facility should not be delayed.

Throughout the United States, there are many different methods of administration, operation, and dispatch of these services, which also vary based on geographic and political boundaries. An example would be a jurisdiction that operates its own PSAP, but not EMS. As a result, there can be overlapping jurisdictions, which often result in delays of longer than 1 minute as information is routed or transferred from 1 jurisdiction to another, or 1 jurisdiction to an independent EMS. In such cases, it is entirely possible to have a 911 call routed to a general information number, resulting in even further delays. Similar delays can occur when the local EMS is occupied with other events; in this instance, a neighboring jurisdiction will be subsequently contacted. An understanding of the structure of these services in any locale, thus, becomes most important in cases of airway compromise, where minutes can make the difference between life and death.

Approximately 80% of 911 calls now come from cell phones, which prevent autolocation of the call, a convenient and time-saving safety feature that is enabled when calls are made from a traditional land line. Autolocation will identify a time of call, name, number, and address of the caller, which typically is voice verified to ensure the accuracy of this information. Additionally, all calls to 911 are recorded. The medicolegal consequences of this recording are obvious, because these phone calls are considered to be a legal document. It behooves each office to learn and understand the specifics of making this call, such that the caller remain calm, organized, and complete in the conveyance of information.

In the proposed "Next-Generation 911" environment, the public will be able to make voice, text, or video emergency calls from any communication device via Internet protocol-based networks. The new infrastructure will also support national networking of 911 services, and transfer of emergency calls to other PSAPs, including any accompanying data.[3]

Surprisingly, the educational requirements for an emergency dispatcher are minimal and optional: for example, a 24-hour course in which students are trained to gather information about the nature of the emergency and patient location, followed by triage and dispatch to the appropriate EMS resource.

OMS offices should ideally develop formal written protocols that describe the specifics of contacting EMS. Specific roles should be preassigned, and instructions given as to who will make the call, and what will be said and revealed to the dispatcher, who typically is trained to follow caller interrogation protocol. This protocol should be reviewed and rehearsed regularly, as part of a larger, comprehensive, written office emergency protocol that also includes procedures and staff roles in responding to an office medical emergency.[4–7] The following questions can be anticipated during this recorded call:

1. 911, What are you reporting?
2. What is the address of the patient?
3. What is the patient's age and gender
4. What telephone number are you calling from?
5. What is your name?
6. Is the patient conscious (awake, conversant, and coherent)?
7. Is the person breathing normally?

If a formal interrogation protocol is not followed, the OMS team should tell the EMS dispatcher the nature of the emergency and, if it is life threatening, they should immediately say so (eg, "the patient is unconscious and not breathing" or "the patient is having a bronchospasm") and specifically request advanced life support (ALS) EMS immediately. Again, the name and address of the office and nearby landmarks to assist in locating the office should be tendered, as well as the nature of ongoing therapy and the telephone number of the office.

The dispatcher will usually ask the caller to stay on the phone, which may occupy the attention of an office staff member whose assistance can often be better used in the ongoing emergency therapy. Occasionally, the dispatcher may have formal written guidelines to verbally "coach" the caller through emergency cardiopulmonary resuscitation or obstructed airway sequences, but there are no guidelines for the dispatcher to offer to the OMS team relating to the management of an anesthetic emergency. As such, little may be gained by staying on the line with the dispatcher, other than to track the arrival of EMS. It is prudent to ask the dispatcher, "How long until advanced life support (paramedics) can be here?" Roam phones can prove to be invaluable in these instances.

The time that the call is made must be documented.

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