

Spotlight on Prevention

BEST PRACTICES FOR RESPONDING TO MEDICAL EMERGENCIES

This toolkit was created to provide information and resources about responses to medical emergencies involving people in settings under Justice Center Jurisdiction.



Justice Center for the
Protection of People
with Special Needs

www.justicecenter.ny.gov | 1 (800) 624-4143

SPOTLIGHT OVERVIEW

BACKGROUND

THE ISSUE

People receiving services often have complex medical needs. As a result, staff may have to respond to medical emergencies. A timely and well-executed response is critical to ensure immediate assistance is provided by first responders. A delay in accessing medical care can have potentially catastrophic consequences. People with special needs are living increasingly longer lives, and multiple studies have identified that they are more likely to have co-occurring conditions including heart disease, diabetes, and epilepsy than the general population, making timely access to quality health care even more critical.

THE SCOPE OF THE PROBLEM

In 2021, the Justice Center substantiated nearly 250 cases involving inadequate medical care, including cases where a lack of a timely and appropriate response to a medical emergency was identified as a contributing factor. This toolkit was developed to provide agencies with resources to help staff respond appropriately to medical crises.



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Case Studies

Could This Happen in Your Program?

Answer Key

Coordinated Response to a Medical Emergency - CALM Chart

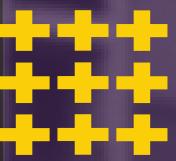
Medical Emergency Guidelines At-A-Glance

Sample Pain Picture

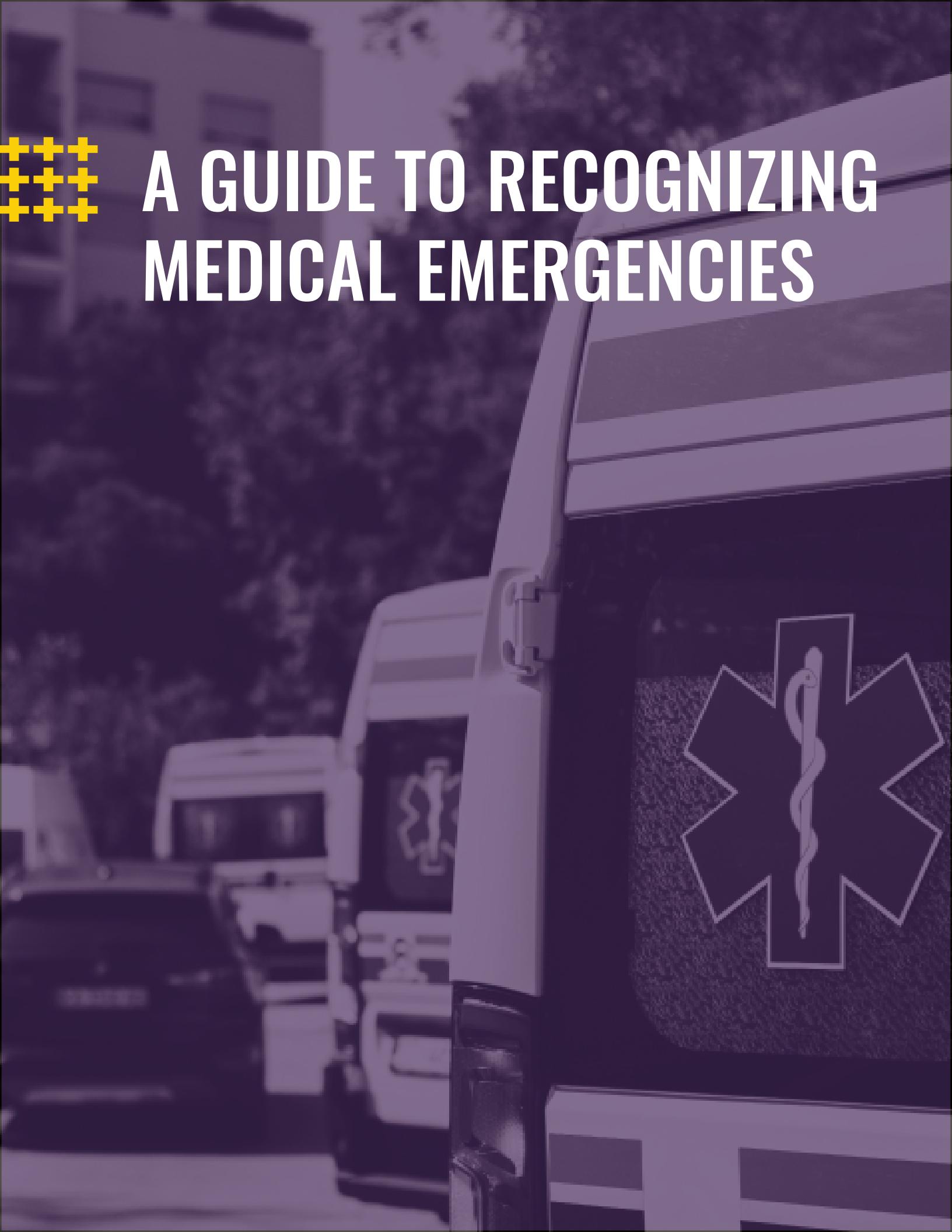
Resources

Sample Mock Emergency Drill Form





A GUIDE TO RECOGNIZING MEDICAL EMERGENCIES



PREPARING FOR MEDICAL EMERGENCIES

AGENCY POLICIES SHOULD INSTRUCT STAFF TO ALWAYS CONTACT 911 FOR MEDICAL EMERGENCIES!



TIME IS OF THE ESSENCE – DON'T DELAY, CALL RIGHT AWAY!

To prepare staff to handle a medical emergency, agencies should:

- Implement protocols and directives for staff to recognize and respond to potential medical emergencies such as breathing difficulties, falls and head injuries.
- Ensure policies empower direct support professionals and other staff to call 911 without first seeking approval from a manager, supervisor, or RN.
- Provide initial and refresher training in First Aid, CPR, and recognizing signs and symptoms of illness.
- Train staff to recognize signs of medical distress specific to the unique diagnoses or medical conditions of people receiving services. Consider using a “pain picture” to help staff recognize when someone is in pain and/or supplementing training with videos that provide a visual depiction of medical distress.

Types of medical emergencies requiring immediate medical intervention:

• Loss of consciousness	• Major broken bones
• Severe shortness of breath	• Suicidal or homicidal feelings
• Facial drooping or weakness in an arm or leg	• Falls
• Chest pain	• Sudden blurry or double vision
• Head trauma	• Suspected overdose
• Uncontrolled bleeding	• Choking
• Poisoning	• Severe/Constant abdominal pain



RECOMMENDED STAFF ACTIONS

- Don't delay, call right away! Call 911 for any concerns about the immediate health and safety of people receiving services.
- If applicable, call an emergency code such as a code blue for an internal emergency response.
- For settings such as day habilitation programs where there are nurses on the premises, call 911 immediately in an emergency, then contact the nurse.
- After calling 911, immediately start CPR for anyone not breathing. If rescue breaths are not possible due to an airway obstruction or the presence of bodily fluids, start chest compressions.
- Try not to panic! Stay calm and follow the directions from the 911 dispatcher.
- Do not delay medical attention because of concerns about staffing. Contact 911 immediately for all medical emergencies, then address staffing concerns.
- Do chest compressions on a hard, flat surface. Place a backboard under the person or move them to the floor if they are not already there.
- Provide emotional support to people who witnessed the medical emergency and may be scared or worried for their peer.

PROGRAMS WITHOUT NURSING SUPPORTS

- Ensure policies and procedures clearly identify when staff should elevate medical concerns to 911 or primary care physicians and empower them to do so without first getting permission for any life-threatening situations.
- Train staff to recognize signs and symptoms of illness, true medical emergencies, and behavioral changes that could indicate an underlying medical issue and to contact primary care physicians or 911 as soon as there are concerns.
- Train program managers, supervisors, & administrators who may provide after hours on-call supports to direct staff to contact 911 when receiving calls regarding medical concerns.
- Consider providing all staff with CPR and first aid training.



BEST POLICIES FOR RESPONDING TO MEDICAL EMERGENCIES: POLICIES

POLICIES

- Ensure agency policies instruct staff to first call 911 for all emergencies.
- Emphasize the importance of not delaying emergency medical care by calling other staff, health care proxies or family members before first contacting 911.
- When directing staff to bring someone to the emergency department tell them to call 911 if immediate medical assistance is required. Consider adopting a protocol to direct staff to call 911 for all emergency department visits to avoid delays in accessing medical care.
- Do not delay medical attention because of staffing concerns. Contact 911 immediately for all medical emergencies regardless of staffing.
- Ensure policies identify time frames for RNs and other on-call supports to respond to staff, including nights, weekends, and holidays and also provide guidance for staff to elevate medical concerns if no response is received.
- Include staff training requirements in policies for medical care, including annual and refresher training requirements for CPR, first aid, and responding to medical emergencies.
- Train staff to use clear and consistent language to accurately relay medical concerns to 911 or nursing staff.
- Ensure policies include a process for debriefing with staff following medical emergencies to provide constructive feedback, positive reinforcement, and/or emotional support as needed.



BEST POLICIES FOR RESPONDING TO MEDICAL EMERGENCIES: ENVIRONMENT

ENVIRONMENT

- Create and post a quick reference guide for staff to follow during emergencies that includes a hierarchy of when to first contact 911 or when to first contact a nurse for emergent medical needs. Display the poster in heavily traveled areas such as the medication room and the kitchen. Include guidance to follow if a medical response is not received in a timely manner.
- Make sure breathing masks and gloves are readily available. Position emergency crash carts, if available, in locations that promote quick access. Ensure staff are aware of the locations of these items. Put in place a system to monitor and restock items in emergency kits or crash carts.
- Ensure all staff have easy access to Narcan for known or suspected opioid overdoses and implement a system to monitor the expiration date and replace when expired.
- Ensure staff have immediate access to emergency medical information “grab and go” binders that include diagnoses, medications, allergies, primary care physician information, and family or guardian contact information.



BEST POLICIES FOR RESPONDING TO MEDICAL EMERGENCIES: TRAINING

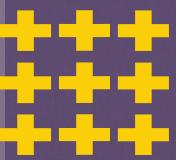
TRAINING

- Train staff in CPR, first aid, and Narcan administration.
- Stress the importance of contacting 911 for any emergency...
Don't delay, call right away!
- Include training information and scenarios about people who may not be able to verbally communicate pain or discomfort and may communicate pain or discomfort through behavioral changes.
- Train staff not to move people after a fall and to contact 911 or nursing for guidance.
- Train staff on DNRs/DNIs and MOLSTS and how this can impact the use of CPR in an emergency
- Clearly identify whose responsibility it is to train staff and ensure all staff are trained, including staff who are absent from initial trainings, and per diem or relief staff.
- Whenever possible, provide in -person, interactive training to promote staff understanding of training content.

TRAINING TIPS

- Consider conducting mock drills for staff to practice responding to medical emergencies. Include a debriefing after drills and after incidents to provide constructive feedback and positive reinforcement.
- Provide realistic training scenarios. For CPR training, consider providing weighted dummies to move from the bed to the floor before beginning CPR, or have staff practice administering CPR using a backboard. Prepare staff that they may encounter blood, vomit, urine, or feces when responding to emergencies.
- Consider using a “pain picture” to help staff recognize when someone is in pain and/or supplementing training with videos that provide a visual depiction of medical distress.





COULD THIS HAPPEN IN YOUR PROGRAM?



COULD THIS HAPPEN IN YOUR PROGRAM?

CASE STUDY

Case #1

Barry started to pace back and forth in the living room of his group home after dinner one night. Staff member Janice noticed this and asked Barry if he was ok. Barry was mostly non-verbal but he could typically indicate when he was in pain. Barry pointed to his stomach while he continued to pace. Janice chuckled and said, "Yep, my stomach hurts a little bit too after that big dinner we had! Your body probably just needs some time to digest and then you'll feel better." Janice and the other staff continued with the evening routine, gave everyone their medications and got them ready for bed. Barry stopped pacing and went to lie down in his room earlier than was normal for him. When Janice checked on him at 9:00 p.m. he was lying quietly on his bed, facing away from Janice.

At 11:00 p.m., Gregor, the overnight staff, arrived and started to do room checks while Janice gathered her belongings and got ready to leave for the evening. When Gregor checked on Barry, he noticed that Barry was sleeping in an unusual position. He went further into Barry's room to check on him. He saw that Barry had vomited and that Barry's eyes were open and fixed. He called Barry's name a few times and tried to find his pulse but Barry did not respond and did not appear to have a pulse. He called out to Janice, "I think something may be wrong with Barry! Can you come check?" Janice came into Barry's room and also observed that Barry was not responsive and did not have a pulse. Janice called the house supervisor, Carol, to let her know that something was wrong with Barry. Carol told Janice to start CPR and call 911. Janice called 911 while Gregor began CPR on Barry while Barry was still lying in his bed.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.



COULD THIS HAPPEN IN YOUR PROGRAM?

CASE STUDY

Case #2

James was complaining of stomach pain and pointing to his stomach. James' blood pressure was regularly monitored. Laureen, a direct care staff, took his blood pressure and noted that it was high. Laureen called the RN about James' blood pressure but did not tell the RN that James was also complaining of stomach pain. The RN directed Laureen to bring James to the emergency department. Instead of immediately taking James there, Laureen waited for her co-worker to return from an outing. She gave James a shower and a shave and changed him into clean clothing while they waited.

When the other staff returned, Laureen took James outside to hail a taxi. While doing so, James collapsed on the sidewalk. Laureen called her supervisor to tell him that James had collapsed. Some bystanders administered CPR to James while Laureen was on the phone.

CASE CONCERNs

Use the space below to identify the case concerns. Answers can be found in the back.

COULD THIS HAPPEN IN YOUR PROGRAM?

CASE STUDY

Case #3

Amelia was admitted to an inpatient substance abuse unit at a hospital for inpatient treatment after finishing four days in the hospital's detox unit. She had a diagnosis of bipolar disorder and opiate use disorder. Amelia used the bathroom in the hallway while walking with staff from the detox unit to the inpatient unit. There she found a medication bottle with a week's supply of hydrocodone. Amelia took the pills out of the bottle and put them in her pocket. Inpatient staff did not conduct a search of her person when she arrived since she came from another area in the hospital. Amelia settled into her room and then crushed the pills and snorted them. Staff found her unconscious on the floor between the wall and her bed a few minutes later. Staff yelled for help and asked that someone bring a Narcan kit. The Narcan was not easily accessible. It was kept in a locked cabinet and only the shift supervisor had a key. When they got the cabinet open, they rushed it to Amelia's room. They had a hard time reaching her because several staff members were crowded around her bed. Staff also discovered the Narcan was expired and they were unsure if they should use it.

CASE CONCERNs

Use the space below to identify the case concerns. Answers can be found in the back.

COULD THIS HAPPEN IN YOUR PROGRAM?

CASE STUDY

Case #4

Georgiana was admitted to an inpatient psychiatric unit for depression, stating that she did not want to live anymore. Georgiana had a specific plan for ending her life and was placed on 15 minute checks for safety. While on the inpatient unit, Georgiana's doctor made changes to her medication regimen. Georgiana appeared to be less depressed and began to talk about plans for the future. LPN Nancy was assigned to provide supervision and 15 minutes safety checks to Georgiana. However, Nancy had been having trouble at home and argued with her husband just before her shift started. Her husband called her while she was working and Nancy stepped into an empty stairwell to speak to him. Nancy was on the phone for approximately 20 minutes. When she came back onto the unit, she spent time at the nurse's station reviewing shift reports and chart updates. When Nancy went to check on Georgiana, it had been 35 minutes since her last check. As Nancy walked down the hall to Georgiana's room she saw that Georgiana's door was closed. As she opened the door she found that Georgiana had used the blanket from her bed to hang herself from the door. Nancy yelled out for someone to call 911 and then ran out of the room to try and find help. Another nurse contacted 911 and the dispatcher directed them to remove the blanket from Georgiana's neck and lower her to the floor and begin CPR. When first responders arrived, they took over CPR but could not revive Georgiana.

CASE CONCERNs

Use the space below to identify the case concerns. Answers can be found in the back.

COULD THIS HAPPEN IN YOUR PROGRAM?

CASE STUDY

Case #5

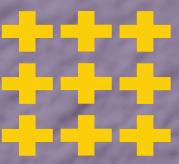
Allana took Ian and Steve out for a ride in the agency vehicle one night in December to look at holiday lights. They spent an hour driving around looking at lights and decorations and had a great time. On the way back home, Allana decided to go to the drive-thru window of a fast food restaurant to get everyone a hot chocolate and a snack. As soon as she got them, she passed the hot chocolate and cookies to Ian and Steve in the back seat. She warned them that the drinks were hot and they needed to wait for them to cool down. Ian decided to wait until they got home to eat his cookie. Steve started eating his right away. Allana turned the radio up loud to listen to a song she liked and laughed as Ian and Steve started to sing along.

Steve stopped singing just long enough to take a bite of his cookie and started singing again. Suddenly he started coughing and sputtering and Ian patted him on the back and said, "Slow down Stevie!" Steve stopped coughing and went silent while Alanna continued singing along to the radio. When she glanced in the rear view mirror, she saw that Steve was slumped over in his seat with his hand on his throat. She yelled to Ian, "Is Steve okay?" while she continued to drive. Ian looked at Steve and shrugged his shoulders. Since they were close to their house, Alanna drove home as quickly as she could. When she pulled into the driveway, she hopped out of the van and ran around to open the passenger door where Steve was sitting. Steve had stopped breathing and was turning blue. Alanna ran into the house and called for someone to help her then ran back to the car and began pounding on Steve's back. Vaughan, another staff who was working that night, called 911 then ran outside to help Alanna with Steve. When the ambulance arrived, they took over resuscitation efforts and transported Steve to the hospital.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.





ANSWER KEY



ANSWER KEY

COULD THIS HAPPEN IN YOUR PROGRAM?

Case #1

Case Concerns

- Janice did not identify changes in Barry's behavior that indicated he was unwell and needed medical attention. She did not take his vital signs when he indicated his stomach hurt and did not notify a nurse that Barry was complaining of stomach pain.
- Although Janice checked on Barry at 9pm she did not check him for signs of life, even though he had indicated that he did not feel well.
- Gregor did not immediately contact 911 when he realized that Barry did not have a pulse.
- Janice called the house supervisor instead of contacting 911 when she realized Barry did not have a pulse.
- Janice and Gregor began CPR on Barry while he was lying in his bed rather than moving him to a hard, flat surface.

Case #2

Case Concerns

- Laureen did not tell the RN that James was complaining of stomach pain.
- Laureen did not tell the RN that she was waiting for another staff to return from an outing before bringing James to the emergency department.
- The RN did not provide a timeframe for when to bring James to the ER or direct Laureen to contact 911.
- Laureen did not immediately bring James to the ER and instead gave him a shower and changed his clothing.
- Laureen did not contact 911 or begin CPR when James collapsed on the sidewalk
- The agency policy did not provide explicit instructions for transporting people receiving services to the ER.



ANSWER KEY

COULD THIS HAPPEN IN YOUR PROGRAM?

Case #3

Case Concerns

- Staff did not check the hallway bathroom for contraband prior to Amelia entering the room.
- Staff did not complete a search of Amelia and her belongings when she was admitted to the inpatient unit.
- The Narcan kit was behind a locked cabinet and was expired.
- Staff did not administer the expired Narcan, causing a delay in a potentially life saving intervention.
- Staff did not call for a code for a medical response.
- Too many staff members attempting to help delayed treatment. No one coordinated response efforts to ensure only essential staff responded.

Case #4

Case Concerns

- There was a delay in staff lowering Georgiana to the floor and beginning CPR. Nancy did not call a code blue, or try to immediately help Georgiana.
- Nancy did not provide the 15 minutes safety checks for Georgiana as required or transfer the responsibility to conduct the checks to another staff when she left the unit.
- Nancy did not let anyone know that she was experiencing difficulty at home that might impact her ability to provide supervision to people receiving services.
- The hospital did not have a policy or practice in place to monitor the completion of safety checks.

Case #5

Case Concerns

- Alanna gave food to Ian and Steve while they were still in the vehicle which was against agency policy.
- Alanna could not supervise Steve while he was eating since she was driving.
- Alanna did not immediately pull over as soon as she saw that Steve was in distress.
- Neither Alanna or Vaughan administered abdominal thrusts on Steve.



COORDINATED RESPONSE TO A MEDICAL EMERGENCY: CALM CHART

A coordinated response to a medical emergency is vital to ensuring care is received in a timely manner. By giving staff members a CALM role, they will know what their individual responsibility is during a medical emergency. If your program has less than four staff, discuss which tasks can be combined to ensure the safety of all people receiving services and staff in the program.

C Communicator	A Assistant	L Leader	M Milieu Manager
<ul style="list-style-type: none">• Meets emergency personnel upon arrival• Shares important information about situation with first responders• Shares the “to go” binder with EMS• Makes necessary internal notifications• Performs necessary life saving procedures as directed	<ul style="list-style-type: none">• Assists the Leader with ensuring the person in crisis remains safe• Brings emergency/first aid supplies• Ensures only essential staff are in the immediate area• Performs necessary life saving procedures as directed	<ul style="list-style-type: none">• Stays with person during crisis• Performs necessary life saving procedures as directed• Models calmness	<ul style="list-style-type: none">• Directs other people away from situation• Monitors other areas around the crisis• Ensures access to residence/unit is clear of debris, snow, ice, and that EMS has clear path• Performs necessary life saving procedures as directed

BEST PRACTICES

- Make staff aware of their CALM role upon arrival to shift. Consider including it on their shift assignment sheet.
- Practice using CALM roles during mock code drills.



MEDICAL EMERGENCY GUIDELINES AT-A-GLANCE

CALL 911:

- Abdominal pain, severe/constant
- Swelling, neck or face (suspected allergic reaction)
- Seizures, new onset or increased frequency
- Standing, unable to bear weight (normally able to do so)
- Bleeding heavily
- Broken bones
- Breathing difficulty, shortness of breath
- Chest pain
- Choking
- Stroke, suspected (one sided weakness/numbness, facial drooping, slurred speech)
- Consciousness, change or loss of consciousness or fainting
- Fall: with head injury, if unable to get up, limbs appear deformed
- Suicidal or homicidal feelings
- Vision, sudden change or loss
- Overdose, suspected
- Vomiting (or diarrhea) bloody
- Poisoning

GO TO EMERGENCY DEPARTMENT:

- Burns with skin damage or blisters
- Falls, gets up on own but complains of pain
- Vomiting, projectile lasting >6 hours, unable to hold down small sips of liquid
- Vomiting or diarrhea lasting >12 hours

CALL RN ON-CALL OR PHYSICIAN:

- Bleeding, moderate that stops after 5 minutes of direct pressure
- Blood pressure changes (upper number 200 or above)
- Blood pressure changes (upper number below 90 when normally above 90)
- Confusion, of new onset
- Fall, no apparent injury
- Fever >100 degrees, or <95 degrees
- Incontinence, new onset
- Rash, new onset
- Vomiting or diarrhea and individual is alert
- Burn, sunburn or mild burn (redness only)
- Chills, shaking with or without fever



SAMPLE PAIN CHART

Recognizing pain for those with complex communication needs, such as people with intellectual and/or developmental disabilities, can be challenging. A pain picture developed with feedback from family, friends, or staff who are familiar with the person can help identify when someone is experiencing pain or discomfort that may indicate an underlying medical issue.

Fig 1. Pain picture - known indicators of pain for Mohammed Adab		
Indicator	Family Observation - normal	Family Observation - pain
Skin colour	Flawless mid-brown with slight glow.	Lacklustre and sometimes mottled. Eyes appear sunken with very dark shadows underneath.
Sweating	Not particularly sweaty, even in warm conditions. Skin can be quite cool to touch.	Excess perspiration, especially hands and neck.
Absence of contentment/facial expression	Very contented, smiles and laughs a lot. Very sociable and likes people. Watches people and animals, and is generally happy.	Very quiet and withdrawn. Looks sad and does not watch people. Limited attempts to relate to others and is unsociable.
Aggression	Occasionally rocks and gently bangs his ear, but no injury caused.	Ear banging increases if he is in pain or unwell, and can be quite frenzied and frequent, causing redness and bruising.
Breathing	Normal breathing, but is sometimes a little wheezy and gurgly.	Becomes breathless and distressed, making loud wheezing sounds.
Facial Expression	Very smiley, happy, good eye contact, engaging.	Looks down and avoids eye contact. Appears sad and distant.
Behaviour (for example, eating, sleeping, behaviour patterns)	Sleeps well, usually from around 10pm until 7am. Has postural care supports in bed to improve body posture and help with breathing. Does not usually sleep during the day.	Wants to sleep all the time, but is restless. Closes eyes and drops off wherever he is. Wakeful and restless at night, and sometimes cries and moans.
Body tension	Quite relaxed.	Increased tension. Can stretch legs in a tense way, but all changes are quite subtle.
Increased vocalisation	Can be quite noisy, shouting and laughing. Uses a range of sounds. Can be quite loud, protesting at movement of limbs when he is moved out of his chair or bed.	Vocalisation increases, with crying and moaning. Responds to sudden pain by screaming.
Crying	Not when well and comfortable	Cries out, but usually no tears. Crying can be sustained for several minutes at a time, resulting in increased wheezing.
Other	Likes to be in his wheelchair and able to engage with others.	Does not like getting in wheelchair when unwell or in pain.
PAIN PROFILE		
Green	<p>Little or no pain identified. No need for extra clinical intervention; maintain interventions that reduce likelihood of pain.</p> <p>Interventions: general massage; rubbing of limbs and feet; likes lively music, especially the Kaiser Chiefs and Snow Patrol; enjoys being out and about with family and friends; hydrotherapy and physiotherapy.</p>	
Yellow	<p>Evidence of some pain. Consider pain relief, including therapeutic approaches known to be helpful (for example, massage, change of position, simple analgesia)</p> <p>Interventions: As for green, plus 1,000mg paracetamol (soluble, administered through PEG), which should also be given if grumpy or unwell.</p>	
Red	<p>Evidence of significant pain. Provide pain relief as appropriate for the person.</p> <p>Interventions: as for green and amber. If vomiting or temperature raised administer 2 x 500mg paracetamol suppository (follow prescription guidelines for frequency, check dose against any soluble paracetamol already administered to ensure prescribed levels are not exceeded). Seek medical advice.</p>	

*The patient's name has been changed.
PEG = percutaneous endoscopic gastroscopy.

Sample pain chart is from nursingtimes.net



RESOURCES

JUSTICE CENTER SPOTLIGHTS ON PREVENTION

PREVENTION RESOURCES

OFFICE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES

OPWDD HEALTH AND SAFETY ALERTS

Bowel Management, Pica Safety Alert, Sepsis Alert, Aspiration Alert, Helmet Safety, Sedation and Anesthesia Risks and Safeguards, Mechanical Lifts

OPWDD TELEPHONE TRIAGE

OPWDD NURSING RESOURCES

OFFICE OF ADDICTION SERVICES AND SUPPORTS

OVERDOSE PREVENTION

CLINICAL SUPPORT TRAININGS

LEARNING THURSDAYS

OFFICE OF MENTAL HEALTH CLINICAL ADVISORIES AND GUIDELINES

CLINICAL ADVISORIES AND GUIDELINES

NEW YORK STATE EDUCATION DEPARTMENT STUDENT SUPPORT SERVICES

SCHOOL HEALTH SERVICES

DEVELOPMENTAL DISABILITIES ADMINISTRATION

BEYOND FIRST AID, RECOGNIZING AND RESPONDING TO EMERGENCIES



SAMPLE MOCK EMERGENCY DRILL FORM

MEDICAL EMERGENCY PRACTICE DRILL		
Date:	Time:	Location:
Description of medical emergency scenario used for drill:		
	Staff response:	If no, please explain:
Was the person checked for responsiveness?		
Was there an internal call for help?		
Did staff simulate calling 911?		
Were CPR, abdominal thrusts or other interventions begun correctly and in a timely manner?		
Was person moved from bed, chair or wheelchair to begin interventions?		
Was anyone directed to meet EMS?		
Were other people receiving services removed from the scene and supervised?		
Did staff remain with the person while waiting for EMS to arrive?		
Were details of event correctly conveyed to EMS?		
Were agency emergency procedures followed?		



Drill Evaluation and Comments:

Staff participating in drill:

Drill Observed by:

Name _____ Signature _____



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