



Scope of Practice

Approved by the State Board of EMS (EMS Board), within the Division of EMS of the Ohio Department of Public Safety

This document offers an “at-a-glance” view of the Scope of Practice for First Responders (FR) and EMTs as approved by the EMS Board. The complete scope of practice can be found in Ohio Revised Code Sections 4765.35 (FR), 4765.37 (EMT-B), 4765.38 (EMT-I), and 4765.39 (EMT-P) and further defined in Ohio Administrative Code Rules 4765-12-04 (FR), 4765-15-04 (EMT-B), 4765-16-04 (EMT-I), and 4765-17-03 (EMT-P).

Performance of services outlined in this document and in the aforementioned code sections, shall only be performed if the First Responder and EMT have received training as part of an initial certification course or through subsequent training approved by the EMS Board. If specific training has not been specified by the EMS Board, the First Responder and EMT must have received training regarding such services approved by the local medical director before performing those services.

In accordance with Ohio Administrative Code Rule 4765-10-06, the individual Medical Director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. Each community may need to tailor and revise the protocol to fit their region and individual practice, but must ensure that they remain within the approved scope of practice.

EMS Medical Directors are reminded that they are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted. The EMS Board may allow First Responders and EMTs to perform services beyond their respective scopes of practices as part of a board-approved research study. The research study must be approved in advance in accordance with rule 4765-6-04 of the Ohio Administrative Code.

EMS medical directors and EMS providers are strongly encouraged to review the EMS Board's policy statement “Regarding EMS Provider Pre-Hospital transport of Patients with Pre-Existing Medical Devices or Drug Administrations” dated January 2004 (attached to this document, page 6). This statement clarifies how EMS providers, in the prehospital setting, should deal with medical devices and medicine administrations that are outside their scope of practice. The policy statement “Regarding EMT Interfacility Transport of Patients and the Scope of Practice” (approved by the EMS Board in June 2008 and attached to this document, page 7) should also be reviewed. This statement provides guidance to EMTs and their medical directors confronted with interfacility transports requiring medications and/or therapies outside of the EMT's normal scope of practice.



State EMS Board Division of EMS/Ohio Dept. of Public Safety

Updated June 18, 2008

	Airway Management	FR	B	I	P
1	Open and maintain the airway	X	X	X	X
2	Oropharyngeal airway adjunct	X	X	X	X
3	Nasopharyngeal airway adjunct	X	X	X	X
4	Obstructed airway management	X	X	X	X
5	Oral suctioning	X	X	X	X
6	ET suctioning		X	X	X
7A	Trach tube suctioning		X	X	X
7B	Trach tube replacement			X	X
8	Pulse oximeter equipment application/reading		X	X	X
9	Oxygen administration				
	a. Nasal cannula	X	X	X	X
	b. Non-rebreather mask	X	X	X	X
	c. Mouth-to-barrier devices	X	X	X	X
10	Ventilation management				
	a. Bag valve mask	X	X	X	X
	b. Ventilation with a flow-restricted O2 powered device	X	X	X	X
11	Orotracheal intubation				X
	a. Apneic patients			X	X
	b. Pulseless AND apneic patients		X	X	X
12	Nasotracheal intubation				X
13	Cricothyrotomy, surgical				X
14	Cricothyrotomy, needle				X
15	Dual lumen airway				X
	a. Apneic patients			X	X
	b. Pulseless AND apneic patients		X	X	X
16	Supraglottic Airways (4/16/08)				X
	a. Apneic patients			X	X
	b. Pulseless AND apneic patients		X	X	X
17	Ventilator management - 16 y/o or older				X
18	Bi-PAP administration and mgt.				X
19	C-PAP administration and mgt. (7/18/07)		X	X	X
20	End Tidal CO ₂ Monitoring & Detection		X	X	X
21	Nasogastric (NG) tube placement (4/16/08)				X
22	Orogastric (OG) tube placement (4/16/08)				X

	Cardiac Management	FR	B	I	P
1	Automated External Defibrillator(AED)	X	X	X	X
2	Cardiac monitor strip interpretation			X	X
3	Manual defibrillation			X	X
4	Cardiopulmonary Resuscitation (CPR)	X	X	X	X
5	Transcutaneous Cardiac pacing				X
6	Aspirin administration		X	X	X
7	Cardiac medication administration				X
8	Cardioversion				X
9	12-lead EKG performance & interpretation				X
10	12-lead EKG set up and application for electronic transmission* (4/16/08)		X	X	X
11	Chest compression assist devices		X	X	X

*If an EMT-P is not present, the EMT-B and EMT-I may only set up and apply a 12 lead electrocardiogram if all of the following conditions are met: 1) completed in accordance with written protocol; 2) only for the purpose of electronic transmission; 3) any delay in patient transport is minimized; 4) electrocardiogram is used in conjunction with destination protocols approved by the local medical director. The EMT-B and EMT-I cannot interpret the EKG.

	Medical Management	FR	B	I	P
1	Glucose monitoring system use (with C.L.I.A waiver in place)		X	X	X
2	Peripheral IV blood specimens			X	X
3	Oral glucose administration		X	X	X
4	Auto-injector Epinephrine (Pt. Assisted)	X	X	X	X
5	Epinephrine administration (Subcutaneous)			X	X
6	Activated Charcoal administration		X	X	X
7	Nitroglycerine administration (Pt. Assisted)		X	X	X
8	Nitroglycerine administration (Non pt. Assist)			X	X
9	Metered dose inhaler (Pt. Assisted)		X	X	X
10	Nebulized medications			X	X

Patient Assisted Definition:

- 1) May assist with patient's prescription upon patient request and with written protocol.
- OR -
- 2) May assist from EMS provided medications with verbal medical direction.

	Pre-hospital ALS Assistance	FR	B	I	P
1	Set up of IV administration kit *		X		
2	Cardiac monitor *		X		
3	12 lead EKG application **		X	X	

* Set-up of equipment only. An EMT-I or EMT-P must be present, or procedure(s) cannot be performed

** Set-up of equipment only. If an EMT-P is not present, procedure(s) shall not be performed except as previously noted in cardiac management section

Trauma Management		FR	B	I	P
1	PASG		X	X	X
2	Long spine board	X	X	X	X
3	Short spine board	X	X	X	X
4	Splinting devices	X	X	X	X
5	Traction splint		X	X	X
6	Cervical Immobilization Device (CID)	X	X	X	X
7	Helmet removal		X	X	X
8	Rapid extrication procedures		X	X	X
9	Needle decompression of the chest			X	X
10	Soft tissue management	X	X	X	X
11	Management of suspected fractures	X	X	X	X
Preparatory / Basic Performances		FR	B	I	P
1	Body Substance Isolation precaution/administration	X	X	X	X
2	Taking and recording of vital signs	X	X	X	X
3	Patient Care Report (PCR) documentation	X	X	X	X
4	Emergency childbirth management	X	X	X	X
5	Trauma triage determination per OAC 4765-14-02	X	X	X	X
Other		FR	B	I	P
1	Medication administration (Protocol approved)			X	X
*** See page 5 for the complete listing of approved medications for the EMT-I level					
2	IV lifeline and fluid administration (does not include blood or blood products)			X	X
3	Intraosseous infusion			X	X
4	Saline lock initiation			X	X
5	IV infusion pump				X
Additional services					
<p>In the event of an emergency declared by the governor that affects the public's health, a first responder, EMT-basic, EMT-intermediate, or EMT-paramedic may perform immunizations and administer drugs or dangerous drugs, in relation to the emergency, provided the first responder or EMT is under physician medical direction and has received appropriate training regarding the administration of such immunizations and/or drugs.</p>					
Nerve Agent or Organophosphate Release					
<p>A first responder, EMT-basic, EMT-intermediate, or EMT-paramedic, may administer drugs or dangerous drugs contained within a nerve agent antidote auto-injector kit, including a MARK I kit, in response to suspected or known exposure to a nerve or organophosphate agent provided the first responder or EMT is under physician medical direction and has received appropriate training regarding the administration of such drugs within the nerve agent antidote auto-injector kit.</p>					

Approved EMT-Intermediate Medications			
Epinephrine 1:1000 (sub-q injection)			
Sublingual nitroglycerin			
Dextrose 50% in water (adult patients)			
Dextrose 25% in water (pediatric patients)			
Diphenhydramine			
Benzodiazepines (4/16/08)			
Bronchodilators			
Naloxone (including intranasal)			
Glucagon			
Nitrous oxide			
Nalbuphine			
Morphine Sulfate			
Ketorolac, meperidine, or other analgesics for pain relief			

As Approved by the EMS Board -

The above medications are the ONLY medications that the EMT-Intermediate has been approved to administer. If a medication does not appear on this listing, it has not been approved by the EMS Board, and SHALL NOT BE ADDED TO THE DEPARTMENT'S PROTOCOL.

The approved route of administration of any specific medication is stated in the respective EMT-Basic, EMT-Intermediate, and EMT-Paramedic curriculum. The EMS provider shall administer medications only via the route addressed in each respective curriculum and consistent with their level of training.

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The EMS Board may allow First Responders and EMTs to perform services beyond their respective scopes of practice as part of a board-approved research study. The research study must be approved in advance in accordance with rule 4765-6-04 of the Ohio Administrative Code.

The Ohio Board of Emergency Medical Services (“EMS Board”) issues the following statement:

**Regarding EMS Provider Pre-Hospital Transport of Patients with
Pre-Existing Medical Devices or Drug Administrations
January 2004**

This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMS Board’s general position on the above issue, this statement in no way precludes the EMS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMS Board will be decided on a case-by-case basis.

Introduction:

The Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMS providers. It is maintained in matrix form and available on-line as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMS Board. Updates to the scope of practice are made as necessary and after approval by the EMS Board. From time to time, EMS providers are confronted on-scene with patients with pre-existing medical situations not included or addressed in their respective EMS Board-approved scope of practice. Specifically, patients with pre-existing medical devices and drug administrations requiring pre-hospital EMS service are becoming more commonplace. The intent of this position paper is to address the EMS provider’s approach to that pre-hospital patient with a pre-existing physician-ordered medical device or drug administration (“MDDA”) not covered in the provider’s scope of practice.

Discussion:

In general, the EMS provider should maintain the pre-existing MDDA and transport the patient to the appropriate facility. There is no expectation that the EMS provider will initiate, adjust, or discontinue the pre-existing MDDA. This implies that the EMS provider will maintain and continue care so that the patient can be transported. The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of pre-hospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (pre-hospital or “911 scene response”). It implies that the most appropriate and available level of EMS provider will respond to the request for pre-hospital EMS service. It also implies that the patient requires the pre-existing MDDA and it is not feasible or appropriate to transport the patient without the pre-existing MDDA.

The number and type of pre-existing MDDAs currently or potentially encountered by the EMS provider in the community setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive list of pre-existing MDDAs. However, as a guideline for the EMS provider, current pre-existing MDDAs may include ventilatory adjuncts (CPAP, BiPAP), continuous or intermittent IV medication infusions (analgesics, antibiotics, chemotherapeutic agents, vasopressors, cardiac drugs), and non-traditional out-of-hospital drug infusion routes (subcutaneous infusaports, central venous access lines, direct subcutaneous infusions, self-contained implanted pumps).

Conclusion:

In conclusion, the EMS provider confronted with a pre-hospital patient with a pre-existing physician-ordered medical device or drug administration not covered in the EMS provider’s respective scope of practice should provide usual care and transportation while maintaining the pre-existing MDDA, if applicable. Concerns or questions regarding real-time events associated with a pre-existing MDDA should be directed to the relevant Medical Control Physician. Concerns or questions regarding previous, recurrent, or future pre-hospital transportations with a pre-existing MDDA should be directed to the appropriate EMS Medical Director and legal counsel.

Reaffirmed by EMS Board 2/20/2008

The Ohio Board of Emergency Medical Services (“EMS Board”) issues the following statement:

**Regarding EMT Interfacility Transport of Patients and the Scope of Practice
May 2008**

This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMS Board’s general position on the above issue, this statement in no way precludes the EMS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMS Board will be decided on a case-by case basis.

Introduction:

The Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMTs. The scope of practice for Emergency medical technicians (EMTs) is established in Ohio Administrative Code Chapters 4765-15, 4765-16, and 4765-17. An outline of the Ohio EMS scope of practice is available in a matrix form and is posted on the Ohio Department of Public Safety, Division of EMS website as a reference for public access. This scope of practice addresses all levels of EMTs and has been approved by the EMS Board. Updates to the scope of practice are made as necessary and must be approved by the EMS Board.

From time to time, during interfacility transport, EMTs are confronted with medications and therapies that are out of their usual scope of practice and training. The intent of this position paper is to address the approach of the EMTs and their medical directors to these situations which are not explicitly covered in the Ohio EMS scope of practice.

Discussion:

The number and type of medications and therapies in the medical field currently or potentially encountered by the EMT in the interfacility transport setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive or exclusive list of therapies and medications that should be included or excluded from the EMT’s scope of practice. Rather, the intention of this document is to frame the discussion around maintenance of patient safety during interfacility transport and provision of patient care that is appropriate to the EMT’s level of training.

Additionally, the success of any EMS service requires robust medical direction from an actively involved physician who meets the requirements set forth in Ohio Administrative Code Rule 4765-3-05. This includes, but is not limited to, the initial and ongoing training of EMTs, as well as an active performance improvement process in which all transports are subject to review for quality assurance.

The scope of this document includes all transports in which the highest level of training of the personnel in the transport vehicle is an EMT-Paramedic. The addition of the registered nurse to the crew creates a mobile intensive care unit which is qualified to transport critical patients as legislated in Section 4766.01 of the Ohio Revised Code and Rule 4766-4-12 of the Ohio Administrative Code.

Conclusion:

Each level of EMT certification is limited to the scope of practice that is set forth in Ohio Administrative Code Chapters 4765-15, 4765-16, and 4765-17. Furthermore, this position paper does not provide an inclusive or exclusive list of therapies and medications that should be included or excluded from the EMT’s scope of practice.

In addition, during the interfacility transportation of patients, the EMT:

- Shall not initiate or continue the infusion of blood or blood products.
- Shall not initiate the infusion of intravenous parenteral nutrition.
- Shall not initiate or continue the infusion of chemotherapeutic agents.

-Shall follow written protocols, which have been developed and signed by the EMS provider's medical director, for the infusion of medications that are not specifically outlined within the EMS scope of practice as outlined by the State of Ohio.

- The training for the infusion of these specific medications shall not be done at the time of the interfacility transfer of the patient.

- This training must be completed well in advance of the transfer.

- The completion of the training must be documented and approved by the medical director of the EMS agency.

- Continuing education and recurrent training on the indications, contraindications, pharmacology, and side effects of these medications is also required.

-Should refuse to initiate a transport for safety reasons, if the EMT feels that adequate training on the infusion of a specific intervention has not been provided well in advance of the transfer as outlined above, or if the EMT feels uncomfortable with the transport for any reason, including but not exclusive to patient scenario or any requested parameter of patient care delivery ordered during patient transport.

Concerns or questions regarding specific interfacility transports should be directed to the Ohio Department of Public Safety, Division of Emergency Medical Services.

Adopted by the EMS Board 5/21/2008