

ADMINISTRATION/OPERATIONS

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EMS LEVELS OF CERTIFICATION

These protocols recognize that there is a role for all levels of Emergency Medical Technician Certification. Not every function defined by the State of Ohio is approved under specific hospital Medical Directors. Patient care should always be delivered at the highest level of EMS available. Every EMS Provider must be aware of the State of Ohio requirements for recertification, and each individual is responsible for personally fulfilling these requirements. Those seeking to fulfill National Registry of Emergency Medical Technician (NREMT) requirements may do so under their own individual responsibility.

Continuing Education certifications must be received through an approved Continuing Education site with a valid accreditation # noted, and must be filed properly. Each EMS Provider must maintain his / her own personal records, and be responsible for his / her own Continuing Education status.

ADMINISTRATION/OPERATIONS
EMS RECERTIFICATION REQUIREMENTS

EMT-BASIC REFRESHER COURSE	EMT INTERMEDIATE	EMT PARAMEDIC
<p>40 hours of CE which includes:</p> <ul style="list-style-type: none"> • 6 hours of pediatric education • 2 hours of geriatric education • 8 hours of trauma training <ul style="list-style-type: none"> • 2 hours of local trauma time protocol/issues training (2 of the 8 hours must be dedicated to local protocol/issues training) <p style="text-align: center;">OR</p> <p>Thirty (30) hours state approved Refresher Course (including pediatric, geriatric and trauma requirements)</p> <p>Current NREMT Renewal Requirements</p> <ul style="list-style-type: none"> • Current registration as an EMT Basic with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal <p>If opting for National Registry Renewal, all that is required is:</p> <ul style="list-style-type: none"> • 2 hours of local trauma/triage/issues training <p style="text-align: center;">OR</p> <p>Exam in Lieu of CE (for all levels) This exam is similar to the exam for initial certification and can be taken during the last six months of your certification cycle. Contact the Division of EMS to obtain information on registering for this exam</p>	<p>60 hours of CE which includes:</p> <ul style="list-style-type: none"> • 8 hours of pediatric education • 4 hours of geriatric education • 8 hours of trauma training • 2 hours of local trauma triage protocol/issues training (2 of the 8 hrs must be dedicated to local/issues training) <p style="text-align: center;">OR</p> <p>Current NREMT Renewal Requirements</p> <ul style="list-style-type: none"> • Current registration as an EMT intermediate with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal <p>If opting for National Registry Renewal, all that is required is:</p> <ul style="list-style-type: none"> • 2 hours of local trauma/triage issues training 	<p>92 hours of CE which includes:</p> <ul style="list-style-type: none"> • 12 hours of pediatric education • 4 hours of geriatric education • 8 hours of trauma training • 2 hours of local trauma triage protocol/issues training (2 of the 8 hrs must be dedicated to local protocols/issues training) <p style="text-align: center;">PLUS</p> <p>12 hours on emergency card ACLS certification or equivalent course approved by EMS Board</p> <p style="text-align: center;">OR</p> <p>Forty-eight (48) hours EMT-Paramedic Refresher Course</p> <p style="text-align: center;">PLUS</p> <p>Forty-four (44) additional hours of CE</p> <p style="text-align: center;">PLUS</p> <p>ACLS certification or equivalent course approved by the EMS Board</p> <p style="text-align: center;">OR</p> <p>Current NREMT-P Renewal Requirements</p> <ul style="list-style-type: none"> • Current registration as a Paramedic with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal <p>If opting for National Registry Renewal, all that is required is:</p> <ul style="list-style-type: none"> • 2 hours of local trauma/triage/ issues training



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.

Updated 11/19/03; 5/17/05; 10/26/05; 10/17/07; 6/18/08

ADMINISTRATION/OPERATIONS
OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS



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
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

ADMINISTRATION/OPERATIONS
OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

	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.I.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

ADMINISTRATION/OPERATIONS
OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

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
<i>*** See page 5 for the complete listing of approved medications for the EMT-I level</i>					
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>					

ADMINISTRATION/OPERATIONS
OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

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.

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.

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 infusions, 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.

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OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

-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

Helicopter/Hospital Intercepts

If the patient requires specialized care, i.e. level 1 trauma center, and conditions allow for rapid transport to the nearest facility, a helicopter/hospital intercept can be initiated. When a helicopter/hospital intercept is initiated, the receiving hospital medical control will be contacted, advised of request for helicopter intercept and minimum patient information of nature of call/chief complaint, and then medical control will direct the appropriate personnel to call for the helicopter.

Scene Flights

Scene flights will be organized with the cooperation of the responding EMS, fire, and law enforcement agencies. The following defines how the on-scene Incident Command (IC) should request an Air Ambulance to the scene of an emergency incident due to the mixture of public fire, EMS and private EMS systems.

KEY POINTS

- Recognize that it is safer to transport a patient from a well-lit, specially designed helipad than it is from an accident scene. EMS must be aware of the potential danger presented by poor lighting and potential scene hazards such as electrical wires or fire. Limit helicopter scene loading to the few cases where it is essential.
 - Patient transportation via ground ambulance will not be delayed to wait for helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance, the transportation will be initiated by ground ambulance.
 - Aeromedical transport should be requested to the ground ambulance destination when appropriate, after conferring with medical control, to ensure the patient is transported to the most appropriate facility.
- Time estimation should be made from the time the patient is ready for transport to arrival at the medical facility/the most appropriate trauma center. This should include aircraft response to the scene.
- A flight physician on the scene assumes care of the patient. If a physician on the scene asks a squad member to perform beyond the squad member's level of authorization, the squad member should inform the physician that he/she is unable to do so.
- EMS should request aeromedical transport of the patient to the closest most appropriate hospital, based upon location, patient or family request, and the capabilities of the hospitals (i.e. Trauma Center, OB Unit, etc.).

ADMINISTRATION/OPERATIONS

ADVANCED DIRECTIVES - DO NOT RESUSCITATE (DNR) ORDERS

PURPOSE

- Ideally, any patient presenting to the EMS system with a valid DNR form shall have the form honored and CPR and ALS therapy withheld in the event of cardiac arrest.
- To honor the end of life wishes of the patient
- To prevent the initiation of unwanted resuscitation

PROCEDURE

Ohio's DNR Comfort Care is the only law encompassing EMS. For any other type of DNR documents, you must contact Medical Control and describe your circumstances to a Physician. The Physician will then decide if EMS should honor the DNR document, or begin resuscitation of the patient. This includes the Ohio Living Will or any other document to this effect.

A DNR order for a patient of a healthcare facility shall be considered current in accordance with the facility's policy. A DNR order for a patient outside a healthcare facility shall be considered current unless discontinued by the patient's attending physician/CNP/CNS, or revoked by the patient. EMS personnel are not required to research whether a DNR order that appears to be current has been discontinued.

***** If you are presented with any in hospital "Limitation of Life Treatment Orders" (DNAR form) or any end of life care document other than the standard Ohio DNR Comfort Care form. Contact Medical Control for guidance. *****

STATE OF OHIO DNR COMFORT CARE GUIDELINES

Under its DNR Comfort Care Protocol, the Ohio Department of Health has established two standardized DNR order forms:

DNR Comfort Care – Terminally ill condition and in effect at all times.
DNR Comfort Care – Arrest – In effect in the event of a cardiac or respiratory arrest.

When completed by a doctor (or certified nurse practitioner or clinical nurse specialist, as appropriate), these standardized DNR orders allow patients to choose the extent of the treatment they wish to receive at the end of life. Ohio DNR Comfort Care can be identified by the original/copy of the State of Ohio DNR Comfort Care Form with official DNR logo, a DNR Comfort Care necklace, bracelet, or card with official DNR Comfort Care logo. The form must be completed with effective date and signed by the patient's physician. To enact the DNR Comfort Care, the patient must be experiencing a terminal event. EMS is not required to search for a DNR identification but should make a reasonable attempt to identify that the patient is the person named on the DNR Comfort Care form. **Only the patient may request reversal of the DNR – Comfort Care order.**

Care to be provided by EMS:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide pain medication
- Provide emotional support
- Contact other appropriate health care providers (hospice, home health, attending physician or certified nurse)

Care NOT to be provided by EMS:

- Administer chest compressions
- Insert artificial airway
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance (other than described above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

ADMINISTRATION/OPERATIONS

ADVANCED DIRECTIVES - DO NOT RESUSCITATE (DNR) ORDERS

KEY POINTS

- The DNR order addresses a patient's current state of health and the kind of medical treatment he/she and their physician decide is appropriate under the current circumstances.
- A DNR order for a patient of a healthcare facility shall be considered current in accordance with the facility policy. A DNR order for a patient outside a healthcare facility shall be considered current unless discontinued by the patient's attending physician/CNP/CNS, or revoked by the patient. EMS personnel are not required to research whether a DNR order that appears to be current has been discontinued.
- It is imperative that a copy of or the original DNR / Comfort Care orders and identification accompany the patient wherever the patient goes. This will help to alleviate any confusion between healthcare givers at multiple sites.
- Be careful to check the patient's DNR order or DNR identification to determine if DNR-CC or DNR-CC Arrest.
- EMS is not required to search a person to see if they have DNR identification. If any of the DNR identifiers are in the possession of the patient, EMS must make a reasonable attempt to identify the patient by patient's name given by patient, family, caregiver, friend, or healthcare worker who knows the patient; ID band from healthcare institution; drivers license or other picture I.D.
- The patient may request resuscitation even if he/she is a DNR Comfort Care or DNR Comfort Care-Arrest Patient and/or the DNR Comfort Care Protocol has already been activated. The patient's request for resuscitation amounts to a revocation of any or all DNR Comfort Care Status and resuscitative efforts must be activated.
- If EMS has responded to an emergency situation by initiating any of the "will not perform actions" prior to confirming that the DNR Comfort Care Protocol must be activated, discontinue them when you activate the protocol. You may continue respiratory assistance, IV medications, etc..., that have been part of the patient's ongoing course of treatment for their underlying condition or disease.
- If the patient's family or bystanders request or demand resuscitation for a patient for whom the DNR Comfort Care Protocol has been activated, do not proceed with resuscitation. Provide "will perform actions" as outlined above and try to help them understand the dying process and the patient's initial choice not to be resuscitated.
- For EMS - The Ohio DNR Comfort Care law is the only one you (EMS) can honor on your own. For any other types of DNR documents, you must contact Medical Control and describe your circumstances to a Physician. The Physician will decide if you should honor the DNR document, or begin resuscitation of the patient.
- A living will document specifies in advance the kind of medical treatment a patient would want if and when he/she has a terminal illness or are in a permanently unconscious state and are no longer able to state their own wishes. It may not protect him/her from receiving CPR or other heroics. It *only* takes effect if they are in a certifiably terminal or permanently unconscious state.
- A Health Care Power of Attorney is a document that names another person (usually a spouse, child, or other relative, and preferably someone who can understand a patients health status and make hard decisions on their behalf, if necessary) to make healthcare decisions for them whenever they are unable to do so. It is not a DNR order, though it ordinarily would permit the person they appoint to agree to a DNR order for them if they are unable to express their wishes at the time.
- The General Power of Attorney usually does not address healthcare issues and ends if he/she becomes disabled. They may have given their general power of attorney to someone to manage their financial affairs while you were on vacation or in the hospital. If you want a *general* power of attorney to continue, even if you become disabled, the document must state that it is a *durable*, or continuing, power of attorney. A healthcare power of attorney is a *durable* power; it continues even after they become disabled and appoints someone to carry out their healthcare wishes.

- Child abuse is a physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare. The recognition of abuse and the proper reporting is a critical step to improving the safety of children and preventing child abuse.

PURPOSE

Assessment of a child abuse case based upon the following principles:

- **Protect** the life of the child from harm, as well as that of the EMS team from liability.
- **Suspect** that the child may be a victim of abuse, especially if the injury/illness is not consistent with the reported history.
- **Respect** the privacy of the child and family.
- **Collect** as much evidence as possible, especially information.

PROCEDURE

1. With all children, assess for and document psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.
2. With all children, assess for and document physical signs of abuse, including any injuries that are inconsistent with the reported mechanism of injury. The back, buttocks, genitals, and face are common sites for abusive injuries.
3. With all children, assess for and document signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. With all children, assess for and document signs of sexual abuse, including torn, stained, or bloody underclothing, unexplained injuries, pregnancy, or sexually transmitted diseases.
5. Immediately report any suspicious findings to the receiving hospital (if transported). Law Enforcement must also be notified.
6. EMS should not accuse or challenge the suspected abuser. This is a legal requirement to report, not an accusation. In the event of a child fatality, law enforcement must also be notified.

ADMINISTRATION/OPERATIONS

CHILD ABUSE / NEGLECT

KEY POINTS

- Child abuse/neglect is widespread enough that nearly all EMS Providers will see these problems at some time. The first step in recognizing abuse or neglect is to accept that they exist and to learn the signs and symptoms.
- Initiate treatment as necessary for any situation using established protocols.
- If possible remove child from scene, transporting them to the hospital even if there is no medical reason for transport.
- If parents refuse permission to transport, notify law enforcement for appropriate disposition. If the patient is in immediate danger, let law enforcement handle scene.
- Advise parents to go to the hospital. **AVOID ACCUSATIONS** as this may delay transport. The adult with the child may not be the abuser.

RED FLAGS TO CHILD ABUSE:

The presence of a red flag does not necessarily mean maltreatment. The suspicion of maltreatment is also based upon the EMS provider's observations and assessment.

Signs that parents may display include (not all inclusive):

- Parent apathy
- Parent over reaction
- A story that changes or that is different when told by two different witnesses
- Story does not match the injury
- Injuries not appropriate for child's age
- Unexplained injuries

Signs that the child may display include (not all inclusive):

- Pattern burns (donuts, stocking, glove, etc...)
- Multiple bruises in various stages of healing
- Not age appropriate when approached by strangers
- Not age appropriate when approached by parent
- Blood in undergarments

ADMINISTRATION/OPERATIONS
CONCEALED WEAPONS GUIDELINES

While the possibility of finding a dangerous weapon on a scene has always existed, EMS personnel must be aware of current issues which impose unique hazards upon them while performing their duties. These dangers present in many different ways regardless of jurisdiction or call volume. Although all accidents can not be prevented, awareness must be made regarding the State of Ohio Concealed-Carry Law.

Ohio's Concealed - Carry Law permits individuals to obtain a license to carry a concealed handgun in Ohio, including into private businesses, if the licensee also carries a valid license and valid identification when carrying the concealed handgun. This law has been in effect since April 8th, 2004. Be aware that all patients may be carrying a dangerous weapon at all times, regardless of whether a permit has or has not been issued.

GUIDELINES

- Upon arrival at the scene, EMS personnel should directly ask patients if they are carrying a weapon prior to performing a physical assessment. If the patient is unable to answer, please proceed with caution.
- If a weapon is present on scene or with a patient, it is recommended that a Law Enforcement Official be present to secure the weapon.
- Caution is advised due to the many types of weapons and the handler's ability to modify them.
- When transporting a patient to the hospital, please inform the receiving facility that a weapon has been found on the patient. This will allow enough time for Security to safely secure the weapon and maintain possession of it until Law Enforcement arrives.

Example of a Standard Warning Sign



PURPOSE

To provide:

- Rapid emergency EMS transport when needed.
- Protection of patients, EMS personnel, and citizens from undue risk when possible.
- Method to document patient refusal of care.

PROCEDURES - ADULT

Consent:

- **Express Consent:** Where a conscious, oriented (to person, place and time) competent adult (over 18 years old) gives the EMS provider permission to care for him/her. This may be in the form of a nod, verbal consent or gesture after the intended treatment has been explained.
- **Implied Consent:** Occurs when a person is incapable of giving permission for treatment due to being unconscious or incompetent. It is assumed that permission would be given for any life saving treatments.

Refusal of Treatment

- An EMS Patient Refusal or Transport sign-off sheet must be completed for all refusals prior to Medical Control contact. See the attached form.
- **Competent Adult:** ****For the purposes of this Protocol, Competent will be defined as – Lucid and capable of making an informed decision, alert to Person, Place, Time, and Event. This definition is consistent with approved EMT-B, EMT-I, and EMT-P textbooks**** A competent adult may refuse treatment even after calling for help. The person must be informed that they may suffer loss of life, limb or severe disability if they refuse care and transport, and sign a Release indicating that they understand this. If the patient refuses to sign, a witness at the scene, preferably a relative should sign. Documentation of the events must be clearly made. It also must be documented on the run sheet that the person is oriented to person place time and event, and a set of vital signs should be obtained if at all possible. An offer to return and transport them at a later time should be made by EMS. Contact with Medical Control should be made. If the need for treatment is obvious, speaking directly to the Nurse or Physician may assist in convincing the patient to be transported.
- **Incompetent patient:** While an adult may refuse treatment, in some situations, their refusal may not be competent. In the following situations, the refusal of treatment may be incompetent:
 - Patients showing altered mental status due to head trauma, drugs, alcohol, psychiatric illness, hypotension, hypoxia, or severe metabolic disturbances.
 - Violent patients.
 - Uncooperative minors.

ADMINISTRATION/OPERATIONS

CONSENT AND REFUSAL OF CARE GUIDELINES

PROCEDURES – MINOR

Consent to treat: (under the age of 18 years in Ohio) Must be obtained from the parent or guardian with two exceptions:

- There is need for life saving immediate treatment which should be given to the point of it being considered elective.
- The Minor is emancipated (i.e. married, living on their own, or in the armed forces and may give permission themselves).

Refusal of Treatment: A **minor** might refuse to cooperate with the EMS crew, or the minor's parent or guardian may refuse to consent to necessary treatment of the minor. A **minor** under the age of 18 years may not refuse treatment in Ohio. Transport should be initiated unless the **parent** or **legal guardian** refuses treatment on behalf of the minor. A circumstance may occasionally arise where the patient is a minor and there is no illness or injury, yet EMS has been called to the scene. Medical Control must be contacted and agree that there is no illness or injury. If the responsible person is not able to be at the scene, it is acceptable for contact to be made by telephone. If care and transport is refused by the parent or guardian, TWO witnesses should verify this, and this shall be documented and signed by both witnesses on the run sheet. It is also acceptable for the minor to be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of Medical Control and the EMT. A second circumstance may occur when the minor patient really needs to be transported and the parent or guardian is refusing transport. In this case, action must be taken in the minor's best interest. This is described in the following section, Incompetent Refusal.

Incompetent Refusal

- Parent/guardian refuse to give consent for treating their child when the child's life or limb appears to be at risk.
- Parent/guardian refuse to give consent where child abuse is suspected.
- Suicidal patients – any age.

In all such cases, **contact with Medical Control and a Physician is mandatory**, as the patient may have a life-threatening problem and is in need of medical care. The involvement of the police in these situations is often necessary and crucial. They may assist the EMS crew with transport as ordered by the On-line Physician. This is described in the Ohio Revised Code, Section 5122.10.

Non-Transports

In the event of a patient assist call and no Emergency Medical Services are rendered, a report should be made but Medical Control need not be contacted.

If the patient is requesting transport and the EMT in charge does not feel it is necessary to transport the patient, Medical Control must be contacted and approve the EMS refusal. This includes any case that might be transported by car or another ambulance service.

ADMINISTRATION/OPERATIONS

EMS COMMUNICATIONS

A member of the prehospital care team must contact Medical Control at the earliest time conducive to good patient care. This may be a brief early notification or a heads-up. It may mean that the hospital is contacted from the scene if assistance is needed in the patient's immediate care or permission is required for part of the patient care deemed necessary by the EMS Provider in charge.

PURPOSE

- To provide the receiving hospital an accurate, updated report of the patient(s) presentation and condition throughout prehospital care and transport.
- To allow the receiving hospital the opportunity to prepare for receiving the patient and continue necessary medical treatment.

PROCEDURE

Contact the receiving facility and provide the following information:

- Type of Squad: Basic, Intermediate, Paramedic
- Age and Sex of Patient
- Type of Situation: Injury and/or Illness
- Specific Complaint: Short and to the point (i.e., chest pain, head injury)
- Mechanism: MVA / MCA / Fall
- Vital Signs: B/P / Pulse / Resp. / LOC / EKG
- Patient Care: Airway Management, Circulatory Support, Drug Therapy
- General Impression: Stable / Unstable
- Destination ETA

KEY POINTS

- When calling in a report it should begin by identification of the squad calling, and the level of care that can be provided to the patient (EMT, EMT-I, EMT-P), and the nature of the call (who you need to talk with, physician or nurse).
- Whenever possible, the EMT responsible for the highest level of direct patient care should call in the report.
- Although all EMS Providers have been trained to give a full, complete report, this is often not necessary and may interfere with the physician's duties in the Emergency Department. Reports should be as complete but concise as possible to allow the physician to understand the patient's condition.
- It is not an insult for the physician to ask questions after the report is given. This is often more efficient than giving a thorough report consisting mostly of irrelevant information.
- If multiple victims are present on the scene, it is advisable to contact Medical Control with a preliminary report. This should be an overview of the scene, including the number of victims; seriousness of the injuries, estimated on-scene and transport times to the control hospital or possible other nearby facilities. This allows preparation for receiving the victims and facilitates good patient care.

ADMINISTRATION/OPERATIONS

EMS DOCUMENTATION

- An EMS patient care report form (PCR) will be completed accurately and legibly to reflect the patient assessment, patient care and interaction between EMS and the patient for each patient contact which results in some assessment component.
- Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.
- EMS providers are to leave a short, hand-written Patient Information Form (PIF) at the patient's bedside in the emergency department until the official electronic form is turned in. This will ensure patient care continuity between prehospital and emergency department staff.

PURPOSE

To document total patient care provided including:

- Care provided prior to EMS arrival.
- Exam of the patient as required by each specific complaint based protocol.
- Past medical history, medications, allergies, living will / DNR, and personal MD.
- All times related to the event.
- All procedures / medications administered and their associated time and patient response.
- Notation of treatment authorization if any deviation from protocol / narcotic use.
- Reason for inability to complete or document any above item.
- A complete set of vital signs.

PROCEDURE

1. The patient care report should be completed as soon as possible after the time of the patient encounter.
2. All patient interactions are to be recorded on the patient care report form or the disposition form (if refusing care).
3. The patient care report form must be completed with the above information.
4. A copy of the patient care report form should be provided to the receiving medical facility.
5. A copy of the patient care report form is to be maintained by the EMS entity.

ADMINISTRATION/OPERATIONS

EMS DOCUMENTATION

KEY POINTS

- Document the contact and any on-line medical direction that is given. If you are not able to reach Medical Control, document attempts and cause for failure. Always describe the circumstances of the call.
- The times that vitals are taken must be noted. Vitals should be repeated a minimum of every five minutes for unstable patients and every 15 minutes for stable patients, or following any medical treatments. Vitals should be completely recorded. If a part of the set of vitals is omitted, the reason should be clearly given. ("Unable to obtain B/P due to clothing" is clear; "unable" written under the B/P space is not clear).
- Use accepted medical abbreviations and terminology. Do not make them up.
- Make an effort to spell correctly. Become familiar with the correct spelling of commonly used words.
- The name, dose, route, time and effect should be documented for all medications.
- When standards are followed, such as in a full arrest, every step should be documented. To write "ACLS protocols followed" is NOT SATISFACTORY.
- When providing copies of the run report for the Emergency Department and the Medical Director, be sure to include the EKG strips and second sheets.
- A complete set of times must be recorded on every report.
- If the patient refuses treatment/transport, the reason for refusal must be documented, along with 3 offers to treat/transport and an offer to return and transport. Medical Control contact should be noted. It is very important to document the mental status and assessment or the reason for lack of an assessment of the patient who refuses treatment/transport.

Documentation of Vital Signs

1. An initial complete set of vital signs includes:
 - Pulse rate
 - Systolic AND diastolic blood pressure
 - Respiratory rate
 - Pain / severity (when appropriate to patient complaint)
 - Pulse Oximetry
2. When no ALS treatment is provided, palpated blood pressures are acceptable for repeat vital signs.
3. Document situations that preclude the evaluation of a complete set of vital signs.
4. Record the time vital signs were obtained.
5. Any abnormal vital sign should be repeated and monitored closely.

FIELD TERMINATION OF RESUSCITATION EFFORTS PROTOCOL

INDICATIONS

When a patient that is in cardiac arrest has failed to respond to Advanced Life Support, it may be decided to terminate the effort and not transport the patient to the hospital. When the paramedic determines that this option is appropriate, the following criteria must be met:

- a. The victim is 18 years or older
- b. The victim must be in asystole in two leads and have the absence of a pulse confirmed.
- c. The victim must not be in arrest due to hypothermia, or apparent drug overdose.
- d. The victim must have a properly placed advanced airway.
- e. The patient must have a patent intravenous access.
- f. At least three rounds of ACLS drugs have been administered.
- g. Medical control must be contacted - the physician must speak directly with the paramedic.

Then the physician and paramedic must agree on the termination of efforts. The physician must give consent for the resuscitation effort to cease.

Until the coroner releases the body, or a physician has agreed to sign the death certificate, do not remove endotracheal tubes, IV'S, etc. If for any reason, the body will not be released (i.e. it will be Coroner's case.) Do not remove any equipment.

Resuscitation of the patient should not be terminated in the back of the medical transport unit.

EACH PATIENT SHOULD BE EVALUATED ON A CASE-BY-CASE BASIS

WHEN IN DOUBT, CONTACT MEDICAL DIRECTION

ADMINISTRATION/OPERATIONS

DEAD ON ARRIVAL (DOA)

PURPOSE

EMS should not begin to resuscitate if any of the following criteria for death in the field are met for a patient who presents pulseless, apneic and with any one of the following:

- Injury incompatible with life (i.e. decapitated, burned beyond recognition).
- Cardiac arrest, secondary to massive blunt trauma without signs of exsanguinating hemorrhage.
- Signs of decomposition, rigor mortis, extreme dependent lividity.
- Adult: Unwitnessed cardiac arrest >20 minutes, history of absence of vitals signs >20 minutes with asystole on the EKG, not secondary to hypothermia or cold water drowning.
- Ohio DNR Comfort Care Order.
- Other DNR as validated by On-line Physician.

PROCEDURE

In all cases, contact with Medical Control should be immediate and well documented. Obtaining an EKG of asystole in two leads may be possible in some cases. When the On-line Physician states to do nothing, it should be documented as the pronouncement of death. **Once this is done, the police and/or Coroner's Office should assume control of the scene.**

KEY POINTS

- If a bystander or first responder has initiated CPR or AED prior to EMT-P arrival and any of the above criteria (signs of obvious death) are present, the EMT-P may discontinue CPR and ALS therapy. All other EMS personnel levels must communicate with medical control prior to discontinuation of the resuscitative efforts.
- If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue until either the Criteria for implementing Termination of Resuscitative efforts protocol have been met or Patient care responsibilities are transferred to the ED staff.
- When a DOA is encountered, EMS should avoid distributing the scene or the body as much as possible, unless it is necessary to do in order to care for other victims. Once it is determined that the victim is dead, EMS should move as rapidly as possible to transfer responsibility/management of the scene to the police.
- Pregnant patients estimated to be 20 weeks or later in gestation should have standard resuscitation initiated and rapid transport to a facility capable of providing as emergency C- section.
- Victims of lightning strike, drowning, or a mechanism of injury that suggested a non-traumatic cause for cardiac arrest should have standard resuscitation initiated.
- If a patient is pronounced at the scene, leave the ETT, IV, and other interventions in place.

- Domestic violence is physical, sexual, or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality healthcare, and preventing further abuse.
- Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of a caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and well - being of senior citizens.

PURPOSE

Assessment of an abuse case is based upon the following principles:

- **Protect** the patient from harm, as well as protecting the EMS team from harm and liability.
- **Suspect** that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the reported history.
- **Respect** the privacy of the patient and family.
- **Collect** as much information and evidence as possible and preserve physical evidence.

PROCEDURE

1. Assess the patient(s) for any psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient (s) for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. The back, chest, abdomen, genitals, arms, legs, face, and scalp are common sites for abusive injuries. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess the patient(s) for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Assess the patient(s) for signs of sexual abuse, including torn, stained, or bloody underclothing, unexplained injuries, pregnancy, or sexually transmitted diseases.
5. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, also contact the Department of Social Services (DSS). After office hours, the adult social services worker on call can be contacted by the 911 communications center.

ADMINISTRATION/OPERATIONS

DOMESTIC VIOLENCE / SEXUAL ASSAULT / RAPE / ELDER ABUSE

KEY POINTS

SEXUAL ASSAULT:

- A victim of a sexual assault has experienced an emotionally traumatic event. It is imperative to be compassionate and non-judgmental. Be sensitive to the victim. Expect a wide range of responses to such an assault, depending upon social, cultural, and religious backgrounds.
- An abbreviated assessment may be indicated based on the patient's mental state.
- Your responsibility is patient care and not detective work. Questioning of the patient should be limited as there is no need for the EMS provider to attempt to get a detailed description of the assault. That type of questioning by EMS can harm the investigation, and should be left up to professional investigators. However, carefully document verbatim anything the patient says about the attack. **DO NOT** paraphrase. Based upon the patient's mental state, the following questions may be asked and documented:
 - What happened? (A brief description is acceptable)
 - When did the attack occur?
 - Did the patient bathe or clean up after the attack?
- If the patient changed his/her clothes, attempt to bring the clothes in a brown paper bag. **DO NOT** use a plastic bag.
- If the patient did not change his/her clothes, have the patient bring a change of clothes to the hospital (if possible).
- Transport the patient to an appropriate medical facility. Some hospitals are capable of providing additional sexual assault care.

What does HIPAA stand for?

- The Health Insurance Portability and Accountability Act. Enacted in 1996, this federal law regulates health insurance and insurance benefit programs.

What is HIPAA's Privacy Rule?

- The privacy rule is a set of laws created to protect the privacy of a patient's health information, including medical records.

Why was HIPAA created?

- Before this rule was created, it was possible for patient information to be easily accessible without the patient's authorization and for reasons that had nothing to do with medical treatment. For example, a patient's medical information might be passed to a bank or lender who might deny or approve a loan requested by the patient.

Who has to follow the rule?

- The privacy rule directly relates to healthcare providers (such as ambulance services, hospitals, physicians, and home health agencies), health plans and insurance companies, and healthcare clearing houses (such as companies that bill for healthcare services).

What if you don't comply?

- The penalty for one violation is \$100, with a limit of \$25,000 per year for any single organization that fails to comply with multiple requirements. The authority to impose penalties is carried out by the Department of Health and Human Services. In cases involving grossly flagrant and intentional misuse of patient information, violators may be socked with criminal penalties up to \$250,000, ten years in jail, or both, depending on the circumstances.

What should I do at the scene?

- Exercise confidentiality on the scene.
- Do not share information with bystanders.
- Limit radio transmissions that identify patients.
- Avoid disclosure of unnecessary information to police (appropriate info includes patient's name, DOB, and destination hospital).
- Protect patient's privacy whenever possible.
- Don't volunteer patient medical information with people at the scene.

Hospital Contact and EMS

The relationship of the hospital and EMS are not really affected by HIPAA. The process of Performance Improvement is an important element of patient care that is worked on at each department under Medical Control and then the issues are addressed by the Medical Director during Run Reviews at each station. Information about the patient may be given to the Emergency Department by radio, phone, fax, or electronically. The information is needed for treatment of the patient and becomes part of the medical record.

Following the privacy policy along with common sense regarding your patient's right will assure that no HIPAA rules are violated.

Ohio law provides that a parent may drop off a newborn baby within the first 72 hours after birth at any law enforcement agency, hospital, or emergency medical service. Should this occur, the first priority is to care for the infant's health and safety. Notification should then be made to the Public Children's Services agency for that county. If possible, obtain any medical information that may be available. If it appears that the infant has suffered any type of physical harm, attempts should be made to detain the person who delivered the child.

PURPOSE

To provide:

- Protection to infants that are placed into the custody of EMS under this law
- Protection to EMS systems and personnel when confronted with this issue

PROCEDURE

1. Initiate the Pediatric Assessment Procedure.
2. Initiate other treatment protocols as appropriate.
3. Keep infant warm.
4. Contact Medical Control as soon as infant is stabilized.
5. Transport infant to medical facility as per local protocol.
6. Assure infant is secured in appropriate child restraint device for transport.
7. Document protocols, procedures, and agency notifications.

All individuals served by the EMS system will be evaluated, furnished transportation (if indicated) in the most timely and appropriate manner for each individual situation.

PURPOSE

To provide:

- Rapid emergency EMS transport when needed.
- Appropriate medical stabilization and treatment at the scene when necessary.
- Protection of patients, EMS personnel, and citizens from undue risk when possible.

PROCEDURE

1. Each situation may dictate its own procedure for the transport of obese patients.
2. It is the responsibility of EMS personnel at the scene to provide the most appropriate medical care, including the protection of the patient, EMS personnel, and bystanders, while transporting morbidly obese patients.
3. Utilization of additional resources may be required, at the discretion of the on scene EMS personnel.

KEY POINTS

Less than one percent of the population has a weight in excess of 300 lbs. This means that in any community there may be one or more individuals who fall into this extreme. As patients, these individuals are frequently classed as high risk because of the increased medical complications associated with their excess weight. In the EMS system they present the additional problem of movement and transportation. These individuals have the right to expect prompt and expert emergency medical care. Therefore, in order to facilitate the care of these individuals without risking the health of EMS workers, the following protocol is established.

- In managing a patient with weight greater than 300 lbs., at no time should the patient be moved without sufficient manpower to assist.
- At the scene, as many EMS personnel as can be mobilized may be supplemented by police or other safety personnel as appropriate. If sufficient manpower is not available, mutual aid may be required.
- It may be necessary to remove doors, walls or windows. The situation is no different than extrication from a vehicle, although property damage may be higher. At all times the patient's life must be the first priority.
- The patient is to be placed on at least 2 (double) backboards or other adequate transfer device for support.
- The patient is to be loaded on a cot that is in the down position, and the cot is to be kept in the down position at all times. Be aware of the cot weight limitations.
- It is necessary to notify the hospital well in advance of arrival so that preparations can be completed in a timely fashion.
- If individuals in the community are known to fall within this special category it is appropriate to inform them in advance of the type of assistance they can expect from the EMS system, and help them make plans well in advance to assist you.
- When calling for the squad, and if they identify themselves and their special needs, it will promote the timeliness of your efforts.
- Truly obese people often live a very private life. Please do not forget to treat these people with the same dignity and respect your other patients receive.

ADMINISTRATION/OPERATIONS

ON SCENE EMT / NURSE / PHYSICIAN INTERVENER

The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care.

PURPOSE

- To identify a chain of command to allow field personnel to adequately care for the patient.
- To assure the patient receives the maximum benefit from prehospital care
- To minimize the liability of the EMS system as well as the on-scene intervener.

PROCEDURE - PHYSICIAN

1. When a non medical-control physician offers assistance to EMS or the patient is being attended by a physician with whom they do not have an ongoing patient relationship, EMS personnel must contact On-line Medical Control and the physician must be approved by On-line Medical Control.
2. When the patient is being attended by a physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the physician if the orders conform to current EMS guidelines, and if the physician signs the PCR. Notify Medical Control at the earliest opportunity. Any deviation from local EMS protocols requires the physician to accompany the patient to the hospital.
3. EMS personnel may accept orders from the patient's physician over the phone with the approval of Medical Control. The paramedic should obtain the specific order and the physician's phone number for relay to Medical Control so that Medical Control can discuss any concerns with the physician directly.

PROCEDURE – EMT

1. Ideally, if no further assistance is needed, the offer should be declined.
2. If the intervener's assistance is required or may significantly contribute to the care of the patient, obtain proper identification and note intervener name/address/certification number on the patient care report.

ADMINISTRATION/OPERATIONS

ON SCENE EMT / NURSE / PHYSICIAN INTERVENER

KEY POINTS

EMT / Nurse / Healthcare – Intervener

On an EMS run where an unknown EMT / Nurse/ Healthcare - Intervener from outside the responding EMS agency wishes to intervene in the care of patients, the following steps should be initiated:

- Ideally, if no further assistance is needed, the offer should be declined.
- If the intervener's assistance is needed or may contribute to the care of the patient:
 - An attempt should be made to obtain proper identification of a valid license/certification. Notation of intervener name, address and certification numbers must be documented on the run report.
 - Medical control should be contacted and permission given.

On Scene Physician

This is a physician with no previous relationship to the patient who is not the patient's private physician, but is offering assistance in caring for the patient. The following criteria must be met for this physician to assume any responsibility for the care of the patient:

- Ideally, if no further assistance is needed, the offer should be declined.
- Medical Control must be informed and give approval. Encourage physician to physician contact.
- The physician must have proof they are a physician. They should be able to show you their medical license. Notation of physician name, address and certification numbers must be documented on the run report.
- The physician should have expertise in the medical field for which the patient is being treated.
- The physician must be willing to assume responsibility for the patient until relieved by another physician, usually at the emergency department.
- The physician must not require the EMT to perform any procedures or institute any treatment that would vary from protocol and/or procedure.
- If the physician is not willing or able to comply with all the above requirements, his / her assistance must be declined.

On Scene Personal Care Physician

This is a physician with a current relationship to the patient, who is offering assistance in caring for the patient. The following criteria must be met for this physician to assume further responsibility for the care of the patient:

- EMS should perform its duties as usual under the supervision of Medical Control or by protocol.
- Physician to Medical Control Physician contact is optimal.
- The physician may elect to treat the patient in his office.
- EMS should not provide any treatment under the physician's direction that varies from protocol. If asked, EMS should decline until contact is made with Medical Control.
- Once the patient has been transferred into the squad, the patient's care comes under Medical Control.

ADMINISTRATION/OPERATIONS
FIELD TERMINATION OF RESUSCITATION EFFORTS PROTOCOL

INDICATIONS

When a patient that is in cardiac arrest has failed to respond to Advanced Life Support, it may be decided to terminate the effort and not transport the patient to the hospital. When the paramedic determines that this option is appropriate, the following criteria must be met:

- a. The victims is 18 years or older
- b. The victim must be in asystole in two leads and have the absence of a pulse confirmed.
- c. The victim must not be in arrest due to hypothermia, or apparent drug overdose.
- d. The victim must have a properly placed advanced airway.
- e. The patient must have a patent intravenous access.
- f. At least three rounds of ACLS drugs have been administered.
- g. Medical control must be contacted - the physician must speak directly with the paramedic. Then the physician and paramedic must agree on the termination of efforts. The physician must give consent for the resuscitation effort to cease.

Until the coroner releases the body, or a physician has agreed to sign the death certificate, do not remove endotracheal tubes, IV'S, etc. If for any reason, the body will not be released (i.e. it will be Coroner's case.) Do not remove any equipment.

EACH PATIENT SHOULD BE EVALUATED ON A CASE-BY-CASE BASIS

WHEN IN DOUBT, CONTACT MEDICAL DIRECTION

ADMINISTRATION/OPERATIONS

Transports, Inter-Facility and Non-Hospital Patient

EMS Providers might be called upon to transport patients from one healthcare facility to another healthcare facility or a non-healthcare facility to another non-healthcare facility or a combination thereof.

Procedure

- The provider(s) will follow the written or pre-existing orders of the transferring physician unless acting as the agent of the receiving facility with superseding medical control, or if a physician accompanies the patient. Regardless of origin or destination, patients remain the responsibility of the transferring physician until received by the accepting physician or his/her agent.
- The decision regarding the level and scope of practice of the transporting agency and the individual providers should be made in consultation with the receiving physician and must be appropriate to the stability of the patient and their medical and equipment needs.
- The transfer papers and accompanying record must document the reason for the transfer as well as the time of contact and name of the receiving facility, physician, and/or accepting agent in accordance with nationally recognized standards and federal regulations.
- If unanticipated problems arise during transport, direct, on line medical control will be obtained. If for technical or logistical reasons this is not possible, the transporting agent should follow written protocols or standing orders until the transferring, receiving, or nearest diversionary facility can be contacted on-line.

KEY POINTS

Any questions or concerns regarding orders, including but not limited to Do Not Resuscitate orders, medication, or treatments must be answered or clarified prior to departure.