



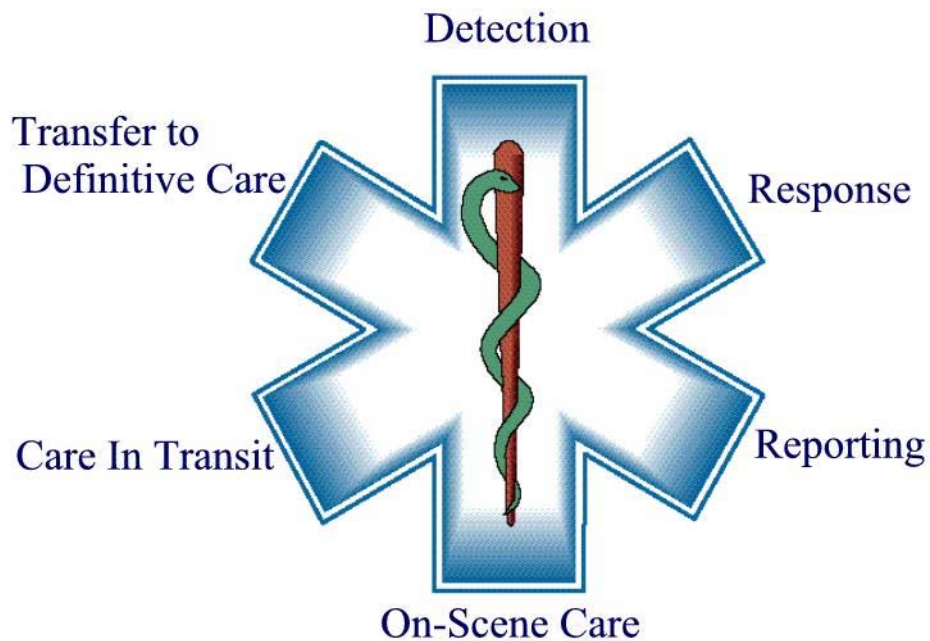
SOUTHWEST GENERAL HEALTH CENTER
Partnering with **University Hospitals Health System**

EMS Services

PRE-HOSPITAL CARE

MEDICAL CONTROL

PROTOCOLS AND PROCEDURES



OVERVIEW / MEDICAL CONTROL
EMS LEVELS OF CERTIFICATION

1

Southwest General Health Center recognizes that there is a role for all levels of Emergency Medical Technician Certification. 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 meeting these requirements. Those seeking to fulfill National Registry of Emergency Medical Technician (NREMT) requirements, may do so under their own individual responsibility.

Continuing Education must be received through an approved and accredited Continuing Education site. Each EMS Provider must maintain his / her own personal records, and be responsible for his / her own Continuing Education status. The EMS office will maintain an ongoing class / data entry for classes attended at SWGHC.

EMS Provider problems will be addressed promptly, and documented by the Medical Director in conjunction with the EMS Coordinator, Fire / EMS Chief. A plan to resolve identified problems will be implemented. The Medical Director has the right to remove an EMS Provider from actively functioning under their Medical Control, either temporarily or permanently.

OVERVIEW / MEDICAL CONTROL		
EMS RECERTIFICATION REQUIREMENTS		
EMT - Basic	EMT - Intermediate	EMT - Paramedic
40 Hours of Continuing Education in 3 years	60 Hours of Continuing Education in 3 years	105 Hours of Continuing Education in 3 years
Mandatory hours required in:	Mandatory hours required in:	Mandatory hours required in:
<ul style="list-style-type: none"> • Pediatric 6 hrs. • Geriatric 2 hrs. • Trauma 8 hrs. • Protocols 2 hrs. 	<ul style="list-style-type: none"> • Pediatric 6 hrs. • Geriatric 4 hrs. • Trauma 8 hrs. • Protocols 2 hrs. • 1 Annual Clinical Rotation 24 hrs. 	<ul style="list-style-type: none"> • Pediatric 12 hrs. • Geriatric 4 hrs. • Trauma 8 hrs. • Protocols 2 hrs. • ACLS / Cardiac 12 hrs. • 1 Annual Clinical Rotation 24 hrs.
• Optional Areas 22 hrs.	• Optional Areas 14 hrs.	• Optional Areas 43 hrs.

**70% of all continuing education through Southwest General Health Center

**One 8 hour annual clinical rotation required at one of the four Southwest Clinical Sites

**The state requires all continuing education through an accredited training center only (all certificates must have the site accreditation number, date, participant name & hours)

**For those of you who maintain National Registry, remember the cycle is every 2 years and the hours of CE are higher.

OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

This document offers an “at-a-glance” view of the Ohio Division of EMS Scope of Practice. The complete scope of practice can be found in the Ohio Revised Code 4765.35, 4765.37, 4765.38, and 4765.39.

The individual Medical Director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. It must be remembered that this is a foundation and baseline protocol. Each EMS Community tailored and revised this protocol to fit their region and individual practice, with careful attention to remaining within the 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 on activities that are permitted.

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, the pre-hospital setting, should deal with medical devices and medicine administrations that are outside their scope of practice.

Updated November 19, 2003, Approved by EMS Board, February 2004

Updated May 17, 2005, Approved by EMS Board, May 18, 2005

Updated October 26, 2005, Approved by EMS Board, July 20, 2005

Updated October 26, 2005

OVERVIEW / PROCEDURES / MEDICAL CONTROL

OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

OHIO PUBLIC SAFETY – Division of EMS

	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 O ₂ powered device	X	X	X	X
11	Orotracheal intubation				
	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 management				X
19	C-PAP administration and management		X	X	X
20	End Tidal CO ₂ Monitoring and Detection		X	X	X
21	Nasogastric (NG) tube placement (4/16/08)				X
22	Orogastric (OG) tube placement (4/16/08)				X

OVERVIEW / PROCEDURES / MEDICAL CONTROL

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	X	X
10	12-lead EKG set –up and application for electronic transmission (4/16/08)				
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: 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	Nitroglycerin administration (pt. assisted)		X	X	X
8	Nitroglycerine administration (non- pt. assisted)			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 on-line 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 – if EMT-Paramedic or EMT-Intermediate is not present, procedure(s) shall not be completed.					
**Set-up of equipment only – if EMT-Paramedic is not present, procedure(s) shall not be completed.					

OVERVIEW / PROCEDURES / MEDICAL CONTROL

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	BSI precaution / administration	X	X	X	X
2	Taking and recording 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)			O	X
	***See page 7 for complete Intermediate listing				
2	IV lifetime and fluid administration (does not include blood or blood products)			X	X
3	Intraosseous infusion			X	X
4	Saline lock initiation				X
5	IV infusion pump				X
	<p>Additional Services: 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> <p>Nerve Agent or Organophosphate Release: 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>				

OHIO PUBLIC SAFETY SCOPE OF PRACTICE STANDARDS

Approved EMT-Intermediate Medications					
Epinephrine 1:1000 (subcutaneous injection)					
Sublingual nitroglycerin					
Dextrose 50% in water (adult patients)					
Dextrose 25% in water (pediatric patients)					
Diphenhydramine					
Benzodiazepines (4/16/08)					
Lorazepam					
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.

EMS COMMUNICATIONS

A member of the pre-hospital care team must contact Medical Control at the earliest time conducive to good patient care. This may be a brief early notification or “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 accurate, updated report of the patient’s presentation and condition throughout pre-hospital 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, skull fracture)
- *Vital Signs:* BP / Pulse / Resp. / LOC / EKG
- *Patient Care:* Airway Management, Circulatory Support, Drug Therapy
- *General Impression:* Stable / Unstable
- *Destination ETA*

General Considerations

- 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 and 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.
Medical Control will notify receiving hospitals.

EMS DOCUMENTATION

- An EMS patient care report will be completed accurately and legibly to reflect the patient assessment, patient care and interactions 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.

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

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

General Considerations

- 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. It is very important to document the mental status of the patient who refuses transport.
- The times vitals are taken must be noted. Vitals should be repeated every five minutes, 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 BP due to clothing" is clear, "unable" written under the BP 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.
- All reports should reflect reassessment following interventions and care.
- All reports should state where and who assumed patient care with EMS completed.

Documentation of Vital Signs:

1. An initial complete set of vital signs includes:
 - Pulse rate AND Respiratory rate
 - Systolic AND diastolic blood pressure
 - Pain / severity (when appropriate to patient complaint)
2. When no ALS treatment is provided, palpated blood pressures are acceptable for repeat vital signs.
3. If the patient refuses this evaluation, the patient's mental status and the reason for refusal of evaluation must be documented, along with an offer to return and transport.
4. Document situations that preclude the evaluation of a complete set of vital signs.
5. Record the time vital signs were obtained.
6. Any abnormal vital sign should be repeated and monitored closely.
7. All completed run reports should contain a summary statement regarding patient status upon transfer of care.

EMS DOCUMENTATION**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.

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.

1) DNR Comfort Care –

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 in the DNR Comfort Care form. **Only the patient may request reversal of the DNR Comfort Care.**

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

2)DNR Comfort Care – Arrest – All life saving measures continue until a cardiac/respiratory arrest occurs at that point all efforts cease.

- The DNR order addresses your current state of health and the kind of medical treatment you and your physician decide is appropriate under current circumstances. If a patient is found in an suspicious or unrelated accident, follow standard protocols.
- A DNR order for a patient of a health care facility shall be considered current in accordance with the facility's policy. A DNR order for a patient outside a health care 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 health care 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 or friend, health care worker who knows the patient, ID band from health care institution, driver's license or other picture I.D. If identification cannot be verified, the protocol should be followed.
- 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 of 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 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.
- Your Living Will document specifies in advance the kind of medical treatment you would want if and when you have a terminal illness or are in a permanently unconscious state and are no longer able to state your own wishes. It may not protect you from receiving CPR or other heroics. It *only* takes effect if you are in a certifiably terminal or permanently unconscious state, and emergency squad personnel cannot determine if you meet these conditions.
- 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 your health status and make hard decisions for you whenever you are unable to do so yourself. It is not a DNR order, though it ordinarily would permit the person you appoint to agree to a DNR order for you, if you are unable to express your wishes at the time.
- The General Power of Attorney usually does not address health care issues and ends if you become disabled. You may have given your General Power of Attorney to someone to manage your 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 is *durable*, or continuing, power of attorney. A health care power of attorney is a *durable* power; it continues even after you become disabled and appoints someone to carry out your health care wishes.

AEROMEDICAL TRANSPORT**PURPOSE**

- Provide life-saving treatment by improving patient care in the pre-hospital setting.
- Allow for expedient transport in serious, mass casualty setting.

GENERAL CONSIDERATIONS

Control of a medical emergency scene should be the responsibility of the EMS Provider who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport. When an EMS unit is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction for the EMS unit. Where on-line medical direction exists, treatment and transport of the patient are the ultimate responsibility of the on-line physician. Where on-line medical direction does not exist, treatment and transport of the patient is the ultimate responsibility of the off-line physician or physician committee.

Activation of an EMS air ambulance is a **MEDICAL CONTROL** and **PRE-HOSPITAL FIELD DECISION**. A request for an air ambulance should be made by adequately trained pre-hospital care providers (either BLS or ALS). Medical direction is to be notified of the need to utilize an air ambulance as soon as possible for the purpose of obtaining orders for patient care and disposition pending the arrival of the aeromedical team.

The following circumstances would lend themselves well to helicopter evacuation.

1. Suspected serious trauma with any of the following conditions to a patient who will require an extrication time of longer than 15-20 minutes: Unsecured airway, unconsciousness Hypotension with Tachycardia, unable to obtain venous access.
2. Serious injury or illness in a patient who is not easily accessible to land vehicles, but where an adequate clearing for helicopter landing is nearby
3. Scene of numerous seriously-injured patients
4. Pediatric patients with severe life threatening injuries to Pediatric Trauma Center

PROCEDURES FOR SUMMONING AEROMEDICAL TRANSPORT

- A. Assess patient and/or scene
- B. Institute appropriate treatment and/or extrication (follow Trauma or Medical Protocols)
- C. **CONTACT MEDICAL CONTROL AS SOON AS POSSIBLE**
- D. Contact appropriate Aeromedical Transport

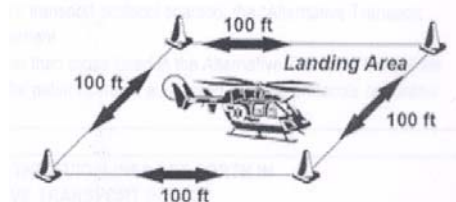
EMS UNIT AND THE AEROMEDICAL TEAM ARE PRESENT ON SCENE

- A. Until the patient becomes the full responsibility of the flight physician, the on-line physician is responsible. If there is any disagreement between the flight physician and the on-line physician, the EMS personnel must only take orders from the on-line physician and place the flight physician in radio or telephone contact with the on-line physician.
- B. Once care of the patient is turned over to the aeromedical team, patient care responsibility rests with the flight physician.
- C. The receiving hospital should be determined in consultation between the on-line physician and the flight physician.

- 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.
- 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.
- The helicopter physician shall use his/her best judgement, at the suggestion of On-Line Medical Direction, and/or prior guidelines agreed to with Off-Line Medical Direction to determine the destination hospital.
- 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.).

AEROMEDICAL LANDING ZONE (LZ) SET UP PROCEDURE

1. LZ should be free of obstruction. Eliminate these hazards:
 - Wires (surrounding the landing area and High Tension power lines within ½ mile)
 - Towers (TV, Radio, Cellular with ½ mile)
 - Trees
 - Signs and Poles
 - Buildings
 - Vehicles
 - People
2. LZ should be 100' X 100' if possible.
3. LZ should have as little of a slope as possible (less than 5 degrees)
4. LZ area should be a hard surface (concrete, asphalt, gravel, lawns, etc.)
5. LZ corners should be marked with highly visible devices (cones, flairs, strobes).
6. No debris on landing surface within 100' of landing area
7. Land the helicopter(s) a safe distance from the scene/patient.
8. Never point bright lights directly at the aircraft.
9. Maintain security of LZ while helicopter is present.
10. Landing Zone Briefing
11. Type of LZ surface and size
12. How LZ is marked (cones, flairs, strobes, etc.)
13. All noted obstructions (see list above)



**NEVER ASSUME FLIGHT CREW WILL SEE A HAZARD
NEVER APPROACH HELICOPTER UNLESS DIRECTED BY FLIGHT CREW**

CHILD ABUSE / NEGLECT

Child abuse is the 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 excessively 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 especially 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 both the receiving hospital (if transported). Law Enforcement must also be notified. 216-696-KIDS hot line is also to 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.

- 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 situation using established protocols.
- If possible, remove child from scene, transporting to hospital even if there is no medical reason for transport.
- If parents refuse permission to transport, notify law enforcement for appropriate disposition. If a patient is in immediate danger, let law enforcement handle scene.
- Advise parents to go to hospital. **AVOID ACCUSATIONS** as this may delay transport. Adult with 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 may 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 may 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

CONCEALED WEAPONS GUIDELINE

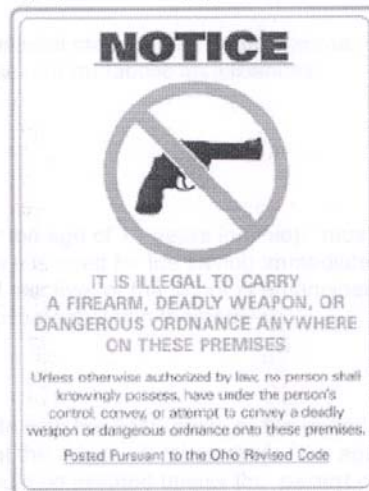
While the possibility of finding a dangerous weapon on-scene has always existed, EMS personnel must be aware of current issues, which impose unique hazards upon them while performing their duties. These dangers present in many different ways, regardless of jurisdiction or call volume. Though not all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

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 8, 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.
- The training of EMS Personnel in the safe handling and use of firearms lock boxes in squads is a departmental and municipal decision.
- 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



CONSENT AND REFUSAL OF CARE GUIDELINES**PURPOSE**

To provide:

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

PROCEDURES – ADULT**Consent:**

Two types apply: **Express Consent**, when a conscious, oriented, (to person, place and time) competent adult (over 18 year old), gives the EMS Provider permission to care for him. 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 their permission for treatment due to being unconscious or incompetent. It is assumed that their permission would be given for any life saving treatments.

Refusal of Treatment:

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 and time, 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 there is any question about the person's competency. 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.

PROCEDURES – MINORS

Consent to treat Minors, (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; or the Minor is

emancipated; ie: married, living on their own, or in the armed forces and may give permission themselves.

CONSENT AND REFUSAL OF CARE GUIDELINES con't.
--

18

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** refuse 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. 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. A request may be made that the person come to the fire station as soon as possible, to sign the release. 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 refuses to give consent where child abuse is suspected.
- Suicidal patient – any age.

In all such cases, contact with Medical Control and a Physician is necessary, as the patient may have a life-threatening problem and is 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 Ohio Revised Code, Section 5122.10.

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:

- Decapitation
- Massive crush injury of the head, chest, or abdomen
- Gross decomposition
- Gross rigor mortis
- Gross incineration
- Severe blunt trauma
- 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 should assume control of the scene, and EMS may go back into service.**

General Considerations

- If a patient is in complete cardiopulmonary arrest (clinically dead) and meets one or more of the criteria below, CPR and ALS therapy need not be initiated:
 - Gross decomposition
 - Gross rigor mortis without hypothermia
 - Gross incineration
 - Dependent lividity
 - Severe blunt force trauma
 - Injury not compatible with life (i.e., decapitation, burned beyond recognition, massive open or penetrating trauma to head or chest with obvious organ destruction.)
 - Extended downtime with Asystole on the EKG
- If a bystander or first responder has initiated CPR or automated defibrillation prior to an EMS Paramedic's arrival and any of the above criteria (signs of obvious death) are present, the paramedic 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 resuscitation efforts until either:
 - Resuscitation efforts meet the criteria for implementing the Termination of Resuscitative Efforts Protocol, if valid in the EMS jurisdiction.
 - Patient care responsibilities are transferred to the destination hospital staff.
 - When a Dead on Arrival (DOA) patient is encountered, the squad members should avoid disturbing the scene or the body as much as possible, unless it is necessary to do so in order to care for and assist other victims. Once it is determined that the victim is in fact dead, the squad members should move as rapidly as possible to transfer responsibility or management of the scene to the Police Department.
 - 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 an emergent C-section. Paramedics CANNOT perform a C-section even with Med Command permission.
 - Victims of lightning strike, drowning, or a mechanism of injury that suggested non-traumatic cause for cardiac arrest should have standard resuscitation initiated.
 - If the patient is pronounced on scene, leave the ETT, IV, and other interventions in place.

GUIDELINES / PROCEDURES / MEDICAL CONTROL

DOMESTIC VIOLENCE / SEXUAL ASSAULT / RAPE / ELDER ABUSE

- 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 health care, and preventing future 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 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 / all 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 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 all patients 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 all patients for signs of sexual abuse, including torn, stained, or bloody underclothing, unexplained injuries, pregnancy, or sexually transmitted diseases.

Domestic Violence / Sexual Assault / Rape / Elder Abuse con't.

21

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 (DDS). After office hours, the adult social services worker on call can be contacted by the 911 communications center.
6. Notify SWGHC Gatekeeper Program if unsafe, unclean living conditions are found.

General Considerations

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 response to such an assault, depending upon social, cultural, and religious background.
- 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, because 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: (do not persist with questions.)
 - 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).
- Notify SWGHC Gatekeeper Program if unsafe, unclean living conditions are found.

GUIDELINES / PROCEDURES / MEDICAL CONTROL

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

22

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 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 \$25,000, ten years in jail, or both—depending on the circumstances.

What should I do at the scene?

- Exercise confidentiality on the scene by:
 - Not sharing information with bystanders.
 - Limiting radio transmissions that identify patients.
 - Avoid disclosure of unnecessary information to police (appropriate info includes patient’s name, DOB, and destination hospital.)
 - Protecting 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.

GUIDELINES / PROCEDURES / MEDICAL CONTROL
NEWBORN ABANDONMENT

Ohio law provides that a parent may drop-off a newborn baby within the first 72 hours at any law enforcement agency, hospital, or emergency medical services. 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 of 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.

POLICIES / PROCEDURES / MEDICAL CONTROL
OBESE PATIENTS

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 morbidly obese patients.
2. It is the responsibility of EMS personnel at the scene to provide the most appropriate medical care, including protection to 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.

General Considerations

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 over 300 lbs., at no time should the patient be moved without at least 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 loaded 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.

POLICIES / PROCEDURES / MEDICAL CONTROL

ON-SCENE EMT / NURSE / PHYSICIAN INTERVENER

The medical direction of pre-hospital 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 pre-hospital care.
- To minimize the liability of the EMS System as well as the on-scene physician.

PROCEDURE

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 review the On-Scene Physician form with the physician. All requisite documentation must be verified 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 Patient Care Report. 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.

General Considerations
<p><u>EMT/Nurse/Healthcare-Intervener:</u></p> <p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 EMT / Nurse / Physician Intervener Con’t.	26
---	-----------

General Considerations
<p><u>On-Scene Physician:</u></p> <p>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:</p> <ul style="list-style-type: none"> • Ideally, if no further assistance is needed, 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 ED Physician may elect to treat the patient in his office.
- Physician to ED 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.

POLICIES / PROCEDURES / MEDICAL CONTROL

TERMINATION OF RESUSCITATIVE EFFORTS

Under the auspices of each EMS jurisdiction and the Medical Director, termination of resuscitative efforts may apply.

PURPOSE

Southwest General Health Center / EMS Services
 Revised 03/2007, 06/2007, 10/2008

The purpose of this policy is to:

- Allow for discontinuation of pre-hospital resuscitation after delivery of adequate and appropriate ALS therapy.

PROCEDURE

1. Discontinuation of CPR and ALS intervention may be implemented prior to contact with Medical Control if ALL of the following criteria have been met:
 - The victim must be 18 years of age or older.
 - The victim must be in asystole and have the absence of a pulse and vital signs confirmed.
 - Adequate CPR has been administered.
 - The victim must have a properly placed endotracheal tube, esophageal combitube placement, or needle cricothyrotomy.
 - The patient must have a patent intravenous access.
 - The victim must not be in arrest due to hypothermia, or apparent drug overdose.
 - At least two rounds of ACLS drugs/and subsequent procedures have been administered without return of spontaneous circulation (palpable pulse).
 - All EMS Paramedic personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate.
 - If all of the above criteria are not met and discontinuation of pre-hospital resuscitation is desired, contact Medical Control. Medical Control must be contacted and the physician must speak directly with the paramedic and must give consent for the resuscitation effort to cease.
 - Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement and Medical Control on EMS Patient Care Report.

Patients found in cardiac arrest from trauma, medical, environmental insult, or hypothermia who present as follows:

Trauma Arrest Patients:

- Trauma patients should be rapidly assessed for signs of life. If the patient is apneic and pulseless but has organized ECG activity, and has a down time less than 20 minutes (less than 10 minutes for blunt trauma) then they should be treated and transported to the nearest appropriate facility. Otherwise resuscitation efforts should be withheld.
- Resuscitative efforts should be withheld if a trauma arrest patient has signs of irreversible death:
 - Decapitation
 - Rigor mortis
 - Decomposition
 - Injuries incompatible with life
 - 90% surface burns with other trauma

Medical Patients:

- Medical patients should be rapidly assessed for signs of life
- Resuscitative efforts should be withheld if a medical arrest patient
 - If the patient did **NOT** have a return of spontaneous pulse or respiration's after 20 minutes of CPR, ACLS, successful ETT with confirmation by a secondary device, minimum of two rounds of medications, and all reversible causes have been identified.
 - Continuous asystole for at least 10 minutes in the adult patient, and 30 minutes in pediatric patients after CPR and successful airway management and a minimum of two rounds of medications, and no reversible causes identified.
 - Initial rhythm is asystole and signs of rigor mortis, or lividity are present.
- A valid DNR directive is present with the patient.
- Rigor mortis
- Decomposition

Drowning Patients: field resuscitation efforts should be withheld if:

- Patient has been submersed in water for more than 60 minutes and is **NOT** hypothermic.
- Any obvious lethal injury is present.

Hypothermia Patients:

- Known prolonged hypothermia and obvious signs of death such as lividity, rigor mortis and asystole.

HAZMAT INCIDENT

EMERGENCY CARE FOR HAZARDOUS MATERIALS EXPOSURE, 2nd Edition and the **DOT GUIDEBOOK & MSDS** are the recommended reference guides.

GENERAL CONSIDERATIONS

- A. **SCENE SAFETY** – rescuer safety is the number one priority. Once chemical contamination is suspected, rescuers will remain a safe distance to assess risk and plan rescue activities.

Delay rescue attempts until chemical risk is identified and adequately trained personnel with proper PPE are available (Fire Departments and/or HazMat Units).

B. **OBJECTIVES IN PATIENT CARE**

1. Terminate exposure
2. Prevent further injury
3. Prompt and effective patient treatment
4. Early notification to receiving hospital with all chemical information available:
 - description of the incident
 - chemical name (spell it and have it spelled back to you.)
 - manufacturer
 - signs and symptoms
 - nature of injuries
 - extent of field decontamination

C. **HEALTH AND SAFETY ISSUES**

1. Prevent spread of contamination
2. Prevent injury or exposure to responders

DECONTAMINATION – occurs in warm zone by properly trained and equipped personnel.

PATIENT TREATMENT – no medical intervention is to be performed until the exposed patient has been decontaminated and NO TRANSPORT of a contaminated patient will occur if the possibility of secondary contamination exists. EMS personnel should not enter the “HOT” or “WARM” zones, but wait to receive the decontaminated patient(s) and initiate pre-hospital care.

CONTACT WITH MEDICAL CONTROL MUST BE ESTABLISHED PRIOR TO ADVANCED PRE-HOSPITAL CARE (i.e., IV's or administration of medications).

Actual treatment modalities – see Hazmat Protocols in the adult section of this document.

START TRIAGE SYSTEM FOR MASS CASUALTY INCIDENTS (MCI's)

START SYSTEM OF TRIAGE

1. INTRODUCTION

- A. Use the Simple Triage And Rapid Transport (START) method of triage to assess a large number of victims rapidly. It can be used easily and effectively by all EMS personnel. However, there are limitations to START (see section 4.12.A below)

2. PROCEDURE

- A. Initial Triage (using the START method).
- 1) Utilize {Triage Ribbons [color-coded strips]}. One should be tied to an upper extremity in a **VISIBLE** location (wrist if possible, preferably on the right.)
 - a) **RED** – Immediate
 - b) **YELLOW** – Delayed
 - c) **GREEN** – Ambulatory (minor)
 - d) **BLACK** – Deceased (non-salvageable)
 - 2) Independent decisions should be made for each victim. Do not base triage decisions on the perception that too many REDs, not enough GREENs, etc.
 - 3) If borderline decisions are encountered, always triage to the most urgent priority (e.g., GREEN/YELLOW patient, tag YELLOW). Move as quickly as possible!
- B. Secondary Triage
- 1) Will be performed on all victims in the Treatment Area.
 - 2) Utilize the Triage Tags (METTAGs or START tags) and attempt to assess for and complete all information required on the tag (as time permits). Affix the tag to the victim and remove ribbon. This is done after patients enter the Treatment Area, not at the initial triage site!
 - 3) The triage priority determined **in the Treatment Area** should be the priority used for transport.

3. START

- A. Locate and remove all of the walking wounded into one location away from the incident, if possible. Assign someone to keep them together (e.g., PD, FD, or initially a bystander) and notify **COMMAND** of their location. Do not forget these victims. Someone should re-triage them as soon as possible.
- B. Begin assessing all non-ambulatory victims where they lie, if possible. Each victim should be triaged in 60 seconds or less, preferably much less. **NOTE: Remember to mnemonic RPM (Respiration's, Perfusion, Mental Status).**
- 1) Assess **RESPIRATION'S**:
 - a) If respiratory rate is 30/min. or less go to **PERFUSION** assessment.
 - b) If respiratory rate is over 30/min., tag **RED**.

- c) If victim is not breathing, open airway, remove obstructions if seen, and assess for (a) or (b) above.
- d) If victim is still not breathing, tag **BLACK**. (Depending on circumstances, you may attempt three rapid respirations before triage to **BLACK**).
- 2) Assess **PERFUSION**:
 - a) Performed by palpating a radial pulse or assessing capillary refill (CR) time.
 - b) If radial pulse is present or CR is two seconds or less, go to **MENTAL STATUS** assessment.
 - c) No radial pulse or CR is greater than two seconds, tag **RED**.
NOTE: In addition, any major external bleeding should also be controlled.
- 3) Assess **MENTAL STATUS**:
 - a) Assess the victim's ability to follow simple commands and their orientation to time, place and person.
 - b) If the victim follows commands and is oriented x3, tag **GREEN**.
NOTE: Depending on injuries (e.g., burns, fractures, bleeding), it may be necessary to tag **YELLOW**.
 - c) If the victim does not follow commands, is unconscious, or is disoriented, tag **RED**.
- 4. **SPECIAL CONSIDERATIONS**
 - A. The **first** assessment that produces a **RED** tag, stops further assessment.
 - B. Only correction of life-threatening problems (e.g., airway obstruction or severe hemorrhage) should be managed during triage.
 - C. To help speed the process, departments should consider utilizing colored (**RED, YELLOW, GREEN, BLACK**) {Ribbons} to initially mark patient categories. Triage Tags are then attached and filled out once the patient reaches the Treatment Area.
 - D. When using Triage Tags, if the patient's condition or the triage priority changes, the bottom portion of the tag should be removed, leaving only the injury information. Add a new tag to identify the new triage priority, and if the time permits, the reason for the change.

RPM: 30, 2, Can Do!

R: Respiration's – 30

P: Perfusion – 2

M: Mental Status – Can Do

DRUG BOX EXCHANGE

PURPOSE: Reduce the risk of medication errors

PROCEDURE

1. Paramedic drug boxes will be purchased by EMS Services.
2. Drugs contained within Southwest General Health Center Pre-hospital protocols will be contained in the paramedic drug boxes.
3. The Pharmacy will stock and restock all drug boxes as they are returned.
4. The Pharmacist restocking the drug box will seal each drug box with a plastic lock.
5. Filled drug boxes will be stored under lock in the Emergency Department in the EMS Supply Room.
6. Additional drug boxes will be stored in the Pharmacy.
7. Filled drug boxes in the fire departments will be stored under lock.
8. The expiration date will be displayed on the front of the drug box. The expiration date denotes the earliest date drugs in the box will expire.
9. Use of one or more drugs in the drug box is reason for exchange.
10. Medics will exchange drug boxes in the EMS Supply Room in the Emergency Department. Used drug boxes will be sealed with the blue numbered lock provided, and, placed in the drug locker and locked. The drug box number and the blue seal number will be recorded on the run sheet.
11. Each drug box has a separate page in the log. The drug box number is located in the upper right hand corner (see attached form).
12. The medic is responsible for recording drug box number, department signing out the drug box, shift, and medic's name, lock number, date out, date in (see attached form).
13. The medic in his normal activity fills out a patient report. A copy of the patient report will be placed in the drug box. This is for Pharmacy information and billing purposes. This copy will be placed into the drug box on all patients who have received medications, whether or not the patient was transported to Southwest General Health Center.
14. The Pharmacy will forward the EMS copy to the EMS Office as soon as they have retrieved the necessary patient information.

MORPHINE / VALIUM KIT

PURPOSE: To facilitate the distribution of morphine and valium within the paramedic drug box exchange system.

MORPHINE / VALIUM KIT

The Southwest General Health Center Morphine Kits contents:

- 5 x 2 mg / mL morphine sulfate tubexes
- 1 tubex holder
- 1 Valium, (diazepam) 10 mg / 2 mL vial
- 1 Injectable Controlled Substance Disposition and Requisition Record

The injectable Controlled Substance Disposition and Requisition Record is a form used to document the administration of narcotics.

When morphine tubexes are used, the Injectable Controlled Substance Disposition and Requisition Record should be completed with the following information:

1. Time
 2. Patient's name
 3. Room (Squads initials)
 4. Physician
 5. Dose (i.e., 4 mg. 6 mg.)
 6. Under "morphine 2 mg Tubex" column fill in number of tubex used (i.e., 2, 3)
 7. Signature of individual administering medication/witnessing waste
- All morphine / valium kits shall be returned with the paramedic drug box to the Emergency Department.
 - The opened paramedic drug boxes with the morphine/valium kits shall be locked in the drug locker in the EMS Supply Room in the Emergency locked cupboard is in the EMS Supply Room.
 - Used morphine tubexes will be placed into the sharps container. Two paramedics and/or a paramedic and registered nurse can witness the wasting of unused morphine / valium. Each must sign and date the form.

CONTROLLED SUBSTANCE REPORT

Form is contained within the Morphine Kit / Valium in the Drug Box.

**PARAMEDIC DISPOSITION RECORD FOR:
MORPHINE & VALIUM**

Box # _____ Date: _____

Patient Name: _____

DRUG	# mg used	Time	Signature

Wastage (requires 2 signatures): _____ mg of **MORPHINE/VALIUM**
(Circle appropriate drug)

(Signature of witness) (Signature of witness)

Total mg of **MORPHINE** used/wasted: _____ mg

Number of unused syringes/vials returned: **MORPHINE: 0 1 2 3 4 5**
VALIUM: 0 1
(Circle appropriate number) (Circle appropriate number)

(Circle appropriate number)

Pharmacy information to be filled out after paramedics have completed the top portion of this sheet:

MORPHINE
2 mg syringe replacement information:
Date filled: _____
Number of MORPHINE 2mg syringes added to box to make a total of 5: _____

VALIUM
10 mg syringe replacement information:
Date filled: _____
Number of VALIUM 10mg vials added to box to make a total of 1: _____

PHARMACIST SIGNATURE: _____

INCLUDE 1 CARPUJECT INJECTOR!
File this sheet with Controlled Substance Records

EQUIPMENT EXCHANGE

PURPOSE: To insure rescue vehicles are adequately equipped to respond to an Emergency after transporting a patient to Southwest General Health Center.

1. Equipment used on patients during transport to Southwest General Health Center will be resupplied to the rescue department (e.g., ET, IV's, dressings, tape, etc.).
2. The equipment will be exchanged on a one-for-one basis.
3. The equipment will be stored in the EMS Supply Room.
4. The Health Center will keep appropriate inventory. All EMT's will restock from the EMS Supply Room.
5. If an exchange article is missing from the EMS Supply Room, the EMT will notify the EMS Secretary or the EMS Coordinator.
6. EMS equipment left at the Health Center for patient care will be cleaned by Central Sterile Supply (CSS).
7. Cleaned equipment will be stored in a safe place for retrieval.
8. EMS personnel will retrieve their equipment as soon as possible after notification that the equipment has been cleaned.
9. Special purchase equipment will be kept under lock and key in the EMS Supply Room. This equipment includes: Quick combi-pads (adult and pediatrics), glucometer test strips, save-a-tooth, disposable laryngoscope blades, Asherman Chest seals, Pediatric Styletts, Pediatric and Neonate Ambu bags, and other expensive items. These are charge items.
10. Do not remove stock or equipment from the Emergency Department patient areas. These rooms are stocked for emergencies and require correct equipment.

CLEANING OF EQUIPMENT

PURPOSE: To provide cleaning of rescue equipment by Central Sterile Supply (CSS).

1. Rescue personnel will be responsible for the labeling of all their equipment.
2. Rescue personnel will discard all disposable components into the appropriate containers.
3. Rescue personnel will discard linen into the hampers.
4. Rescue personnel will discard disposable needles and sharps into the appropriate sharps containers.
5. Items to be cleaned will be placed into a red biohazard bag that is secured with a twist tie.
6. Items to be cleaned will be left in the utility room in the Emergency Department.
7. The Emergency Department staff will do steps 2 through 6 if the equipment was left on the patient when the rescue squad left the Emergency Department.
8. Backboards will be cleaned in CSS. Cleaned backboards will be stored in the locked cabinet located in the Emergency Department. Please retrieve on a timely basis.

QUALITY IMPROVEMENT

PURPOSE: The responsibility for quality Emergency Medical System Care is provided by Emergency Medical Technicians Paramedics (EMTP), Emergency Medical Technicians Intermediates (EMTI), and Emergency Medical Technicians Basic (EMTB) as specified by chapter 47 of the ORC.

PHILOSOPHY

The EMERGENCY MEDICAL SYSTEM CARE services under the Medical Direction of SWGHC will provide quality care consistent with professionally recognized standards. Quality assessment activities involve establishing, maintaining, and documenting mechanisms that demonstrate nonpunitive evaluation and correction of identified concerns.

OBJECTIVES

- A. Enhance patient care through continued assessment.
- B. Provide for monitoring of established protocols.
- C. Provide for the correction of identified concerns.
- D. Conduct selective Emergency Medical System Care Q.I. in conjunction with the Health Center and/or medical staff Q.I. process.
- E. Resolve interdepartmental issues through active communications.

PROCESS

The Medical Director and members of the EMS Q.I. Committee and other appropriate personnel will identify areas of concern through:

- A. Review of patient care as specified by the protocols
- B. Tracking of unusual occurrences
- C. Review of volume and quality indicators as developed by the Q.I. process of the Medical Staff, Health Center, and EMS Q.I. Committees
- D. Patient/ Family surveys
- E. Review of minutes from meetings and conferences
- F. Request from EMS personnel, Health Center personnel and/or physicians
- G. Patient Care follow-up and physician evaluation in the Emergency Department
- H. Documentation followed by appropriate corrective intervention

ANNUAL REVIEW

Emergency Medical System Care Quality Improvement action plans will be reviewed annually for outcomes. A report will be prepared summarizing:

- 1. Relevant findings
- 2. Action taken
- 3. Impact on improved patient care

CONFIDENTIALITY

All Quality Improvement data gathered, analyzed, and trended with respect to EMERGENCY MEDICAL SYSTEM CARE is confidential. Quality Improvement and

peer review is secure and not amenable to the laws of discovery as elaborated in ORC.
SEC 2305.251

QUALITY IMPROVEMENT

PURPOSE: To gather pertinent data in order to coordinate efforts to reach the goal of delivering Emergency Medical Care that is consistently of high quality and uniformly appropriate.

1. The Medical Director will be responsible for the overall Quality Improvement Program.
2. The Fire Chief will assign a member or members of his department to review all patient encounters (i.e., transported, non-transported, refusal of care and/or transported to another facility).
3. The EMS Advisory Board of SWGHC under the direction of the Medical Director will identify important aspects of care.
4. The EMS Advisory Board will list specifics known as indicators to monitor for appropriateness of that care.
5. The Fire Department reviewer will monitor for the indicators specified.
6. The indicators will be published for all EMS personnel prior to the monitoring.
7. The EMS Coordinator will be responsible for generating a quarterly report that will state the overall number of charts reviewed, list all the indicators specified, list the number of indicators complied with, and the number of indicators omitted and report to S.A.F.E.S. Medical Director, EMS Quality Improvement Board, EMS Advisory Board, and the Health Center Risk Manager.
8. The EMS Coordinator will list all exceptions or justifications stated.
9. The EMS Coordinator will include in the quarterly report the relevant findings.
10. The EMS Coordinator will present the information to the Medical Director, EMS Quality Improvement Board, and the EMS Advisory Board of Southwest General Health Center for appropriate actions and/or to resolve concerns.

INTERNAL AWARENESS FORM (IAF)

PURPOSE: The Internal Awareness Form is an extension of Southwest General Health Center EMS Quality Improvement Plan and is designed to increase the level of communication between all levels of EMS, Health Center personnel, and Medical Staff.

1. The Internal Awareness Form (IAF) should be used any time EMS and/or health center personnel wish to communicate an occurrence to the Southwest General Health Center EMS System.
2. The Internal Awareness Form shall be completed by the individual identifying the occurrence and delivered to the EMS Coordinator. The Internal Awareness Form is not to be copied.
3. The EMS coordinator will:
 - a. investigate and address the issue and place the resolution / disposition in writing
 - b. follow-up actions may include:
 - discussion of the reported issue with the appropriate Health Center personnel, or
 - discussion with the Medical Director, or
 - discussion with Health Center Administration
4. The EMS Coordinator will maintain an IAF file and documentation of trends for report to the EMS and Health Center Q. I. Committees.

INTERNAL AWARENESS FORM (IAF)

Date / Time: _____

Reported by: _____ Title: _____

Department: _____ Shift: _____

Regarding: Patient Nurse Fire Personnel Physician Other

Name of Patient: _____ Phone No: _____

**THIS IS AN
INTERNAL
FORM ONLY**

STATEMENT OF EVENT: _____

EMS COORDINATOR FOLLOW-UP ACTION / SOLUTION:

SIGNATURE: _____ Date: _____

ISSUE IS: _____

RESOLVED _____ FYI _____

UNRESOLVED: Forward for ED Head Nurse Review / Date: _____

UNRESOLVED: Forward for Critical Care Dir. Review / Date: _____

UNRESOLVED: Forward for Medical Director Review / Date: _____

UNRESOLVED: Forward for Fire Chief Review / Date: _____

UNRESOLVED: Forward to / Date: _____

THIS FORM CANNOT BE DUPLICATED

*Confidential Quality Assessment and Peer Review Document
Ohio Revised Code Sec. 2305-251 For Use In SWGHC Only*

OFFER OF ASSISTANCE CARD

ATTENTION

Thank you for your offer of assistance. Be advised that these EMT Paramedics (EMTP), EMT Intermediates (EMTI) and/or EMT Basics (EMTB) are operating under the authority of the Ohio State Law and medical protocols established by Southwest General Health Center (SWGHC).

No On-Scene EMT / Nurse / Physician or other Intervener may intercede in patient care without the Emergency Physician on duty at SWGHC relinquishing responsibility of the scene via radio or telephone.

If responsibility is given to a physician at the scene, that physician is responsible for any and all care given at the scene of the incident and enroute to the Health Center and said physician will be responsible to sign the medical record. Paramedics, Intermediates, or Basics cannot be directed to provide care beyond the scope of their protocols.

Thank you.

James J. Rybak, MD
Director, Emergency Medicine
Southwest General Health Center

Southwest General Health Center / EMS
Approved Documentation Abbreviations

PATIENT INFORMATION/CATEGORIES			42
Chief complaint	CC	Complains of	c/o
Date of Birth	DOB	History and Physical	H&P
History	Hx	Impression	IMP
History of present illness	HPI	Newborn	NB
Medications	Meds	Patient	Pt
Past Medical History	PMH	Signs and Symptoms	S/S
Private Medical Doctor	PMD	Weight	Wt
Vital signs	VS	Year-old	y/o

BODY SYSTEMS			
Abdomen	Abd	Cardiovascular	CV
Central nervous system	CNS	Ear, nose, and throat	ENT
Gastrointestinal	GI	Genitourinary	GU
Gynecological	GYN	Obstetrical	OB
Respiratory	Resp		

COMMON COMPLAINTS			
Abdominal Pain	Abd pn	Chest pain	CP
Dyspnea on exertion	DOE	Fever of unknown origin	FUO
Gunshot wound	GSW	Headache	H/A
Lower back pain	LBP	Nausea/vomiting	n/v
No apparent distress	NAD	Pain	pn
Shortness of breath	SOB		

DIAGNOSES			
Abdominal aortic aneurysm	AAA	Acute myocardial infarction	AMI
Adult respiratory distress syndrome	ARDS	Alcohol	ETOH
Atherosclerotic heart disease	ASHD	Chronic obstructive pulmonary disease	COPD
Cerebral vascular attack	CVA	Chronic renal failure	CRF
Congestive heart failure	CHF	Coronary artery bypass graft	CABG
Coronary artery disease	CAD	Cystic fibrosis	CF
Dead on arrival	DOA	Delirium tremens	DTs
Deep vein thrombosis	DVT	Diabetes mellitus	DM
Dilation and Curettage	D&C	End stage renal failure	ESRF
Foreign body obstruction	FBO	Hepatitis B virus	HBV
Hiatal hernia	HH	Hypertension	HTN
Inferior wall myocardial infarction	IWMI	Insulin-dependant diabetes mellitus	IDDM
Intracranial pressure	ICP	Mass casualty incident	MCI

Mitral valve prolapse	MVP	Motor vehicle crash	MVC
-----------------------	------------	---------------------	------------

DIAGNOSES (CONT.)			43
Multiple sclerosis	MS	Non insulin dependant diabetes mellitus	NIDDM
Otitis media	OM	Overdose	OD
Peptic ulcer disease	PUD	Pelvic inflammatory disease	PID
Pregnancies / births (gravida / para)	G/P		
Pregnancy induced hypertension	PIH	Pulmonary embolism	PE
Rheumatic heart disease	RHD	Sexually transmitted disease	STD
Transient ischemic attack	TIA	Tuberculosis	TB
Upper respiratory infection	URI	Urinary tract infection	UTI
Veneral disease	VD	Wolff-Parkinson-White syndrome	WPW

MEDICATIONS			
Angiotensin-converting enzyme	ACE	Aspirin	ASA
Bicarbonate	HCO₃⁻	Birth control pills	BCP
Calcium	Ca⁺⁺	Calcium channel blocker	CCB
Digoxin	Dig	Chloride	Cl⁻
Diphenhydramine	DPHM	Diphtheria-pertussis-tetanus	DPT
Hydrochlorothiazide	HCTZ	Lactated Ringer's	LR
Nitroglycerine	NTG	Nonsteroidal anti-inflammatory drug	NSAID
Normal saline	NS	Penicillin	PCN
Sodium bicarbonate	NaHCO₃	Potassium	K⁺
Sodium chloride	NaCl		

ANATOMY / LANDMARKS			
Abdomen	Abd	Antecubital	AC
Anterior axillary line	AAL	Anterior cruciate ligament	ACL
Anterior/posterior	A/P	Gallbladder	GB
Dorsalis pedis (pulse)	DP	Lateral collateral ligament	LCL
Intercostal space	ICS	Left lower quadrant	LLQ
Left lower lobe	LLL	Left upper quadrant	LUQ
Left upper lobe	LUL	Midaxillary line	MAL
Left ventricle	LV	Right lower lobe	RLL
Right lower quadrant	RLQ	Right middle lobe	RML
Right upper lobe	RUL	Right upper quadrant	RUQ
Temporomandibular joint	TMJ		

PHYSICAL EXAM / FINDINGS			44
Blood pressure	BP	Breath sounds	BS
Cerebrospinal fluid	CSF	Bowel movement	BM
Cincinnati Stroke Scale	CCS	Central venous pressure	CVP
Electrocardiogram	ECG, EKG	Chest X-Ray	CXR
Heart rate	HR	Dorsalis pedis (pulse)	DP
Jugular venous distention	JVD	Expiratory	Exp
Level of consciousness	LOC	Glascow coma scale	GCS
Laceration	Lac	Inspiratory	Insp
Nontender	NT	Pupils equal and reactive to light	PEARL
Palpation	Palp	Respiratory Rate	RR
Pulse	P	Temperature	T
Range of motion	ROM		

MISCELLANEOUS DESCRIPTORS			
After (post-)	p	Anterior	ant.
Alert and oriented	A/O	APGAR	APGAR
Approximate	≈	Celsius	°C
As needed	prn	Decreased	↓
Body surface area (%)	BSA	Equal	=
Change	Δ	Increased	↑
Emergency Medical Service	EMS	Left	Ⓛ
Fahrenheit	°F	Motorcycle accident	MCA
Immediately	stat	Negative	-
Inferior	inf.	Not applicable	n/a
Moderate	mod.	Occasional	occ
Motor vehicle accident	MVA	Posterior	Post.
No, Not, None	∅	Prior to arrival	PTA
Number	No. or #	Rule out	R/O
Positive	+	Superior	sup.
Right	Ⓡ	Unequal	≠
Secondary to	2°	While awake	WA
Times (for 3 hours)	X (x3h)	Without (sine)	S
Warm and dry	W/D	Zero	0
With (cum)	c		

TREATMENTS / DISPOSITIONS			45
Advanced cardiac life support	ACLS	Advanced life support	ALS
Against medical advice	AMA	Automated external defibrillator	AED
Bag-valve mask	BVM	Basic life support	BLS
Cardiopulmonary resuscitation	CPR	Continuous positive airway pressure	CPAP
Do not resuscitate	DNR	Endotracheal tube	ET
Estimated time of arrival	ETA	External cardiac pacing	ECP
Intermittent positive pressure ventilation	IPPV	Nasogastric	NG
Nasal cannula	NC	Nothing by mouth	NPO
Nasopharyngeal airway	NPA	Oropharyngeal airway	OA
Nonrebreather mask	NRB	Physical therapy	PT
Oxygen	O₂	Treatment	Tx
Positive end-expiratory pressure	PEEP	Therapy	Rx

MEDICATION ADMINISTRATION / METRICS			
Centimeter	cm	Drop(s)	gtt(s)
Drops per minute	gtts/min	End tidal carbon dioxide	EtCO₂
Every	q	Fraction of inspired oxygen	F_iO₂
Gram	g, gm	Hour	hr
Hydrogen-ion concentration	pH	Intramuscular	IM
Intraosseous	IO	Intravenous	IV
Intravenous push	IVP	Joules	j
Keep vein open	KVO	Kilogram	kg
Pound	lb.	Liter	L
Liters per minute	LPM, L/min	Microgram	mcg
Milliequivalent	mEq	Milligram	mg
Milliliter	mL	Millimeter	mm
Millimeters of mercury	mmHg	Minute	min
Orally	PO	Subcutaneous	subcut.
Sublingual	SL	To keep open	TKO

Cardiology			46
Atrial fibrillation	AF	Atrial tachycardia	AT
Atrioventricular	AV	Bundle branch block	BBB
Complete heart block	CHB	Idioventricular rhythm	IVR
Junctional rhythm	JR	Normal sinus rhythm	NSR
Paroxysmal atrial tachycardia	PAT	Paroxysmal supraventricular tachycardia	PSVT
Premature atrial contraction	PAC	Premature junctional contraction	PJC
Premature ventricular contraction	PVC	Pulseless electrical activity	PEA
Supraventricular tachycardia	SVT	Ventricular fibrillation	VF
Ventricular Tachycardia	VT	Wandering atrial pacemaker	WAP

INFECTION CONTROL / S.O.P.

PURPOSE: To provide a comprehensive infection control system which maximizes protection against communicable diseases for all individuals, and for the public they serve.

Southwest General Health Center recognizes that communicable disease exposure is an occupational health hazard. Communicable disease transmission is possible during any aspect of emergency response including in-station operations. While the health and welfare of each individual is the responsibility of each department (where employed), we recognize the joint concern and responsibility of the chain of command. The goal of this S.O.P. is to provide all personnel with the best available protective equipment and to insure its proper use.

It is reasonably anticipated that any operation, including fires, Haz-mat, extrication, MVA's etc. or call may involve exposure to blood, body fluids or other potentially infectious material.

I. It is the policy of this Southwest General EMS System:

- A. To follow recommendations of the Medical Control Health Center, its protocols and guidelines.
- B. To provide fire, rescue and emergency medical services to the public without regard to known or suspected diagnoses of communicable disease in any patient.
- C. To regard all patients contacts as potentially infectious. Standard precautions shall be observed at all times. This means handling the blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin of all patients with care. This is for the protection of the health care worker as well as the patient.
- D. To provide all individuals with training, immunizations and personal protection from blood borne pathogens as required in OSHA standards.

II. Personal Protective Equipment (PPE):

- A. In general, individuals shall select PPE appropriate to the potential for spill, splash or exposure to body fluids. No standard operating procedure or PPE ensemble can cover all situations. Common sense must be used. When in doubt, maximal rather than minimal PPE shall be selected.
- B. Disposable gloves shall be worn during any patient contact when potential exists for contact with blood, mucous membranes, body fluids, non-intact skin, or other contaminated material(s).
- C. Gloves shall be replaced as soon as possible when soiled, torn, or punctured. Wash hands after glove removal.
- D. Where possible, gloves shall be changed between patients in multiple casualty situations.
- E. Structural fire fighting gloves shall be worn in situations where sharp or rough edges are likely to be encountered.
- F. Heavy-duty utility gloves may be used for handling, cleaning, or decontamination's of patient care equipment.
- G. Facial protection shall be used in any situation where splash contact with the face is possible. Facial protection may be afforded by using both a face mask and eye protection, or by using a full-face shield. When treating a patient with known or suspected airborne transmissible disease, face masks shall be used. The first choice is to mask the patient; if this is not feasible, the caregiver shall mask.
- H. Face shields on structural fire fighting helmets are not adequate and shall not be used for infection control purposes exclusively.

Fluid resistant gowns are designed to protect clothing from splashes. Structural fire fighting gear may be substituted to protect from splashes and is preferable in fire, rescue or vehicle extrication activities. Gowns may interfere with or present a hazard to the individual in these circumstances. The decision to use barrier protection to protect clothing and the type of barrier protection used will be left to the

individual. Structural fire fighting gear shall always be worn for fire suppression and extrication activities.

- I. Under certain circumstances, head covers and/or shoe covers will be required to protect these areas from potential contamination. Structural fire fighting gear (impervious boots, helmets) also may be used for barrier protection.

I. PPE SUMMARY:

- A. If it is wet, it may be infectious; use gloves.
- B. If it could splash onto your face or become airborne, use protective eye shields and mask or a full-face shield.
- C. If it is airborne, mask the patient and/or yourself.
- D. If it could splash on your clothes, use a gown or structural firefighter gear.
- E. If it could splash on your head or feet, use appropriate barrier protection.

II. Scene operations (includes getting in-service at the Health Center):

- A. Wear PPE, as described above, during scene operations.
- B. While complete control of the emergency scene is not possible, conduct scene operations to limit splashing, spraying or aerosolization of body fluids as much as possible.
- C. The minimum number of members required to complete the task safely will be used for all on-scene operations. Where communicable exposure is possible or anticipated, individuals not immediately needed will remain a safe distance from operations.
- D. Do not recap or purposely bend needles. Discard needles and the like in a "sharps" container or puncture resistant biohazard container utilized by EMS services.
- E. Eating, drinking, smoking, handling contact lenses or applying cosmetics or lip balm is prohibited at the scene of operations.

III. Hand washing is the most important infection control procedure.

Hand washing with soap and water will be performed for ten to fifteen seconds. If soap and water is not available at the scene, a waterless disinfectant type hand wash may be used, provided that a soap and water is performed immediately upon return to quarters or Health Center. Individuals will wash hands:

- A. After removing PPE
- B. After each patient contact
- C. After handling potentially infectious material
- D. After cleaning or decontaminating equipment
- E. After using the bathroom
- F. Before eating
- G. Before and after handling or preparing food

IV. If you know you are contaminated, keep from spreading the contaminated as much as possible by limiting the touching of non-contaminated areas and objects.

- A. When moderate to heavy contamination of the head areas occurs, the individual should first seek the assistance of another member to judge the degree of contamination and assist in the removal of the contaminated articles so as not to infect or contaminate others.
- B. Report any puncture wounds, splashes or contact with mucous membranes, (eyes, nose, mouth, etc.) to your supervisor and get necessary treatment (see for infectious disease follow-up).

I. Cleaning Equipment (gloves shall be worn while cleaning equipment):

- A. Any equipment used during an incident shall be properly disposed of, if it is disposable, or the equipment shall be left at the Health Center to be decontaminated or sterilized. Do not bring equipment back to the station without it having been cleaned first.
- B. Any body fluids, which come in contact with the cot, shall be washed off at the Health Center using disinfectant recommended by the Health Center.
- C. Any body fluids, which come in contact with the squad, shall be washed off at the Health Center using disinfectant recommended by the Health Center.
- D. The cardiac monitor and cables shall be disinfected at the Health Center, using disinfectant recommended by the Health Center.

II. Post response and in-station procedures:

- A. Upon return to quarters, contaminated equipment shall be removed and replaced with clean equipment. Supplies of PPE on response vehicles shall be replenished.
- B. Contaminated equipment shall be stored only in the decontamination area. Cleaning and decontamination shall be performed as soon as practical.
- C. Disposable equipment and other waste generated during on-scene operations should go with the transporting squad to the Health Center for disposal. Equipment and waste not immediately taken to the Health Center should be placed in an appropriately labeled red biohazard bag and as soon as possible, following the incident be taken to the Health Center for proper disinfecting or disposal.
- D. Gloves shall be worn for all contact with contaminated equipment or materials. Other PPE shall be used depending on the splash or spill potential. Heavy-duty utility gloves may be used for cleaning, disinfecting or decontamination of equipment.
- E. If there are manufacturer's guidelines, they will be used for the cleaning and decontamination of all equipment. Otherwise, disinfecting will be performed with a 10:1 solution of bleach. All disinfectants will be tuberculocidal and EPA approved and registered.

III. Personal guidelines:

- A. Eating, drinking, smoking, handling contact lenses or applying cosmetics or lip balm is prohibited during cleaning or decontamination procedures.
- B. Under no circumstances shall kitchens, bathrooms or living area be entered by contaminated personal, be used for decontamination, or for the storage of patient equipment or infectious waste.
- C. The seats of response vehicles contaminated with blood or body fluids from soiled PPE or clothing shall be disinfected upon return to station.
- D. Contaminated work clothes (jump suits, T-shirts, uniform pants) shall be removed and exchanged for clean clothes. The individual shall shower if body fluids were in contact with the skin under work clothes.
- E. All individuals shall have at least two (2) complete changes of uniform clothing.
- F. Immediately upon return to quarters, wash contaminated uniforms in hot water with the washer provided by the department at the respective station. If the washer is being used, place clothing into a biohazard bag and wash A.S.A.P. Under no circumstances shall contaminated clothing be removed from the station without being washed.
- G. Contaminated structural fire fighting gear [turnout coats/bunker pants] shall be cleaned according to the manufacture's recommendations found on attached labels. Normally, this will consist of a wash with hot soapy water following by a rinse with clean water. Turnout gear will be air-dried. Chlorine bleach may impair the fire-retardant properties of structural fire fighting gear and shall not be used.

IV. Contaminated boots shall be brush-scrubbed with a hot solution of soapy water, rinsed with clean water and allowed to dry.

V. Infectious waste generated during cleaning and decontamination shall be properly bagged and placed in a bio-hazard area for proper disposal at the Health Center.

COMMUNICABLE DISEASES / STANDARD PRECAUTIONS

PURPOSE: Prevention of spread of communicable diseases

STANDARD PRECAUTIONS

1. Treat all patients as if they have a communicable disease.
2. Wash hands after each patient contact whether fluid impermeable gloves have been worn or not.
3. Wear disposable exam gloves at all times if you anticipate exposure to blood or other body fluids or items soiled with them.
4. Wear disposable exam gloves when in contact with mucous membranes.
5. Clean the back and front of the squad on a routine and as needed basis. Document the cleaning.
6. Wear a gown or apron if soiling is likely.
7. If the patient is coughing, use a mask for Oxygen therapy.
8. Wear glasses and a facemask if splashing of blood or other bodily fluids is anticipated.
9. The use of individual sharps containers is mandatory.
10. Do not recap or bend needles. Discard needles and syringes intact, into disposable sharps containers.
11. Treat all patient specimens as infectious.
12. If, despite all your efforts, you become soiled with blood or other body fluids, wash well as soon as possible.
13. If splashing has occurred, rinse with copious amounts of water or saline.
14. If your uniform is contaminated, shower and change upon returning to the station.
15. The squad will be cleaned on a routine basis.

COMMUNICABLE DISEASES / TUBERCULIN TESTING

PURPOSE: The prevention of the spread of tuberculosis

1. EMS under the medical direction of SWGHC can obtain annual tuberculin skin testing.
2. SWGHC annual skin testing complies with OSHA Standards and Fire Department policies.
3. The procedure involves the injection of 5TU of Purified Protein Derivative (PPD) solution intradermally into the inner aspect of the forearm.
4. The intradermal injections will be administered at Associate Occupational Health Services or at either of the Urgicares, (Brook Park or Strongsville).
5. Both for the PPD test and for the reading of the PPD test, the form on the next page of this document must accompany the person to the Urgicares or Associate Occupational Health Services at SWGHC.
6. TB, PPD test shall be read by a trained reader 48 to 72 hours after the test is administered.
7. To become a designated reader, one must attend an inservice to certify training in reading of the skin test after PPD administration.
8. The PPD test will be read at the facility that administered the test, or, the fire department may designate a person or persons to become the trained reader.
9. Anyone who receives the PPD test but does not have it read in the specified time, will assume the responsibility for the cost of repeating the test within that calendar year.
10. The fire departments will assume responsibility for assuring that a trained reader reads the TB tests in the specified time and that a record is kept.
11. The Fire Department reader / readers will fill out paper work to verify the test results and to comply with Fire Department specifications.
12. An indurated area of 10 millimeters or greater is considered a significant positive reaction in persons not known to be recent contacts of tuberculosis.

13. A physician must evaluate persons exhibiting a significant reaction (usually their private physician or the TB Clinic of the county of their residence). Annual documentation of review of signs and symptoms with a physician referral and a chest X-Ray should take place thereafter.
14. After the first year of testing, persons converting from a non-significant skin test to significant results will receive a physician evaluation and a chest X-ray. If there is no evidence of active disease, the infected person should receive prophylaxis unless medically contraindicated.
15. Work restrictions are not necessary for those placed on prophylaxis.
16. If disease is present, the EMS person will be referred to their private physician and must be off work until sputum smears are negative for acid fast bacilli.



PERMIT FOR TUBERCULIN TESTING

<p>Brook Park Urgicare 14401 Snow Road Brook Park, OH 44142 Phone: 440.816.8744 Fax: 216.265.3609</p>	<p>Strongsville Urgicare Center 18181 Pearl Road Strongsville, OH 44136 Phone: 440.816.2273 Fax: 440.238.8813</p>
<p>URGICARE HOURS Every day of the week 8:00 AM until 10:00 PM</p>	

ASSOCIATE OCCUPATION HEALTH SERVICES AT
SOUTHWEST GENERAL HEALTH CENTER
SWGHC Building C Suite 303
Monday , Tuesdays, Wednesdays, Fridays
7 AM to 3 PM
(No TB testing on Thursdays because no one is available to read results on Saturdays)

I give Southwest General Health Center, Associate Occupational Health Services, or Southwest General Urgicare, permission to administer to me a TB test. I have reviewed the tuberculin section in the information manual. I absolve the institution, the individual giving the test, the fire department, and the person reading the test of all responsibility.

Signature: _____ Date: _____

Print Name: _____ Witness: _____

Tear here and return bottom portion to record

RESULTS OF TUBERCULIN TESTING

_____ Mantoux administered to *(Print Name Above)* _____ Fire Dept. Number: _____

Date Administered: _____

Date Read: _____

Results: _____

Read By: _____

Strongsville Urgicare

Brook Park Urgicare

Associate Occupational Health Services

COMMUNICABLE DISEASES / TUBERCULIN TESTING

If there is a positive reaction to tuberculin testing, the person must follow up with their private physician or the TB Clinic in the county of residence. They should not receive PPD testing again. However, each year they should answer the following questionnaire and follow up with their private physician when indicated.

POSITIVE SKIN TEST QUESTIONNAIRE

Name: _____ Date: _____
Job Title: _____ Date of birth: _____
Department: _____
1. Private Physician's Name: _____ Last Visit: _____
2. Reason for last visit: _____
3. When was your last physical? At work: _____ Your Doctor: _____
4. Have you had any health problems recently or within the past year? [] Yes [] No
Describe: _____
5. Have you had a weight loss in the past year? [] Yes [] No Intentional? [] Yes [] No
Did you use a weight program? [] Yes [] No Which one? _____
Did you do it on your own? [] Yes [] No Describe: _____
If it was intentional, have you sought treatment? [] Yes [] No
With what physician? _____
6. Do you have a persistent cough? [] Yes [] No For what length of time? _____
Is it productive? [] Yes [] No Describe: _____
Did you see a physician? [] Yes [] No What was his explanation? _____
7. Have you had any fevers or fevers, which have not been explained? [] Yes [] No
If so when? _____ Under what circumstances? _____
Did you see a physician? [] Yes [] No
What was his explanation? _____
8. Do you have any shortness of breath? [] Yes [] No When? _____
9. Do you have asthma or a respiratory condition for which you are receiving treatment?
[] Yes [] No
10. Have you had a recent chest X-Ray? [] Yes [] No When? _____ Where? _____
Why? _____ What were the results? _____
11. Do you Smoke? [] Yes [] No How much? _____

EMS / POLICE INFECTIOUS DISEASE INQUIRIES

POSITIVE SKIN TEST QUESTIONNAIRE CONTINUED

12. Have you ever had tuberculosis? [] Yes [] No When? _____
Were you treated? [] Yes [] No Medically _____ Date: _____
Surgically? _____ Date: _____
Describe _____

13. Have you ever received medication because of your positive skin test reaction?
If so, do you recall what it was? _____

14. When were you first told you had a positive reaction to the tuberculin test?

15. Please remember that once you react positive to a tuberculin test - you will always react positively.
You should take no further tuberculin skin tests.

Signature _____
Date _____

Thank you for answering this questionnaire. You will be expected to respond to this questionnaire annually to fulfill your obligation to remain disease free for you own welfare and the welfare of associates and the client.

If at any time you have shortness of breath, unexplained fevers, a persistent cough, blood tinged sputum or an unintentional weight loss and general feeling of malaise, see your physician.

EMS / POLICE INFECTIOUS DISEASE INQUIRIES

- I. INQUIRIES FROM EMS AND/OR POLICE**
- A. EMS and/or Police should be directed to make inquiries regarding diseases reasonably likely to be transmitted by air or blood during the normal course of duties to the Infection Control Office (see attached list of diseases).
 - B. At other times EMS and/or Police who believe they have suffered significant exposure may need further information.
 - 1. A written request for information should be made.
 - 2. Request must include:
 - a) Name, address and phone number of inquirer
 - b) Name, address and phone number of supervisor
 - c) Name, address and phone number of employer
 - d) Date, time, location and manner of exposure
 - e) Patient's name
 - 3. The request must be hand delivered to the Infection Control Office.
 - 4. The request is valid for ten (10) days after it is made and may be renewed if necessary by following the same procedures.
 - C. The Infection Control Department response to inquiry
 - 1. Within two (2) working days after the diagnosis is made of a disease reasonably likely to be transmitted by air or blood during the course of normal duties; or, if test results are confirmed positive, an Infection Control Nurse will contact the person inquiring and his/her supervisor.
 - 2. The information to be given includes:
 - a) Name of disease, symptoms, exposure date, incubation period, mode of transmission, precautions to prevent and appropriate prophylaxis, treatment, and counseling.
 - 3. Within three (3) working days after giving oral information about disease, written information will follow.
 - 4. At the end of the ten (10) day period, a request is invalid if no tests have been performed to determine a communicable disease; no diagnosis has been made; or test results are negative:
 - a) The person inquiring will be so advised.
 - b) Records will be maintained in the Infection Control Office.
 - c) When any EMS person sustains an exposure, he/she should feel free to contact an Infection Control nurse. The purpose of the call would be to verify that the Infection Control Department has been aware of the exposure incident.
 - d) The infection Control Department number is 816-8734 or if they are not in the office, the switchboard will page them if the EMS person calls and so requests.

- II. FOLLOW-UP WITH OTHER AGENCIES
 - A. The EMS and/or Police inquiries may involve patients transferred to other Health Centers or deceased sent to a coroner.
 - B. The Infection Control Nurse will assist EMS and/or Police in obtaining information from the receiving agency.
- III. CONFIDENTIALITY
 - A. Confidentiality of the source patient will be maintained.
 - B. Records will be maintained in a secured area of Infection Control Office.

REQUEST FOR INFORMATION ON INFECTIOUS DISEASES

_____ Name of person reporting	_____ Date and time of report
_____ Home address	_____ Home phone number
_____ Name of employer	_____ Address of employer
_____ Employer's phone	_____ Supervisor's name
_____ Supervisor's address	_____ Supervisor's phone
_____ Run number	_____ Date and time of exposure
_____ Location of exposure	_____ Patient's name

DESCRIPTION OF EXPOSURE, INCLUDE ANY INVOLVED BODY FLUIDS:

WERE YOU TREATED? YES NO

IF TREATED WHERE: _____ WHEN: _____

INSTRUCTIONS: Deliver originals of this report and a copy of the Emergency Dept. records to the Infection Control Dept. Deliver a second copy to the EMS office.

Received in Infection Control Office: DATE: _____ TIME: _____