



Southwest General

Partnering with



University Hospitals

EMS Services

Section 2

PRE-HOSPITAL CARE

MEDICAL CONTROL

PROTOCOLS AND PROCEDURES

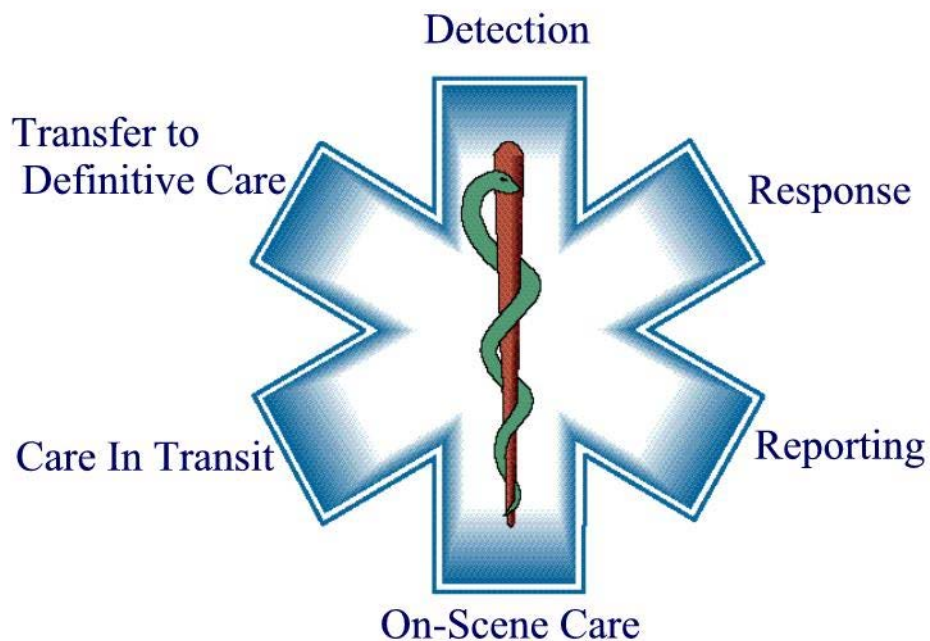


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EMS LEVELS OF CERTIFICATION

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 - Advanced	EMT - Paramedic
40 Hours of Continuing Education in 3 years	60 Hours of Continuing Education in 3 years	86 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. 	<ul style="list-style-type: none"> • Pediatric 8 hrs. • Geriatric 4 hrs. • Trauma 8 hrs. • 1 Annual Clinical Rotation 6 hrs. 	<ul style="list-style-type: none"> • Pediatric 12 hrs. • Geriatric 4 hrs. • Trauma 8 hrs. • ACLS / Cardiac 6 hrs. • 1 Annual Clinical Rotation 6 hrs.
• Optional Areas 24 hrs.	• Optional Areas 34 hrs.	• Optional Areas 50 hrs.

- **70% of all continuing education through Southwest General Health Center
- **One 6 hour annual clinical rotation required at Southwest General Hospital.
- **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 recertification cycle is every 2 years and the hours of CE are higher.



Scope of Practice

Approved by

State Board of Emergency Medical, Fire and Transportation Services

Division of EMS, Ohio Department of Public Safety

This document offers an “at-a-glance” view of the Scope of Practice for Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics as approved by the State Board of Emergency Medical, Fire and Transportation Services (EMFTS Board). The authorized services can be found in sections 4765.35 (FR/EMR), 4765.37 (EMT-B/EMT), 4765.38 (EMT-I/AEMT), and 4765.39 (EMT-P/Paramedic) of the Revised Code. The scopes of practice can be found in rules 4765-12-04 (EMR), 4765-15-04 (EMT), 4765-16-04 (AEMT), and 4765-17-03 (Paramedic) of the Administrative Code.

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

In accordance with rule 4765-10-06 of the Administrative Code, the individual medical director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. Each community may need to tailor and revise the protocol to fit their region and individual practice, but must ensure that they remain within the approved scope of practice. EMS medical directors are reminded that they are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted.

EMS medical directors and EMS providers are strongly encouraged to review the EMFTS Board’s policy statement “Regarding EMS Provider Pre-Hospital transport of Patients with Pre-Existing Medical Devices or Drug Administrations” dated January 2004 (attached to this document, page 6). This statement clarifies how EMS providers, in the prehospital setting, should deal with medical devices and medicine administrations that are outside their scope of practice.

Pursuant to rule 4765-6-04 of the Administrative Code, the EMFTS Board may allow EMRs, EMTs, AEMTs, and Paramedics to perform services beyond their respective scopes of practices as part of a board-approved research study. An entity must submit a research proposal to the EMFTS Board in accordance with the requirements of rule 4765-6-04 of the Administrative Code. The EMFTS Board is not obligated to approve the proposed research study nor accept any recommendation to permanently amend the scope of practice.

Updated 11/19/03; 5/17/05; 10/26/05; 10/17/07; 3/8/12; 8/22/13, 10/16/13, 12/18/13, 4/16/2014



**State Board Emergency Medical, Fire and Transportation Services
Division of EMS/Department of Public Safety**

Updated April 16, 2014

	Airway Management	EMR	EMT	AEMT	PARAMEDIC
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	Manual removal of obstructed airway	X	X	X	X
5	Laryngoscopy for removal of airway obstruction			X	X
6	Oral suctioning	X	X	X	X
7	Endotracheal (ET) tube suctioning via through a previously established airway or a stoma		X	X	X
8	Tracheostomy tube replacement			X	X
9	Cricothyrotomy, surgical				X
10	Cricothyrotomy, needle				X
11	Pulse oximeter and capnography equipment application and reading	X	X	X	X
12	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
	d. Partial rebreather mask		X	X	X
	e. Venturi mask		X	X	X
13	Ventilation management				
	a. Bag valve mask	X	X	X	X
	b. Ventilation with a flow-restricted oxygen-powered device	X	X	X	X
	c. Positive pressure ventilation devices (manually triggered or automatic ventilators)		X	X	X
14	Ventilator management - 16 years of age or older				X
15	Orotracheal intubation				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients			X	X
16	Nasotracheal intubation				X
17	Dual lumen airway				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
18	Extraglottic airways				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
19	CPAP administration and management		X	X	X
20	BiPAP administration and management				X

	Positive end-expiratory pressure (PEEP)				X
21	End tidal CO ₂ monitoring and detecting		X	X	X
22	Oxygen humidifier equipment application and monitoring		X	X	X
23	Chest tube monitoring and management				X
24	Nasogastric (NG) tube placement				X
25	Orogastric (OG) tube placement				X

	Cardiac Management	EMR	EMT	AEMT	PARAMEDIC
1	Cardiopulmonary resuscitation (CPR)	X	X	X	X
2	Chest compression assist devices		X	X	X
3	Automated external defibrillator (use of an AED)	X	X	X	X
4	Manual defibrillation			X	X
5	Administration of cardiac medication				X
6	Set up cardiac monitor ^A		X		
7	Cardiac monitor strip interpretation			X	X
8	Cardioversion				X
9	Carotid massage				X
10	Transcutaneous cardiac pacing				X
11	12-lead EKG performance and interpretation				X
12	12-lead EKG application assisting Paramedic ^B		X	X	
13	12-lead EKG set up and application for electronic transmission ^C		X	X	X

^A Set up of cardiac monitor only. Procedure shall not be performed unless an AEMT or Paramedic is present.

^B Set up of 12-lead EKG application only. Procedure shall not be performed unless a Paramedic is present.

^C An EMT or AEMT may set up and apply a 12-lead electrocardiogram when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met: 1) performed in accordance with written protocol; 2) EMT or AEMT shall not interpret the electrocardiogram; 3) delay in patient transport is minimized; and 4) EKG is used in conjunction with destination protocols approved by the local medical director.

	Medical Management	EMR	EMT	AEMT	PARAMEDIC
1	Epinephrine administration via auto-injector	X	X	X	X
2	Epinephrine administration via SQ or IM routes			X	X
3	Epinephrine administration via IV or IO route				X
4	Aspirin administration		X	X	X
5	Oral glucose administration		X	X	X
6	Activated charcoal administration		X	X	X
7	Nitroglycerin administration (patient assisted) ^D		X	X	X
8	Nitroglycerin administration (non-patient assisted)			X	X
9	Aerosolized or nebulized medications administration (patient assisted) ^D		X	X	X
10	Administration of aerosolized or nebulized medications (non-patient assisted)			X	X
11	Naloxone administration via auto-injector	X	X	X	X
12	Naloxone administration via intranasal route	X	X	X	X
13	Naloxone administration via ETT, IM, IV, IO, or SQ routes			X	X
14	Medication administration (protocol-approved) ^E			X	X

15	Administration of intranasal medications (in addition to naloxone)			X	X
16	Immunizations for influenza to firefighters or EMS providers (ORC 4765.391)				X
17	Set up of IV administration kit ^E		X		
18	IV maintenance and fluid administration			X	X
19	Maintenance of medicated IV fluids				X
20	Central line monitoring				X
21	IV infusion pump				X
22	Intraosseous needle insertion			X	X
23	Saline lock initiation			X	X
24	Peripheral IV blood specimens			X	X
25	Maintenance of blood administration				X
26	Thrombolytic therapy initiation and monitoring				X
^D Patient Assisted Definition: May assist with 1) patient's prescription upon patient request and with written protocol - OR – 2) EMS provided medications with verbal medical direction. ^E See "AEMT Medications Approved by the EMFTS Board." ^F Set up of IV equipment only. Procedure shall not be performed unless an AEMT or Paramedic is present.					

	Trauma Management	EMR	EMT	AEMT	PARAMEDIC
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
12	Controlling of hemorrhage	X	X	X	X

	Basic Performances	EMR	EMT	AEMT	PARAMEDIC
1	Body substance isolation precaution/administration	X	X	X	X
2	Taking and recording of vital signs	X	X	X	X
3	Patient Care Report (PCR) documentation	X	X	X	X
4	Trauma triage determination per OAC 4765-14-02	X	X	X	X

	Additional Services	EMR	EMT	AEMT	PARAMEDIC
1	Emergency childbirth management ^G	X	X	X	X
2	Glucose monitoring system use (with Clinical Laboratory Improvement Amendments (CLIA) waiver in place)		X	X	X
3	Blood chemistry analysis				X
4	Eye irrigation	X	X	X	X

5	Eye irrigation with Morgan lens				X
6	Maintenance of blood administration				X
7	Thrombolytic therapy initiation and monitoring				X
^g An EMR may only assist with emergency childbirth management.					

Emergency Medical Services in Hospital	EMR	EMT	AEMT	PARAMEDIC
An EMS provider may perform emergency medical services in the hospital emergency department (ED) or while moving a patient between the ED and another part of the hospital. The EMS provider shall be under physician medical direction and has received appropriate training. (ORC 4765.36)	X	X	X	X
Additional Services in a Declared Emergency	EMR	EMT	AEMT	PARAMEDIC
In the event of an emergency declared by the governor that affects the public's health, an EMS provider may perform immunizations and administer drugs or dangerous drugs, in relation to the emergency, provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such immunizations and/or drugs. (OAC 4765-6-03)	X	X	X	X
Nerve Agent or Organophosphate Release	EMR	EMT	AEMT	PARAMEDIC
An EMS provider 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 EMS provider is under physician medical direction and has received appropriate training regarding the administration of such drugs within the nerve agent antidote auto-injector kit. (OAC 4765-6-05)	X	X	X	X

AEMT Medication Administration Approved by the EMFTS Board

A certified AEMT may administer medications from the following list, provided the AEMT is under physician medical direction and has received appropriate training regarding the administration of such medications. A medication that does not appear on the following list SHALL NOT be added to the department's AEMT protocol.

Benzodiazepines	Nalbuphine
Bronchodilators	Naloxone
Dextrose in water	Narcotics or other analgesics for pain relief
Diphenhydramine	Nitrous oxide
Epinephrine 1:1,000 (subcutaneous or intramuscular)	Oral ondansetron ^H
Glucagon	Sublingual nitroglycerin
Lidocaine for pain relief after intraosseous needle insertions	

^HA certified AEMT may administer oral ondansetron to patients are the age of 18 years and older. For patients from the age of 12 years to 17 years who weigh greater than or equal to 40 kg, the maximum dose of ondansetron that can be administered is 4 mg. The administration of ondansetron is not permitted for patients of the age of 12 years to 17 years who weigh less than 40 kg nor is its administration permitted for all patients under the age of 12 years.

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

The Ohio Board of Emergency Medical, Fire, and Transportation Services (“EMFTS Board”) issues the following statement:

Regarding EMS Provider Pre-Hospital Transport of Patients with
Pre-Existing Medical Devices or Drug Administrations
October 2013

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

Introduction:

The EMFTS Board and the Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMS providers. It is maintained in matrix form and available on-line as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMFTS Board. Updates to the scope of practice are made as necessary and after approval by the EMFTS Board.

From time to time, EMS providers are confronted on-scene with patients with preexisting medical situations not included or addressed in their respective EMFTS Board approved scope of practice. Specifically, patients with pre-existing medical devices and drug administrations requiring prehospital EMS service are becoming more commonplace. The intent of this position paper is to address the EMS provider’s approach to that prehospital patient with a pre-existing physician-ordered medical device or drug administration (“MDDA”) not covered in the provider’s scope of practice.

Discussion:

In general, the EMS provider should maintain the pre-existing MDDA and transport the patient to the appropriate facility. There is no expectation that the EMS provider will initiate, adjust, or discontinue the pre-existing MDDA. This implies that the EMS provider will maintain and continue care so that the patient can be transported.

The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of prehospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (prehospital or “911 scene response”). It implies that the most appropriate and available level of EMS provider will respond to the request for prehospital EMS service. It also implies that the patient requires the pre-existing MDDA and it is not feasible or appropriate to transport the patient without the pre-existing MDDA.

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

Conclusion:

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

Approved by the EMFTS Board February 2014

The Ohio Board of Emergency Medical, Fire, and Transportation Services (“EMFTS Board”) issues the following statement:

Regarding Interfacility Transport of Patients by EMS Providers and the Scope of Practice
October 2013

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

Introduction:

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

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

Discussion:

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

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

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

Conclusion:

The EMT, AEMT, and Paramedic certification is limited to the scope of practice that is set forth respectively in Ohio Administrative Code Chapters 4765-15, 4765-16, and 4765-17. Furthermore, this position paper does not

provide an inclusive or exclusive list of therapies and medications that should be included or excluded from the EMS provider's scope of practice.

In addition, during the interfacility transportation of patients, the EMS provider:

- Shall not initiate the infusion of blood or blood products including the initiation of infusion of additional units. Under the current scope of practice, the Paramedic may only maintain the infusion of blood or blood products.
- Shall not initiate the infusion of intravenous parenteral nutrition including the initiation of infusion of additional units. Under the current scope of practice, the Paramedic may only maintain the infusion of intravenous parenteral nutrition.
- Shall not initiate or continue the infusion of chemotherapeutic agents.
- Shall follow written protocols, which have been developed and signed by the EMS provider's medical director, for the infusion of medications that are not specifically outlined within the EMS scope of practice as outlined by the State of Ohio.
 - The training for the infusion of these specific medications shall not be done at the time of the interfacility transfer of the patient.
 - This training must be completed well in advance of the transfer.
 - The completion of the training must be documented and approved by the medical director of the EMS agency.
 - Continuing education and recurrent training on the indications, contraindications, pharmacology, and side effects of these medications is also required.
- Should refuse to initiate a transport if the EMS provider feels that adequate training on a specific intervention has not been provided well in advance of the transfer as outlined above or if the EMS provider feels uncomfortable with the transport for any reason, including but not exclusive to safety reasons, patient scenario, or any requested parameter of patient care delivery ordered during patient transport.

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

EMS COMMUNICATIONS

A member of the pre-hospital care team must contact Medical Control at the earliest time convenient 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, Advanced, 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-A, 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 forwarded electronically to the receiving medical facility.
- A copy of the patient care report can be accessed electronically by the EMS Department or Agency.

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.
- Always attach the 12 Lead tracing electronically to run reports and transmit 12 Lead EKG’s to ED.
- 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.

All completed run reports should contain a summary statement regarding patient status upon transfer of care.

AEROMEDICAL TRANSPORT

The following principles regarding on-scene use of a helicopter have been adopted by the Cuyahoga County EMS Advisory Board, and are endorsed by these protocols. Air transport should be utilized whenever patient care can be improved by decreasing transport time, due to extended extrication or by giving advanced care not available from ground EMS.

PURPOSE

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

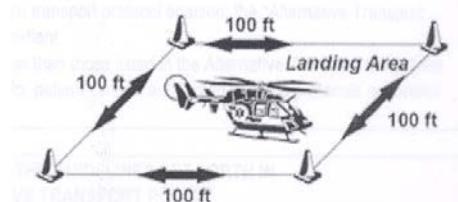
INDICATIONS FOR AEROMEDICAL TRANSPORT

1. Aeromedical services may be requested directly to the scene by:
 - An On – Scene EMS organization
 - Hospitals and healthcare facilities
2. A request for aeromedical service response may be initiated when one or more of the following conditions exists:
 - The patient's airway, breathing, or hemorrhage / circulation can not be controlled by conventional means and the estimated arrival time of the air medical service is less than the time required for ground transport to the nearest hospital.
 - High priority patient with > 20 minute transport time.
 - Entrapped patients > 10 minute estimated extrication time.
 - Access hard to reach victims for whom the helicopter will have a special advantage.
 - When sufficient other Mutual Aid resources are not available.
 - Transport assist in dispersing multiple, serious victims to more distant hospitals. It is recognized that in major emergency incidents, the Cuyahoga County Emergency Management Plan permits no direct communications by squads with On-Line Medical Direction.
 - To bring a physician and equipment resources to a patient who specifically needs these on the scene. (Physician not available on all helicopter services).
 - Multiple casualty incident with red / yellow tag patients.
 - Multi-trauma or medical patient requiring life-saving treatment not available in prehospital environment (i.e., blood transfusion, invasive procedure, operative intervention).
3. If a potential need for air transport is anticipated, but not yet confirmed, an air medical transport service can be placed on standby.
4. If the scene conditions or patient situation improves after activation of the air medical transport service and air transport is determined not to be necessary, paramedic or administrative personnel may cancel the request of air transport.
5. Minimal Information which should be provided to the air medical transport service include:
 - a. Number of patients
 - b. Age of patients
 - c. Sex of patients
 - d. Mechanism of injury or complaint (MVC, fall, etc)

- 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 within 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.
 - Landing Zone Briefing
 - Type of LZ surface and size
 - How LZ is marked (cones, flairs, strobes, etc.)
 - All noted obstructions (see list above)



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

ALTERNATIVE TRANSPORT

- **Under the auspices of each individual EMS jurisdiction and the Medical director,** this protocol provides an alternative transportation option for use by EMS personnel for patients that do not require emergent ambulance transportation.

PURPOSE

- To provide a suggested alternative transportation option to non-emergent patients who do not require emergent ambulance transportation.

PROCEDURE

Before advocating other means of transportation, EMS personnel must perform ALL of the following:

1. Appropriate medical exam, including vital signs.
2. Obtain pertinent patient information.
3. Contact Medical Control

ALTERNATIVE TRANSPORT GUIDELINES

Patient complaints for which EMS personnel **may recommend other means of transportation** to medical care are limited to the following:

- Ear pain with no apparent object in ear
- Minor extremity lacerations with no gross loss of function
- Pain or burning on urination
- Penile discharge
- Minor vaginal discharge unless the patient is obviously pregnant or suspects she is pregnant
- Toothache without swelling or radiating jaw pain. Pt must be transported if evident of impending airway compromise
- Minor sore throats and colds
- Prescription refills
- Scheduled clinic appointments

KEY POINTS

EMS personnel **MAY NOT** decline transport, or in any way suggest alternative means of transportation for any of the following patients, complaints, or situations:

1. Less than 18 years of age
 2. Suicide Attempt
 3. Intoxication
 4. Abuse or negligence of adult or child
 5. Any situation where the crew's best judgement indicates transport
- Whenever presented with a medical complaint other than those listed in the Alternative Transport Guidelines section, follow the appropriate treatment protocol for patient care as authorized in these protocols or contact Medical Control

**DO NOT DEVIATE FROM THE GUIDELINES SET FORTH IN
THE ALTERNATIVE TRANSPORT POLICY**

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 passive 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) and law enforcement. 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

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 EMS Equipment Room in the Emergency Department. Please retrieve on a timely basis. Remove the dated sticker from CSS indicating the equipment has been cleaned.
9. Equipment cleaned by departments is to be completely wiped off with standard hospital cleaning products. If patient is known or suspect of infection, bleach cleaning products are to be used to wipe equipment.

Refer to Infection Control SOP – pages 36-48.

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: **Expressed Consent**, when a conscious, oriented, (to person, place and time) competent adult (over 18 years 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 will 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

Southwest General Health Center / EMS Services

Revised 03/2007, 06/2007, 10/2008, 09/2009, 01/2012, 08/2012, 05/2015

Refusal of Treatment:

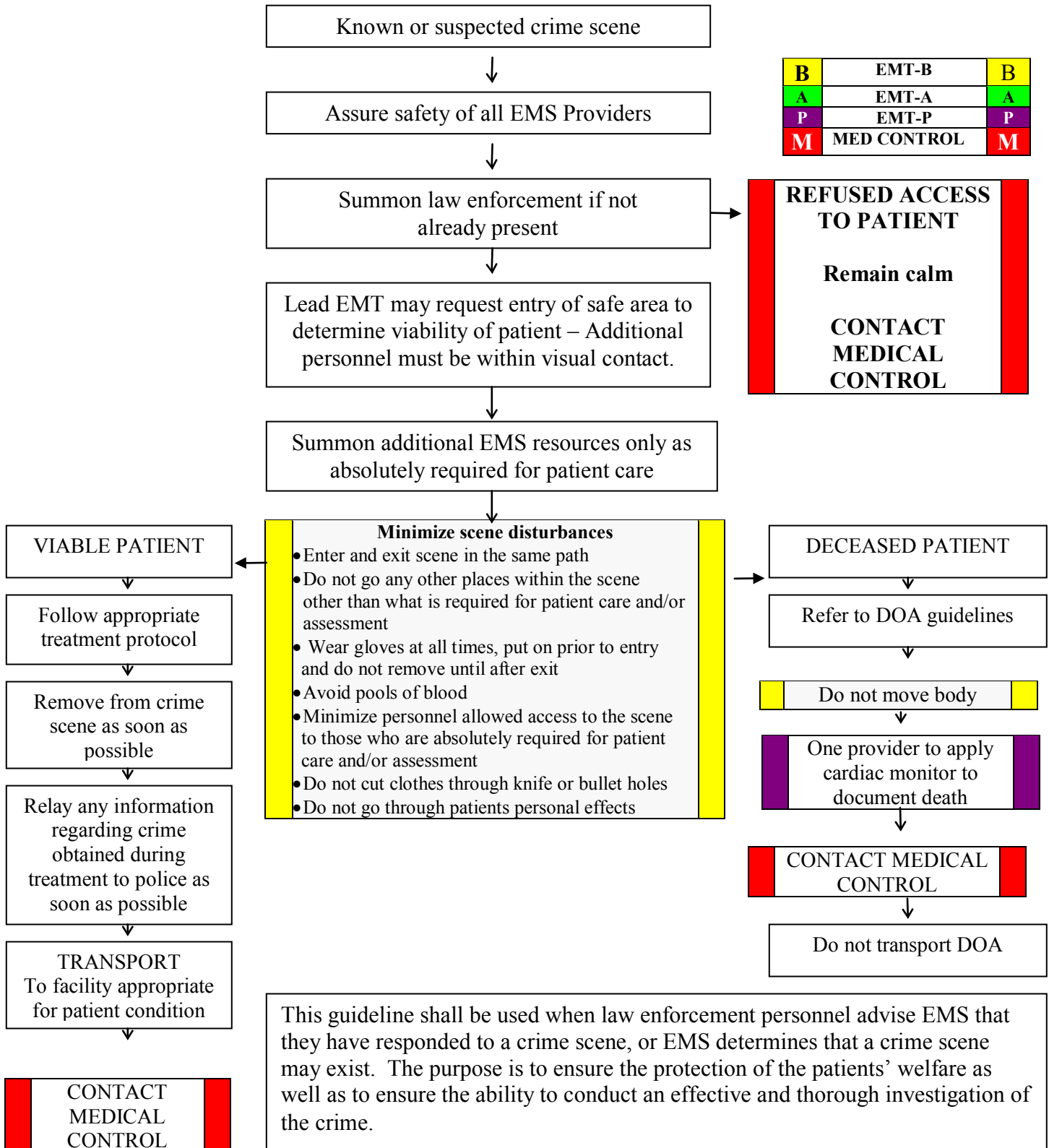
A **minor** might refuse to cooperate with the EMS crew, or the minor's parent or guardian may refuse to consent to necessary treatment of the minor. A **minor** under the age of 18 years may not refuse treatment in Ohio. Transport should be initiated unless the **parent** or **legal guardian** refuse 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 in need of medical care. The involvement of the police in these situations is often necessary and crucial. They may assist the EMS crew with transport as ordered by the On-line Physician. This is described in Ohio Revised Code, Section 5122.10.

CRIME SCENE GUIDELINES



B	EMT-B	B
A	EMT-A	A
P	EMT-P	P
M	MED CONTROL	M

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 a 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.

DO NOT RESUSCITATE-DNR**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.

DNR Comfort Care – Terminally ill condition and in effect at all times.

DNR Comfort Care – Arrest – In effect in the event of a cardiac or respiratory arrest.

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 a 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 was 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.



DNR IDENTIFICATION FORM

(Check only one box)

- DNRCC** (If this box is checked the DNR Comfort Care Protocol is activated immediately.)
- DNRCC-Arrest** (If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:		
Address:		
City:	State:	Zip:
Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Signature: (optional)		

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

- Do-Not-Resuscitate Order**—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.
- Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Ohio Living Will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:	
Signature:	Date:
Address:	Phone:
City/State:	Zip:

*A DNR order may be issued by a certified nurse practitioner, clinical nurse specialist, or a physician assistant when authorized by section 2133.211 of the Ohio Revised Code.

See reverse side for DNR Protocol

3701-62-04



DO NOT RESUSCITATE COMFORT CARE PROTOCOL

After the State of Ohio DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

WILL:

- 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, such as hospice, home health, attending physicians, CNPs, and CNSs

WILL NOT:

- Administer chest compressions
- Insert artificial air way
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance (other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

If you have responded to an emergency situation by initiating any of the WILL NOT actions prior to confirming that the DNR Comfort Care Protocol should 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 an underlying disease.

If family or bystanders request or demand resuscitation for a person for whom the DNR Comfort Care Protocol has been activated, do not proceed with resuscitation. Provide comfort measures as outlined above and try to help the family members understand the dying process and the patient's choice not to be resuscitated.

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.

5. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, also contact the Department of Social Services (DSS). After office hours, the adult social services worker on call can be contacted by the 911 communications center.
6. Notify SWGH ED, Physician and Case Manager at Ext. 5916 if unsafe 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.

AREAS FOR CONCERN

Please refer to the list below to see if any of the following apply to your patient. Also, look for changes or extremes in behavior.

<u>Communication</u>	<u>Physical Condition</u>	<u>Social Condition</u>	<u>Condition of Home</u>
~ Confused	~ Walks with difficulty	~ Lives alone	~ Needs repair
~ Disoriented	~ In wheelchair	~ Isolated from others	~ Bad odor
~ Forgetful	~ Dirty clothes	~ May be abused	~ Pets neglected
~ Can't hear well	~ Uncombed hair	~ May be exploited	~ Yard neglected
~ Can't speak well	~ Unshaven	~ May be neglected	~ Rubbish lying about
~ Can't speak English	~ Bruises, cuts, sores		
<u>Economic Condition</u>	<u>Emotional Condition</u>		
~ Confused about finances	~ Excessive reminiscing	~ Appears withdrawn	
~ Has difficulty paying bills	~ Doesn't eat well	~ Appears depressed / cries easily	
~ Can't afford food	~ Doesn't sleep well		
~ Can't afford medicine	~ Recent death in family		
~ Can't afford transportation	~ Appears nervous		
		<u>Substance abuse</u>	
		~ Alcohol	
		~ Other drugs	

EMS DRUG EXCHANGE SYSTEM

Fire Departments under Southwest General Medical Control participate in a 1:1 drug exchange. All departments must have a copy of their current drug license, drug addendum, and list of certified providers on file with hospital pharmacy issued Biometric for Pyxis access. All Departments will notify the EMS Dept. immediately of personnel termination/suspension.

Strict control of the drug supply is an important function of all EMS units. Components of the drug control system include:

1. Responsible person for department (i.e: EMS Coordinator /Fire Chiefs)
2. Responsible person for shift (reports to EMS Coordinator)
3. Weekly drug Inventory tracked on written form
4. Replacement of expired drugs as needed
5. Daily drug inspection at change of shift
6. Daily box security check
7. Check of box security after every EMS run (by Medic in charge)
8. Daily check of drug administration equipment (ie: needles/syringes)
9. Written records of all controls
10. Maintenance of double-lock system for all controlled drugs

EMS services not under Southwest General Medical Control are also eligible for a 1:1 exchange if they have the necessary drug license documents on file with the hospital, as listed above. Private Ambulance companies, are not eligible for drug replacement.

All drug replacements will occur as a 1:1 exchange through the EMS Pyxis medication machine. Each individual medic will use only his/her designated Bio ID & fingerprint for access. All controlled substances will be acquired through an ED RN. An EMS Patient Report for Medication Exchange will be submitted for all drug replacement. All medications, time, dose, route will be documented on EMS Patient Reports.



EMS Patient Report for Medication Exchange

Date			Fire Department			Run Number	
Patient Name						Date of Birth	
Chief Complaint:			HX Of Event			<u>PMH</u>	
Time	B/P	PULSE	RESP	SPO2	GLUCOSE	OTHER Pertinent information	
<u>MEDICATIONS:</u>							
NKA:		<u>ALLERGIES:</u>					
TIME	MEDICATION	DOSE/ROUTE	TIME	Controlled SUBSTANCE	AMOUNT WASTED	WITNESS SIGNATURE	
MEDIC SIGNATURE:							



EMS Patient Report for Medication Exchange

Date			Fire Department			Run Number	
Patient Name						Date of Birth	
Chief Complaint:			HX Of Event			<u>PMH</u>	
Time	B/P	PULSE	RESP	SPO2	GLUCOSE	OTHER Pertinent information	
<u>MEDICATIONS:</u>							
NKA:		<u>ALLERGIES:</u>					
TIME	MEDICATION	DOSE/ROUTE	TIME	Controlled SUBSTANCE	AMOUNT WASTED	WITNESS SIGNATURE	
MEDIC SIGNATURE:							

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). A dated tag will be placed on the equipment indicating cleaned.
7. Cleaned equipment will be stored in the EMS Equipment Room for retrieval. A dated sticker will be placed on all cleaned equipment.
8. EMS personnel will retrieve their equipment as soon as possible after notification that the equipment has been cleaned, remove the sticker and place back in service.
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.

HAZMAT INCIDENT

EMERGENCY CARE FOR HAZARDOUS MATERIALS EXPOSURE, 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.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT (HIPAA)**

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.

INFECTION CONTROL / S.O.P.

PURPOSE

It is reasonably anticipated that any operation, including fires, Haz-mat, extrication, MVA's etc. may involve exposure to blood, body fluids or other potentially infectious material. The health and welfare of each individual is the responsibility of each department (where employed), however Southwest General Health Center recognizes the need to offer guidance to minimize each individual's risk of exposure to communicable diseases during all aspects of care. This comprehensive program will provide individuals with education, immunization and personal protective equipment to minimize exposure to bloodborne pathogens and/or communicable diseases. The major areas of exposure control encompasses:

- Standard Precautions
- Engineering Controls
- Work Practice Controls
- Hand Hygiene
- Personal Protective Equipment
- Cleaning Procedures
- Hepatitis B vaccination
- Training regarding infection prevention and control will occur upon hire, yearly & as needed.

STANDARD PRECAUTIONS

The blood and body fluids/substances of ALL patients are to be treated as potentially infectious, regardless of diagnosis (or before diagnosis is determined in the case of prehospital care). Appropriate barrier precautions (i.e., gloves, gowns, masks, and goggles) must be routinely and consistently used for contact with blood and body fluids/substance, mucous membranes and non-intact skin of ALL patients.

ENGINEERING CONTROLS

The following engineering controls are available to hospital care providers:

- Hand Hygiene methods (soap & water – sinks &/or hand sanitizers in rescue vehicles)
- Sharps containers are available at point of use – they are puncture resistant and leak proof
- Sharps safety devices are available for venipuncture devices, syringes and lancets
- Exposure from failed engineering controls must be reported to allow review of incident and follow-up.

PATIENT CARE EQUIPMENT CLEANING

- Patient care equipment will be cleaned on a daily, weekly or monthly schedule as determined by individual fire departments. See Addendum; Sample Patient Care Equipment Cleaning Schedule.
- EMS will follow any additional recommendations for decontamination given by SWGHC Infection Control, Cuyahoga County Board of Health, Ohio Dept. of Health and/or Centers for Disease Control.

INFECTION CONTROL / S.O.P.

- Hand hygiene is routinely and consistently performed (methods are described below).
- Avoid touching eyes, nose, or mouth while giving patient care or handling contaminated equipment.
- Contaminated needles and sharps are handled and disposed of in the appropriate container.
 - Needles are never to be recapped, bent or broken or otherwise manipulated.
 - After use, all needles & sharps are discarded uncapped and intact into needle disposal container.
 - Safety devices **MUST** be activated by the user.
 - Needle/sharps containers are changed when $\frac{3}{4}$ full and sealed.
- All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets. Caregivers must anticipate potential exposures and wear appropriate protective equipment to protect themselves from splashing or spraying.
- Patient items/equipment – any reusable patient care equipment that becomes contaminated must be cleaned with an appropriate disinfectant or sterilized before it used again.
- Eating, drinking, smoking, applying cosmetics/lip balm or handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
- Food and drink are not kept in refrigerators, freezers, counter tops or in other storage areas where blood or other potentially infectious materials are present.
- Where communicable exposure is possible or anticipated, individuals not immediately needed will remain a safe distance from operations.
- Patients will be advised of respiratory etiquette (cover their nose/mouth when coughing/sneezing, use tissue to contain respiratory secretion/dispose of tissue after use, perform hand hygiene prn, wear a surgical mask if he/she is unable to cover his nose/mouth or contain respiratory secretions).
- Disposal of infectious waste in red biohazard bags to prevent further contamination to personnel, patients, and the environment. The types of waste designated as infectious at S.W.G.H. are: Microbiologicals, pathological waste, blood and blood products, sharps, contaminated laboratory waste, fluid-filled containers of body substances, items that would release blood or other potentially infectious materials (OPIM) in a liquid or semi-liquid state if compressed (i.e. drippy or super-saturated), items caked with dried blood or OPIM and are capable of releasing these during handling.
- EMS, Infection Control and ED will follow established lines of communication to allow 24/7 alerting of prehospital care providers, surveillance of potentially infectious disease outbreaks and minimize risks.
- Post exposure follow-up will be done through EMS, ED and Infection Control Depts.
- If an exposure occurs, complete patient care, then seek immediate treatment in the ED.
- It is essential that the source patient be identified and tested.

INFECTION CONTROL / S.O.P.

Hand hygiene is the single most important means of preventing the spread of infection.

HAND HYGIENE: includes “washing” with soap and water or “sanitizing” with alcohol based hand rub.

Wash with soap and water (scrub together, at least 15 seconds) in the following situations:

- On your arrival to work
- When hands are visibly soiled (dirty)
- When hands are visibly contaminated with blood or body fluids
- Before eating or after using the bathroom
- Before preparing, handling or serving food
- On completion of duty before going home

Sanitize with an alcohol hand rub in the following situations: (soap & water may also be used)

- Before and after having direct contact with patients (taking BP, pulse or lifting a patient)
- Before inserting indwelling catheters, peripheral vascular catheters or other invasive devices not requiring a surgical procedure
- Before donning sterile gloves when inserting a central intravascular device
- After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if hands are not visibly soiled
- If moving from a contaminated body site to a clean body site
- After contact with inanimate, environmental objects (including medical equipment) in the immediate vicinity of the patient
- After removing personal protective equipment (i.e. gloves, gowns, masks)
- After sneezing, coughing, or blowing your nose

Alcohol hand rub is available in all rescue vehicles and in the EMS rooms at the health center.

INFECTION CONTROL / S.O.P.**PERSONAL PROTECTIVE EQUIPMENT**

Occupational exposure may remain after engineering and work control practices have been implemented, requiring the use of personal protective equipment (PPE). PPE is a barrier that prevents blood or other infectious materials from passing through to skin and/or clothing underneath. These barriers include but are not limited to single use gloves, disposable gowns, face shields/masks, and protective eyewear. Individuals must anticipate the type of exposure that may occur during each patient contact and wear the appropriate PPE to prevent an exposure to blood and/or other potentially infectious body fluids. Although each situation will be different, below are general guidelines to consider for PPE:

GLOVES

1. Gloves should be worn for all EMS runs.
2. Gloves shall be replaced as soon as possible when soiled, torn, or punctured.
3. "Disposable gloves" are single patient use only, carefully remove by turning gloves inside out and disposing in the trash
4. "Structural fire fighting gloves" shall be worn in situations where sharp or rough edges are likely to be encountered. If contaminated, gloves must be washed before being re-used.
5. "Heavy-duty utility gloves" may be used for handling, cleaning, or decontamination of equipment.
6. Wash hands immediately after glove removal.

GOWNS/SHOES/HEAD COVERS

Fluid resistant disposable gowns are worn when it is anticipated that clothing may be soiled by blood or body fluids during the performance of a task or procedure. Under certain circumstances, head covers and/or shoe covers will be required to protect these areas from potential contamination. The goal is to protect the employee and their clothing from becoming contaminated. Structural fire fighting gear may be substituted to protect clothing from splashes and preferable in fire, rescue or vehicle extrication activities. Disposable, paper gowns may interfere with or present a hazard to the individual in these circumstances. The decision of what type of barrier protection to use to protect clothing will be left to the individual. If disposable gowns are used:

1. Shoe and head covers and gowns are single patient use and only removed immediately after use.
2. They should be rolled/folded with contaminated surface inside and disposed in the trash.

INFECTION CONTROL / S.O.P.

MASK/EYE/MOUTH PROTECTION

1. Masks and/or eye protection must be used whenever a reasonable potential for splashing or aerosolization of blood or body fluids to the eyes, nose or mouth exists.
2. Face shields on structural fire fighting helmets are not adequate for infection control purposes.
3. When treating a patient with known or suspected droplet transmissible disease (i.e. seasonal influenza, meningitis), a surgical mask must be worn if you anticipate being within 3 feet of the patient.
4. When treating a patient with known or suspected airborne transmissible disease (i.e. TB, Avian Flu), N95 face masks must be used. If possible have the patient wear a surgical mask. (Also, notify the ED of need for isolation as they will need to prepare a negative pressure room for the patient.)
5. In times of limited supplies of N95 masks, masks can be re-used by the same person unless wet, dirty or torn. Place disposable surgical mask over N95 to prevent external contamination and extend use.

MOUTH TO MOUTH RESUSCITATION EQUIPMENT

Emergency mouth to mouth resuscitation should not be performed. Bag Valve mask should be equipment of choice.

AFTER REMOVAL OF PPE

- Upon returning to quarters, wash grossly contaminated uniforms in hot water with washer provided by department. If washer is being used, place clothing into biohazard bag and wash A.S.A.P. **Under no circumstance should grossly contaminated clothing be removed from the station without being washed.**
- After any contact with contaminated item perform hand hygiene. (wash or sanitize hands)
- No living area may be entered by personnel if clothes are contaminated.
- The individual shall shower if body fluids were in contact with skin under work clothes.
- All individuals shall have (2) complete changes of uniform clothing.
- Per NFPA 1971 contaminated structural fire fighting gear shall be cleaned according to the manufacturer's recommendations found on attached labels. (i.e. gloves, boots, turnout coats, bunker pants.)

INFECTION CONTROL / S.O.P.

Expanded precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens spread by airborne or droplet transmission or by contact with the patient or contaminated surfaces. It is felt, at this time, that precautions beyond Standard Precautions are necessary or may be helpful to interrupt transmission in health care settings both pre-hospital and in the health center.

Southwest General has identified four (4) types of Expanded Precautions. These precautions are to be used in addition to Standard Precautions.

EXPANDED PRECAUTION TYPE	PRE-HOSPITAL IMPLEMENTATION
<p><u>CONTACT PRECAUTIONS (Green)</u></p>	<ul style="list-style-type: none"> • <u>Gloves</u> worn by everyone providing care and/or handling patient care equipment. • <u>Gowns required</u> for anyone having direct contact with patient or patient environment. • Wash hands with <u>soap and water</u> after care. • DO NOT use alcohol hand rub (sanitizer)
<p><u>DROPLET PRECAUTIONS (Orange)</u></p>	<ul style="list-style-type: none"> • Surgical mask required if you are within 3 feet of the patient. <u>OR</u> • Surgical mask on patient during transport.
<p><u>AIRBORNE PRECAUTIONS (Pink)</u></p>	<ul style="list-style-type: none"> • N95 mask for everyone providing care. <u>OR</u> • Turn on exhaust fan in transporting vehicle <u>OR</u> • Surgical mask on patient during transport.
<p><u>COMPROMISED PATIENT (White)</u> The immuno-compromised host is a person with one or more defects in the body's normal defense mechanisms that predispose them to infections, often life-threatening, that would otherwise not occur.</p>	<ul style="list-style-type: none"> • Frequent, meticulous hand hygiene. • Associates with active infections such as colds, herpes virus, upper respiratory illness, diarrhea, or other infectious diseases must have no contact with the patient. If this is unavoidable, they must wear a mask or other appropriate barriers.

INFECTION CONTROL / S.O.P.

PREPAREDNESS

Routine surveillance may detect an individual who requires “Expanded Precautions” such as a person being transported with possible Tuberculosis, Clostridium Difficile, or MRSA (Methicillin Resistant Staphylococcus Aureus). This is handled with routine procedures.

Some patient presentations may require extraordinary procedures such as implementation of internal, external or hazmat disaster plans at the health center. This may be for suspected cases of SARS, Avian Flu, Bioterrorism, etc...or for clusters of unusual infectious diseases being identified. EMS will notify the ED of suspected cases that may require the health center to implement their Emergency Management Plans. If this happens, “PPE” (Personal Protective Equipment) may be added to the disaster phase if it is implemented.

Examples of situations that may require activation of disaster plans (Internal/External/Hazmat) and PPE is announced with the Disaster Phase:

<p>PHASE I</p> <p>PHASE I PPE</p>	<ul style="list-style-type: none"> • A threatened biologic incident, an event where an intention is expressed or warning made that an infectious agent will be used (or has been used) to cause harm to people. No patients are presenting at this time. • New influenza virus (i.e. SARS, Avian Flu) is detected in the United States. • Unusual infectious disease cases identified or suspected such as SARS, Anthrax, Avian Flu, etc.... • Clinical staff needs to locate their PPE (including N95 mask if already fit-tested).
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<p>PHASE II</p> <p>PHASE II PPE</p>	<ul style="list-style-type: none"> • Potential terrorist utilizing biologic agents may not always threaten or notify that an event has taken place. Recognition then, in some instances, takes place by hospitals, ED Physicians, laboratory personnel who report increased numbers of ill persons to their supervisor, risk manager or infection control. • Clusters of patient with unusual infectious disease identified or suspected in one or more Southwest General facilities. • New influenza virus (i.e. SARS, Avian Flu) is detected in Ohio. • Clinical staff responding to patient care areas must look for and follow Expanded Precautions signs: “Contact”, “Droplet”, “Airborne”, or “Compromised Patient”. • Personal Protective Equipment will be available in their usual locations. • Nurse Managers or designees are responsible to obtain replacement N95’s from Protection Services. Labor Pool may be utilized to assist with their distribution.
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<p>PHASE III</p> <p>PHASE III PPE</p>	<ul style="list-style-type: none"> • Pandemic Level 6 determined by the World Health Organization (virus transmission increases significantly and there is sustained transmissibility in the general population). • Multiple infectious patients are presenting to all Southwest General facilities. • All associates in all Southwest facilities will be required to wear PPE. • Infection Control will determine what PPE will be required. • Associate Occupational Health Services (AOHS) Department will distribute PPE. • Associates report to Jones Atrium to be screened by AOHS (i.e. temperature checked, history asked). If cleared, associate will be given appropriate PPE.
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INFECTION CONTROL / S.O.P.

Routine * Cleaning Schedule for : Fire Department (SAMPLE)

In addition to "routine" cleaning, items cleaned **if visibly soiled or used for patient on expanded precautions.*

Unless otherwise noted, use these disinfectants: Super Sani clothes (general use) or TB-Cide Quat (blood spill).

Contaminated equipment shall be stored only in the decontamination area.

Between Each Patient**	Daily	Weekly
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Cot	BP Cuff <input type="checkbox"/>	Monday
Chart	BP Machine, portable <input type="checkbox"/>	Bath in Bag warmer & cart <input type="checkbox"/>
Clipboards, patient care	Glucose Monitors - SureStepFlexx (clean outside with alcohol wipe, clean strip guide with warm water only) <input type="checkbox"/>	Nurse Server Cart, inside <input type="checkbox"/>
Doppler	Thermometers <input type="checkbox"/>	Tuesday
EKG Cables	<input type="checkbox"/>	Computer Keyboard <input type="checkbox"/>
EKG Monitor	<input type="checkbox"/>	Computer Screen (dust only) <input type="checkbox"/>
EKG Machine & wires	<input type="checkbox"/>	<input type="checkbox"/>
IV Poles	<input type="checkbox"/>	<input type="checkbox"/>
Lead Wires	Telephones <input type="checkbox"/>	Wednesday
Pulse Oximeter & cable	Desk Countertop <input type="checkbox"/>	Coffee Maker (soap/water) <input type="checkbox"/>
Stethoscopes, bandage scissors, hemostats, each staff member	<input type="checkbox"/>	Microwave (soap/water), staff <input type="checkbox"/>
Wheelchair (wipe seat & arms)	Back and front of squad?? <input type="checkbox"/>	Refrigerator (soap/water), staff <input type="checkbox"/>
Squad seats, floor, doors, etc.	<input type="checkbox"/>	Thursday
		<input type="checkbox"/>
		Clipboards, unit <input type="checkbox"/>
	<i>*Initials signify completion</i>	<i>*Initials signify completion</i>
	Department Specific*	Department Specific*
Assigned To	Assigned To	Assigned To
Initials	Initials	Initials
7-3	7-3	7-3
3-11	3-11	3-11
11-7	11-7	11-7

*For any new equipment, please forward information to Infection Control for cleaning schedule recommendations and then add to Unit Specific list above.

**Oversight and delegation of these items will be the responsibility of the Charge Person.

INFECTION CONTROL / S.O.P.**NOTIFICATION OF EMS WORKERS****POLICY:**

- The health center will respond to an EMS Worker's written request for notification of the presence of a contagious or infectious disease in a patient received at Southwest General Health Center.
- An EMS Worker who believes he has suffered a significant exposure through contact with a patient may submit a written request to be notified of the results of any test done on the patient to determine the presence of a contagious or infectious disease.
- A request for notification does not obligate the health center to conduct testing for an infectious or contagious disease.

DEFINITIONS:

- An EMS Worker includes:
 - A peace officer or sheriff as defined in ORC 109.71.
 - An employee of an emergency medical service as defined in ORC 3303.08 (G).
 - A fire fighter employed by a political subdivision.
 - A volunteer fire fighter, emergency or rescue operator.
 - An employee of a private organization that renders rescue services, emergency medical care or transportation to accident victims and persons suffering serious illness or injury.
- A contagious or infectious disease means a disease specific by the Public Health Council.
- A patient means a person, whether dead or alive, who was treated, handled, or transported by an EMS Worker.
- A significant exposure means either:
 - A percutaneous or mucous membrane exposure to the blood, semen, vaginal secretions or spinal, synovial, pleural, peritoneal, pericardial or amniotic fluids of a patient, or
 - Exposure by a route known to cause transmission of a contagious or infectious disease.

INFECTION CONTROL / S.O.P.**NOTIFICATION OF EMS WORKERS****PROTOCOL:**

- The Request of Notification Form (see attachment) will be available in the Emergency Room and shall require the following information:
 - The name, address and telephone numbers of the EMS Workers submitting the request.
 - The name of the EMS Worker's employer and his/her supervisor.
 - The date, time, manner and site of the exposure.
- The Infection Control Nurse shall be informed of the request as soon as possible.
- The form shall be forwarded to the Infection Control Department.
- The request for notification is valid for 10 days after it is made.
 - If at the end of the 10 day period no test has been performed to determine the presence of a contagious or infectious disease, no diagnosis has been made, or the result of the test is negative, the Infection Control Nurse or designee shall notify the EMS Worker in writing using the appropriate form (see attached).
 - The notification shall not include the name of the patient.
 - The request may be renewed in accordance with the same procedures and requirements as the original request.
- The Infection Control Nurse shall provide oral notification to the EMS Worker and his/her supervisor of the presence of a contagious or infectious disease or of a confirmed positive test result, if known.
 - This notification shall be made as soon as test results are available, but not to exceed two (2) days after determining the presence of an infectious or contagious disease or a confirmed positive test result.
 - A written notification shall be completed by the Infection Control Nurse and shall follow oral notification within three (3) days.
 - Both oral and written notification shall include the following:
 - The name of the disease
 - Its signs and symptoms
 - The date of the exposure
 - The incubation period
 - The mode of transmission
 - The medical precautions necessary to prevent transmission to other persons, and
 - The appropriate prophylaxis, treatment and counseling of the disease
 - The notification shall not include the name of the patient

INFECTION CONTROL / S.O.P.

NOTIFICATION OF EMS WORKERS

- The information required as part of the notification shall not obligate the hospital to conduct testing for any contagious infectious disease.
- If the patient has been transferred from Southwest General Health Center, the Infection Control Nurse shall assist the EMS Worker in locating the patient (could be another health care facility or coroner's office).

INFECTION CONTROL / S.O.P.

NOTIFICATION OF EMS WORKERS

Emergency Medical System
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

Employers phone

Supervisor's name

Supervisors 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 Department record to Infection Control Department. Deliver a second copy to the EMS office.

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

INFECTION CONTROL / S.O.P.

**RESPONSE TO EMERGENCY CARE WORKERS
REQUEST FOR NOTIFICATION**

ORAL NOTIFICATION GIVEN:

To: _____

Date: _____ Time: _____

By Whom: _____
(Signature/Title)

WRITTEN NOTIFICATION SENT:

To: _____ and _____
(Name of ECW) (Name of Supervisor)

Date: _____

Date and Type of Exposure: _____

Name of disease: _____

Incubation period: _____

Signs and symptoms: _____

Mode of transmission: _____

Precautions necessary to prevent transmission to others: _____

Prophylaxis and/or treatment (if applicable): _____

Other follow-up: _____

Signature/Title of person

Identify, Isolate, Inform: Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients Who Present with Possible Ebola Virus Disease (Ebola) in the United States



SCOPE: Applies to emergency medical services providers (including emergency medical technicians (EMTs), paramedics, and medical first responders who could be providing patient care in the field—such as law enforcement and fire service personnel). For more detailed information, reference “*Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients Who Present with Possible Ebola Virus Disease in the United States*” (<http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html>).

DISPATCH/9-1-1 PSAPS

1 Inquire about travel and direct exposure history within the previous 21 days.

- Has patient traveled to, or lived in, a country with **widespread Ebola virus transmission** or uncertain control measures (a list of countries can be accessed at the following link: <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html>)?
- Has patient had contact with blood or body fluids (such as urine, saliva, vomit, sweat, or diarrhea) of a person who is confirmed or suspected to have Ebola?

NO

If **ALL** responses for Box #1 are “No,” continue with usual triage, assessment, and instructions

YES TO ANY

2 Ask about signs and symptoms.

Does the patient have signs or symptoms of Ebola: Fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, or unexplained hemorrhage (bleeding or bruising)?

NO

- If **ALL** responses for Box #2 are “No,” continue with usual triage, assessment, and instructions
- Contact public health authority, if appropriate

YES – Patient may meet criteria for suspected Ebola Infection

3 Provide Instructions to Patients and EMS Providers.

- Instruct other people at the scene to restrict contact with patient unless wearing appropriate personal protective equipment (PPE).
- Alert any first responders and EMS providers being dispatched of potential for a patient with possible exposure/signs and symptoms of Ebola **before they arrive on scene**.
- Advise EMS providers that at a minimum, they should use the following PPE before direct contact with a patient has any of these symptoms: fever, fatigue, headache, muscle pain, or weakness (<http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html>):
 - Face shield and surgical face mask,
 - Impermeable gown, and
 - Two pairs of gloves.
- If a patient is exhibiting obvious bleeding, vomiting, copious diarrhea or there is a concern for bleeding, vomiting, or diarrhea, advise EMS providers before entering the scene to wear PPE recommended for use by healthcare workers managing Ebola patients in U.S. hospitals (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>).
- If responding at an airport or other port of entry to the United States, the PSAP or EMS unit should notify the CDC Quarantine Station for the port of entry. Contact information for CDC Quarantine Stations can be accessed at <http://www.cdc.gov/quarantine/quarantinationstationcontactlistfull.html>.

4 Medical director may consider additional questions/actions specific to the local area/region.

Additional Resources

CDC’s Case Definition for Ebola Virus Disease (EVD):
<http://www.cdc.gov/vhf/ebola/hcp/case-definition.html>.

International Academy of Emergency Dispatch protocols:
[http://www.emergencydispatch.org/sites/default/files/pdf/ebola_updates/MPDS-EIDS_Tool_\(Ebola\)_v5.0.1_NAE.pdf](http://www.emergencydispatch.org/sites/default/files/pdf/ebola_updates/MPDS-EIDS_Tool_(Ebola)_v5.0.1_NAE.pdf).

EMS dispatched



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

EMS—PRIOR TO ARRIVAL AT PATIENT

Considerations for Infection Control and PPE

- If 9-1-1 PSAP call takers advise that the patient is suspected to have Ebola, EMS providers should put on the PPE appropriate for suspected or confirmed cases of Ebola before entering the scene.
- Avoid direct contact with a patient who may have Ebola without wearing appropriate PPE.
- PPE should be put on before entering a scene to attend to a suspected Ebola patient and continued to be worn until providers are no longer in contact with the patient. PPE should be carefully put on and taken off under the supervision of a trained observer as described in the *“Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)”* (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>).
- If, based on the initial screening, the EMS provider suspects the patient has Ebola then level of PPE should be reassessed before coming within 3 feet of the patient.
- **To minimize potential exposure,**
 - Limit the number of EMS providers to essential personnel only who provide care for a patient with suspected Ebola. All EMS providers having direct contact with a suspected Ebola patient must wear PPE.
 - One EMS provider should approach the patient and perform the initial screening from at least 3 feet away from the patient.
 - Keep the other emergency responders further away, while assuring they are still able to support the provider with primary assessment duties. Consider the strategy of one provider putting on PPE and managing the patient while the other provider does not engage in patient care but serves in the role of trained observer.
 - Use caution when approaching a patient with possible Ebola. On rare occasions, illness can cause delirium, with erratic behavior (e.g., flailing or staggering) that can place EMS providers at additional risk of exposure.
- There may be situations where a patient must be carried and multiple providers are required to put on PPE. EMS providers wearing PPE who have cared for the patient must remain in the back of the ambulance and should not serve as the driver.
- If needed, consider requesting additional resources, such as a dedicated driver.

Occupational Exposure

- If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with an EMS provider’s unprotected skin or mucous membranes, then the EMS provider should immediately stop working and:
 - Immediately wash the affected skin surfaces with a cleansing or antiseptic solution. Mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution, as per usual protocols.
- All wipes and solution should be placed in a biohazard bag.
- Place all waste in a biohazard bag.
- Notify your chain of command and report exposure to an occupational health provider, supervisor or designated infection control officer for follow-up as soon as possible.
- Follow agency policy for medical evaluation and follow-up care and monitoring.

Identify, Isolate, Inform: Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients Who Present with Possible Ebola Virus Disease (Ebola) in the United States

EMS ARRIVAL AT SCENE

Has PSAP call taker advised that the patient is suspected to have Ebola and EMS personnel should put on the PPE appropriate for suspected or confirmed cases of Ebola before entering the scene?

NO

YES – Patient meets criteria for suspected Ebola Infection

1 Consider appropriate PPE in the EMS setting for a person with suspected Ebola.

Is the patient exhibiting obvious bleeding, vomiting, or diarrhea or has a clinical condition that warrants invasive or aerosol-generating procedures (e.g., intubation, suctioning, active resuscitation)?

If no, then EMS personnel should at a minimum wear the following PPE (link: <http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html>):

- Face shield and surgical face mask
- Impermeable gown, and
- Two pairs of gloves

If yes, then use PPE recommended for use by healthcare workers managing Ebola patients in U.S. hospitals (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>).

2 Inquire about travel and direct exposure history within the previous 21 days.

- Has patient traveled to, or lived in, a country with widespread Ebola virus transmission or uncertain control measures (a list of countries can be accessed at the following link: <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html>)?
- Has patient had contact with blood or body fluids (such as urine, saliva, vomit, sweat, or diarrhea) of a person who is confirmed or suspected to have Ebola?

NO

If ALL responses for Box #2 are “no,” continue with usual triage, assessment, and care

YES TO ANY

3 Assess signs and symptoms.

- Does the patient have fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, diarrhea, or unexplained hemorrhage (bleeding or bruising)?

NO

- Continue with usual triage, assessment, and care
- Contact appropriate public health authority

YES – Patient meets criteria for suspected Ebola Infection

4 Isolate patient immediately and revisit Step #1 from EMS Arrival at Scene. Consider:

If you anticipate performing pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, or cardiopulmonary resuscitation, conduct these procedures while wearing the PPE recommended for use by healthcare workers managing Ebola patients in U.S. hospitals (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>).

5 Avoid unnecessary direct contact while managing patient, then prepare to transfer to an appropriate facility.

- Limit the number of providers to essential personnel only who provide care for a patient with suspected Ebola. All EMS providers having direct contact with a suspected Ebola patient must wear PPE.
- Remove and keep nonessential equipment away from the patient, so as to minimize contamination, on the scene and in the ambulance.
- Do not perform phlebotomy or any other invasive procedures unless urgently required for patient care or stabilization. Handle any needles and sharps with extreme care and dispose in puncture-proof, sealed containers that are specific to the care of this patient, in accordance with OSHA's Bloodborne Pathogens Standard. Do not dispose of used needles and sharps in containers that have sharps from other patients in them.
- Consider giving the patient oral medicine to reduce nausea, per medical director protocols and consistent with scope of practice.
- If patient is vomiting, give them a large red biohazard bag to contain any emesis. For profuse diarrhea, consider wrapping the patient in an impermeable sheet to reduce contamination of other surfaces.

Suspected Ebola Patients Should Only be Transported to a Healthcare Facility Prepared to Further Evaluate and Manage the Patient According to the Community's Predefined Transportation/Destination Plan Developed by Public Health Officials, Hospital, Medical and EMS Personnel.

TRANSPORT TO A HEALTHCARE FACILITY

6 Prepare for transport according to agency/local protocol.

- Separate the driver from the patient compartment.
- The driver should contact the receiving emergency department or hospital and follow previously agreed upon local or regional protocols to transport the patient to the receiving hospital. This will allow the facility to prepare for receipt of the patient.

7 Follow infection control principles during transport to the hospital.

- Avoid contamination of reusable porous surfaces that are not designated for single use. Use only a mattress and pillow with plastic or other covering that fluids cannot penetrate. Cover the stretcher with an impermeable material.
- During transport, ensure that an appropriate disinfectant U.S. Environmental Protection Agency (EPA) - approved hospital grade disinfectant with a non-enveloped virus claim is available (for example, in spray bottles or as commercially prepared wipes).
- Provide patient care, as needed, to minimize the contact with patient and following infection control guidelines as noted below. If performing pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation, conduct these procedures under safer circumstances (e.g., stopped vehicle, hospital destination) and wear the PPE recommended by CDC to use during aerosol generating procedures (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>).

AT HOSPITAL

8 After patient transfer, perform supervised/observed doffing of PPE.

In collaboration with the receiving hospital, EMS agencies should consider how best to facilitate

- A supervised doffing process. Doffing of PPE must
 - Be performed in a designated location
 - Adhere to established procedures and in the presence of a trained observer in order to prevent self-contamination or other exposure to Ebola virus.
- A shower for EMS providers, if available, or an area to change into clean clothing.

See guidance on PPE doffing for more information: <http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>.

9 Decontaminate and disinfect (clean) vehicle and equipment while wearing appropriate PPE. Address disposal of waste.

- Consider repositioning a trained crew wearing appropriate PPE to perform these operations, so that EMS personnel can focus on doffing PPE, communicating with hospital, and finishing appropriate documentation.
- Put on fresh PPE as recommended by CDC before decontaminating and disinfecting the vehicle when body fluids from a patient with suspected Ebola are present. If no body fluids are present then minimal PPE should be worn, including face shield and surgical mask; impermeable gown, and two pairs of gloves.
- Use an EPA-registered hospital disinfectant with a label claiming inactivation for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces of vehicle and equipment used with suspected or confirmed Ebola virus infection. (<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).
 - Follow instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids.
 - After the bulk waste is wiped up, the surface should be disinfected as described below. There should be the same careful attention to the safety of the EMS providers during the cleaning and disinfection of the transport vehicle as there is during the care of the patient.
- A blood spill or spill of other body fluid or substance should be managed by personnel wearing correct PPE, and includes removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient. (<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).
- Clean and disinfect patient-care surfaces and equipment, and other areas that are likely to become contaminated after each transport. Avoid contamination of reusable porous surfaces that are not designated as single use.
- Place contaminated reusable patient care equipment (e.g., glucometer, blood pressure cuff) in biohazard bags and label for cleaning and disinfection. Clean and disinfect reusable equipment according to agency policies and manufacturer's instructions by trained personnel wearing correct PPE.
- Discard any bodily secretions (such as urine or vomit) as directed by hospital staff.
- EMS systems should work with designated receiving hospitals to dispose of waste from suspected Ebola patients. Discarded materials suspected of being contaminated with Ebola (i.e., used PPE, used linens, non-fluid-impermeable pillows or mattresses and bulk waste) that are transported to an off-site disposal facility must be packaged and transported in accordance with the Hazardous Materials Regulations (HMR, 49 C.F.R. Parts 171-180).
- Leave vehicle to dry as normal.
- Once cleaning is complete, doff PPE using same procedures and trained observer in a designated area as with the patient care crew.

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)

**THIS IS AN
INTERNAL
FORM ONLY**

Date / Time: _____

Reported by: _____ Title: _____

Department: _____ Shift: _____

Regarding: Patient Nurse Fire Personnel Physician Other

Name of Patient: _____ Phone No: _____

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*

MORPHINE / VALIUM KIT / VERSED

PURPOSE: To facilitate the distribution of controlled substances.

MORPHINE / VALIUM KIT / VERSED

The Southwest General Health Center Controlled Substance Kit contents:

- 5 - 2 mg / mL morphine sulfate tubexes
- 1 - tubex holder
- 1 - Valium, (diazepam) 10 mg / 2 mL vial
- 1 - Versed 5 mg / 1 mL vial
- 2 - Versed 2 mg / 2 mL vials

The EMS Patient Report for medication exchange form is to be used to document the administration of controlled substances.

When controlled substances and all medications are used, the Medication Exchange Form must be completed.

- All controlled substance kits shall remain locked in the paramedic drug box.
- Controlled substances will be placed into the sharps container. Two paramedics and/or a paramedic and registered nurse can witness the wasting of unused morphine / valium / versed. Each must sign and date the form, and leave the form in the Emergency Department/EMS Medication Room.
- A one-to-one drug replacement will be supplied by Southwest General Hospital. A completed EMS Patient Report and Medication Exchange Form will be required to receive the drug from an ED nurse.

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.

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.
- Be aware of weight limits on all equipment used. Do not exceed amounts set by equipment manufacturer.

OFFER OF ASSISTANCE CARD

ATTENTION

Thank you for your offer of assistance. Be advised that these EMT Paramedics (EMTP), EMT Advanced (EMTA) 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.

Susan Tout, MD
Director, Emergency Medicine
Southwest General Health Center

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

EMT/Nurse/Healthcare-Intervener:

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

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

General Considerations**On-Scene Physician:**

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

- Ideally, if no further assistance is needed, 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.

QUALITY IMPROVEMENT

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

PHILOSOPHY

The EMERGENCY MEDICAL SYSTEM CARE services under the Medical Direction of SWGH 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.

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. Loudly ask that all who can hear you wave hands.
- C. Begin assessing all non-waving and non-ambulating victims where they lie, if possible. Each victim should be triaged in 60 seconds or less, preferably much less. **NOTE: Remember the 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 comands and is oriented x3, tag GREEN.
NOTE: Depending on injuries (e.g., burns, fractures, bleeding), it may be necessesary 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.
 - E. Use Jump START procedures for pediatric patients.

RPM: 30, 2, Can Do!

R: Respiration's – 30

P: Perfusion – 2

M: Mental Status – Can Do

TERMINATION OF RESUSCITATIVE EFFORTS

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

PURPOSE

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, King Airway, or needle cricothyrotomy.
 - The patient must have a patent intravenous access or IO.
 - 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.

**Southwest General Health Center / EMS
Approved Documentation Abbreviations**

PATIENT INFORMATION/CATEGORIES			67
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.)			68
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
Venereal 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			69
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	Glasgow 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			70
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			71
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

