TAB 1
OPERATIONAL GUIDELINES
TAB 1 GUIDELINE 1

CLINICAL PRACTICE STANDARDS FOR EMS

1. Medical Direction:
   a. Northwest Ohio EMS Consortium
      i. Melissa Amonette, MD
      ii. Teresa Bridges, MD, FACEP
      iii. James Case, MD
      iv. Dan Neumeyer, DO
      v. Matthew White, DO
      vi. Steve Zohn, MD
   b. Website – http://www.nwoems.com

2. Guideline Specific Definitions:
   a. Incident
      i. A dispatch of 911 resources to a location by a person or third party.
   b. Patient
      i. Any person who has a physical or medical complaint or condition from an illness or injury.
      1. **Infant patient** (less than 2 years of age)
      2. **Pediatric patient** (age 2 – 16 years of age); Age of consent > 18
      3. **Adult patient** (16 years or older)
      4. **Geriatric patient** (70 years or older)
      5. No patient contact is defined as a disregard by the requesting person or agency or would be patient is gone upon arrival.
   c. Intoxicated – any person presenting with “diminished” physical, mental control or ability to make decisions by reason of the influence of alcohol, drugs or other substance.
   d. Patient Care Report (PCR) – this is the form (either electronic or written) that documents the assessment and medical care provided to a patient.

3. Policy
   a. EMS agencies shall utilize their individual operational policies and procedures (SOP / SOG), and utilize this medical guideline for patient care. **EMS personnel will work within the State of Ohio Scope of practice for their level of certification.** EMR, EMT’s and Advanced EMT’s shall maintain BLS certification; Paramedics shall maintain
**BLS / ACLS / PALS (or equivalent) certification and reference those certifications when necessary. ITLS and ENLS certification is recommended.**

b. All newly hired medical personnel will undergo an orientation and evaluation to ensure that the crew member understands the Northwest Ohio EMS Consortium guidelines and the state of Ohio Scope of Practice. This orientation and evaluation will also include driving operations, scene management, patient assessment and medical skills assessment.

c. Responsibility

i. It is the responsibility of the member with the highest level of medical training at the scene to guide the medical decisions regarding patient care and transportation.

d. Assessment

i. All subjects identified as a patient as defined above will be assessed using criteria consistent with the provider’s level of training. This will include but not limited to the following:

1. Vital signs – blood pressure, pulse rate, respiratory rate and pulse oximetry reading, Temperature and Capnography when applicable.

2. Mental status – evaluate to establish the patient’s level of consciousness (alert and oriented to person, place, time and situation) using the AVPU method within the context of the expected developmental level.

3. History of present illness / injury.

4. Medications – ALL current medications and allergies to medications.

5. Focused assessment / physical examination to include all pertinent positive or pertinent negative symptoms.

e. Treatment

i. All patients assessed by EMS personnel will be treated as directed by the guidelines contained herein based on the initial patient history of the presenting illness and physical examination.

1. **Within this guideline, not all of the medications in Tab 9 and on the individual EMS drug formularies will be utilized or made available to the EMS crews.**

2. **Individual medications are potentially made available at different time periods depending on drug shortages and / or special need situations.** Having the medication in this guideline and / or on the drug formulary
and not available for use does not constitute a breach of duty or neglect from the EMS crew member.

ii. Appropriate body substance isolation precautions should be taken.

iii. Maintain airway.

iv. Establish IV / IO if potentially needed.

v. Apply cardiac monitor if appropriate and available.

vi. EMS Provider should request ALS back-up or intercept if they feel the patient’s condition and needs exceed or may exceed their level of training / care.

4. Documentation

   a. All aspects of the patient’s medical assessment, treatment and transportation will be documented in the PCR. Each EMS unit that interacts with the patient shall complete a PCR on that patient:

      i. Member completing the PCR will sign the form as a medical document.

      ii. Activities performed by any person involved with the patient’s care will be documented on the unit’s PCR.

      iii. All patients will, as a minimum, have assessment criteria documented as above. If assessment criteria are not obtained, documentation supporting the inability to gather an assessment will be included.

      iv. All records of cardiac rhythms (including heart monitoring and AED tracing if able) should be collected and archived as part of the patient’s record.

5. **Standard of care will be provided for all patients**

   a. Scene safety and ensure appropriate patient care area

   b. Primary survey (A, B, C, D, E)

   c. Vital signs with GCS

   d. Chief complaint

   e. History, allergies and medications

   f. Secondary survey when appropriate

   g. Excess time should not be spent on scene completing all treatment of the patient. Most treatment may be completed during transport.

   h. Treatment and transport must be done expeditiously and according to guidelines

      i. Oxygen where indicated in the guideline and/or provider’s discretion

      ii. Monitor vital signs every 5 minutes for the unstable patient, and as needed for the stable patient (at minimal every 15 minutes)
iii. Cardiac monitor and pulse oximetry where indicated in guideline and/or at provider’s discretion. A strip of the cardiac rhythm should be attached to all copies of the patient care chart (PCR)

iv. All patients in restraints will have frequent assessment and documentation of distal circulation, motor and sensation. The patient will also have continuous monitoring of their airway and breathing status.

i. Base hospital contact must be made at any time the provider has a question regarding patient care.

j. You may return to the hospital “Code 3” in justifiable situations when the benefit to the patient in reduced transport time will outweigh the risk of Code 3 transport.

k. All crew members are expected to function as a team. While the highest level of licensure/certification is ultimately responsible for the care of the patient, they are not required to perform all patient care or documentation. Crew members are encouraged to allow their fellow crew members to function up to their level of expertise and training. All crew members are responsible for patient care.
## TAB 1 GUIDELINE 2
EMS SCOPE OF PRACTICE

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

Updated October 18, 2017

<table>
<thead>
<tr>
<th>Airway Management</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Open and maintain the airway</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>2 Oropharyngeal airway adjunct</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>3 Nasopharyngeal airway adjunct</td>
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<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>4 Manual removal of obstructed airway</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>5 Laryngoscopy for removal of airway obstruction</td>
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<td>x</td>
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<tr>
<td>6 Oral suctioning</td>
<td>x</td>
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<tr>
<td>7 Endotracheal (ET) tube suctioning via through a previously established airway or a stoma</td>
<td></td>
<td>x</td>
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<tr>
<td>8 Tracheostomy tube replacement</td>
<td></td>
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<td>x</td>
<td>x</td>
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<tr>
<td>9 Cricothyrotomy, surgical</td>
<td></td>
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<tr>
<td>10 Cricothyrotomy, needle</td>
<td></td>
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<tr>
<td>11 Apply and obtain readings of pulse oximeter, CO-oximeter, and capnography or capnometry equipment</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>12 Oxygen administration</td>
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<tr>
<td>a. Nasal cannula</td>
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<tr>
<td>b. Non-rebreather mask</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>c. Mouth-to-barrier devices</td>
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<td>d. Partial rebreather mask</td>
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<td>e. Venturi mask</td>
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<tr>
<td>13 Ventilation management</td>
<td></td>
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<tr>
<td>a. Bag valve mask</td>
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<tr>
<td>b. Ventilation with a flow-restricted oxygen-powered device</td>
<td>x</td>
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<tr>
<td>c. Positive pressure ventilation devices (manually triggered or automatic ventilators)</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>14 Ventilator management - 16 years of age or older</td>
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<td>15 Orotracheal intubation</td>
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<tr>
<td>a. Apneic patients</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>b. Pulseless and apneic patients</td>
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<tr>
<td>16 Nasotracheal intubation</td>
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<tr>
<td>17 Dual lumen airway</td>
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<tr>
<td>a. Apneic patients</td>
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<tr>
<td>b. Pulseless and apneic patients</td>
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<tr>
<td>18 Extraglottic airways</td>
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<tr>
<td>a. Apneic patients</td>
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<td>x</td>
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<tr>
<td>b. Pulseless and apneic patients</td>
<td>x</td>
<td>x</td>
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<tr>
<td>19 CPAP administration and management</td>
<td>x</td>
<td>x</td>
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<tr>
<td>20 BIPAP administration and management</td>
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<tr>
<td>Positive end-expiratory pressure (PEEP)</td>
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<tr>
<td>End tidal CO₂ monitoring and detecting</td>
<td>X</td>
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<tr>
<td>Oxygen humidifier equipment application and monitoring</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Chest tube monitoring and management</td>
<td>X</td>
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<tr>
<td>Nasogastric (NG) tube placement</td>
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<tr>
<td>Orogastric (OG) tube placement</td>
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<table>
<thead>
<tr>
<th>Cardiac Management</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
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</thead>
<tbody>
<tr>
<td>1 Cardiopulmonary resuscitation (CPR)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>2 Chest compression assist devices</td>
<td>X</td>
<td>X</td>
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<tr>
<td>3 Automated external defibrillator (use of an AED)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>4 Manual defibrillation</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>5 Negative impedance threshold devices</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>6 Administration of cardiac medication</td>
<td>X</td>
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<tr>
<td>7 Set up cardiac monitor in the presence of an AEMT or Paramedic</td>
<td>X</td>
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<tr>
<td>8 Cardiac monitor strip interpretation</td>
<td>X</td>
<td>X</td>
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<tr>
<td>9 Cardioversion</td>
<td>X</td>
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<td>10 Carotid massage</td>
<td>X</td>
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<tr>
<td>11 Transcutaneous cardiac pacing</td>
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<tr>
<td>12 12-lead EKG performance and interpretation</td>
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<tr>
<td>13 12-lead EKG application assisting Paramedic who is present</td>
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<tr>
<td>14 12-lead EKG set up and application for electronic transmission</td>
<td>X</td>
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</tbody>
</table>

*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.*

<table>
<thead>
<tr>
<th>Medical Management</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Epinephrine administration via auto-injector</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2 Epinephrine administration via SQ, or IM routes</td>
<td>X</td>
<td>X</td>
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<tr>
<td>3 Epinephrine administration via IV or IO route</td>
<td>X</td>
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<tr>
<td>4 Aspirin administration</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>5 Oral glucose administration</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>6 Activated charcoal administration</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>7 Nitroglycerin administration (patient assisted)</td>
<td>X</td>
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<tr>
<td>8 Nitroglycerin administration (non-patient assisted)</td>
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<tr>
<td>9 Aerosolized or nebulized medications administration (patient assisted)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>10 Administration of aerosolized or nebulized medications (non-patient assisted)</td>
<td>X</td>
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<tr>
<td>11 Naloxone administration via auto-injector</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12 Naloxone administration via intranasal route</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13 Naloxone administration via ETT, IM, IV, IO, or SQ routes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Medication administration (protocol-approved)</td>
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<tr>
<td>15</td>
<td>Administration of intranasal medications (in addition to naloxone)</td>
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<tr>
<td>16</td>
<td>Immuniizations for influenza to firefighters, EMTs, AEMTs, or paramedics (ORC 4765.391)</td>
<td></td>
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<tr>
<td>17</td>
<td>Set up of IV administration kit in the presence of an AEMT or Paramedic</td>
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<tr>
<td>18</td>
<td>Transport of central/peripheral IV without an infusion</td>
<td>X</td>
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<tr>
<td>19</td>
<td>IV maintenance and fluid administration</td>
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<td>X</td>
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<tr>
<td>20</td>
<td>Maintenance of medicated IV fluids</td>
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<tr>
<td>21</td>
<td>Central line monitoring</td>
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<tr>
<td>22</td>
<td>IV infusion pump</td>
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<td>23</td>
<td>Intraosseous needle insertion</td>
<td>X</td>
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<td>24</td>
<td>Saline lock initiation</td>
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<tr>
<td>25</td>
<td>Peripheral IV blood specimens</td>
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<td>26</td>
<td>Maintenance of blood administration</td>
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<td>27</td>
<td>Thrombolytic therapy initiation and monitoring</td>
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</tbody>
</table>

*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. See “AEMT Medications Approved by the EMFTS Board.”*
3. Blood chemistry analysis

4. Eye irrigation

5. Eye irrigation with Morgan lens

6. Maintenance of blood administration

7. Thrombolytic therapy initiation and monitoring

An EMR may only assist with emergency childbirth management.

<table>
<thead>
<tr>
<th>Emergency Medical Services in Hospital</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>x</td>
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</table>

<table>
<thead>
<tr>
<th>Additional Services in a Declared Emergency</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nerve Agent or Organophosphate Release</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
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</table>

**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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>Lidocaine for pain relief after intraosseous needle insertions</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>Narbuphine</td>
</tr>
<tr>
<td>Dextrose in water</td>
<td>Naloxone</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>Narcotics or other analgesics for pain relief</td>
</tr>
<tr>
<td>Epinephrine 1 mg per 1 ml (subcutaneous or intramuscular)</td>
<td>Nitrous oxide</td>
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<tr>
<td>Glucagon</td>
<td>Oral ondansetron²</td>
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<tr>
<td>Ketamine</td>
<td>Sublingual nitroglycerin</td>
</tr>
</tbody>
</table>

A 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.
TAB 1 GUIDELINE 3

DOCUMENTATION OF VITAL SIGNS

Every patient encounter by EMS shall 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 in the patient care report (PCR) for any patient who receives any assessment component.

Purpose:

1. To ensure:
   a. Objective evaluation of every patient’s general clinical status
   b. Documentation of a complete set of vital signs

Procedure:

1. An initial complete set of vital signs includes:
   a. Pulse rate
   b. Systolic AND diastolic blood pressure (cap refill may be substituted in children < 3)
      • Initial blood pressure should be a manual blood pressure
      • Generally, children > 3 years of age should have a BP measured, and cap refill measured for < 3 years of age.
      • For young children, the need for BP measurement should be determined on a case-by-case basis considering the provider’s rapport with the child and the child’s clinical condition.
   c. Respiratory rate
   d. Pain / severity (when appropriate to patient complaint)
   e. GCS for Injured Patients

2. When no ALS treatment is provided, palpated blood pressures are acceptable for REPEAT vital signs.

3. Based on patient condition, complaint, and guideline used, vital signs may also include:
   a. Pulse Oximetry, Temperature, End Tidal CO2

4. If the patient refuses evaluation, an assessment of capacity (Medical Legal Considerations Guideline) and a patient disposition form must also be completed. In addition, providers should record any vital signs that the patient or situation allows (e.g. a respiratory rate may be obtained by observation alone), and include an explanation of the clinical situation and refusal in the PCR narrative.
5. When any components of vital signs were obtained using the cardiac monitor, the data should be exported electronically to the PCR if available. Where values are inconsistent with manually obtained values, values may be appropriately edited to reflect the manually obtained values.

6. Record the time that vital signs were taken
TAB 1 GUIDELINE 4
CRITERIA FOR UTILIZATION OF ALS
AND TRANSFER OF CARE

These guidelines are not meant to be definitive in calling for an Advanced Life Support unit, but are meant to give direction as to the possible need for such. The EMS personnel, using his / her skills in patient assessment and the listed criteria should exercise his / her best judgment in determining the need for ALS care. Any time a patient meets the criteria listed below, and the patient is not assessed by an ALS unit, justification for such, should be noted on the run sheet.

<table>
<thead>
<tr>
<th>ABNORMAL VITAL SIGNS</th>
<th>ANATOMY</th>
<th>TRAUMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BP</strong></td>
<td>Penetrating wounds to the head, chest, abdomen Penetrating trauma to extremities proximal to knee or elbow with neurovascular compromise Significant injuries to head, neck, torso Abdominal tenderness, distention or seatbelt sign Pelvic fracture Two or more proximal long bone fractures Flail chest or multiple rib fractures Amputations proximal to the wrist or ankle Extremity injury with crush or neurovascular compromise Signs of suspected spinal cord injury Burns &gt; 10% or to airway, face, feet, hands, genitalia</td>
<td></td>
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<tr>
<td>o SBP &lt; 90 mmHg with symptoms o SBP &gt; 180 mmHg with symptoms o DBP &gt; 110 mmHg with symptoms</td>
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<tr>
<td>o Pulse &lt; 60 or &gt; 110 with symptoms</td>
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<td>o Respiration &lt; 8 or &gt; 24 with symptoms</td>
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<tr>
<td>o SpO2 &lt; 92% with symptoms</td>
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<td></td>
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<tr>
<td>o Glucose &lt; 60 or &gt; 250 or HHH (on glucose meter) with symptoms</td>
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<tr>
<td><strong>ABDOMINAL PAIN</strong></td>
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<tr>
<td><strong>ANATOMY</strong></td>
<td></td>
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<tr>
<td>Altered level of consciousness</td>
<td></td>
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<tr>
<td>Abnormal vital signs of signs of shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy or a possibility of pregnancy</td>
<td></td>
<td></td>
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<tr>
<td>o Imminent birth</td>
<td></td>
<td></td>
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<tr>
<td>o 1st pregnancy with labor pains 2 minutes apart</td>
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<td></td>
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<tr>
<td>o 2nd pregnancy with labor pains 5 minutes apart</td>
<td></td>
<td></td>
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<tr>
<td>o 2nd or 3rd trimester bleeding</td>
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<tr>
<td>o Miscarriage in the 2nd trimester or beyond</td>
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<td></td>
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<tr>
<td>o Multiple births (twins)</td>
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<tr>
<td>Major bleeding</td>
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<tr>
<td>Vomiting blood or a coffee ground like emesis</td>
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<tr>
<td>Rectal bleeding or bloody / tarry stools</td>
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<tr>
<td>Pulsating mass in the abdominal area</td>
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<tr>
<td>CHEST PAIN WITH</td>
<td>BURNS</td>
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<td>----------------</td>
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<td></td>
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<tr>
<td>• Altered level of consciousness</td>
<td>• Altered level of consciousness</td>
<td></td>
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<tr>
<td>• Abnormal vital signs or signs of shock</td>
<td>• Abnormal vital signs or signs of shock</td>
<td></td>
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<tr>
<td>• History:</td>
<td>• Full thickness burns involving the hands, feet, face, upper airway or genitalia area</td>
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<tr>
<td>o Age &gt; 40 or 30 with risk factors</td>
<td>• Full thickness burns covering</td>
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<tr>
<td>o Without provocation</td>
<td>• Adult &gt; 10% of total body surface</td>
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<tr>
<td>o Drug abuse – cocaine or stimulants</td>
<td>• Children &lt; 5 or adults &gt; 55; 2 – 10% of total body surface</td>
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<tr>
<td>o Female &gt; 40 with fatigue, SOB or syncope</td>
<td>• Partial thickness burns covering</td>
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<tr>
<td>• Risk factors include:</td>
<td>• Adults &gt; 30% of total body surface</td>
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<tr>
<td>o diabetes, increased cholesterol, family history, hypertension or smoking</td>
<td>• Children &lt; 5 or adults &gt; 55; 15 – 30% of total body surface</td>
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<tr>
<td>• Breathing difficulty with</td>
<td>• Burns associated with respiratory injury</td>
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</tr>
<tr>
<td>• Altered level of consciousness</td>
<td>• Burns complicated by a painful, swollen and deformed extremity</td>
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</tr>
<tr>
<td>• Abnormal vital signs or signs of shock</td>
<td>• Superficial burns covering &gt; 50% on children &lt; 5 or adult &gt; 55</td>
<td></td>
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<tr>
<td>• Abnormal breathing pattern or rate &lt; 8 or &gt; 24</td>
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<tr>
<td>• Audible signs</td>
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<td></td>
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<tr>
<td>o Stridor or Wheezing</td>
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<tr>
<td>• Complaint of breathing difficulty with</td>
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<tr>
<td>o History of asthma</td>
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<td></td>
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<tr>
<td>o COPD / emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Congestive heart failure</td>
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<table>
<thead>
<tr>
<th>MENTAL STATUS CHANGES</th>
<th>MECHANISM OF INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any decline in mental status from baseline</td>
<td>• Fall &gt; 20 feet with injuries</td>
</tr>
<tr>
<td>• Seizure / diabetic emergencies</td>
<td>• Ejection from auto with injuries</td>
</tr>
<tr>
<td>o Altered level of consciousness</td>
<td>• Dead passenger in same auto</td>
</tr>
<tr>
<td>o Abnormal vital signs or signs of shock</td>
<td>• Auto pedestrian with injuries</td>
</tr>
<tr>
<td>o Adult seizure with no previous history and loss of consciousness</td>
<td>• Motorcycle collision with demonstrable injuries</td>
</tr>
<tr>
<td>• Burn associated with respiratory injury</td>
<td>• Extended extrication</td>
</tr>
<tr>
<td>• Burns complicated by a painful, swollen and deformed extremity</td>
<td></td>
</tr>
<tr>
<td>• Superficial burns covering &gt; 50% on children &lt; 5 or adult &gt; 55</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STROKE</th>
<th>GERIATRIC TRAUMA (age &gt; 70 years with changes to above criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Altered level of consciousness</td>
<td>• Altered level of consciousness or GCS &lt; 14 with suspected head injury</td>
</tr>
<tr>
<td>• Abnormal vital signs or signs of shock</td>
<td>• Altered level of consciousness GCS &lt; 13</td>
</tr>
<tr>
<td>• Airway compromise</td>
<td>• SBP &lt; 100 mmHg or absent radial pulse with carotid pulse</td>
</tr>
<tr>
<td>Onset &lt; two (2) hours with deficits</td>
<td>• Fracture to one (1) proximal long bone sustained in vehicular crash</td>
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<td></td>
<td>• Pedestrian struck by a motor vehicle</td>
</tr>
<tr>
<td></td>
<td>• Fall from any height with evidence of Traumatic Brain Injury (TBI)</td>
</tr>
</tbody>
</table>
Care of the following patients cannot be transferred to a lower level credential (i.e. to an Advanced EMT or EMT from a Paramedic):

1. Any patient who requires or might reasonably require additional or ongoing medications, procedures and/or monitoring beyond the scope of practice of the lower credentialed provider. This includes any critically ill or unstable patient as advanced airway management may be required in any decompensating patient. EMT and Advanced EMT providers may be credentialed to perform some but not all airway management, and medications associated with airway management are limited to Paramedic scope of practice.

2. Any patient for whom ALL EMS providers on scene do not agree can be safely transported without an ALS provider in attendance in the patient care compartment. As a general rule, if BLS providers are questioning who should attend the patient, the ALS provider should attend the patient.

3. Any patient suffering from chest pain of suspected cardiac origin, cardiac arrhythmia, moderate to severe respiratory distress, multiple trauma, or imminent childbirth.

4. Post-ictal seizure patients due to the possibility of a re-occurrence of a seizure.

5. Patients who have been medicated on the scene may only be transferred to a technician of lower credential whose formulary includes the medications that were administered.
TAB 1 GUIDELINE 5
PATIENT PRIORITY RESPONSE | DISPOSITION | TRANSPORTATION

1. Purpose:
   a. To provide guidelines on the use of lights and sirens for EMS response and patient transportation
   b. To provide guidelines for patient disposition types and scene / bedside time limits
   c. Ensure that drivers of an emergency vehicle or public safety vehicle drive with due regard for the safety of all persons using the street or highway
   d. Ohio Revised Code (Section 4511). The Ohio Revised Code governs the driving of emergency vehicles. All Northwest Ohio EMS Consortium approved Fire / EMS Agencies will abide by the Ohio Revised Code.

2. Medical Priority Response
   a. Where Emergency Medical Dispatchers (EMD) and/or a tiered response are/is available, the EMS Agency is encouraged to develop procedures that reduce unnecessary use of lights and siren. The procedures may include, but are not limited, the use of established EMD call screening protocols / guidelines and evaluation of the patient by First Responders
      i. Priority 1: Life threatening or potentially life threatening emergencies
         1. RESPONSE: Life support vehicles, in compliance with Ohio Revised Code, use lights and sirens while responding to the scene
      ii. Priority 2: Unknown Emergency
         1. RESPONSE: Only the first responding life support vehicle, in compliance with Ohio Revised Code, responds lights and sirens to the scene. All other life support vehicles respond with no lights and sirens to the scene unless upgraded
      iii. Priority 3: Non-Life Threatening Emergency
         1. RESPONSE: Life support vehicles, in compliance with Ohio Revised Code, responds with no lights and sirens to the scene

3. All patients attended by the EMS personnel following these medical guidelines will have one of the following dispositions:
   a. Emergent – immediate threat to life or limb:
      i. Specific situations include: Unstable airway, STEMI, Stroke, and Trauma patients
ii. Transport to the closest appropriate medical facility capable of handling the emergency:
   1. STEMI and Cardiac Arrest patients should be transported to STEMI centers / hospitals with cardiac catheterization ability
   2. Stroke patients should be transported to either primary or comprehensive stroke center based upon RACE Score
   3. Trauma patients should be transported to trauma centers

iii. Hospital capacity status does not affect hospital choice

iv. On scene / bedside time should be limited to 10 minutes unless a critical intervention (airway management) is necessary for patient care. All other interventions should be performed while en route to the hospital

b. Emergent – NO immediate threat to life or limb:
   i. Patient request shall be honored based on specific departmental policy
   ii. Hospital capacity status should be discussed with the patient prior to the patient or family departure to hospital of choice
   iii. On scene time, should be limited to 20 minutes

c. Non-Emergent – chronic or minor illness or injury:
   i. Patient request shall be honored unless otherwise directed by departmental policy.
   ii. Hospital capacity status should be discussed with the patient prior to the patient or family departure to hospital of choice

d. Special cases:
   i. Combative patients – the patient presents a significant threat to EMS staff; a police officer should accompany the patient during transport in the EMS unit
   ii. Toxic ingestion – ALL patients with suspected or reported toxic ingestion shall be properly decontaminated prior to transport

e. Refusal of care or transport
   i. Patients not requiring treatment / transport may be transported by other means or left in care of self or family. Document treatment / transport refusal
   ii. Patients refusing treatment or transport should be made fully aware of the possible consequences of their decision. Be aware that it is a patient’s right to refuse treatment and still consent to transport. Patient is to sign the AMA form and the EMT should document the treatment refused. (A family member’s signature is also highly desirable)
iii. Any ALS patient refusing transport to the closest appropriate facility should be transported to the facility of their choice, after they are made fully aware of the possible complication of a longer transport. An AMA form should be obtained indicating the reason for by-passing the closest appropriate hospital. The patient and a witness (preferably a family member) should sign the AMA form.

f. **No Patient Contact, No Incident Found or other “third party” calls where the person states they did not call for EMS assistance**, the EMS provider does not need to obtain a written refusal / release at scene.

4. Medical Priority Transport
   a. The purpose is to protect the EMS system and personnel from potential harm and liability associated with the transportation of adult / geriatric and pediatric patients
   b. Drive cautiously at safe speeds observing traffic laws
   c. Tightly secure all monitoring devices and other equipment.
   d. Priority 1: Imminent life threatening emergencies
      i. Examples include:
         1. Unsecured airway or ongoing severe respiratory distress
         2. Clinical signs of shock
         3. Deteriorating mental status
         4. ST Elevated Myocardial Infarction
         5. Acute Stroke < 4.5 hours from time of onset
   ii. TRANSPORT: Life support vehicles, in compliance with Ohio Revised Code, use lights and sirens
   e. Priority 2 and 3: No imminent threat to life
      i. Examples include:
         1. Chest or abdominal pain
         2. Diabetic emergencies
         3. Extremity injuries
   ii. TRANSPORT: Life support vehicles, in compliance with Ohio Revised Code, DO NOT use lights and sirens
   f. Pediatric patient transportation
      i. Without special considerations, children are at risk of injury when transported by EMS providers. EMS must provide appropriate stabilization and protection to pediatric patients during EMS transport.
ii. Ensure that all pediatric patients less than 40 lbs (18 Kg) are restrained with a NHTSA approved child restraint system (CRS) [NHTSA approved car seat, Pedi Mate, Neo Mate Pediatric Restraint system or equivalent type system] secured appropriately to the stretcher or captain’s chair

iii. Transport adults and children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible. Do not allow parents, caregivers, or other passengers to be unrestrained during transport

iv. NEVER attempt to hold or allow the parents or caregivers to hold the patient during transport

v. For patients with medical conditions that may be aggravated by stress, make every attempt to optimize safety when comforting the child

vi. Do not transport the pediatric patient who is assessed as meeting trauma center criteria in a child seat that was involved in the collision that produced the child’s injury

5. Emergency Vehicle Operation
   a. Use of seatbelts
      i. All persons riding on department apparatus shall be seated in approved riding positions and shall be secured to the vehicle by seat belts any time the vehicle is in motion
      ii. Standing while riding is prohibited. (Exception; persons providing medical care in ambulances)
      iii. Riding on tailboards, sidesteps, running boards, or in any other exposed position is prohibited
   b. Vehicle speed and positioning
      i. The driver will always maintain a speed consistent with safe operation of the vehicles under prevailing conditions
      ii. Driving in the center turn lane or in the left of center lane into on-coming traffic is extremely dangerous and should be avoided whenever possible. Speed of apparatus while traveling against traffic shall not exceed 20 MPH
      iii. Apparatus shall obey all posted limits in school zones during emergency and non-emergency driving. School zones will be avoided whenever possible during emergency responses
iv. Apparatus following other apparatus during an emergency response will maintain a clear and safe distance between vehicles (a minimum of 3 seconds). Drivers in following vehicles will be especially attentive at every intersection to ensure that cross-traffic does not proceed into the intersection after the first emergency vehicle has passed or acquired the intersection.

v. When operating on a multi-lane highway under emergency conditions, vehicles will travel on the inside lane as most motorists will automatically pull to the right when an emergency vehicle is approaching. Highway speeds call for greater following distances.

vi. During emergency response and non-emergency travel, drivers of responding vehicles shall come to a complete stop at all unguarded railroad grade crossings. Drivers shall assure that it is safe to proceed before crossing railroad tracks. Every responding unit shall stop, regardless of any previous units crossing the same tracks.

vii. When transporting “Emergency or Critical” the driver shall use visual warning devices, with use of audible warning devices as needed, to ensure safe transport of the patient.

viii. When transporting patients to the hospital, the driver will advise dispatch either Non-Emergency transport or Emergency / Critical transport.

c. Response through intersections

i. Driver/operators will bring their apparatus to a complete stop in the following situations:

1. When directed by a law enforcement officer
2. Red traffic lights and Stop signs
3. Negative right of way intersections and blind intersections
4. When the driver cannot account for all lanes of traffic at an intersection
5. When other intersection hazards are present
6. When encountering a stopped school bus with flashing warning lights (Until the bus driver indicates it is safe to pass)

ii. When it has been determined by the driver/operator that traffic has stopped in every direction and that it is safe to continue, the driver/operator may proceed through the intersection.

iii. Apparatus may proceed through intersections that are controlled to limit the entrance of cross traffic, and green traffic lights, without stopping. However, all
intersections should be approached at a speed that will allow the driver/operator to safely take evasive action should it become necessary. Be particularly attentive to right turn lanes, as people are prone to using them to go around stopped traffic.

iv. When approaching an intersection, the driver will be alert for other emergency vehicles that may be responding to the same alarm. If two emergency vehicles are attempting to enter the same intersection at the same time, the vehicle that is proceeding straight through the intersection shall be granted the right-of-way. If both vehicles are required to turn, the vehicle turning to the right shall be granted the right of way.

6. Emergency Medical Technicians (EMTs) may transport a patient with a central venous line (CVL); (e.g. PICC lines, dialysis catheters, broviac lines) or peripheral intravenous (IV) as long as there are NO IV infusions being delivered through the central venous line or peripheral intravenous (IV) catheter

   a. All patients that had a peripheral IV placed at the scene must have either an Advance EMT or Paramedic present during transport.
TAB 1 GUIDELINE 6

APPROPRIATE TRANSPORT FACILITY

1. The closest “EMERGENCY DEPARTMENT” is appropriate for any life or limb-threatening emergencies transported by an EMS Provider ambulance. This also includes any traumatic or cardiac arrest patient, or any patient with an unstable airway or airway obstruction.

2. If there is any doubt of which facility to transport to, on-line Medical Control should be contacted. (Not all designated centers are listed below).

<table>
<thead>
<tr>
<th>Burn Center</th>
<th>Children's Hospital Medical Center of Akron</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mercy Health St Vincent Medical Center</td>
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<tr>
<td></td>
<td>MetroHealth Medical Center</td>
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<tr>
<td></td>
<td>Nationwide Children’s Hospital</td>
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<td></td>
<td>Ohio State University Medical Center</td>
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<td></td>
<td>St Joseph Hospital (Ft Wayne)</td>
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<tr>
<td>Cardiac Cath Lab</td>
<td>Blanchard Valley Medical Center</td>
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<td></td>
<td>Bryan Hospital</td>
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<td></td>
<td>Firelands Regional Medical Center</td>
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<td>Lima Memorial Hospital</td>
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<td>Lutheran Hospital (Ft Wayne)</td>
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<td></td>
<td>Mercy Health St Anne’s Hospital</td>
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<td></td>
<td>Mercy Health St Rita’s Medical Center</td>
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<tr>
<td></td>
<td>Mercy Health St Vincent Medical Center</td>
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<td></td>
<td>Ohio State University Medical Center</td>
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<td>Parkview Regional Medical Center (Ft Wayne)</td>
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<td>St Luke’s Hospital</td>
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<td>The Toledo Hospital</td>
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<td></td>
<td>University of Toledo Medical Center</td>
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<td>Critical Pediatrics</td>
<td>Lutheran Hospital (Ft Wayne)</td>
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<td></td>
<td>Mercy Health St Vincent Medical Center</td>
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<td></td>
<td>MetroHealth Medical Center</td>
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<td></td>
<td>Nationwide Children’s Hospital</td>
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<td></td>
<td>Parkview Regional Medical Center (Ft Wayne)</td>
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<td></td>
<td>The Toledo Hospital</td>
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<tr>
<td></td>
<td>University Hospitals Rainbow Babies &amp; Children's Hospital</td>
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</tbody>
</table>
Hyperbaric Chamber  (919) 684-9111 (This hotline number rings into Duke University operators, state you have a DAN or a Diving emergency and they will call a DAN assistant for closest open hyperbaric facility.)

Stroke Center - Cleveland Clinic
Comprehensive Mercy Health St Vincent Medical Center
MetroHealth System
Miami Valley Hospital
Ohio State University Hospitals
Riverside Methodist Hospital
Toledo Hospital
University Hospitals Cleveland Medical Center

Trauma Center
Blanchard Valley Medical Center (Level III) – Findlay
Firelands Regional Medical Center (Level III) – Sandusky
Fisher-Titus (Level III) – Norwalk
Grant Medical Center (Level I) – Columbus
Lima Memorial Health System (Level II) – Lima
Lutheran Hospital (Level I) – Ft Wayne
Mercy Health St Charles Medical Center (Level III) – Oregon
Mercy Health St Rita’s Medical Center (Level II) – Lima
Mercy Health St Vincent Medical Center (Level I) – Toledo
MetroHealth Medical Center (Level I / Level II Pediatric) – Cleveland
Miami Valley Hospital (Level I) – Dayton
Nationwide Children’s Hospital (Level I) – Columbus
Ohio State University Medical Center (Level I) – Columbus
Parkview Regional Medical Center (Level I) – Ft Wayne
The Toledo Hospital (Level I) – Toledo
University of Toledo Medical Center (Level I) – Toledo
University Hospital Case Medical Center (Level I) – Cleveland
TAB 1 GUIDELINE 7
ON-LINE MEDICAL CONTROL CONTACT

1. An EMS provider in the Northwest Ohio EMS system operates under a Medical Director’s supervision and obtains his/her immediate direction from assigned On-Line Medical Control. Upon radio or telephone contact, a doctor/patient relationship has been established between the patient and On-Line Medical Control.

2. Contact with On-Line Medical Control should occur when time permits to allow for:
   a. Early notification of patient assessment
   b. Notification of treatments rendered in the field
   c. Request of additional therapies outlined within the guidelines as Medical Control Order
   d. Patient refusal of treatment and/or transport
   e. Treat and Release authorization
   f. Transport capabilities and transport decisions. (i.e., transport by BLS vs. ALS)
   g. Intervener on-scene physicians

3. On-Line Medical Control contact is required for any patient transported by transporting EMS squads

4. Patients deemed BLS following ALS evaluation does not require On-Line Medical Control contact. A completed patient care report (PCR) is required detailing patient assessment, any interventions, justification for deeming patient BLS, and disposition of the patient

5. In the event a paramedic (or paramedic officer) on a first responding ALS vehicle renders ALS care, and the ALS squad is subsequently canceled prior to patient contact, the first responding paramedic must make On-Line Medical Control contact to detail the assessment and events of patient contact. A completed patient care report (PCR) is required detailing patient assessment, any interventions and disposition of the patient. (Example: ALS care by first response paramedic with patient improvement and refusal of transport).
TAB 1 GUIDELINE 8

ACTIVATION OF AIR AMBULANCE | MOBILE ICU | COAST GUARD

1. Aero-medical helicopter should be placed on stand-by status or launched whenever the EMS provider believes, from the information available, that the potential to utilize the helicopter may exist. This should be done through the dispatch agency having jurisdiction for the incident.

2. Personnel should consider mobilization of aero medical helicopter in the following circumstances:
   a. Any patient meeting the State or Regional Trauma Triage Guidelines criteria when ground transport to an appropriate trauma center is more than thirty (30) minutes (this can include extrication time).
   b. When the transport of critically ill and/or injured patients may take an extended period of time with the potential for deterioration of the patient’s condition.
   c. Multiple critically ill and/or injured patients.
   d. Transport from an area not readily accessible by conventional land transports.
   e. Prolonged extrication.
   f. Geriatric patients (age 70 or greater) with multiple injuries.

3. If the helicopter does not arrive prior to, during or immediately after the extrication of a trauma patient, and the transport time to the closest trauma center is less than 30 minutes, then the patient should be placed in the ambulance and transport and treatment should be initiated. Under NO circumstances will transport of a patient be delayed to use a helicopter.

4. In most suburban or urban areas, transport to the closest Trauma Center by ground is often the best/fastest option as use of the Aero-medical helicopter resources may actually prolong the definitive transport of critically injured Trauma patients.

5. The following guidelines will be used for setting up a LZ (landing zone) for Aero-medical Helicopter.
   a. It is preferred that the landing surface be flat and hard such as a roadway. One person not involved with patient care should be in charge of the LZ as the landing zone officer and establish direct communication with the pilot on your local or police frequency.
   b. Daylight hours:
      i. LZ is required to be 100’ x 100’.
      ii. Double check for overhead wires or any other obstruction.
      iii. The LZ should be somewhat removed from the scene as possible so loose items will not create a hazard.
   c. Nighttime hours:
i. All corners of the LZ must be illuminated with lights or fire apparatus.

6. In the event that an Air Medical Helicopter is not available due to weather conditions and there are no ferryboats running, the EMT should consider calling the USCG in Marblehead for transport off of the islands. (2) Separate phone calls have to be made:

   d. The physician at Coast Guard Controller Detroit Group has to accept the patient for transport. Phone number is 313-568-9524.

   e. It is at the Coast Guards ship commander at Marblehead that has discretion as to whether or not they are available for transport. Phone number is 419-798-4444.

   f. One EMT should be available to accompany the patient on the Coast Guard vessel.
TAB 1 GUIDELINE 9
COMMUNICATION PROCEDURES | FAILURE

1. When transporting a patient from the pre-hospital environment into the emergency department, on-line Medical Control should be established at the receiving hospital via radio or cellular phone

2. When communicating with on-line medical control providers should use a recorded line

<table>
<thead>
<tr>
<th>Allen County</th>
<th>419-226-5002</th>
<th>St Rita Medical Center</th>
<th>419-226-9024</th>
</tr>
</thead>
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<tr>
<td>Lima Memorial Hospital</td>
<td>419-226-5002</td>
<td>St Rita Medical Center</td>
<td>419-226-9024</td>
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<tr>
<td>Auglaize County</td>
<td>419-394-9508</td>
<td>Squad phone</td>
<td>419-394-7773</td>
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<td>Joint Township Hospital</td>
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<td>Squad phone</td>
<td>419-394-7773</td>
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<td>Crawford County</td>
<td>419-563-9338</td>
<td>Galion Community Hospital</td>
<td>419-468-0738</td>
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<td>Bucyrus Hospital</td>
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<td>Galion Community Hospital</td>
<td>419-468-0738</td>
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<td>Defiance County</td>
<td>419-542-5577</td>
<td>Defiance Regional Med Ctr</td>
<td>419-783-6954</td>
</tr>
<tr>
<td>Community Memorial</td>
<td>419-542-5577</td>
<td>Defiance Regional Med Ctr</td>
<td>419-783-6954</td>
</tr>
<tr>
<td>Mercy Defiance Med Ctr</td>
<td>419-782-8444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erie County</td>
<td></td>
<td>Firelands Regional</td>
<td>419-626-7455</td>
</tr>
<tr>
<td>Fulton County</td>
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<td>Fulton County Health Ctr</td>
<td>419-330-2626</td>
</tr>
<tr>
<td>Hancock County</td>
<td>419-423-5207</td>
<td>Squad phone</td>
<td>419-423-5219</td>
</tr>
<tr>
<td>Blanchard Valley Hospital</td>
<td>419-423-5207</td>
<td>Squad phone</td>
<td>419-423-5219</td>
</tr>
<tr>
<td>Fostoria Comm Hospital</td>
<td>419-436-6640</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hardin County</td>
<td></td>
<td>Hardin Memorial</td>
<td>419-675-8212</td>
</tr>
<tr>
<td>Henry County</td>
<td></td>
<td>Henry County Hospital</td>
<td>419-591-3800</td>
</tr>
<tr>
<td>Huron County</td>
<td>419-668-8101</td>
<td>Squad phone</td>
<td>419-660-2527</td>
</tr>
<tr>
<td>Fisher-Titus</td>
<td>419-668-8101</td>
<td>Squad phone</td>
<td>419-660-2527</td>
</tr>
<tr>
<td>Mercy Willard Hospital</td>
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<td>Squad phone</td>
<td>419-964-5601</td>
</tr>
<tr>
<td>Lucas County</td>
<td>419-407-1444</td>
<td>ProMedica Flower Hospital</td>
<td>419-824-5678</td>
</tr>
<tr>
<td>Mercy Health St Anne Hosp</td>
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<td>419-824-5678</td>
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<tr>
<td>Mercy Health St Charles Hos</td>
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<td>ProMedica Toledo Hosp</td>
<td>419-291-4622</td>
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<tr>
<td>Mercy Health St Vincent Hos</td>
<td>419-251-4354</td>
<td>St Luke Hospital</td>
<td>419-893-5920</td>
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<tr>
<td>Mercy Health Sylvania</td>
<td>567-455-5819</td>
<td>UT Medical Center</td>
<td>419-383-3888</td>
</tr>
<tr>
<td>ProMedica Bay Park Hosp</td>
<td>419-690-7911</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marion County</td>
<td>419-383-8999</td>
<td>Squad Phone</td>
<td>740-383-8443</td>
</tr>
</tbody>
</table>
3. Communication failure
   a. If there is a communications failure that prevents contact with on-line MEDICAL CONTROL, the EMS provider may proceed with Medical Guidelines past the point in the Standing Orders where contacting on-line MEDICAL CONTROL is indicated, if the life of the patient is in immediate danger. Such a communication failure should be documented and forwarded to the EMS coordinator through the EMS provider’s chain of command.
   b. **On-line MEDICAL CONTROL can always be obtained through Mercy Health St Vincent Medical Center (419) 251-4354 in discussion with an Emergency Medicine attending.**
TAB 1 GUIDELINE 10
MEDICAL LEGAL CONSIDERATIONS

1. Legal complications, which may occur during an emergency medical situation, are best managed by direct communication between the providers and on-line MEDICAL CONTROL or ideally between the patient and on-line MEDICAL CONTROL.

<table>
<thead>
<tr>
<th>Consent</th>
<th>Decisional Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consent is “informed” if the patient allows you to treat them</td>
<td>• A patient has decisional capacity if he / she:</td>
</tr>
<tr>
<td>• Consent is “implied” when the patient is unable to consent to treatment</td>
<td>1. Is able to understand the nature and consequences of his / her illness or injury.</td>
</tr>
<tr>
<td>• Age</td>
<td>2. Is able to understand the nature and consequences of the proposed treatment.</td>
</tr>
<tr>
<td>1. Age of consent is 18 years of age</td>
<td>3. Have sufficient emotional control, judgment and discretion to manage own affairs.</td>
</tr>
<tr>
<td>2. Or between 15 and 18 years in an emancipated adult (living apart from his / her parents). This requires a court order</td>
<td></td>
</tr>
<tr>
<td>• Mental status</td>
<td>• Consent should be obtained from another responsible party who must have decisional capacity and legally “of age” such as a:</td>
</tr>
<tr>
<td>• Medical condition</td>
<td>1. Spouse</td>
</tr>
<tr>
<td>• If the patient is a minor, consent should be from:</td>
<td>2. Adult son or daughter</td>
</tr>
<tr>
<td>• Competent natural parent</td>
<td>3. Parent</td>
</tr>
<tr>
<td>• Adopted parent</td>
<td>4. Adult brother or sister</td>
</tr>
<tr>
<td>• Legal guardian</td>
<td>5. Legal guardian</td>
</tr>
</tbody>
</table>

2. If the patient does not have decisional capacity and none of the above persons can be reached, the person should be treated and transported to the hospital.

3. **DUTY TO ACT**
   a. The prehospital care provider has an obligation to treat the patient in accordance with the standard of care to be expected from other medical care providers of the same training and skill level.
b. Once treatment has been rendered, the prehospital care provider has a duty to care for the patient until care can be transferred to a competent health care provider who accepts responsibility for the patient.

4. **CONFIDENTIALITY**

   a. The patient-physician relationship, the patient-registered nurse relationship, and the patient-EMS relationship are recognized as privileged unless:
      i. The patient consents
      ii. The disclosure is allowable by law (such as Medical Board or Nursing Board proceedings, or criminal or civil litigation in which the patient's medical condition is in issue)

   b. The prehospital provider must keep the patient's medical information confidential. The patient likely has an expectation of privacy, and trusts that personal, medical information will not be disclosed by medical personnel to any person not directly involved in the patient's medical treatment.
      i. Exceptions:
         1. The patient is not entitled to confidentiality of information that does not pertain to the medical treatment, medical condition, or is unnecessary for diagnosis or treatment.
         2. The patient is not entitled to confidentiality for disclosures made publicly.
         3. The patient is not entitled to confidentiality with regard to evidence of a crime.

   c. **HIPAA Compliance**
      i. All protected health information collected and shared will be performed per HIPAA guidelines / protocols. At no time, will information be shared with non-essential personnel. Absolutely no information will be put on social media including but not limited to Facebook / twitter / Instagram. No information should leave the base site unless purpose of quality improvement or billing or with permission from the EMS or Fire Chief.
      
      ii. Exercise confidentiality on the scene by:
         1. Not sharing information with bystanders.
         2. Limiting radio transmissions that identify patients.
         3. Avoid disclosure of unnecessary information to police (appropriate info includes patient’s name, DOB, and destination hospital.)
4. Protecting patient’s privacy whenever possible.

5. Don’t volunteer patient medical information with people at the scene.

iii. Hospital contact

1. The relationship of the hospital and prehospital providers 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.

2. 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.

d. Additional Considerations:

i. Any disclosure of medical information should not be made unless necessary for the treatment, evaluation or diagnosis of the patient.

ii. Any disclosures made by any person, medical personnel, the patient, or law enforcement should be treated as limited disclosures and not authorizing further disclosures to any other person.

iii. Any discussions of prehospital care by and between the receiving hospital, the crewmembers in attendance, or at in-services or audits are done strictly for educational or performance improvement purposes. Further disclosures are not authorized.

e. Radio communications should not include disclosure of patient names unless warranted to help improve delivery of care prior to the patient getting to the hospital.
SPECIAL CONSIDERATIONS:

1. Reporting concern of abuse, neglect or exploitation
   a. Per Ohio Revised Codes (ORC) 2151.421 and 5101.61 EMS and Fire personnel are required to report abuse, neglect or exploitation of adult (elderly) or child (under the age of 18)
   b. Report suspected child abuse, neglect or exploitation to Ohio’s Public Children Service Agencies for your respective county or free hotline at 855-642-4453
   c. Report suspected elderly abuse, neglect or exploitation to Ohio’s Adult Protective Services for your respective county or free hotline at 855-644-6277
TAB 1 GUIDELINE 12
MEDICAL LEGAL CONSIDERATIONS – 
ON-SCENE EMS | NURSE | PHYSICIAN INTERVENER

1. The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. EMS Personnel operate under the NWO EMS Medical Director’s supervision and obtain his / her immediate direction from assigned on-line MEDICAL CONTROL. A doctor / patient relationship IS established between the patient and on-line MEDICAL CONTROL.

2. An “intervener physician” is a licensed physician wishing to assume on-scene medical control, and who is:
   a. Willing to provide evidence of his / her license (State of Ohio).
   b. Willing to accompany the patient to the hospital should such control be granted by on-line MEDICAL CONTROL through a recorded line.
   c. On-line MEDICAL CONTROL may transfer control to the “intervener physician”. On-line MEDICAL CONTROL maintains right of managing the case entirely, working with the “intervener physician” or allowing him / her to assume responsibility.
   d. All orders to the EMT are documented on the run report, EMT’s are not allowed to go outside of their Scope of Practice and will decline any orders that are contrary to, or exceed the level of their training.
      i. The “intervener physician” must sign the run sheet containing any orders he / she has given.
   e. On-line MEDICAL CONTROL is ultimately responsible if there is any disagreement between the “intervener physician” and on-line MEDICAL CONTROL, the EMT should take orders from the EMS on-line MEDICAL CONTROL physician.

3. On - Scene Intervener Physician:
   a. 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:
      i. Ideally, if no further assistance is needed, offer should be declined.
      ii. The Physician should have expertise in the medical field for which the patient is being treated:
          1. Emergency medicine physicians are preferred
          2. Family practice, Internal medicine, Pediatrician or Surgeon
3. OB-GYN / Midwife for pregnant patients
4. Orthopedic surgeon for fractures / musculoskeletal problems
5. Anesthesiologist / CRNA for airway management

iii. The physician must have proof they are a Physician. They should be able to show you their medical license and medical Control must be informed and give approval. Encourage Physician to Physician contact.

iv. Notation of Physician name, address and license numbers must be documented on the run report.

v. The Physician must be willing to assume responsibility for the patient until relieved by another Physician, usually at the Emergency Department.

vi. The Physician must not require the EMT to perform any procedures or institute any treatment that would vary from their level of scope of practice.

vii. The “intervener physician” must accompany the patient to the hospital in the emergency vehicle in cases of single patient encounters. However, in the case of a multiple casualty incident or a disaster, patient care may require that the “intervener physician” remain at the scene.

viii. If the Physician is not willing or able to comply with all the above requirements, his / her assistance must be declined.

4. On - Scene Personal Care Physician:
   a. 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:
      i. EMS should perform its duties as usual under the supervision of Medical Control or by protocol.
      ii. Physician to ED Physician contact is optimal.
      iii. The Physician may elect to treat the patient in his office.
      iv. EMS should not provide any treatment under the Physician's direction that varies from guidelines. If asked, EMS should decline until contact is made with Medical Control.
      v. Once the patient has been transferred into the EMS unit, the patient's care comes under Medical Control.
5. The Medical Directors or approved Emergency Medical Resident may assume on-scene medical control if they arrive on scene and request such. If necessary these physicians will sign the run form, assume patient care responsibility and accompany the patient to the hospital.

6. EMT / Nurse / Healthcare - Intervener:
   a. 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:
      i. Ideally, if no further assistance is needed, the offer should be declined.
      ii. If the intervener's assistance is needed or may contribute to the care of the patient:
         1. 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.
         2. Medical Control should be contacted and permission given.
NORTHWEST OHIO EMS

PHYSICIAN ON SCENE FORM

This EMS service would like to thank you for your effort and assistance. Please be advised that the EMS Professionals are operating under strict guidelines established by the medical directors of Northwest Ohio EMS Consortium and the State of Ohio. As a licensed physician, you may assume medical care of the patient. In order to do so, you will need to:

1. Show proper identification including a current State of Ohio Medical Board Licensure.
2. **Have expertise in the medical field for which the patient is being treated.**
3. Receive approval to assume the patient’s medical care from the EMS agencies Online Medical Control Physician.
4. Accompany the patient to the hospital.
5. Carry out any interventions that do not conform to the Northwest Ohio EMS Guidelines. EMS personnel cannot perform any interventions or administer medications that are not included in their guidelines or scope of practice.
7. Assume all medico-legal responsibility for all patient care activities until the patient’s care is transferred to another physician at the destination hospital.
8. Complete the “Assumption of Medical Care” section of this form below.

**ASSUMPTION OF MEDICAL CARE**

I, ____________________________________________, MD / DO; License #: ____________________________

(Please Print your Name Here)

have assumed authority and responsibility for the medical care and patient management for

________________________________________________

(Insert Patient’s Name Here)

I understand that I must accompany the patient to the Emergency Department. My malpractice insurance may not cover me performing medical care. I further understand that all EMS personnel must follow the State of Ohio’s EMS scope of practice as well as the Northwest Ohio EMS Guidelines.

__________________________________________, MD Date: _____/_____/______ Time: ______ AM / PM

(Physician Signature Here)

__________________________________________, EMS

(EMS Signature Here)  ________________________________ Witness

(Witness Signature Here)
TAB 1 GUIDELINE 13
MEDICAL LEGAL CONSIDERATIONS –
REFUSAL OF TREATMENT OR TRANSPORT | RELEASE AT SCENE

1. Competent patients have the right to accept or refuse any or all prehospital care and transportation provided the decision to accept or refuse treatment or transportation is made on an informed basis and these patients have the decisional capacity to make and understand the implications of such a decision. Patients who are REFUSING TREATMENT or TRANSPORT (this includes to the closest appropriate facility) should be made fully aware of the nature of the problem and the possible consequences of their specific condition.

2. Who may refuse care:
   a. Patient.
      i. If a patient is legally, mentally and situational competent, the patient has the right to refuse care.
   b. Parent or guardian.
      i. A custodial parent / guardian may refuse on behalf of a minor child (less than 18 years of age).
      ii. Legal guardian is one who appointed by a court to act as “guardian of person” of an individual who has been found by a court to be incapacitated.
         1. Person indicating that they are a legal guardian to the patient, attempt to obtain documentation of the fact. If no such documentation is available, may obtain refusal signature from the guardian as long as you are doing so in good faith.
   3. The patient must be considered alert, oriented and not under the influence of alcohol, drugs or a medical condition that can impede his / her decision-making ability. The patient must also have decisional capacity.
      a. When repeated efforts to reason with the patient fail, then a release for the release of treatment or transport shall be signed and witnessed.
      b. In the event of refusal to sign by the patient, a family member’s signature is acceptable as long as the family member is aware of the consequences of the patient’s action.
      c. In the event that a patient, who refuses to sign, refuses care and no relatives are present, witness of refusal by two (2) persons (preferably not EMS crew) and clear documentation of all information must be placed on the run report.
4. If the patient is under the influence of alcohol, drugs or a medical condition that can impede his / her decision-making ability, neither the patient nor the family member can refuse treatment. The patient must be treated and transported as medically appropriate unless on-line MEDICAL CONTROL is contacted with an assessment and they say the patient is “OK” to sign the release form. Police assistance and / or transportation to the hospital are to be a consideration if needed.
   a. Patients that are intoxicated and with responsible caregivers in their own home may refuse treatment / transport.

5. The patient who has attempted suicide or who has suicidal ideation may not refuse treatment or transport. Police assistance and / or transportation to the hospital should be considered if needed.

6. Release at scene (RAS)
   a. Low risk patients that have received medical treatment may be released at the scene under their own care / cared by others.
   b. EMS personnel concur with the appropriateness of scene release and the medical appropriateness of the follow-up plan.
   c. Situations include:
      i. Diabetic patient with low blood sugar that responded to therapy.
      ii. Asthmatic patient that has responded to nebulizer therapy and is back to baseline.
      iii. Minor injuries not requiring additional medical assistance.
         1. Minors determined to have only a minor injury or illness not requiring immediate treatment or transportation may be released to themselves after online medical control is obtained.
      iv. Tased / Conducted energy weapon patient that is in custody of law enforcement who is not complaining of any symptoms.
      v. Patient has a clearly articulated plan (including reasonable and prudent transportation) for medical assessment and/or follow-up if necessary.
   d. EMS personnel should attempt to contact the patient’s parent or designated caregiver prior to release if the patient is a minor being released to himself / herself.
   e. Online medical control shall be made by the highest medical authority on scene in close proximity to the patient is required prior to releasing the following classes of patients:
      i. Patients who have been released at scene within the previous 24 hours.
      ii. Children 3 years of age or under.
      iii. Patients age 4 – 17 years old without a responsible adult signature.
7. False calls or other “third party” calls where the person states they did not call for EMS assistance; the EMS provider does not need to obtain a written refusal / release at scene.

8. Calls for assistance for transfer, where no mechanism of injury exists, the EMS provider does not need to obtain a written refusal / release at scene. An EMS report still needs to be completed by the EMS provider for the emergency response.

9. **SPECIAL CONSIDERATIONS:**
   a. Be certain that the patient with decisional capacity understands not only the nature of his / her illness or injury, but also understand the nature and consequences of the proposed treatment and of refusing this treatment before you obtain his / her signature refusing treatment or transport.
   b. It is also appropriate to let on-line MEDICAL CONTROL talk directly to the patient via the radio to reinforce the consequences of the patient’s decisions.
   c. You should also read out loud to the patient the refusal form and ask them if they understand what you have read to them.
   d. Remember to fill out both the medical refusal form and the patient care report. Include all information to adequately document the refusal of medical treatment and / or transport.
   e. Patients may refuse all / or portions of treatment offered, c-spine precautions, or transportation to the closest facility. Patients must be made aware of the risks and benefits of such refusal and sign the refusal form of these specific measures. You should document such refusals on the refusal form and in the narrative of the patient care report.
   f. **Notification to the supervisor / chief, and then “if necessary or indicated” to the Medical Director or his / her designee,** of all patient treatment / transport refusals should occur within 24 hours of patient refusal for quality assurance purposes.

10. **All patients should receive a patient instruction sheet if they are refusing treatment or transport and instructed to call 911 or local emergency number immediately for any additional assistance**
### PATIENT INSTRUCTIONS

- **YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.**
- **YOU SHOULD CALL TO MAKE AN APPOINTMENT WITH YOUR PHYSICIAN IMMEDIATELY OR GO TO AN URGENT CARE OR THE EMERGENCY DEPARTMENT FOR YOUR CONDITION**
- **IF YOU WERE PRESCRIBED MEDICATION FOR YOUR CONDITION FROM A PHYSICIAN, THEN YOU SHOULD TAKE THAT MEDICATION AS DIRECTED**
- **ALWAYS TAKE MEDICATION AS DIRECTED ON THE LABEL. NEVER TAKE SOMEONE ELSE’S PRESCRIPTION MEDICATION**
- **IF ANY TIME YOU TAKE A MEDICATION AND BECOME SHORT OF BREATH, START WHEEZING, GET HIVES OR A RASH, OR HAVE AN UNEXPECTED REACTION, CALL 9-1-1 OR YOUR LOCAL EMERGENCY NUMBER IMMEDIATELY**
- **IF YOU CHANGE YOUR MIND OR YOUR CONDITION BECOMES WORSE AND YOU DECIDE TO ACCEPT TREATMENT AND TRANSPORT BY EMERGENCY MEDICAL SERVICES, PLEASE DO NOT HESITATE TO CALL US BACK**

### ABDOMINAL PAIN
- Abdominal pain is also called belly pain. Many illnesses can cause abdominal pain and it is very difficult for EMS to identify the cause.
- Take your temperature every 4 hours.
- If you take medication for abdominal pain, take your medication as directed.

### BACK PAIN
- If the injury is less than 72 hours, then apply ice to the area, otherwise apply heat to the painful area to help relieve pain for 10 – 20 minutes every hour.
- Begin normal activities when you can do them without causing pain.
- When picking things up, squat down. Never bend from the waist only.

### CHEST PAIN
- Chest pain can be caused by a number of causes. You may be having a heart attack or other potential life threatening condition that requires a physician.
- If you smoke, QUIT.
- If you take medication for chest pain, take your medication as directed.

### EXTREMITY INJURY
- Apply ice on the injured part or area for 15 – 20 minutes each hour for the first (21) days.
- Elevate the injured part above the level of the heart as much as possible for the first (21) days to help decrease pain and swelling.
- Use the injured part as pain allows.
- Take Tylenol or Motrin for pain as directed on the bottle.

### FAINTING
- Many things can cause fainting which can include: heart rhythms, heart attacks, low blood pressure from bleeding or dehydration, low blood sugar, stroke, heat stroke and head injury.
- Fainting can indicate a serious problem.
- If you have been having vomiting or diarrhea, refer to that section in these instructions.
- If you take medication for fainting, take your medication as directed.

### FEVER
- Take your temperature every (4) hours.
- Always take medicine as directed on the label. Acetaminophen (Tylenol) and ibuprofen (Motrin) can be taken at the same time.
- If you are taking antibiotics, take them until they are gone, not until you feel better.
- Drink extra non-caffeinated liquids (1 glass of water, soft drink, gatorade every hour of fever for an adult).

### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Your pain gets worse or is now only in 1 area.
- You vomit (throw up) blood or find blood in your bowel movement.
- You become dizzy or faint.
- Your abdomen becomes enlarged or swollen.
- You have a temperature over 101 F.
- You have trouble passing urine.
- You have trouble breathing.
- You smoke.
- You have any weakness or numbness to your fingers, arms or hands.
- You have numbness or weakness in your legs, feet, arms or hands.
- You have shooting pains into your buttocks, neck or back.
- Your pain gets worse, travels to your arms, neck or back.
- You develop shortness of breath, nausea or vomiting, cough, chills fever, see blood in your urine, fever greater than 101 F.
- You have blood come up when you cough.
- You develop black or sticky stools.
- You faint (pass out).

### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Your pain gets worse or is now only in 1 area.
- You vomit (throw up) blood or find blood in your bowel movement.
- You become dizzy or faint.
- Your abdomen becomes enlarged or swollen.
- You have a temperature over 101 F.
- You have trouble passing urine.
- You have trouble breathing.
- Your pain gets worse, travels to your arms, neck or back.
- You develop shortness of breath, nausea or vomiting, cough, chills fever, see blood in your urine, fever greater than 101 F.
- You have blood come up when you cough.
- You develop black or sticky stools.
- You faint (pass out).

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- You have trouble passing urine.
- You have trouble breathing.
- Your pain gets worse, travels to your arms, neck or back.
- You develop shortness of breath, nausea or vomiting, cough, chills fever, see blood in your urine, fever greater than 101 F.
- You have blood come up when you cough.
- You develop black or sticky stools.
- You faint (pass out).

### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Your pain gets worse, travels to your arms, neck or back.
- You develop shortness of breath, nausea or vomiting, cough, chills fever, see blood in your urine, fever greater than 101 F.
- You have blood come up when you cough.
- You develop black or sticky stools.
- You faint (pass out).
<table>
<thead>
<tr>
<th>HEADACHE</th>
<th>HEAD INJURY</th>
<th>INSECT BITE / STING</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are many causes of a headache which can include migraines, tension headaches, infection and bleeding in your brain.</td>
<td>You may have a headache, nausea or vomiting after a blow to the head.</td>
<td>A bite or sting typically is a red lump that may have a hole in the center. You may have pain, swelling and a rash. Severe stings may cause a headache or upset stomach.</td>
</tr>
<tr>
<td>He cause of your headache cannot be determined by EMS</td>
<td>Ice may be applied to the injured area to decrease pain.</td>
<td>Some people will have an allergic reaction to a bite or sting. Difficulty breathing, throat or tongue swelling or chest pains are emergencies that require immediate care.</td>
</tr>
<tr>
<td>Rest in a quiet, dark room for 20 – 30 minutes</td>
<td>Drink clear, non-alcoholic liquids for the first 12 hours after the injury.</td>
<td>Elevation of the injured part and ice applied to the area will help decrease pain and swelling.</td>
</tr>
<tr>
<td>If you take medication for headaches, take your medication as directed</td>
<td>Acetaminophen (Tylenol) may be used for pain.</td>
<td>Diphenhydramine (Benadryl) may be used as directed to control itching and hives.</td>
</tr>
</tbody>
</table>

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Your headache worsens or does not improve within 24 hours.
- Your vision changes or you become sensitive to light.
- You develop a fever greater than 101 F or have a seizure.
- You have a rash.
- Your family cannot awaken you.
- You are not acting as you normally do.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Your headache worsens or is not improving with Acetaminophen (Tylenol).
- The injured person is vomiting multiple times, is not able to be awakened, has trouble walking or using an arm or leg, has a seizure, develops unequal pupils, has clear or blood fluid coming from the ears or nose or has strange behavior.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- You develop chest pain, difficulty breathing, swelling of the tongue or throat, start vomiting or have intense abdominal cramping or pain.
- The area becomes warm, tender and swollen beyond the area of the bite or sting.
- You develop a fever above 101 F.

LOW BLOOD SUGAR

- Today your blood sugar was ________ mg/dL.
- Taking too much insulin / diabetes medicine, too much exercise, delayed or skipping meals can cause low blood sugar.
- Test your blood sugar. If it is below 80 your should drink 8 ounces of whole milk, eat a candy bar or use glucose tablets. Then you should eat a light meal to help keep your blood sugar up.
- Be sure to tell your doctor of this event.

OVERDOSE

- Today you were found to have an overdose on a medication that was corrected by a medication called Narcan (naloxone) which only corrects opioid types of drugs.
- You should seek help for a potential drug addiction problem.
- If you are injected, this can cause you to have a series infection that can kill you.

SHORTNESS OF BREATH

- Respiratory distress is also known as shortness of breath or difficulty breathing.
- There are many causes for respiratory distress.
- You should avoid substances that cause you any difficulty breathing.
- If you take medication for difficulty breathing, take your medication as directed.

SEIZURES

- Today you had a convulsion or seizure.
- A seizure can be caused from multiple conditions including low blood sugar, infection, trauma or epilepsy.
- If you take medication to control seizures, take your medication exactly as directed. Seizure medication require you to take them every day to keep the right level in your blood.
- If you had a seizure and are taking medication then call your doctor.

STOMACH INJURY

- You have another seizure and it lasts for more than 5 minutes.
- You have a fever, neck stiffness or headache followed by a seizure.
- You do not wake up between seizures.
- Temperature is greater than 101 F.

VOMITING / DIARRHEA

- Many things can cause vomiting (throwing up).
- It can occur in anyone and should be watched closely.
- Diarrhea can also occur in anyone and can be a reaction to food or infection.
- Dehydration (loss of water) can occur with either vomiting or diarrhea.
- Drink clear liquids without alcohol (water, juice or Gatorade) for the first 12 hours. Begin with small sips and slowly increase the amount you drink.

WOUND CARE

- Wounds include cuts, scraps, bites, abrasions or puncture wounds.
- Clean the wound twice daily with soapy water and keep the wound dry. It is safe to shower but do not place the wound in a bath or dish water.
- Change the bandage at least daily or when dirty.
- You will need a tetanus shot if you have not had one in (10) years.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- You have any seizure activity.
- Any new or severe symptoms.
- Shaking, sweating, irritability, pounding heart, feeling faint, weakness, sleepiness, having a seizure, confusion, slurring words, or stumbling.
- You have a fever above 101 F.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Any new or severe symptoms.
- You are not acting as you normally do.
- Anyone sees that you are not breathing, pupils are pinpoint, you cannot be woken up.
- You develop a fever above 101 F.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- The cough, wheeze or difficulty breathing become worse or does not improve, even if taking medication.
- You have chest pain.
- You sputum (spit) turns colors.
- You are not able to perform normal activities.
- Temperature is greater than 101 F.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Vomiting or diarrhea lasts longer than 24 hours, you notice blood in the vomit or diarrhea or have black or sticky stools.
- You cannot keep fluids down or you have not urinated in 8 hours (less than 4 wet diapers for babies).
- Temperature is greater than 101 F.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Bruising, swelling or pain gets worse or bleeding is not controlled with direct pressure and bandage.
- Any signs of infection such as redness, pus, red streaks, intense pain, or a bad smell from the wound.
1. Scope and Purpose.
   a. This policy will reflect recommendations and provide information regarding infection control precautions and procedures commonly referred to as *standard precautions*.
   b. EMS providers are in a high-risk group for infectious disease exposure. Infection control is a shared responsibility between the employer and employee.

2. Goals.
   a. To regard all patient contacts as potentially infectious and institute standard precautions on all patients.
   b. To provide or assist system providers with personal protection equipment (PPE) and the necessary training to utilize this equipment.
   c. Recommend the need for proper immunizations.
   d. To recognize the need for work restrictions based upon infection control concerns.
   e. To inform personnel of proper procedures for the exchange or cleaning of equipment and supplies.
   f. To inform personnel of the proper disposal procedure for infectious waste.
   g. To inform personnel of the proper procedures after an exposure.

3. Front Line Personnel Protection.
   a. Available PPE should include:

   | Disposable gloves | Infection control kit (pouch) |
   | Head covers       | Hazardous waste bags          |
   | N95 Healthcare Particulate Respirators | Various sharps containers |
   | Disposable Gowns / facemasks | Germicidal hand wipes |
   | Eye protection    | Germicidal spray cleaner      |
   | Shoe Covers       |                              |

   b. Front-line field EMS providers are in a high-risk group for infectious disease transmission. In addition to standard precautions, the following procedures should be followed:
      i. Gloves should be changed after each patient contact and hands cleaned with an appropriate germicidal agent.
      ii. All extraordinary exposure incidents should be reported to the receiving hospital and the employee’s supervisor.
iii. The amount, type, and location of personal protection equipment (PPE) should be standardized on all first response units.

c. Non-rebreather masks or surgical masks should be placed on patients with possible communicable respiratory disease.

d. Care should be taken to not cross contaminate other equipment while wearing gloves.


a. The N95 Healthcare Respirators are intended to minimize but not eliminate wearer to exposure to specific airborne particles. The respirators should meet the CDC guidelines for TB exposure control and certified by NIOSH.

b. Fit Test.

i. Each system EMT | paramedic will be issued a respiratory mask through their respective department with a qualitative test being performed by a recognized fit-test instructor.

c. High Risk Groups (Infectious Disease Transmission).

<table>
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<th>Signs / Symptoms</th>
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<td>Productive cough</td>
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<tr>
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<td>Correctional facilities</td>
<td>Weight loss</td>
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<td>Long term care facilities</td>
<td>Loss of appetite</td>
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d. Medical procedures performed in the field increase the risk of infectious disease transmission. Respiratory masks should be considered for use when performing:

i. Aerosolized medications.

ii. Endotracheal intubation.

iii. Suctioning.

iv. Transporting in a closed vehicle.

v. Surgical cricothyrotomy.

vi. Chest decompression.
TAB 1 GUIDELINE 15
INFECTION CONTROL – BED BUGS

PURPOSE:
• To provide personal protection recommendations to EMS providers who are presented with a patient in a known or suspected bed bug infestation.

PROCEDURE:
• Take universal precautions.
• Take only needed equipment into the area of infestation to minimize exposure.
• Seal equipment in plastic bags when necessary to prevent exposure.
• Avoid sitting on beds or furniture. If you have to sit, do so on a hard surface.
• If you feel you have been infested, shower and seal clothes in a plastic bag.
• Place potentially exposed clothing in a hot dryer for 10 minutes to kill the bugs.
• Footies, caps, and gloves should be worn if available during care.
• Remove these items before entering the vehicle and place in a plastic bag.
• Dispose of trash bags containing used PPE equipment in sealed containers.
• Keep patients wrapped during transport as much as possible to prevent transfer of bed bugs to the ambulance, or locations other than the hospital room the patient is put into.
• Clean and disinfect the vehicle as soon as possible.
• Notify the receiving facility as soon as possible regarding potential for bed bug exposure.
TAB 1 GUIDELINE 16
INFECTION CONTROL – OUTBREAK

Scope and Purpose:

- This guideline is presented for the use of multiple organizations within varying EMS systems. The Medical Directors strongly encourage individual departments to implement these guidelines for the protection of their prehospital providers as well as their patients.
- Protect the health and safety of our personnel during a public health emergency.

Public Safety Answering Points (PSAP):

- Dispatchers should screen all callers for any symptoms of acute febrile respiratory illness. Callers should be asked if they or anyone else at the incident location have any of the following signs and symptoms:
  - Fever
  - Nasal congestion
  - Runny nose (rhinorrhea)
  - Cough or difficulty breathing
  - Sore throat
  - Coughing up blood
  - Or other symptoms in accordance with the specific disease involved
- Dispatch the call as normal
- When the squad advises that they are responding, advise them that the patient or someone else at the scene has signs and / or symptoms of an acute febrile respiratory illness.

Personal Protective Equipment:

<table>
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</tr>
<tr>
<td>Shoe Covers</td>
<td></td>
</tr>
</tbody>
</table>

Patient Assessment:

- A minimal number of personal should enter the scene in order to avoid unnecessary exposure. In most cases the first arriving crew should assess the patient and only have additional personnel enter the scene if needed.
• If the outbreak has been reported in our region, then don appropriate PPE prior to entering the scene.
• EMS personnel should maintain a distance of at least six (6) feet (when possible) from anyone with suspected acute febrile respiratory illness while exercising appropriate respiratory droplet precautions.
• A patient history should be obtained to determine if the patient is likely suffering from the suspected disease. Do they have fever plus one or more of the following:
  o Nasal congestion
  o Runny nose (rhinorrhea)
  o Cough or difficulty breathing
  o Sore throat
  o Coughing up blood
• If no symptoms of acute respiratory illness, then process with normal EMS care.
• If symptoms of acute febrile respiratory illness, then assess for travel to an affected geographic area or close contact with someone who has traveled to affected area in the last seven days or close contact with someone who is known or suspected to have the disease.
  o If possible exposure, don appropriate PPE if not already done and place a standard surgical mask on the patient (if tolerated). If oxygen therapy is necessary, use a non-rebreather mask. If possible, avoid droplet producing procedures including nebulizer, bag-valve mask, suctioning or intubation. If bag-valve-mask ventilation is needed use a BVM with a HEPA filter if available.
  o If no exposure, place a standard surgical mask on the patient (if tolerated) and use appropriate PPE for cases of acute febrile illness.
  o Isolate the driver’s compartment from the patient compartment by closing the door / window.
  o Alert the receiving facility that you are bringing in a suspected case.
Vehicle Cleaning:
• After the patient has been transferred, open all the doors and windows and leave the ventilation system running.
• Routine cleaning methods should then be used throughout the vehicle and on non-disposable equipment. In general, an agent that is tuberculocidal and effective against HIV / HBV should be sufficient.
1. Northwest Ohio EMS Consortium provides the opportunity for controlled substances (medications) to EMS department Life Squads and ALS First Responder units. Individual EMS departments are responsible for the acquisition and maintenance of their own controlled substances. As an ALS provider within the Northwest Ohio EMS system, controlled substances are authorized for use following strict guidelines and procedures as outlined in: 1) The State of Ohio Administrative Code Chapter 4729-33, DEA regulations; 2) US Department of Justice Drug Enforcement Administration Office of Diversion Control, Title 21 CFR, Part 1300 – 1399; and 3) Northwest Ohio EMS ALS Guidelines.

2. The Controlled Substance Policy has been established to ensure that Northwest Ohio EMS system advanced EMTs and paramedics adhere to appropriate laws, procedures and policies regarding the possession and use of Controlled Substances. All crew members shall adhere to all procedures contained within this Controlled Substance Policy and any SOPs or SOGs of their respective departments. This Controlled Substance Policy has been approved by the Northwest Ohio EMS Medical Director Consortium.

3. **Initial receipt of controlled substance stock**
   a. The NWO EMS Medical Director or his / her designee (via Power of Attorney) may order Controlled Substances for initial stock and restock.
   b. Controlled Substances will only be handled by designated personnel per discretion of the EMS Medical Director and individual EMS departments.
   c. Upon receipt of any Controlled Substance(s) at the EMS department, two (2) of the Designated Personnel shall count and record the Controlled Substance(s) on the Controlled Substance Central Supply Inventory / Disbursement Log.

4. **Storage of controlled substances**
   a. Upon receipt and inventory at the EMS departments, all Controlled Substances shall be placed in the locked safe / cabinet. Access to the safe / cabinet shall be strictly limited to the Designated Personnel. The safe and cabinet shall be in a locked room that is again limited to the Designated Personnel.
   b. Controlled Substances disbursed to field personnel will be stored in either the medication vault or in respective medication box.
   c. **Apparatus inventory – Medication Box**
i. Par levels of medications carried in the medication box have been established per individual department CONTROLLED SUBSTANCE Policy.

ii. The plastic storage compartment for Controlled Substances will be tagged with a numbered seal at all times except when it is in the immediate possession of an advanced EMT or paramedic who is either transferring possession of a Controlled Substance or administering a Controlled Substance to a patient.

5. Controlled substance daily verification procedure

a. At the beginning of every shift, the assigned advanced EMT or paramedic shall inspect the medication box for an intact numbered seal and the appropriate medications per the EMS departments’ par level.

b. Advanced EMTs and Paramedics must also check the expiration dates of the Controlled Substances for currency.

c. If an irregularity or discrepancy is apparent in a Controlled Substance container, the on-duty EMS officer / controlled substance supervisor and NWO EMS medical director must be notified.

d. Interns, paramedic students or other persons not employed by the governing EMS departments are not authorized to inspect, count, or sign for Controlled Substances.

e. Expired Medications

i. Drug boxes shall be checked to assess for expired medications

1. Ideally the drug check should occur on a weekly basis, but at minimum on a monthly basis

ii. All expired medications will be removed from the drug boxes and given to the delegated departmental person to destroy the medications. All narcotic medications must follow board of pharmacy protocol for destruction

f.

6. Administration of controlled substances

a. The administration and use of Controlled Substances shall be limited to the following scope and application. Advanced EMTs and Paramedics are not authorized to administer Controlled Substances unless the following requirements are met:

i. The advanced EMT or paramedic is administering the Controlled Substance under a specific NWO EMS guideline.

ii. The advanced EMT or paramedic has received a Medical Control Order, if needed, for the specific Controlled Substance.
b. When the above requirements have been met, an advanced EMT or paramedic is authorized to administer a Controlled Substance to the patient under their care. The advanced EMT or paramedic must then inspect the Controlled Substance and see that it possesses ALL of the following qualities:
   i. Appropriate labeling for the type, amount, and concentration to be used
   ii. An intact control number label on the Controlled Substance container
   iii. Inspection of the Controlled Substance reveals no discoloration, cloudiness, or particulate matter.
   iv. The Controlled Substance’s expiration date has not been exceeded
   v. If any detected irregularity is noted, the Controlled Substance shall not be used. The on-duty EMS officer / controlled substance supervisor and Northwest Ohio EMS Medical Director must be informed of any and all noted discrepancies upon completion of a response or medical call.

7. Discarding (wasting) the unused portion of a controlled substance
   a. Any remnants of Controlled Substances that were not administered to a patient must be discarded in the following manner:
      i. The advanced EMT or paramedic who initially accesses the Controlled Substance remains responsible for the Controlled Substance until any portion that may be remaining is discarded. The responsible advanced EMT or paramedic must discard the Controlled Substance in the presence of another advanced EMT or paramedic crew member.
      ii. All of the remaining Controlled Substance must be discarded. The unused portion may be discarded in a sink, sharps disposal, placed in a secured bag and then back into the secured drug cabinet to be sent back to the pharmacy for disposal.
      iii. The names and training level of the personnel involved in the disposal process must be thoroughly documented on the Controlled Substance Administration Report that corresponds with the control number on the Controlled Substance.
      iv. Interns or paramedic students are not authorized to sign for or witness the discarding of a Controlled Substance.

8. Restocking Controlled Substances
   a. Controlled Substances must be restocked immediately if the par level of any controlled substance falls to zero (0).
b. Expired Controlled Substances should be removed from circulation, placed in a sealed Controlled Substance evidence bag, and stored:
   i. Designated secured area within the EMS station (i.e., office, officer’s room)
   ii. ALS crews taking possession of partially stocked Controlled Substances from an off-going crew should have all Controlled Substances, Controlled Substance Administration Card(s), and expired meds (if any) accounted for during the daily verification procedure.

9. Documentation
   a. Controlled Substance Logs – Information, Purpose, and Use
      i. A NWO EMS system advanced EMT or paramedic, by his or her acceptance of the possession of a Controlled Substance, thereby accepts complete responsibility for the security, handling, and use of the Controlled Substance.
      ii. Random monthly audits shall be performed by the EMS departments for quality control purposes, and the findings reported to the Medical Director.
   b. Patient Care Reports (PCRs) must be complete in order to thoroughly document the use of a Controlled Substance, and should be clear regarding the following:
      i. The patient assessment must justify the administration of a Controlled Substance according to NWO EMS treatment guidelines.
      ii. The On-Line Medical Control order must be clearly stated (if applicable).
      iii. The amount of Controlled Substance actually administered to the patient and time(s) of administration must be clearly documented.
      iv. The patient’s vital signs before and after administration of the Controlled Substance must be clearly documented.
      v. The patient’s condition and vital signs must be clearly documented upon the patient’s arrival at the receiving facility.
      vi. The name of the advanced EMT or paramedic administering the Controlled Substance must be documented.

10. Controlled substance discrepancies
    a. The strict adherence to the Controlled Substance policy will prevent discrepancies. Any discrepancy involving Controlled Substances shall result in the immediate, mandatory notification of the on-duty EMS officer and Northwest Ohio EMS Medical Director.
    b. The paramedic(s) involved must complete and fax a Controlled Substance Discrepancy Report to Northwest Ohio EMS at 419-251-2698, attn. NWO EMS Medical Director.
c. On duty and/or off-going personnel may be asked to submit the ALS Controlled Substance Log(s) for the entire shift prior to the discovery of the discrepancy.
d. All evidence must be retained for inspection by EMS Department officers. Any evidence (if applicable) will be sealed in a Controlled Substance evidence bag.
e. **If at any time theft of narcotics are found, then immediate notification to the Fire or EMS Chief / Supervisor and law enforcement (including local and DEA). Notification should then be made to NWOEMS Medical Director or one of their delegates.**

11. **Quality improvement**
   a. The following procedures shall be performed to maintain Quality Improvement for the Controlled Substance Policy:
      i. All ALS Controlled Substance Daily Verification Logs shall be maintained at the respective EMS departments.
      ii. The NWO EMS Medical Director or one of his / her designees may perform random audits of field units, logs, inventory and related materials. Logs shall be signed to indicate an audit has been performed.
      iii. In cases of serious discrepancies, the designated EMS department controlled substance supervisor will review all documentation pertaining to discrepancies and notify the NWO EMS Medical Director and others as appropriate.
      iv. The designated EMS department controlled substance supervisor shall submit a monthly summary report to the NWOEMS Medical Director. The report shall include the beginning and ending system inventory counts, monthly use and discrepancy information.

b. **Monthly notification of controlled substances**
   i. At the beginning of every month, the assigned advanced EMT or paramedic shall send using the Controlled Substance Notification Form the end count, used / administered, purchased and expired / wasted controlled substance for the previous month
   ii. This form can be accessed online at http://www.nwoems.com
PRACTITIONER DISCIPLINARY POLICY

1. A practitioner’s right to practice medicine affiliated with the Northwest Ohio EMS consortium is based on written and verbal authorization from the EMS Medical Directors per Ohio Law [4765.35(D)(1), 4735.37(D)(1), 4765.38(C)(1), 4765.39(C)(1)].

2. For the purposes of this procedure, a “practitioner” is any individual practicing in the NWO EMS System at the level of Medical Responder or higher level of certification. If, in the opinion of the Medical Director, an action (or failure to act) on the part of a practitioner is of such a nature that the action or failure to act is inconsistent with, or a violation of, these procedures, or the practice standard generally accepted in the medical community, the actions described below shall occur.

3. The practitioner will be notified in writing of the issues/concerns that merit attention by the Medical Director. Notwithstanding this written-notice provision, the provisions of 4 and 5, below, and based on the severity and nature of the act (or failure to act), the Medical Director or his designee may suspend a practitioner’s right to practice upon receipt of information sufficient in the judgment of the Medical or his designee Director to support immediate suspension in the interests of patient safety. If the Medical Director or his designee invokes an immediate suspension, this shall be followed by written notice within three (3) working days of such immediate suspension.

4. A written explanation by the individual explaining the incident shall be presented to the Medical Director within three (3) working days of receipt of the Medical Director’s issues/concerns. If no written explanation of the incident is sent to the Medical Director by that deadline, the Medical Director may base his decision upon such information that is available to him/her as of that deadline.

5. The Medical Director or the individual may request a second meeting to further discuss the issues/concerns. If this option is exercised, the meeting shall occur within five (5) working days of receipt of the request.

6. After reviewing all materials, the Medical Director will issue a disposition of the matter. The Medical Director may exercise one or more of the following options:

   a. No action taken / matter resolved
   b. Remediation training
   c. Warning
   d. Require to precept at the approved level again
e. Temporary suspension of all practice privileges or suspension of specific practice privileges
f. Permanent Suspension of practice privileges

7. Situations that will result in immediate suspension of practice privileges
   a. Practicing in an unsafe or unprofessional manner or poses an “imminent threat” to public health and safety if allowed to continue as a prehospital provider
   b. Physical, sexual or mental assault / harm to a patient, family member or other prehospital provider
   c. Performing duties as prehospital provider while intoxicated (alcohol or drug, including prescription medications)
   d. Diversion of any medication (controlled or non-controlled)
   e. Falsification of patient care documentation
   f. Inability to meet established performance standards for skills and procedures

8. Situations that may result in suspension of practice privileges
   a. Deviations from established protocols or guidelines
   b. Complaints from patients, bystanders, ED staff or other EMS providers
   c. Discourtesy to patient, staff and emergency service personnel
   d. Failure to comply with requirements such as applicable certifications, CME requirements, mandated in-service training, etc
   e. Repeated occurrences of the same or similar actions
   f. Failure to complete remedial training or actions

9. Any suspension of practice privileges will extend to all jurisdictions where the practitioner’s right to practice relies on the Northwest Ohio EMS System Medical Directors to practice medicine
TAB 1 GUIDELINE 19
UNIVERSAL PATIENT CARE

SCENE SAFETY
Bring all necessary equipment to patient's side
Demonstrate professionalism and courtesy

UNIVERSAL PRECAUTIONS
Consider Airborne or Droplet if indicated

ESTABLISH RESPONSIVENESS
(Alert, Verbal, Pain, Unresponsive)

INITIAL ASSESSMENT
BLS Maneuvers
Consider Spinal Immobilization
If Pediatric Patient, consider Broselow Tape

AIRWAY PROCEDURES (if required)
(Adult or Pediatric)

VITAL SIGNS
(Temperature and Blood Glucose measurement when appropriate)

Consider
CO Oximetry / Supplemental O₂

Consider
Cardiac Monitor / 12-Lead ECG

Go to Appropriate Guidelines

Transport to appropriate destination

Go to appropriate Guideline
• Cardiac Arrest
• Cardiac Arrest – Hypothermic
• Cardiac Arrest – Traumatic
• Asystole / Pulseless Electrical Activity
• Ventricular Fibrillation / Pulseless Ventricular Tachycardia

LEGEND
EMR
EMT
A-EMT
EMT-P
MC Order

Glucose ≤ 60

Oral Glucose 15 – 30 Grams if awake and no risk for aspiration
50% Dextrose IV – Adult IV
25% Dextrose IV – Pediatric
Glucagon 1 mg IN / IM (if no IV access)

Assess Rhythm
12-Lead ECG Interpretation

Patient doesn’t fit a guideline?
Contact Medical Control

Glucose < 60

Transport to appropriate destination

Go to Appropriate Guidelines
SPECIAL CONSIDERATIONS:

1. **Scene Safety Evaluation:** Identify potential hazards to rescuers, patient and public. Identify number of patients and utilize triage guideline if indicated. Observe patient position and surroundings.

2. **General:** All patient care must be appropriate to your level of training and documented in the PCR.

3. **Special note on oxygen administration and utilization:** Oxygen is a pharmaceutical agent with indications, contraindications as well as untoward side effects. Recent research demonstrates a clear link with increased mortality when given in overdose (hyperoxia/hyperventilation) in cardiac arrest. Utilize oxygen when indicated and not because it is available. **Reasonable target oxygen saturation for most patients is 94 – 99% regardless of delivery device.**

4. **Pearls**
   a. **Recommended Exam:** Minimal exam if not noted on the specific guideline is vital signs, mental status with GCS, and location of injury or complaint.
   b. **AIRWAY:** Follow the airway management guideline (adult versus pediatric).
   c. **BREATHING:** Listen for audible sounds
      i. Hoarseness / Wheezing / Fragmented Sentences / Stridor / Inspect chest and auscultate lung sounds.
   d. **CIRCULATION:**
      i. Inspect for uncontrolled hemorrhage (control as appropriate)
      ii. Palpate a pulse (carotid, radial, femoral, or brachial)
      iii. Check capillary refill
      iv. Look for JVD
   e. **DISABILITY:**
      i. Inspect for gross deformities
      ii. Pupillary response
      iii. Glasgow Coma Scale / Cincinnati stroke scale
      iv. Distal pulses, motor function, and sensation
   f. **SAMPLE HISTORY:**
      i. Signs and Symptoms / Allergies / Medications / Past Medical History / Last Oral Intake / Events leading to illness / injury
   g. Prepare for transport and perform ongoing exam.