

Scott County EMS Treatment Appendices

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Iowa Scope of Practice 2020

Airway and Breathing					
SKILL	FR-79	FR-G	EMR	EMT-D	EMT
Airway - Manual	X	X	X	X	X
Airway-Oral			X	X	X
Airway-Nasal				X	X
CPAP					+
Impedance Threshold Device					+
Obstruction - Manual	X	X	X	X	X
Oxygen Delivery			X	X	X
Oxygen Delivery-Humidified				X	X
Suctioning - Upper Airway	X	X	X	X	X
Ventilations - Bag Valve	X	X	X	X	X
Ventilations – via Mouth	X	X	X	X	X
Ventilations- Manually Triggered				X	X
Ventilator - Automatic Transport					X

+ Additional training and medical director approval required

Assessment					
SKILL	FR 79	FR-G	EMR	EMT-D	EMT
Blood Glucose Monitor					+
Blood Pressure	X	X	X	X	X
Pulse Oximetry	X	X	+	X	X

+ Additional training and medical director approval required

Pharmacological Intervention					
SKILL	FR 79	FR-G	EMR	EMT-D	EMT
Autoinjector- Self/Peer Rescue			X		X
Autoinjector – Epinephrine					+
Autoinjector – Naloxone	X	X	X	X	X
OTC Medications				X	X
Patient Assisted Meds (including Epi-pen/Naloxone)					X
Buccal					1
Oral			++		2
Intranasal - naloxone	X	X	X	X	X

+ Additional training and medical director approval required
 ++ EMRs may administer aspirin with additional training and medical director approval

EMT DRUG LIST

- | | |
|----------|-----------------|
| 1 Buccal | Oral Glucose |
| 2. Oral | Glucose/Aspirin |

Iowa Scope of Practice 2020

Emergency Trauma Care					
SKILL	FR 79	FR-G	EMR	EMT-D	EMT
Cervical Stabilization - Manual	X	X	X	X	X
Cervical Stabilization – C-Collar	X	X		X	X
Extremity Stabilization - Manual	X	X	X	X	X
Extremity Splinting				X	X
Eye Irrigation	X	X	X	X	X
Hemorrhage Control	X	X	X	X	X
PASG				X	X
Spinal Immobilization				X	X

Medical/Cardiac Care					
SKILL	FR 79	FR-G	EMR	EMT-D	EMT
Assisted Delivery	X	X	X	X	X
CPR - Manual	X	X	X	X	X
CPR - Mechanical				X	X
Defibrillator - Automated	X	X	X	X	X

Iowa Scope of Practice 2020

Airway and Breathing				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Airway - Manual	X	X	X	X
Airway-Nasal	X	X	X	X
Airway-Oral	X	X	X	X
Airway- Multi-Lumen	X	X	X	X
Airway-Esophageal/Tracheal	X	X	X	X
BiPAP/CPAP	++	CPAP	X	X
Bridge Airway Devices		X	X	X
Capnography/ETCO ₂		X	X	X
Chest Tube Placement-Assist				X
Chest Tube-Monitoring			X	X
Cricothyrotomy - Percutaneous		X	X	X
Cricothyrotomy - Surgical				X
Endotracheal Intubation- Nasal/Oral		X	X	X
Gastric Decompression - NG or OG tube		X	X	X
Impedance Threshold Device	+		+	X
Needle Chest Decompression		X	X	X
Obstruction - Direct Laryngoscopy		X	X	X
Obstruction - Manual	X	X	X	X
Oxygen Delivery (including humidified)	X	X	X	X
PEEP Therapeutic (>6 cm H ₂ O pressure)			X	X
Suctioning - Upper Airway	X	X	X	X
Ventilations - Bag Valve	X	X	X	X
Ventilations – via Mouth	X	X	X	X
Ventilations- Manually Triggered	X	X	X	X
Ventilator - Automatic Transport	X	X	X	X
Ventilator - Enhanced				X
Suctioning - Tracheobronchial	X	X	X	X
+ Additional training and medical director approval required				
++ CPAP may be used with additional training and medical director approval required				

Assessment				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Blood Chemistry Analysis			X	X
Blood Glucose Monitor	X	X	X	X
Blood Pressure	X	X	X	X
Blood Sampling - Arterial				X
Blood Sampling - Capillary Tube		X	X	X

Iowa Scope of Practice 2020

Assessment (cont)				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Blood Sampling - Venous		X	X	X
Central Line Monitoring			X	X
EKG - Multi lead (interpretive)			X	X
EKG - Single lead (interpretive)		X	X	X
Hemodynamic Monitoring (including arterial line)				X
ICP Monitoring				X
Pulse Oximetry	X	X	X	X

Pharmacological Intervention				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Autoinjector- Self/Peer Rescue	X	X	X	X
Autoinjector – Epinephrine/Naloxone	X	X	X	X
OTC Medications	X	X	X	X
Patient Assisted Meds	X	X	X	X
Aerosolized/Nebulized	1	X	X	X
Buccal	2	X	X	X
Endotracheal tube		X	X	X
Inhaled - Self administered	3	X	X	X
Intramuscular	4	X	X	X
Intranasal	9	X	X	X
Intravenous push	5	X	X	X
Intravenous piggyback		X	X	X
Nasogastric		X	X	X
Oral	6	X	X	X
Rectal		X	X	X
Subcutaneous	7	X	X	X
Sublingual	8	X	X	X
Arterial Line - Monitoring				X
Blood Administration		X	X	X
Central Line Access	+	+	X	X
IO Insertion	X	X	X	X
IV Fluid Infusion	X	X	X	X
Peripheral IV Insertion	X	X	X	X
Thrombolytic Administration			X	X

AEMT DRUG LIST

1 Aerosolized/Nebulized	Beta Agonist
2 Buccal	Oral Glucose
3 Inhaled - Self administered	Nitrous Oxide
4 Intramuscular	Naloxone/Epinephrine/Glucagon
5 Intravenous push	Naloxone/Dextrose/Glucagon

Iowa Scope of Practice 2020

6. Oral	Glucose/Aspirin
7. Subcutaneous	Epinephrine/Glucagon
8. Sublingual	Nitroglycerin
9. Intranasal	Naloxone

Emergency Trauma Care				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Cervical Stabilization - Manual	X	X	X	X
Extremity Stabilization - Manual	X	X	X	X
Extremity Splinting	X	X	X	X
Eye Irrigation	X	X	X	X
Eye Irrigation - Morgan Lens		X	X	X
Hemorrhage Control	X	X	X	X
PASG	X	X	X	X
Spinal immobilization	X	X	X	X

Medical/Cardiac Care				
SKILL	AEMT	EMT-P	PARAMEDIC	CCP
Assisted Delivery	X	X	X	X
Cardioversion		X	X	X
Carotid Massage		X	X	X
CPR – Manual/Mechanical	X	X	X	X
Defibrillation - Manual		X	X	X
Defibrillator - Automated	X	X	X	X
Intra-aortic balloon pump (monitoring/timing)				X
Transcutaneous Pacing		X	X	X
Urinary Catheterization		X		X

Appendix B - EMS Out-of-Hospital Do-Not-Resuscitate Protocol

Purpose: This protocol is intended to avoid unwarranted resuscitation by emergency care providers in the out-of-hospital setting for a qualified patient.¹ There must be a valid Out-Of-Hospital Do-Not-Resuscitate (OOH DNR) order signed by the qualified patient's attending physician or the presence of the OOH DNR identifier indicating the existence of a valid OOH DNR order.

No resuscitation: Means withholding any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to:

1. Chest compressions,
2. Defibrillation,
3. Esophageal/tracheal airway; endotracheal intubation, or
4. Emergency drugs to alter cardiac or respiratory function or otherwise sustain life.

Patient criteria: The following patients are recognized as qualified patients to receive no resuscitation:

1. The presence of the uniform OOH DNR order or uniform OOH DNR identifier, or
2. The presence of the attending physician to provide direct verbal orders for care of the patient.

The presence of a signed physician order on a form other than the uniform OOH DNR order form approved by the department may be honored if approved by the service program EMS medical director. However, the immunities provided by law apply only in the presence of the uniform OOH DNR order or uniform OOH DNR identifier. When the uniform OOH DNR order or uniform OOH DNR identifier is not present contact must be made with on-line medical control and on-line medical control must concur that no resuscitation is appropriate.

Revocation: An OOH DNR order is deemed revoked at any time that a patient, or an individual authorized to act on the patient's behalf as listed on the OOH DNR order, is able to communicate in any manner the intent that the order be revoked. The personal wishes of family members or other individuals who are not authorized in the order to act on the patient's behalf shall not supersede a valid OOH DNR order.

Comfort Care (♥): When a patient has met the criteria for no resuscitation under the foregoing information, the emergency care provider should continue to provide that care which is intended to make the patient comfortable (a.k.a. ♥ Comfort Care). Whether other types of care are indicated will depend upon individual circumstances for which medical control may be contacted by or through the responding ambulance service personnel.

♥ **Comfort Care** may include, but is not limited to:

1. Pain medication.
2. Fluid therapy.
3. Respiratory assistance (oxygen and suctioning).

Qualified Patient means an adult patient determined by an attending physician to be in a terminal condition for which the attending physician has issued an Out of Hospital DNR order in accordance with the law. Iowa Administrative Code 641-142.1 (144A) Definitions.

IPOST PROCESS

Emergency Medical Services

Overview

- IPOST form **belongs** to the patient.
- IPOST form is **valid** as a medical order statewide regardless of where the patient resides.
- IPOST is appropriate for an individual who is frail and elderly, or who has a chronic, critical medical condition or terminal illness.
- IPOST form **cannot** be used as a physician order in an Illinois facility at this time. The Illinois Uniform Do-Not-Resuscitate (DNR) Advanced Directive (POLST) form **is accepted** in Iowa.

Use of form

- **Ask every facility if resident has IPOST form prior to transfer.**
- **Ask every patient/family member in the home if they have an IPOST form prior to transfer.**
- IPOST form is salmon in color and printed on cardstock.
- No copies for permanent medical record.
- Do not label or sticker form.
- Inpatient units (ward clerks, secretaries etc) **MUST** ensure form is sent with patient at discharge – **please verify prior to transfer to facility/home.**
- If patient has Advance Directive (AD) that is known to be in conflict with IPOST form, AD takes precedence.
- A conversation with the patient, or surrogate, should occur to discuss the differences between the IPOST and AD. When the wishes of the patient are clarified, the incorrect document should be voided and dated to prevent future discrepancies. A new form, either the IPOST or AD, can be created to ensure both documents reflect the correct wishes of the patient.

Documentation

- Document any indicated treatments that have been deferred as related to IPOST form instructions.
- Document IPOST form was received and to whom the form was transferred to at the receiving facility.

Copies/Faxes

- Copies/faxes of signed IPOST forms are legal and valid; **HOWEVER** our process does **NOT** recommend copies under most circumstances.
- A copy/fax may be valid only if original form was not sent with patient. If inpatient facility validates with receiving facility that copy/fax is the most recent for a patient, it may be used. An example: if patient transfers from facility to Emergency Department and IPOST did not arrive with patient; ED may accept fax of IPOST after validation with facility it is most recent version. **Use of original form is strongly encouraged!**
- Documentation in the medical record must reflect this has occurred.

Iowa Form Front

HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY				
 <p>Iowa Physician Orders for Scope of Treatment (IPOST) First follow these orders, THEN contact the physician, nurse practitioner or physician's assistant. This is a medical order sheet based on the person's current medical condition and treatment preferences. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.</p>		Last Name _____		
		First/Middle Name _____		
		Date of Birth _____		
A Check one	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse AND is not breathing. <input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation			
B Check one	MEDICAL INTERVENTIONS: Person has a pulse AND/OR is breathing. <input type="checkbox"/> COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</i> <input type="checkbox"/> LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. Do not use intubation, or mechanical ventilation. May consider less invasive airway support (BIPAP, CPAP). May use vasopressors. <i>Transfer to hospital if indicated, may include critical care.</i> <input type="checkbox"/> FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. <i>Transfer to hospital if indicated. Includes critical care.</i> Additional Orders: _____			
C Check one	ARTIFICIALLY ADMINISTERED NUTRITION Always offer food by mouth if feasible. <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube.			
D	MEDICAL DECISION MAKING Directed by: (Listed in order of Iowa Code/Statute for Priority of Surrogates; check only one) <input type="checkbox"/> Patient <input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Spouse <input type="checkbox"/> Majority of Adult Children <input type="checkbox"/> Parents <input type="checkbox"/> Majority rule for nearest relative <input type="checkbox"/> Other: _____		Rationale for these orders: (check all that apply) <input type="checkbox"/> Advance Directives <input type="checkbox"/> Patient's known preference <input type="checkbox"/> Limited treatment options <input type="checkbox"/> Poor prognosis <input type="checkbox"/> Other: _____	
	Physician/ARNP/PA signature (mandatory)	Print Physician/ARNP/PA Name	Date	Phone Number
	Patient/Resident or Legal Surrogate for Health Care Signature as identified above (mandatory)			Date
SEND IPOST WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED				
DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON				

Iowa Form Back

Use of original form is strongly encouraged. Photocopies and Faxes of signed IPOST forms are legal and valid.

HIPAA PERMITS DISCLOSURE OF IPOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Information for Person named on this Form Person's Name (print) _____

This form records your preferences for life-sustaining treatment in your current state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your treatment preferences as best understood by your surrogate.

Contact Information

Surrogate (optional)	Relationship	Phone Number
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Directions For Health Care Professionals

Completing IPOST

- Must be completed by a health care professional based on patient treatment, preferences and medical indications.
- IPOST must be signed by a physician, nurse practitioner or physician's assistant to be valid. Verbal orders are acceptable with follow-up signature by physician, nurse practitioner or physician's assistant in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed IPOST forms are legal and valid.

Using IPOST

- Any section of the IPOST not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation" unless otherwise specified.
- Deactivation of internal defibrillators if comfort measures only are in effect.
- Medications by alternative routes of administration to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Voiding IPOST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- To void this form, draw line through sections A through C and write "VOID" in large letters across the form and sign and date that line if IPOST is replaced or becomes invalid.
- Any changes require a new IPOST.

Transferring/Discharging with IPOST

- The IPOST form belongs to the person.
- The IPOST form **MUST** accompany the person upon all transfers between care settings.
- Document that the IPOST was sent with the person.
- Recommended use at home. Advise patient they must keep IPOST in easily accessible location that the ambulance service could find if no family or friends present (example may be in an envelope or baggie on the refrigerator).

Reviewing IPOST

- This IPOST should be reviewed periodically whenever:
 1. The person is transferred from one care setting or care level to another, or
 2. There is a substantial change in the person's health status, or
 3. The person's treatment preferences change.

Reviewed by:	Date:	Reviewed by:	Date:	Reviewed by:	Date:

Prepared by:

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
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**ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED
DOCUMENT THAT IPOST FORM WAS TRANSFERRED WITH PERSON**

Revised 01/31/09; 1/30/09, 07/0/09; 8-3-10; 6/25/12

Illinois Form Recognized By Iowa Front

UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE			
Illinois Department of Public Health UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)			
HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT			
Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written. See also Guidance for Health Care Professionals at http://www.idph.state.il.us/dnr/books/scvln.htm .			
Patient Last Name		Patient First Name	MI
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Address (street/city/state/ZIP code)			
A CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse and is not breathing.			
<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR means Intubation and Mechanical Ventilation in Section B is selected)			
<input type="checkbox"/> Do Not Attempt Resuscitation/DNR			
When not in cardiopulmonary arrest, follow orders B and C.			
B MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.			
<input type="checkbox"/> Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</i> Treatment Plan: Maximize comfort through symptom management.			
<input type="checkbox"/> Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). <i>Transfer to hospital if indicated. Generally avoid the intensive care unit.</i> Treatment Plan: Provide basic medical treatments.			
<input type="checkbox"/> Intubation and Mechanical Ventilation In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> Treatment Plan: Life support measures, including intubation, in the intensive care unit.			
<input type="checkbox"/> Additional Orders _____			
C ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired.			
<input type="checkbox"/> No artificial nutrition by tube. Additional Instructions (e.g., length of trial period) _____			
<input type="checkbox"/> Defined trial period of artificial nutrition by tube. _____			
<input type="checkbox"/> Long-term artificial nutrition by tube. _____			
D DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)			
<input type="checkbox"/> Patient		<input type="checkbox"/> Agent under health care power of attorney	
<input type="checkbox"/> Parent of minor		<input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list)	
Signature of Patient or Legal Representative			
Signature (required) _____		Name (print) _____	Date _____
Signature of Witness to Consent (Witness required for a valid form)			
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.			
Signature (required) _____		Name (print) _____	Date _____
E SIGNATURE OF ATTENDING PHYSICIAN			
My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.			
Print Attending Physician Name (required) _____		Phone _____	
Attending Physician Signature (required) _____		Date (required) _____	
SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED			
Page 1			

Illinois Form Recognized By Iowa *Back*

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY										
Patient Last Name	Patient First Name	MI								
The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is always voluntary and is for persons with advanced or serious illness or frailty. This order records your wishes for medical treatment in your current state or health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.										
Advance Directive Information										
I also have the following advance directives (OPTIONAL)										
<input type="checkbox"/> Health Care Power of Attorney <input type="checkbox"/> Living Will Declaration <input type="checkbox"/> Mental Health Treatment Preference Declaration										
Contact Person Name	Contact Phone Number									
Health Care Professional Information										
Preparer Name	Phone Number									
Preparer Title	Date Prepared									
Completing the IDPH Uniform Do Not Resuscitate (DNR) Advance Directive Form <ul style="list-style-type: none"> The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time. A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC. Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy. Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms. 										
Reviewing a Do Not Resuscitate (DNR) Advance Directive Form <p>This DNR form should be reviewed periodically and if:</p> <ul style="list-style-type: none"> The patient is transferred from one care setting or care level to another or there is a substantial change in the patient's health status, or the patient's treatment preferences change, or the patient's primary care professional changes. 										
Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form <ul style="list-style-type: none"> A patient with capacity can void or revoke the form, and/or request alternative treatment. Changing, modifying or revising a DNR form requires completion of a new DNR form. Draw line through sections A through E and write "VOID" in large letters if any DNR form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign. If included in an electronic medical record, follow all voiding procedures of facility. 										
Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Patient's guardian of person</td> <td style="width: 50%;">5. Adult sibling</td> </tr> <tr> <td>2. Patient's spouse or partner of a registered civil union</td> <td>6. Adult grandchild</td> </tr> <tr> <td>3. Adult child</td> <td>7. A close friend of the patient</td> </tr> <tr> <td>4. Parent</td> <td>8. The patient's guardian of the estate</td> </tr> </table>			1. Patient's guardian of person	5. Adult sibling	2. Patient's spouse or partner of a registered civil union	6. Adult grandchild	3. Adult child	7. A close friend of the patient	4. Parent	8. The patient's guardian of the estate
1. Patient's guardian of person	5. Adult sibling									
2. Patient's spouse or partner of a registered civil union	6. Adult grandchild									
3. Adult child	7. A close friend of the patient									
4. Parent	8. The patient's guardian of the estate									
For more information, visit the IDPH Statement of Illinois law at: http://www.idph.state.il.us/public/books/advdir.htm										
HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT										
IDPH - IDCI 15-361		Page 2								

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Appendix C: Adult Out-Of-Hospital Trauma Triage Destination Decision Protocol

The following criteria shall be utilized to assist the EMS provider in the identification of time critical injuries, method of transport and trauma care facility resources necessary for treatment of those injuries

Step 1 - Assess for Time Critical Injuries: Level of Consciousness & Vital Signs

- Glasgow Coma Score \leq 13
- Respiratory rate $<$ 10 or $>$ 29 breaths per minute, or need for ventilatory support.
- Systolic B/P (mmHg) less than $<$ 90 mmHg

If ground transport time to a Resource (Level I) or Regional (Level II) Trauma Care Facility is less than 30 minutes, transport to the nearest Resource (Level I) or Regional (Level II) Trauma Care Facility. If greater than 30 minutes, ground transport time to Resource (Level I) or Regional (Level II) Trauma Care Facility, transport to the nearest appropriate Trauma Care Facility. If time can be saved or level of care needs exist, tier with ground or air ALS service program

If step 1 does not apply, move on to step 2

Step (Box) 2 - Assess for Anatomy of an Injury

- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Suspected two or more proximal long-bone fractures
- Suspected pelvic fractures
- Crushed, degloved, mangled, or pulseless extremity
- Open or depressed skull fracture
- Amputation proximal to wrist or ankle
- Paralysis or Paresthesia
- Partial or full thickness burns $>$ 10% TBSA or involving face/airway

If ground transport time to a Resource (Level I) or Regional (Level II) Trauma Care Facility is less than 30 minutes, transport to the nearest Resource (Level I) or Regional (Level II) Trauma Care Facility. If greater than 30 minutes ground transport time to Resource (Level I) or Regional (Level II) Trauma Care Facility, transport to the nearest appropriate Trauma Care Facility. If time can be saved or level of care needs exist, tier with ground or air ALS service program

If step 2 does not apply, move on to step 3

Step (Box) 3 - Consider Mechanism of Injury & High Energy Transfer

- Falls
 - Adult: $>$ 20 ft. (one story is equal to 10 feet)
- High-risk auto crash:
 - Interior compartment intrusion, including roof: $>$ 12 inches' occupant site; $>$ 18 inches any site
 - Ejection (partial or complete) from automobile
 - Death in same passenger compartment
 - Vehicle telemetry data consistent with high risk of injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant ($>$ 20 mph) impact
- Motorcycle crash $>$ 20 mph

Transport to the nearest appropriate Trauma Care Facility, need not be the highest level trauma care facility.

If step 3 does not apply, move on to step 4

Step (Box) - Consider risk factors:

- Older adults
 - Risk of injury/death increases after age 55 years
 - SBP $<$ 110 might represent shock after age 65 years
- EMS provider judgment
- Low impact mechanisms (e.g. ground level falls) might result in severe injury
- ETOH/Drug use
- Pregnancy $>$ 20 weeks
- Anticoagulants and bleeding disorders
- Patients with head injury are at high risk for rapid deterioration

Transport to the nearest appropriate Trauma Care Facility, need not be the highest level trauma care facility.

If none of the criteria in the above 4 steps are met, follow local protocol for patient disposition. When in doubt, transport to nearest trauma care facility for evaluation.

For all Transported Trauma Patients:

1. Patient report to include: MOI, Injuries, Vital Signs & GCS, Treatment, Age, Gender and ETA
2. Obtain further orders from medical control as needed.

Pediatric Out-Of-Hospital Trauma Triage Destination Decision Protocol

The following criteria shall be utilized to assist the EMS provider in the identification of time critical injuries, method of transport and trauma care facility resources necessary for treatment of those injuries

Step (Box) - Assess for Time Critical Injuries: Level of Consciousness & Vital Signs

- **Abnormal Responsiveness:** abnormal or absent cry or speech. Decreased response to parents or environmental stimuli. Floppy or rigid muscle tone or not moving. Verbal, Pain, or Unresponsive on AVPU scale.

OR

- **Airway/Breathing Compromise:** obstruction to airflow, gurgling, stridor or noisy breathing. Increased/excessive retractions or abdominal muscle use, nasal flaring, stridor, wheezes, grunting, gasping, or gurgling. Decreased/absent respiratory effort or noisy breathing. Respiratory rate outside normal range.

OR

- **Circulatory Compromise:** cyanosis, mottling, paleness/pallor or obvious significant bleeding. Absent or weak peripheral or central pulses; pulse or systolic BP outside normal range. Capillary refill > 2 seconds with other abnormal findings.
- Glasgow Coma Score ≤13

If ground transport time to a Resource (Level I) or Regional (Level II) Trauma Care Facility is less than 30 minutes, transport to the nearest Resource (Level I) or Regional (Level II) Trauma Care Facility. If greater than 30 minutes, ground transport time to Resource (Level I) or Regional (Level II) Trauma Care Facility, transport to the nearest appropriate Trauma Care Facility. If time can be saved or level of care needs exist, tier with ground or air ALS service program

If step 1 does not apply, move on to step 2

Step (Box) 2 - Assess for Anatomy of an Injury

- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Suspected two or more proximal long-bone fractures
- Suspected pelvic fractures
- Crushed, degloved, mangled, or pulseless extremity
- Open or depressed skull fracture
- Amputation proximal to wrist or ankle
- Paralysis or Paresthesia
- Partial or full thickness burns > 10% TBSA or involving face/airway

If ground transport time to a Resource (Level I) or Regional (Level II) Trauma Care Facility is less than 30 minutes, transport to the nearest Resource (Level I) or Regional (Level II) Trauma Care Facility. If greater than 30 minutes ground transport time to Resource (Level I) or Regional (Level II) Trauma Care Facility, transport to the nearest appropriate Trauma Care Facility. If time can be saved or level of care needs exist, tier with ground or air ALS service program

If step 2 does not apply, move on to step 3

Step (Box) 3 - Consider Mechanism of Injury & High Energy Transfer

- Falls
 - Death in same passenger compartment
 - Vehicle telemetry data consistent with high risk of injury
- >10 feet or two times the height of the child
- High-risk auto crash:
 - Interior compartment intrusion, including roof: >12 inches occupant site; >18 inches any site
 - Ejection (partial or complete) from automobile
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph

Transport to the nearest appropriate Trauma Care Facility, need not be the highest level trauma care facility.

If step 3 does not apply, move on to step 4

Step (Box) 4 - Consider risk factors:

- Pregnancy > 20 weeks
- Anticoagulants and bleeding disorders
- Patients with head injury are at high risk for rapid deterioration
- EMS provider Judgment
- ETOH/Drug use

Transport to the nearest **(Any Level)** Trauma Care Facility.

If none of the criteria in the above 4 steps are met, follow local protocol for patient disposition. When in doubt, transport to nearest trauma care facility for evaluation.

For all Transported Trauma Patients:

1. Patient report to include: MOI, Injuries, Vital Signs & GCS, Treatment, Age, Gender and ETA
2. Obtain further orders from medical control as needed

Appendix D: Physician on Scene

Your offer of assistance is appreciated. However, this EMS service, under law and in accordance with nationally recognized standards of care in Emergency Medicine, operates under the direct authority of a Physician Medical Director. Our Medical Director and physician designees have already established a physician-patient relationship with this patient. To ensure the best possible patient care, and to prevent inadvertent patient abandonment or interference with an established physician-patient relationship, please comply with our established protocols.

Please review the following if you wish to assume responsibility for this patient:

1. You must be recognized or identify yourself as a qualified physician.
2. You must be able to provide proof of licensure and identify your specialty.
3. If requested, you must speak directly with the on-line medical control physician to verify transfer of responsibility for the patient from that physician to you.
4. EMS personnel, in accordance with state law, can only follow orders that are consistent with the approved protocols.
5. You must accompany this patient to the hospital, unless the on-line medical control physician agrees to re-assume responsibility for this patient prior to transport.

Appendix E: Air Medical Transport - Utilization Guidelines for Scene Response

PURPOSE:

These guidelines have been developed to assist with the decision making for appropriate use of air medical transport by the emergency medical services community. The goal is to match the patient's needs to the timely availability of resources in order to improve the care and outcome of the patient from injury or illness.

RECOGNITION:

- A. An air ambulance may be utilized in any situation that any public safety personnel feels may benefit patient care.

CLINICAL INDICATORS:

1. Advanced level of care need (skills or medications) exists that could be made available more promptly with an air medical tier versus tiering with ground ALS service, and further delay would likely jeopardize the outcome of the patient
2. Transport time to definitive care hospital can be significantly reduced for a critically ill or injured patient where saving time is in the best interest of the patient
3. Multiple critically ill or injured patients at the scene where the needs exceed the means available
4. EMS Provider 'index of suspicion' based upon mechanism of injury and patient assessment

DIFFICULT ACCESS SITUATIONS:

1. Wilderness or water rescue assistance needed
 2. Road conditions impaired due to weather, traffic, or road construction / repair
 3. Other locations difficult to access
- B. Air ambulance may be requested by any Scott County Ambulance or Fire personnel through recognized dispatch center. Availability of air ambulance will be determined at this time.
 1. Any Scott County Public Safety Agency may activate the air ambulance immediately upon receipt of dispatch information.
 2. The air ambulance may not be cancelled prior to arrival of any Scott County Ambulance or Fire Agency until scene size-up, and patient assessment are completed, preferably by an advanced life support provider.
 - C. Dispatch will notify the air ambulance and personnel enroute of all status changes.
 - D. Air ambulance service will notify dispatch of:
 1. Ability to fly
 2. Flight time
 3. Radio frequency
 4. Special circumstances

Appendix E: Air Medical Transport - Utilization Guidelines for Scene Response

Continued

UTILIZATION GUIDELINES FOR SCENE RESPONSE:

- A. After the air ambulance has been requested, dispatch will contact all responding agencies to advise of air ambulance activation
- B. Incident Commander or his/her designee will notify air ambulance of:
 - 1. Landing site
 - 2. Wind direction and velocity
 - 3. Hazards in the area

 - 4. Ground conditions
 - 5. Patient status after update from EMS personnel
 - 6. Permission to Land or Cancel
- C. Landing Zone (LZ) recommendations:
 - 1. 100' X 100' zone
 - 2. Relatively level and clear of debris
 - 3. No overhead wires or obstacles in LZ
 - 4. No overhead wires or obstacles in the approach path
 - 5. Mark LZ with amber flashers at the four corners or other approved means.
- D. Safety concerns in LZ:
 - 1. Do not approach aircraft until signaled by flight crew
 - 2. *ALWAYS* approach from the front, never from the rear
 - 3. Secure all loose objects before approaching aircraft
 - 4. No smoking within 50 feet of the aircraft
- E. Air ambulance flight nurse and/or flight physician will assume patient care responsibilities after landing.
- F. On scene personnel or family members of victims will not be permitted in the air ambulance at any time unless approved by flight crew
- G. Any involved agencies may request a run review within 30 days of air ambulance activation. The involved parties shall include, but not be limited to medical directors and all participating agencies. The Scott County Public Health Services Coordinator will facilitate the run review process.

Appendix G: Reperfusion Therapy Screening Not Limited to Paramedic Level

This form should be completed for patients suffering from Acute Coronary Syndromes. This tool will be used to triage patients to the appropriate receiving facility, and provide a template for passing information on to the receiving facility. Fibrinolytic screening may be done at the EMT level; however, the decision to bypass a local hospital to transport to a Percutaneous Coronary Intervention (PCI) capable facility is reserved for the PS and Paramedic levels.

1. If available, obtain 12-Lead EKG and transmit to receiving facility
2. EMT level – Transport patient to closest appropriate facility. Contact medical control for decision on completing thrombolytic checklist.
3. PS/Paramedic Level – Evaluate 12-Lead for evidence of STEMI.

If STEMI is present, determine appropriate destination.

- If transport time to a facility capable of providing emergency PCI care is 60 minutes or less, it is recommended that all of these patients be transported directly to the emergency PCI capable facility.
- If transport time to a facility capable of providing emergency PCI care is between 60 - 90 minutes, transport to the PCI capable facility should be considered.
- If transport is initiated to a non-PCI facility:

Complete fibrinolytic therapy checklist on next page.

- If a local protocol for fibrinolytic therapy in the field has been established, then proceed with fibrinolytic protocol if:
 - Authorized by voice contact with medical control, and
 - The PS/Paramedic has received training and has the approval of their physician medical director

In all instances those patients requiring immediate hemodynamic or airway stabilization should be transported to the closest appropriate facility.

If STEMI is not present, transport patient to closest appropriate facility.

Note: See Fibrinolytic Checklist on the following page

Fibrinolytic Checklist

Any **YES** findings will be relayed to medical control. **Absolute Contraindications** preclude the use of fibrinolytics. **Relative Contraindications** require consultation with medical control.

DATE:	PATIENT AGE:	MALE	FEMALE	INCIDENT/RECORD #:	YES	NO
ABSOLUTE CONTRAINDICATIONS						
Any known intracranial hemorrhage?						
Known structural cerebral vascular lesion?						
Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours?						
Suspected aortic dissection?						
Active bleeding or bleeding diathesis (excluding menses)?						
Significant closed head trauma or facial trauma within 3 months?						
RELATIVE CONTRAINDICATIONS						
History of chronic, severe, poorly controlled hypertension?						
Severe, uncontrolled hypertension on presentation (S >180mmHg or D >110mmHg)						
History of prior ischemic stroke >3 months, dementia, or known intracranial pathology?						
Traumatic or prolonged (>10 min) CPR or major surgery (<3 weeks)						
Non-compressible vascular punctures?						
Pregnancy?						
Active peptic ulcer?						
Current use of anticoagulants?						
EMS Provider Print Name:				Signature:		

Appendix G: Strategies for Reperfusion Therapy: Acute Stroke

Reperfusion Therapy Screening Not Limited to Paramedic Level

This appendix should be used for suspected acute stroke. This tool will be used to triage patients to the appropriate receiving facility, and provide a template for passing information to the receiving facility.

1. Perform a validated stroke assessment such as the MEND exam.
2. If assessment is positive for stroke, and onset of symptoms can be established within the past 4.5 hours, then determine the appropriate destination:
 - a. If transport time to a Primary Stroke Center is less than 30 minutes, it is recommended that all of these patients be transported directly to the Primary Stroke Center
 - b. If transport time to a Primary Stroke Center is greater than 30 minutes, then transport to the nearest stroke capable hospital.
3. Consider the use of air transport if it will facilitate the arrival of the acute stroke patient for treatment within 4.5 hours to a Primary Stroke Center or stroke capable hospital.
4. If transport to a Primary Stroke Center or stroke capable hospital cannot be achieved to arrive within 4.5 hours, then transport to the closest appropriate facility.
5. In all instances, those patients requiring immediate hemodynamic or airway stabilization should be transported to the closest appropriate facility.
6. Complete the fibrinolytic checklist on next page.

Levels of Stroke Care Capacity:

Comprehensive Stroke Center: Hospitals that have been certified by the Joint Commission-accredited acute care hospitals and must meet all the criteria for Primary Stroke Certification

Primary Stroke Center: Hospitals that have been certified by the Joint Commission on Hospital Accreditation or an equivalent agency to meet Brain Attack Coalition and American Stroke Association guidelines for stroke care

Stroke capable hospital: Hospitals that have the following:

- rt-PA readily available for administration
- Head CT, laboratory and EKG capabilities 24/7
- Process in place for transporting appropriate patients to a Primary Stroke Center
- Stroke protocol in place that follows American Stroke Association guidelines
- Emergency department coverage by physician, or advanced practitioner

The list of Iowa Hospital Triage Designations is available on the Iowa Healthcare Collaborative web site at:

<https://www.ihconline.org/additional-tools/initiatives/coverdell-stroke-project/>

If directed by medical control, complete fibrinolytic checklist below

Fibrinolytic Checklist

Any **YES** findings will be relayed to medical control. **Absolute Contraindications** preclude the use of fibrinolytics. **Relative Contraindications** require consultation with medical control.

DATE:	PATIENT AGE:	MALE	FEMALE	INCIDENT/RECORD #:	YES	NO
ABSOLUTE CONTRAINDICATIONS						
Any known intracranial hemorrhage?						
Known structural cerebral vascular lesion?						
Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours?						
Suspected aortic dissection?						
Active bleeding or bleeding diathesis (excluding menses)?						
Significant closed head trauma or facial trauma within 3 months?						
RELATIVE CONTRAINDICATIONS						
History of chronic, severe, poorly controlled hypertension?						
Severe, uncontrolled hypertension on presentation (S >180mmHg or D>110mmHg)						
History of prior ischemic stroke >3 months, dementia, or known intracranial pathology?						
Traumatic or prolonged (>10 min) CPR or major surgery (<3 weeks)						
Non-compressible vascular punctures?						
Pregnancy?						
Active peptic ulcer?						
Current use of anticoagulants?						
EMS Provider Print Name:				Signature:		

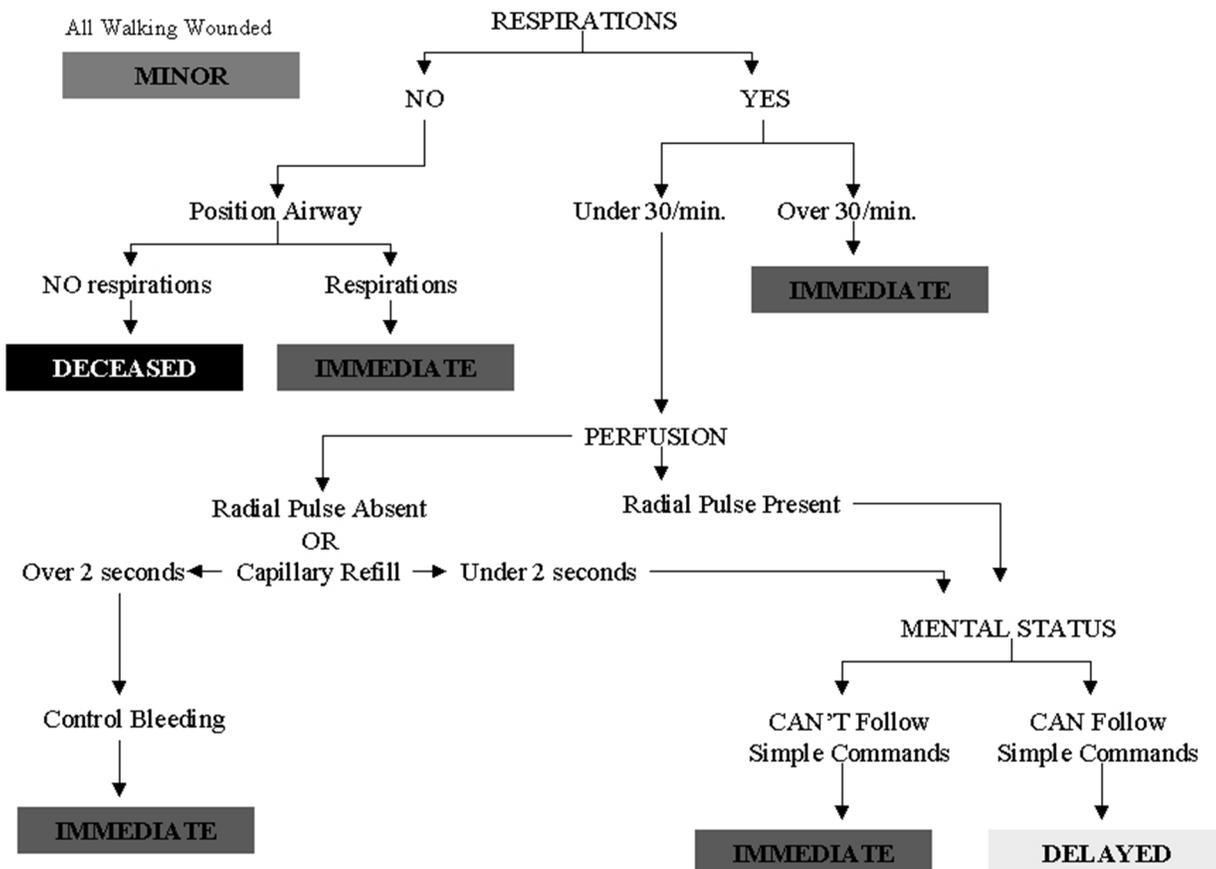
Appendix H: Simple Triage and Rapid Treatment (START)

START

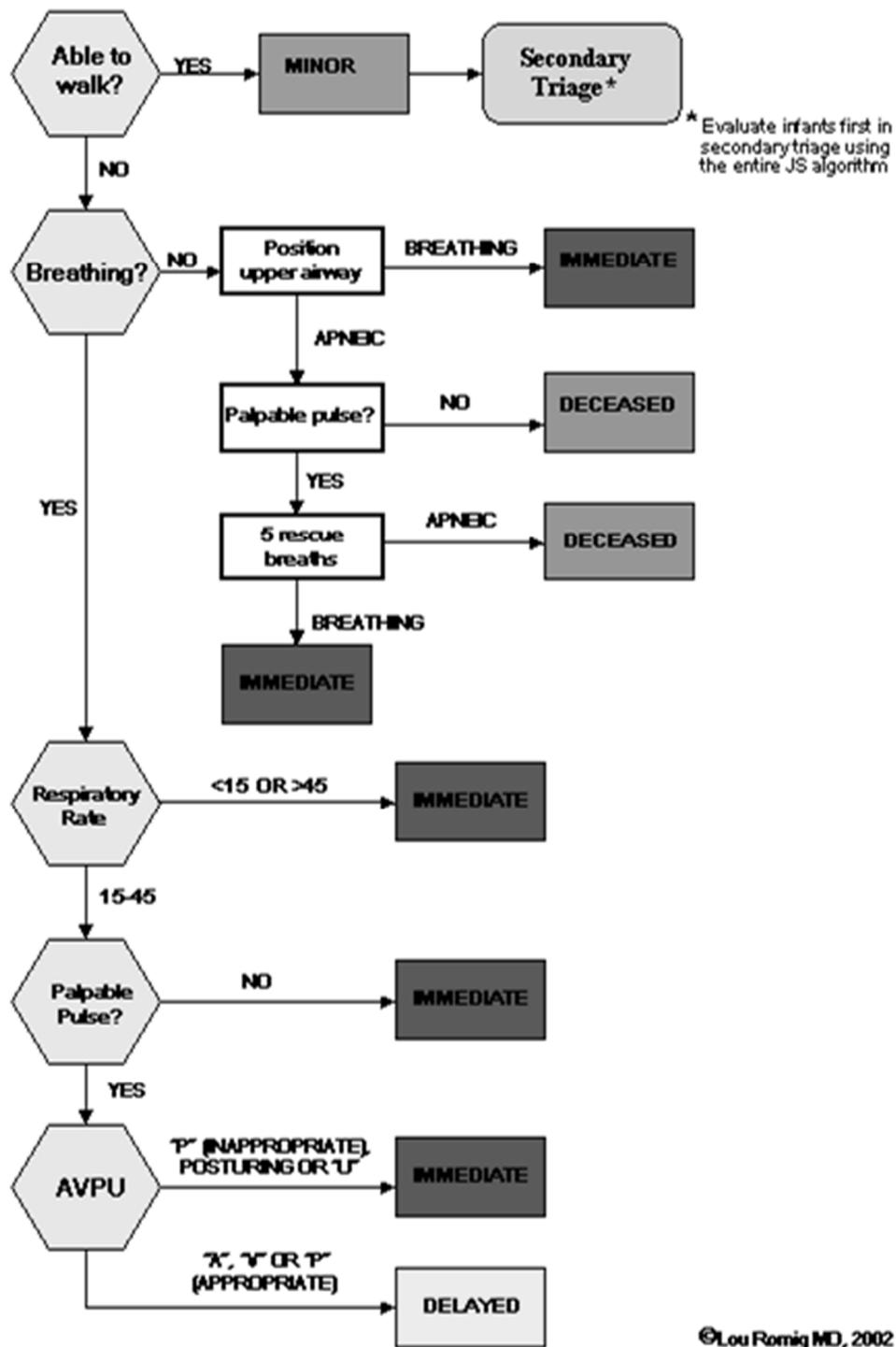
The following are guidelines for initial tactical triage using the START method. START is most useful in initially clearing the disaster zone where there are numerous casualties. **It focuses on respiration rate, perfusion, and mental status and takes under one minute to complete.** Once the patient moves toward a higher level of care (evacuation), a more detailed approach to triage may be needed.

Respirations
Perfusion
Mental Status

Green = Minor/Ambulatory
Yellow = Delayed
Red = Immediate
Black = Deceased/Expectant



Appendix I: Simple Triage and Rapid Treatment – Pediatric JumpSTART



Appendix I: Suspected Abuse/Assault/Neglect/Maltreatment

- a) Provide reassurance
- b) Contact local law enforcement if not present
- c) Provide appropriate medical care per protocol
- d) Do not burden patient with questions about the details of the assault
- e) Be alert to immediate scene and document what you see.
- f) Touch only what you need to touch at the scene
- g) Do not disturb any evidence unless necessary for treatment of patient. (If necessary to disturb evidence, document why and how it was disturbed.)
- h) Preserve evidence; such as clothing you may have had to remove for treatment, and make sure that it is never left unattended at any time, to preserve "chain of evidence"
- i) Provide local referrals as available
- j) Communicate vital information only – additional info can be given to receiving RN and/or Physician on arrival
- k) Record observations and factual information on run report

Pediatric Considerations:

- a) Approach child slowly in order to establish rapport (except in life-threatening situations), then perform exam
- b) Provide appropriate medical care per protocol
- c) Genital exam only if indicated in the presence of blood, known or obvious injury and or trauma
- d) Interview parents separate from child, if possible
- e) Transport if permitted by parents
- f) If parents do not allow transport, notify law enforcement for assistance

Report all suspected abuse to the pediatric and dependent adult hotline at 1-800-362-2178 within 24 hours of your contact of the patient. This will be an oral report only. Within 48 hours of oral reporting, you must submit a written report for all suspected abuse to the Iowa Department of Human Services

Appendix J: Guidelines for EMS Provider Initiating Organ and Tissue Donation at the Scene of the Deceased

1. All appropriate patient care protocols will be enacted to assure patient care is provided according to prevailing standards.
2. If resuscitation efforts are unsuccessful or if upon arrival the patient is deceased and without indications to initiate resuscitation, then on-line medical direction will be contacted to confirm that no further medical care is to be given.
3. As per Iowa Code 142C.7 a medical examiner or a medical examiner's designee, peace officer, fire fighter, or emergency medical care provider may release an individual's information to an organ procurement organization, donor registry, or bank or storage organization to determine if the individual is a donor.
4. As per Iowa Code 142C.7 any information regarding a patient, including the patient's identity, however, constitutes confidential medical information and under any other circumstances is prohibited from disclosure without the written consent of the patient or the patient's legal representative.
5. At least one EMS provider should remain at the scene until the appropriate authority (medical examiner, funeral home, public safety, etc.) is present.
6. Contact Iowa Donor Network at 800-831-4131

Appendix K: Guidelines for EMS Providers Responding to a patient with special needs

This protocol is not intended for interfacility transfers

These guidelines should be used when an EMS provider, responding to a call, is confronted with a patient using specialized medical equipment that the EMS provider has not been trained to use, and the operation of that equipment is outside of the EMS provider's scope of practice. The EMS provider may treat and transport the patient, as long as the EMS provider doesn't monitor or operate the equipment in any way while providing care.

When providing care to patients with special needs, EMS personnel should provide the level of care necessary, within their level of training and certification. When possible, the EMS provider should consider utilizing a family member or caregiver who has been using this equipment to help with monitoring and operating the special medical equipment if necessary during transport.

Some examples of special medical devices:

- PCA (patient controlled analgesic)
- Chest Tube
- Respirator
- Wound Drainage Devices (i.e. wound vac)
- Left Ventricular Assist Device (LVAD)
- Jackson-Pratt (JP) Drain

Appendix L: EMS Approved Abbreviations

a	Before	CHB	Complete heart block	EMS	Emergency Medical Services
ABC	Airway, breathing, Circulation	CHF	Congestive heart failure	ENT	Ear, nose & throat
Abd.	Abdominal	CID	Cervical immobilization device	Epi	Epinephrine
AC	Antecubital	Circ	Circulation	ER	Emergency room
AED	Automated external defibrillator	Cm	Centimeter	ETA	Estimated time of arrival
A-fib	Atrial fibrillation	CMS	Circulation, motor, sensation	ETC	Emergency treatment center
AIDS	Acquired immunodeficiency syndrome	CNS	Central nervous system	ETOH	Alcohol
ALS	Advanced life support	C/O	Complains of	Et	And
AMA	Against medical advice	CO	Carbon monoxide	ET	Endotracheal
AMI	Acute myocardial infarction	CO ₂	Carbon dioxide	ETT	Endotracheal tube
Amp(s)	Ampule(s)	COPD	Chronic obstructive pulmonary disease	Extrem.	Extremity
Amt.	Amount	CP	Chest pain	F	Fahrenheit
Ant.	Anterior	CPR	Cardiopulmonary resuscitation	Fib	Fibrillation
Antecub.	Antecubital	Cric.	Cricothyrotomy or Cricothyroidotomy	FB	Foreign body
ASA	Aspirin	Cric.	Cricothyroidotomy	FD	Fire Department
Asap	As soon as possible	CSF	Cerebrospinal fluid	FR	First Responder
ASHD	Arteriosclerotic heart disease	CVA	Cerebrovascular accident	Fx	Fracture
AT	Atrial Tachycardia	CVP	Central venous pressure	Ga	Gauge
AV	Atrioventricular	CVU	Cardiovascular unit	GAD	Gadolinium
AVB	Atrioventricular block	CXR	Chest x-ray	GB	Gallbladder
BBB	Bundle branch block	DA	Direct admit	GCS	Glasgow Coma Scale
Bett.	Bettendorf	Dav.	Davenport	GI	Gastrointestinal
BFR	Bettendorf Fire and Rescue	D & C	Dilatation and curettage	gm	Gram
Bicarb	Sodium bicarbonate	DCAP-BTLS	Depressions, Contusions Abrasions, Penetrations, -	GMC-E	Genesis Medical Center, East Campus
BID	Twice a day		Burns Tenderness, Lacerations, Swelling	GMC-W	Genesis Medical Center, West Campus
BLS	Basic life support	D/C	Discontinue	gr	Grain
BM	Bowel movement	DFD	Davenport Fire Department	GROM	Good range of motion
BP	Blood pressure	Disch.	Discharge	GSW	Gunshot wound
BPD	Bettendorf Police Department	D ₅₀	Dextrose 50% solution	gtt/gtts	Drop/drops
BS	Blood sugar	D ₅ W	5% Dextrose in Water	GU	Genitourinary
BSA	Body surface area	DPD	Davenport Police Department	Gyn	Gynecology
BVM	Bag valve mask	DOA	Dead on arrival	H ₂ O	Water
c	With	DOB	Date of birth	HA	Headache
C	Centigrade	Drsg	Dressing	Haz Mat	Hazardous material
CA	Cancer	DTs	Delirium tremens	HEENT	Head, eyes, ears, nose & throat
CABG	Coronary artery bypass graft	Dysp	Dyspnea	HIV	Human Immunodeficiency Virus
CAD	Coronary artery disease	Dx	Diagnosis	HPI	History of present illness
CAO X 3 or 4	Conscious, alert, oriented X3 or 4 (person, place, time, & event)	Ea.	Each	h/hr	Hour
Cap.	Capillary	ECC	Emergency Care Center	HR	Heart rate
CAT	Computer axial tomography	ECF	Extended care facility	Hx	History
Cath	Catheter, catheterization, Catheterize	ECG/EKG	Electrocardiogram	la	Iowa
CC	Chief complaint	ED	Emergency Department	ICU	Intensive Care Unit
cc	Cubic centimeter	EDD	Esophageal detection device	IDDM	Insulin dependent diabetes mellitus
C-collar	Cervical collar	EDC	Estimated date of confinement (pregnancy due date)	IL	Illinois
CU	Coronary care unit	EEG	Electroencephalogram	IM	Intramuscular
		EJ	External jugular	IN	Intra Nasal
				Inf	Inferior
				I/O	Intraosseous
				Irrig	Irrigate

IV	Intravenous	NG	Nasogastric	PVC	Premature ventricular contraction/complex
IVP	Intravenous pyelogram	NKA/NKDA	No known allergies/no known drug allergies	Px	Physical
ISHD	Ischemic heart disease	Noc	Night	q	Every
Jct/Junc	Junctional	NOI	Nature of illness	QD	Every day
JVD	Jugular venous distention	NPA	Nasopharyngeal airway	QID	Four times a day
K+	Potassium	NPO	Nothing by mouth	QOD	Every other day
KCl	Potassium Chloride	NSR	Normal sinus rhythm	R, Rt	Right
Kg	Kilogram	NTG	Nitroglycerin	RBBB	Right bundle branch block
KVO	Keep vein open	N & V	Nausea and vomiting	Reg	Regular
L/lt	Left	NS	Normal saline	Rehab	Rehabilitation
L	Liter	O ₂	Oxygen	R/Resp	Respiration
Lab	Laboratory	OB	Obstetrics	RHD	Rheumatic heart disease
Lac	Laceration	OD	Overdose, right eye	R.I.	Rock Island
Lat	lateral	OPA	Oropharyngeal airway	RLE	Right lower extremity
Lb	Pound	OR	Operating room	RLL	Right lower lobe
LBBB	Left bundle branch block	Oint.	Ointment	RLQ	Right lower quadrant
LBP	Low back pain	Ortho	Orthopedics	RML	Right middle lobe
LLE	Left lower extremity	OS	Left eye	RN	Registered Nurse
LLL	Left lower lobe	OU	Both eyes	R/O	Rule out
LLQ	Left lower quadrant	p	After	ROM	Range of motion
LMA	Laryngeal mask airway	P	Pulse	RUL	Right upper lobe
LMP	Last menstrual period	PAC	Premature atrial contraction/complex	RUQ	Right upper quadrant
LOC	Level of consciousness	Palp.	Palpation	Rx	Drug treatment
LP-5, 10, 12	LifePak 5, 10, 12	PAT	Paroxysmal atrial tachycardia	s	Without
LPM	Liters per minute	Path.	Pathology	SaO ₂ , SpO ₂	Arterial oxygen saturation
LPM	Licensed Practical Nurse	PCR	Patient care record	SB	Sinus bradycardia
LR	Lactated Ringers'	PD	Police department	SC	Subcutaneous
LSB	lons spineboard	PE	Physical exam,pulmonary edema, pulmonary embolism	Sec	Second
LUE	Left upper extremity	PEA	Pulseless electrical activity	SIDS	Sudden infant death syndrome
LUL	Left upper lobe	Peds/pedi	Pediatrics	SL	Sublingual
LUQ	Left upper quadrant	PERL	Pupils equal and react to light	S/P	Status post
mA	Milliamp	PJC	Premature junctional contraction/complex	SR	Sinus rhythm
MAEW	Moves all extremities well	PMH	Past medical history	S/S	Signs and symptoms
Mcg	Microgram	PMS	Pulse Motor Sensation	Staph.	Staphylococcus
MCI	Mass Casualty Incident	PID	Pelvic Inflammatory Disease	Stat	At once; immediately
MD	Medical doctor	po	By mouth	STD	Sexually transmitted disease
med	Medication	pr	Per rectum	Strep	Streptococcus
mEq	Milliequivalent	Post.	Posterior	Supp	Suppository
mg	Milligram	Post Op	Postoperative	SQ	Subcutaneous
MI	Myocardial infarction	Pre Op	Preoperative	ST	Sinus Tachycardia
Min	Minute	prn	As needed	Tach	Tachycardia
mL	Milliliter	PSVT	Paroxysmal supraventricular Tachycardia	TB	Tuberculosis
mm	Millimeter	Psych.	Psychiatric	Tbsp	Tablespoon
mod.	Moderate	Pt.	Patient	Temp	Temperature
MOI	Mechanism of injury	PTCA	Percutaneous coronary angioplasty	TIA	Transient ischemic attack
Mol.	Moline	PTA	Prior to arrival	TID	Three times a day
MRI	Magnetic Resonance Imaging	PWD	Pink, warm, dry	TKO	To keep open
MRSA	Methicillin resistant staph aureus			TMC	Trinity Medical Center
MS	Morphine sulfate			TOT	Turned over to
MVC	Motor vehicle crash			Transf	Transfer
NaCl	Sodium chloride			TS	Trauma score
NAD	no acute distress			Tsp.	Teaspoon
NaHCO ₃	Sodium bicarbonate			TTP	Trinity Terrace Park
Neg	Negative			Tx	Treatment
NIDDM	Non-insulin dependent diabetes mellitus			UA	Urinalysis

UHF	Ultrahigh frequency
UGI	Upper gastrointestinal
URI	Upper respiratory infection
UTI	Urinary tract infection
UTL	Unable to locate
Vag	Vaginal
VD	Venereal disease
VF or V Fib	Ventricular fibrillation
VHF	Very high frequency
VO	Verbal order
VRE	Vancomycin resistant
enterococcus	
V/S	Vital signs
VT or V Tach	Ventricular Tachycardia
WBC	White blood cell count
W/C	Wheelchair
WNL	Within normal limits
W/O	Wide open
WPW	Wolfe Parkinson White
WS	Watt seconds
Wt	Weight
X	Times
y/o	Year old

Symbols

↑ Increased, elevated

↓ Decreased, depressed

△ Change

+ Positive

- Negative

> Greater than

< Less than

Appendix M: Guidelines for New Protocol Development

Making a decision to develop a new protocol or evaluate an existing one should be based on a rational process. Questions that should be asked and answered when considering a new drug therapy or procedure are as follows:

Key Questions for any New Protocol

1. Is the drug therapy or procedure medically indicated and safe?
2. Is it within the scope of practice for the provider?
3. How specifically will this protocol benefit patient care?
4. What specifically is needed to implement this protocol (education/training, medical director protocol development/authorization, equipment needs, etc.)?
5. How will this protocol impact operation?
6. What is the opinion of providers concerning this protocol?
7. Does the medical community support this protocol change?
8. What are all the costs versus benefits associated with implementation and maintenance?
9. What are the medical-legal implications?
10. What ongoing provider involvement such as skills maintenance and continuous quality improvement is necessary?
11. How will success be measured?

Rational Protocol Development Process to Make the Right Protocol Decision

1. Study the issue thoroughly
2. Identify key questions
3. Compare with goals
4. Assess fit with system
5. Cost benefit analysis
6. Identify measuring tools

Stakeholders in this process are recognized to include, but not be limited to:

1. Medical direction (on-line and off-line)
2. Educators/training programs
3. Regulators of policy and rules
4. Service directors
5. Service providers
6. Consumers
7. Third party payers

**SCOTT COUNTY
EMERGENCY MEDICAL SERVICES
PHYSICIANS ADVISORY BOARD
(EMS-PAB)**



PURPOSE: To provide the residents of Scott County with a higher level of care while they are en-route to a medical facility.

OBJECTIVE: In Scott County, Iowa there are basic EMT level ambulance services. In the event patients who are served by EMT ambulances have medical symptoms that may require pre-hospital interventions only provided by paramedic ambulances, this policy provides medical authorization by the Scott County EMS Physicians Advisory Board for a paramedic ambulance to be called to assist an EMT ambulance when needed.

For these emergencies, a Paramedic Assist Program will enhance the care rendered to ambulance patients in Scott County. When patient condition warrants the EMT ambulance will call the paramedic ambulance service. At the rendezvous the paramedic will board the EMT ambulance with the equipment needed and proceed with the EMT ambulance to the hospital. Paramedic interventions may proceed while the ambulance is en-route.

Emergency conditions where implementation of this policy would be considered appropriate are as follows:

- INDICATIONS:**
1. Cardiac/Respiratory Arrest
 2. Medically unstable; including but not limited to: chest pain, dyspnea, diabetes, trauma, unconscious patient, active seizure, overdose and behavioral emergencies
 3. Major trauma patients as defined by the Iowa Out of Hospital Trauma Triage Destination Decision Protocol
 4. Childbirth

Appendix O: Left Ventricular Assist Devices (LVAD)

This procedure applies to the management of all patients who have a Left Ventricular Device (LVAD) implanted. An LVAD is a mechanical pump that supports heart function and blood flow in people who have weakened hearts. The device takes blood from the lower chambers of the heart and helps to pump it to the body through the aorta.

- For a patient with an LVAD and a non-cardiac related medical complaint, follow the appropriate protocol based on the chief complaint beginning with the *Initial Patient Care Protocol*.
 - Contact the LVAD Coordinator, the number should be with the LVAD gear bag.
 - In a majority of LVAD patients a pulse will not be palpable. This occurs because of the nature of the continuous pumping fashion that the LVAD pump operates.
 - A manual blood pressure may not be obtainable. An automatic cuff will give you a pressure with a narrow pulse pressure. Your treatment of the patient will be based off of the Mean Arterial Pressure (MAP) which should be between 60 and 90 mmHg.
 - If the patient is unconscious, unresponsive to stimuli and pulseless listen to the patient's chest with a stethoscope. If you hear the whirring sound of the LVAD, **DO NOT PERFORM CPR** as the LVAD has been surgically implanted into the left ventricle and can become dislodged with CPR causing death.
 - If an LVAD patient presents in a Ventricular Tachycardia or Ventricular Fibrillation rhythm, treat with DC or chemical Cardioversion per procedure.
 - These patients and their families are well trained on this equipment and its operation.
 - Patients will have backup equipment including extra fully charged batteries, and a second controller for the device. Gather this equipment and transport with the patient.
 - Transport caregiver with the patient as they will serve as subject matter experts in the event that the patient is unconscious or unreliable.
 - If a low flow alarm sounds, obtain IV access and administer a 250ml Normal Saline Bolus
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Appendix P: Discontinuation of Pre-Hospital Resuscitation

Purpose:

The purpose of this appendix is to allow for discontinuation of prehospital resuscitation after the delivery of adequate and Appropriate Advanced Life Support (ALS) therapy by **Paramedics Only**, when, *in the medical judgement of the Medical Control Physician*, the patient has died and **continued** treatment of the patient would be ineffective and, therefore, inappropriate.

Unsuccessful Cardiopulmonary Resuscitation (CPR) and other ALS interventions may be discontinued **prior to transport** if this procedure is followed.

1. Discontinuation of CPR and ALS intervention may be implemented with contact to **Medical Control** if **ALL** of the following criteria have been met:
 - a. Patient must be 18 years of age or older
 - b. Adequate CPR has been continuously conducted by a Scott County First Responder
 - c. An Advanced Airway has been placed such as an endotracheal tube, blind insertion airway device or cricothyrotomy
 - d. IV or IO has been established
 - e. Rhythm appropriate medications and defibrillation have been administered according to ACLS guidelines
 - f. Persistent refractory VF, Asystole or agonal rhythm is present
 - g. A minimum of 25 minutes of resuscitation has been attempted
 - h. ETCO₂ reading of less than 10.
 - i. ALL ALS level personnel involved in the care agree that discontinuation of the resuscitation is appropriate
2. If all of the above criteria are not met and discontinuation of prehospital resuscitation is desired, contact Medical Control
3. Document all patient care and interaction with the patient's family, personal physician, medical examiner, law enforcement and Medical Control in the Patient Care Report (PCR).

Appendix Q: Non-Transport Evaluate and Release for Suspected COVID-19

Purpose:

The purpose of this appendix is to allow for EMS personnel to medically evaluate a patient and release them to their own care or provide them with a connection to telehealth or similar platform.

Treat and Release at home without transport may be considered if the following criteria are met.

- Symptoms suggestive of a respiratory illness (fever, cough, upper respiratory symptoms, etc.)
AND:
 - Age between 2 and 55 years of age
 - No comorbidities such as diabetes, heart disease, chronic lung disease (COPD/Asthma), chronic renal disease (dialysis), liver disease, cancer, autoimmune disorder, patients on chemotherapy or immunosuppressive medications, or are immunosuppressed.
 - Vital signs are stable after 2 complete sets of vital signs (minimum of 5 minutes apart)
 - Vitals are within normal limits for age
 - Pulse oximetry (oxygen saturation) greater than 94% on room air
 - The patient can safely/effectively maintain home quarantine or isolation
- If the criteria above are not met or the patient has any other medical or traumatic complaint that the EMS Provider, based upon the EMS provider's discretion, feels may not need transport to a hospital, **contact medical control**.
- Assess and document the individual's capacity to make a valid judgment concerning the extent of his/her illness or injury
 - If the EMS provider has doubts about whether the individual lacks the mental capacity to understand and make medical decisions, **contact medical control** to discuss
 - If patient has capacity, clearly explain to the individual and all responsible parties the possible risks and overall concerns with regards to non-transport
 - Document in the patient care report the initial assessment findings and the discussions with all involved individuals regarding the possible consequences of non-transport
- If patient is released without transport:
 - Direct patient to call their doctor or healthcare provider
 - Direct patient to call their county Public Health department for quarantine / self-isolation instructions (if the patient has respiratory symptoms or Covid-19 exposure)
 - Provide patient the necessary phone or web-based (CDC, IDPH, or the patient's Health System) resources for self-isolation instructions and a care at home plan
 - Inform patient when to seek additional care or call 911 (such as worsening, shortness of breath, or based upon their doctor or healthcare provider's recommendation).

If the patient insists on seeking hospital care and refuses the Keep at Home/Home Quarantine strategy, EMS will **contact Medical Control** or transport the patient to a hospital.