EMERGENCY MEDICAL TECHNICIAN (EMT) SCOPE OF PRACTICE

"Emergency Medical Technician I" or "EMT-I" means a person who has successfully completed an EMT-I course which meets the requirements of this Chapter, has passed all required tests, and who has been certified by the EMT-I certifying authority.

100063. Scope of Practice of Emergency Medical Technician-I (EMT-I).

a) During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a supervised EMT-I student or certified EMT-I is authorized to do any of the following:

1) Evaluate the ill and injured.
2) Render basic life support, rescue and emergency medical care to patients.
3) Obtain diagnostic signs to include, but not be limited to the assessment of temperature, blood pressure, pulse and respiration rates, level of consciousness, and pupil status.
4) Perform cardiopulmonary resuscitation, including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
5) Use the following adjunctive airway breathing aids:
   A) oropharyngeal airway;
   B) nasopharyngeal airway;
   C) suction devices;
   D) basic oxygen delivery devices; and
   E) manual and mechanical ventilating devices designed for prehospital use.
6) Use various types of stretchers and body immobilization devices.
7) Provide initial prehospital emergency care of trauma.
8) Administer oral glucose or sugar solutions.
9) Extricate entrapped persons.
10) Perform field triage.
11) Transport patients.
12) Set up for ALS procedures, under the direction of an EMT-II or EMT-P.
13) Perform automated external defibrillation when authorized by an EMT AED service provider.
14) Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

b) In addition to the activities authorized by subdivision (a) of this section, the medical director of the local EMS agency may also establish policies and procedures to allow a certified EMT-I or a supervised EMT-I student in the prehospital setting and/or during interfacility transport to:

1) Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer’s lactate for volume replacement;
2) Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid; and

3) Transfer a patient who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines;

4) Monitor preexisting vascular access devices and peripheral lines delivering intravenous fluids with additional medications pre-approved by the Director of the EMS Authority (not currently allowed in Contra Costa County).

c) The scope of practice of an EMT-I shall not exceed those activities authorized in this Section, Section 100064, and Section 100064.1.

**BLS Management of Patients Encountered Prior to Activation of 9-1-1**

EMT-I's who encounter a patient where the 9-1-1 system has not been activated should assess the patient to determine whether the care needed by that patient is beyond their scope of practice. If it is determined that the patient may benefit from ALS level care, the 9-1-1 system should be activated. After assuring activation of the 9-1-1 system, EMT-I personnel should assess the patient and begin any care required that is allowed in the EMT-I Scope of Practice.

If the EMT-I unit has transport capabilities, the personnel should determine if the ETA of the paramedic unit is greater than the transport time to the closest appropriate receiving facility. If so, the EMT-I unit should proceed with patient transport and cancel the ALS unit. If the ETA of the paramedic unit is less than the transport time to the closest appropriate receiving facility, remain on scene and turn the patient over to the paramedic unit upon their arrival.

Documentation of the patients chief complaint, history of present illness, past medical history, medications, allergies, vital signs, findings from the physical exam, and a general assessment and any treatment initiated is to be completed. A copy of the patient documentation should be given to the transport unit prior to transport, if possible.

**Administration of Oral Glucose**

EMT-I's may administer an approved oral glucose agent by utilizing the following procedure:

1. Confirm altered level of consciousness in a patient with a known history of diabetes, and that the patient is conscious and able to sit in an upright position.

2. Dispense up to 30 grams of the oral glucose solution into the patient's mouth. Optimally, the patient will self-administer the solution.

3. If the patient has difficulty swallowing the solution, discontinue the procedure. The first priority is keeping an open airway.

4. Record the administration of the oral glucose solution with the time given and any changes in the patients level of consciousness.
PUBLIC SAFETY DEFIBRILLATION

PATIENT ASSESSMENT

All patients are to be assessed upon arrival for level of consciousness and the presence or absence of a pulse and respirations, even if CPR is being done. The results of this initial assessment are to be verbalized in the initial report.

If the patient is an unwitnessed arrest or a witnessed arrest with no CPR for 5 minutes or more, two minutes of CPR shall be done prior to attaching the defibrillator for analysis. If the patient was a witnessed arrest with CPR or a downtime less than 5 minutes proceed to attach defibrillator and immediately initiate analysis.

VERBAL REPORT

Verbal reports are very important and should begin once the self-check for the AED has cleared the screen. The initial report should include the name of the person reporting, engine company designation, status of the defibrillator self-check (e.g., self-check ok), patient location, estimated patient age, patient sex, and findings from the initial assessment of the patient. Continue to verbally report events as they occur (e.g., attaching electrodes, analyzing rhythm, paramedics (unit number) on-scene at...). If a shock is advised, verify that everyone (including the operator) is clear of the patient, and verbalize that everyone is clear.

DEFIBRILLATOR ELECTRODES

Do not use the defibrillation electrode if the gel is torn, separated or split from the foil. This may cause arcing and patient burns. Peel the protective backing from the electrode slowly to prevent damage to the gel.

Patients with implanted pacemakers or implantable defibrillators are treated just like any other patient. If possible, do not place the electrodes on the pulse generator of the pacemaker. EMS personnel may feel the shock from an implantable defibrillator as a slight "buzz", but it will not harm them.

PATIENT CARE DATA

Patient data should be downloaded and a patient care report completed and sent to the EMS Agency as soon as possible after the use of the AED.
Public Safety Defibrillation

NON-TRANSPORTING UNIT

1. CONFIRM:
   - unconscious, pulseless, and apneic or
   - unconscious, pulseless with agonal respirations
   - if 1-8 years of age, attach pediatric electrodes, if available. If not, attach adult electrodes if able to do so without electrodes touching

IF TRAUMA: Prepare patient for immediate transport. As time permits, prior to transport unit arrival, initiate defibrillation protocol

2. If unwitnessed or there is a known down time of 5 minutes or greater with no effective CPR
   - CPR for 2 minutes
   - If patient remains unconscious, pulseless and apneic proceed to 3

   If witnessed and the down time is less than 5 minutes proceed to 3

3. Attach Defibrillator and Initiate Analyze/Defibrillation
   - Clear bystanders and crew
   - Have machine analyze the patient’s rhythm

3.1 If the rhythm is shockable
   - Clear bystanders and crew
   - Deliver shock
   - Resume CPR
   - Machine will reanalyze rhythm as indicated by manufacturer protocol

3.2 If the rhythm is NOT shockable
   - Resume CPR beginning with chest compressions
   - Machine will reanalyze the rhythm as indicated by manufacturer protocol

4. If the patient begins breathing or becomes responsive:
   - Maintain airway
   - Assist ventilations as necessary
   - Check blood pressure, if equipment is available

   If the patient again stops breathing or becomes unresponsive:
   - Clear bystanders and crew
   - Have the machine analyze the patient’s rhythm
   - Proceed as in 3 above

5. If a paramedic unit arrives to transport the patient, turn the patient over to paramedic personnel when you reach the point where CPR is appropriate. If turnover is delayed, continue to provide care according to this protocol.

If a BLS unit, without defibrillation capability, arrives to transport the patient, accompany the patient to the hospital providing care enroute. Deliver no more than nine (9) defibrillations on-scene prior to beginning transport.
Spinal Immobilization

Spinal immobilization is a critical procedure necessary in many, but not all patients suffering trauma. Proper evaluation, including assessment of the mechanism of injury (high velocity motor vehicle crash, significant fall, penetrating trauma that may have potential spinal involvement, etc.), assessment of the patient (particularly with regard to neurologic function) and assessment of confounding factors (drugs, pain, etc.) are necessary in order to make a proper decision about spinal immobilization.

If any doubt exists as to whether a patient has sustained a spinal injury, immobilization should be done. In all situations, airway and ventilation have the highest priority and must be addressed with minimal movement of the patient prior to full assessment.

Indications

- Penetrating Injury (Trauma to head, neck or torso):
  - presence of neurologic complaint or deficit – paralysis, weakness, numbness, tingling, priapism or neurogenic shock, loss of consciousness
  - anatomic deformity of spine

- Blunt Injury (regardless of mechanism):
  - altered level of consciousness (GCS less than 15)
  - presence of spinal pain or tenderness
  - anatomic deformity of spine
  - presence of neurologic complaint or deficit – paralysis, weakness, numbness, tingling, priapism or neurogenic shock

- Blunt Injury (when mechanism of injury is concerning):
  - presence of alcohol or drugs or acute stress reaction/anxiety
  - distracting injury (e.g., long bone fracture, large laceration, crush or degloving injury, large burns)
  - inability to communicate (e.g., speech or hearing impaired, language gap, small children, developmental or psychiatric conditions)

Concerning mechanisms of injury include but are not limited to:

- Violent impact to head, neck, torso or pelvis (e.g. assault, entrapment in structural collapse)
- Sudden acceleration, deceleration or lateral bending forces to neck or torso (e.g. moderate- to high-speed motor vehicle crash, pedestrian struck, explosion)
- Falls (especially in elderly patients)
- Ejection from motorized or other transportation device (e.g. scooter, skateboard, bicycle, motor vehicle, motorcycle, recreational vehicle, or horse)
- Victims of shallow-water diving incident
» **Equipment**

- Rigid cervical collar
- Long backboard
- Straps (for torso immobilization)
- Head immobilization device
- Padding

» **Procedure**

1) Provide manual in-line immobilization immediately, moving the head into a proper in-line position, unless contraindicated*. Continue to support and immobilize the head without interruption.

2) Evaluate the patient's ABC's and provide any immediately required intervention.

3) Examine patient to determine if an indication for immobilization exists. Check motor and sensory function and circulation in all four extremities.

4) If patient meets criteria for spinal immobilization:
   a. Examine the neck and apply a properly fitting, effective cervical collar.
   b. Pick the immobilization device that you will use, and immobilize the torso to the device so that the torso cannot move up or down, left or right.
   c. Evaluate and pad behind the head as needed.
   d. After the torso straps have been tightened, immobilize the head, maintaining a neutral in-line position.
   e. Tie the feet together and immobilize the legs so that they can not move anteriorly or laterally.
   f. Fasten the arms to the immobilization device.
   g. If patient is pregnant, elevate spine board on patient's right side to approximately 15 degree angle (left lateral recumbent) to promote venous return.
   h. Recheck the ABC's and motor, sensory, and circulation in all four extremities.

* In-line movement should not be attempted if the patient's injuries are so severe that the head presents with such misalignment that it no longer appears to extend from the midline of the shoulders. Other contraindications would be if careful movement of the head and neck into a neutral in-line position results in neck muscle spasm, increased pain, the commencement or increase of a neurological deficit such as numbness, tingling or loss of motor ability, or compromise of the airway or ventilation.