

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE
Friday, November 14, 2008, 9:00 AM

OREGON MEDICAL BOARD
1500 SW 1st Ave Ste 620
Portland, OR 97201

Board Accepted 01/09/09
Committee Approved 02/13/09

MEMBERS PRESENT

Paul S. Rostykus, MD, Chair
Matt Eschelbach, DO
Toni R. Grimes, EMT-P
Rose Howe, EMT-I
Dave Lapof, EMT-B

STAFF PRESENT

Kathleen Haley, Executive Director
Diana Dolstra, Licensing Manager
Malar Ratnathacam, Licensing Manager

GUESTS

Jan Acebo, REACH
Peggy Andrews, Chemeketa Community College
Shawn Baird, Oregon Ambulance Association
Paul Bollinger, Medical Teams International
John Brett, Washington Co. EMS
Jonathan Chin, Washington County EMS
Randy Jackson, Keizer Fire
Doug Kelly, EMS, Chief, Redmond Fire & Rescue
Bob Leopold, DHS EMS & Trauma Systems
John Praggastis, OSPA
Ritu Sahni, MD, DHS EMS & Trauma Systems

AGENDA

Approve minutes of the August 15, 2008 EMT Advisory Committee meeting

First Review of OAR 847-035-0030, deleting reference to "emergency care procedures" in First Responder and EMT scope of practice.

Discuss EMTs and non-pre-hospital care (either in the hospital or treat and release at the scene)

Discuss eliminating the non-supervised First Responder scope of practice – Dave Lapof, EMT-B

Discuss scope of practice changes - EMT-P and central IV access

Discuss scope of practice changes – EMT-P and medications or blood products

Discuss scope of practice changes – ECG monitoring

Paul Rostykus, MD, Chair, called the meeting to order at 9:00 AM.

APPROVE MINUTES OF THE AUGUST 15, 2008 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE AUGUST 15, 2008 EMT ADVISORY COMMITTEE MEETING, AS AMENDED.

Motion passed unanimously.

FIRST REVIEW OF OAR 847-035-0030, DELETING REFERENCE TO “EMERGENCY CARE PROCEDURES” IN FIRST RESPONDER AND EMT SCOPE OF PRACTICE.

This was discussed at the last meeting, and it was an action item to put the results of the discussion into a proposed rule amendment to be presented at this Committee meeting.

Dave Lapof was concerned that deleting “emergency and “non-emergency” in OAR 847-035-0030 (7) allowed First Responders without standing orders from a supervising physician to care for suspected fractures and assist with prehospital childbirth in a situation that could be a non-emergency. Dave asked at what level does the First Responder need to be working with a supervising physician? The answer is in their scope of practice and is when they need to provide oxygen.

First Responders can use AEDs (automatic defibrillators) without a physician order, as a lay-person, but First Responders with supervising physicians cannot use them. Bob Leopold asked whether now was the time to correct this imbalance in the scope of practice. It was decided to bring that back at the next Committee meeting as this was not the focus of this agenda item.

Kathleen Haley asked whether by removing “emergency care” from the scope whether First Responders and EMTs can perform emergency and non-emergency procedures at any time.

Dr. Rostykus responded by saying that yes, EMTs may provide prehospital care, which is not limited to emergency care, which includes the operation of an ambulance and other public and private safety duties. The beginning of each level of scope of practice states that the EMT-Basic or Intermediate or Paramedic may provide the following emergency and non-emergency procedures, and then it lists what the emergency procedures are, but there are no non-emergency procedures listed. Does that mean they can perform non-emergency procedures because they aren't listed, and if they aren't listed, what non-emergency procedures

can they perform? This was the reason to delete the reference to emergency and non-emergency procedures and just reference "procedures."

Ms Haley felt that there should be a definition of "public and private safety duties" in the administrative rules. She also asked what the history is, and why the procedures listed were considered were emergency procedures.

John Praggastis recounted the history of Senate Bill 435 (1997). The issue he and Shawn Baird were trying to resolve was what care can an EMT provide to non-emergency patients? John Praggastis said that he drafted the language about "public and private safety duties." This phrase is meant to cover situations where emergency care may be provided but the EMT providing the care does not follow the patient into the ambulance (state fair, Rose Garden) or where there is an EMT providing care but no transport, such as EMTs with a fire department. Public safety duties are the fire departments, private safety duties are agencies such as AMR. John Praggastis said EMTs wanted to be able to treat emergencies or emergency patients even when they were not transported.

Shawn Baird said that when they wanted to define the non-emergency transports and the public event stand-bys, they could not come up with new language that was satisfactory to everyone, and they just added the phrase non-emergency into the existing statutory language. Ms Haley added that once non-emergency is added it underscores the public and private safety duties and that is where the need for the definition comes in because that becomes the highlight.

Ritu Sahni, MD said that under the definition of non-emergency care in the statutes, the majority of patients being transported in an ambulance do not fit the definition of a patient needing emergency care, which is they are "expected to die, become permanently disabled or suffer permanent harm within the next 24 hours." There are only a small percentage of patients who fit the definition of being a patient who needs emergency care, most come under the definition of non-emergency care. The wording at the beginning of each the scope for each level of certification says that the First Responder or EMT may perform emergency and non-emergency procedures, and then says that they may perform the following emergency procedures. The scope does not specify any non-emergency procedures, and the majority of patients are non-emergency patients and the scope does not indicate how these patients can be treated.

Non-transporting agencies may go out and evaluate a patient, administer medications; the patient may be transported by an ambulance. They are agencies like Portland Fire Department, Tualatin Fire and Rescue. They respond to 911 calls, they have EMTs on their rigs, they provide care at the scene, they hand off care and transportation to a hospital to an ambulance. People may walk in to fire stations, but they are non-transporting. An ambulance may go out and provide care and there may or may not be a need to transport the patient.

Dr. Rostykus reviewed the definitions in ORS 682.025 and said that two definitions were missing: "the operation of an ambulance," and "public or private safety duties." These two are in the definition of prehospital care and it does not appear that they are further defined anywhere else in the statutes.

NOTE: Ms Dolstra found a memo written by the Board's legal counsel dated September 8, 1998 on the subject of defining "public or private safety duties." *EXHIBIT A*

Shawn Baird said that to define public and private safety duties would require a huge dialogue and process to capture everyone that may fall under providing public and private safety duties as part of

prehospital care. Ms Haley said that this becomes a necessity if you blend emergency and non-emergency in the First Responder and EMT scope of practice.

Dr. Rostykus said that he would like bring back this agenda item at a future meeting with some research done on legislative history.

ACTION PLAN: Staff and Committee to continue drafting rules amending references to emergency and non-emergency procedures and bring back to the 02/13/09 Committee meeting.

DISCUSS EMTS AND NON-PRE-HOSPITAL CARE

David Lapof said that discussion of EMTs working in areas of non-pre-hospital care has mainly centered on EMTs in the emergency department. The Board's legal counsel has said that as long as EMTs do not represent themselves as emergency care providers they can work in the emergency department. Mr. Lapof felt that it would be beneficial to have this in the administrative rules.

ACTION PLAN: Dave Lapof will draft administrative rule language that says that EMTs working outside their emergency care setting can do so if they are not representing themselves as an EMT, and bring to 02/13/09 Committee meeting.

DISCUSS ELIMINATING THE NON-SUPERVISED FIRST RESPONDER SCOPE OF PRACTICE – DAVE LAPOF, EMT B

Dave Lapof wanted to determine why the First Responder level had two scopes of practice; one without standing orders or a supervising physician, and one with standing orders and a supervising physician. The EMT levels all require standing orders and a supervising and he asked whether the First Responder should also require both as well.

Toni Grimes told her ambulance company that the First Responder scope of practice without a supervising level perform the procedures that an EMT can perform without a supervising physician, if they come upon an accident on the road, or assist with a health emergency in the supermarket, etc.

Dr. Rostykus said that the Good Sam law took care of EMTs when they provide care under an emergency situation such as a car accident, and they can provide a much higher level of care than the First Responder level.

Peggy Andrews noticed some language in the First Responder scope of practice that did not read correctly in OAR 847-030-0035 (8)(b).

It was moved and second that

THE EMT COMMITTEE WILL REVIEW THE LANGUAGE IN OAR 847-030-0035 8)(b) ON THE FIRST RESPONDER SCOPE OF PRACTICE AND USE OF AIRWAYS AT THE NEXT COMMITTEE MEETING IN FEBRUARY 2009 AND PROPOSE AMENDED ADMINISTRATIVE RULE LANGUAGE.

Motion passed unanimously.

ACTION PLAN: Rose Howe will draft amended rule language in OAR 847-030-0035 (8)(b) to be reviewed at the 02/13/09 Committee meeting.

DISCUSS SCOPE OF PRACTICE CHANGES - EMT-P AND CENTRAL IV ACCESS

EXHIBIT B

Dr. Rostykus read the current scope of practice for the EMT-P and femoral IV lines, and said there are people walking around with implanted catheters, central IV ports and pike lines, and he suggested replacing scope of practice language that allows the use of femoral lines with the ability to access with indwelling catheters.

Supervising physicians would have to write a protocol for it to be done. Dr. Rostykus was not thinking of using dialysis catheters except in truly life-threatening cardiac arrest. Implanted central IV ports require having the right needle and do need about 4 hours of training. Suggested language change to EMT-P scope of practice is the national scope of practice language.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD APPROVE THE PROPOSED AMENDED LANGUAGE IN OAR 847-030-0035 (11)(h) TO "ALLOW EMT-PS TO ACCESS INDWELLING CATHETERS AND IMPLANTED CENTRAL IV PORTS FOR FLUID AND MEDICAL ADMINISTRATION."

Motion passed unanimously.

DISCUSS SCOPE OF PRACTICE CHANGES - EMT-P AND MEDICATIONS OR BLOOD PRODUCTS

EXHIBIT B

Dr. Rostykus read the current scope of practice and the proposed change in language.

This proposed change to the scope is based on an incident when an EMT was told by a physician to administer a drug but the EMT didn't know anything about the drug. The proposed rule change includes language that says there has to be some education provided to the EMT about the medication or drug prior to the administration of the drug. This would be helpful for medications given during transports.

Shawn Baird suggested putting this in the medical standing orders instead of changing the scope of practice, saying that the EMT receiving any request to administer drugs other than the ones listed, such as for transfers, must be briefed on indications, counter-indications, so that the EMT has the information he needs before leaving on the transfer. Shawn felt there was a liability if the words training and adequate were used.

It was pointed out that if it is in rule it affects all EMT-Ps; the physician that told the EMT to give the medication didn't care what the EMT's standing order said, he was giving the EMT a direct order. The argument is always going to be that the training is not adequate.

Some drugs require classroom training, and the phrase education and training does imply more formal training. Dr. Rostykus suggested "has been adequately informed of risks, benefits and use." Peggy Andrews asked whether the Committee needed to make a scope of practice change or was this isolated incident.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD APPROVE THE PROPOSED AMENDED LANGUAGE IN OAR 847-030-0035 (11)(j) TO "THE EMT-P HAS HAD ADEQUATE AND APPROPRIATE INSTRUCTION, INCLUDING THE RISKS, BENEFITS AND USE OF THE MEDICATION OR BLOOD PRODUCT. "

Motion passed unanimously.

DISCUSS SCOPE OF PRACTICE CHANGES – ECG MONITORING

EXHIBIT B

Dr. Rostykus read the current scope of practice for EMT-Is and ECG monitoring, and his understanding of rhythm is atrial fibrillation, normal science and v-fib, which does not talk about ST elevation; so can they interpret ST elevation; what level of EMT can interpret ST elevation?

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD APPROVE THE PROPOSED AMENDED LANGUAGE IN OAR 847-035-0030(11)(k) TO ALLOW THE EMT-I TO "INITIATE AND INTERPRET ELECTROCARDIOGRAPHIC MONITORING."

Motion failed.

Toni Grimes said that when this has been discussed previously the Committee has felt comfortable allowing EMT-Is to obtain ECGs via a 12-lead and to transmit them.

Peggy Andrews said that the EMT-I curriculum was kept pretty simple with training on 3-lead, v-fib and v-tach. It was left it up to the medical director to allow and train for the 12-lead.

Is an ST elevation part of a rhythm? Should EMT-Is be able to adequately recognize ST elevation? Per Dr. Sahni, only three states allow the EMT-Intermediate to independently interpret 12-lead ECGs; two of those states have the 350 hour EMT-I curriculum. About 60% of the states, in their rules, allow EMT-Basics to obtain a 12-lead for transmitting for computerized interpretation.

Dr. Rostykus said that per the current scope of practice, neither EMT-I or EMT-Ps can read ST elevation; but they are doing it in Jackson County. EMT-Is do not have the training to reliably interpret ST-elevation. Ritu Sahni, MD, felt it was a waste of 24 hours of training to train EMT-Is to be able to independently interpret ST elevation.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD APPROVE THE AMENDED LANGUAGE IN OAR 847-035-0030 (11)(k) TO ALLOW THE EMT-P TO "INITIATE AND INTERPRET ELECTROCARDIOGRAPHIC MONITORING."

Motion passed unanimously.

Dr. Sahni was interested in discussing language allowing the EMT-B to apply 12-lead ECGs. Dr. Rostykus requested that he fill out the EMT Scope of Practice Change Form and it can be discussed at the next meeting.

CONFIRM DATES OF NEXT COMMITTEE MEETINGS

Friday, February 13, 2009 and May 15 or May 29, 2009, are the next meeting dates.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 11:45 AM.

HARDY MYERS
ATTORNEY GENERAL

DAVID SCHUMAN
DEPUTY ATTORNEY GENERAL



EXHIBIT A

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DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

MEMORANDUM

DATE: September 18, 1998

TO: Kathleen Halley, JD
Executive Director
1500 SW 1st Street, Suite 620
Portland, Oregon 97201-5826

FROM: *WGF* Warren G. Foote, Assistant Attorney General
Business Activities Section

SUBJECT: Defining "public or private safety duties"

You have asked for an opinion defining "public or private safety duties. In order to answer this question, it is first necessary to define what are "public or private safety agencies." This term is defined by ORS 401.710(11) as:

any unit of state or local government, a special-purpose district or a private firm that provides or has authority to provide fire-fighting, police, ambulance or emergency medical services.

It logically follows that public or private safety duties would include any duties incident to providing fire-fighting, police, ambulance or emergency medical services.

Placing the term in context is helpful in further defining the term. In Oregon, every public or private safety agency must participate in a 9-1-1 emergency reporting system, see ORS 401.720(2) and Klamath County Communication Agency v. Oregon, 116 Or App 123, 751 P2d 751 (1992). Given the legislative intent not to expand the scope of EMT practice, it seems consistent to define "duties" as falling within the context of providing emergency response assistance, recognizing that non-emergency care may be provided by the first responders.

The Board of Medical Examiners has established a scope of practice for emergency medical technicians, see ORS 682.245 and OAR 847-035-0030. It may, in its discretion, use its rule-making authority to define the term "public or private safety duties" as found in ORS 682.025(15). In addition to its rule-making authority, the Board may also elect to define the term by making conclusions of law during the course of deciding a case brought before it.

WGF\strm:WGF\BME\EMT1

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD

PROPOSED RULES CHANGES – JANUARY 2009

FIRST REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Oregon Medical Board has established a scope of practice for emergency and nonemergency care for First Responders and EMTs. First Responders and EMTs may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001 (5).

(2) The scope of practice for First Responders and EMTs is not intended as statewide standing orders or protocols. The scope of practice is the maximum functions which may be assigned to a First Responder or EMT by a Board-approved supervising physician.

(3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.

(4) Standing orders for an individual EMT may be requested by the Board or Section and shall be furnished upon request.

(5) No EMT may function without assigned standing orders issued by Board-approved supervising physician.

(6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and

EMTs shall request and honor life-sustaining treatment orders executed by a physician, nurse practitioner or physician assistant if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

(7) The scope of practice for emergency and nonemergency care established by the Board for First Responders is intended as authorization for performance of procedures by First Responders without direction from a Board-approved supervising physician, except as limited by subsection (2) of this rule. A First Responder may perform the following emergency care procedures without having signed standing orders from a supervising physician:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for soft tissue injuries;
- (g) Provide care for suspected fractures;
- (h) Assist with prehospital childbirth; and
- (i) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a copy of that report to the senior EMT with the transporting ambulance.

(8) A First Responder may perform the following procedures only when the First Responder is providing emergency care as part of an agency which has a Board-approved supervising physician who has issued written standing orders to that First Responder authorizing the following:

- (a) Administration of medical oxygen;

(b) Open and maintain an airway through the use of a nasopharyngeal and a noncuffed oropharyngeal and pharyngeal suctioning devices;

(c) Operate a bag mask ventilation device with reservoir;

(d) Provision of care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia; and

(e) Administer epinephrine by automatic injection device for anaphylaxis;

(f) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator, only when the First Responder:

(A) Has successfully completed a Section- approved course of instruction in the use of the automatic or semi-automatic defibrillator; and

(B) Complies with the periodic requalification requirements for automatic or semi-automatic defibrillator as established by the Section.

(9) An Oregon-certified EMT-Basic may perform emergency and nonemergency procedures. Emergency care procedures shall be limited to the following basic life support procedures:

(a) Perform all procedures that an Oregon-certified First Responder can perform;

(b) Ventilate with a non-invasive positive pressure delivery device;

(c) Insert a cuffed pharyngeal airway device in the practice of airway maintenance. A cuffed pharyngeal airway device is:

(A) A single lumen airway device designed for blind insertion into the esophagus providing airway protection where the cuffed tube prevents gastric contents from entering the pharyngeal space;

or

(B) A multi-lumen airway device designed to function either as the single lumen device when placed in the esophagus, or by insertion into the trachea where the distal cuff creates an endotracheal seal around the ventilatory tube preventing aspiration of gastric contents.

(d) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;

(e) Provide care for suspected shock, including the use of the pneumatic anti-shock garment;

(f) Provide care for suspected medical emergencies, including:

(A) Obtaining a capillary blood specimen for blood glucose monitoring;

(B) Administer epinephrine by subcutaneous injection or automatic injection device for anaphylaxis;

(C) Administer activated charcoal for poisonings; and

(D) Administer aspirin for suspected myocardial infarction.

(g) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator;

(h) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(i) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician;

(j) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(k) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician and that are in the possession of the patient at the time the EMT-Basic is summoned to assist that patient; and

(l) In the event of a release of military chemical warfare agents from the Umatilla Army Depot, the EMT-Basic who is a member or employee of an EMS agency serving the DOD-designated Immediate Response Zone who has completed a Section-approved training program may administer atropine sulfate and pralidoxime chloride from a Section-approved pre-loaded auto-injector device, and perform endotracheal intubation, using protocols promulgated by the Section and adopted by the

supervising physician. 100% of EMT-Basic actions taken pursuant to this section shall be reported to the Section via a copy of the prehospital emergency care report and shall be reviewed for appropriateness by Section staff and the Subcommittee on EMT Certification, Education and Discipline.

(m) In the event of a release of organophosphate agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride by autoinjector, using protocols approved by the Section and adopted by the supervising physician.

(10) An Oregon-certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:

(a) Perform all procedures that an Oregon-certified EMT-Basic can perform;

(b) Initiate and maintain peripheral intravenous (I.V.) lines;

(c) Initiate and maintain an intraosseous infusion;

(d) Initiate saline or similar locks;

(e) Draw peripheral blood specimens;

(f) Administer the following medications under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician:

(A) Physiologic isotonic crystalloid solution.

(B) Vasoconstrictors:

(i) Epinephrine

(ii) Vasopressin;

(C) Antiarrhythmics:

(i) Atropine sulfate,

(ii) Lidocaine,

(iii) Amiodarone;

(D) Antidotes:

(i) Naloxone hydrochloride;

(E) Antihypoglycemics:

(i) Hypertonic glucose,

(ii) Glucagon;

(F) Vasodilators:

(i) Nitroglycerine;

(G) Nebulized bronchodilators:

(i) Albuterol,

(ii) Ipratropium bromide;

(H) Analgesics for acute pain:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine,

(iv) Fentanyl;

(I) Antihistamine:

(i) Diphenhydramine;

(J) Diuretic:

(i) Furosemide;

(K) Intraosseous infusion anesthetic;

(i) Lidocaine;

(g) Administer immunizations in the event of an outbreak or epidemic as declared by the Governor of the state of Oregon, the State Public Health Officer or a county health officer, as part of an emergency immunization program, under the agency's supervising physician's standing order;

(h) Administer routine or emergency immunizations, as part of an EMS Agency's occupational health program, to the EMT's EMS agency personnel, under the supervising physician's standing order.

(i) Insert an orogastric tube;

(j) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for such maintenance have been provided by the physician, nurse practitioner or physician assistant at the sending medical facility;

(k) Initiate electrocardiographic monitoring and interpret presenting rhythm;

(l) Perform cardiac defibrillation with a manual defibrillator.

(11) An Oregon-certified EMT-Paramedic may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to:

(a) Perform all procedures that an Oregon-certified EMT-Intermediate can perform;

(b) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Tracheal suctioning techniques;

(C) Cricothyrotomy; and

(D) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway.

(c) Initiate a nasogastric tube;

(d) Provide advanced life support in the resuscitation of patients in cardiac arrest;

(e) Perform emergency cardioversion in the compromised patient;

(f) Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;

(g) Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;

(h) [~~Initiate placement of a femoral intravenous line when a peripheral line cannot be placed~~]

Access indwelling catheters and implanted central IV ports for fluid and medication administration;

(i) Initiate placement of a urinary catheter for trauma patients in a prehospital setting who have received diuretics and where the transport time is greater than thirty minutes; and

(j) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician **providing that the EMT-P has had adequate and appropriate instruction, including the risks, benefits, and use of the medication or blood product.**

(k) Initiate and interpret electrocardiographic monitoring.

(12) The Board has delegated to the Section the following responsibilities for ensuring that these rules are adhered to:

(a) Designing the supervising physician and agent application;

(b) Approving a supervising physician or agent; and

(c) Investigating and disciplining any EMT or First Responder who violates their scope of practice.

(d) The Section shall provide copies of any supervising physician or agent applications and any EMT or First Responder disciplinary action reports to the Board upon their request.

(13) The Section shall immediately notify the Board when questions arise regarding the qualifications or responsibilities of the supervising physician or agent of the supervising physician.