

BOARD OF MEDICAL EXAMINERS

1500 SW 1st Ave, Suite 620

Portland, Oregon 97201

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, December 10, 2004, 9:00 AM

MEMBERS PRESENT

Gregory Lorts, MD, Chair

John J. Herbold, EMT-I

Dave Lapof, EMT-B

Paul S. Rostykus, MD

Jon Tardiff, EMT-P

STAFF PRESENT:

Kathleen Haley, Executive Director

Diana Dolstra, Licensing Administrator

Jennifer Lannigan, Licensing Coordinator

GUESTS

Peggy Andrews, Chemeketa Community College

Chris Benson, OFMAA, Lane County Fire District #1

Wyatt Chamberlain, EMT-P

Jon P. Cloutier, ZOLL

Justin Dillinger, OHSU, Paramedic Education

Tina Greiner

Cameron Helikson, EMT-I, Newberg Fire District

Tim Hennigan, Department of Human Services-EMS

Randy Jackson, Keizer Fire District

Gregg Lander, Chemeketa Community College

Gary McLean, EMT-P, OSPA

Shane Moore, Portland Community College/Hooper Detox

Elizabeth E. Morgan, Department of Human Services-EMS

John Praggastis, OSPA

Pontine Rosteck, AMR

Ritu Sahni, MD, ATREC/LOFD/OHSU

Holly Scholles, MA, CPM, LDM, Birthingway College of Midwifery

Donna Wilson, Department of Human Services-EMS

Paula Wilson, Portland Community College

AGENDA

Approve minutes of the September 17, 2004 EMT Advisory Committee meeting

EMTs providing care when called to home deliveries by nurses and lay midwives – Paul

Rostykus, MD

Request for waiver of EMT-P scope of practice – Ritu Sahni, M.D., Medical Director for All - Terrain Rescue, Education and Consulting (ALTREC)

Discuss draft of the EMT-Intermediate curriculum – Peggy Andrews, EMT-P and
First Review of OAR 847-035-0030 - Changing terminology of airway device; changing
EMT-Intermediate scope of practice to reflect the new EMT-Intermediate curriculum

Several questions that require clarification of scope of practice – Cameron Helikson

Discuss EKG monitoring and rhythm interpretation by EMT-Is – Paul Rostykus, MD

Consistent terminology for airway devices – Paul Rostykus, MD

Clarification of language in EMT-B scope of practice on obtaining a peripheral blood specimen –
Dave Lapof, EMT-B

Final Review – OAR 847-035-0030 – Adding administration of epinephrine for anaphylaxis by
auto-injector to EMT-Basic scope of practice; changing spelling of a drug

Other business

Future meeting date

Gregory Lorts, MD, Chair, called the meeting to order at 9:15 AM.

APPROVE MINUTES OF THE SEPTEMBER 17, 2004 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded

THE MINUTES OF THE SEPTEMBER 17, 2004 EMT ADVISORY COMMITTEE MEETING BE ACCEPTED AS AMENDED.

Motion passed unanimously.

EMTs PROVIDING CARE WHEN CALLED TO HOME DELIVERIES BY NURSES AND LAY MIDWIVES

Dr. Rostykus felt no change was needed to the scope of practice, but that the goal was to improve interpersonal skills, and that mutual understanding of cultures and protocol is key. EMTs are expert in transport and transfer.

Ms. Scholles described all the different types of midwives. Midwives are able to use IVs and some medications. She encouraged collaboration between midwives and EMTs, but she understood medical directors want a protocol. If a birth has not happened when the EMTs arrive, she suggested allowing the midwife to attend to the birth, and then the EMTs can start an IV if needed, and transport the mother and baby. She said it is a matter of understanding the EMT

protocol and the midwives' practice, and to identify areas of potential conflict and resolve them. There have been some bad outcomes when the EMTs have taken over the care of a newborn, such as the baby dying.

Peggy Andrews said that there is not much interface with midwives in EMT training, and felt it is a communication issue. Perhaps there could be an article with information about midwives in an upcoming issue of the EMS newsletter.

REQUEST FOR WAIVER OF EMT-P SCOPE OF PRACTICE

Ritu Sahni, MD, Medical Director for All - Terrain Rescue, Education and Consulting (ALTREC) had submitted a request for a waiver for a group of EMT-Ps to practice in Southeast Asia under a federal contract. The Committee discussed the contract with Dr. Sahni and asked him questions about training the EMTs in performing tube thoracostomy (chest tube). The Committee determined that if the EMTs were practicing out of state or outside the country, they can do whatever they want in terms of practice.

OUTCOME: The Committee determined that the First Responder and EMT scope of practice for Oregon does not extend beyond the borders of the state, and therefore has no jurisdiction over the EMTs providing care through the US Department of Defense in Southeast Asia.

DISCUSS DRAFT OF THE EMT-INTERMEDIATE CURRICULUM & APPROVE FIRST REVIEW OF OAR 847-035-0030

Peggy Andrews, EMT-P, presented a draft of the EMT-I curriculum, with a Powerpoint presentation of the development and major points of the new curriculum (*Exhibit A*). Ms. Andrews is the chair of the Education Modality Workgroup.

Ms. Andrews reviewed the history of the development of the EMT-I curriculum, which has become cognitive-based training rather than a recipe-based training. Out of the survey that Jonathan Chin conducted, it was found that Intermediates wanted more capability, to be able to use more medications, more frequently, and have more tools at their disposal. At the same time, they felt nervous about performing clinical procedures because they did not have enough opportunity to practice them to become skilled in performing them. Several sub-committees were formed, one was a physicians group, to review the curriculum once it was written and give approval to it. The other group was the Education Modality Workgroup chaired by Peggy Andrews and Donna Wilson. The goal when they started in February was to have the curriculum completed in December.

The current EMT-I curriculum is 120 hours: 76 hours of lecture and 44 hours of lab. Instructors around the state commonly add about 20 hours because they cannot complete the curriculum within those hours. The proposed EMT-I curriculum has 135 hours: 74 hours of lecture, 53 hours of skills lab, and 8 hours of clinical experience. They looked to rural community needs, not urban community needs, when developing the curriculum. The litmus test for any change to the curriculum was the question "does it have the potential to save a life within two hours?" The workgroup identified the two-hour time frame because the average transport time in the rural area is two hours.

The process will be that an EMT-Intermediate candidate must be currently certified in Oregon as an EMT-Basic, in good standing, and agency-sponsored, with a written statement of competency from the supervising physician or designee, and must complete a written pre-test within two weeks of the class starting, which will be used for advisory purposes. The supervising physician will verify the skills the EMT-Basic has coming into the Intermediate class.

Case-based scenarios will be emphasized in the skills labs. For the 8 hours of clinical experience, the workgroup felt it important for the students to see some role modeling in terms of patient assessment and decision making for patient care. The workgroup felt this would be best found in a hospital or a clinic in their community, and they would shadow a nurse or physician a minimum of 8 hours and obtain 20 patient contacts. The student may need to spend more time than 8 hours in order to obtain 20 patient contacts. The student will not be the one treating the patient; the student will observe the nurse or physician treating the patient; observing 20 patient contacts between nurse/physician and patient so the student can see the decision making in how the patient is treated.

For the pharmacology portion of the curriculum, the workgroup proposed adding amiodarone and vasopressin because they believe the Intermediate should be able to follow the existing ACLS algorithms as they are written to the level of an Intermediate. Other medications being proposed are Atrovent and Combivent, Nubain and Toradol, benadryl, glucagon and Lasix. Lasix caused a great deal of discussion. There is a need to do some physician education so the supervising physicians are careful in how they write their protocols if they choose to have their Intermediates giving Lasix. Neither valium nor versed was added for seizure management, because, for rural Intermediates, the seizure has passed by the time the Intermediate gets to the patient, or the patient has died.

The only two skills being proposed added to the new Intermediate curriculum is manual defibrillation and IM (intramuscular) injection, which is needed for glucagon.

A member of the workgroup who did the section on airway did a lot of research on the Laryngeal Mask Airway (LMA), and felt it was not appropriate to teach it in the new Intermediate curriculum. The Department of Human Services-EMS is not proposing that it be deleted from the scope of practice, but that if the supervising physician wants his/her EMTs to use the LMA then he/she can teach it as an in-service.

Dr. Lorts said that, as Peggy Andrews mentioned, several things need to come together at the same time. The proposed administrative rules need to be written, and the workgroup has provided the Committee with a draft of some rules to review, but it could be a minimum of six months before the rules are adopted.

The Education Modality Workgroup would like a couple of pilot courses to be taught before the new Intermediate curriculum is actually being taught in a widespread manner around the state.

The proposed administrative rules will be adopted in six months or so, give or take a procedure or a drug. The worst case scenario might be that the students in the pilot courses learn something that does not end up in the adopted scope of practice.

Committee members commented on the proposed Intermediate curriculum, and a list of the suggested changes is as follows:

- Consistent terminology for the term medical director/supervising physician
- Use generic terms for the drugs throughout. Delete Combivent because it is a specific trade formulary, include albuterol, and ipatropium bromide instead of Atrovent
- Consistent terminology for airway management, such as for the Combitube
- Have 8 hours of ride-along time instead of or in addition to 8 hours of patient contacts, so students can do field IVs, or have 5 IV starts as part of 20 patient contacts
- Move some of the lab hours into the clinical portion of the curriculum so that they actually perform some of the clinical procedures on real people; spend time in the ER or on the ambulance because it is a real life situation
- Charting, part of the thought process, not just part of medication

Peggy Andrews agreed that Intermediates need more real life clinical experiences as part of the curriculum, but she did not believe that this is the real issue. She believes that the Intermediates have not been taught to think critically and have not learned how to make decisions. The proposed new Intermediate curriculum has been developed to help the student develop critical thinking and make immediate decisions, and they will perform the skills they need to perform when it is necessary. The report card will come in two to three years once there are some newly trained Intermediates out in the field and the instructors can do a retrospective look at how the new Intermediates are doing in comparison to the EMT-Is who were trained previously.

Dr. Rostykus asked where the EMT-Intermediate courses are being taught, and Liz Morgan answered that they are taught at and through Treasure Valley Community College and Blue Mountain Community College. Peggy Andrews said that the community college will approve the course and approve the instructor but the course may be taught 60 or 100 miles away. There is a class in Monument, one in Reedsport, one in Enterprise. Dr. Rostykus suggested getting the hospital personnel and the supervising physician to buy into the curriculum and get them to help teach portions of the class.

Dr. Lorts summarized the discussion. It will be difficult to require clinical experience in the ER or on an ambulance, unless it is the ambulance where the student is employed, for several reasons, one of which is liability insurance. Do we say, yes, it's huge, but we just have to require that kind of clinical experience and it slows things down for the Intermediate student, or do we put more clinical lab hours into the curriculum? We do wish Intermediate students to have clinical experience of some of these techniques, with the optimum being in the back of an ambulance, whether that is real or simulated, not just for IVs, but for several other procedures. Peggy Andrews was not keen on having lab time transferred from the specific modules of the curriculum to a clinical portion of the curriculum, but some requirements could be added to the clinical hours that would increase these clinical hours. Jon Tardiff's idea would move 7 hours from the lab hours to the clinical component of the curriculum.

Peggy Andrews said that the curriculum will teach about drugs and how they are made, regulated, metabolized, excreted, the therapeutic index, and then go through the different

classifications of drugs in the scope, when to use them, what they do to the body, when not to use them, and then about the specific drugs; but they are not going spend an hour on each drug. The students are expected to do some personal work and study on their own regarding the medications. The students will be expected to know the indications, the dose, and the contraindications of each drug they can administer.

The curriculum deletes “for pain management” with the use of morphine and “for chest pain” with the use of nitroglycerine. It will require a higher level of education, which Peggy Andrews assured the Committee will be provided in the new Intermediate scope of practice.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE APPROVES THE PROPOSED EMT-INTERMEDIATE CURRICULUM AS PRESENTED, WITH AMENDMENTS RESULTING FROM THE COMMITTEE DISCUSSION, AND PROPOSED ADMINISTRATIVE RULE CHANGES IN THE EMT-INTERMEDIATE SCOPE OF PRACTICE IN OAR 847-035-0030 (10), WITH CLARIFICATION OF THE AIRWAY AT THE EMT-BASIC LEVEL AS A “CUFFED PHARYNGEAL” AIRWAY (*Exhibit B*).

Motion passed unanimously.

SEVERAL QUESTIONS THAT REQUIRE CLARIFICATION OF SCOPE OF PRACTICE

Mr. Helikson had sent an updated letter, since some of his questions had been answered by the proposed Intermediate curriculum. He did want the Committee to discuss his request regarding non-invasive devices in the First Responder and EMT scope of practice. Mr. Helikson said that he is requesting clarifying language for the administrative rules to include examples of non-invasive devices. This is because his EMS coordinator, when they were going through a revision of their standing orders, insisted that EMT-Is could not use end-tidal CO2 monitors because they were not listed in the scope of practice as a non-invasive device.

Mr. Helikson said that the broader the administrative rule language the harder it is to interpret.

Mr. Helikson said that his EMS coordinator associated the end-tidal CO2 as only being useful with an ET (endotracheal tube).

Dr. Lorts said that the Committee elected not to list all the non-invasive devices an EMT might use because sometime in the future there will be more, and as they are not a part of the scope of practice, it was not necessary to write a list of them.

ACTION PLAN: Staff will write a letter to Mr. Helikson explaining why the rules were written the way they were for non-invasive devices and explain that EMTs can use the end-tidal CO2 monitoring device as it is considered a non-invasive device and is therefore not a part of the scope of practice.

DISCUSS ECG MONITORING AND RHYTHM INTERPRETATION BY EMT-IS AND EMT-PS

It was decided that since this is being covered in the new Intermediate curriculum, it does not have to be discussed by the Committee. Dr. Rostykus frequently gets this question, though, and he did not know whether or not Intermediates are taught to monitor ECGs and interpret rhythms.

Gary McLean, EMT-P, said this question came up a couple of years ago, and the Health Division said that Intermediates were not taught to interpret ECG rhythms.

CONSISTENT TERMINOLOGY FOR AIRWAY DEVICES

Dr. Rostykus said we need to change the scope of practice for the language “uncuffed pharyngeal” airways and First Responders and he would like to see consistent language on airway devices throughout the scope of practice.

A member of the public attending the meeting presented the Committee with information that the King LT airway has the FDA classification as an oropharyngeal airway, provided the Committee with the US Food and Drug Administration definition of an oropharyngeal airway device, and proposed administrative rule language in the First Responder and EMT-Basic scope of practice defining airways as “uncuffed oropharyngeal” and “oropharyngeal” airways.

ACTION PLAN: Jon Tardiff will go through the scope of practice to make sure that terminology for airway devices is consistent, and bring back suggestions for wording changes to the next Committee meeting. Proposed rules changes regarding uncuffed oropharyngeal and oropharyngeal airway in the First Responder and EMT-Basic scope of practice will also be reviewed.

CLARIFICATION OF LANGUAGE IN EMT-B SCOPE OF PRACTICE ON OBTAINING A PERIPHERAL BLOOD SPECIMEN

Dave Lapof proposed some language change in the EMT-Basic scope of practice which would allow them to obtain a capillary blood specimen for appropriate diagnostic testing. There was discussion on other tests the EMT-Basic could be requested to obtain and the need then to provide more training to the EMT-Basic because the EMT could not read the results.

Dr. Lorts and Dr. Rostykus felt there should be more discussion before allowing EMT-Basics to obtain a blood specimen for anything other than blood glucose monitoring.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS APPROVING A CHANGE TO THE SCOPE OF PRACTICE TO ALLOW AN EMT-BASIC TO OBTAIN A CAPILLARY BLOOD SPECIMEN FOR BLOOD GLUCOSE MONITORING.

Motion approved unanimously.

ACTION PLAN: At the March 2005 meeting review the letter from Chris Benson, EMT-P, EMS Coordinator, Lane County Fire District #1 regarding peripheral blood specimens.

FINAL REVIEW – OAR 847-035-0030 – ADDING ADMINISTRATION OF EPINEPHRINE FOR ANAPHYLAXIS BY AUTO-INJECTOR TO EMT-BASIC SCOPE OF PRACTICE

Proposed rules adds the administration of epinephrine by automatic injection device for anaphylaxis to the First Responder scope of practice, and amends the EMT-Basic scope of practice to allow them to administer epinephrine for anaphylaxis rather than just anaphylactic shock, and corrects the spelling of the drug naloxone.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS ADOPT THE PROPOSED ADMINISTRATIVE RULES IN OAR 847-035-0030, ADDING ADMINISTRATION OF EPINEPHRINE BY AUTOMATIC INJECTION DEVICE FOR ANAPHYLAXIS FOR FIRST RESPONDERS, CHANGING THE ADMINISTRATION OF EPINEPHRINE FOR ANAPHYLACTIC SHOCK TO ANAPHYLAXIS IN THE EMT-BASIC SCOPE OF PRACTICE, AND CORRECTING THE SPELLING OF THE DRUG NALOXONE IN THE EMT-PARAMEDIC SCOPE OF PRACTICE (*Exhibit C*).

Motion carried unanimously.

NEW BUSINESS

Jon Tardiff's position on the Committee ends on June 30, 2005 and there was discussion of the timing of notification to all the EMT associations and the list of interested people.

ACTION PLAN: A notice will be sent out to all interested parties and EMT associations prior to the March 2005 meeting.

FUTURE MEETING DATE

Next meeting date is Friday, March 11, 2005 at 9:00 AM.

ADJOURNMENT

There being no more business to discuss, the meeting was adjourned at 1:30 PM.

Oregon EMT-Intermediate Curriculum Revision

Peggy Andrews, Silverton
(EMT-P) Instructor (Chair)

Donna Wilson, Central Oregon
(EMT-P) Instructor (Co-chair)

Rose Howe, Monument
(EMT-I) Instructor

Fred Siewert, Reedsport
(EMT-P) Instructor

Reta Warner, Enterprise
(EMT-I) Instructor

Adam Glaser, Life-flight
(EMT-P) Instructor

Shane Moore, Portland
(EMT-I) Instructor

**Education
Modality
Workgroup**

Existing curriculum vs Proposed curriculum

<ul style="list-style-type: none"> Existing ~ 120 hours <ul style="list-style-type: none"> - 76 hours lecture - 44 hours lab Commonly ~ 20 hours added by institution 	<ul style="list-style-type: none"> Proposed 135 Hours <ul style="list-style-type: none"> - 74 Hours lecture - 53 Hours lab - 8 hours clinical
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The goal

- EMT-Intermediates will be more confident and competent, have flexibility within a limited scope of practice, and have a program structure that better meets the needs of the rural/frontier community.

Teach "why" of disease processes and skills.

- The litmus test for any change was "does it have the potential to save a life within the next two hours?"

The process

- Pre-requisites
- EMT-I candidates will:
 - Possess current Oregon certification as EMT - Basics
 - Be in 'good standing' with DHS-EMS
 - Be agency sponsored
 - Provide written verification of competency in certain Basic skills
 - Complete a written pre-test, to be used for advisory purposes

The pre-test

- Will be completed within two weeks of the first class section. **For advisory use**
- Will include questions about:
 - Scope of practice
 - On-line & off-line medical control
 - Supervising physician role/responsibilities
 - Continuing education requirements
 - Universal precautions
 - Prehospital care reports and documentation requirements
 - EMT-Basic questions
 - Scenario-based questions

The curriculum

- Skills pretest: verified by letter from physician advisor
 - BVM, naso/oropharyngeal airways, suctioning
 - C-spine; seated or supine (random)
 - Long bone traction device placement
 - An organized initial and detailed patient assessment

- Educational methodology will be cognitive based
- 74 - Didactic hours
- 53 - Skills lab hours
- Case-based scenarios will be emphasized
- 8 - Clinical experience
 - Can be observation

The curriculum

- Roles & Responsibilities
 - Didactic 4
 - Lab 0
- Emergency Pharmacology
 - Didactic 14
 - Lab 6
- Venous Access & Medication Administration
 - Didactic 4
 - Lab 10

The curriculum, cont.

- ECG Monitoring & Management of Dysrhythmias
 - Didactic 10
 - Lab 8
- Airway & Ventilation
 - Didactic 2
 - Lab 2
- Advanced Airway techniques
 - Didactic 4
 - Lab 4

The curriculum, cont.

- Airway Disease
 - Didactic 4
 - Lab 2
- Cardiovascular Emergencies
 - Didactic 4
 - Lab 2

The curriculum, cont.

- Altered Mental Status
 - Diabetic & Neuro emergencies
 - Didactic 5
 - Lab 3
- Trauma Systems/Mechanism of Injury/Hemorrhage & Shock/Burns
 - Didactic 6
 - Lab 4

The curriculum, cont.

- Environmental Emergencies
 - Didactic 1
 - Lab 0
- Pediatrics
 - Didactic 6
 - Lab 2

The curriculum, cont.

- Geriatrics
 - Didactic 6
 - Lab 2
- Clinical decision-making
 - Didactic 2
 - Lab 4
- Case-Based Scenarios
 - Didactic 2
 - Lab 4

*Proposed pharmacology *already in scope*

- Antiplatelet
 - Aspirin*
- Vasodilator
 - Nitroglycerine*
- Antiarrhythmic
 - Atropine*
 - Lidocaine*
 - Amiodarone
- Cardiac Stimulator/Vasoconstrictor
 - Epinephrine 1:1,000*
 - Epinephrine 1:10,000*
 - Vasopressin

Proposed pharmacology

- Antidote
 - Activated charcoal*
 - Narcan*
- Bronchodilator
 - Albuterol*
 - Atrovent
 - Combi-vent
- Analgesic
 - Morphine sulfate*
 - Nubain
 - Toradol
- Antihistamine
 - Benadryl
- Antihypoglycemic
 - Dextrose 50%*
 - Oral glucose*
 - Glucagon
- Diuretic
 - Lasix

Proposed skills –

- Cardiac Arrest – follow ACLS algorithm to intermediate level
- Manual Defibrillation
- IM Injection
- Adult IO
- CO₂ monitoring
- Information about SaO₂ monitoring

Summary

- As we developed this curriculum draft, we were mindful of the following concerns expressed by rural EMT-Intermediates:
 - Respond to the needs of the rural intermediate, not the urban intermediate.
 - Define the rural EMT-I as providing care in agencies 10 miles or more from a population of 30,000 or more

Steps for approval

- Presented to:
- EMT consortium 10/04
 - Approved
- Curriculum project - Physician advisors subcommittee 11/04
 - Approved
- SEMC- Subcommittee on education 12/04
 - Approved
- SEMSC 12/04
 - Approved

Next steps to curriculum approval/completion

- Presentation to BME
 - Approval?
 - Scope of practice change

Next steps, cont.

- Administrative rule changes?
- Develop PPT for lectures
- Instructor rollout
- Pilot courses
- Develop pre and post-test
- Bridge class for existing Intermediates

Summary, cont.

- Emphasis on the critical thinking process
- CE requirements need to be increased (not yet addressed)
- Increased physician involvement will be critical

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS

PROPOSED RULES CHANGES – JANUARY 2005

FIRST REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Board of Medical Examiners 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 or a nurse practitioner, 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 an oropharyngeal and nasopharyngeal airway 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 [~~dual-lumen~~] **cuffed pharyngeal** airway device in the practice of airway maintenance;

(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 peripheral blood specimen for blood glucose monitoring, obtained via fingerstick, heelstick, or earlobe puncture;

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

(C) Administer activated charcoal for poisonings, following local written standing orders; 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 or pharyngoesophageal 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 chemical agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, using protocols approved by the Section and adopted by the supervising physician, if:

(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or

(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.

~~[(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 when specifically authorized by the physician;~~

~~(e) Infuse any physiologic isotonic crystalloid solution;~~

~~(f) Draw peripheral blood specimens;~~

~~(g) Initiate or administer the following medications:~~

~~(A) Epinephrine 1:10,000;~~

~~(B) Atropine sulfate;~~

~~(C) Lidocaine bolus for ventricular fibrillation, post-ventricular fibrillation/ventricular tachycardia cardiac arrest, ventricular tachycardia, or wide complex tachycardia;~~

~~(D) Naloxone hydrochloride;~~

~~(E) Hypertonic glucose;~~

~~(F) Nitroglycerine for chest pain;~~

~~(G) Beta-2 specific nebulized bronchodilators;~~

~~(H) Morphine for pain management;~~

~~(h) Insert a laryngeal mask airway (LMA) device in the practice of airway maintenance;~~

~~(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 personnel at the sending medical facility.~~

~~(k) Perform cardiac defibrillation with a manual defibrillator if the EMT-Intermediate has satisfactorily completed a Section-approved training course in manual defibrillation, including written and practical examinations and the EMT-Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an "EMT-Intermediate Manual Defibrillation Waiver" by the Section.]~~

(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 1:10,000,

(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:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine;

(I) Antihistamine:

(i) Diphenhydramine;

(J) Diuretic:

(i) Furosemide;

(g) Insert an orogastric tube;

(h) 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;

(i) Perform cardiac defibrillation with a manual defibrillator [~~if the EMT Intermediate has satisfactorily completed a Section approved training course in manual defibrillation, including written and practical examinations and the EMT Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an “EMT Intermediate Manual Defibrillation Waiver” by the Section].~~

(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) Needle 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) Initiate electrocardiographic monitoring and interpret presenting rhythm;

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

(f) Perform emergency cardioversion in the compromised patient;

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

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

- (i) Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;
- (j) 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
- (k) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician.

(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.

OREGON ADMINISTRATIVE RULES
CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS
PROPOSED RULES CHANGES – JANUARY 2005
FINAL REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Board of Medical Examiners 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 or a nurse practitioner, 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 an oropharyngeal and nasopharyngeal airway 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;

[(e)] **(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 dual lumen airway device in the practice of airway maintenance;

(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 peripheral blood specimen for blood glucose monitoring, obtained via fingerstick, heelstick, or earlobe puncture;

(B) Administer epinephrine by subcutaneous **injection** or automatic injection device for ~~[anaphylactic shock]~~ **anaphylaxis**;

(C) Administer activated charcoal for poisonings, following local written standing orders;
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 or pharyngoesophageal 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 chemical agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, using protocols approved by the Section and adopted by the supervising physician, if:

(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or

(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.

(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 when specifically authorized by the physician;

(e) Infuse any physiologic isotonic crystalloid solution;

(f) Draw peripheral blood specimens;

(g) Initiate or administer the following medications:

(A) Epinephrine 1:10,000;

(B) Atropine sulfate;

(C) Lidocaine bolus for ventricular fibrillation, post ventricular fibrillation/ventricular tachycardia cardiac arrest, ventricular tachycardia, or wide complex tachycardia;

(D) [~~Naxolone~~] **Naloxone** hydrochloride;

(E) Hypertonic glucose;

(F) Nitroglycerine for chest pain;

(G) Beta-2-specific nebulized bronchodilators;

(H) Morphine for pain management;

(h) Insert a [~~dual lumen airway or~~] laryngeal mask airway (LMA) device in the practice of airway maintenance;

(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 personnel at the sending medical facility.

(k) Perform cardiac defibrillation with a manual defibrillator if the EMT-Intermediate has satisfactorily completed a Section-approved training course in manual defibrillation, including written and practical examinations and the EMT-Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an “EMT-Intermediate Manual Defibrillation Waiver” by the Section.

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(b) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Tracheal suctioning techniques;

(C) Needle 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;

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

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

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

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