



## Scope of Practice

Approved by

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

This document offers an “at-a-glance” view of the Scope of Practice for Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics as approved by the State Board of Emergency Medical, Fire and Transportation Services (EMFTS Board). The authorized services can be found in sections 4765.35 (FR/EMR), 4765.37 (EMT-B/EMT), 4765.38 (EMT-I/AEMT), and 4765.39 (EMT-P/Paramedic) of the Revised Code. The scopes of practice can be found in rules 4765-12-04 (EMR), 4765-15-04 (EMT), 4765-16-04 (AEMT), and 4765-17-03 (Paramedic) of the Administrative Code.

Performance of services outlined in this document and in the aforementioned code sections, shall only be performed if the EMR, EMT, AEMT, and Paramedic have received training as part of an initial certification course or through subsequent training approved by the EMFTS Board. If specific training has not been specified by the EMFTS Board, the EMR, EMT, AEMT, and Paramedic must have received training regarding such services approved by the local medical director before performing those services.

In accordance with rule 4765-10-06 of the Administrative Code, the individual medical director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. Each community may need to tailor and revise the protocol to fit their region and individual practice, but must ensure that they remain within the approved scope of practice. EMS medical directors are reminded that they are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted.

EMS medical directors and EMS providers are strongly encouraged to review the EMFTS Board’s policy statement “Regarding EMS Provider Pre-Hospital transport of Patients with Pre-Existing Medical Devices or Drug Administrations” dated February 2016 (attached to this document, page 7). This statement clarifies how EMS providers, in the prehospital setting, should deal with medical devices and medicine administrations that are outside their scope of practice.

Pursuant to rule 4765-6-04 of the Administrative Code, the EMFTS Board may allow EMRs, EMTs, AEMTs, and Paramedics to perform services beyond their respective scopes of practices as part of a board-approved research study. An entity must submit a research proposal to the EMFTS Board in accordance with the requirements of rule 4765-6-04 of the Administrative Code. The EMFTS Board is not obligated to approve the proposed research study nor accept any recommendation to permanently amend the scope of practice.

Updated 11/19/03; 5/17/05; 10/26/05; 10/17/07; 3/8/12; 8/22/13, 10/16/13, 12/18/13, 4/16/2014, 10/19/16, 2/15/17, 10/18/17, 6/20/18



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

**Updated June 20, 2018**

	<b>Airway Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Open and maintain the airway	X	X	X	X
2	Oropharyngeal airway adjunct	X	X	X	X
3	Nasopharyngeal airway adjunct	X	X	X	X
4	Manual removal of obstructed airway	X	X	X	X
5	Laryngoscopy for removal of airway obstruction			X	X
6	Oral suctioning	X	X	X	X
7	Endotracheal (ET) tube suctioning via through a previously established airway or a stoma		X	X	X
8	Tracheostomy tube replacement			X	X
9	Cricothyrotomy, surgical				X
10	Cricothyrotomy, needle				X
11	Apply and obtain readings of pulse oximeter, CO-oximeter, and capnography or capnometry equipment	X	X	X	X
12	Oxygen administration				
	a. Nasal cannula	X	X	X	X
	b. Non-rebreather mask	X	X	X	X
	c. Mouth-to-barrier devices	X	X	X	X
	d. Partial rebreather mask		X	X	X
	e. Venturi mask		X	X	X
13	Ventilation management				
	a. Bag valve mask	X	X	X	X
	b. Ventilation with a flow-restricted oxygen-powered device	X	X	X	X
	c. Positive pressure ventilation devices (manually triggered or automatic ventilators)		X	X	X
14	Ventilator management - 16 years of age or older				X
15	Orotracheal intubation				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients			X	X
16	Nasotracheal intubation				X
17	Dual lumen airway				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
18	Extraglottic airways				X
	a. Apneic patients			X	X
	b. Pulseless <u>and</u> apneic patients		X	X	X
19	CPAP administration and management		X	X	X
20	BiPAP administration and management				X
21	Positive end-expiratory pressure (PEEP)				X

22	End tidal CO <sub>2</sub> monitoring and detecting		X	X	X
23	Oxygen humidifier equipment application and monitoring		X	X	X
24	Chest tube monitoring and management				X
25	Nasogastric (NG) tube placement				X
26	Orogastric (OG) tube placement				X

	<b>Cardiac Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Cardiopulmonary resuscitation (CPR)	X	X	X	X
2	Chest compression assist devices	X	X	X	X
3	Automated external defibrillator (use of an AED)	X	X	X	X
4	Manual defibrillation			X	X
5	Negative impedance threshold devices		X	X	X
6	Administration of cardiac medication				X
7	Set up cardiac monitor in the presence of an AEMT or Paramedic		X		
8	Cardiac monitor strip interpretation			X	X
9	Cardioversion				X
10	Carotid massage				X
11	Transcutaneous cardiac pacing				X
12	12-lead EKG performance and interpretation				X
13	12-lead EKG application assisting Paramedic who is present		X	X	
14	12-lead EKG set up and application for electronic transmission <sup>A</sup>		X	X	X

<sup>A</sup> An EMT or AEMT may set up and apply a 12-lead electrocardiogram when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met: 1) performed in accordance with written protocol; 2) EMT or AEMT shall not interpret the electrocardiogram; 3) delay in patient transport is minimized; and 4) EKG is used in conjunction with destination protocols approved by the local medical director.

	<b>Medical Management</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
1	Epinephrine administration via auto-injector	X	X	X	X
2	Epinephrine administration via SQ or IM routes			X	X
3	Epinephrine administration via IV or IO route				X
4	Aspirin administration		X	X	X
5	Oral glucose administration		X	X	X
6	Activated charcoal administration		X	X	X
7	Nitroglycerin administration (patient assisted) <sup>B</sup>		X	X	X
8	Nitroglycerin administration (non-patient assisted)			X	X
9	Aerosolized or nebulized medications administration (patient assisted) <sup>B</sup>		X	X	X
10	Administration of aerosolized or nebulized medications (non-patient assisted)			X	X
11	Naloxone administration via auto-injector	X	X	X	X
12	Naloxone administration via intranasal route	X	X	X	X
13	Naloxone administration via ETT, IM, IV, IO, or SQ routes			X	X
14	Medication administration (protocol-approved) <sup>C</sup>			X	X
15	Administration of intranasal medications (in addition to naloxone)			X	X

16	Immunizations for influenza to firefighters, EMTs, AEMTs, or paramedics (ORC 4765.391)				X
17	Set up of IV administration kit in the presence of an AEMT or Paramedic		X		
18	Ultrasound-guided peripheral venous access when approved by the medical director and appropriately trained				X
19	Transport of central/peripheral IV without an infusion		X	X	X
20	IV maintenance and fluid administration			X	X
21	Maintenance of medicated IV fluids				X
22	Central line monitoring				X
23	IV infusion pump				X
24	Intraosseous needle insertion			X	X
25	Saline lock initiation			X	X
26	Peripheral IV blood specimens			X	X
27	Maintenance of blood administration				X
28	Thrombolytic therapy initiation and monitoring				X

<sup>B</sup> Patient Assisted Definition: May assist with 1) patient's prescription upon patient request and with written protocol - OR – 2) EMS-provided medications with verbal medical direction.

<sup>C</sup> See "AEMT Medications Approved by the EMFTS Board."

	Trauma Management	EMR	EMT	AEMT	PARAMEDIC
1	PASG		X	X	X
2	Long spine board	X	X	X	X
3	Short spine board	X	X	X	X
4	Splinting devices	X	X	X	X
5	Traction splint		X	X	X
6	Cervical immobilization device (CID)	X	X	X	X
7	Helmet removal		X	X	X
8	Rapid extrication procedures		X	X	X
9	Needle decompression of the chest			X	X
10	Soft tissue management	X	X	X	X
11	Management of suspected fractures	X	X	X	X
12	Controlling of hemorrhage	X	X	X	X

	Basic Performances	EMR	EMT	AEMT	PARAMEDIC
1	Body substance isolation precaution/administration	X	X	X	X
2	Taking and recording of vital signs	X	X	X	X
3	Patient Care Report (PCR) documentation	X	X	X	X
4	Trauma triage determination per OAC 4765-14-02	X	X	X	X

	Additional Services	EMR	EMT	AEMT	PARAMEDIC
1	Emergency childbirth management <sup>D</sup>	X	X	X	X
2	Glucose monitoring system use (with Clinical Laboratory Improvement Amendments (CLIA) waiver in place)		X	X	X
3	Blood and body fluid analysis, with the exception of				X

	amniotic fluid				
4	Eye irrigation	X	X	X	X
5	Eye irrigation with Morgan lens				X
6	Maintenance of blood administration				X
7	Thrombolytic therapy initiation and monitoring				X

<sup>D</sup> An EMR may only assist with emergency childbirth management.

<b>Emergency Medical Services in Hospital</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
An EMS provider may perform emergency medical services in the hospital emergency department (ED) or while moving a patient between the ED and another part of the hospital. The EMS provider shall be under physician medical direction and has received appropriate training. (ORC 4765.36)	X	X	X	X
<b>Additional Services in a Declared Emergency</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
In the event of an emergency declared by the governor that affects the public's health, an EMS provider may perform immunizations and administer drugs or dangerous drugs, in relation to the emergency, provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such immunizations and/or drugs. (OAC 4765-6-03)	X	X	X	X
<b>Nerve Agent or Organophosphate Release</b>	<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>PARAMEDIC</b>
An EMS provider may administer drugs or dangerous drugs contained within a nerve agent antidote auto-injector kit, including a MARK I <sup>®</sup> kit, in response to suspected or known exposure to a nerve or organophosphate agent provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such drugs within the nerve agent antidote auto-injector kit. (OAC 4765-6-05)	X	X	X	X

### AEMT Medication Administration Approved by the EMFTS Board

***A certified AEMT may administer medications from the following list, provided the AEMT is under physician medical direction and has received appropriate training regarding the administration of such medications. A medication that does not appear on the following list SHALL NOT be added to the department's AEMT protocol.***

Benzodiazepines	Lidocaine for pain relief after intraosseous needle insertions
Bronchodilators	Nalbuphine
Dextrose in water	Naloxone
Diphenhydramine	Narcotics or other analgesics for pain relief
Epinephrine 1 mg per 1 ml (subcutaneous or intramuscular)	Nitrous oxide
Glucagon	Oral ondansetron <sup>E</sup>
Ketamine	Sublingual nitroglycerin

<sup>E</sup>A certified AEMT may administer oral ondansetron to patients are the age of 18 years and older. For patients from the age of 12 years to 17 years who weigh greater than or equal to 40 kg, the maximum dose of ondansetron that can be administered is 4 mg. The administration of ondansetron is not permitted for patients of the age of 12 years to 17 years who weigh less than 40 kg nor is its administration permitted for all patients under the age of 12 years.

***The approved route of administration of any specific medication is stated in the respective EMT, AEMT, and Paramedic curriculum. The EMS provider shall administer medications only via the route addressed in each respective curriculum and consistent with their level of training.***

The Ohio Board of Emergency Medical, Fire, and Transportation Services (“EMFTS Board”) issues the following statement:

Regarding EMS Provider Transport of Patients with

## Pre-Existing Medical Devices or Drug Administrations February 2016

*This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMFTS Board's general position on the above issue, this statement in no way precludes the EMFTS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMFTS Board will be decided on a case-by-case basis.*

### **Introduction:**

The EMFTS Board and the Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMS providers. It is maintained in matrix form and available on-line as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMFTS Board. Updates to the scope of practice are made as necessary and after approval by the EMFTS Board.

From time to time, EMS providers are confronted on-scene with patients with preexisting medical situations not included or addressed in their respective EMFTS Board approved scope of practice. Specifically, patients with pre-existing medical devices and drug administrations requiring prehospital EMS service are becoming more commonplace. In addition, patients with pre-existing medical devices and drug administrations may require EMS service for emergent interfacility transfers due a declared disaster or emergency. The intent of this position paper is to address the EMS provider's approach to that prehospital patient with a pre-existing physician-ordered medical device or drug administration ("MDDA") not covered in the provider's scope of practice and the interfacility transfer of such a patient in a disaster or emergency scenario.

### **Discussion:**

In general, the EMS provider should maintain the pre-existing MDDA and transport the patient to the appropriate facility. There is no expectation that the EMS provider will initiate, adjust, or discontinue the pre-existing MDDA. This implies that the EMS provider will maintain and continue care so that the patient can be transported.

The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of prehospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (prehospital, "911 scene response", or threat to a patient's life secondary to a declared disaster or emergency). It implies that the most appropriate and available level of EMS provider will respond to the request for EMS service in the prehospital setting or for emergent interfacility transfer following a declaration of a disaster or an emergency. It also implies that the patient requires the pre-existing MDDA and it is not feasible or appropriate to transport the patient without the pre-existing MDDA.

The number and type of pre-existing MDDAs currently or potentially encountered by the EMS provider in the community setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive list of pre-existing MDDAs. However, as a guideline for the EMS provider, current pre-existing MDDAs may include ventilatory adjuncts (CPAP, BiPAP), continuous or intermittent IV medication infusions (analgesics, antibiotics, chemotherapeutic agents, vasopressors, cardiac drugs), and nontraditional out-of-hospital drug infusion routes (subcutaneous infusions, central venous access lines, direct subcutaneous infusions, self-contained implanted pumps).

### **Conclusion:**

In conclusion, the EMS provider confronted with a prehospital patient with a pre-existing physician-ordered medical device or drug administration not covered in the EMS provider's respective scope of practice or such a patient who requires emergent interfacility transfer due to a declared disaster or emergency should provide usual care and transportation while maintaining the pre-existing MDDA, if applicable. Concerns or questions regarding real-time events associated with a pre-existing MDDA should be directed to the relevant Medical Control Physician. Concerns or questions regarding previous, recurrent, or future pre-hospital transportations with a pre-existing MDDA should be directed to the appropriate EMS Medical Director and legal counsel.

**Approved by the EMFTS Board February 18, 2016**