	SOUTHERN FOX VALLEY EMERGENCY MEDICAL SERVICES SYSTEM POLICY & PROCEDURES
TITLE: EXPANDED SCOPE OF PRACTICE FOR INTER-FACILITY TRANSFERS	
SECTION: GENERAL POLICIES	POLICY NUMBER: D-36.0
APPROVED BY: DR. ARTHUR PROUST EMS MEDICAL DIRECTOR	
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A. PURPOSE:

To establish criteria for inter-facility transfers by Paramedics and/or Pre- Hospital RN's (PHRN).

B. POLICY:

This policy is to be utilized by Paramedics and/or PHRN in the Southern Fox Valley EMS System for inter-facility transfers only. This policy should be used for transfers, in which these solutions and/or medications have been initiated by the sending facility. They are approved under the expanded scope of practice; therefore, Continuous Quality Improvement (CQI) tracking will be conducted on each run utilizing this policy.

The EMS MD shall appoint a physician or self-appoint for critical care medical direction. The Specialized Emergency Medical Services Vehicle MD shall be a physician licensed to practice medicine in all of its branches in Illinois, certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, in a specialty relevant to the provider agency mission, with competency in critical care transport

1. Will have experience in emergency or critical care and
2. Within six months after being appointed, complete in-field observation and/or participation on at least 10 ambulances run, half of which shall be at the highest level of service provided by the System.

C. PATIENT INCLUSION / EXCLUSION:

This procedure may be initiated for patients that meet the criteria listed in Department of Public Health Title 77, Chapter I, Part 515, and Section 515.860 for Tier I.

Example: patients that have medications listed in section H of this policy, and/or patients that need a ventilator for transport, and/or patients that have a chest tube. All medications, ventilators, and chest tubes must be initiated at the sending facility. However, interventions may be performed by attending providers in the event of patient decompensation that may require such procedures that may include, but not limited to, needle decompression, and/or replacement or continuation of advanced airway if required.

This procedure may not be initiated for patients that meet the criteria listed in Department of Public Health Title 77, Chapter I, Part 515, Section 515.860 Tier II and Tier III.

Example: patients that have arterial lines; that need central lines accessed during transport; that need medications titrated during transport; that need medication assisted intubation.

D. STAFFING, EDUCATION AND LICENSURE:

a. Minimum staffing;
    i. EMT-Basic, Intermediate, or Paramedic/PHRN as a driver; and
    ii. Paramedic or PHRN that has been credentialed by the EMS System as an Expanded Scope trained provider. This expanded scoped provider MUST remain with the patient.
b. All expanded scope staff must meet the licensure requirements as outlined in policy C-32 Expanded Scope Educational Requirements.

E. EQUIPMENT AND SUPPLIES:

a. Portable ventilator; and
b. Infusion pumps

F. VEHICLE STANDARDS:

a. Any vehicle used for providing expanded scope of practice care shall comply, at a minimum, with Department of Public Health Title 77, Chapter I, Part 515, Section 515.830 (Ambulance Licensing Requirements) or Section 515.900 (Licensure of SEMSV Programs-General) and 515.920 (SEMSV Program Licensure Requirements for ALL Vehicles) regarding licensure of SEMSV programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section.
b. Any vehicle used for expanded scope of practice transport shall be equipped with an onboard alternating current (AC) supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during transport of a patient.

G. MEDICAL CONTROL:

a. The ED physician will provide medical oversight communications for expanded scope providers.
b. Expanded scope providers will follow System policy for establishing medical control; or
c. As outlined in this policy.

H. PROCEDURE:

a. Medications and IV Drips:

Approved expanded scope IV drip medications:

(All of these medications are initiated by the sending facility.)

i. Accepted Infusing Medications (IV drips) include:
    1. Amiodarone
    2. Antihypertensive medications (i.e. esmolol, nicardipine)
    3. Ativan (lorazepam)
    4. Cardizem (diltiazem)
    5. Dilantin (phenytoin)
    6. Dopamine
    7. Dobutamine
    8. Epinephrine
    9. Glycoprotein IIB/IIA Receptor Inhibitors (i.e. Aggrastat, ReoPro, Integrilin)
    10. Heparin
    11. Insulin
    12. Intravenous Piggyback Antibiotics
    13. Keppra (levetiracetam)
    14. Levophed (norepinephrine)
    15. Lidocaine

16. Magnesium Sulfate
17. mannitol
18. Morphine
19. Nitroglycerin
20. Phenobarbital
21. Potassium Chloride Riders
22. Propofol
23. Protonix (pantoprazole)
24. Sodium Bicarbonate
25. Sodium Nitroprusside
26. tPa
27. valporic acid
28. Versed (midazolam)

ii. Accepted IV solutions include

Standard Crystalloid Solutions, including those containing Multiple Vitamin additive or Potassium additive (KCL concentrations no more than 20 mEq/liter)

1. 0.9% NaCl
2. 0.45% NaCl
3. D5W
4. D5 0.2% NaCl
5. D5 0.45% NaCl
6. D5 0.9% NaCl
7. D5 LR
8. D10W
9. Kcentra (prothrombin complex concentrate/PCC/factor IX complex)
10. Lactated Ringers
11. PRBC (packed red blood cells)
12. Plasma
13. TXA (tranexamic acid)
14. Platelets

iii. Patient controlled pain management drips (PCA pumps) including

1. Morphine Sulfate
2. Dilaudid (hydromorphone)
3. Fentanyl Citrate
4. Toradol (ketorolac)
5. Versed (midazolam)

iv. Obtain patient report from the transferring primary RN caring for the patient, with special attention to the following:
    1. Condition of the patient including current vital signs
    2. Familiarity and knowledge of all medications infusing
    3. Rate of each infusion
    4. IV pump settings
    5. EMS Patient Care Report should have documentation of each of the above listed components
v. Obtain transfer orders including measures to be implemented if bleeding occurs which

cannot be controlled with direct pressure.

vi. Assess patient for any signs of bleeding
vii. All medications and IV solutions listed above with KCL additive must be maintained on an IV pump at the ordered rate of infusion. The settings on the IV pump must be verified by the transferring RN prior to departure
viii. Frequent infusion checks to ensure the correct rate
ix. Observe IV site for any signs of infiltration. If infiltration occurs, the following procedure should be followed:
    1. Discontinue the IV
    2. Apply pressure dressing
    3. Contact medical control
    4. Restart an IV line as soon as possible
    5. Continue infusion at the same rate, per medical control orders
    6. Document infusion disruption time
    7. Report to receiving facility staff what occurred
x. Monitor patient for signs of potential hemorrhage, check the following sites frequently
    1. Infusion sites
    2. Previous needle stick sites (IV, Lab draws, ABG sites)
    3. Mucous membranes
xi. If bleeding or suspected bleeding occurs, follow transfer orders and contact on-line medical control for instructions
xii. Monitor patient's vital signs every 10 minutes, or less if necessary, while en route to the receiving facility
xiii. Any questions or problems regarding the patient's condition should be directed to medical control. Medical control should be the transferring hospital. If unable to contact transferring hospital, contact a system hospital for instructions.
xiv. Documentation should contain the following information:
    1. Clear documentation on the reason the patient is being transferred
    2. Medication infusing
    3. Patient condition including frequent vital signs
    4. Rate of each infusion
    5. IV pump settings
    6. Documented verification of pump settings with transferring RN
    7. Documented pump settings at receiving hospital
    8. Documented report to receiving RN at receiving facility

b. Medical Equipment and Supplies:

Approved expanded scope medical equipment and supplies:

i. Ventilators:
    1. Obtain patient report from the transferring primary RN caring for the patient with special attention to the following:
        a. Condition of the patient, including current vital signs
        b. Familiarity and knowledge of ventilator
        c. Ventilator settings
        d. EMS Patient Care Report should have documentation of each of the above listed components
    2. Obtain transfer orders, including measures to be implemented if ventilator malfunctions.
    3. The settings on the ventilator must be verified by the transferring RN or

Respiratory therapist prior to departure

4. Frequent ventilator checks to ensure correct rate
5. If ventilator malfunction occurs the following procedure should be followed:
    a. Discontinue the ventilator
    b. Start Bagging the PT using BVM
    c. Restart the ventilator as soon as possible
    d. Contact medical control
    e. Continue ventilating at the same rate, per medical control orders
    f. Document ventilator disruption time
    g. Report to receiving facility staff what occurred
6. If ventilator malfunction occurs, follow transfer orders and contact on-line medical control for instructions
7. Monitor patient's vital signs every 10 minutes, or less if necessary, while en route to the receiving facility
8. Any questions or problems regarding the patient's condition should be directed to medical control. Medical control should be the transferring hospital. If unable to contact transferring hospital, contact a system hospital for instructions.
9. Documentation should contain the following information
    a. Clear documentation on the reason the patient is being transferred
    b. Type of Ventilator being used
    c. Patient condition, including frequent vital signs
    d. Ventilator settings
    e. Documented verification of ventilator settings with transferring RN
    f. Documented ventilator settings at receiving hospital
    g. Documented report to receiving RN at receiving facility

ii. Chest Tubes:

1. Chest tubes are to be maintained only.
2. Obtain patient report from the transferring primary RN caring for the patient, with special attention to the following:
    a. Condition of the patient, including current vital signs
    b. Familiarity and knowledge of chest tube
    c. EMS Patient Care Report should have documentation of each of the above listed components
3. Obtain transfer orders, including measures to be implemented if chest tube becomes clogged or dislodged.
4. Assess patient for any signs of bleeding.
5. The chest tube must be verified by the transferring RN once pt. is in the ambulance, prior to departure
6. Frequent checks of the chest tube to ensure suction is being maintained and has not been dislodged.
    a. Maintain the chest drainage unit below the level of the chest to facilitate the flow of drainage and prevent reflux into the chest cavity. With water seal chest drainage units, keep the unit upright to prevent the loss of the water seal.
    b. The tubing should be gently coiled without dependent loops or kinks.
    c. Assess and document fluctuation, output, color of drainage, and air leak.
7. Observe chest tube site for any signs of air leak, dislodgement or clotting. If air leak, dislodgement, or clotting is suspected, the following procedure should be followed:
    a. The water level in the water seal chamber should gently rise and fall with each breath. Assess for an air leak by looking for bubbling in the water seal chamber. Constant bubbling in the water seal chamber

indicates an air leak either in the lung, in the chest drainage unit, or tubing.

b. An air leak is an expected finding with an unexpanded lung.
c. Leaks may originate from:
    i. The chest tube drainage system
    ii. A continued air leak in the lung
    iii. Injury to the esophagus or bronchus
    iv. A malpositioned chest tube
d. If an air leak is suspected, assess that all connections are tight. Turn off suction and reassess after one minute.
e. To assess the location of the leak, intermittently occlude the chest tube or drainage tubing beginning at the dressing site, progressing to the chest drainage unit, if needed. If the bubbling in the water seal chamber immediately stops when the chest tube is occluded at the dressing site, the air leak is inside the patient's chest or under the dressing. Reinforce the occlusive dressing and notify the physician.
f. If the bubbling does not stop when the chest tube is occluded at the dressing site, continue to intermittently occlude down the tubing at various positions until the bubbling stops. When the bubbling stops, the air leak is between the occlusion and the patient's chest.
g. If the bubbling does not stop with occlusion, contact medical control for further orders.
h. Never clamp the tube unless medical control orders it. If it is ordered, keep reassessing your patient for possible tension pneumothorax.
i. A one-way-valve should be used primarily during transport, to ensure one-way drainage in the event the chest drainage unit is damaged or placed above the level of the chest.
j. Document if any air leak, dislodgement, or occlusion occurs.
k. Report to receiving facility staff what occurred

8. If bleeding or suspected bleeding occurs, follow transfer orders and contact on-line medical control for instructions
9. Monitor patient's vital signs every 10 minutes, or less if necessary, while en route to the receiving facility
10. Any questions or problems regarding the patient's condition should be directed to medical control. Medical control should be the transferring hospital. If unable to contact transferring hospital, contact a system hospital for instructions.
11. Documentation should contain the following information
    a. Clear documentation on the reason the patient is being transferred
    b. Type of chest tube being used
    c. Patient condition, including frequent vital signs
    d. Suction unit settings
    e. Documented verification of chest tube with transferring RN
    f. Documented chest tube function at receiving hospital
    g. Documented report to receiving RN at receiving facility

I. Quality Assurance/Improvement:

a. In accordance with the Illinois Administrative Code 515.680, all specialty care transport providers shall participate in a Quality Assurance Plan developed by Southern Fox Valley EMS System. This Plan has been developed to ensure that competent pre-hospital care is being delivered by each specialty care transport provider. The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. Each transport provider

will provide quarterly QA reports to the EMS CQI Coordinator at Southern Fox Valley EMS System for the first 12 months of operation. These reports shall contain information as defined in the QA plan listed in this policy.

b. OVERSIGHT
    i. The Specialty Care Transport Quality Assurance Plan shall be directed by the SFVEMS System Medical Director, EMS System Coordinator, and the EMS System CQI Coordinator.

c. PLAN COMPONENTS
    i. ALL transports shall have the following items evaluated for the first 12 months of operation. After the first year, SFVEMSS will determine the frequency of quality reports, if the System has not identified any deficiencies or adverse outcomes. If deficiencies are identified or adverse outcomes have occurred, all transports will continue to be reviewed.
    ii. The following items will be reviewed for each transport:
        1. Review of transferring physician orders and evidence of compliance with those orders.
            a. Both written and verbal orders shall be reviewed.
        2. Documentation of vital signs every ten (10) minutes or less. Including evidence that abnormal vital signs, or trends suggesting an unstable patient, were appropriately detected and managed.
        3. Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events. This would include contact of Medical Control for further direction.
        4. Documentation of any unanticipated discontinuation of a catheter, or rate adjustments of infusions, along with rationale and outcome.
        5. Documentation of any Medical Control contact for further direction.
        6. Documentation that any unusual occurrences were communicated to the EMS System within 24 hours. This will be done via the SFVEMSS incident Report form.
        7. A root cause analysis will be conducted for any event or care inconsistent with standards. The EMS System Medical Director and EMS System Coordinator will develop a corrective action plan. This plan will be carried out by the EMS System Continuing Education Specialist under the direction of the EMS System Coordinator.
        8. This Quality Assurance Plan will be reviewed on a regular basis to maintain its integrity.