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COMMUNITY PARAMEDIC/MOB

CRHC CLINIC REFERRALS

Policy

The Community Paramedic (CP) will respond to a residence on order from the CRHC primary care provider requesting a community paramedic to follow up to a recent clinic visit

Purpose

To assist the CRHC primary care provider with an automatic referral process to ensure the patients receive proper follow up care.

Procedure

- Referrals will be sent to the EMS office via fax or email
- These referrals will be automatic upon the completion of a clinic visit for pediatric patients 0 – 12 years of age who meet the following diagnosis criteria:
 - Pneumonia
 - RSV
 - Flu
 - UTI
 - Asthma
 - Fever (with the discretion of the provider)
- If while on scene the CP discovers anything that is alarming such as but not limited to, abnormal V/S, worsening condition of the patient that was mentioned in the patient's last visit notes or any acute illness, the CP will contact CRHC Clinic while still on scene and report these findings to the provider or the clinic nurse.

REFERRALS

Policy

The Community Paramedic (CP) program will accept requests from Page County Public Health Adult and Child Protection caseworkers to assist them on a visit where they believe there is either a known or potentially unmet medical need in the home.

Procedure

Adult and Child Protection Referrals/Orders

1. The caseworker will fax a copy of the Community Paramedic referral/order form to the CP office as soon as the need is identified to the requested visit. If an urgent visit is needed during business hours, the caseworker will contact the CP directly.
2. The referral/order form must have the signature of the County Medical Officer.
3. The referral/order must also include the contact information of the caseworker, and if known the identified Primary Care Physician (PCP).
4. The CP office will then contact the caseworker and schedule the visit.
5. If there is an emergent medical needs found upon arrival, the CP will follow the chain of command protocol to get the patient additional medical attention.
6. Subsequent follow up will be coordinated through the patient's caseworker and treating medical provider.

REFERRALS (CONTINUED)

Post-Partum Visits

1. The caseworker will fax a copy of the referral form to the CP office one week prior to the requested visit.
2. The CP office will then contact the caseworker and schedule the visit.
3. The CP will visit the home and make sure the client is receiving all the necessary resources to adequately provide for them and their children.
4. Following the visit, the CP will fax a copy of the report to the caseworker within 72 hours of the visit.
5. No report will be faxed to any medical provider because is not a medical visit.

HOME VISITATION

Policy

The Community Paramedic (CP) will provide home visits for patients in response to a medical provider's order.

Purpose

- To outline the standardized procedure of all home visits performed by the CP.
- To describe the difference between initial and repeat visits for the same diagnosis.
- To describe the difference between medical and non-medical/educational visits.

Procedure

Medical Visits

1. Medical provider referrals will be sent to the CP office via fax or email
2. The referral form (depending on which system is used) will include the patient's name, DOB, contact information, diagnosis, reason for visit and medical provider's signature.
3. The CP will access the patient's H&P, visit notes, lab results, and list of current medications through the hospital's electronic medical record system, if available. If not, the CP will request a copy of the patient's record from the medical provider.
4. The CP coordinator will schedule the CP visit with the patient.
5. CP will arrive at the patient's home in a marked vehicle.
6. The CP will arrive at the visit wearing an official agency uniform and wearing an ID badge.
7. Upon arrival the CP will have the patient fill out the initial consents and program paperwork if needed.
8. In addition to what is ordered by the medical provider, per protocol, each initial CP visit will receive a complete H&P including V/S and will provide the following as needed.
 - Home safety assessment
 - Social assessment
9. Repeat visits for the same diagnosis will cover what the medical provider orders. The CP will add more services if indicated upon arrival to the patient's home and after the initial assessment is completed.
10. Schedule any follow up visit that are necessary.
11. Upon completion of the visit the CP will document the visit notes in the electronic patient care record.

HOME VISITATION (CONTINUED)

12. After completing the visit the CP will send a copy of the patient's care summary to the medical provider within 24 hours. This will include the patient's care report and any additional services provided by the CP, such as the home safety assessment.

Non-Medical / Educational Visits

1. The CP will follow the same procedure as medical visits but without a physical exam or medical services provided
2. Non-Medical / Education visits do not require a medical provider order. The order can come from caseworkers, social workers, school health assistants, etc.
3. The CP visit will cover what services are ordered. If more services are indicated upon arrival, the CP will contact the ordering provider to obtain additional orders.

MEDICAL DIRECTION / CHAIN OF COMMAND

Policy

All Community Paramedics (CP) work in full capacity within their current scope of practice under the medical directors' license for CRHC EMS.

Purpose

- The Community Paramedic will follow medical provider orders and administering care within the current scope of practice for IOWA EMS.
- The CP report directly through spoken or written dialogue with the patient's referring and primary physician(s).

Procedure

If additional medical needs are identified during a CP visit, the following will occur based on the urgency of care needed:

1. If an emergent medical need is found upon arrival, the CP will call 911 to request an ambulance for immediate transport, or treat and transport if in an ambulance.
2. If there are any medical needs that do not require immediate transport to a hospital, however, the CP feels the patient should be seen urgently in a medical provider's office, the CP will:
 - First attempt to contact the patient's referring/primary medical provider.
 - Second attempt will be to contact the ordering medical provider's on-call doctor.
 - Third attempt will be to contact the CRHC Medical Director
 - Fourth attempt will contact the online Medical Control.
 - If unsuccessful, the CP will attempt to make arrangements with the patient to have them transported to the nearest ER.

MEDICAL EQUIPMENT

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting a community paramedic to inspect and ensure proper usage of home medical equipment.

Purpose

To assist the medical provider and patient in ensuring efficacy of home medical equipment. This will be done through knowledge of patient history, educating the patient to proper usage, inspection of equipment, assistance in troubleshooting and contacting appropriate resources.

Procedure

1. Obtain and review patient history and medical provider orders prior to appointment.
2. Follow medical provider orders.
3. Inspect equipment
4. Review usage with the patient
5. Troubleshoot if necessary
6. Communicate with medical provider's office
7. Contact medical supply company and provide follow up resources for patient to contact if needed.
8. Document the visit and notify the medical provider's office.
9. Refer patient to PT or OT as needed through PCP

ASTHMA MANAGEMENT

Policy

The Community Paramedic will respond to a residence on request from the medical provider or patient/parent of patient and follow guidelines outlined by the medical providers' orders for the management of asthma.

Purpose

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology. To demonstrate and review technique of all devices used to treat asthma. To evaluate and identify home triggers of disease in an effort to lesson exacerbations. To communicate with the medical provider on the general wellbeing of the patient as well as continuing medication reconciliation.

Procedure

1. Obtain and review patient health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Educate patient in use of spirometer.
4. Review pathophysiology with the patient
5. Record current patient history including frequency of symptoms at rest, activity and with sleep. Further history will include exacerbating factors including virus exposure, aeroallergen exposure, exercise, cold air, tobacco smoke, chemical irritants etc.
6. Observe home in an effort to possibly identify exacerbating factors.
7. Review devices used by the patient including short/long acting medications and MDI/continuous neb devices.
8. Review when to call health care provider.
9. Communicate all updated information to the medical provider.

CPAP/BIPAP/SLEEP APNEA/OXYGEN SAT CHECKS

Policy

The Community Paramedic will respond to a residence on request from the medical provider and/or patient and follow guidelines outlined by the medical provider's orders for follow up on recently diagnosed and discharged or chronic sufferers of sleep apnea.

Purpose

To assist the medical provider in observing and documenting recently diagnosed/chronic sufferers of obstructive sleep apnea through written and /or verbal communication to ensure proper ventilation of the Patient during sleep for the purpose of avoidance of long term OSA pathologic outcomes.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Patient must be closely observed for hemodynamic instability the first 8 hours after starting CPAP/BiPAP
4. Conduct assessment
 - . Necessary VS assessments including PO2 and ETCO2 and weight/BMI?
 - . Sleep habits (work nights? Irregular work schedule)
 - . Alcohol/recreational drug use? Prescription drug use? Compliant?
5. Quality of life - Noticeable changes after usage.
6. Communicate with medical providers' office.
7. Troubleshoot if necessary including ensuring proper fit of mask and use of machine as well as general condition of machine.
8. Connect patient with necessary resources (Oxygen supply company, etc.)
9. Document the visit and notify medical provider's office.

DIABETIC EDUCATION

Policy

The Community Paramedic will respond to a residence on request from the medical provider or patient and follow guidelines outlined by the medical providers orders to assist in wellbeing checks for the diabetic patient.

Purpose

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic.

This will be accomplished through blood glucose monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Review history and physical exam
4. Review pathology with patient including signs and symptoms of disorder and corrective actions.
5. Receive medical providers orders including plan for diet, blood glucose levels, and insulin administration.
6. Observe patient's physical state/general wellbeing.
7. Obtain BGL and compare with home glucometer.
8. Note directions for insulin administration and record compliance.
9. Note diet.
10. Note and record patients concerns about treatment (insulin levels, blood sugar levels).
Communicate with doctor about request for prescription change.
11. Document the visit and notify medical provider's office.
12. Determine if follow up needed with medical provider and/or community paramedic.

FOLLOW UP / POST DISCHARGE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for proper follow-up from a medical provider, ER visit, and/or a hospital post discharge.

Purpose

To assist the medical provider in observing and documenting the patients post discharge healing and/or adjustment to new medications, and/or therapy regimen. This will allow for timely adjustment/healing as well as quick identification of unwanted results and alternative direction in care.

Procedure

General Follow-up:

1. Obtain and review patient history and medical provider's orders prior to appointment.
2. Follow medical provider's orders/ discharge pamphlets.
3. Obtain VS including P/BP/RR/temp/and ECG as necessary.
4. Discuss and review with patient the ideal recovery plan, and their current response to treatment.
5. Discuss when to call and follow up with the medical provider.
6. Communicate unusual findings to the medical provider and assist with arrangement of follow up.

Post-injury Follow-up:

1. Review discharge instructions with the patient to make sure they have full understanding of limitations and expectations.
2. Assess patient's pain control and understanding of recommended medications.
3. Assess patient's limited mobility due to the injury. Make recommendations and/or changes in the home environment to decrease chance of further injury.
4. Assess injury site for inflammation. Discuss using ice and non-steroidal anti-inflammatory medications as recommended treatment.
5. Assess ability to care for injury.

Post-stroke Follow-up:

1. Assess patient's understanding of what a stroke is and the short and long term effects
2. Review the discharge instructions with the patient to make sure they have full understanding of limitations and expectations.

FOLLOW UP / POST DISCHARGE (CONTINUED)

3. Review the patient's medication list. Most likely the patient may be taking some or all of the following types of medications: Antithrombotics, ACE Inhibitors, Statins, and/or Diuretics.
4. Review the patient's exercise plan
5. Review the patient's diet plan
6. Discuss the warning signs of stroke
7. Discuss the need to stop smoking, if the patient is a smoker
8. Assess and review the patient's plan for rehabilitation (PT, OT, Speech, home health, etc.)

HISTORY AND PHYSICAL

Policy

The Community Paramedic (CP) will respond to a residence on order from the medical provider requesting CP care and follow guidelines outlined by the medical provider's orders for proper history and physical exam assessments.

Purpose

To assist the medical provider in observing and documenting objective and subjective information for the purpose of identifying the patient's state of health and comparing it to the ideal.

Procedure

- Obtain and review patient's health history and medical provider's orders prior to appointment.
- Follow medical provider's orders.
- All information may be recorded prior to paramedic's consultation. It will be decided by the medical provider and paramedic what information to update.

Health History

1. Demographic Data (if not already recorded)
 - Including name, gender, address and telephone #, birth date, birthplace, race, culture, religion, marital status family or significant others living in home, social security number, occupation, contact person, advance directive, durable power of attorney for health care, source of referral, usual source of health care, type of health insurance

Reason for seeking care/ Chief Complaint

1. Present Health Status
 - Current health promotion activities (diet, exercise, etc.), clients perceived level of health, current medications, herbal preparations, type of drug, prescribed by whom, when first prescribed, reason for prescription, dose of med and frequency, clients perception of effectiveness of med.
 - Symptom analysis- location (where are the symptoms), quality (describe characteristics of symptom), quantity (severity of symptom), chronology (when did the symptom start), setting (where are you when the symptom occurs), associated manifestations (do other symptoms occur at the same time), alleviating factors, aggravating factors.
2. Past Health History
 - Allergies, childhood illnesses, surgeries, hospitalizations, accidents or injuries, chronic illnesses, immunizations, last examinations, obstetric history

HISTORY AND PHYSICAL (CONTINUED)

3. Family History

- Develop Genogram
- Family history should include questions about Alzheimer's, Cancer, Diabetes, Heart Disease, Hypertension, Seizures, Emotional problems, Alcoholism/drug use, Mental Illness, Developmental delay, Endocrine diseases, Sickle cell anemia, Kidney disease, Cerebrovascular accident

4. Environmental Assessment

- PEAT scale for all patients on initial visit
- Repeat PEAT scale as need arises

Review of Systems

1. General Health Status

- Fatigue, weakness
- Sleep patterns
- Weight, unexplained loss or gain
- Self-rating of overall health status

2. Integumentary System

- Skin disease, problems, lesions (wounds, sores, ulcers)
- Skin growths, tumors, masses
- Excessive dryness, sweating, odors
- Pigmentation changes or discolorations
- Rashes
- Pruritus
- Frequent bruising
- Texture or temperature change
- Scalp itching
- Hair
 - All body hair, changes in amount, texture, character, distribution
- Nails
 - Changes in texture, color, shape
- Head
 - Headache
 - Past significant trauma
 - Vertigo
 - Syncope
- Eyes
 - Discharge
 - Puritis

HISTORY AND PHYSICAL (CONTINUED)

- Lacrimation
- Pain
- Visual disturbances
- Swelling
- Redness
- Unusual sensations or twitching
- Vision changes
- Use of corrective or prosthetic devices
- Diplopia
- Photophobia
- Difficulty reading
- Interference with activities of daily living
- Ears
 - Pain
 - Cerumen
 - Infection
 - Discharge
 - Hearing changes
 - Use of prosthetic device
 - Increased sensitivity to environmental noises
 - Change in balance
 - Tinnitus
 - Interference with activities of daily living
- Nose, Nasopharynx, and Para nasal Sinuses
 - Discharge
 - Epistaxis
 - Sneezing
 - Obstruction
 - Sinus pain
 - Postnasal drip
 - Change in ability to smell
 - Snoring
 - Pain over sinuses
- Mouth and Oropharynx
 - Sore throat
 - Tongue or mouth lesion (abscess, sore, ulcer)
 - Bleeding gums
 - Voice changes or hoarseness
 - Use of prosthetic devices (dentures, bridges)
 - Difficulty chewing
- Neck
 - Lymph node enlargement

HISTORY AND PHYSICAL (CONTINUED)

- Swelling or masses Pain/tenderness
- Limitation of movement
- Stiffness
- Breasts
 - Pain/tenderness
 - Swelling
 - Nipple discharge
 - Changes in nipples
 - Lumps, masses, dimples
 - Discharge

3. Cardiovascular System

- Heart
 - Palpitations
 - CP
 - Dyspnea
 - Orthopnea
 - Paroxysmal nocturnal dyspnea
- Peripheral vasculature
 - Coldness/numbness
 - Discoloration
 - Varicose veins
 - Intermittent claudication
 - Paresthesia
 - Leg color changes

4. Respiratory System

- Colds/Virus
- Cough, nonproductive or productive
- Hemoptysis
- Dyspnea
- Night sweats
- Wheezing
- Stridor
- Pain on inspiration or expiration
- Smoking history, exposure

5. Gastrointestinal System

- Change in taste
- Thirst

HISTORY AND PHYSICAL (CONTINUED)

- Indigestion or pain associated with eating
- Pyrosis
- Dyspepsia
- Nausea / Vomiting
- Appetite changes
- Food intolerance
- Abdominal pain
- Jaundice
- Ascites
- Bowel habits
- Flatus
- Constipation
- Diarrhea
- Changes in stool
- Hemorrhoids
- Use of digestive or evacuation aids

6. Urinary System

- Characteristics of urine
- Hesitancy
- Urgency
- Change in urinary stream
- Nocturia
- Dysuria
- Flank pain
- Hematuria
- Suprapubic pain
- Dribbling or incontinence
- Polyuria
- Oliguria
- Pyuria

7. Genitalia

- General
 - Lesions
 - Discharges
 - Odors
 - Pain, burning, pruritus
 - Painful intercourse
 - Infertility

HISTORY AND PHYSICAL (CONTINUED)

- Men
 - Impotence
 - Testicular masses/pain
 - Prostate problems
 - Change in sex drive
 - Penis and scrotum self-examination practices
- Women
 - Menstrual history
 - Pregnancy history
 - Amenorrhea
 - Menorrhagia
 - Dysmenorrhea
 - Metrorrhagia (irregular menstruation)
 - Dyspareunia (pain during intercourse)
 - Postcoital bleeding
 - Pelvic pain
 - Genitalia self-examination

8. Musculoskeletal System

- Muscles
 - Twitching, cramping pain
 - Weakness
- Bones and joints
 - Joint swelling, pain, redness, stiffness
 - Joint deformity
 - Crepitus
 - Limitations in joint range of motion
 - Interference with activities of daily living
- Back
 - Back pain
 - Limitations in joint range of motion
 - Interference with activities of daily living

9. Central Nervous System

- History of central nervous system disease
- Fainting episodes or LOC
- Seizures
- Dysphasia
- Dysarthria
- Cognitive changes (inability to remember, disorientation to time/place/person, hallucinations)

HISTORY AND PHYSICAL (CONTINUED)

- Motor-gait (loss of coordinated movements, ataxia, paralysis, paresis, tic, tremor, spasm, interference with activities of daily living)
- Sensory-paresthesia, anesthesia, pain

10. Endocrine System

- Changes in pigmentation or texture
- Changes in or abnormal hair distribution
- Sudden or unexplained changes in height or weight
- Intolerance of heat or cold
- Presence of secondary sex characteristic
- 3 P's
- Anorexia
- Weakness

Psychosocial Status

1. General statement of patient's feelings about self
 - Degree of satisfaction in interpersonal relationships
 - Client's position in-home relationships
 - Most significant relationship
 - Community activities
 - Work or school relationships
 - Family cohesiveness
2. Activities
 - General description of work, leisure and rest distribution
 - Hobbies and methods of relaxation
 - Family demands
 - Ability to accomplish all that is desired during period
3. Cultural or religious practices
4. Occupational history
 - Jobs held in past
 - Current employer
 - Education preparation
 - Satisfaction with present and past employment
5. Recent changes or stresses in client's life
6. Coping strategies for stressful situations
7. Changes in personality, behavior, mood
 - Feelings of anxiety or nervousness
 - Feelings of depression
 - Use of medications or other techniques during times of anxiety, stress or depression
8. Habits

HISTORY AND PHYSICAL (CONTINUED)

- Alcohol / Drugs Use
 - Type of alcohol/drugs
 - Frequency per week
 - Pattern over past 5 years; over the past year
 - Alcohol/drug consumption variances when anxious, stressed, or depressed
 - Driving or other dangerous activities while under the influence
 - High risk groups: Sharing/using unsterilized needles and syringes
- Smoking / Tobacco Use
 - Type
 - Amount per day
 - Pattern over 5 years; over the past year
 - Usage variances when anxious or stressed
 - Exposure to secondhand smoke
- Caffeine: Coffee, tea, soda, etc.
 - Amount per day
 - Pattern over 5 years; over the past year
 - Consumption variances when anxious or stressed
 - Physiological effects
- Other
 - Overeating, sporadic eating or fasting
 - Nail biting
- Financial status
 - Sources of income
 - Adequacy of income, Recent changes in resources or expenditures

Environmental Health

1. General statement of patients' assessment of environmental safety and comfort
2. Hazards of employment (inhalants, noise etc.)
3. Hazards in the home (concern about fire etc.)
4. Hazards in the neighborhood or community (noise, water and air pollution, etc)
5. Hazards of travel (use of seat belts etc.)
6. Travel outside the US

Consider Age-Related Variations in the Health History

1. Newborn
2. Infants
3. Children
4. Adolescents
5. Older Adults

Physical Assessment

HISTORY AND PHYSICAL (CONTINUED)

1. Techniques
 - Inspection
 - Palpation
 - Percussion
 - Auscultation
2. Positioning
3. Vital Signs
 - Temperature
 - Pulse
 - Respiration
 - Blood Pressure
4. General Assessment
 - Weight
 - Height
 - Skinfold Thickness
5. Age-Related Variations
 - Newborns and Infants
 - Recumbent Length
 - Head Circumference
 - Chest Circumference
 - Vital Signs-Temp, Pulse and Respirations
 - Children
 - Height and Weight
 - Head and Chest Circumference
 - Vital Signs-Temp, Blood pressure
 - Adolescents
 - Weight and Height
 - Older Adults
 - Weight and Height
 - Vital signs
6. Documentation
 - Document all information and communicate with the medical provider.
 - If on evaluation of the patient any of the following S/S are found contact the patient's referring medical provider via phone while still on scene with the patient.
 - Systolic BP > 190 or < 80
 - Diastolic BP > 120
 - Temperature when ordered of > 101.5
 - Pulse at rest > 120
 - Respirations at rest >24
 - O2 sat of < 88% on children < 14 y/o
 - O2 sat of < 86 on any patient not on O2

HOME MEDICATIONS

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for home medication checks.

Purpose

- To assist the patient in proper usage of home medications through information/education and vital sign checks.
- To assist the medical provider in a thorough documentation of all prescription and non-prescription medications for the purpose of avoiding adverse drug reactions.
- To ensure proper continuum of care during medical provider care provider transitions.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Review history and physical.
4. Review patient's information with the patient, including medical and medication history, current medications the patient is receiving and taking, compliance, time of doses, medical provider who prescribed medications and sources of medications such as the pharmacy.
5. Ask the patient if there are any other medications or supplements they take that might be from another medical provider or over the counter.
6. Assess vital signs
7. Assist patient in sorting medications.
8. Stress importance of medication compliance.
9. Contact referring medical provider if paramedic or patient has concerns.

Document all medications whether prescribed or over the counter and communicate list and current health/reactions to medical provider.

HOME SAFETY ASSESSMENT

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for a home safety assessment.

Purpose

To ensure the home is in safe condition to meet the medical needs of the patient. Can be used to conduct a pre-surgical assessment, post-operative assessment, or an evaluation of the safety of the home at any time.

Procedure

1. Follow the Home Safety Inspection checklist including the inspection of the following areas of the home:
 - Outside of the house
 - Living room
 - Kitchen
 - Stairs
 - Bathroom
 - Bedroom
 - General Inspection
2. Complete the Overall Tips inspection
3. Complete comments on any sections marked "no" during the inspection
4. Complete recommendations for the resident and possible referrals
5. Discuss the findings with the patient and resources to remedy
6. Have the patient sign off the report with the understanding they understand the recommendations
7. Complete report and return a copy to the ordering medical provider.
8. If any life-threatening issues are identified, notify the ordering provider immediately.

IMMUNIZATIONS

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring the healthy physical and mental development of the young community member.

Purpose

To assist the primary medical provider, and/or public health nurse in administering immunizations to prevent disease transmission.

Procedure

1. Obtain medical provider's orders prior to appointment.
2. Obtain and review patient's health history (this includes immunization history, contraindications, health status, and allergies).
3. Obtain immunization in public health with cooler and ensure temperature stays within normal limits for vaccine
4. Obtain necessary paperwork will include the following:
 - 1) Vaccine Information Sheets (VIS)
 - 2) Administrative consent forms
 - 3) Patient's immunization record from one of the following:
 - . Patient's medical provider
 - . Authorized State of IA Public Health immunization record from IRIS
 - . Authorized State of IA school immunization record.
 - . International immunization record.
5. Verify the order with the correct vaccine, person, dose, site and time.
6. Administer vaccine through proper route and technique.
7. Observe for adverse reactions for 15 minutes
8. Discuss reactions and educate parents on side effects from the vaccinations
9. If an adverse reaction occurs, follow the CRHC EMS medical protocols.
10. Update immunization record.
11. If sequential vaccines are indicated, refer the patient for follow-up at the medical provider's office or public health clinic.

INTRAVENOUS CATHETER CHANGES

Policy

The Community Paramedic will respond to a residence on order from the primary medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders and/or CRHC EMS medical protocols for the removal and reinsertion of intravenous (IV) catheters.

Purpose

To remove and reinsert IV catheters for the purpose of continuing IV access and avoidance of possible local and systemic infections and/or patient discomfort.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow CRHC EMS medical protocols for IV access.
3. Be cognizant of complications of long-term catheter use and effects of termination of IV. Educate patient on signs of infection.
4. Take into account certain medications, which could lead to uncontrolled bleeding.
5. Communicate any unusual findings with medical provider.

I-STAT

Policy

The Community Paramedic will respond to a residence on request from the medical provider and follow guidelines outlined by the medical provider's orders for obtaining ISTAT values.

Purpose

To assist the medical provider in obtaining certain blood laboratory values while in the patients home.

Procedure

1. Using BSI technique, obtain sample of patients' venous blood with use of a butterfly needle of at least 20 g and a green top blood tube.
2. Roll the tube back and forth in hands at least 5 (five) times.
3. Using a 1 cc syringe with at least a 20-gauge needle, withdraw 1 cc blood from the green top tube.
4. Expel 2 drops of blood from the syringe prior to filling I-STAT chamber.
5. Remove cartridge from the package handling the cartridge from the sides only.
6. Place cartridge on a flat surface.
7. Fill the cartridge with the blood sample only to the appropriate level as marked on the cartridge.
8. Close cover over sample well.
9. Turn on I-STAT and enter operator and patient ID numbers.
10. Insert cartridge into analyzer (Do not remove while "cartridge locked" message is on).
11. Print records of results and attach to the patient care report prior to faxing report to medical provider.

Precautions

1. Avoid drawing blood from an arm with an IV already in place as this will dilute the sample and may interfere with test results.
2. Venous stasis as with prolonged tourniquet application may alter lab results.
3. Avoid having the patient use extra muscle activity such as clenching the fist as this may increase potassium results.

Special Notes

1. Cartridges are good for two (2) weeks at room temperature.
2. Lab results will not be interpreted in the field alone and will always be sent to the referring medical provider.
3. If the paramedic notices a possible life threatening abnormal lab value, they will immediately contact the referring medical provider via cell phone to discuss the results

LAB DRAW

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of obtaining a lab specimen for testing.

Purpose

To assist the medical provider in obtaining specimens for appropriate diagnostic and testing procedures. By performing the lab draws in the home, it prevents the patients from needing to go into a medical provider's office for a minor procedure that can be managed by the Community Paramedic.

Procedure

1. Perform lab draw
2. Tubes should be collected in the order of red, green, purple, and blue.
3. Fill out the label for each of the tubes to include the patient's name, date of birth, provider's initials, and date and time of the lab draw.
4. Affix the label to the blood tubes
5. Complete the lab paperwork provided by the medical provider's office or hospital
6. Put samples in a biohazard bag
7. Deliver samples to the appropriate ordering medical provider's office or hospital

OTOSCOPE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring proper healing of a patient with an ear infection.

Purpose

To assist the medical provider in observing and documenting the patient's response to medical care through follow up visual inspection of patient's ear.

Procedure

Adult

1. Use otoscope with largest ear speculum that ear canal will accommodate.
2. Position the patient's head and neck upright.
3. Grasp auricle firmly and gently pull upwards, backward and slightly away from head.
4. Hold otoscope handle between thumb and fingers and brace hand against patient's face.
5. Insert speculum into ear canal, directing it somewhat down and forward and through hairs.
6. Inspect ear canal noting discharge, foreign bodies, redness and/or swelling.
7. Inspect eardrum noting color and contour and perforations.

Child

1. Child may sit up or lie down.
2. Hold otoscope with handle pointing down toward child's feet, while pulling up on auricle.
3. Hold the head and pull up on auricle with one hand, while holding otoscope with other hand.
4. See adult inspection above for inspecting canal and eardrum.

Findings

- Acute otitis media is common in children and presents with red, bulging tympanic membrane with dull or absent light reflex. Purulent material may also be seen behind tympanic membrane.

POST-PARTUM VISITS

Policy

The Community Paramedic (CP) will respond to a residence on the request of the provider to perform a post-partum check of the mother and to assess the newborn.

Purpose

To assess both the newborn and mother in the home and to determine if there are any unmet medical needs. To see if there is any further education that needs to be done and to provide mother and family with any information on services that could be helpful.

Procedure

1. Perform a general H&P on newborn which includes:
 - Weight
 - Oxygen saturation check
 - V/S including pulse, heart tones, respirations
 - Physical examination
2. Review of mother's post-delivery health and well being
3. Evaluate mother for postpartum depression and discuss warning signs
4. PEAT scale
5. Home safety assessment with the following additions:
 - Safe sleeping recommendations for the newborn
 - Newborn equipment safety check
 - Car seat check
6. Nutrition evaluation of both mother and newborn
7. Social evaluation
8. CP will send report of all findings to both the referring provider and also to the patients PCP if different from referring provider within 24 hours of visit.

SOCIAL ASSESSMENT

Policy

The Community Paramedic (CP) will respond to the home on the request of the provider to perform a social assessment.

Purpose

To assess the social environment in which the patient lives. This will enable the CP to determine if adequate support systems are in place and to offer any assistance in providing the patient with available resources that are wanted and/or needed. This will also allow the paramedic to assess the basic financial needs of the home and be able to link the patient in with possible assistance programs.

Policy

1. The CP will complete the 'Social Evaluation Checklist' through an interview with the patient.
2. The CP will then fax a completed copy of the report to the referring provider within 24 hours of the visit.
3. The CP will notify the CP Coordinator of any potential unmet needs and the coordinator will then be responsible for following up with the appropriate resources and relaying this information back to both the provider and the patient.

WELL BABY CHECKS

Policy

The Community Paramedic (CP) will respond to a residence on order from the medical provider requesting CP care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring the healthy physical and mental development of the young community member.

Purpose

To assist the medical provider in observing and documenting height and weight gain as well as recognizing proportionality for the healthy development of the child. To provide/assist in immunizations and/or blood testing for the purpose of preventing disease and/or determining physiological and biochemical states for the early detection of disease.

Procedure

1. Well baby checks are advised for the following ages: 2-4 weeks, then every 2 months until 6-7 months, then every 3 months until 18 months, then 2 years, 3 years, at preschool, and every 2 years after.
2. Obtain and review patient's health history and medical provider's orders prior to appointment.
3. Follow medical provider's orders.
4. Developmental assessment:
 - Denver II
5. Obtain Patient health history:
 - Note diet, feedings, mother-child interactions, signs of neglect, signs of physical abuse or obvious physical illness such as diarrhea or chronic infection.
 - Calorie count should be done to ensure adequate caloric intake.
 - Prenatal care/ health prior to birth/labor and delivery/growth/development?
6. Head to toe assessment
 - General appearance
 - Skin
 - Variations of color, texture, temp, turgor, accessory structures
 - Lymph Nodes
 - Head
 - Neck
 - Eyes
 - Internal/external exam
 - Use Ophthalmoscope
 - Ears
 - Internal/external exam
 - Use Otoscope
 - Nose
 - Internal/external exam

WELL BABY CHECKS (CONTINUED)

- Mouth and Throat
 - Internal/external exam
- Chest
- Lungs
 - Inspection, palpation, percussion, auscultation
- Heart
 - Inspection, palpation, auscultation

WOUND CHECK / POST-OP DRESSING CHANGE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of wound care and post-operative dressing changes.

Purpose

To assist the medical provider in attending to soft tissue injuries for the purpose of restoration of function through repair of injured tissue while minimizing risk of infection and cosmetic deformity. This will be accomplished through visual inspection, wound cleaning and dressing/bandage change, and patient education.

Procedure

1. Obtain patient history including history of wound, medical illnesses (certain illnesses may delay wound healing and increase risk of infection), current vaccinations (Tdap) and medical provider's orders.
2. Obtain VS including P/BP/RR/Temp and ECG as necessary.
3. Visually inspect dressings and wound.
 - Examine dressings for excess drainage.
 - Examine wounds for infection and delayed healing including increasing inflammation, purulent drainage, foul odor, persistent pain, and fever.
 - If needed, document wound with digital camera and send to medical provider with updated records.
4. If signs of infection, contact medical provider immediately for follow up.
5. If no signs of infection clean and dress wound per medical provider's orders, and educate patient on signs and symptoms of infection and risk management.
6. Make sure patient is up to date on vaccinations (Tetanus) and if needed offer vaccine on sight or connect to public health.
7. Record required information and connect with medical provider.

REFERENCES

The policies and procedures were compiled using the following references:

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Approved ____/____/_____

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