

South Carolina Community Paramedic Protocols

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These standards have been developed according to widely accepted treatment practices at local, state, and national levels and were developed for and in conjunction with South Carolina Community Paramedics. The Community Paramedic Protocols were developed and intended to be a resource to EMS agencies. For the purposes of this document, “Community Paramedic” and “Mobile Integrated Healthcare” are used interchangeably; this allowance applies only for clarification within this document and does not imply any other recognition or allowances for Community Paramedic and/or Mobile Integrated Healthcare Programs.

Definitions:

1. **Ordering Physician:** The Community Paramedic (CP) Physician(s) that approves and requests CP services for an eligible patient.
2. **Referrals:** A request from a physician and/or mid-level provider to include a patient in the Community Paramedic program.
3. **Encounters:** An in-person, telephone interaction, and/or Primary Care visit between a Community Paramedic, a Community Paramedic patient, and/or Primary Care Provider.
4. **Values:** Information provided regarding the specific administration of medical care to yield effective care.
5. **Life Threatening:** A condition/state for which there is a strong possibility of patient fatality.

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General Guidelines

Community Paramedic Acts Allowed

The acts allow for individual certification holders in the State of South Carolina that are governed by the [South Carolina EMS Formulary](#) and [Regulation Number 61-7 Emergency Medical Services](#). Any change to the *EMS Formulary* and *Regulation Number 61-7 Emergency Medical Services* may render the acts allowed as listed in this manual obsolete. Providers are responsible for knowing the *State EMS Protocols*, *South Carolina EMS Formulary*, and *Regulation Number 61-7 Emergency Medical Services*; adhering to any limitations until this manual can be updated to reflect those changes.

The Medical Director reserves the right to limit the scope of practice allowed within the *South Carolina EMS Formulary* and approved scope of practice for those practicing under his/her medical license. Those limitations are reflected within this manual. Although some exceptions can be made if a written physician order is obtained and the act is still within the *EMS Formulary* and scope of practice for that provider level. Updates to this manual will be made on an on-going basis in order to best serve the needs of patients.

Medical Direction

The Community Paramedic (CP) will follow physician orders outlining care so much as it is within scope under the [South Carolina EMS Formulary](#) and [Regulation Number 61-7 Emergency Medical Services](#), and report directly through verbal or written dialogue with the patient's primary physician. Any case in which the patient's life and/or limb may be in danger during the duration of the CP visit should result in a request for ambulance to transport to the closest appropriate facility.

Policy

All Community Paramedics (CP) will work within the full capacity of their current scope of practice. This is done under the EMS Agency Medical Director(s); and more specifically, the CP Program.

Purpose

- The CP will follow medical provider orders and administering care within the current scope of practice for South Carolina ([SECTION 44-61-10](#)).
- The CP report directly through verbal or written dialogue with the patient's ordering 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. The CP visit will immediately end and the CP will act as a first responder until 911 transport arrives. The CP will not accompany the patient in the ambulance unless the responding crew requests their assistance.
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 primary medical provider
 - Second attempt will be to contact the EMS Agencies Medical Director
 - Third attempt will contact the online Medical Control

Medical Equipment

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient requesting a CP to inspect and ensure proper usage of personal medical equipment.

Purpose:

To assist the primary care physician (PCP) and patient in ensuring efficacy of personal medical equipment. This will be done through knowledge of patient history, educating patient of proper usage, inspection of equipment, assistance in troubleshooting and contacting appropriate resources.

Procedure:

1. Obtain and review patient history and physician orders prior to appointment.
2. Follow physician orders.
3. Inspect equipment and troubleshoot.
4. Review usage with patient and contact other services as needed.
5. Document the visit and notify physician office.
6. Determine if follow up is needed with physician and/or community paramedic.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Community Paramedic Program Referrals

Policy:

The Community Paramedic (CP) will provide home/place of residence visits for patients in response to the Ordering Physician requesting that a patient be added to the Community Paramedic program.

Purpose:

To assist the Primary Care Provider (PCP) with an automatic referral process to ensure the patients are enrolled and receive proper CP home/place of residence visit(s).

Procedure:

1. Referrals will be sent to the CP office via fax, email, or other electronic transfer from the Ordering Physician.
2. The referral form (depending on what system is used) will include the patient's name, date of birth, contact information, diagnosis, reason for CP visit and medical provider's signature.
3. The CP will access the patient's H&P, visit notes lab results and list of current medication through the hospitals EHR, if available. If not, the CP will request a copy of the patient's record from the medical provider.

Scheduled Patient Encounters

Policy:

The Community Paramedic (CP) will respond to the CP patient location, in a non-permitted vehicle, on order from the Ordering Physician requesting a Community Paramedic to conduct a home/place of residence visit.

Purpose:

To standardize the components of scheduled CP patient encounters.

Procedure:

A. Types of Scheduled Patient Encounters

1. Initial Consultation
2. Comprehensive Needs Assessment
3. Follow-up Encounters(s)
 - i. Labs
 - ii. Education
 - iii. Program Status Change

B. Initial Consultation

1. Following a CP Program referral, an Initial Consultation should be conducted. This consultation will include the following:
 - i. An Overview of the CP Program
 - ii. A brief screening of the patient's needs
 - iii. Determine next steps (schedule a Comprehensive Needs Assessment or conclude that no further CP involvement is necessary)
2. Initial Consultation may be completed in person or via the telephone by either the CP or the hospital case manager, and/or ordering physician.
3. Typically, consultations should be completed prior to scheduling a Comprehensive Needs Assessment.

C. Comprehensive Needs Assessment

1. Comprehensive Needs Assessment encounters are scheduled events that typically take place at the patient's home/place of residence (home, apartment, shelter, etc.).
Comprehensive Needs Assessments typically include the following:
 - i. History and Physical
 - ii. Home Safety Assessment
 - iii. Medication Adherence
 - iv. Resource Assistance Programs
 - v. Patient Discharge

D. Follow-up Evaluations

2. Follow-up evaluations may be performed to assess the patient's progress. These evaluations should be scheduled and agreed upon by the patient and Community Paramedic.
3. Frequency of Follow-up Evaluations
4. General Follow-up
 - i. Obtain and review patient history and physician(s) orders prior to appointment.
 - ii. Follow physician orders / discharge pamphlets.
 - iii. Obtain vital signs including P/BP/RR/temp/and EKG as necessary.
 - iv. Discuss and review with patient the ideal recovery plan, and their current response to treatment.
 - v. Communicate unusual findings to the Ordering Physician and assist with arrangement of follow up.
5. Post-injury Follow-up
 - i. Review discharge instructions with the patient to make sure they have full understanding of limitations and expectations.
 - ii. Assess patient's pain control and understanding of recommended medications.
 - iii. Assess patient's limited mobility due to the injury. Make recommendations to Ordering Physician in an effort to prevent further injury.
 - iv. Assess injury site for inflammation. Discuss using ice and non-steroidal anti-inflammatory medications as recommended treatment.

E. Discharge from the Community Paramedic Program

6. The goal of the Community Paramedic (CP) is to improve the patient's overall health by educating the patient in the proper management of their identified conditions and linking them with the appropriate resources.
7. CP patients should remain enrolled in the program until a resolution is reached, with several possible outcomes:
 - i. Patient is referred to and is actively under the care of an appropriate resource provider and no longer requires CP interventions (PCP, mental health, home health, etc.).
 - ii. Patient demonstrated the ability to independently manage their conditions by Ordering Physician.
 - iii. Patient declines continued Community Paramedic services.
 - iv. Patient is discharged from the CP program by the Ordering Physician.
8. Patients will be notified of discharge from the Community Paramedic program, whether in person, by telephone or mail.

Medical Guidelines

Asthma Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders for the management of asthma.

Purpose:

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of asthma. 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 Ordering Physician on the general well-being of the patient as well as continuing medication adherence.

Procedure:

1. Obtain and review patient health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review pathophysiology with patient including signs and symptoms of disorder and corrective actions.
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. Educate patient in use of inspirimeter.
8. Review additional devices used by the patient including short/long acting medications and MDI/continuous nebulizer devices.
9. Connect patient with necessary resources.
10. Document the visit and notify physician office.
11. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local Ordering Physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Chronic Heart Failure (CHF) Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the CHF patient.

Purpose:

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of CHF. To evaluate and identify home triggers of the disease in an effort to decrease exacerbations. To communicate with the Ordering Physician on the general well-being of the patient.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
5. Record current patient history including recent exacerbations of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cough or weight gain.
6. Obtain history of medication adherence; complete medication review and obtain history of salt and fluid intake.
7. Obtain weight and orthostatic blood pressures along with general physical examination.
8. Educate patient on medication(s); specifically, the use of diuretics as it relates to increasing weight gain and fatigue.
9. Utilize lab testing if appropriate; BMP/BNP/Magnesium.
10. Review patient's level of dyspnea with activities of daily living in home.
11. Observe the compliance with telemetry monitoring for heart failure if present.
12. Connect patient with necessary resources.
13. Document the visit and notify physician office.
14. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Chronic Kidney Disease

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the Chronic Kidney Disease (CKD) patient.

Purpose:

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of Kidney Failure. To communicate with the Ordering Physician on the general well-being of the patient.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
5. Record current patient history of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cough or weight gain.
6. Record current patient history of medication adherence and history of salt and fluid intake.
7. Record current patient history of weight, orthostatic blood pressure and nutritional status along with general physical examination.
8. Educate patient on medications; specifically, the use of diuretics, if still producing some urine, as it relates to increasing weight gain and fatigue.
9. Utilize lab testing if appropriate; BMP, Magnesium and Phosphorus.
10. Review patient's fatigue with activities of daily living in home.
11. Observe the compliance with hemodialysis or peritoneal dialysis.
12. Connect patient with necessary resources.
13. Document the visit and notify physician office.
14. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Chronic Obstructive Pulmonary Disease (COPD) Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the COPD patient.

Purpose:

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of COPD. To demonstrate and review technique of all devices used for the treatment of COPD. To evaluate any home triggers of the disease in an effort to decrease exacerbations.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
5. Record current patient history including symptoms at rest, with activity and sleep. Changes in sputum color and tenacity and any recent exacerbating factors viral URI, smoking, allergens, cold air, etc.
6. Educate patient on the use of peak flow meter and pulse oximetry.
7. Check home for any exacerbating factors, i.e. inadequate ventilation of heating system, lack of A/C in the humid months.
8. Review devices/MDI/nebulizers with patient. Have patient demonstrate capability of using devices correctly.
9. Review medications for adherence and side effects.
10. Connect patient with necessary resources.
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Diabetes Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the diabetic patient.

Purpose:

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic patient. 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 physician's orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
5. Complete a detailed history and physical exam.
6. Observe patient's physical state/general well-being.
7. Obtain blood glucose level (BGL) and compare with home glucometer.
8. Note directions for insulin/medication administration and record compliance.
9. Note and record compliance with diet and exercise plan.
10. Note and record patient's concerns about treatment plan (insulin levels, blood sugar levels).
11. Document and follow-up with patient's physician if a significant increase or decrease in patient's normal BGL level.
12. Connect patient with necessary resources.
13. Document the visit and notify physician office.
14. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Respiratory Management of Sleep Apnea

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders for follow up on recently diagnosed and discharged or chronic sufferers of sleep apnea.

Purpose:

To assist the Ordering Physician 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 health history and physician orders prior to appointment.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Conduct assessment.
 - a. Necessary VS assessments including Po₂ and ETCO₂ and weight/BMI
 - b. Sleep habits; Irregular work schedule?
 - c. Alcohol/recreational drug use? Prescription drug use?
 - d. Additional patient complaints?
 - e. Quality of life - Noticeable changes after usage.
5. Troubleshoot if necessary including ensuring proper fit of mask and use of machine as well as general condition of machine.
6. Connect patient with necessary resources (Oxygen Supply Company, etc.).
7. Document the visit and notify physician office.
8. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local physician order.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Hospice/Palliative Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in hospice or palliative care patient.

Purpose:

To assist the patient in non-life intervening measures as written in the hospice care plan. To provide the patient and care giver with comfort and education as to the patient's disease process, focusing on signs or symptoms to expect. To ensure that the patient's wishes and requests are fulfilled. To intervene as necessary; when signs and symptoms are not indicative of the terminal disease process.

Procedure:

1. Obtain and review patient's health history and physician orders in hospice care plan.
2. Follow physician orders. Communicate with the patient hospice nurse or hospice nurse on call.
3. Review patient's information with the patient/care givers, including medical/medication history, current medications the patient is receiving and taking, adherence, time of doses, physician who prescribed medications and sources of medications (pharmacy).
4. Ask the patient if there are any medications they take which they do not want to disclose.
5. Obtain and trend (if applicable) the patient's vital signs.
6. Consult with the hospice nurse if patient current signs and symptoms are not within their normal status.
7. Provide appropriate treatment for the patient as per the hospice care plan, the hospice nurse, or online hospice medical control.
8. Check the patient's medications to assure that the patient is taking them correctly or the family understands how to administer them correctly.
9. Continue to communicate with the hospice nurse until they arrive on scene.
10. If the family becomes adamant that the patient be transported to the emergency department call for an ALS transport unit.
11. Communicate all signs/symptoms, medication adherence problems, change in the patient normal status, or any other issues on scene, that affect the patient successful hospice/palliative care, with the patient hospice nurse or ordering physician.
12. Document the visit and notify physician office.
13. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through dispatch for any life-threatening S/S.

Hypertension Management

Policy:

The Community Paramedic (CP) will respond to a residence on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the hypertensive patient.

Purpose:

To ensure the proper maintenance of hypertensive patient and their adherence with medications, diet, and exercise. This will be accomplished through blood pressure monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs; obtain manual and/or automated blood pressure readings.
4. Review pathology with patient including signs and symptoms of disorder and corrective actions.
5. Observe patient's physical state/general well-being.
6. Determine whether the patient has additional symptoms which may be related to their elevated blood pressure such as: chest pain, shortness of breath, other pain, headache, or neurological symptoms. Symptomatic patients should be considered for transport to the Emergency Department for evaluation.
7. Note directions for medication administration and record adherence.
8. Note diet and exercise.
9. Note and record patients concerns about treatment plan (varying BP readings).
10. Connect patient with necessary resources.
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Lab Draw

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician's orders for the purpose of obtaining a lab specimen for testing

Purpose:

To assist the Primary Care Provider (PCP) 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, pink, 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 medical provider's office or hospital; following all facility specific protocols.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Mental Health Management

Policy:

The Community Paramedic (CP) will respond to CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in the management of mental disorders. Behavioral and substance abuse patients are included in this protocol.

Note: The threshold for identifying a psychiatric emergency is based on the level of agitation, violence, or uncooperative behavior that poses a threat to self or others. Although most patients seen by a CP may be unlikely to cross that threshold, the safety of any scene can deteriorate rapidly and a patient's condition can change rapidly – certainly from visit to visit. As a CP, you need to be alert to the signs of imminent behavioral change, even violence.

Purpose:

To ensure the proper maintenance of mental health patients and their adherence with medications. This will be accomplished through providing the patient with a safe environment, both physically and emotionally.

Procedure:

1. Obtain and review patient's health history, physical exam and physician orders prior to appointment; including plan for lifestyle change and medication usage.
2. Observe patient's physical state/general well-being.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
5. Determine whether the patient has additional symptoms which may be related to their condition such as: chest pain, shortness of breath, other pain, headache, or neurological symptoms.
6. Determine through patient interview if there are internal or external factors that exacerbate their condition.
7. Note any abnormal feelings the patient has experienced since being last seen by their physician or community paramedic (thoughts of suicide, hurting themselves or others, anxiety, depression).
8. Note directions for medication administration and record adherence.
9. Note and record patient's concerns about treatment plan. Communicate with physician about the patient and community paramedic's concerns.
10. Assess the patient's ability to perform daily functions (clothe, bathe, eat or prepare meals, ambulate). If the patient has any concern, communicate with the primary physician to align the patient with community resources.
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Non-Emergent 12 Lead EKG

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and follow guidelines outlined by the physician's orders to perform a non-emergent 12 Lead EKG.

Purpose:

To allow Community Paramedics to perform non-emergent 12 Lead EKG outside of the usual 911 setting. To include any time when a CP deems a cardiac assessment necessary during any patient assessment.

Procedure:

1. The Community Paramedic will respond to the patient's location at the scheduled appointment time after receiving a referral from patient's physician.
2. After the EKG is obtained, the EKG will be sent to the physician (transmitted when appropriate or indicated by the requesting physician). A notification will be sent to the Ordering Physician for review.
3. If the patient requires acute medical intervention, the Community Paramedic will call for a 911 ALS unit to respond to the scene. The Community Paramedic will revert from their CP/MIH Medical Guidelines and treat the patient according to EMS Agency Medical Guidelines. When the 911 ALS unit arrives, patient care shall be transferred to the transport Paramedic. If transport is refused by the patient then the responding ambulance crew is to initiate the standard transport refusal protocol, and document as such.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Post Cerebrovascular Accident (CVA)

Policy:

The Community Paramedic will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in post discharge assessments for CVA patients.

Purpose:

To ensure the proper maintenance of CVA patients and their adherence with medications, diet, and exercise. This will be accomplished through lifestyle change, vital sign monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for lifestyle change and medication usage.
1. Follow physician orders and refer to discharge instructions.
2. Obtain and trend (if applicable) the patient's vital signs.
3. Review pathophysiology with patient including signs and symptoms of disorder and corrective actions.
4. Observe patient's physical state/general well-being.
5. Determine whether the patient has additional symptoms which may be related to their condition such as: chest pain, shortness of breath, other pain, headache, or neurological symptoms.
*Symptomatic patients should be considered for transport to the Emergency Department for evaluation.
6. Note directions for medication administration and record adherence.
7. Note diet and exercise recommendations from physician and note any discrepancies or concerns the patient has in accomplishing their goals.
8. Note and record patient's concerns about treatment plan (inability due to deficits). Communicate with doctor about the patient and Community Paramedic concerns.
9. Assess the patient's ability to perform daily functions (clothe, bathe, eat or prepare meals, ambulate). If the patient has any concern, communicate with the primary physician to align the patient with community resources.
10. Document the visit and notify physician office.
11. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Post Stroke Management

Policy:

The Community Paramedic (CP) will respond to the CP patient location on request from the Ordering Physician and/or patient and follow guidelines outlined by the physician's orders to assist in well-being checks for the stroke patient.

Purpose

To ensure the proper maintenance of stroke patients and their adherence with medications, diet, and exercise and adapting to life-style changes. This will be accomplished through appropriate prescription drug usage, recognition of desired drug effects, and further education/resources.

Procedure:

1. Obtain and review patient's health history and physician's orders prior to appointment; including plan for lifestyle change and medication usage.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Complete a detailed history and physical exam.
5. Review pathophysiology with patient including signs and symptoms of disorder and corrective actions.
6. Observe patient's physical state/general well-being with any side effects from the stroke; paralysis, weak muscle control.
7. Determine and record medication adherence.
8. Review warning signs and symptoms of subsequent strokes and educate to immediately contact 911.
9. Note and record patients concerns about treatment and medications.
10. Connect patient with necessary resources.
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Wound Check / Post-Operative Dressing Change

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician's orders for the purpose of wound care and post-operative dressing changes.

Purpose:

To assist the Ordering Physician 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 physician's orders.
2. Obtain and trend (if applicable) the patient's vital signs.
3. Visually inspect dressings and wound.
 - a. Examine dressings for excess drainage.
 - b. Examine wounds for infection and delayed healing including increasing inflammation, purulent drainage, foul odor, persistent pain, and fever.
 - c. If needed, document wound with digital camera and send to physician with updated records.
4. If signs of infection, contact physician immediately for follow up.
5. If no signs of infection, clean and dress wound per physician orders and educate patient on infection S/S and risk management.
6. Make sure patient is up to date on vaccinations (Tetanus/Rabies) and if needed connect with primary care physician (PCP).
7. Connect patient with necessary resources.
8. Document the visit and notify physician office.
9. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Comprehensive Needs Assessment Guidelines

History and Physical

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician's orders for proper history and physical exam assessments.

Purpose:

To assist the Ordering Physician 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 physician's orders prior to appointment.

Follow physician's orders. All information may be recorded prior to paramedic's consultation. It will be decided by the physician and community paramedic what information to update.

I. Health History

1. Demographic Data (if not already recorded)
 - a. 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 healthcare, source of referral, usual source of health care, type of health insurance.

II. Reason for Seeking Care/Chief Complaint

1. Present Health Status
 - a. 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 medication.
 - b. 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
 - a. Allergies, childhood illnesses, surgeries, hospitalizations, accidents or injuries, chronic illnesses, immunizations, last examinations, obstetric history.
3. Family History
 - a. Develop Genogram.
 - b. 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 – PEAT scale for all patients

III. Review of Systems

1. General Health Status

- a. Fatigue, weakness
- b. Sleep patterns
- c. Weight, unexplained loss or gain
- d. Self-rating of overall health status

2. Integumentary System

- a. Skin disease, problems, lesions (wounds, sores, ulcers)
- b. Skin growths, tumors, masses
- c. Excessive dryness, sweating, odors
- d. Pigmentation changes or discolorations
- e. Rashes
- f. Pruritus
- g. Frequent bruising
- h. Texture or temperature change
- i. Scalp itching
- j. Hair
 - i. All body hair, not just head and pubic area, changes in amount, texture, character, distribution
- k. Nails
 - i. Changes in texture, color, shape
- l. Head
 - i. Headache
 - ii. Past significant trauma
 - iii. Vertigo
 - iv. Syncope
- m. Eyes
 - i. Discharge
 - ii. Puritis
 - iii. Lacrimation
 - iv. Pain
 - v. Visual disturbances
 - vi. Swelling
 - vii. Redness
 - viii. Unusual sensations or twitching
 - ix. Vision changes
 - x. Use of corrective or prosthetic devices
 - xi. Diplopia
 - xii. Photophobia

- xiii. Difficulty reading
- xiv. Interference with activities of daily living
- n. Ears
 - i. Pain
 - ii. Cerumen
 - iii. Infection
 - iv. Discharge
 - v. Hearing changes
 - vi. Use of prosthetic device
 - vii. Increased sensitivity to environmental noises
 - viii. Change in balance
 - ix. Tinnitus
 - x. Interference with activities of daily living
- o. Nose, Nasopharynx, and Paranasal Sinuses
 - i. Discharge
 - ii. Epistaxis
 - iii. Sneezing
 - iv. Obstruction
 - v. Sinus pain
 - vi. Postnasal drip
 - vii. Change in ability to smell
 - viii. Snoring
 - ix. Pain over sinuses
- p. Mouth and Oropharynx
 - i. Sore throat
 - ii. Tongue or mouth lesion (abscess, sore, ulcer)
 - iii. Bleeding gums
 - iv. Voice changes or hoarseness
 - v. Use of prosthetic devices (dentures, bridges)
 - vi. Difficulty chewing
- q. Neck
 - i. Lymph node enlargement
 - ii. Swelling or masses
 - iii. Pain/tenderness
 - iv. Limitation of movement
 - v. Stiffness
- r. Breasts
 - i. Pain/tenderness
 - ii. Swelling
 - iii. Nipple discharge

- iv. Changes in nipples
 - v. Lumps, masses, dimples
 - vi. Discharge
- 3. Cardiovascular System
 - a. Heart
 - i. Palpitations
 - ii. Chest pain
 - iii. Dyspnea
 - iv. Orthopnea
 - v. Paroxysmal nocturnal dyspnea
 - b. Peripheral vasculature
 - i. Coldness/numbness
 - ii. Discoloration
 - iii. Varicose veins
 - iv. Intermittent claudication
 - v. Paresthesia
 - vi. Leg color changes
- 4. Respiratory System
 - a. Colds/Virus
 - b. Cough, nonproductive or productive
 - c. Hemoptysis
 - d. Dyspnea
 - e. Night sweats
 - f. Wheezing
 - g. Stridor
 - h. Pain on inspiration or expiration
 - i. Smoking history, exposure
- 5. Gastrointestinal System
 - a. Change in taste
 - b. Thirst
 - c. Indigestion or pain associated with eating
 - d. Pyrosis
 - e. Dyspepsia
 - f. Nausea / Vomiting
 - g. Appetite changes
 - h. Food intolerance
 - i. Abdominal pain
 - j. Jaundice
 - k. Ascites
 - l. Bowel habits

- m. Flatus
 - n. Constipation
 - o. Diarrhea
 - p. Changes in stool
 - q. Hemorrhoids
 - r. Use of digestive or evacuation aids
6. Urinary System
- a. Characteristics of urine
 - b. Hesitancy
 - c. Urgency
 - d. Change in urinary stream
 - e. Nocturia
 - f. Dysuria
 - g. Flank pain
 - h. Hematuria
 - i. Suprapubic pain
 - j. Dribbling or incontinence
 - k. Polyuria
 - l. Oliguria
 - m. Pyuria
7. Genitalia
- a. General
 - i. Lesions
 - ii. Discharges
 - iii. Odors
 - iv. Pain, burning, pruritus
 - v. Painful intercourse
 - vi. Infertility
 - b. Men
 - i. Impotence
 - ii. Testicular masses/pain
 - iii. Prostate problems
 - iv. Change in sex drive
 - v. Penis and scrotum self-examination practices
 - c. Women
 - i. Menstrual history
 - ii. Pregnancy history
 - iii. Amenorrhea
 - iv. Menorrhagia
 - v. Dysmenorrhea

- vi. Metrorrhagia (irregular menstruation)
 - vii. Dyspareunia (pain during intercourse)
 - viii. Postcoital bleeding
 - ix. Pelvic pain
 - x. Genitalia self-examination
8. Musculoskeletal System
- a. Muscles
 - i. Twitching, cramping pain
 - ii. Weakness
 - b. Bones and joints
 - i. Joint swelling, pain, redness, stiffness
 - ii. Joint deformity
 - iii. Crepitus
 - iv. Limitations in joint range of motion
 - v. Interference with activities of daily living
 - c. Back
 - i. Back pain
 - ii. Limitations in joint range of motion
 - iii. Interference with activities of daily living
9. Central Nervous System
- a. History of central nervous system disease
 - b. Fainting episodes or LOC
 - c. Seizures
 - d. Dysphasia
 - e. Dysarthria
 - f. Cognitive changes (inability to remember, disorientation to time/place/person, hallucinations)
 - g. Motor-gait (loss of coordinated movements, ataxia, paralysis, paresis, tic, tremor, spasm, interference with activities of daily living)
 - h. Sensory-paresthesia, anesthesia, pain
10. Endocrine System
- a. Changes in pigmentation or texture
 - b. Changes in or abnormal hair distribution
 - c. Sudden or unexplained changes in height or weight
 - d. Intolerance of heat or cold
 - e. Presence of secondary sex characteristic
 - f. 3 P's
 - g. Anorexia
 - h. Weakness

IV. Psychosocial Status

1. General statement of patient's feelings about self
 - a. Degree of satisfaction in interpersonal relationships
 - b. Client's position in-home relationships
 - c. Most significant relationship
 - d. Community activities
 - e. Work or school relationships
 - f. Family cohesiveness
2. Activities
 - a. General description of work, leisure and rest distribution
 - b. Hobbies and methods of relaxation
 - c. Family demands
 - d. Ability to accomplish all that is desired during period
3. Cultural or religious practices
4. Occupational history
 - a. Jobs held in past
 - b. Current employer
 - c. Education preparation
 - d. 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
 - a. Feelings of anxiety or nervousness
 - b. Feelings of depression
 - c. Use of medications or other techniques during times of anxiety, stress or depression
8. Habits
 - a. Alcohol / Drugs Use
 - i. Type of alcohol/drugs
 - ii. Frequency per week
 - iii. Pattern over past 5 years; over the past year
 - iv. Alcohol/drug consumption variances when anxious, stressed, or depressed
 - v. Driving or other dangerous activities while under the influence
 - vi. High risk groups: sharing/using unsterilized needles and syringes
 - b. Smoking / Tobacco Use
 - i. Type
 - ii. Amount per day
 - iii. Pattern over 5 years; over the past year
 - iv. Usage variances when anxious or stressed
 - v. Exposure to secondhand smoke
 - c. Caffeine: Coffee, tea, soda, etc.

- i. Amount per day
 - ii. Pattern over 5 years; over the past year
 - iii. Consumption variances when anxious or stressed
 - iv. Physiological effects
 - d. Other
 - i. Overeating, sporadic eating or fasting
 - ii. Nail biting
 - e. Financial status
 - i. Sources of income
 - ii. Adequacy of income, Recent changes in resources or expenditures

V. Environmental Health

1. General statement of patient's 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

VI. Consider Age-Related Variations in the Health History

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

VII. Physical Assessment

1. Techniques
 - a. Inspection
 - b. Palpation
 - c. Percussion
 - d. Auscultation
2. Positioning
3. Vital Signs
 - a. Temperature
 - b. Pulse
 - c. Respiration
 - d. Blood Pressure
 - e. Oxygen Saturation
4. General Assessment
 - a. Weight
 - b. Height

- c. Skinfold Thickness
- 5. Age-Related Variations
 - a. Newborns and Infants
 - i. Recumbent Length
 - ii. Head Circumference
 - iii. Chest Circumference
 - b. Children
 - i. Height and Weight
 - ii. Head and Chest Circumference
 - c. Adolescents
 - i. Weight and Height
 - d. Older Adults
 - i. Weight and Height
- 6. Documentation
 - a. Document all information and communicate with primary physician.
 - b. If on evaluation of the patient any of the following S/S are found contact the patient's referring physician via phone while still on scene with the pt.
 - i. Systolic BP > 190 or < 80
 - ii. Diastolic BP > 120
 - iii. Temperature when ordered of > 101.5
 - iv. Pulse at rest > 120
 - v. Respirations at rest >24
 - vi. O2 sat of < 88% on children < 14 y/o
 - vii. O2 sat of < 86 on any patient not on O2

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Home Safety Assessment

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician'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. Complete the Home Safety Inspection.
2. Complete comments on any sections marked "no" during the inspection.
3. Complete recommendations for the resident and appropriate referrals.
4. Discuss the findings with the patient.
5. Connect patient with necessary resources.
6. Have the patient sign off the report with the understanding they comprehend the recommendations.
7. Complete report and return a copy to the Ordering Physician.
8. If any life-threatening issues are identified, notify the proper resource immediately.

References:

Home Safety Assessment Checklist

Medication Adherence

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician's orders for home medication checks; first order received from the Ordering Physician with the second order from CP Program pharmacist if available.

Purpose:

To assist the patient in proper usage of home medications through information/education and vital sign checks. To assist the Ordering Physician in a thorough documentation of all prescription and non-prescription medications, from all sources for the purpose of avoiding adverse reactions due to drug omissions, duplications, drug-drug and drug-disease interactions and other errors due to miscommunication and/or misinterpretation. To ensure proper continuum of care during physician/health care provider transitions.

Procedure:

1. Obtain and review patient's health history and physician(s) orders prior to appointment; including plan for lifestyle change and medication usage.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review patient's information with the patient, including medical/medication history, current medications the patient is receiving and taking, adherence, time of doses, physician who prescribed medications and sources of medications (pharmacy).
5. Ask the patient if there are any medications they take which they do not want to disclose.
6. Assist patient in sorting medications.
7. Stress importance of medication adherence.
8. Document all medications whether prescription or otherwise and communicate list and current health/reactions to primary physician.
9. Connect patient with necessary resources.
10. Contact referring physician if CP or patient has concerns.
11. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Patient Discharge

The purpose of this policy is to establish guidelines for patients whom are discharged from a Community Paramedic Program. There will be two types of discharges planned and unplanned.

Planned Discharges

Patients who have completed the Community Paramedic Program successfully, will be eligible for a planned discharge. The criteria for a planned discharge will be as follows:

- **Goals Met** - Any patient who has successfully met all goals set forth in their Care Plan. These patients must have been on a maintenance plan for a satisfactory period of time. The patient must have shown some sense of independence during this time. Patient must be able to display a basic knowledge of their chronic condition along with their current medications. Prior to discharge, the patient must be notified of their discharge from the Community Paramedic Program. The patient's Doctor must also be notified of their discharge from the program prior to discharge.
- **Referral to Higher Level of Care** - Any patient who has been seen by a Community Paramedic and it is deemed that the patient needs a higher level of care (Ex. Home Health). These patients must have been enrolled into the specific agency prior to discharge from the Community Paramedic Program.

Unplanned Discharge

Patients who have not completed the Community Paramedic Program but are being discharged for these reasons. All other situations will be handled according to the provider's discretion.

- **Non-Adherence to Goals** - Any patient who is refusing to adhere to their Care Plan goals for a period of 2 months will be eligible for discharge. These patients should have had their risk explained to them for non-adherence. If the Community Paramedic deems necessary, the patient may also be seen by another Community Paramedic prior to discharge.
- **Missing more than 3 Visits** – Any patient who is a no call / no show for more than 3 visits. This is established for those patients who fail to call and reschedule their visits prior to a Community Paramedic going to the patient's residence/location.
- **Relocation** - This may either be a planned or unplanned discharge. Any time a patient moves out of EMS agencies response area, they shall be discharged from the Community Paramedic program. An attempt will be made to refer the patient into another appropriate program, if available.
- **Patient / Family Request** - At any time, the patient or their family may request that they no longer participate in the Community Paramedic program.
- **Unsafe Home Situation** - At any time during a visit the Community Paramedic deems an unsafe environment, the patient shall be discharged from the Community Paramedic program. Some examples of unsafe situations are drug or suspected drug use, violence and irate patients.

Prior to discharge, the Community Paramedic must complete the following things.

1. The Community Paramedic should complete the discharge form.
2. The Community Paramedic should provide the patient with a current medication list and a copy of the discharge form at the time of discharge.
3. The patient's doctor should be notified of plans to discharge.

Resource Assistance Programs

Policy:

The Community Paramedic (CP) will respond to the CP patient location on order from the Ordering Physician requesting Community Paramedic care and follow guidelines outlined by the physician's orders for support in obtaining access to health care services, including medication.

Purpose:

To assist the patient in obtaining health care services through information/education and program enrollment if appropriate. To assist the ordering physician in a thorough documentation of all prescription and non-prescription medications, from all sources for the purpose of avoiding adverse reactions due to drug omissions, duplications, drug-drug and drug-disease interactions and other errors due to miscommunication and/or misinterpretation. To ensure proper continuum of care during physician/health care provider transitions.

Procedure:

1. Obtain and review patient's medication history and physician(s) orders prior to appointment.
2. Follow physician orders.
3. Review patient's information with the patient, including medical/medication history, current medications the patient is receiving and taking, compliance, time of doses, physician who prescribed medications and sources of medications (pharmacy).
4. Ask the patient if there are any medications they take which they do not want to disclose.
5. Determine need and potential eligibility for health care supports, for example, SC Thrive web-based system. Complete applications and provide follow up information as indicated.
6. Determine need and potential eligibility for pharmaceutical assistance programs. If uninsured, help patient complete and submit application forms in conjunction with the patient's primary care provider office.
7. Provide additional medication resources to patient including linkages to Welvista, local pharmacies and \$4 drug lists if appropriate.
8. Document all medications whether prescription or otherwise and communicate list and current health/reactions to primary physician, especially concerning medications the patient is unable to access due to cost.
9. Contact referring physician if CP or patient has concerns.
10. Determine if follow up is needed with physician and/or community paramedic.

* Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Pediatric Guidelines

New Born Home Assessment

Policy:

The Community Paramedic (CP) will respond to CP patient location on order from the Ordering Physician/ Pediatric Physician requesting a sequence of home safety assessments and education.

Purpose:

To assess the home for hazards relevant to the daily activities, development, and growth of the new born. The home assessment is an attempt to prevent future injury, illness, or death.

Procedure:

1. Complete the Home Safety Inspection.
2. Complete comments on any sections marked “no” during the inspection.
3. Complete recommendations for the parent and advise of available resources.
4. Discuss the findings with the parent.
5. Connect parent/guardian with necessary resources.
6. Have the parent sign off the report with the understanding that they were advised of recommendations.
7. Complete report and return to CP newborn file.
8. If any life-threatening issues are identified, notify the community paramedic medical control.

References:

Pediatric Home Safety Assessment Checklist

Pediatric Asthma Management

Policy:

The Community Paramedic (CP) will respond to a residence on request from the Ordering Physician or patient/guardian and follow guidelines outlined by the physician's 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 primary physician on the general well-being of the patient as well as continuing medication adherence.

Procedure:

1. Obtain and review patient health history and physicians orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review pathophysiology with patient and parent/guardian.
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. **Auscultate breath sounds with recording stethoscope and log on patients Electronic Chart.**
7. Educate patient in use of Peak flow meter.
8. Review additional devices used by the patient including short/long acting medications and MDI/continuous nebulizer devices.
9. Observe home in an effort to possibly identify exacerbating factors.
10. Note and record patient/guardian's concerns about treatment plan.
11. Connect patient with necessary resources.
12. Document the visit and notify physician office.
13. Determine if follow up needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Pediatric Diabetic Education

Policy:

The Community Paramedic (CP) will respond to a residence on request from the Ordering Physician or patient/guardian and follow guidelines outlined by the physician's orders to assist in well-being 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 focusing on the point of diagnosis and physician's orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Review pathology with patient/guardian including signs and symptoms of disorder and corrective actions.
4. Obtain vital signs for patient health trends.
5. Observe patient's physical state/general well-being. Create a parameter for the patient's "Norm".
6. Obtain blood glucose level (BGL) and compare with home glucometer. Provide a glucose chart if the patient/guardian does not have one on hand.
7. Note directions for insulin administration and record adherence.
8. Record adherence with all medications.
9. Note diet, education given on diet and resources shared to help with diet compliance.
10. Note and record patient/guardian's concerns about treatment plan (insulin levels, blood sugar levels, diet).
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

Pediatric Seizure Management

Policy:

The Community Paramedic (CP) will respond to a residence on request from the Ordering Physician or patient/guardian and follow guidelines outlined by the physician's orders to assist in well-being checks for the pediatric seizure patient.

Purpose:

To ensure the proper maintenance of seizure medication, seizure-controlled diets, and environmental risk factors. This will be accomplished through strict medication regimens, dietary education, recognition of desired drug effects, seizure tracking, and further education/resources.

Procedure:

1. Obtain and review patient's health history and physician's orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Review pathology with patient/guardian including signs and symptoms of disorder and corrective actions.
4. Obtain vital signs for patient health trends.
5. Observe patient's physical state/general well-being.
6. Obtain, specifically, blood glucose level (BGL), temperature, seizure tracking data, and vital signs.
7. Note directions for any medication prescribed and note adherence.
8. Note diet.
9. Note and record patient/guardians concerns about treatment plan.
10. Note any changes in the patient's mobility and sensory reflexes.
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.

*Values determined and directed by local ordering physician.

*Request ambulance response through 911 dispatch for any life-threatening S/S.

References

Home Safety Assessment

Date of visit: _____

Occupant name: _____ Paramedic Name: _____

OUTSIDE OF HOUSE

1. Sidewalk and/or pathway to house is level and free from any hazards. Yes ___ No ___ N/A ___
2. Driveway is free from debris/snow/ice. Yes ___ No ___ N/A ___
3. Outside stairs are stable and have sturdy handrail. Yes ___ No ___ N/A ___
4. Porch lights are working and provide adequate lighting. Yes ___ No ___ N/A ___

LIVING ROOM

1. Furniture is of adequate height and offers arm rests that assist in getting up and down. Yes ___ No ___ N/A ___
2. Floor is free from any clutter that would create tripping hazards. Yes ___ No ___ N/A ___
3. All cords are either behind furniture or secured in a manner that does not cause trip hazards. Yes ___ No ___ N/A ___
4. All rugs are secured to floor with double-sided tape. Yes ___ No ___ N/A ___
5. Lighting is adequate to light room. Yes ___ No ___ N/A ___
6. All lighting has an easily accessible on/off switch. Yes ___ No ___ N/A ___
7. Phone is readily accessible near favorite seating areas. Yes ___ No ___ N/A ___
8. Emergency numbers are printed near all phones in house. Yes ___ No ___ N/A ___

KITCHEN

1. Items used most often are within easy reach on low shelves. Yes ___ No ___ N/A ___
2. Step stool is present, is sturdy and has handrail. Yes ___ No ___ N/A ___
3. Floor mats are non-slip tread and secured to floor. Yes ___ No ___ N/A ___
4. Oven controls are within easy reach. Yes ___ No ___ N/A ___
5. Kitchen lighting is adequate and easy to reach switches. Yes ___ No ___ N/A ___
6. ABC fire extinguisher is located in kitchen. Yes ___ No ___ N/A ___

STAIRS

- 1. Carpet is properly secured to stairs and/or all wood is properly secured. Yes ___ No ___ N/A ___
- 2. Handrail is present and sturdy. Yes ___ No ___ N/A ___
- 3. Stairs are free from any clutter. Yes ___ No ___ N/A ___
- 4. Stairway is adequately lit. Yes ___ No ___ N/A ___

BATHROOM

- 1. Tub and shower have a non-slip surface. Yes ___ No ___ N/A ___
- 2. Tub and/or shower have a grab bar for stability. Yes ___ No ___ N/A ___
- 3. Toilet has a raised seat. Yes ___ No ___ N/A ___
- 4. Grab bar is attached near toilet for assistance. Yes ___ No ___ N/A ___
- 5. Pathway from bedroom to bathroom is free from clutter and well-lit for ease of movement in the middle of the night. Yes ___ No ___ N/A ___

BEDROOM

- 1. Floor is free from clutter. Yes ___ No ___ N/A ___
- 2. Light is near bed and is easy to turn on. Yes ___ No ___ N/A ___
- 3. Phone is next to bed and within easy reach. Yes ___ No ___ N/A ___
- 4. Flashlight is near bed in case of emergency. Yes ___ No ___ N/A ___

GENERAL

- 1. Smoke detectors in all areas of the house (each floor) and tested. Yes ___ No ___ N/A ___
- 2. CO detectors on each floor of house and tested. Yes ___ No ___ N/A ___
- 3. Flashlights are handy throughout the home. Yes ___ No ___ N/A ___
- 4. Resident has all medical information readily available and in an area area emergency providers will easily find. Yes ___ No ___ N/A ___
- 5. All heaters are away from any type of flammable material. Yes ___ No ___ N/A ___
- 6. Are there any issues or hazards to having oxygen in the home? Yes ___ No ___ N/A ___
- 7. Are there any issues or hazards to having pets in the home? Yes ___ No ___ N/A ___
- 8. Oxygen equipment inspected and current. Yes ___ No ___ N/A ___

OVERALL TIPS

- 1. Homeowner has good non-skid shoes to move around house. Yes ___ No ___ N/A ___
- 2. All assisted walking devices are readily accessible and in good condition. Yes ___ No ___ N/A ___
- 3. There is a phone near the floor for ease of reach in case of a fall. Yes ___ No ___ N/A ___
- 4. All O2 tubing is less than 50 ft. and is not a trip hazard. Yes ___ No ___ N/A ___
- 5. Resident has had an annual hearing and vision check by a physician. Yes ___ No ___ N/A ___
- 6. Resident has the proper hearing and visual aids prescribed and are in good working order. Yes ___ No ___ N/A ___
- 7. All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses. Yes ___ No ___ N/A ___

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

After evaluation I recommend the resident be considered for the following referrals:

Signature of resident: _____

Signature of Community Paramedic: _____

References: Centers for Disease Control and Prevention / <http://www.cdc.gov>
A. 'Check for Safety' A Home Fall Prevention Checklist for Older Adults
B. U.S. Fall Prevention Programs for Seniors – Selected Programs Using Home Assessment and Modification.

*Compiled and created by Kevin Creek NREMT-P / Community Paramedic
Western Eagle County Health Services District, 360 Eby Creek Road, P.O. Box 1809, Eagle CO 81631 May 2011*

Newborn Home Safety Assessment

Date of visit: _____

Guardian/Parent name: _____ Paramedic Name: _____

OUTSIDE OF HOUSE

1. Sidewalk and/or pathway to house are level and free from any hazards. Yes ___ No ___ N/A ___
2. Fence around any pools or hot tubs. Yes ___ No ___ N/A ___
3. Fence is at least 4ft tall around the pool/hot tub. Yes ___ No ___ N/A ___
4. Doors to the outside are secure and have a cover. Yes ___ No ___ N/A ___

LIVING ROOM

1. All unstable furniture is anchored. Yes ___ No ___ N/A ___
2. Floor is free from any clutter that would create tripping hazards. Yes ___ No ___ N/A ___
3. Furniture has rounded corners or toddler shields. Yes ___ No ___ N/A ___
4. All objects on lower shelves moved, out of reach. Yes ___ No ___ N/A ___
5. Fireplace hearth is padded. Yes ___ No ___ N/A ___
6. Barrier device over the fireplace. Yes ___ No ___ N/A ___
7. Sliding doors have locks. Yes ___ No ___ N/A ___
8. Decorative plants are out of reach. Yes ___ No ___ N/A ___

KITCHEN

1. Latches over cabinets with cleaners, appliances, and trash bags. Yes ___ No ___ N/A ___
2. Latches on drawers with knives, forks, or utensils. Yes ___ No ___ N/A ___
3. Latches on cabinets with glassware. Yes ___ No ___ N/A ___
4. All medicine bottles and alcohol are sealed and stored out of reach. Yes ___ No ___ N/A ___
5. Counter appliances are out of reach with no dangling cords. Yes ___ No ___ N/A ___
6. ABC fire extinguisher is located in kitchen. Yes ___ No ___ N/A ___
7. High chair has straps for securing. Yes ___ No ___ N/A ___

STAIRS

1. Handrail is present and sturdy. Yes ___ No ___ N/A ___
2. Stairs are free from any clutter. Yes ___ No ___ N/A ___

- 3. Safety Gate in place. Yes ___ No ___ N/A ___
- 4. No furniture near balcony. Yes ___ No ___ N/A ___

BATHROOM

- 1. Non-slip mat in the tub Yes ___ No ___ N/A ___
- 2. All toiletries are out of reach. Yes ___ No ___ N/A ___
- 3. Lid lock on toilet. Yes ___ No ___ N/A ___
- 4. Waste basket under sink. Yes ___ No ___ N/A ___
- 5. All electrical appliances in a secure place out of reach. Yes ___ No ___ N/A ___

BEDROOM

- 1. Mattress fits snugly in the crib. Yes ___ No ___ N/A ___
- 2. Crib away from window and out of reach from window treatments. Yes ___ No ___ N/A ___
- 3. Crib is away from lamps and other electrical appliances. Yes ___ No ___ N/A ___
- 4. Changing table has rails or safety belt. Yes ___ No ___ N/A ___
- 5. Dressers are secured to the wall with drawers closed. Yes ___ No ___ N/A ___
- 6. Night lights are clear from any fabric. Yes ___ No ___ N/A ___
- 7. Crib hardware is secure. Yes ___ No ___ N/A ___
- 8. Crib free of bumper pads, stuffed animals, and other stuffed animals or pillows. Yes ___ No ___ N/A ___

Laundry Room/Garage

- 1. All cleaning products stored high or in a latched cabinet. Yes ___ No ___ N/A ___
- 2. All doors to the garage or laundry room are secured. Yes ___ No ___ N/A ___

GENERAL

- 1. Smoke detectors in all areas of the house (each floor) and tested. Yes ___ No ___ N/A ___
- 2. CO detectors on each floor of house and tested. Yes ___ No ___ N/A ___
- 3. Flashlights are handy throughout the home. Yes ___ No ___ N/A ___
- 4. Resident has all medical information readily available and in an area emergency providers will easily find. Yes ___ No ___ N/A ___
- 5. All heaters are away from any type of flammable material. Yes ___ No ___ N/A ___
- 6. Hot water heater set to 120 degrees. Yes ___ No ___ N/A ___

- 7. Fire extinguisher readily available. Yes ___ No ___ N/A ___
- 8. Fire evacuation plan in place. Yes ___ No ___ N/A ___
- 9. All fire starters locked in a drawer. Yes ___ No ___ N/A ___
- 10. All outlets are covered. Yes ___ No ___ N/A ___
- 11. All appliances grounded. Yes ___ No ___ N/A ___
- 12. No smoking rule. Yes ___ No ___ N/A ___
- 13. Rule to always supervise pets around children. Yes ___ No ___ N/A ___
- 14. All firearms locked away and out of reach. Yes ___ No ___ N/A ___
- 15. Emergency plan in place with emergency numbers available. Yes ___ No ___ N/A ___
- 16. Household is educated in CPR. Yes ___ No ___ N/A ___

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

After evaluation I recommend the resident be considered for the following referrals:

Signature of Guardian/Parent: _____

Signature of Community Paramedic: _____

Reference:

A. "Household Safety Checklists." *KidsHealth*. Ed. Rupal Christine Gupta. The Nemours Foundation, n.d. Web. 11 July 2017.

*Compiled and created by Magen Hall NREMT-P / Community Paramedic
Abbeville County EMS*

Canceled Appointment/Not Home/Refusal of Service

Patient Name: _____

Address: _____

Original Appointment Date: _____

Did the patient call in advance to cancel? _____

Did the patient reschedule for a later appointment? _____

Did the patient refuse services of the CP program? _____

If so, reason for refusal? _____

Patient Signature: _____

CP Signature: _____

Social Assessment Form

Name:			MRN:
Section I- Household Composition			
Name	Age	Relationship	Works/Attends School
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
			<input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home
Section II- Primary Caregiver Assessment			
Name of Primary Caregiver	Age	Relationship	Phone #
Section III- Patient Assessment			
Does the patient attend: <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Retired	If work or school, time: <input type="checkbox"/> days <input type="checkbox"/> evenings <input type="checkbox"/> nights. Days: Mon Tues Wed Thurs Fri Sat Sun		Name of school or employer:
Patient is: <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal	Does the patient take medications? <input type="checkbox"/> No <input type="checkbox"/> Yes		If YES, who gives the medications?
Does the patient use adaptive equipment? <input type="checkbox"/> No <input type="checkbox"/> Yes	If YES, what type of equipment?		
Section IV- Dietary Factors			
Is there a medical reason (e.g. a special diet) that requires the patient's meals to be prepared separately from the family's meals? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, please specify			
Who prepares the patient's		What is their relationship to the patient?	
Does the use assistive devices for eating (e.g., feeding tube, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES, specify:			
Is the patient able to feed self without assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes		If No, Specify the type of assistance needed.	
Section V- Home Environment			
Describe access to home (e.g., stairs, doors, walks, etc.), include recommendation for assistance (e.g. Ramps, Wheel Chair Walker, etc.):			
Describe home living space (e.g., number of bedrooms, bathrooms, etc.):			

Section V –Home Environment Continued	
Describe home location (e.g. rural, urban, on bus line, access to transportation, etc.)	
Where does the patient do laundry?	
Section VI-Social Support System	
List other friends, relatives or neighbors that assist in caring for the patient or in giving relief to the primary caregiver.	
Name	Type of assistance provided
Any other services that the patient is receiving and how often? (list)	

Community Paramedic Signature:

Date:

Physical Environment Assessment Tool

(P.E.A.T. Scale)

Total Score: _____ by observation: by interview: Score unable to obtain:

(Guidelines: 7-16 urgent intervention, 17-27 referral assistance, 28-31 less than optimal, 32-36 healthy)

Dwelling <small>(select all that apply)</small>		Cleanliness <small>(select one)</small>		Social Structure <small>(select one)</small>		Hazards <small>(select one)</small>	
enclosed shelter	2	immaculate	4	lives with other(s)	12	none	12
electricity	2	clutter	3	lives alone	9	possible	9
running water	2	small bio. waste	2	verbal abuse/neglect	6	probable	6
temp. safe	2	large bio. waste	1	phys. abuse/neglect	3	certain	3
add up (0-8)		score (1-4)		score (3-12)		score (3-12)	

notes: _____ Follow up? Y N

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