NORTHERN CALIFORNIA EMS, INC.
1890 Park Marina Drive Suite 200, Redding, CA 96001
Phone: (530) 229-3979 Fax: (530) 229-3984

MEMORANDUM

To: All EMS Stakeholders in the Nor-Cal EMS Region

From: Eric M. Rudnick, FACEP, and FAAEM
Medical Director – Nor-Cal EMS

Date: May 18, 2016

Subject: Clarification of the Scope of Practice for Emergency Medical Responder (EMR) versus First Responders (FR)

As we continue the transition from First Responder (curriculum and scope of practice) to Emergency Medical Responder (curriculum and scope of practice) there has been confusion. There are differences from the GAP Analysis document from the National Association of State EMS Officials (NAEMSO) and the State of California scope of practice. After reviewing California Code of Regulations, Title 22, Chapter 1.5 First Aid and CPR Standards and training for Public Safety Personnel, the GAP Analysis document, and extensive discussions with the Emergency Medical Services Authority I felt that it was necessary to clarify multiple issues.

First, the curriculum for EMR is more extensive with added skills (including optional skills that the LEMSA can authorize). ***The transition from FR to EMR is much more than merely changing the name of the responder!*** Second, Nor-Cal EMS is not going to require EMRs to take the NREMT examination for accreditation, although this is always an option for people who may want to move to other states and be recognized as an EMR. The credentialing process for EMRs will be similar to that of the FRs. Let me take this opportunity to remind providers that the EMS Medical Director authorizes the credentialing to allow them to practice in the EMS environment.

Please note that there is not complete agreement between the GAP analysis document and state regulations. The following are in the EMR curriculum and scope of practice that may not be in the FR curriculum and scope of practice.

1) Active shooter/Hostile event protocol (being developed); basic scope.
2) Administration of oral glucose solution; basic scope.
3) Assist patients with physician prescribed naloxone administration either by auto-injector or intranasal; optional scope.
4) Assist patients with physician prescribed epinephrine auto-injector; optional scope.
5) Control of bleeding, including tourniquet and hemostatic dressings (State of California approved); basic scope.
6) Oxygen administration either by nasal cannula or high flow non-rebreather; basic scope.
7) Bag-Mask-Valve (BVM) utilization; basic scope.
8) Dudote and/or Mark I auto-injector for self or partner administration; optional scope.

9) Both oral and Nasal pharyngeal airway insertion; basic scope. Please note that the NAEMSO Gap analysis document say that it is no longer in scope. However, California still allows this skill.
10) Mass casualty incident training; basic scope.
11) Centers for disease (CDC) trauma triage utilization; basic scope.
12) Suctioning the upper airway only; basic scope.
13) Eye irrigation; basic scope.

In regards to naloxone and epinephrine auto-injector use there is still some controversy. Currently there is California law that enables the lay public to use both the naloxone and epinephrine auto-injectors. In addition, the use of naloxone by First Responders, Emergency Medical Responders, EMTs, Fire, and Law Enforcement should occur once the LEMSA writes enabling protocol. We at Nor-Cal EMS anticipate writing these protocols within the next 6 months. I am working out the details with the Emergency Medical Services Authority (EMSA) to help ensure we are correct in the interpretation of current regulation (Title 22, Chap 1.5 versus other enabling legislation). The sticking point is whether the EMR can assist or administer the auto-injector.

The question of assisting a patient with their own prescribed medications that are either nebulized or aerosolized (inhalers or breathing treatments) is frequently asked. Furthermore, assisting a patient with their own prescribed sublingual (spray or tablet) nitroglycerin (NTG) is also asked. The ability to offer direct assistance with their own prescribed medications as mentioned above is not within either the FR or EMR scope of practice. It is therefore my recommendation that the provider asks the patient whether they have the appropriate medication for the clinical scenario. If the patient responds in the affirmative, then the provider should strongly recommend they take their own prescribed medication(s).

In regards to Optional Scope items listed earlier in the document, the provider (EMR) will need to demonstrate appropriate training and competency for both skills and didactic education. This will be done every two years and require submission to Nor-Cal EMS to be allowed to use the Optional Scope items. It is my recommendation to all EMR instructors that they teach the Optional Scope items and subsequently submit the required data to Nor-Cal EMS.