

OSF Saint James John W Albrecht Medical Center EMS System Policies

0257

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Title of Policy: <i>911 Emergency Calls Initiated from Hospitals</i>	Policy Number: Ops-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

911 Emergency calls made from a hospital can create confusion within the EMS System for the EMS responders as well as the Emergency Dispatching agency. This policy outlines the process to be taken when a 911 call is received from an area hospital.

Policy Statement:

The purpose of this policy is to clarify the process that must be taken when a 911 call is received from a hospital, whether it is initiated in the Emergency Department or from a hospital room.

Policy:

- a. When a 911 call is received at the Emergency Dispatching Center it is not up to the Dispatcher to determine if the call is a true emergency or not. The Dispatcher must page the call out to the appropriate agency just as they would for any other emergency 911 call. When the call is paged, the responding agency should be made aware of the location of the patient.
- b. When a responding agency receives an emergency dispatch to a hospital, they need to notify the hospital that they are responding to through the MERCI radio to the Emergency Department. This information shall be relayed to the Charge RN or Emergency Department M.D. while the agency is en-route to the call.
- c. The Emergency Department Charge RN or M.D. will then forward the information to the appropriate department of the hospital so that they can assess the validity of the call before the EMS personnel arrive. An Emergency Department RN or MD shall meet the responding ambulance at the door when they arrive to direct them to the appropriate area.
- d. When the responding agency arrives in the Emergency Department, they will speak with the charge RN or MD to find out the location of the call and proceed to that area. The EMTs will make direct contact with the patient that initiated the call.
- e. The EMTs along with the patient will determine the outcome of the call. If the patient does not need EMS at that time, then a refusal form will be signed by the patient. If the patient insists on being transported to another facility, then the hospital staff will fill out the appropriate paperwork with the patient for discharge from that facility.

Title of Policy: <i>Abuse of Controlled Substances by System Personnel</i>	Policy Number: DI-101
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Discipline	Approvals: MD, System

Background to Policy:

To insure competent patient care and safety by identifying pre-hospital providers with substance abuse problems and assisting the provider in seeking treatment and/or removal of the provider from the patient care environment.

Policy Statement:

The OSF Saint James EMS System considers substance abuse (drug dependency and/or alcoholism) to be a health problem, and it will assist an EMS System member who becomes dependent on alcohol and/or drugs. The OSF Saint James EMS System and ultimately Systems' patients will suffer the adverse effects of having a pre-hospital care provider whose performance is below acceptable standards. Any respective EMS System member whose substance abuse problems jeopardize the delivery, performance or activities in the care of an EMS System patient requiring medical care, shall be subject to disciplinary action by the EMS Medical Director.

Policy:

- a. Any pre-hospital care provider as a member of the OSF Saint James EMS System who voluntarily requests assistance with a personal substance abuse problem shall be referred directly to the EMS Medical Director for an evaluation and referral for treatment when necessary.
- b. Any pre-hospital care provider as a member of the OSF Saint James EMS System who is suspect to have a personal substance abuse problem and who is suspect of being under the influence of alcohol and/or drugs, while in the provision of emergency care shall be referred to the EMS Medical Director for an evaluation and referral for treatment when necessary.
- c. With the exception of EMS Students, the OSF Saint James EMS System **DOES NOT** require EMS System members to submit to blood and/or urine testing for alcohol and/or drug use.
- d. If the EMS Medical Director has determined that the individual, within reasonable medical certainty, is under the influence of alcohol and/or drugs while in provision of emergency care, and whose performance is below acceptable standards, shall be subject to disciplinary action.
 - i. The first occurrence shall result in a referral of the pre-hospital care provider to the appropriate assistance program and subject to disciplinary action. **The pre-hospital care provider will not be responsible for any associated costs.**
 - ii. The second occurrence, within one year, shall result in disciplinary action as determined by the EMS Medical Director and **may result in suspension of the EMT license and/or System participation.**

- iii. If a System member under the influence of alcohol and/or drugs while engaged in provision of emergency care does not cooperate or refuses physician evaluation and/or treatment, ***the EMSMD shall subject that member to potential suspension of their EMT license and System participation.***
- e. The use, sale purchase, transfer, theft or possession of an illegal drug is a violation of the law. “Illegal drug” means any drug which is; (a) not legally obtainable or, (b) legally obtainable but was not legally obtained. The term “illegal drug” includes prescription drugs not legally obtained and prescription drugs legally obtained but not being used for prescribed purposes. Anyone in violation of illegal drug activities shall be referred to the appropriate law enforcement agency.

Resources:

1. [Substance Abuse- Journal of Emergency Medical Services](#)
2. [Addiction in EMS: The real tragedy behind the headlines-EMS1](#)
3. [Code Green Campaign Resources](#)

Title of Policy: <i>Guideline for the Use of Aeromedical Resources</i>	Policy Number: Ops-102
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To provide guidelines for the appropriate and safe use of aeromedical resources.

Policy:

Aeromedical resources should be used in the following situations.

1. When emergency personnel determine that the time needed to transport the patient by ground to an appropriate facility poses a threat to the patient's recovery.
2. When weather, road or traffic conditions would seriously delay the patient access to ALS care.
3. When critical care equipment and personnel are not available but deemed necessary to care for the patient during transport.
4. When a critically injured patient is entrapped and an extended extrication time is expected.
5. When a critically injured patient is in a location not easily accessed by ground vehicles.

Dispatch Standby Criteria

1. Unless the ground transport time is less than 20 minutes, aeromedical resources should be placed on standby at the time of dispatch for the following MOI:
 - Ejection from the vehicle at highway speed
 - Pedestrian struck by a vehicle at highway speed
 - Motorcycle crash (rider/bike separation) at highway speed
 - Crush/pinning of head, neck or torso
 - GSW to head, neck or torso
 - Falls greater than 20 feet
2. It shall be the responsibility of the personnel requesting the standby to cancel or launch the aeromedical resource after the patient and scene have been properly assessed.

General Guidelines and Considerations

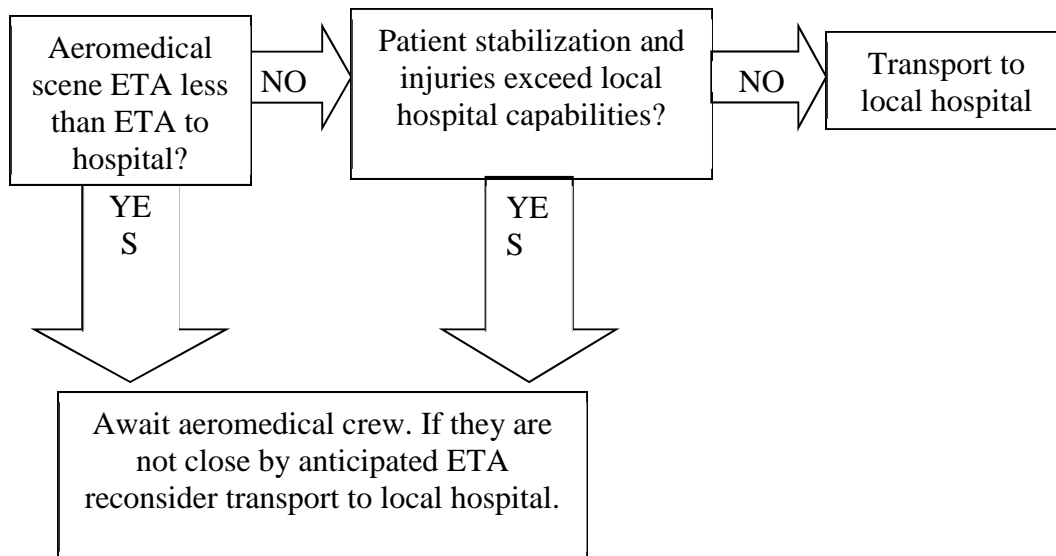
1. In general, when ground transport of a seriously injured or ill patient will exceed 20 minutes, aeromedical resources should be considered. (**Crews should not stay on scene waiting for aeromedical resources if the ETA for aeromedical resources is greater than the transport time to a ED for patient stabilization**)
2. All requests for aeromedical resources shall be made through the agency's dispatch center. Personnel making the request will provide all necessary information that is available.
3. If aeromedical resources are dispatched, an ALS ground unit shall be dispatched at the same time (if not already on scene or enroute).

4. Medical control must be kept informed of any situation in which aeromedical resources are used.
5. Aeromedical transport is contraindicated for patients in cardiac arrest.

Landing Zone Safety Precautions

1. The landing zone (LZ) should be a minimum of 100 foot by 100 foot level (less than 5 degree of slope) area clear of trees, wires and loose debris. For night time operations the LZ should optimally be 150 foot by 150 foot.
2. The four corners may be marked with flares. If flares are used, crews must ensure they are well secured and do not pose additional risks to scene safety.
3. Vehicles may be used to mark the LZ. Position the vehicles at two corners of the LZ with the headlights crossing in the center in the direction of the wind.
4. Monitor statewide MERCI or other frequency as assigned prior to landing as the pilot may select a different landing zone due to safety, wind or other considerations.
5. Personnel shall remain at least 100 feet away from the aircraft during landing and takeoff.
6. Care should be taken to protect eyes from flying debris during landing and takeoff.
7. All loose objects such as blankets shall be secured prior to takeoff and landing.
8. Vehicle strobe lights should be turned off prior to the aircraft landing.
9. Never approach a running helicopter unless accompanied by a core crewmember.
10. When approaching a running aircraft with a core member escort you will always approach and depart from the front of the aircraft after making eye contact with the pilot and being acknowledged, maintaining a crouched position in full view of the pilot. **Never approach or depart aircraft from the rear.**
11. Long objects shall be carried horizontally and no higher than waist high.
12. All IVs should be placed in a pressure bag and secured to the patient.

Aeromedical Consideration Algorithm



Title of Policy: <i>Agency Inspection</i>	Policy Number: A-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To assure that all agency participants of the EMS Systems will meet the respective System and I.D.P.H. standards for equipment and supplies for an EMS vehicle.

Policy Statement:

The OSF Saint James EMS System is responsible to the Illinois Department of Public Health for compliance by their respective EMS Agencies of the Illinois EMS Act [210 ILCS 50], Administrative Code [77 Ill Adm. Code 515] as well as the EMS System Plan for required equipment and supplies.

Policy:

- A. In accordance with the Administrative Code derived from the State of Illinois EMS legislation, inspections may be conducted at any time at any EMS Agency by I.D.P.H. officials, the EMS Medical Director and/or the EMS System Manager/Coordinator.
- B. At the time of these inspections, the respective EMS System Manager/Coordinator shall file a report on the results of the inspection with the EMS Medical Director (EMSMD). If remedial action is necessary, the EMS System Coordinator and/or EMSMD shall make a determination of what shall be required to bring the vehicle or agency into compliance.
- C. Each EMS Agency (FR, BLS, ILS, ALS) is required to complete routine inspection to insure compliance.

Resources:

1. [IDPH 515.830 Ambulance Licensing Requirements](#)
2. [IDPH 515.330 EMS System Program Plan](#)
3. [IDPH 515.810 EMS Vehicle System Participation](#)

Title of Policy: <i>Ambulance Report Requirements</i>	Policy Number: A-101
Effective Date: 10/07/2019	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To insure appropriate documentation of all patient encounters by pre-hospital personnel who are affiliates of the OSF Saint James EMS system

Policy Statement:

Documentation of all patient encounters is essential for record keeping and essential to the continuum of care.

Policy:

- A. All agencies must complete a report for all patient encounters or calls for emergency/non-emergency response.
- B. Report shall be completed using system approved software or forms.
 - a. ESO, Code Red, EM Scan (IDPH)
- C. All reports shall be uploaded to the state database on a monthly basis, no later than the 15th of the following month in accordance with IDPH regulation
- D. All transport agencies must report data to the state database in the NEMESIS version in effect at the time
- E. Reports are to be completed and distributed as soon as possible after the call. If a sufficient reason exists to delay completion of the report immediately after the call, the report must be completed and distributed to the receiving facility within 2 hours of the patient arriving at the receiving facility.
- F. Ideally reports should be left with the receiving hospital immediately after completion of the call. In the event that the reports cannot be left, they must be transmitted by facsimile to the receiving hospital within 2 hours (**Ambulance Short form/notes should be left with all patient transports unless full electronic report is left initially.**)
- G. Agencies and or personnel that fail to meet the requirements of items C and/or D above will be reported to the Medical Director who will take action as is deemed appropriate to insure reports are completed and transmitted in a timely manner
- H. Agencies must be sure to have all patient demographics, reason for call, narrative, times of call.
- I. **All EKG's, paper notes, refusal forms should be uploaded to the electronic report if system is not automatically doing so.**

Resources:

1. [IDPH Section 515 Appendix E](#)
2. [IDPH Section 515.350 Data Collection and Submission](#)

Title of Policy: <i>Assistance by Non-System Personnel</i>	Policy Number: OPS-103
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To clearly delineate the roles of healthcare providers at an out-of-hospital scene to better provide quality patient care and insure compliance with State of Illinois laws and licensing requirements.

Policy Statement:

Only a LICENSED EMS provider or EMS student under the direct supervision of a preceptor, who are approved members of the OSF Saint James EMS System are authorized to perform direct patient care may perform in the out-of-hospital setting. Although, assistance by non-system approved personnel may be have great benefit in specific situations.

Policy:

If unidentified ambulance/EMS personnel arrive at a scene, the following procedures should be performed:

- A. Ask for identification and proof of licensure from any of the following healthcare providers
 - a. First Responder/EMR
 - b. Emergency Medical Technician
 - c. PHRN; or
 - d. SEMSV Aero medical flight crew member

NOTE: The Illinois Nursing Act does not make licensing provisions to allow the Licensed Registered Professional Nurse to provide patient care in the out-of-hospital setting. Only Registered Nurses with licensure from the Illinois Department of Public Health as a PHRN may provide field EMS care. License Registered Professional Nurses are able to provide patient care on patients during interfacility transports.

- B. If their assistance is not needed, excuse them from the scene in a professional manner.
- C. If their assistance is needed, contact medical control and advise of the presence of personnel who are not members of the OSF Saint James EMS System and of their capabilities. Medical control must approve this assistance
- D. Non-System personnel should function under the direction of the EMS transporting agency having jurisdiction over the scene. The member of the OSF Saint James EMS System must stop the non-system personnel if they are performing potentially harmful actions to the patient. If this occurs, the non-system personnel should be requested to cease patient care.

Resources:

1. [225 ILCS 65/ Nurse Practice Act](#)

Title of Policy: <i>Authority of the Associate EMS Medical Director</i>	Policy Number: A-102
Effective Date: 10/07/2019	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To insure a mechanism for the replacement of the EMS Medical Director when the unavailability of the EMS Medical Director occurs and to comply with all statutory requirements of the EMS Act.

Policy Statement:

The OSF Saint James EMS System recognizes the EMS Medical Director will be periodically unavailable (i.e., Out of town work, Vacations, Illness, etc....) to exercise his/her responsibilities as the EMS Medical Director. The Associate EMS Medical Director will function as the EMS Medical Director during the primary EMS Medical Director's absence or at the direction of the primary Medical Director.

Policy:

- A. When the EMS Medical Director has determined he/she will be unavailable to fulfill their responsibilities, he/she shall contact the appointed Associate to ensure of their availability during specific dates and times.
- B. The EMS Medical Director shall obtain from the Associate, his/her contact numbers (i.e., home and work telephone numbers, pager number, cellular telephone number) and his/her work schedule with their basic personal itinerary for purposes of immediate contact, if necessary, by the EMS System Manager/Coordinator and/or by the Medical Control Physician.
- C. When the EMS Medical Director is unavailable to fulfill the duties and responsibilities as the EMSMD, the Associate EMS Medical Director has the delegated full authority to serve as the EMS Medical Director with identical duties and responsibilities as the EMSMD.
- D. If the EMS Medical Director or Associate EMS Medical Director are not accessible, the duties and responsibilities as the EMSMD will be delegated to the on-duty Medical Control Physician with guidance from the EMS System Manger/Coordinator.

Resources:

Title of Policy: Bi-Annual Skill Checks	Policy Number: C-105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

All EMR's (First Responders) are trained in Defibrillation, medications and basic airway management. These skills must be validated/checked twice a year.

All EMT-Basics are trained in defibrillation, airway management and medications. These skills must be validated/checked twice a year.

All EMT-Intermediates/Advanced are trained in defibrillation, advanced airway, IV/IO access and medication administration. These skills must be validated/checked twice a year.

All Paramedics are trained in defibrillation/Cardiac Monitoring, advanced/basic airways, IV/IO/EJ and medication administration. These skills must be validated/checked twice a year.

All PHRN's that operate in the system are required to perform skill checks at the level they are tested at in the system and fall in line with the above levels.

All skill checks MUST also include a pediatric component testing all the same skills as adults for all levels.

PURPOSE

To ensure all skill levels are operating at high standards, providing high quality patient care.

Policy:

1. Skill checks are to be done twice a year.
2. Skill Checks are a requirement for our system to keep proficient in skill level according to licensure level.
3. If EMS personnel are unable to attend their agency's scheduled skill check, it is that person's responsibility to make up the check with their agency or at another agency in the system. (*A provider must attend a skill check that offers the same level as they are able to provide.*)
4. If EMS personnel fails to complete the skill check within **30 days** of the scheduled date, they must contact the EMS office to make up the session and complete a written exam as well. EMS personnel will lose their standing in the system and will not be able to function in the OSF Saint James EMS System.

Title of Policy: <i>BLS IM Injection Program</i>	Policy Number: E-102
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Equipment	Approvals: MD, System

Background to Policy:

For many years, the cost of providing emergency medical care at all levels of EMS has been steadily increasing. One of the most expensive interventions carried by BLS providers was Epinephrine auto-injector. In 2016 the Illinois Department of Public Health altered their stance on allowing EMT-Basics to give IM Injections.

Policy Statement:

This policy lays out the process needed to become a BLS IM approved agency

Policy:

A. Notification

- a. Any BLS agency that wishes to become an IM approved agency will notify the EMS System Coordinator of their intention.
- b. An agency must choose one method or the other. If an agency becomes IM approved they will give both glucagon and epinephrine IM.

B. Training

- a. After the notification, the EMS System will provide a minimum 2 hour training session. Topics to be covered in this session include indications, contraindications, potential complications, and practice of the psycho motor skills.

C. Prescription

- a. After the required training, has been completed, the system will issue an updated prescription for the needed supplies.

D. Equipment

- a. Only equipment that has been placed on the EMS System BLS equipment checklist will be permitted to be carried. Needle and syringe sizes will be prescribed by the system
- b. All BLS system vehicles will be required to carry 1 vial containing 1 mg of 1:1000 Epinephrine. Only vials are acceptable. Glass ampules, which have to be broken open are not acceptable for the BLS level.
- c. All BLS system vehicles that are IM equipped may choose to carry 1 box (1mg) of Glucagon as opposed to the required 2.

Resources:

1. [Illinois Public Act 099-0862](#)

Title of Policy: <i>Bypass Status- Diversion to a Hospital, Trauma Center, or Regional Trauma Center Other Than the Nearest Hospital</i>	Policy Number: Ops - 104
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To clarify for Medical Control and pre-hospital care providers the bypass or the diversion of a patient to a hospital other than the nearest hospital, trauma center or Regional trauma center.

Policy Statement:

Patients of EMS agencies affiliated with the OSF Saint James EMS System shall not be transported to a hospital other than the nearest hospital, Cardiac Cath Center, Regional Trauma Center or Trauma Center unless the EMS Medical Director or a qualified designee (Medical Control Physician) has certified that the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from the transport to the more distant facility, **or the transport is in accordance with the EMS System's Policy, for "Patient Hospital Preference" or "Patient Right of Refusal"**.

Policy:

- A. NO BYPASS OR DIVERSION OF AN EMERGENCY PATIENT(S) TO A HOSPITAL OTHER THAN THE NEAREST HOSPITAL UNDER ANY CIRCUMSTANCES WITHOUT MEDICAL CONTROL PHYSICIAN AUTHORIZATION IS PERMITTED. IT IS THE RESPONSIBILITY AND THE MANDATE BY ILLINOIS STATE LAW THAT THE MEDICAL CONTROL PHYSICIAN IS THE ONLY PERSON WHO MAY AUTHORIZE THE BYPASS OR DIVERSION OF A PATIENT(S).**
- B. Patients of EMS agencies affiliated with the OSF Saint James EMS System shall not be transported to a hospital other than the nearest hospital, Regional Trauma Center or Trauma Center unless the EMS Medical Director or a qualified designee (Medical Control Physician) has certified that, the Medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from the transport to the more distant facility, or the transport is in accordance with the EMS Systems Policy and Procedure for "Patient Hospital Preference" or "Patient Right of Refusal".
- C. The Medical Control Physician may determine a trauma or STEMI patient may benefit from the transport directly to a level I Trauma Center or specialty care center (e.g. Cardiac, burn center), rather than transport to the nearest hospital that is not a trauma or Cardiac center.

- D. REGARDLESS IF A FACILITY IS ON BYPASS STATUS OR NOT, A PATIENT IN A LIFE- THREATENING CONDITION SHALL BE **TRANSPORTED TO THE CLOSEST FACILITY**.**
- E. A hospital can declare a resource limitation under certain circumstances, (i.e., internal disaster, unavailability of critical or monitored beds). Seek Medical Control direction.
- F. **BYPASS STATUS MAY NOT BE HONORED** if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes. Seek Medical Control direction.

Resources:

Title of Policy: <i>Cardiac Monitor and AED on Emergency Vehicles</i>	Policy Number: E-105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Equipment	Approvals: MD. System

Background to Policy:

To assure all approved transport and non-transport EMS response emergency vehicles are equipped with an approved Cardiac Monitor AED.

Policy Statement:

All EMS agencies have the responsibility of providing Emergency Medical Services utilizing a primary emergency transport/non-transport vehicle approved by the EMS System and licensed by the Illinois Department of Public Health. They are required to equip that unit with a Cardiac Monitor or AED in compliance with the specifications of this policy.

Policy:

- A. All automated external defibrillators must be programmed to function only in the “semi-automatic” mode. This means that the EMS provider must hit a button in order for the device to discharge
- B. All automated external defibrillators must meet or exceed the following features and specifications:
 1. Energy level modes to comply with the AHA national standards
 2. Voice prompts for semi-automatic mode
 3. ECG Monitor screen with at least 3 second visual
 4. Code summary documentation print-out
 5. Two (2) rechargeable sealed lead acid batteries
 6. Utilizes defibrillation pads
- C. All EMR and licensed Basic Life Support alternate response EMS vehicles are to be equipped with an A.E.D. Although, if the vehicle is licensed for defibrillation, the A.E.D. must comply with the specification as listed in “B: item 1, item 4 and item 6” of this policy with all other features listed in “B” optional.
- D. A licensed BLS **transport** EMS vehicle should be equipped with a device(s) capable of 12-lead and defibrillation.
- E. A licensed ILS vehicle **must have** the ability to do the above, and synchronize cardiovert/Pace.
- F. A licensed ALS vehicle **must have** the ability of all of the above

Resources:

Title of Policy: <i>Communicable Disease Policy</i>	Policy Number: IC-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Infection Control	Approvals: MD, System

Background to Policy:

- a. To ensure the protection of Emergency Medical Service (EMS) personnel and patients, break the chain of infection of certain diseases, and provide guidance if a significant exposure occurs. Those communicable diseases are but not limited to: HIV, AIDS, Hepatitis, Pulmonary TB, Meningococcal Meningitis and Chicken Pox.
- b. Pre-hospital care providers have an ethical and moral responsibility to provide care to all patients to the best of their abilities. In this role, they place themselves in certain circumstances, at a higher than normal risk of being exposed to blood and body fluids that might contain infectious diseases. When administering care to patients, EMS providers will not always be aware or informed that these patients have a communicable disease. This policy also applies to paramedic students involved with the OSF Saint James Paramedic Program.

Policy Statement:

The following best practices are for the use of protective equipment; the cleaning and disinfecting techniques that have been established in accordance with the Centers for Disease Control.

Policy:

- a. **Treating and Exposure**
 - i. **If you are exposed percutaneously:**
 1. Wipe off blood or fluid and apply alcohol.
 2. After arriving at the hospital, and as soon as patient care allows, wash your hands and the wound.
 3. If the wound is such that requires sutures, seek prompt medical attention.
 4. If you have received a puncture wound, seek medical attention to evaluate your tetanus immunization status.
 - ii. **If you are exposed mucocutaneously:**
 1. Flush your eye(s) or rinse your mouth with saline or water.
 2. After arriving at the hospital, and as soon as patient care allows, wash your face.
 3. Seek medical advice if further treatment or evaluation is necessary.
- b. **Protective Measures**
 - iii. The best way to avoid exposures to body fluids is to use protective procedures on all responses. It is better to enter a situation with protective gear in place than to delay treatment while you put on protective clothing.
 - iv. All pre-hospital care personnel must wash their hands before and after contact with any patient. This should be done regardless of the use of gloves.

- v. Before reporting for duty, cover any cuts, abrasions, or insect bites with a dressing.
- c. **Needles and Syringes**
 - vi. Needles should be disposed of in a red biohazard, rigid, puncture-resistant container kept inside the back compartment of the ambulance. Needles should never be recapped or intentionally bent or broken. Also, a needle cutting device should not be used. There are new products on the market that employ a guard that automatically locks into place around the needle as you withdraw in from the patient. Your local ambulance distributor should be contacted for purchase of those devices.
- d. **Cleansing of Ambulance and Equipment**
 - vii. The ambulance and equipment used should be cleansed with a 1:10 bleach solution after each patient use or other commercially available cleaning solution approved for biohazards. Appropriate personal protective equipment should be used when cleaning any contaminated surface.
- e. **Soiled Clothing**
 - viii. According to the Center for Disease Control, they recommend the following: Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed with detergent in water at least 71° C (160°F) for 25 minutes. If low-temperature water (70°C [158°F]) in the laundry cycle is used, chemicals suitable for low-temperature washing at properly used concentration should be used.
- f. **Masks**
 - ix. Masks should be worn whenever there is direct contact with a patient that has a transmissible respiratory disease. Masks must also be worn when there is a risk of blood or body fluid splashing onto mucous membranes, such as when intubating or suctioning a patient, or when you are caring for a patient with major bleeding.
- g. **Protective Eye Wear**
 - x. Use of glasses or goggles is recommended when there may be splattering of blood or bodily fluids.
- h. **Gloves**
 - xi. Gloves should be utilized when there will be contact with blood or other body fluids from a patient. Any open cut or any skin dermatitis that leaves skin open (i.e., eczema, psoriasis) on pre-hospital care personnel should be covered with a sealed moisture proof covering. These precautions should be taken before the EMT leaves the ambulance to care for a patient.
- i. **Cardiopulmonary Resuscitation**
 - xii. Disposable resuscitating masks and one-way airways should be carried in all ambulances and easily retrievable when the need arises. **No one** should be administering unprotected mouth-to-mouth resuscitation.
 - xiii. Guidelines for Use of Protective Gear during CPR:
 - 1. Gloves: The following types of gloves must be available to pre-hospital personnel

- a. Heavy duty leather gloves for performing light extrication or assist with Extrication tasks.
 - b. Medical-grade gloves for patient care procedures that require dexterity and sensitivity but may involve contamination of the hands with blood or body fluids. Procedures may include IV insertions, dressing and splinting open injuries, and establishing airways.
 2. Hepa Mask
 - a. If EMS personnel believe that blood or body fluids might be splashed in their face, they should utilize a medical-grade face mask.
 3. Eye Protection
 - a. Plastic goggles are available for situations in which blood or body fluids could be splashed into the eyes, of such a design that allows clear vision and does not obstruct peripheral vision.
 4. Airway management
 - a. Respiratory assist devices should be utilized whenever possible and are to be of a disposable type only.
- j. **Sharps**
 - xiv. Special care should be taken when handling sharp needles, objects, and glass. Needles should not be recapped, bent or broken. Needles and other sharp objects should be disposed of properly in the heavy puncture-proof plastic containers in the ambulance.
- k. **Hand washing**
 - xv. Hands are to be thoroughly washed after each patient transport and as soon as patient care allows. In the field, waterless hand cleaners and alcohol are available for hand washing; hands are to be thoroughly cleaned with soap and water as soon as the necessary facilities are available.
- l. **Cleaning Procedures**
 - xvi. Non-critical types of equipment such as spinal immobilization devices, stretchers, blood pressure cuffs, stethoscopes, etc. are to be thoroughly cleaned with hot water and disinfectant detergents, such as a 1:10 dilution of bleach.
 - xvii. Critical items that come in contact with mucous membranes but are not disposable, such as laryngoscope blades require high level disinfection with a Cidex or 70% Isopropyl alcohol solution for at least thirty (30) minutes.
 - xviii. **Always wear gloves when cleaning and disinfecting pre-hospital equipment.**
 - xix. **Interior of Transport Vehicles**
 1. For the interior of transport vehicles, routine and consistent cleaning procedures with detergent disinfectants and hot water will provide adequate decontamination. The use of bleach is not recommended since repeated applications corrode metal and may damage some equipment.
 - xx. **Care of Clothing**

1. Routine laundering practices are adequate to decontaminate clothing that is soiled with blood or body fluids, utilizing hot water (106°F) and detergent.

m. Ineffective Procedures

- xxi. All disinfectants require a clean surface before they can work.
- xxii. The spraying of disinfectants is not recommended. Sprays are applied unevenly so that the amount sprayed may not disinfect the area adequately. Spray disinfectants can cause electrical equipment to malfunction.

n. Types of Disinfectants and Antiseptics:

- xxiii. Commercial available biohazard substance cleaning substances.

xxiv. Bleach

1. Uses

- a. As a powerful anti-microbial agent, bleach is recommended for cleaning up fresh un-dried blood spills or surfaces that are difficult to clean. Good disinfectant for plastic materials.

2. Concentration

- a. 1:10 dilution (5000ppm) = 1 cup of bleach to 9 cups water (slightly more than ½ gallon).

3. Contact time

- a. Thirty (30) minutes.

4. Precautions

- a. Highly corrosive to metal even at low concentrations. Can hamper the function of electrical connections and electronic equipment. Can decolorize fabrics. Undiluted and 1:10 dilutions can cause eye, skin and respiratory irritations.

xxv. Alcohol, 70% Isopropyl

1. Uses

- a. Can be used around electrical connections and electronic equipment because it leaves no ionic residue and does not corrode metal. A good skin antiseptic; the primary anti-microbial ingredient of most waterless hand washing products.

2. Contact time

- a. Five (5) to thirty (30) minutes for high-level disinfection.

3. Precautions

- a. Equipment must be immersed for disinfection; not recommended for disinfection of surfaces that cannot be immersed since it evaporates quickly. Flammable; inactivated by the presence of blood and dirt; can stiffen and crack plastic. May dry and irritate the skin.

xxvi. Glutaraldehyde, 2%

1. Uses

- a. Powerful disinfectant; can kill bacteria, fungi, viruses. Most commonly utilized for respiratory equipment disinfection. Can work in the presence of blood and

dirt. Acid Glutaraldehyde does not corrode metal; most brands will not affect plastic or rubber.

2. Contact time
 - a. Ten (10) to thirty (30) minutes for high-level disinfection.
3. Precautions
 - a. Alkalized Glutaraldehyde will corrode and stain high-carbon metals such as stainless steel and leave residue on same. Unstable, expensive products that must be mixed freshly with each use to maximize effectiveness. Must never be used to disinfect environmental surfaces. Can cause burns on human skin and mucous membranes and are eye and respiratory irritants.

xxvii. Hydrogen Peroxide

1. Uses
 - a. Good for dissolving dried blood and body fluids from the surfaces of equipment. Can be used as a skin and oral antiseptic.
2. Concentration
 - a. 3%
3. Contact time
 - a. Reacts immediately upon contact.
4. Precautions
 - a. A 3% solution is not considered a disinfectant, so cleaning and decontamination are still required.

xxviii. Iodophors

1. Uses
 - a. Excellent skin antiseptics
2. Concentration
 - a. Varies with product.
3. Contact time
 - a. Must dry in air for maximum effectiveness
4. Precautions
 - a. Not recommended for disinfecting equipment. Corrode metal, dissolve rubber, crack plastic and stain metals. Can irritate fresh, open wounds or burns.

xxix. Phenolic and Quaternary Ammonium Compounds

1. Uses
 - a. Common classes of hospital environmental disinfectants.
2. Concentration
 - a. See manufacturers' recommendation.
3. Contact time
 - a. See manufacturers' recommendation
4. Precautions

- a. Should not be used to disinfect equipment; leave ionic residues; if used consistently for routine cleaning, these compounds must be stripped periodically from all surfaces. Affect the function of electrical and electronic equipment. Must be used exactly in accordance with label instructions. Material Safety Data Sheets should be obtained for these products.
- xxx. Detergent Disinfectants**
- 1. Uses
 - a. For cleaning and decontaminating environmental surfaces, non-critical equipment and laundering. Available in grocery stores. The words “disinfectant” and “detergent” are clearly visible on the label. Registered with the EPA because they are labeled as disinfectants.
 - 2. Concentration
 - a. See label instructions.
 - 3. Contact time
 - a. See label instructions.
 - 4. Precautions
 - a. See label instructions.
- o. Significant Exposure**
- xxxi. Definition:** *Significant Exposure* means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that resulted from the performance as an EMS provider.
 - xxxii. Classifications of EMS Providers**
 - 1. EMS Students
 - 2. First Responders, EMT-B, EMT-I, EMT-P
 - 3. Other ambulance service personnel
 - xxxiii. Procedure for Exposure Incident**
 - 1. Any EMS Students or EMS Systems member with significant exposure in the clinical setting (i.e. Emergency Department, ALS Unit...) must report the incident to their educational supervisor and the EMS System office.
 - 2. Any EMT or other ambulance service/rescue personnel with significant exposure shall report the incident immediately to their agency supervisor, Director, Chief or Command Officer. The Individual must comply with the guidelines of their agency’s “Exposure Control Program”.
 - 3. Complete a detailed incident report including, but not limited to the following:
 - a. Documentation of the route(s) of exposure, and the circumstance under which the exposure incident occurred;
 - b. Identification and documentation of the source individual.
 - 4. Seek treatment at the emergency department of the hospital clinical site or where the source individual was transported, if transported to an emergency department.

5. If the patient was not transported to an emergency department, treatment should be sought at a local emergency department. NOTE: ***An EMS employer may require an individual to seek medical attention at a medical facility contracted with the EMS Agency to provide such services that is not an emergency department.***
6. Complete follow-up care as directed.

Resources:

1. https://www.ems.gov/pdf/workforce/Guide_Infection_Prevention_EMS.pdf
2. <http://www.emsworld.com/article/10322573/best-practices-infection-control>
3. <http://centegra.org/wp-content/uploads/2013/06/Infection-Control-Guidance-for-EMS-Providers.pdf>

Title of Policy: <i>Communications Etiquette</i>	Policy Number: C-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Communications	Approvals: MD, System

Background to Policy:

To assure that appropriate and complete radio communication exists in the OSF Saint James EMS System.

Policy Statement:

All OSF Saint James EMS System agencies communicate with area hospitals on a daily basis. To reduce the circumstances that may lead to misinformation or misunderstandings when transmitting patient information and treatment orders, criteria have been developed which comply with regulations of the Federal Communications Commission.

Policy:

- a. Only the precise air time necessary to transfer essential patient care information should be utilized by all EMS providers and all Medical Control sites, whether on UHF radio, VHF radio, or cellular phone.
- b. If it is necessary to transmit telemetry ECG recordings to Medical Control, the life net system shall be utilized. Failures of the Life Net system should be reported to the EMS office within 1 business day.
- c. Medical Control is the designated authority to elicit efficient radio transmissions as circumstances arise.
- d. Voice communications must remain professional at all times. Foul language must never be used as it is an illegal act. Do not use slang or other words that may not be commonly spoken in the region. In addition, providers and ECRN's should be aware of their tone of voice, and remain professional.
- e. Do not use 10 codes.
- f. Any violation of this policy shall be reported to the EMS System immediately via an incident report and may result in disciplinary action.

Resources:

Title of Policy: <i>Communications Recording Procedures</i>	Policy Number: C-101
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Communications	Approvals: MD, System

Background to Policy:

To ensure recording of all patient care information given via radio and cellular telephone communications and provide operational guidance to the ECRN and Medical Control Physician.

Policy Statement:

The following guidelines have been established to assist the ECRN or the Medical Control Physician in the proper procedure of recording all in-bound, pre-hospital patient care information. The purpose for recording all calls is two-fold. First, is to seek Continuous Quality Improvement through retrospective evaluation of out-of-hospital care and secondly, to validate patient care in cases of litigation.

Policy:

- a. All EMS communications at the operational medical control points shall be recorded.
- b. The radio should be programmed at all times for automatic recording.
- c. All communication where patient information was received and Medical Control provided verbal orders shall be documented in the ECRN radio log.
- d. Any failure in the communications system requires immediate corrective action. If the communications system fails at the primary Resource Hospital, refer to the Emergent Transfer of Resource Hospital policy.
- e. Any failure in the communications system, requires the completion of an "EMS System Incident Report" and forwarding the report to the EMS System office.

Resources:

1. [EMS System Incident Report Form](#)

Title of Policy: <i>Conceal Carry Policy</i>	Policy Number: OPS 105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

Policy Statement:

The purpose of this policy is to outline common expected procedures for intervening with patients and/or their families who under the law may be carrying a concealed deadly weapon. The intent is to reduce the potential risk of injury to emergency responders, healthcare personnel and the public. This policy aims to mutually respect the right of citizens who lawfully carry a concealed weapon as well as to provide safety for emergency responders and healthcare providers.

Policy:

1. The OSF Saint James EMS System policy is that EMS personnel who have a Conceal Carry Weapon permit shall not knowingly bring any firearm onto any prohibited area.
2. At no time shall open carry (“OC”) and/or Conceal Carry Weapon (“CCW”) be permitted when on official EMS business, to include, meetings, emergency response, training or any other function of OSF Healthcare or on any EMS organizations’ properties. The only exception to this is if the EMS provider is a sworn law enforcement officer that is on duty at the time.
3. It is further the policy of OSF Saint James EMS system that patients and visitors shall not have weapons on their persons while on any and all EMS property which also includes transport and/or non-transport vehicles.

Applicable Scenarios

- A. Conscious patients willing to relinquish a weapon
- B. Conscious patients unwilling to relinquish a weapon
- C. Patients with altered levels of consciousness
- D. Family members and/or friends of a patient who have weapons and want to be with the patient in emergency response vehicles
- E. Chain of custody transfer between emergency responders and medical facilities

General Guidelines

- A. Emergency responders and healthcare personnel should always assume that all firearms are loaded.
- B. Optimally, weapons should be safely secured by the patient at their residence and not be transported with the patient or family/friend in an emergency response vehicle or to a healthcare facility.
- C. Optimally, a patient with a CCW away from their residence should be taken control by local law enforcement. The goal is for the EMS provider to minimally handle any weapon.
- D. All OSF Saint James EMS System members who are licensed to carry a concealed weapon and doing so at the time of a call should secure their weapon either at home or in their personal vehicle prior to entering the station, entering response equipment or entering a scene.
- E. For EMS personnel with a CCW arriving on scene from home, the weapon must remain secure in their personal vehicle. Privately remove the weapon and place the weapon in the lock box in their personal vehicle. Place the key in a pocket until the weapon has been retrieved after completion of the call.
- F. Patients with an altered level of consciousness, severe pain, or with difficulties in motor control should not be encouraged to disarm themselves. An emergency response or healthcare worker may need to obtain control of the weapon for the safety of responding personnel, the public and the patient. Caution should be used at all times when handling a weapon. Emergency response and healthcare workers should not attempt to unload a firearm. Regardless of a person's familiarity with firearms, there is no way to know if the gun is in proper working order.
- G. A public or private hospital, hospital affiliate, hospital parking lot, nursing home or mental health facility is a no carry zone. Other no carry zones include:
 - 1. Any building, real property, and parking area under the control of a public or private elementary or secondary school.
 - 2. Any building, real property, and parking area under the control of a preschool or child care facility, including any room or portion of a building under the control of a pre-school or child care facility.
 - 3. Any building, parking area, or portion of a building under the control of an officer of the executive or legislative branch of government.
 - 4. Any building designated for matters before a circuit court, appellate court, control of the Supreme Court.

5. Any building or portion of a building under the control of a unit of local government.
6. Any building, real property, and parking area under the control of an adult or juvenile detention or correctional institution, prison, or jail.
7. Any bus, train, or form of transportation paid for, in whole or in part with public funds, and any building, real property, and parking area under the control of a public transportation facility paid for in whole or in part with public funds.
8. Bars or other establishments that serve alcohol.
9. Any public gathering or special event conducted on property open to the public that requires the issuance of a permit from the unit of local government.
10. Any public playground.
11. Any public park, athletic area, or athletic facility under the control of a municipality or park district.
12. Any building, classroom, laboratory, medical clinic, hospital, artistic venue, athletic venue, entertainment venue, officially recognized university-related organization property, whether owned or leased, and any real property, including parking areas, sidewalks, and common areas under the control of a public, or private community college, college, or university.
13. Any building, real property, or parking area under the control of a gaming facility licensed under the Riverboat Gaming Act or the Illinois Horse Racing Act of 1975, including inter-track wagering location licensee.
14. Any stadium, arena, or the real property or parking area under the control of a stadium, arena, or any collegiate or professional sporting event.
15. Any building, real property, or parking area under the control of a public library.
16. Any building, real property, or parking area under the control of an airport.
17. Any building, real property, or parking area under the control of an amusement park.
18. Any building, real property, or parking area under the control of a zoo or museum.
19. Any street, driveway, parking area, property, building, or facility, owned, leased, controlled, or used by a nuclear energy, storage, weapons, or development site or facility regulated by the

federal Nuclear Regulatory Commission. The licensee shall not under any circumstance store a firearm or ammunition in his or her vehicle or in a compartment or container within a vehicle located anywhere in or on the street, driveway, parking area, property, building, or facility described in this paragraph.

20. Any area where firearms are prohibited under federal law.

- H. EMS agencies are encouraged to designate themselves as a weapons-free facility. No-carry signage should be clearly posted in emergency squads and EMS facilities. Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles or in hospitals that have declared themselves as no-carry zones.
- I. Under no circumstances should an emergency responder or healthcare worker compromise his/her safety in regards to these guidelines. When in doubt about a patient with a weapon or the weapon itself, emergency responders and healthcare personnel should contact local law enforcement. Law enforcement officers will make the decisions regarding disarming the patient and the weapon.
 - 1. **Note:** *Do not ask the patient whether he/she has the right to carry a weapon. If the person has no legal right, they may become alarmed and cause EMS personnel harm.*
 - 2. All weapons are removed from the patient. The only exception is a conscious and alert law enforcement officer. No EMS personnel shall provide medical care to an armed person.

Conscious Patient Willing to Relinquish a Weapon

- A. Patients who are alert and oriented and for whom the emergency response is occurring at their place of residence should be asked to leave their weapons in a secure location at home prior to transport. Patients should be told that EMS vehicles are no carry zones.
- B. Patients for whom the emergency response is occurring away from their residence may relinquish their weapon to law enforcement officer on scene if one is available.
- C. If patient is not at their residence or if a law enforcement officer is not available, emergency response personnel should do the following:
 - 1. Place weapon into the "Lock Box."
 - 2. Secure the Lock Box with a numbered security seal and place the Box in a locked exterior vehicle compartment for transport.
 - 3. Complete and have the patient sign the Chain of Custody Form

4. Conduct a thorough secondary survey.
5. If additional weapons are found, begin again at Step (1). If no additional weapons are found, load the patient into the vehicle and transport to an appropriate medical facility.
6. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
7. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.
8. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody form*.
9. Medical facility personnel shall give an empty replacement box to the emergency responders.

Conscious Patient Unwilling to Relinquish a Weapon

- A. Emergency responders should engage alert and oriented patients in calm discussion about the rationale to secure the weapon prior to transport. Simple explanations can be given including that these regional guidelines are in place.
- B. If the patient continues to refuse to relinquish the weapon, emergency responders should refrain from continuing the assessment and from transporting to a medical facility.
- C. EMS Providers should be suspicious of ill or injured patients unwilling to relinquish weapons.
- D. Law enforcement shall be called to intervene in the situation.
- E. If the situation becomes threatening, emergency responders should evacuate the scene to a secure rendezvous point a safe distance away and notify law enforcement.

Patients with Altered Levels of Consciousness

- A. Emergency responders must use extreme caution when approaching patients with altered levels of consciousness.
- B. If a weapon is found on an awake patient with an altered level of consciousness, emergency responders should not attempt to have the patient hand over the weapon. EMS personnel should

not attempt to remove a weapon from a patient whose level of consciousness could precipitate use of that weapon against them. Law enforcement should be called to assist in disarming these patients. If a weapon is removed by a law enforcement officer, the officer will maintain possession of the weapon.

- C. If the patient is unconscious and requires emergent care but law enforcement is not on the scene, emergency medical services (EMS) personnel will need to carefully separate the weapon from the patient prior to transport. **Optimally a firearm should be removed from the patient while still in the holster.** If removing the holster and weapon together jeopardizes the safety of the patient or emergency response personnel, or it is physically impossible to remove the holster and firearm together, the weapon may be removed without the holster. Once removed, emergency response personnel shall:
1. Handle all weapons carefully as they will most likely be loaded and may not have an engaged safety.
 2. Place the weapon or weapon-in-the-holster into the Lock Box.
 3. Secure the Lock Box with a numbered security seal and place the Box in the locked exterior vehicle compartment for transport.
 4. Complete the *Chain of Custody Form*.
 5. Conduct a thorough secondary survey.
 6. If additional weapons are found and removed, begin again at step (1). If no additional weapons are found, load the patient into the vehicle and transport to an appropriate medical facility.
 7. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
 8. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.
 9. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form*.
 10. Medical facility personnel shall give an empty replacement box to the emergency responders.

Family Members and Friends Who Have Weapons and Want to be with Patients in Emergency Response Vehicles

- A. The decision to transport family members and/or friends with the patient solely rests with existing policies of individual emergency response agencies.
- B. Agencies that permit transport of family/friends with the patient shall;
 - 1. Ask the family member/friend to declare if they have a concealed weapon.
 - 2. Explain that no unsecured weapons may be transported in the emergency vehicle.
- C. If a family member/friend discloses a concealed weapon AND the patient's condition is such that the emergency medical personnel deem it in the best interest of the patient to transport the family member/friend with them:
 - 1. The family member/friend should be instructed to leave the weapon in a secure place at the home. If the family member/friend refuses, emergency response personnel have the prerogative to decline transport of the family member/friend with the patient. No family member/friend should be transported with an unsecured weapon.
- D. If the scene is not at the family member's/friend's residence, or circumstances prevent the weapon from being secured in the home:
 - 1. Have the family member/friend place the weapon into the Lock Box.
 - 2. Secure the Lock Box with a numbered security seal and place the Box in a locked exterior vehicle compartment for transport.
 - 3. Complete and have the family member/friend sign the *Chain of Custody Form* (Attachment A).
 - 4. If additional weapons are discovered, begin again at Step (1). If no additional weapons are discovered, load the patient into the vehicle and transport to an appropriate medical facility.
 - 5. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
 - 6. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.

7. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form*.
8. Medical facility personnel shall give an empty replacement box to the emergency responders.

Patients Transported via Emergency Responders to a Medical Facility

- A. EMS should make every attempt to screen all patients for concealed weapons prior to transport to a medical facility.
- B. Patients with concealed weapons that could not be secured at their residence may have had them placed in a Lock Box by emergency personnel. In the absence of an established community protocol whereby the local law enforcement agency of the emergency responders meets the transport vehicle at the medical facility to assume control of the weapon, medical facilities may need to assume control when the patient is delivered.
- C. While en route, emergency response personnel shall notify the receiving facility that a weapon is being transported in a Lock Box with the patient.
- D. Facility security personnel shall meet the transport vehicle at the doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with coded snap locks in place.
- E. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form*.
- F. Facility security personnel shall give an empty replacement box to the emergency responders.

Lock Box

- A. A System-wide exchange program is established under these guidelines such that all emergency response agencies and healthcare facilities participating shall purchase similar safety boxes to secure deadly weapons. The recommended new box is manufactured by Flambeau. The box name is the "Flambeau Safe Shot Pistol Gun Case, 14-inch Polymer Black," product number 682841 (Attachment B).
- B. Each participating agency shall procure their own boxes. Each agency shall draw/paint a gun template with indelible medium outside of the Lock Boxes to indicate the direction of the barrel of a stored firearm. A gun template is attached with these guidelines (Attachment C).

- C. These Lock Boxes shall be secured with a numbered security seal to document a chain of evidence. Emergency response agencies and healthcare facilities shall procure their own locks. Each Lock Box shall have an outside label indicating “CAUTION: DEADLY WEAPON (Attachment D).”
- D. Lock boxes containing weapons must be stored in a secure, locked storage compartment or cabinet by emergency response agencies and healthcare facilities. The Lock Boxes will be exchanged at the interface of emergency responders and healthcare facilities when patients are delivered who had a weapon that could not be left at their residence.
- E. Emergency response personnel shall hand-over a Lock Box secured with coded snap locks to a healthcare facility security officer. In exchange the healthcare security officer will provide an empty box back to the emergency responder. The intent is to minimize the handling of potentially dangerous weapons by emergency response and healthcare facility staff. Additionally, at the discretion of the emergency response agency, a family member/friend may be transported with the patient. If the family member/ friend has a weapon and is transferred, the family member’s/friend’s weapon must also be secured and given to a healthcare facility’s security staff by emergency response personnel. As above, the healthcare facility security officer and emergency responder shall exchange the Lock Box with the weapon for an empty Lock Box.

Activities Which Shall Result in Immediate Licensure Suspension

- A. Attempting to engage a “safety” or undoing a “safety” on a handgun, stun gun or pepper spray.
- B. Treating a gun as if it were not loaded.
- C. Unloading a gun.
- D. Failure to place a weapon in a Lock Box.
- E. Showing off a weapon or flashing a weapon.
- F. Making remarks about violence with a weapon
- G. Bringing a weapon into a prohibited area while on duty.

Title of Policy: <i>Continuous Quality Improvement Policy</i>	Policy Number: Ops - 107
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Policy Statement:

The OSF Saint James Medical Center EMS System will participate in a Quality Improvement Plan (including adult and pediatric population) developed by the EMS System. All information collected and reviewed by the QI plan is strictly confidential. Any breach of this confidentiality will result in system discipline.

PURPOSE

To ensure that quality patient care is provided by EMS personnel to citizens of their communities and to identify areas of improvement and excellence.

Policy:

1. All EMS personnel will file the appropriate EMS run report on all calls, filling them out accurately and completely.
2. EMS run reports will be completed electronically and locked per reporting system guidelines
3. A QI Schedule will be prepared for each year identifying the subject areas to be reviewed and the specific identifiers. Additional subject areas will be added as appropriate.
4. EMS run reports will be reviewed by EMS Office staff for appropriate documentation, time parameters set forth by the medical director and protocol adherence within the specified subject areas and report to each agency.
5. All QI material will be reviewed by the EMS system and EMS Medical Director and brought to the appropriate regional committee meetings as needed.
6. Any major deficiencies found will be immediately reviewed by the EMS System Manager/Coordinator and EMS Medical Director and brought to the EMS Provider and the EMS agency for appropriate corrective actions.
7. Training Program applications and schedules with objectives will be submitted to the EMS system for approval prior to submitting the documents to IDPH for approval and site code issuance.
8. Training Programs will have class and instructor evaluations on a regular basis and will be reviewed by the EMS Office.
9. Yearly CE Schedules with objectives and applications will be submitted to the EMS System for approval prior to submitting the documents to IDPH for approval and site code issuance.

10. EMS Transporting Agencies (Ambulances) will be inspected annually by IDPH and the EMS System on their respective anniversary dates to ensure all required equipment and supplies are in order. Unannounced ambulance inspections may be conducted when deemed necessary.
11. EMS Non-Transporting Agencies will be inspected by the system or self-inspection prior to the expiration date of their Non-Transport License. (February). These inspections will be scheduled by the EMS System. The EMS system shall decide if the service will be conducting a self-inspection or the system will be conducting the inspection.
12. All Quality Improvement information will be kept on file in the EMS Office.
13. The EMS System Manager/Coordinator will oversee all QI activities within the EMS system.

Resources:

Title of Policy: <i>EMS Staffing</i>	Policy Number: OPS 108
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD , System

Policy Statement:

To ensure proper vehicle staffing for all EMS vehicles operating within the OSF Saint James EMS System.

PURPOSE

To stay within the rules and regulations of IDPH and EMS system policies.

Policy:

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Transports/Non-Transport Vehicles

1. First Responder/EMR
 - a. Each FR/EMR vehicle shall be staffed 24 hours a day, every day of the year unless approved IDPH staffing waiver is in place, with 2 certified First Responders/EMR's.
2. BLS
 - a. Each BLS vehicle shall be staffed 24 hours a day, every day of the year unless approved IDPH staffing waiver is in place, with 2 EMT-Basics.
3. ILS/Advanced
 - a. Each ILS vehicle shall be staffed 24 hours a day, every day of the year unless approved IDPH staffing waiver is in place, with at least one EMT-Basic and one EMT Intermediate/Advanced. (Can also be staffed with 2 EMT I/Advanced)
4. ALS
 - a. Each ALS vehicle shall be staffed 24 hours a day, every day of the year unless approved IDPH staffing waiver is in place, with 2 Paramedics or One Paramedic and one EMT B or I/Advanced.

Ambulance Assist Vehicles – Dispatched same time as Ambulances and equipped same as non-transport but only needs one licensed provider at the same level as the vehicle is licensed for.

Resources:

Title of Policy: <i>EMS Staffing Waiver Provision</i>	Policy Number: Ops - 109
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Policy Statement:

The Illinois Department of Public Health allows providers to petition for a waiver if unreasonable hardship results from compliance requirements of the EMS Act or its Rules and Regulations or System Program Plan.

PURPOSE

Assist in agencies ability to respond to an emergency call providing care to the sick and injured.

Policy:

1. The petition shall be in writing and contain the following information:
 - a. An explanation as to why the waiver is necessary.
 - b. A written description of the alternate means of handling of the matter.
 - c. A projected target date and action plan of correction for compliance with the requirement in petition to be waived.
2. The provider will submit the petition to the EMS office and the Project Medical Director for review. They will make recommendations to the waiver and agency before sending the waiver to IDPH where they will evaluate the waiver and consider approval.
3. Once approval is given by IDPH, EMS office will notify agency of approval and monitor agency to ensure action plan is being followed.

Resources:

Title of Policy: EMS <i>Consent for Treatment of Minors</i>	Policy Number: L-102
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To assure EMS personnel do not accept a minor's consent or refusal for consent in emergency situations and when a consent or refusal from a parent or legal guardian cannot be quickly obtained, it is understood implied consent is given as the legal basis to provide pre-hospital care and transportation to the hospital.

Policy Statement:

EMS personnel must take special care in dealing with minors. As a matter of law, minors DO NOT have the ability to consent or refuse consent. It does not matter how rational or intelligent the minor may be- the minor's inability to consent always exists. Only a minor's parent or legal guardian has the legal authority to give consent. In cases of an emergency and/or consent from another party cannot be quickly obtained, the EMS provider in either situation must provide treatment and transport to the nearest emergency department.

Policy:

DEFINITIONS:

EMERGENCY: A medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Illinois EMS Systems Act [210 ILCS 50] Section 3.5)

MINOR: A minor is anyone under the age of 18. The parent or legal guardian of a minor may consent to treatment on the minor. The parent or guardian need not be 18 years of age or older to consent. (Illinois Revised Statutes Chapter 111, Section 4502)

IMPLIED CONSENT: Situations involving an unconscious patient where care is initiated under the premise that the patient would desire such care if they were conscious and able to make the decision. In the case of a minor, if a parent or legal guardian is not present, care and transportation is given on a basis of Implied Consent.

- A. Minors DO NOT have the ability to consent or refuse consent. It does not matter how rational or intelligent the minor may be-the minor's inability to consent always exists.
- B. Only a minor's parent or legal guardian has the legal authority to give consent. In cases of an emergency and/or consent from a parent or legal guardian cannot be quickly obtained, the EMS provider in either situation must provide treatment and transport to the nearest emergency department.
- C. If the minor's parent or legal guardian is present at the scene, consent or refusal of care must be obtained from the parent or legal guardian.
- D. In the situation of a minor requiring emergency treatment but the parent or legal guardian do not consent due to religious beliefs, then the EMS provider should advise the parent or guardians of the risks involved and follow the Patient Right of Refusal policy.

- E. When faced with a questionable consent problem, in all cases, contact Medical Control.
- F. Exceptions based on minor's legal status are as follows:
- Emancipated (1), Pregnant or Married Minors may consent for their own treatment:** A minor between the age of 16 and 18 years old who presents a court order declaring him or her emancipated, or a pregnant or married minor of any age, may lawfully consent to the performance of any medical or surgical procedure. (2)
 - Minors who are parents may consent for their own treatment:** A minor who is a parent may lawfully consent to his or her own health care treatment. (3) But, if the minor's status as a parent ends, for example, if the minor gives up his or her child for adoption, then it would appear the minor no longer has authority to consent to his or her own treatment.
 - Minors who are parents may consent for their child's treatment:** Any parent, including a parent who is a minor, regardless of age, may consent to health care on behalf of his or her child. (4) This provision applies to parents who are divorced or separated; either parent may consent for the child, so long as the divorce decree or custody order does not state otherwise. The hospital does not have an obligation to investigate the terms of the divorce decree or custody order. In most cases, it is sufficient if a parent is present and seeking care for his or her child.
 - Inpatient Mental Health Services:** A minor 16 of age or older may consent to admission to a mental health facility for inpatient services if the minor himself executes the application for voluntary admission. Unlike outpatient services, providers must immediately inform the minor's parent, guardian or person in *loco parentis* (5) of the admission, even if the minor does not consent to the disclosure. (6)
 - Birth Control Services:** Birth control services and information may be rendered by doctors licensed in Illinois to any minor: (1) Who is married, (2) Who is a parent, (3) Who is pregnant, (4) Who has the consent of his parent or legal guardian; or (5) If the failure to provide such services creates a serious health hazard; or (6) If the minor is referred for such services by a physician, clergyman or a planned parenthood agency.
 - Temporary Custody:** If a physician has taken temporary protective custody of an abused or neglected child at a hospital, he/she shall immediately notify DCFS and make every reasonable effort to notify the person responsible for the child's welfare. He/she shall also notify the person in charge of the hospital and shall become responsible for the further care of the child in the hospital or similar institution under the direction of DCFS.
 - Emancipated Minors:** Emancipation does not arise solely because a minor is living or acting independently of his/her parent; this is a legal procedure requiring a court petition. A minor may be completely or partially emancipated; a copy of the court emancipation order must be reviewed to determine if the minor has authority to consent to his/her own treatment.
- G. Exceptions based on minor's medical treatment are as follows:
- Emergency medical treatment may be provided to a minor without parental consent when, in the opinion of the provider, obtaining consent is not "reasonably feasible under the circumstances without adversely affecting the condition of the minor's health." A "provider" includes a physician, dentist, hospital, physician assistant or advanced practice nurse.
 - Any minor who is a victim of sexual assault or abuse may consent to medical care or counseling related to the diagnosis or treatment of "any disease or injury arising from such offence."
 - A minor 12 years or older may consent to treatment or counseling related to the diagnosis and treatment of a sexually transmitted disease. Unless the minor consents, providers cannot seek the

family's involvement in the minor's treatment. On the other hand, providers *may, but are not obligated to*, inform parents or guardians about treatment or counseling provided to a minor with any sexually transmitted disease.

4. A minor 12 years of age or older may consent to outpatient mental health services for the treatment of mental illness or emotional disturbance. The minor's parent or guardian cannot be informed of counseling or psychotherapy without the consent of the minor.

H. Refusal of Transport after Emergency Treatment

1. Some patients will refuse care after emergency treatment, i.e., hypoglycemia in diabetic patients.
2. If the patient meets the criteria for competency and the patient has received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "High Risk" refusal. After contact with Medical Control, obtain the patient's refusal signature.

If the patient meets the criteria for competency, has not received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "Low Risk" refusal. Obtain the patient's refusal signature.

Note: False calls or other "third party" calls where the person states they did not call for EMS assistance, the EMS provider does not need to obtain a written refusal. An EMS report still needs to be completed by the EMS provider for the emergency response.

Resources:

1. [Emancipated minors are minors between the ages of 16 and 18 who have obtained a court order which states that they are legally emancipated. \(Emancipation of Minor's Act, 750 ILCS 30/1, et. Seq.\)](#)
2. [Consent by Minors to Medical Procedures Act, 410 ILCS 210/1, et. Seq.](#)
3. [410 ILCS 210/2](#)
4. The term "in loco parentis" might include an aunt or uncle or some other adult who does not have legal guardianship but who otherwise stands in the shoes of a parent.
5. [405 ILCS 5/3-502](#)
6. [Birth Control Services for Minors Act, 325 ILCS 10/1](#)

Title of Policy: EMS <i>Controlled Substances</i>	Policy Number: E-104
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Equipment	Approvals: MD, System

Background to Policy:

This policy is to ensure the safe storage, administration and restocking of controlled substances. This will also provide a tracking mechanism for the wasted medication not given the patient.

Policy Statement:

The OSF Saint James EMS System recognizes the importance of medications carried on Advanced level EMS vehicles in relation to patient care. It is also important to understand the risks involving the potential abuse and addiction of controlled substances.

Policy:

- A. All controlled substances will be kept inside each ambulance. The medication will be secured inside a pouch or container sealed with a numbered tamper-proof tag or key/lock container.
- B. At the beginning of each shift, the on-coming EMT-I or EMT-P will verify that the controlled substance tag is secure and the tag number is to be verified with the log.

After assuring the tag is intact and the number corresponds with the log, the EMT-I or EMT-P must sign the controlled substance shift log.

- C. If the tag is not intact or the number is not verifiable, a complete inventory should be taken immediately and an EMS Agency Supervisor shall be notified. An incident report shall be completed and forwarded to the EMS System office.
- D. Controlled substances shall be available for inspection by the Illinois Department of Public Health, EMS System Coordinator or authorized other individual by the EMS System.
- E. Each usage of a controlled substance must be properly documented including the following information:
 - Date of administration
 - Time of administration
 - Old tag number
 - New tag number
 - Patient name
 - Drug and dose given
 - Drug amount wasted
 - Total amount of drug
 - EMT-I or EMT-P signature
 - Witness signature of waste, EMT/ RN at receiving hospital (waste)

- F. Once a month controlled substances shall be inspected. The inspection will be documented with the old and new tag number. Any discrepancies (missing medication, broken seals, etc.) should be reported to the EMS Agency supervisor immediately. If no problems are found, the log will be signed and witnessed. By signing the log, the EMT-I or EMT-P is ensuring that the controlled substances are secure.

Any deviation of the required controlled substances shall be fully documented.

- G. Any controlled substance that has not been administered must be properly disposed. The amount wasted must be noted on the log and witnessed by other EMT, a nurse or physician at the receiving hospital. When the replacement medication is received from the pharmacy, the EMT-I or EMT-P will sign the narcotic log in the Hospital.
- H. At the end of each shift, the EMT-I or EMT-P will verify that the controlled substance tag is secure and the tag number is verified with the log. Any new tag number will be documented on the log.

After assuring the tags are intact and the number corresponds with the log, the EMT-I or EMT-P must sign the controlled substance shift log.

Resources:

1. [EMS and the DEA JEMS](#)

Title of Policy: <i>EMS Transport of Law Enforcement K-9's</i>	Policy Number: OPS- 110
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

In 2017 the state of Illinois amended the EMS System act with passage of [Public Act 100-0108](#). That legislation authorizes the following: *“An EMR, EMT, EMT-I, A-EMT, or Paramedic may transport a police dog injured in the line of duty to a veterinary clinic or similar facility if there are no person requiring medical attention, or transport at that time. For the purposes of this subsection, “police dog” means a dog owned or used by a law enforcement department or agency in the course of the department or agency’s work, including a search and rescue dog, service dog, accelerant detection canine, or other dog that is in use by a county, municipal, or State law enforcement agency.”*

Policy Statement:

It is the intention of the OSF Saint James EMS System, and its affiliate agencies to be cooperative partners within the public safety community. The EMS System authorizes, but does not require agency affiliates to transport police K-9’s.

Policy:

1. EMS agencies have the individual discretion and autonomy to decide whether or not they will transport police dogs. If an agency chooses to provide this service they must do so in compliance with this policy.
2. All human patients must be transported or dispositioned in accordance with the systems [Patient Right of Refusal Policy](#) and/or [Patient Abandonment vs Prudent use of EMS Resources Policy](#).
 - a. The severity of injuries or lack thereof to either a human patient or the K-9 is irrelevant. The human patient will always have priority.
3. Under no circumstance shall an injured K-9 be transported with a human patient. The only acceptable exception to this would be the transport of an injured law enforcement officer and an injured police K-9.
 - a. In this instance, the law enforcement officer will be transported to a hospital first. The K-9 can then be transported to a veterinary clinic or similar facility.
4. Under no circumstance shall an injured K-9 be transported to a hospital, as defined by its standard definition and connotation for emergency care.
5. Items, which EMS agencies are required to have prescription to purchase such as medications, IV fluids, IV catheters, needles, ET tubes, etc. are prescribed by the EMS System Medical Director. The intended use for these prescription supplies and medications is for use on human patients.
 - a. As a result, ILS/ALS services may not perform advanced level procedures on K-9’s.
 - b. EMR/BLS/ILS/ALS providers are prohibited from administering medication to K-9’s other than Oxygen or Naloxone.

6. If a Doctor of Veterinarian Medicine, is on the scene, then he/she may utilize supplies and medications that are available on the ambulance, with the exception of controlled substances.
7. The EMS System is not empowered or authorized by the [EMS System Act](#), the [Medical Practice Act](#), the [Veterinary Medicine and Surgery Practice Act of 2004](#), or any state administrative rule to create protocols or in any way regulate the practice of veterinary medicine. Related there is no authority for an EMS System to create protocols for the provision of pre-hospital care to animals of any kind.
8. As a result of sections 5 and 6 above, the EMS provider should confine their interventions to transport, BLS bleeding control, and/or basic first aid. It is acceptable to administer oxygen therapy utilizing a pet oxygen mask system.
 - a. As Naloxone administration has been included in the basic first aid curriculums for the public, EMS providers at any level may administer Naloxone if necessary to a police K-9. If administered the dosage recommended is 2 mg for an average sized police dog.
9. As there is no patient provider relationship established the EMS System does not make a recommendation in regards to the permissibility of the use of lights and sirens in transporting injured police K-9.
10. Due to the protective instincts of these animals it is recommend that the animal be transported with a handler who is familiar with the commands with which the dog was trained.
11. Due to the protective instincts of these animals it is strongly recommended that the animal be transported with a muzzle if practical, to protect EMS providers from the possibility of being bitten.
 - a. Should an EMS provider be bit, that provider shall follow the significant exposure procedure for their agency in additions to following the procedures outlined in the system [communicable disease policy](#).
 - b. In addition to the standard communicable disease policy, verification of the K-9's rabies vaccination status.
12. Agencies which have a working relationship with a law enforcement agency that regularly employs the use of K-9's are encouraged to have a conversation beforehand to identify a plan of action for these situations that is consistent not only with this policy, but also the policies and procedures of the involved law enforcement agency.

Resources:

Title of Policy: EMS Cardiac Resuscitation vs. Cease Efforts and Coroner Notifications	Policy Number: L-103
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To provide the EMS provider and Medical Control direction in determining between resuscitation efforts or death is recognized and the coroner is notified.

Policy Statement:

The EMS provider is responsible to make every effort to preserve life, if there is any chance that life exists, at the scene and during transport to a medical facility. There are times when death is obvious and no resuscitation is indicated.

Policy:

A. Resuscitation vs. Recognition of Death

If an EMS provider finds that the patient is pulse less and non-breathing, resuscitation must be attempted **UNLESS:**

- The patient has obvious signs of biological death which are rigor mortis, dependent lividity, or injuries which are incompatible with life (i.e., decapitation, massive head injuries, transected torso, incineration, etc.).
- The patient has a valid DO NOT RESUSCITATE Order.
- The patient's physician is at the scene, assumes Medical Control and orders that resuscitative efforts not be initiated.
- The Medical Control Physician orders resuscitation efforts to be discontinued.

B. Guidelines for determining resuscitation efforts or ceasing efforts:

- Begin CPR, if indicated.
- Contact the Medical Control Physician. Transmit as much pertinent history as possible (age, vital signs, EKG, pupil status, length of time since onset of cardiac arrest) and receive resuscitation instructions or cease effort orders.
- If on-site resuscitation is not successful and **Medical Control** has authorized the cease efforts, follow the coroner notification policy.

C. No signs of life present, signs of death not notably evident (i.e., no blood pressure, pulse, respirations, EKG is asystole, patient down time is unknown, body temperature warm):

- Initiate CPR
- Initiate Field Treatment Protocols as appropriate
- **Contact Medical Control**
- Continue resuscitative measures as directed

- D. Signs of death are notably evident:
- Confirm no Blood Pressure, respirations, or EKG activity
 - **Contact Medical Control**
 - Receive direction to notify Coroner
- E. Upon EMS arrival, CPR is in progress:
- Continue CPR
 - Determine if life signs are present
 - **Contact Medical Control**
 - Continue resuscitative measures as directed
- F. Special circumstance where prolonged resuscitation efforts are indicated:
- Hypothermia
 - Pediatric patients
 - Treatable contributing factors

Resources:

Title of Policy: EMS Coroner Notifications	Policy Number: Ops-111
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To assure out-of-hospital personnel are aware of and adhere to Coroner and EMS System Policies and Procedures involving death cases.

Policy Statement:

This procedure has been developed to provide guidelines for EMS crews to follow when they have encountered a death scene in the out-of-hospital setting.

Policy:

A. Recognition of Death

Refer to *"Reporting of Suspecting Crimes and Crime Scene Responsibilities"* and *"Cardiac Resuscitation vs. Cease Effort and Coroner Notification"* policies for additional information involving determination and death at scene responsibilities.

B. Notification Requirements and Procedures

Under 55 ILCS 5/3-320 of the Illinois Revised Statutes - Coroners, it is written that;

Every law enforcement official, funeral director, **EMS Provider**, hospital director or administrator or person having custody of the body of a deceased person, where the death is one subjected to investigation under Section 3-3013 of this Act, and any physician in attendance upon such a decedent at the time of his death, shall notify the coroner promptly. Any such person failing to so notify the coroner promptly shall be guilty of Class A misdemeanor, unless such person has reasonable cause to believe that the coroner had already been notified.

C. Those deaths that are subjected to an investigation, are classified in the following categories:

1. ACCIDENTAL DEATHS

- Anesthetic Accident (death on the operating table or prior to recovery from anesthesia)
- Blows or other forms of mechanical violence.
- Burns
- Crushed beneath falling objects
- Cutting or stabbing
- Drowning
- Electric shock
- Explosion

- Firearms
- Fracture of bones. Such as cases to be reported even when fracture is not primarily responsible for death.
- Falls
- Carbon Monoxide poisoning
- Hanging
- Thermal Exposure
- Poisoning
- Strangulation
- Suffocation
- Vehicular Accidents

2. HOMICIDAL DEATHS**3. SUICIDAL DEATHS**

4. **ABORTIONS** -Criminal or self-induced maternal or fetal deaths.

5. **SUDDEN DEATHS** - When in apparent good health or in any suspicious or unusual manner including sudden death on the street, at home, in a public place, at ultimately is the subject of investigation.

D. In notifying the coroner, or his designee, give the following information:

- Your name
- Your provider
- Location
- Phone number and/or radio frequency from which you may be contacted.
- Brief explanation - i.e., possible suicide, car accident - two dead.
- During transport of an emergent patient and the patient goes into cardio-pulmonary arrest, run a monitor strip while noting the time and location and then contact medical control (obtain the ED physician name) while following appropriate medical protocols. Record this information on the run sheet.

EXCEPTION: During a non-emergent inter-facility transport (patient to a residence or long term care facility) **and** the patient has a valid advanced directive **and** the patient goes into cardio-pulmonary arrest: continue transport to the final destination (if this is a private residence or long term care facility) and wait for the coroner at that location. If at any time under this exception transport of the patient would mean either:

1. crossing a county line, or
2. have the final destination of this transport be a hospital

then the ambulance should be pulled over at the next closest safe location and request the coroner to meet at that location.

- E. Once this information has been given, wait for the coroner or his designee to arrive, or for further instructions. If family and friends are present, the EMS providers' attention should be shifted to these individuals to care for any grief related matters.
- F. Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified. EMS crews may be called upon to assist law enforcement personnel.
- G. Upon arrival at a suspected crime scene, note the following:
- Immediately notify the police or call your dispatcher to do so.
 - If the victim is obviously dead, then he or she should remain undisturbed. Even the position of the body can provide valuable clues.
 - Do not touch, move, or relocate any item at the scene unless absolutely necessary to provide treatment to an injured victim. You should mark the location of any item that must be moved so the police and/or coroner can determine its original position. (Also, refer to "Interaction of Law Enforcement/Evidence" policy).
- H. When death is obvious at the scene:
- If you are the first to arrive on a scene where death is obvious, insure that the police and coroner are enroute to the scene.
 - If you are the first to arrive on a scene where death is obvious and police have yet to arrive, keep everyone away from the area including family and friends.
 - If police and/or coroner have yet to arrive and death is obvious at the scene which is inside a building, (i.e. house or apartment) leave the room and protect the scene from the outside.

Resources:

1. [55 ILCS 5/3-320](#)

Title of Policy: EMS <i>Do Not Resuscitate</i>	Policy Number: L-104
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To provide guidance to EMS personnel in situations where a valid DNR order is encountered. A valid DNR order should reflect the patient's personal views and wishes related to end of life decisions.

Policy Statement:

A Do Not Resuscitate Policy is a tool to be used in the pre-hospital setting to set forth guidelines for providing CPR/resuscitation or for withholding resuscitation efforts. The purpose of this policy is to specify requirements for valid DNR orders and to establish a procedure for field management of these situations. A DNR policy shall be implemented only after it has been reviewed and approved by the Department of Public Health, in accordance with the requirements of Section 515.380.

Policy:

- A. Any EMR, EMT, EMT-I/AEMT, EMT-P or Pre-hospital RN who is actively participating in a Department approved EMS System may honor, follow and respect a valid DNR order. Medical Control will be contacted in all cases involving DNR's.
- B. DNR refers to the withholding of life sustaining treatment such as:
Cardiopulmonary resuscitation (CPR); electrical therapy to include pacing, cardio version and defibrillation; tracheal intubation and manually or mechanically assisted ventilation, unless otherwise stated on the DNR order.
- C. By itself, a DNR order does not mean that any other life prolonging therapy, hospitalization or use of the Emergency Medical System is to be withheld. On-line Medical Control must be consulted in cases involving DNR orders. DNR orders do not affect treatment of patients **not in full cardiac arrest (pulseless and breathless)**.
- D. A DNR order may be invalidated if the immediate cause of a respiratory/cardiac arrest is related to trauma or mechanical airway obstruction.
- E. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR is not in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist:
 - Obvious signs of biological death are present
 - Decapitation
 - Rigor mortis without profound hypothermia
 - Dependent lucidity
 - Obvious mortal wounds with no signs of life
 - Decomposition

1. The patient has been declared dead by the patient's physician or a coroner.
 2. A valid DNR order is present and the EMS provider has made reasonable effort to verify the identity of the patient named in a valid DNR order (i.e., identification by another person, ID band, Photo ID or facility or homecare/hospice nursing staff)
 3. If the above signs of death are recognized, EMS personnel must contact Medical Control to confirm the decision not to attempt resuscitation (cease effort or do not resuscitate orders) prior to notifying the coroner.
 4. If the EMS provider has concerns regarding the validity of the DNR orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition the provider should immediately institute BLS measures and contact Medical Control for further directions.
- F. When EMS personnel arrive on scene and discover CPR is in progress, the EMS provider should:
- Assess pulse and breathing and analyze EKG activity.
 - Determine if signs of death are present or a valid DNR exist.
 - Continue resuscitation if signs of death are not obvious and a valid DNR is not available.
 - **Contact Medical Control** for orders, including possible cease effort orders.
- G. If the patient's primary care physician is at the scene or on the telephone and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity (if not known to the EMT) and notify Medical Control of the request of the on-scene physician. The physician on scene shall sign the ambulance report form if Medical Control approves his request(s).
- I. **Effective July 1, 2001**, the only recognized DNR forms EMS providers are obligated to honor, follow and respect is the IDPH uniform **Do Not Resuscitate (DNR) Advance Directive** form, which is easily identified by its brightly colored paper and the Seal of the State of Illinois. (see attached)—OR—the Illinois Department of Public Health POLST (physician orders for life sustaining treatment) form (See Attached). Photocopies are acceptable of either form.
- J. Any other advance directives or "living will" cannot be honored, followed and respected by pre-hospital care providers. EMS personnel must contact Medical Control for direction regarding any other type of advanced directive. Resuscitation should not be withheld during the process of contacting or discussing the situation with Medical Control.
- K. A Durable Power of Attorney for Health Care is an agent who has been delegated by the patient to make any health care decisions (including the withholding or withdrawal of life sustaining treatment) which the patient is unable to make. When a patient's surrogate decision maker is, present or has been contacted by pre-hospital personnel and they direct that resuscitative efforts not be instituted:
- The EMT is required to ask the durable power of attorney for health care agent to provide

positive identification (i.e., driver's license, picture ID, etc.), see the document and ask the agent to point out the language that confirms that the 'power' is in effect and that it covers the situation at hand (i.e., assure the scope of authority the durable power of attorney for health care has, and that the patient's medical or mental condition complies with the document designating the DPAH).

- A durable power of attorney for health care agent or a surrogate decision maker can provide consent to DNR order, but the order itself must be written by a physician.
 - An EMT cannot honor a verbal or written DNR request or order made directly by a durable power of attorney for health care agent or a surrogate decision maker or any other person, other than a physician. If such a situation is encountered, contact Medical Control for direction in interpreting the validity of the order or request.
- L. Revocation of a written DNR order is accomplished when the DNR order is physically destroyed or verbally rescinded by the physician who signed the order and/or the person who gave written consent to the order. Pre-hospital care providers have a duty to act and provide care in the best interest of the patient. This requires to provision of full medical and resuscitative interventions when medically indicated and not contraindicated by the wishes of the patient. All patients should have access to emergency medical services and may refuse treatment including CPR.
- M. When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear (i.e., upset family situation, no agreement on DNR, etc.), EMS personnel should provide assessment, initiate resuscitative measures and contact Medical Control for further directions.
- N. If EMS personnel are transporting a patient with a valid DNR order to or from home and the patient arrest enroute, contact Medical Control for orders regarding the transport. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
- O. If EMS personnel are transporting a patient transfer with a valid DNR order during an inter-hospital and the patient arrest enroute, continue transport to the hospital and contact Medical Control for orders. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
- P. If System personnel are transporting a patient facility with a valid DNR order from a long-term care and the patient arrest enroute, continue transport to the hospital and contact Medical Control. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
- Q. If System personnel arrive at the scene and the family states that the patient is a hospice patient with a valid DNR order, do not initiate resuscitative measures and contact Medical Control for further orders.
- R. On occasion, EMS Personnel may encounter an out-of-town patient with a valid DNR order visiting in the EMS System area. If the DNR order appears to be valid (signed by the patient and physician and has a current date), contact Medical Control for orders.
- S. The coroner will be notified of any patient or family wishes that there is to be tissue donation and the patient is not transported to the hospital.

- T. The on-line Medical Control physician's responsibility is to make reasonable effort to confirm the DNR order is valid and order resuscitative measures within the directives of the DNR order. If the DNR order cannot be validated, EMS personnel should be ordered to initiate or continue resuscitative measures.
- U. All EMS System personnel will receive a copy of the policy and education will be conducted initially, annually and on an 'as needed' basis.
- V. All associate and participating hospitals, area physicians and Medical Society staff, extended care facilities, hospice and home health agencies, coroners, dispatchers and private duty nursing agencies within the service area of the EMS System will also receive copies of the policy, as appropriate. The policy may be reviewed with these parties as requested or warranted by quality assurance activities.
- W. Education shall include, at a minimum, the following information:
- An overview of the System DNR policy.
 - Approved forms and/or the required components of a valid DNR order.
 - Healthcare staff for signs of obvious death and DNR situations.
 - Instructions on System access.
- X. Appropriate pre-hospital care reports will be completed on all patients who are not resuscitated in the pre-hospital setting. A copy of the DNR form should be retained and attached as supporting documentation to the pre-hospital care report form.
- Y. Continuous monitoring and evaluation will be conducted on all charts involving DNR orders.
- Z. All System personnel are to submit an incident report regarding difficulties experienced with DNR situations. These will be evaluated on an individual basis and summarized quarterly. Any quality issues identified will be reported to the EMS Medical Director, as well as any corrective action necessary.

Resources:

1. [IDPH Administrative Code 515.380](#)
2. [Illinois POLST Form](#)
3. [Illinois POLST Website](#)
4. [IDPH Advances Directives Website](#)
5. [IDPH POLST Training](#)

Title of Policy: EMS& <i>Domestic Violence</i>	Policy Number: L-106
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To provide for proper reporting of an incident through notification of appropriate persons and resources and offering immediate and adequate information regarding services available to victims of abuse or for any person suspected to be a victim of domestic abuse.

Policy Statement:

The following guidelines have been established to provide the EMR, EMT, EMT-I/AEMT, Paramedic and/or Pre-hospital RN direction in cases of domestic violence or suspected victim of domestic abuse. It is the lawful duty of the EMS provider to report suspected cases of child abuse and/or neglect. The EMS provider must also provide emergency medical care as appropriate and insure the suspected victim or victim of abuse receives immediate and adequate information regarding services available to victims of abuse.

Policy:

DEFINITION- Domestic Violence

Although commonly thought of as hitting, shoving, kicking, stabbing and other serious physical attacks, domestic violence may also be sexual or psychological. It involves: The infliction or threat of infliction of any bodily injury or harmful physical contact or the destruction of property or threat thereof as a method of coercion, control, revenge or punishment upon a person with whom the actor is involved in an intimate relationship (i.e. between spouses, former spouses, past or present unmarried couples, between children, between children and parent(s), between children and a relative).

ILLINOIS STATE LAW

ABUSE and NEGLECT REPORTING; DOMESTIC VIOLENCE REFERRALS

- All persons licensed, certified or approve under the Illinois EMS Systems Act shall report suspected cases of child abuse or neglect in accordance with the requirements of the Abused and Neglected Child Reporting Act. (325 ILCS 5/4).
 - All persons licensed, certified or approved under the Illinois EMS System Act shall offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse, in accordance with Section 401 of the Illinois Domestic Violence Act of 1886.
- A. Expressed or Implied consent shall be obtained to provide emergency medical care and transfer of the victim to the hospital facility of the victim's choice or to the nearest appropriate facility.
 - B. All cases of domestic violence shall be treated as victims of a crime and the assault and/or battery shall be reported to the appropriate law enforcement agency.

- C. It is important for the EMS provider to convey an attitude of concern, respect, and confidentiality to the patient. Provide support and encouragement to the victim. Understand the victim's fears of future violence if he/she expresses concern and/or fear.
- D. All victims or suspected victims of domestic abuse including child abuse or neglect shall be provided immediate and adequate information regarding services available.

All victims or suspected victims shall be offered emergency medical care as appropriate and transfer to a hospital facility for additional medical care including abuse referrals to an appropriate agency or service.

All victims or suspected victims who refuse or do not require emergency medical care shall be offered to the following domestic violence services as appropriate:

Resources:

- **Countering Domestic Violence, or CDV**, a 24 hour hotline, (309) 827-7070
- **IHR Counseling Services** – 815-844-6109
- **ResourcesMid Central Community Action's Countering Domestic Violence Shelter**, 309-827-7070
- **DOVE**, serves DeWitt and Macon Counties, (217) 935-2241
- **Chestnut Health Systems, SECURE Program**, 309-820-3500
- **Tri-County Women Strength**, serves Peoria, Tazewell and Woodford Counties, (309) 691-4111 or (309) 691-0551
- **AVERT**, for males accused of domestic violence, (309) 828-2860
- **McLean County Child Protection Network**, (309) 888-5656
- **Illinois Department of Children and Family Services, DCFS**, (800) 252-2873
- **National Domestic Violence Hotline**, 800-799-SAFE (7233) TDD Hotline 800-787-3224
- **Child Abuse (Any Setting)**, 1-800-252-2873
- **Domestic Abuse (Any Setting)**, 1-800-787-3224
- **Disabled Abuse (Any Setting)**, 1-800-368-1463
- **Elder Abuse (In Nursing Home)**, 1-800-252-4343 **(Other Settings)**, 1-800-252-8966 **(After Hours)** 1-866-800-1409

Title of Policy: EMS <i>Duty to Perform all Services Without Discrimination</i>	Policy Number: A-103
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To ensure all EMS providers within the OSF Saint James EMS System shall perform all services without unlawful discrimination

Policy Statement:

The OSF Saint James EMS System recognizes and respects each patient in the provision of care in accord with fundamental human, civil, constitutional and statutory rights. The OSF Saint James EMS System further recognizes that each patient is an individual with unique health care needs, and because of the importance of respecting each patient's personal dignity, provides considerate, respectful care focused on the patient's individual needs, regardless of the patient's ability to pay

Policy:

- a. All EMS providers of the OSF Saint James EMS System have the duty to perform all services without any type of discrimination.
- b. The OSF Saint James EMS System respects the rights of each individual and EMS patient care providers shall provide care to all individuals respecting their fundamental human, civil, constitutional and statutory rights.
- c. All individuals requesting emergency medical services shall have reasonable access to care.
- d. All individuals shall be provided emergency medical care without regard to race, age, religion, beliefs, sex, national origin, communicable disease carrier and/or the inability to pay for services.

Resources:

Title of Policy: <i>Emergency Vehicle Response Greater Than Eight Minutes</i>	Policy Number: Ops-112
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To ensure the caller of Emergency Medical Services has the right to know when the response time to the scene of an emergency will be longer than six minutes.

Policy Statement:

The following guidelines have been established for the purposes of providing direction to dispatch centers in situations where the EMS vehicle response time to the scene will be greater than six minutes.

Policy:

All EMS transport agency members of OSF Saint James EMS System that provide emergency ambulance response to their respective service area has committed to an optimum response time of six minutes in their primary coverage area.

Each respective agency response time to their secondary and outlying areas is greater than six minutes. If a call is received by dispatch center and it is known at the time of the call, for any reason the response time to the scene will be longer than six minutes by the responding agency, the following protocol shall be followed.

- A. Calls received by the OSF Saint James EMS System dispatch center in the primary coverage area:
 - Consider mutual aid if ambulance or staffing is not immediately available.
 - Notify caller of the estimated time of arrival of the responding unit.
- B. Calls received by dispatch for the secondary and outlying areas:
 - Consider mutual aid, if ambulance or staffing is not immediately available.
 - Notify caller of the estimated time of arrival of the responding transport unit.
 - Contact and request response of the nearest EMS first responder agency in situations of an emergency.
- C. If a transport agency is not able to respond their ambulance to an emergency call, an incident report should be filed with the OSF Saint James EMS System within 24 hours.

Resources:

Title of Policy: <i>Emotionally Disturbed Patient</i>	Policy Number: L-107
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To insure patients who are emotionally disturbed receive appropriate emergency medical care and mental health services.

Policy Statement:

When the EMS personnel or family reasonably suspects that an emotionally disturbed patient “at the time the determination is being made or within a reasonable time thereafter, would intentionally or unintentionally physically injure himself or other persons, or is unable to care for his own physical needs” and is in need of mental health treatment, against his or her will, shall receive emergency medical care and transportation to the hospital for definitive care. This does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years.

Policy:

DEFINITIONS:

EXPRESSED CONSENT: The consent given by adults who are of legal age and mentally competent to make a rational decision in regards to their medical well-being.

IMPLIED CONSENT: Situation involving an unconscious patient where care is initiated under the premise that the patient would desire such care if they were conscious and able to make the decision. In the case of an adult individual where he/she is unable to understand Expressed Consent, who may have a legal guardian who is not present, emergency care and transportation is given on the basis of Implied Consent.

- A. Attempt to orient the patient to reality and to persuade this person to be transported to the hospital so that he/she can get emergency medical care and mental health services.
- B. If persuasion is unsuccessful, contact Medical Control and relay with history and/or have the Medical Control Physician talk with patient. The EMS crew will then follow the direction of the Medical Control Physician.
- C. NOTIFY THE APPROPRIATE LAW ENFORCEMENT AGENCY TO RESPOND.
- D. If the Medical Control Physician determines the patient cannot understand EXPRESSED CONSENT for patient care and transportation to the hospital and emergency treatment is required to preserve life or prevent serious impairment to health, the Physician shall order, against patient will, and based upon IMPLIED CONSENT the emergency care and transportation to the hospital.

- E. IN NO WAY does this mean that the EMS crew are committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of mental health treatment to a hospital against his/her will so that a physician may further evaluate said patient.
- F. If patient requires restraints, EMS personnel shall use all the force reasonably required to restrain the patient. "Reasonable force" depends on the degree of resistance on part of the patient.
- G. If patient runs from EMS, this matter should be left to law enforcement personnel.

Title of Policy: EMS Clinical Hours	Policy Number: C-106
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

EMS personnel will follow established guidelines in completing required clinical time.

PURPOSE

To ensure that EMS students doing clinical time, receive the highest level of training and benefit.

Policy:

- I. **General:** In the course of the clinical time experience, EMS providers/students are responsible to the Charge Nurse of the ED. While they are functioning in this capacity, they are considered a part of the emergency health care team and are expected to assist nurses and doctors in many different situations. EMS Providers/Students will at no time be expected or ordered to perform any function that other health care providers are not expected to do. It should be kept in the mind of the provider/student that this is not an experience of observation but one of active participation. Regular interaction with the nurses and doctors is essential in developing and maintaining the unique relationship and trust that is needed for success and high quality of an EMS system.
- II. **Scheduling Clinical Time:** All clinical time will be scheduled through the EMS office.
- III. **Time:** Clinical hours may be done for any course requirements or for continuing education hours in the ED or other specified department, on or off duty. This matter is to be decided by the provider and the chief/director of their service.
- IV. **Cancellation of Clinical Time:** If a provider/student is unable to do clinical time after being scheduled, they must contact the EMS office during office hours and the department they are doing clinical time in regardless of time. This must be done as soon as possible, as another person may utilize the open slot.
- V. **Attire:** While doing clinical time, the provider/student can wear the department uniform as well as their System Name Tag. If a student or provider does not have a uniform shirt to wear, they may wear a polo or buttoned shirt, casual pants, and shoes. **NO JEANS. Appearance must be neat and clean at all times.**
- VI. **Supervision:** Upon arrival at the scheduled time, the provider/student should report to the supervisor or charge nurse of the department. They must advise them of their name, status as a student and at which level of EMT. The provider/student will operate under the direct supervision of the nursing staff and physician at all times. The provider/student is **not** to operate above their trained scope of practice for any reason. Each department will orientate the provider/student to the various parts of the department and the various equipment they may use.
- VII. **Documentation:** It is the provider's responsibility to keep track of all clinical time and turn it in to their instructors/directors in a timely manner. Clinical time forms should be completed each time, in every department the provider/student is supposed to go to. All documentation has to be signed by the nurse/physician on skills performed and that verification of the clinical time.
- VIII. **Infection Control:** Universal precautions must be utilized at all times when performing clinical procedures. Thorough hand washing is also a must before and after each patient to minimize exposures.



Saint James-John W. Albrecht Medical Center

System 0257

Title of Policy: <i>EMS Medication Replacement</i>	Policy Number: E-105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Equipment	Approvals: MD, System

Background to Policy:

This policy is to insure the safe restocking and documentation of use of medications within the OSF Saint James EMS System.

Policy Statement:

The OSF Saint James EMS System recognizes the importance of medications carried on emergency medical service (EMS) response vehicles in relation to patient care.

Policy:

- A. Most medications will be dispensed individually via the EMS Medications Dispensing machine located in the EMS room off of the OSF Saint James ED department.
- B. EMS Providers have ID codes allowing them to access the machine and pick the medications needed.
- C. All controlled substances will require a double ID code to ensure security of the medication.
- D. All ILS and ALS controlled substances must be secured inside a pouch or container sealed with a numbered tamper-proof tag inside each ambulance within the drug box.
- E. All ID codes are tracked and that person is responsible for the medication and that proper storage for the medication is followed
- F. EMS medication inventory shall be available for inspection by the Illinois Department of Public Health, EMS System Coordinator or EMS System designee

Resources:



Saint James-John W. Albrecht Medical Center

System 0257

Title of Policy: <i>EMS Quality Council</i>	Policy Number: A-108
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To insure Continuous Quality Improvement in pre-hospital care in the OSF Saint James EMS System.

Policy Statement:

Continuous Quality Improvement is the watchword within the health care industry today. In business terms, it means to continually adjust services to become more customer oriented. In EMS, our customers are our patients.

Policy:

- A. The OSF Saint James EMS System Quality Council established in January 2020. The responsibilities of the Council are as follows:
- Overall management of the joint Quality Improvement Program for the OSF Saint James EMS System.
 - Establishing and maintaining standards of care.
 - Establishment and implementation of EMS policy with well-defined expectations.
 - Binding authority of all disciplinary action, but requires agreement with recommended action by the EMS Medical Director.
 - Establishing objective criteria for chart audits as well as focused audits.
 - Evaluate chart audits, focused audits, and recommendations provided by peer QI Teams and implement appropriate PROSPECTIVE educational programs for quality improvement.
 - Assist QI Teams in retrospective per debriefing.
 - Evaluate data collection and chart review performed by the EMS System and implement appropriate PROSPECTIVE educational programs for QI.
 - Evaluate data collection for trending and create educational objectives.
 - Provide retrospective feedback to all EMS Provider members of the OSF Saint James EMS System.
 - EMSMD's and Coordinators serve as advisors to QI Teams.
- B. The Council formally functions in the following manner:
- Conducted according to "Robert Rules of Order"
 - All members of the Council may vote with exception of QA Coordinator. The QA Coordinator votes in case of ties only.
 - Council bylaws are developed and implemented by the initial Council members.
 - Report to the Council.
 - Chairperson is a voting member of Quality Council.
 - Assist and recommend to the Council objective criteria for specific chart audits and focused audits.
 - Provide peer review of chart audits and focused audits, and report findings to Quality Council.
 - Make other recommendations to the Council as deemed appropriate.
 - Participate in Peer retrospective debriefing.

- C. The membership of QI Teams is comprised of peers, consisting of the following:
- ALS QI Team - Four or more Paramedic members, Chairperson determined by Team, Ex-officio, non-voting member, Executive Committee Member.
 - BLS QI Team - Four or more EMT-B members, Chairperson determined by Team, Ex-officio, non-voting member, Executive Committee Member.
 - Emergency Communications QI Team - Four or more members, at least two Tele-communicators V-Com, Chairperson determined by Team, Ex-officio, non-voting member, Executive Committee Member.
- D. The QI Team functions in the following manner:
- Conducted according to “Robert Rules of Order”
 - All members of QI Teams are voting members
 - Chairperson of QI Teams serves as a voting member of the Quality Council

Resources:

Title of Policy: <i>EMS System Incident Report</i>	Policy Number: A-107
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To properly communicate and address any violation of policy, procedure or protocol which may arise in the OSF Saint James EMS System.

Policy Statement:

Pre-hospital care providers, emergency department physicians and nurses and any other person directly involved in pre-hospital care in the OSF Saint James EMS System shall complete an “EMS Systems Incident Report Form” whenever a violation in policy, procedure or protocol has occurred. When completing the form, describe the specific violation, including a brief narrative summary and any additional documentation that would help describe the incident.

Policy:

- A. When a violation of policy, procedure or protocol has occurred, an “EMS System Incident Report Form” shall be completed within 24 hours of the occurrence and submitted to the EMS System Manager/Coordinator.
- B. The purpose of the “Incident Report Form” is to properly communicate and address violations. Any situation that may be corrected through education or presents itself as an opportunity to improve the local delivery of emergency medical services shall be documented on an “IOR Form”. Refer to “Improvement Opportunity Report Form” policy.
- C. Once an Incident Report has been received, it shall be reviewed by the EMS System Manager/Coordinator. Those reported violations which may or did have an adverse effect on a patient or crewmember of the OSF Saint James EMS System will be reported immediately to the EMS Medical Director and the OSF Saint James EMS System. Situations that do not adversely affect others may be dealt with by the OSF Saint James EMS System.
- D. All Incident Reports with documented violations adversely affecting others shall eventually be referred to the Quality Council. Refer to “EMS Quality Council” policy.
- E. The person originating the report shall be notified of the receipt of the Incident Report.

Resources:

1. [EMS System Incident Report Form](#)
2. [EMS System Improvement Opportunity Report Form](#)

EMS System Review Form

Date of Occurrence: _____ Time of Occurrence: _____ Date of Report: _____
EMS Service: _____ Run Number: _____

Type of Occurrence:

- | | |
|---|--|
| <input type="checkbox"/> Variation of EMS Policy | <input type="checkbox"/> ED/Hospital Staff Related |
| <input type="checkbox"/> Variation of Service SOP's | <input type="checkbox"/> MERCI/Communications |
| <input type="checkbox"/> Variance in SMO/Protocol | <input type="checkbox"/> Strength/Kudo Identified |
| <input type="checkbox"/> Other _____ | |

Description of Occurrence:

Signature: _____ Date: _____

Review of Occurrence: EMS Office Service

Signature: _____ Date: _____

Recommendations:

Signature: _____ Date: _____
_____ Date: _____

Copies To: Service EMS Office PMD Files

Title of Policy: EMS System Missed Call by Primary Agency	Policy Number: A- 200
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administrative	Approvals: MD, System

Policy Statement:

Any instances where an agency in the OSF Saint James EMS System misses a call due to lack of personnel or mechanical issues, the agency shall notify the EMS Office within 48 hours in writing of the missed call. An explanation of why the call was missed and corrective actions to be taken will be included in the written notification.

PURPOSE

To help the system monitor the agency's ability to respond to emergency calls and assist those agencies to correct response problem. **This is not a means for disciplinary action.**

Policy:

1. All agencies should have a backup plan for response to emergency calls should they not be able to respond to a call due to lack of manpower or mechanical issues. (auto-aid, mutual aid agreements)
2. Within 48 hours of missed call, the agency shall complete a missed call form and route to the EMS Office for review.
3. If the agency continues to miss calls in their primary response area, they will need to submit an action plan within 30 days for what changes they will make to correct the lack of response. (This should be with the **assistance** of the EMS office)

Title of Policy: <i>Encountering a Scene While Already Having a Patient</i>	Policy Number: Ops-113
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To assure there is no interruption in patient care due to encountering another incident.

Policy Statement:

While involved in the ambulance transport of a patient on occasion the EMS crew may come upon the scene of an accident. The following guidelines shall be used to determine what action to take.

Policy:

- A. Should the EMS crew discover an emergency requiring assistance during the course of patient transport; the local 911 system will be activated. Priorities are to the onboard patient. If current transport includes more than two pre-hospital providers, one member may attend the scene while the other completes the original task.
- B. When a EMS crew is already responding to an Emergency call and come upon another emergency type of call, accident, the responding EMS crew should proceed to the original emergency call but ensure that more emergency units are responding to the new emergency. This may be done using any form of communication such as but not limited to cell phone or radios.
- C. In the event, there is not a patient onboard the ambulance and an emergency situation is encountered, the crew may stop and render care. However, the local 911 system should be activated.

Resources:

Title of Policy: <i>Field Triage of the Trauma Patient</i>	Policy Number: Ops-114
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

The goal of triage is prompt and appropriate treatment, at a facility with capabilities for optimal care of the individual's injuries.

Policy Statement:

Triage has been defined as the classification of patients according to medical need. Field triage requires EMS personnel to make an estimation of injury severity and match patient needs with available resources.

Policy:

- A. The Trauma Field Triage Criteria as created by the committee on Trauma of the American College of Surgeons, 1993, and by the American College of Emergency Physicians, "Trauma Care System Guidelines" 1992, has been adapted for use in Region 2. Any patient who meets the ACS guidelines for field triage, as defined, will be considered to have entered the Trauma System.
- B. **TRANSPORT TIME LESS THAN 25 MINUTES:** Any trauma patient who meets the following criteria shall be transported to the closest Trauma Center.
- C. **TRANSPORT TIME GREATER THAN 30 MINUTES:** Any trauma patient who meets the following criteria with a transport time greater than 30 minutes to a Trauma Center or to an affiliate trauma hospital, transport to the nearest hospital.
- D. **TRANSPORT TIME GREATER THAN 45 MINUTES:** Any trauma patient who meets the following criteria with a transport time greater than 45 minutes to a Trauma Center or to an affiliate trauma hospital in a rural area where there is no comprehensive hospital available, transport to the nearest hospital.
- E. Field Triage Medical/Legal Considerations.
 - If patient is unconscious and meets ACS Trauma Field Triage Criteria, the patient shall be taken to a Level I or II Trauma Center.
 - If a patient has an altered level of consciousness and meets ACS Trauma Field Triage Criteria, the patient shall be taken to a Level I or II Trauma Center.
 - If an adult patient is alert and oriented to person, place and time with stable vital signs, refer to the Patient Hospital Preference policy.
 - In the case of a Minor or an Incompetent Adult patient, and a guardian or person with the Power of Attorney for Healthcare is present at the emergency scene, that person can provide the Informed Consent for the patient to be transported to the appropriate facility according to the ACS Trauma Field Triage Criteria. Also, refer to the Patient Hospital Preference policy.

- If there are any questions regarding the patient's status, treatment or destination, the EMS provider must contact the Medical Control Physician.
 - ACS strongly recommends that pre-hospital care providers inform the patient, the patient's legal guardian or Power of Attorney for Healthcare, or the patient's family member(s) of the appropriate Trauma Center care availability and capability. The patient's choice, the patient's legal guardian or Power of Attorney for Healthcare choice of receiving hospital shall be documented.
- F. If the more distant hospital is full or is on Trauma Center bypass, the patient shall be transported to the nearest hospital.

Resources:

1. [Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage, 2011](#)
2. [IDPH 515. Appendix C Minimum Trauma Field Triage Criteria](#)

Title of Policy: ILS/ALS Intercept Policy	Policy Number: Ops-115
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals:

Background to Policy:

To assure the highest level of care is being utilized when indicated and available.

Policy Statement:

When a patient's condition warrants the highest level of available care, in-field service level upgrades (*) shall be utilized to optimize patient outcome.

Policy:

- A. When a patient's condition warrants a higher level of care and an advanced level is available, the more advanced agency shall be called immediately for assistance. It is the responsibility of the responding agency or on-line Medical Control to request response of the higher level of care when patient condition warrants. This shall be done when the condition has been recognized as listed below but not limited to:
- Trauma patients entrapped with required extrication
 - Patients with compromised or obstructed airways
 - Impending cardiac and/or respiratory arrest
 - Patients exhibiting signs of hypoxemia (respiratory distress, restlessness, cyanosis, altered LOC).
 - Unstable cardiac
 - Chest pain unresolved
 - Chest pain resolved prior to arrival; upon arrival; or resolved when on-scene of BLS/ILS
 - Patient exhibiting signs of impending or decompensating shock (B/P<100, diaphoresis, altered LOC, tachypnea)
 - Unconscious patients
 - Any case deemed by the responding agency or Medical Control as beneficial to patient outcome
 - Pediatric cases with any of the conditions listed above
- B. Availability of advance assistance
1. If the primary response area (***) is covered by any combination of BLS, ILS or ALS, the highest level of service shall be utilized for any patient whose condition warrants advanced level care as indicated in item A above.
 2. When determining need for assistance from an advanced secondary or tertiary provider, consideration should be given to the following:
 - Transport time to hospital
 - Rendezvous site
 - Availability of resources
 - Interventions needed (i.e., defibrillation, airway, drugs)

- Transport of the patient should not be unreasonably delayed for transfer of care
- Decisions for or against requesting advanced assistance should be based on the patient's best interest.
- Regardless of response jurisdiction, if two different agencies with differing levels of care are dispatched to and arrive on the scene of an emergency, the agency with the highest licensure level shall assume control of the patient(s).

3. When requesting an advanced secondary or tertiary provider, specify the exact resource and the route of travel.

4. Communicate with the responding higher level of care unit via radio to provide a brief patient condition report and confirm route of travel/rendezvous site.

C. Transfer of care

- Safety will be emphasized throughout the intercept and transfer of care.
- Patient transport should not be delayed.
- Neither the assessment nor the transfer of care can be initiated if it would appear to jeopardize the patient's condition.
- The transfer of care must occur under the immediate direction of on-line Medical Control.
- EMS vehicles should rendezvous at the site predetermined unit-to-unit radio contact.
- Rendezvous should not take place on heavily traveled roadways. Sites considered for rendezvous should be parking lots, safe shoulders or side streets.
- Patients should **not be transferred** from ambulance-to-ambulance. The higher-level personnel from the intercepting ambulance or alternate response vehicle, with proper portable equipment, shall board the transporting vehicle and oversee patient care with the assistance of the requesting agency's personnel.
- The higher-level personnel which have boarded the transporting ambulance will determine the transport code for the remainder of patient transport (i.e., emergency transport with lights and siren in operation; transport with all normal traffic laws observed and no operation of lights and siren).
- Pertinent patient information should be transmitted to the intercepting ambulance prior to rendezvous (i.e., nature of problem, need for intubation, defibrillation, drugs, etc.).

* "In-Field Service Level Upgrades" as referred to in this policy imply services above the level of care provided by the initial responding agency. This may include a higher-level ambulance or higher level alternate response vehicle. **The closest available higher level vehicle shall always be requested.**

** "Primary Response Area" is the immediate coverage area of an agency.

Resources:

Title of Policy: <i>In Field Service Level Upgrade (Only applies to agencies serving <7500 people)</i>	Policy Number: Ops-116
Effective Date: 09/2015	Review Date: 10/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To ensure that agencies and providers are given clear guidance on how to initiate in-field service level upgrade in accordance with IDPH administrative code 515.833

Policy Statement:

The OSF Saint James Area EMS System recognizes that at time there may be providers working with an agency that hold IDPH licensure at a level above that of the vehicle, which they are currently working. Furthermore, the OSF Saint James EMS System recognizes the unique challenges faced by rural agencies in providing timely BLS/ILS/ALS care. This policy applies equally to Ambulances, Non-Transport Vehicles, and Specialized Emergency Medical Services Vehicles.

Policy:

- A. Any agency wishing to apply for in field service level upgrade will notify the EMS office of that intent in writing. The letter must identify the vehicle requesting the upgrade by vin (last 4 digits) as well as license plate number if applicable. The letter must also include a statement indicating that the provider will remain compliant with annual IDPH inspection.
- B. The agency requesting the upgrade shall also complete a system modification form, and return it to the system office along with the letter mentioned in section A
- C. The agency requesting the upgrade shall provide a detailed plan including the manner in which the provider will secure and store equipment, supplies and medications that are reserved for the level being upgraded to.
- D. The agency requesting the upgrade shall provide a detailed plan outlining the type of quality assurance measures the provider will perform
- E. The agency requesting the upgrade shall provide written assurances that will only advertise the level of care that can be provided 24 hours a day.

Security

- A. All equipment that is not permitted at the primary licensure level of the unit must be secured in a locked cabinet. This may be accomplished by key lock, digital lock, or combination lock
 - a. A plastic number lock does not meet the requirements of this policy
- B. The only individuals who shall be provided access to this locked cabinet(s) shall be providers employed by the agency licensed and approved by the system to function at the level of the upgrade.
 - a. Agencies which are multi- jurisdictional, or have documented mutual aid agreements in place at the discretion of both agencies may share access information with providers from those agencies, but only if they are approved to practice by the system at the upgrade level
- C. No required ambulance equipment for the primary licensure of the vehicle may be stored in the locked cabinet
 - a. le. Providers at the primary licensure level need to be able access all equipment needed for their level of licensure

Equipment

- A. In field service level upgrade units are required to carry the equipment and supplies outlined on the respective EMS System supply and equipment form
- B. In field service level upgrade units will follow the same medication/equipment and replenishment procedures as vehicles permanently licensed at that level.
- C. Requests for waiver of specific equipment will be considered by the EMS System and IDPH on a case by case basis.

Quality Improvement

- A. Any instance that results in an in-field service level upgrade shall be reported to the EMS Office within 24 hours. Included with that notification shall be a copy of the run report (computer chart or non-transport form whichever is applicable)
- B. Any instance in which a transport vehicle with an in-field service level is unable to provide that care and requires an intercept at the same level shall file with the EMS System within 24 hours.
 - a. If a BLS ambulance with ALS in-field capabilities requests an ALS intercept
- C. The EMS office will compile this data and will forward information to IDPH on a regular basis. This information will be completed on a form as prescribed by IDPH. Data forwarded shall include, but not limited to the number of usages by agency, and any adverse outcomes associated with the in-field service level upgrade
- D. All agencies with an in-field service level upgrade vehicle by the last day of every month submit to the EMS office a completed Equipment/Medication inspection sheet.
- E. As is the same with all other licensed vehicles, in field upgrade vehicles are subject to inspection by the EMS System or IDPH at any time.

Personnel

- A. In order to apply for the in-field service level upgrade, the agency making the request must have at least one individual on their EMS System Roster for the level being requested
- B. In the event that an agency initially able to fulfill the requirement becomes unable to fulfill the personnel requirement they shall notify the EMS office in writing within one business day, and the agencies in field service level upgrade privileges shall be suspended. In addition, any and all medications outside the primary level of the agency shall be disposed of or stored in a manner deemed acceptable by the Medical Director.

Special Considerations

- A. In order for a vehicle to be eligible for in field service level upgrade, when not in use the vehicle must be stored in an environment that does not have an average temperature <45 degrees nor > 85 degrees.

Resources:

Title of Policy: <i>Interaction with Law Enforcement/Evidence</i>	Policy Number: Ops-117
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To clarify the roles and responsibilities of the EMS provider at a crime scene and the interaction with law enforcement to assist in preservation of the scene.

Policy Statement:

Often the EMR, EMT, EMTI/AEMT/ Paramedic and/or Pre-hospital RN may arrive at the scene of a violent crime before the police arrive. This requires an understanding by the EMS provider of law enforcement in preserving, collecting and using evidence. Anything at the scene may provide valuable clues and evidence for the police. Although it is extremely important to assist police in preserving the scene that action should never interfere with emergency treatment of serious injuries, as that is the EMS provider's first priority.

Policy:

a. Arrival at the scene

- i. Observe any individuals or vehicles in the area.
- ii. If possible, park your vehicle so that other vehicle tracks will not be destroyed.
- iii. When you leave, remember where you parked your vehicle for later crime scene reconstruction.
- iv. Watch where you walk. Do not walk over vehicle tracks, footprints, etc.
- v. Do not track dirt or snow into the scene and do not walk through blood or other possible evidence at the scene.
- vi. Do not touch anything unless absolutely necessary. If you do, remember where you touched, i.e., light switch, any article you had to move, etc.
- vii. Do not move an article unless it is absolutely necessary. If, moved, do not attempt to put it back in its original position.
- viii. Do not use ashtrays, bathroom, etc.
- ix. Do not cut through ropes, bindings, etc.; however, if it is necessary, never cut through or untie knots.

b. Treatment

- i. When you insert an airway or use resuscitation, inform the police. Resuscitative efforts can contribute to confusing elements for pathologists and law enforcement personnel if they are not informed. Some of these elements are:
 1. Marks on external aspects of the body fracture of ribs and/or sternum
 2. Spleen and liver lacerations
 3. Alteration of the airway
 4. Change in contents in the mouth

- ii. During treatment or patient exam, if you find a cartridge or any other evidence, leave it and notify law enforcement authorities.
 - iii. In drug overdose cases, if you take medication bottles, remember where you obtained them. If you give them to medical personnel at the hospital, record who you gave them to and the time.
 - iv. Do not rinse or clean hands of the patient for it may disrupt certain evidence, i.e. gun powder, blood, dirt.
- c. Clothing**
- i. Do not tear or cut through bullet holes, knife wounds, etc.
 - ii. If you must cut clothing or remove clothing, be careful, as the slightest movement can destroy evidence such as paint, hair, fiber and gun powder, etc.
 - iii. If you recover clothing, do not put everything in one bag; put each item in a separate PAPER BAG; NEVER USE PLASTIC OR CELLOPHANE.
- d.** Below is a partial list of items a law enforcement agency or crime lab might take as evidence from a crime scene
- i. Stains: blood and body fluids (saliva, semen, tears, perspiration, urine, human milk, pus)
 - ii. Fiber and textiles, clothing examination, glass.
 - iii. Gun powder particles, paints, narcotics.
 - iv. Tool mark comparison and identification with suspect tool.
 - v. Restoration of obliterated data, explosive residue.
 - vi. Soil examination, fingernail scrapings.
 - vii. Comparative microscopy: firearms, tool marks, fingernail striations.
- e.** When death is obvious at the scene
- i. If you are the first to arrive on a scene where death is obvious, insure that the police are in route to the scene.
 - ii. If you are the first to arrive on a scene where death is obvious and police have yet to arrive, keep everyone away from the area including family or friends.
 - iii. If police have yet to arrive and death is obvious at the scene which is inside a building, (i.e., house apartment) leave and protect the scene from the outside.

Resources:

Title of Policy: <i>Interfacility/Interregional Transport Policy</i>	Policy Number: Ops-118
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To provide consistent guidelines to OSF Saint James EMS System agencies/providers and hospital personnel for interfacility/interregional transports.

Note: This policy assumes that all EMS agencies/providers that provide interfacility/interregional transports have had System specific training for such transports.

Policy Statement:

The following policy is to outline what is allowed to be transported by BLS, ILS, and ALS providers from one healthcare facility to another without a RN or other appropriate professional personnel.

Policy:

1. An attending physician, clinic physician or Emergency Department physician will authorize or request interfacility transports.
2. The transferring physician will determine the appropriate receiving facility.
3. The transferring physician will receive confirmation of acceptance of the patient from the receiving facility and the receiving physician.
4. It is the transferring physician's responsibility to indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.
5. EMS agencies providing interfacility transports may only function to their level of licensure as defined by the DOT curriculum/EMS Education Standards and Department regulations unless otherwise stated in this policy.
6. Ambulance services must give consideration to maintaining adequate coverage to their service area prior to accepting the patient transfer.
7. Any patient requiring care at a level higher than the highest level of pre-hospital care provider available must be transported with an RN or other appropriate professional personnel including but not limited to a perfusionist or respiratory therapist.
8. Prior to the transfer, EMS providers shall obtain written orders from the transferring physician regarding any fluid therapy/medications and/or equipment being transferred with the patient. EMS providers may only administer/monitor fluids and medications listed within this policy.

Levels of EMS providers:

Basic Life Support (BLS) services include basic airway management, cardiopulmonary resuscitation including the use of AED's, basic shock management and control of bleeding, and basic fracture management.

Minimum staffing: 2 EMT-Basic providers

Intermediate Life Support (ILS) services include all BLS services, IV cannulation/fluid therapy, cardiac monitoring advanced airway management (Cannot do RSI/Drug assistant Intubation) and limited medication administration.

Minimum staffing: 1 EMT-Intermediate and 1 EMT-Basic

Advanced Life Support (ALS) services include all BLS and ILS services, cardiac monitoring including cardiac pacing, manual defibrillation, and cardioversion, and administration/monitoring of medications.

Minimum staffing: 1 EMT-Paramedic or Prehospital RN and 1 EMT-Basic

Fluids and Medication list:

- Crystalloid and colloid solutions may be transported by ILS and ALS providers. Saline locks may be transported by BLS providers.
- All medications as outlined in the OSF Saint James EMS System protocols for BLS, ILS or ALS, whichever is appropriate for the level of licensure of the ambulance being utilized.

Equipment that may be transported by all levels of providers (BLS, ILS, ALS):

Foley catheters

Gastric devices (NG tubes, G tubes, ostomy equipment)

Saline locks

Wound drains

Clamped vascular devices (Central lines, Groshong catheters, PIC lines)

Equipment that may be transported and used by ALS providers only:

BiPAP/Cpap- if trained

IV infusion pumps – if trained

Pain medication pumps-if trained

Portable ventilators-if trained

Chest tubes attached to suction

Nitroglycerin drips on pumps- if trained

Heparin drips on pumps – if trained

Morphine drips on pumps – if trained

Gravity Chest Tubes –

Resources:

Title of Policy: <i>Licensure Reinstatement Policy</i>	Policy Number: LI 100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Licensure	Approvals: MD, System

Background to Policy:

To ensure that qualified former EMS providers are afforded the opportunity to apply for licensure reinstatement in accordance with applicable EMS administrative code.

Policy Statement:

The OSF Saint James EMS System will allow providers, whose Illinois Department of Public Health licensure has expired within the past 36 months, to apply for reinstatement of licensure through the Department (IDPH) if the provider meets the requirements stated below.

Policy:

- A. An Illinois Emergency Medical Technician or Paramedic whose licensure has been expired for less than 36 consecutive months may apply for reinstatement through the OSF Saint James EMS System.
- B. The applicant shall provide the following to system office personnel:
 - a. State of Illinois issued photo identification
 - b. Copy of lapsed EMS certification
 - c. Current CPR/BLS for healthcare provider card, issued by an official American Heart Association training center or official American Red Cross training site. Cards “taught in accordance with AHA/ARC guidelines” but not taught by an approved training site will not be accepted for the purposes of this requirement.
 - d. ILS/ALS providers (EMT-Intermediate, EMT-Paramedic, Advanced EMT, Paramedic): current ITLS/PHTLS certification card
 - e. ILS/ALS providers (EMT-Intermediate, EMT-Paramedic, Advanced EMT, Paramedic): current PALS/PEPP certification card
 - f. Letter from most previous EMS system verifying provider was in good standing at time of licensure lapse.
 - g. Proof of completion of a prorated number of approved continuing education units based on expiration date:
 - i. 0-12 months lapsed: 30 CEU’s
 - ii. 13-24 months lapsed: 60 CEU’s
 - iii. 24-36 months lapsed: 90 CEU’s
- C. The applicant must complete an in-person interview with and receive the approval of the system Director or his/her designee to be eligible for skills testing.
- D. The applicant shall participate in a skills demonstration session to verify competency in clinical skills at the level of EMS licensure sought to be reinstated. The EMS Medical Director will then provide a letter of recommendation, attesting to the clinical qualifications and eligibility for testing, to the Illinois Department of Public Health. A current list of skills at each level to be demonstrated will be available upon request at the system office

- E. The candidate will be responsible for fees and costs associated with the reinstatement process. These fees will include, but are not limited to administrative fees, skills demonstration fee, EMS testing fees, and reinstatement fees due to IDPH. A current schedule of fees for reinstatement will be available upon request at the system office.
- F. Once the applicant has successfully completed the paperwork, interview, and skills competency requirements of this policy, the applicant will be released to challenge the applicable state licensure exam. Applicants must successfully challenge the certification exam before licensure will be reinstated.
- G. All requirements must be completed prior to the applicant reaching the 36th month of lapsed licensure
- H. Nothing in this policy shall be construed as a guarantee of licensure reinstatement, and no guarantee of reinstatement is implied

Resources:

1. [IDPH 515.640 Reinstatement](#)

Title of Policy: <i>Line of Duty Death Notification</i>	Policy Number: A109
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

Unfortunately, the rise in public safety line of duty deaths is on the rise due to various causes.

Policy Statement:

It is necessary to notify the Illinois Department of Public Health by the next business day when a licensed EMS provider is killed in the line of duty

Policy:

1. Any agency that suffers a line of duty loss of a licensed EMS provider should notify the EMS office as soon as practical.
2. The EMS System Manager/Coordinator will notify the IDPH Division Chief of Highway Safety and the IDPH Regional Emergency Medical Services Coordinator the next business day following a line of duty death.
3. If the EMS System Manager/Coordinator becomes aware through unofficial means they will verify the information and then forward the information on to those outlined in step 2

Resources:

Title of Policy: <i>Mass Casualty Incident Policy</i>	Policy Number: D-101
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Disaster/MCI	Approvals: MD, System

Policy:

I. General

- A. Mass casualty incidents for the purpose of this policy shall be defined as:
 - 1. An incident with 5 or more patients that are triaged Immediate (red) and or Delayed (yellow)
 - 2. An incident with more than 10 patients regardless of triage category
 - 3. An incident with 5 or more patients of any category that require special resources to treat or to gain access. Such as technical rescue, HazMat response, and or enhanced scene security.
- B. The first arriving company at an incident meeting the above definition shall notify dispatch that a mass casualty has occurred and shall institute the provisions of this standard
- C. Responding personnel at each MCI shall utilize the National Incident Management System.

II. Command and Control

- A. It shall be the responsibility of the first arriving company to establish command and manage the incident until relieved
- B. A staging area should be established and announced over the radio
- C. As more people arrive on scene one person should be assigned as the Operations Section Chief.
- D. Once an Operation Section Chief is assigned a Medical Group Supervisor should be assigned
- E. If no Operations Section is established the Incident Commander will assume the role of Section Chief.
- F. If no Medical Group Supervisor is established the Operations Section Chief will assume the role of the Medical Group Supervisor
- G. The Medical Group Supervisor shall establish a Triage Team, Treatment Team, and a Transport Team
- H. Each team leader shall report directly to the Medical Group Supervisor
- I. As the incident evolves the Incident Commander should assign the General Staff Functions

III. Responsibilities

- A. Incident Command
 - 1. Overall management of the incident.
 - 2. Establish the appropriate Divisions/ Groups and summon sufficient resources.
 - 3. Ensure that the EMS system coordinator and resource hospital are notified
- B. Triage

1. The immediate area where rescue operations and initial patient evaluation is being performed. Multiple triage teams may be necessary depending on the magnitude of the incident. Responsibilities include:
 - a) Identify and prioritize mitigation of scene hazards
 - b) Identify and categorize patients on scene using the START triage system
 - c) Manage the disposition of victims who are obviously deceased
- C. Treatment/Casualty Collection Point (CCP)
 1. An area located a safe convenient distance from the triage area where victims are taken for pre transport stabilization. Secondary and ongoing triage shall be performed in this area. This team can be divided by patient triage category IE Red, Yellow, Green Responsibilities include:
 - a) Secondary and ongoing triage
 - b) Pre transport treatment and packaging
 - c) Determine the level and type of transportation required and communicate this information to the transport team leader.
 - d) Supervise the delivery of patients to the transport area
- D. Staging
 1. An area where personnel, ambulances and fire apparatus report to prior to being assigned. The level and number of staging areas will be determined by the size and magnitude of the incident. Responsibilities include:
 - a) Determine the level of staging
 - b) Maintain a record of the names of all personnel deployed at the incident and record the amount and type of equipment managed by staging
 - c) Maintain a reserve of at least one ambulance, and a sufficient number of other resources as may be required
 - d) Request and deploy additional resources as needed
- E. Transport
 1. A separate area adjacent to the treatment area where the packaged patient is assigned to an ambulance for transportation to a medical facility Responsibilities include:
 - a) Ensure a communications link is established and maintained with the Resource Hospital
 - b) Notify Resource Hospital of the types and numbers of casualties including any special hazards e.g. hazardous materials
 - c) Obtain the patient's hospital destination from Medical Control and write the destination on the patients triage tag
 - d) Assign and arrange patient transportation using the patient's triage category and Resource Hospital assignment as indicated on the triage tags
 - e) Maintain a record of the patients transported and their respective destinations
 - f) Keep staging informed of estimated transport needs

- A. To achieve maximum effectiveness and efficiency certain objectives must be met with each response. These objectives are outlined below and later described as operational phases. These phases are not intended to be a “step by step” requirement. These phases describe a flow of operational objectives or events that should be met to help ensure the best possible management of a mass casualty incident.
1. Initial agency response
 2. Establishment of incident command
 3. Scene report
 4. MCI declaration
 5. Secondary response
 6. Continued incident management
 7. Release/ termination
 8. Incident documentation/ review
- B. Phase 1- Initial agency response
1. Upon receipt of a call for service by the agency’s dispatch center, the primary jurisdiction shall be dispatched and provided all pertinent call information in accordance with established protocols and policies. The primary agency responding, based on dispatch information may declare a MCI or choose to wait until a scene assessment has been made.
- C. Phase 2 - Establishment of command
1. Incident command shall be established by the first arriving unit. This person will remain in command until relieved by a person of higher rank, training, and or experience. Regardless of who the incident commander is they should not be directly involved in patient care or triage
- D. Phase 3 - Scene report
1. As soon as the pertinent information is collected the following information should be communicated to the agency’s dispatch center
 - a) Location of incident (to become incident name)
 - b) Type of incident
 - c) Hazards
 - d) Casualty Estimates
 - e) Primary casualty types
 - f) Initial access
 - g) MCI declaration
- E. Phase 4 - MCI declaration
1. Once it has been determined that the incident meets the definition of a MCI as defined by this policy the incident commander will ensure the resource hospital and EMS system Manager/coordinator are notified. The agency’s dispatch center will dispatch resources as requested by the incident commander following the agencies EMS run cards.
- F. Phase 5 - Secondary response
1. The secondary response is defined as the units responding per run card assignments or special call by the incident commander. Responding units shall report to the designated staging area or assignment. Personnel shall stay with their unit and maintain crew integrity with exception made for incoming command staff requested to assist in unified command or

to staff a position in the command structure. Responders are not to report on scene and begin an operation without being properly assigned and accounted for. Freelancing will hinder the effectiveness of the operation and put responders or other victims at risk.

G. Phase 6 - Continued incident management

1. The incident commander shall continue to manage the incident and expand or decrease as needed. Most initial branches, divisions, and groups should be established by this point. Operational objectives should be defined and in the process of completion.

H. Phase 7 – Release / termination

1. The incident commander shall release units as soon as possible, in the interest of maintaining optimal coverage for all assigned jurisdictions. No units shall return to service without accounting for their personnel and being release by the incident commander. Once all victims have reached their final disposition the IC shall notify the Resource Hospital. Upon completion of the operation the IC shall notify all participating agencies including the Resource Hospital that the operation is complete and command is terminated

I. Phase 8 Incident documentation / review

1. Incident documentation will be coordinated through the EMS office. The primary responding agency will be responsible for overall documentation. Each responding unit will be responsible for the documentation of the patients they transport.

2. After every MCI a review shall be conducted. These reviews will be used solely to address the effectiveness of the system and modify the system or components as needed. The review can also identify objectives regarding MCI operations. Each participating agency (inclusive of law enforcement, dispatch, hospitals etc.) will be asked to be represented in the review.

V. Operational considerations

A. Triage

1. Initial triage of adult patients will use the START triage system
2. Initial triage of patients less than 8 years of age will use the Jump START triage system
3. Triage personnel will place SMART triage tags on all patients
 - a) Triage tags should be attached to the patient's upper or lower extremities. The head and neck can be used as a last resort
 - b) Triage tags should include the time and triage category

B. Treatment

1. Treatment areas should be established if patient transport cannot be accomplished quickly or if on scene stabilization will be necessary
2. Treatment areas and teams should be divided by triage category
3. For the establishment of long term treatment operations requests for RMERT or IMERT should be made by incident command to the EMS system Manager/coordinator
4. In the absence of a treatment area a casualty collection point (CCP) shall be established. The CCP shall be supervised and staffed so at a minimum secondary triage can be performed

C. Transport

1. Patient destination shall be determined by medical control through consultation with the treatment sector.

2. Transport from scene does not have to be linear by triage category; i.e. all red then all yellow then all green. Patients of differing triage category may be transported in the same unit depending on patient acuity, crew capability and crew size.
3. Transport destination may be to a hospital or other designated alternative treatment site
4. Utilize alternative transport methods; i.e. busses, med vans, etc.
5. Aeromedical transport should be consistent with the aeromedical policy

D. Patient tracking

1. Transport leader

- a) The transportation leader on scene is responsible for ensuring that patient data including triage tag number, name (if available) triage category, transporting unit and destinations is recorded and that the information is accurate and current

2. Transport unit

- a) The transport unit is responsible for ensuring that patient data including triage tag number, name (if available) triage category, assessment, care provided and destination is documented

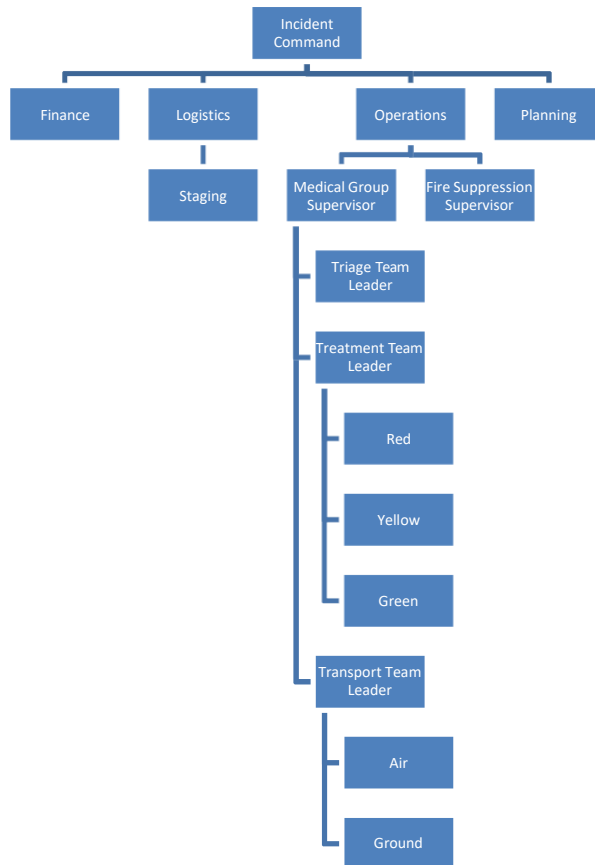
E. Responding transport units

1. Responding units are to report to the staging area unless directed otherwise by incident command. Once at staging the personnel should sign in and remain with their unit.
2. Emergency warning lights should be turned off once in staging
3. While transporting a patient a brief radio report should be given to the receiving facility. It shall ONLY include:
 - a) Triage category
 - b) Life threats
 - c) ETA
4. After transporting the unit should return to service and return to the scene unless directed otherwise.
5. Responding units are responsible for documentation for the patients they cared for.

VI. Agency requirements

- A. All EMS agencies shall review this policy, associated disaster plans and MCI management annually

VII. Sample Organization Chart



Resources:

Title of Policy: <i>Medical Control- Operational Control Point</i>	Policy Number: C-105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Communications	Approvals: MD, System

Background to Policy:

To clarify the roles and responsibilities of the Medical Control Physician and ECRN at each operational control point.

Policy Statement:

OSF Saint James John W Albrecht Medical Center of the OS Saint James EMS System are committed to providing on-line medical control at each of the emergency department operational control points, 24 hours per day. All voice orders shall be given by or under the direction of the EMS Medical Directors, or the EMS MD's designee, who shall be an ECRN or Emergency Department Physician.

Policy:

- a. The operational control point telecommunications equipment allows EMS Medical Director or their designee to monitor all EMR, EMT-Basic, EMT-I/AEMT and Paramedic to- hospital transmissions, and all hospital to First Responder, EMT-B, EMT-I/AEMT and EMT-P transmissions within the area serviced by OSF Saint James EMS System.
- b. The telecommunications equipment at all Resource and Associate Hospitals are to be staffed and maintained 24 hours every day, which includes the VHF radio control points and the required telephone equipment. All operational control points must to have the ability to receive 12-lead ECG's.
- c. All voice orders via VHF/UHF radios or on telephone equipment shall be given by or under the direction of the EMS Medical Directors or by the EMS MD's designee, who shall be an ECRN or an Emergency Department Physician. All voice communications must be recorded. These recordings must be stored for seven (7) years.
- d. Upon receiving a radio or telephone call at the operational control point, the ECRN shall initiate contact and document all appropriate information. The EMS MD or the designated on-duty emergency department physician shall be notified of the incoming call, as soon as possible.
- e. Once the EMS MD or the Medical Control Physician designee has arrived at the operational control point, the ECRN and Physician shall continue to utilize the field treatment protocols as a patient treatment guide during the EMS call. If the EMS MD or the Medical Control Physician is not readily available, the ECRN has the authority, delegated by the EMS Medical Directors, to CONTINUE EMERGENCY CARE IN ACCORDANCE WITH THE FIELD TREATMENT PROTOCOLS.
- f. If the EMS MD or Medical Control Physician is not present at the operational control point at the time of a call which requires orders for procedures marked contact medical control, THE ECRN IS NOT AUTHORIZED TO INITIATE THAT ORDER. Those orders marked **contact medical control**

REQUIRE MEDICAL CONTROL PHYSICIAN DIRECT VERBAL ORDERS TO PERFORM. However, this verbal order may be relayed through an ECRN.

- g. In the absence of the EMS MD at the operational control point, the on-duty Medical Control physician has the responsibility to follow the field treatment protocols as approved by and under the authority of the EMS Medical Directors.
- h. Communications from the operational control point must be available to the OSF Saint James EMS System for review.

Resources:

1. [IDPH 515.740 Emergency Communication Registered Nurse \(ECRN\)](#)

Title of Policy: <i>MERCI Radio Operations</i>	Policy Number: C-106
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Communications	Approvals: MD, System

Background to Policy:

To ensure the proper use of the M.E.R.C.I. radio and provide operational guidance to the ECRN and the Medical Control Physician.

Policy Statement:

The following guidelines have been established to assist the ECRN or Medical Control Physician in the proper use of the M.E.R.C.I. radio system. The guidelines were adopted from the Rules and Regulations of the Federal Communications Commission and the Illinois Department of Public Health.

Policy:

- a. Do not use "10" codes during any radio transmission.
- b. Only ECRN's, the EMS System Manager/Coordinator, and Medical Control Physicians are permitted to receive patient information and transmit verbal orders via M.E.R.C.I. radio.
 - i. While not ideal, another individual such as a tech or a secretary, may answer a radio call and tell the EMS unit to standby for an ECRN or Medical Control Physician.
- c. Insure M.E.R.C.I. radio recorder is on and operating correctly at all times.
- d. End all radio communications by clearly stating the current time and the radio call sign.
- e. Difficulties encountered during radio operations should be reported to the EMS System office on an incident report.

Resources:

Title of Policy: <i>Mutual Aid Services</i>	Policy Number: Ops-120
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To verify all affiliate agencies of the OSF Saint James EMS System provide and receive mutual aid services as dispatched by their respective Telecommunications Center in accordance with established protocols.

Policy Statement:

All ambulance transport agencies affiliated with the OSF Saint James EMS System are in compliance with the [Title 77: Illinois Adm. Code, Chapter I, Part 515, Section 515.810h] requirement of utilizing a back-up system providing or receiving mutual aid services. All non-transporting agencies including EMR Services of the EMS Systems also have simultaneous dispatched mutual aid services provided by a transporting ambulance service. Tele-communicators utilize protocols that provide for automatic, simultaneous, or back-up mutual aid services depending upon specific needs or situations.

Policy:

- A. All agencies within the OSF Saint James EMS Systems are dispatched by Tele-communicators. Tele-communicators utilize protocols that provide for **automatic, simultaneous or back-up mutual aid services** depending upon specific needs or situations.
- B. All non-transporting agencies including Emergency Medical Responder within the OSF Saint James EMS System also have **simultaneous dispatched mutual aid services** provided by a transporting ambulance service.
- C. In cases of an emergency arising within the response area of the OSF Saint James EMS System affiliate agency where the situation is beyond its own resources of personnel and/or equipment to provide EMS services, or is unable to provide EMS services (i.e. manpower...) shall request mutual aid assistance through contacting their respective telecommunications Center.
- D. The Telecommunications Center shall dispatch according to established protocol of the nearest appropriate EMS agency and resources.
- E. All agencies within the OSF Saint James EMS System must have a completed EMS "Box Card" on file to follow in a MCI incident.

Resources:

Title of Policy: <i>Notification of Ambulance Personnel of Exposure to Communicable Disease</i>	Policy Number: IC-101
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Infection Control	Approvals: MD, System

Background to Policy:

1. To identify and notify those pre-hospital personnel who transport a patient with a communicable or infectious disease, so that those personnel may take necessary precautions prior to or seek recommended treatment following patient contact.

Policy Statement:

1. The hospital shall notify pre-hospital care providers if it is determined a patient transported by ambulance personnel has a communicable or infectious disease.

Policy:

- a. Pre-hospital providers shall complete a patient care report on each patient transported and submit a copy to the receiving facility.
- b. Pre-hospital patient care reports shall include any significant exposure to patient body substances.
- c. If patients transported by pre-hospital services are diagnosed as having a communicable or infectious disease, the involved pre-hospital personnel shall be notified by the hospital's Infection Control department within seventy-two (72) hours after the confirmed diagnosis. The designated employer or person in charge of the pre-hospital service has the responsibility of notification of the involved pre-hospital providers.
- d. If EMS personnel that are transporting a patient are directly exposed to a patient's body substances, the pre-hospital personnel should indicate "*Significant Exposure*" on the run sheet.
- e. All pre-hospital care providers, including those from outlying areas, shall complete an incident form with an explanation of "*Significant Exposure*."
- f. Types of Exposure
 - i. Parenteral (i.e., needle stick)
 - ii. Mucous membrane (eyes, mouth, genital)
 - iii. Significant skin exposure (i.e., open sores, cuts, cracks in skin) to blood, urine, saliva, bile, semen
- g. When a hospital patient with a listed communicable disease is to be transported by pre-hospital personnel, the hospital staff sending the patient shall inform the pre-hospital personnel of any precautions to be taken to protect against exposure to disease. If the pre-hospital personnel fail to take precautions and a significant exposure occurs, the pre-hospital personnel shall complete an incident report form and send it to the EMS System office.
- h. Pre-hospital personnel shall maintain all information received as confidential medical records.

Resources:

1. [System Incident Report Form](#)
2. [IDPH Reportable Diseases Poster](#)

Title of Policy: <i>Patient Abandonment vs. Prudent Use of EMS Personnel</i>	Policy Number: L-105
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD/System

Background to Policy:

To assure that pre-hospital abandonment of patients does not occur unless specifically defined conditions exist.

Policy Statement:

Patient abandonment occurs when there is termination by the physician (or his agency, i.e. the EMR/EMT/EMT-I/AEMT/Paramedic/Pre- hospital RN) of the doctor/patient (EMS/patient) relationship without consent of the patient and without allowing sufficient time and resources for the patient to find equivalent care. This is assuming, and unless proven otherwise, there exists a need for continuing medical care and the patient is accepting treatment.

Policy:

- a. EMS personnel must not leave a patient if there is a need for continuing medical care that must be provided by a knowledgeable, skilled, licensed EMS provider unless one or more of the following conditions exist.
 - i. The patient or legal guardian refuses pre-hospital care and transportation. In this instance, follow the procedure as outlined in the “Patient Right of Refusal” policy.
 - ii. Pre-hospital personnel are physically unable to continue care of the patient due to exhaustion or injury.
 - iii. When law enforcement, fire officials or the EMS crew determine the scene is not safe and immediate life or injury hazards exist.
 - iv. The patient has been determined to be dead and all policies and procedures related to death cases have been followed.
 - v. If medical control concurs with a DNR order.
 - vi. Whenever specifically requested to leave the scene due to a specific overbearing need (i.e., disaster, triage prioritization).
 - vii. Medical care and responsibility for the patient is assumed by comparably trained, certified and licensed personnel. Refer to “Physician/Nurse at Scene” policy and “Patient Hospital Preference” policy.
- b. If EMS personnel determine that a continuing medical need does exist and the patient refuses care, the EMS crew shall establish communication with Resource Hospital Medical Control and request medical direction in determining the patient’s right to refuse. Refer to “Patient Right of Refusal” policy for the process to follow for refusal of care regardless of circumstances surrounding the refusal.
- c. EMS personnel may leave the scene of an episodic illness or injury incident where initial care has

been provided to the patient or securing a signed refusal, if the following conditions exist:

- i. Delay in transportation of another patient from another patient from the same incident would threaten life or limb.
 - ii. An individual or occurrence of a more serious nature elsewhere necessitates life-saving intervention which could be provided by the EMS crew and without consequence to the original patient.
 - iii. Definitive arrangements for the transfer of care and transportation of the initial patient to other appropriate personnel must be made prior to the departure of the EMS crew; and, the alternate arrangements, should, in no way, jeopardize the well-being of the initial patient.
- d. If the patient requests transportation to a hospital outside of the ambulance primary response area, and there exists no obvious need for stabilization at a nearer hospital, the EMS crew may make arrangements for transfer of the patient's care to a more appropriate ambulance service. Alternate arrangements and release of the patient should be carried out with the approval of Medical Control. Whenever possible, the EMS crew should remain with the patient until the arrival of the transporting ambulance. The "Patient Right of Refusal" policy and "Patient Hospital Preference" policy should also be referenced in such cases. Consult your agency's policies regarding transport of patient's out-of-district.
- e. If the patient requests transportation to a hospital outside of the ambulance primary response area, and there exists obvious or potential need for stabilization at a nearer hospital, the EMS crew should immediately contact Medical Control and follow the directions of the Resource Hospital Physician. The "Patient Right of Refusal" policy and "Patient Hospital Preference" policy should also be referenced in such cases.

Resources:

Title of Policy: <i>Patient Confidentiality/Release of Information</i>	Policy Number: A-106
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To assure appropriate confidentiality of personal and sensitive information regarding patient care and/or prognosis as well as ensure the legal authorization on release of patient information.

Policy Statement:

All OSF Saint James EMS System personnel are exposed to or engaged in the collection, handling, documentation or distribution of patient information. Therefore, all EMS System personnel are responsible for the protection of this information. The OSF Saint James EMS System and affiliate EMS agencies have a statutory duty to protect the confidentiality of patient records. In all situations, including subpoenas, to obtain legal release of patient information, all requests for pre-hospital patient care information shall be directed to the EMS agency's affiliate Resource Hospital's Medical Records Department.

Policy:

- A. The OSF Saint James EMS System agencies and personnel and all others involved in EMS patient care have a statutory duty to protect the confidentiality of patient medical records in accordance with the Illinois EMS Systems Act [210 ILCS, 50/3.195], and the Illinois Medical Patients' Rights Act [410 ILCS 50/3 (d)]. Under 735 ILCS 5/8-802 which was amended in 1995 to broaden the definition of health care providers subject to Medical Records as privileged communications, includes entities which provide medical services. Clearly the services as an Emergency Medical Technician or Pre-hospital RN fulfill the role of one providing medical services.
- B. In all situations, including subpoenas, to obtain legal release of patient information, all requests for pre-hospital patient care information shall be directed to the EMS agency's affiliate Resource Hospital's Medical Records Department. It is the responsibility of the Medical Records Department to verify a legal release of patient medical records, written or recorded. The duty of confidentiality would be breached by production of any written or recorded documentation **BY ANYONE** pursuant to:
 - A subpoena directed to the Resource Hospital's Medical Records Department; or
 - A signed authorization by the patient for "Release of Information/Medical Records; and
 - Verification of legal release of patient information by the Medical Records Department.
- C. Unnecessary sharing of confidential information will not be tolerated by the OSF Saint James EMS System. EMS personnel must understand that breach of confidentiality is a serious infraction with personal legal implications and may result in corrective action, including System licensure suspension.
 1. Written
 - Confidentiality regarding written patient care documentation is governed by the "Need to Know" concept.

- Only EMS System personnel and Hospital Medical staff from third party payers should be directed to the Resource Hospital's Medical Records Department.
- Request for Release of all patient care information, including request from third party payers, should be directed to the Resource Hospital's Medical Records Department.
- Request by law enforcement, coroner, fire or other agencies for patient care reports must also be directed to the Medical Records Department.

2. Verbal

- System personnel are not to discuss specific patients in public areas. Loose or "elevator talk" regarding specific patient problems and/or care is inappropriate.
- Do not repeat to your friends and relatives, or the friends and relatives of patients, any information learned through the course of carrying out your duties. If you learn of the hospitalization of a friend or relative, you may not act on that information or pass it on unless it came from an outside source or the patient himself. If you happen upon information (or the chart) of a friend or relative in the course of performing your job, you are responsible for keeping that information confidential.

3. Radio

- Generally, no patient name will be mentioned in the process of pre-hospital radio transmissions utilizing MERCI regarding non-direct admit patients.
- Customary "Direct Admits" may need to have the initials of patient's names included in the radio transmissions. This is necessary for identification and is acceptable to transmit.
- Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.

D. Scene

- Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and en route.
- EMS personnel should limit bystanders at the scene of an emergency. Law enforcement may be called upon to assist in maintaining bystanders at a reasonable distance.
- EMS providers whom encounter an individual filming a scene, should not directly confront the individual. Rather create a barrier around the patient using providers, vehicles, or blankets. The patient should be moved as quickly as what is safe to the waiting ambulance.

Title of Policy: <i>Patient Hospital Preference</i>	Policy Number: Ops-121
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD/System

Background to Policy:

To assure patient hospital preference is respected unless such preference would potentially jeopardize or would compromise patient outcome. Ensure compliance with State and Federal laws and regulations.

Policy Statement:

The patient has the right to choose the hospital he/she is transported to unless Medical Control determines otherwise. Any ambulance service provider with OSF Saint James EMS System affiliation, which is owned and operated by any of the System's participating hospitals (OSF Healthcare) are subject to transport an emergency patient to the provider's own hospital by mandate of Federal Anti-dumping Statute (42 CFR 489.24) of the Emergency Medical Treatment and Active Labor Act (EMTALA)

Policy:

DEFINITIONS:

EMERGENCY- A MEDICAL CONDITION OF RECENT ONSET AND SEVERITY THAT WOULD LEAD A PRUDENT LAY PERSON, POSSESSING AS AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, TO BELIEVE THAT URGENT OR UNSCHEDULED MEDICAL CARE IS REQUIRED. (Illinois EMS Systems Act [210 ILCS 50] Section 3.5)

EMTALA - Emergency Medical Treatment and Active Labor Act (42 CFR 489) requires a hospital that operates an ambulance service to insure an emergency patient is transported to the ambulance provider's own hospital. To transfer the patient anywhere else would be a EMTALA transfer. The hospital with ownership of that ambulance service must comply with all requirements of a EMTALA transfer if the patient is not transported to said hospital.

TRANSFER - The movement of an emergency patient from the pre-hospital scene to a medical facility at the direction of the agency's Medical Control Physician.

INFORMED CONSENT -

A patient who is of legal age and is a mentally competent adult signifying that he/she knows, understands and agrees to patient care rendered and is aware of:

1. The nature of the illness or injury
2. The recommended treatment and associated risks
3. The alternative treatment and risks involved
4. The danger of refusing treatment

In the pre-hospital setting, EMS providers are not obligated to obtain consent at the same

degree as within a health care facility. The patient must only verbally agree or at least not object to the general nature of the treatment.

- STABILIZED -** In respect to a patient with an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer, (as defined in this part), of an individual to a medical facility other than the nearest appropriate facility.
- A. Patient choice and medical urgency should be the guiding principles to EMS personnel as to where each ambulance case is delivered. However, it is inherent that each patient has the right to make an informed decision, provide Informed Consent, as to which hospital they are transported to within the service area of the ambulance agency as defined by the EMS System Plan.
- B. **NO EMERGENCY PATIENT** of any EMS agency affiliated with the OSF Saint James EMS System shall be transported to a medical facility which is not within the service area of said EMS agency without first being STABILIZED and approved by the Medical Control Physician.
- C. ALL EMS AGENCIES OWNED BY A HOSPITAL PARTICIPATING IN THE OSF Saint James EMS SYSTEM ARE REQUIRED TO COMPLY WITH EMTALA AS DEFINED IN THIS PART.**
- If transport to the EMS agency's own hospital bypasses the closest hospital or trauma center; the receiving hospital has no EMTALA transfer issue, but the hospital directing the transport (which may be a different hospital) must still comply with the EMS System Bypass/Diversion policy.
 - If a patient is transported to the closest hospital or trauma center but that is not the hospital that operates the ambulance service:
 - The hospital giving medical direction has no EMS System bypass/diversion issue, but the EMS agency's own hospital must still handle it as a EMTALA transfer issue.
- D. Should the patient refuse to be transported to the nearest appropriate facility, the patient should be advised of the risk, if any, associated with not being transported to the nearest appropriate hospital. Once risk factors have been explained, the patient's decision should be honored unless superseded by the Medical Control Physician (in compliance with this part), by the Trauma Policy/ or Bypass/Diversion Policy.
- E. All **TRAUMA** patients shall be subject to the Field Triage of the Trauma Patient policy, as well as the Illinois Department of Public Health Rules and Regulations, Section 515. Appendix C, "Minimum Trauma Field Triage Criteria".
- F. Patient hospital preference should be documented on the EMS EPCR.

Title of Policy: <i>Patient Restraints</i>	Policy Number: S-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Safety	Approvals: MD, System

Background to Policy:

1. The use of patient restraints should be held to a minimum and only used as a last resort to transport a patient who exhibits physical resistance to transport or violence towards EMS personnel. The purpose of restraints is not to arrest, but to protect the patient and others from his or her irrationality.

Policy Statement:

1. To assure appropriate use of patient restraints in the pre-hospital setting.

Policy:

- a. The use of restraints is determined by the physical resistance to transport or violence towards EMS personnel by a patient who meets the criteria for implied consent and intentionally or unintentionally physically injures himself/herself or others.
- b. Whenever possible, Medical Control is contacted for guidance and concurrence in determining the need for restraints. Unless patients possess an immediate threat to themselves or other persons, Medical Control should be contacted prior to the restraint.
- c. Attempt voluntary application of restraints.
- d. Notify the local law enforcement to respond.
- e. If voluntary restraint is not possible, assemble adequate personnel. Ideally, this should include one person for each of the patient's limbs.
- f. For Involuntary Restraint, do not spend much time bargaining with the patient. If the patient does not respond in a brief time to the request for voluntary restraint, then move quickly to apply involuntary restraint. Indecisiveness may agitate the patient even further.
- g. EMS Personnel shall use all the force reasonably required to restrain the patient for the safety of all involved individuals. "Reasonable force" depends on the degree of resistance on part of the patient. The force of restraint must equal the degree of combativeness. Legal claims of excessive force may be made for restraint beyond what is necessary.
- h. Once the patient is on the stretcher, begin application of restraints. The patient should be gently grasped and placed on his/her back. In addition to four extremity restraints, the cot's five straps (over-the-shoulder, chest, hips and legs) should be applied.
- i. The gender of the pre-hospital personnel present when restraints are being applied should be considered in relation to the patient's problem (i.e., it is better to have same gender EMS crewmember present when a patient is out of control and needs restraint).
- j. After application of restraints, the patient must at no time be left alone. Someone must be assigned to talk with the patient about the patient's feelings and explain the purpose of the restraints.
- k. Restraints must periodically be checked for proper application (i.e., adequate circulation to limbs,

with documentation in the Patient Care Report that these periodic checks were conducted at least every five minutes).

- I. A patient under arrest by a law enforcement agency must first be restrained with hand-cuffs. Restraint and/or transport of a patient to a hospital by EMS personnel who is under arrest but has not been restrained initially with hand-cuffs by law enforcement ARE NOT TO BE RESTRAINED

AND/OR TRANSPORTED BY EMS PERSONNEL until hand-cuffs have been applied. The application of hand-cuffs must not interfere with patient care. If a patient has hand-cuffs applied then law enforcement must accompany patient in the back of the ambulance.

- m. Documentation Requirements
 - i. Indication for using restraints (i.e., presence of self-destructive behavior, danger to others, meets criteria for implied consent, under arrest by law enforcement).
 - ii. Prior attempts at less restrictive alternatives (i.e., verbal communication).
 - iii. Periodic checks for proper application.
- n. Avoiding Injury
 - i. Keep at a safe distance whenever possible.
 - ii. Expect the unexpected.
 - iii. Never turn your back to the patient.
 - iv. Watch out for the patient's head; the patient can and will bite.
 - v. Remove any sharp objects from the patient's immediate environment.
 - vi. Never restrain a patient face down.
 - vii. Never restrain the legs to the arms.
 - viii. Assess for digital circulation every five minutes after restraint application.

Title of Policy: <i>Patient Right of Refusal</i>	Policy Number: L-107
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Policy Statement:

Competent patients have the right to accept or refuse any or all prehospital care and transportation provided the decision to accept or refuse treatment or transportation is made on an informed basis and these patients have the mental capacity to make and understand the implications of such a decision.

Policy:

Patient – A person for whom EMS was activated, that has suffered some form of mechanism and/or verbalizes a complaint, and the EMS provider establishes verbal and/or physical contact.

Minor – Any person under 18 years of age.

Emergency – A medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and unscheduled medical care is required.

Implied consent – A situation involving and unconscious or incompetent patient where care is initiated under the premise that the patient would desire such care if they were able to make the decision. In the case of a minor, if a parent or legal guardian is not present, care and transportation is provided on the basis of “Implied Consent”.

Against Medical Advice (AMA) – The refusal of treatment or transport by a patient against the advice of medical personnel on scene and Medical Control.

Competency – The ability of a person to understand the nature of his/her illness/injury with no significant mental impairment by illness, injury, or mind altering substances and understands the consequences of refusing medical care. Competency of a patient will be assessed by:

1. Orientation to person, place, and time.
2. The ability to hear and understand
3. Lack of significant illness that would affect sound judgment, i.e. hypo perfusion, hypoxia, hypoglycemia, or other organic illness
4. Lack of significant injury that would affect sound judgment, i.e. head injury, hypoxia, hypo-perfusion
5. Lack of mind altering substances, i.e. alcohol, drugs, medications, or other substances

Pre-hospital personnel allowed to obtain refusals;

1. Paramedic
2. PHRN
3. EMT-I/AEMT
4. EMT-B
5. EMR (Low risk patients only)

High risk patients include, but not limited to:

1. Head injury (based on mechanism or signs and symptoms)
2. Any trauma with significant mechanism (i.e. MVC rollover)
3. Chest pain
4. SOB/dyspnea
5. Syncope
6. Seizure (new onset)
7. Head ache (new onset)
8. TIA/resolving stroke symptoms
9. Pediatric complaints
10. Presence of alcohol and/or drugs
11. Altered level of consciousness or impaired judgment

Low risk patients:

1. Slow speed MVC without injury
2. Isolated injuries not associated with significant mechanism
3. Low mechanism of injury
4. Ground level fall

Who May Refuse Care

1. The patient
 - a. If a patient is legally, mentally, and situationally competent, the patient has the right to refuse care. Obtain refusal signature.
2. Parent
 - a. A custodial parent (i.e., a parent with a legal right to custody of a minor child) may refuse on behalf of a minor child. Obtain refusal signature from parent.
 - b. A parent of a patient who is 18 years of age or older may not refuse care for his or her child (unless the parent is also happens to be a legal guardian - see below).
 - c. A minor (i.e., under 18 years of age) may refuse care for his or her child. Obtain refusal signature from minor parent.
3. Guardian

- a. A legal guardian is one who is appointed by a court to act as “guardian of person” of an individual who has been found by a court to be incapacitated.
 - b. Legal guardian may also be appointed in lieu of parents for a minor
 - c. If a person indicates they are a legal guardian to the patient, attempt to obtain documentation of this fact (court order, etc.) and attach to trip sheet. If no such documentation is available, you may obtain refusal signature from the guardian as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the legal guardian of the patient.
4. Health Care Agent (Attorney in Fact)
- a. A person appointed by the patient in a durable power of attorney document may refuse care of behalf of the patient if the power of attorney contains such authorization.
 - b. Attempt to obtain a copy of the durable power of attorney document to attach to the trip sheet. If no such documentation is available, you may obtain refusal signature from the health care agent (“attorney in fact”) as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the health care agent or “attorney in fact” of the patient.

Procedure:

- A. All patients will be offered treatment and transportation to a hospital after an accurate patient assessment has been conducted to include: patient’s complaint, history and objective findings, and patient’s ability to make sound decisions.
- B. Determine mental competency of the patient and the reason for refusing care. (Complete the Informed Decision Making Form) Providers should assess three major areas prior to permitting a patient to refuse care and/or transportation:
 1. Legal Competence
 - a. Assure that patient is at least 18 years of age
 - b. Or, if a minor, patient may refuse care if he or she is a 17 year old high school graduate, is married, or is currently or has ever been pregnant.
 - c. Patients subject to court decree of incapacity are not legally competent to refuse care.
 2. Mental Competence
 - a. Start with the presumption that all patients are mentally competent unless your assessment clearly indicates otherwise.
 - b. Ensure that patient is oriented to person, place, time, and purpose.
 - c. Establish that patient is not a danger to himself or others.
 - d. Ensure that patient is capable of understanding the risks of refusing care or transportation and any proposed alternatives.
 - e. Check to be sure that patient is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, etc.

3. Medical or Situational Competence
 - a. Ensure that patient is suffering no acute medical conditions that might impair his or her ability to make and informed decision to refuse care or transportation.
 - b. If possible, rule out conditions such as hypovolemia, hypoxia, head trauma, unequal pupils, metabolic emergencies (e.g., diabetic shock), hyperthermia, hypothermia, etc.
 - c. Attempt to determine if patient lost consciousness for any period of time.
 - d. If any conditions in (a)-(c) impair patient's decision-making ability, patient *may* not be competent to refuse care. This would be considered a "High Risk Refusal" and Medical Control should be contacted. Your documentation should clearly establish that the patient understood the risks, benefits, and advice given to him.

- C. Explain to the patient the risk associated with their decision to refuse treatment and transportation.

- D. Inform the patient they may contact EMS if they change their mind

- E. Advise the patient to seek medical care, i.e. go to a hospital, doctor's office, clinic, etc.

- F. High risk patients:
 1. Establish voice contact via MERCI radio or cellular telemetry with Medical Control and relay the patient's complaint, history, complete assessment and vital signs. Clearly state that the patient refuses treatment and transport.

The hospital will respond with the following statement to be heard by the patient:

You have not been evaluated by an emergency department physician; therefore the EMS system does not recommend refusals of treatment and transport. Since you are refusing treatment and transport despite being informed of the associated risks, it is recommended you be evaluated by your primary physician or the nearest emergency department as soon as possible.

 2. After receiving concurrence by Medical Control to accept refusal, complete the Release of Medical Responsibility Form (example pp.46-47) and have the patient sign the form. If a minor, this form must be signed by a legal guardian. **MINORS CANNOT REFUSE CARE AND TRANSPORTATION TO THE HOSPITAL!**

 3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.

- G. Low risk patients
 1. EMR's will establish contact with Medical Control and follow the recommendations of the Physician or ECRN.
 2. EMT-B, I/AEMT, and P pre-hospital personnel will complete the Release of Medical Responsibility form and reasonably assure the patient understands the refusal

3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.
 4. A crew member may sign as a witness, but only when no other appropriate bystanders, police, or family are available to witness the refusal.
- F. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and also refuses to sign the release, clearly document refusal to sign on the bottom section of the report, and have the entire crew witness the statement. Have an additional witness sign preferably a police officer. Include unit and badge number. Establish voice contact via MERCI or cellular telemetry with Medical Control and state that the patient refuses treatment/transport, and also refuses to sign the release. Request the tape number and mark the chart to be reviewed.
- G. Refusal of transport to the nearest appropriate medical facility
1. If a patient refuses transport to the closest appropriate medical facility and the refusal would create a life threatening or "high risk" situation, follow the policy for "Patient Right of Refusal" and treat it as a "High Risk" refusal. After contact with Medical Control, obtain the patient's refusal signature and transport to the requested medical facility.
 2. If a patient refuses transport to the closest appropriate medical facility and the refusal would **not** create a life threatening or "high risk" situation, follow the policy for "Patient Right of Refusal" and treat it as a "Low Risk" refusal. Obtain the patient's refusal signature and transport to the requested medical facility.

Bypass or Diversion of a Hospital

1. If a hospital diverts an incoming ambulance or in any way refuses to accept an emergency patient, transport the patient to the nearest appropriate medical facility. Complete and Incident Report and forward to the EMS Office.

Refusal of Transport after Emergency Treatment

1. Some patients will refuse care after emergency treatment, i.e., hypoglycemia in diabetic patients.
2. If the patient meets the criteria for competency and the patient has received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "High Risk" refusal. After contact with Medical Control, obtain the patient's refusal signature.
3. If the patient meets the criteria for competency, has not received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "Low Risk" refusal. Obtain the patient's refusal signature.

NOTE:

1. **False calls or other "third party" calls where the person states they did not call for EMS assistance, the EMS provider does not need to obtain a written refusal. An EMS report still needs to be completed by the EMS provider for the emergency response.**
2. **Calls for assistance for transfer, where no mechanism of injury exists, the EMS provider does not need to obtain a written refusal (e.g. transfer from chair to bed, transfer from car to home). An EMS report still needs to be completed by the EMS provider for the emergency response**

EMS SYSTEM REFUSAL FORM AND INSTRUCTIONS

AGENCY	DATE/TIME OF CALL	PATIENT'S NAME
SECTION A: MEDICAL DECISION MAKING CAPACITY (Must be completed by medical provider)		
1. New onset of altered mental status?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Known or suspected head trauma?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Active suicidal ideations or evidence of recent self-inflicted harm present?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Is there any loss of consciousness associated with this incident?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Does the patient present as a significant life threat to self or others?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Did the patient score greater than 8 on the capacity exam? <i>(see checklist on back of page)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Is the patient unable to communicate choice? Is there a language barrier?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Is the patient under the age of 18?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Is the patient unable to engage in reasoning about treatment options?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Is the patient under the influence of alcohol or medication to the point of altering judgment and/or decision making capacity? <i>(see list on back of page)</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES is checked to any of the questions, and the patient is refusing EMS care and/or transport, they may not have adequate decision making capabilities. Medical control should be contacted.		Telemetry Run #
SECTION B: ASSESSMENT/TREATMENT REFUSED (Check all that apply)		
<input type="checkbox"/> Patient deemed competent, refuses all EMS care and ambulance transportation.		
<input type="checkbox"/> Patient deemed competent, accept the following pre-hospital care; yet refuses transport. <i>(List care below)</i> _____ _____		
<input type="checkbox"/> Patient deemed competent, accepts ambulance transportation, but refuses the following pre-hospital care <i>(Check all that apply)</i>		
<input type="checkbox"/> Oxygen <input type="checkbox"/> Physical Exam <input type="checkbox"/> IV access <input type="checkbox"/> Spinal Precautions <input type="checkbox"/> EKG application <input type="checkbox"/> Vital Sign assessment <input type="checkbox"/> Medication _____ <input type="checkbox"/> Other _____		
SECTION C: PATIENT/GUARDIAN/POWER OF ATTORNEY HAD BEEN ADVISED		
1. EMS explained the potential known and unknown problems including, but not limited to: _____ _____		
*Patient is able to verbalize understanding of their clinical situation. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No is marked Medical Control needs to be contacted.</i>		
2. EMS explained potential for fatal or permanently disabling consequences including, but not limited to: _____ _____		
*Patient is able to verbalize understanding of risks. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No is marked Medical Control needs to be contacted.</i>		
<input type="checkbox"/> Advised patient to seek care with an Emergency Department or physician as soon as possible. <input type="checkbox"/> Advised the patient to call 9-1-1 or their local EMS if their condition changes or they change their mind regarding care and transport.		
3. What is patient's plan to seek further medical evaluation? _____		
SECTION D: PATIENT SIGNATURE (This section to be completed by the patient or patient representative)		
I (we), the undersigned, hereby certify that I (we) refuse <input type="checkbox"/> recommended treatment and/or <input type="checkbox"/> ambulance transportation to the appropriate hospital emergency department for <input type="checkbox"/> myself <input type="checkbox"/> minor less than 18 or <input type="checkbox"/> Other: _____.		
I (we) having been so advised by Ambulance Medical Personnel that treatment or transportation is recommended, hereby accept all responsibility connected with my (our) refusal and release the Ambulance Company, their employees, medical personnel, administrative and executive officers from any and all liability or claims resulting from any such refusal of treatment and/or transportation. Instruction form provided to patient <input type="checkbox"/> YES <input type="checkbox"/> NO		
SIGNATURE	PRINTED NAME	DATE
PATIENT OR REPRESENTATIVE		
WITNESS		
EMT/PARAMEDIC		

PATIENT DECISION MAKING CAPACITY CHECKLISTS

Brief Mental Capacity Evaluation

Item	Score		
	# of Errors	x (Weight)	= (Total)
What year is it now?	0 or 1	x 4	= _____
What month is it?	0 or 1	x 3	= _____
Present memory phrase: Ask the patient to repeat the phrase and remember it. “<u>John Brown</u>, <u>42 Main St Peoria</u>”			
About what time is it currently? <i>(Answer correct if within 1 hour)</i>	0 or 1	x 3	= _____
*Count backwards from 20 to 1	0, 1, or 2	x 2	= _____
*Say the months of the year backwards	0, 1, or 2	x 2	= _____
Repeat the memory phrase. <i>(each of the underlined portions is worth 1 point)</i>	0, 1, 2, 3, 4, 5	x 2	= _____
* <i>Note that although it is possible to make more than two errors when counting backwards from 20 to 1 or saying to months in reverse, the maximum number of points given would be 4 in each case.</i>	Final score is equal to the sum of the totals = _____ A score of 0 to 8 indicates normal capacity A score of 9 to 19 indicates mildly impaired capacity A score of 20 to 28 indicates severely impaired capacity		= _____

Potential Signs and Symptoms of patient Intoxication.	Remember Some Conditions can Mimic Intoxication
• Impairment of reasoning and memory	• Infections
• Exaggerated behavior and intensified emotions	• Respiratory disease, hypoxia
• Slurred speech	• Head injury, subdural haematoma
• Impairment of motor coordination	• Diabetes, hypoglycemia
• Reduced judgment and self-control	• Epilepsy (temporal lobe), post-ictal
• Rapid movement of eyes to one side (nystagmus)	• Meningitis
• unsteady gait,	• CVA or TIA

INSTRUCTIONS

X UNIVERSAL INSTRUCTIONS:

- If you change your mind or your condition becomes worse and you decide to accept treatment and transport by Emergency Medical Services, please do not hesitate to call us back or seek other medical care.
- If any time you take a medicine and become short of breath, start wheezing, get hives or a rash, or have an unexpected reaction, call 9-1-1 or your local emergency number immediately. **ALWAYS** take medicine as directed on the label. **NEVER** take someone else's prescription medication.

<p>___ CHEST PAIN:</p> <ul style="list-style-type: none"> • There are many causes of chest pain. The cause of your chest pain cannot be determined. • Avoid activity that increases your pain. • If you smoke, QUIT! • Take deep breaths each hour even if it hurts. • If you take medicines for chest pain, take your medicine as directed. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Your pain worsens with activity.</i> • <i>You develop difficulty breathing.</i> • <i>You develop cough, chills, fever, upset stomach, shoulder, jaw, or back pain, throw up blood, see blood in your urine, fever greater than 101°</i> • <i>You have blood come up when you cough.</i> • <i>You develop black or sticky stools</i> • <i>You faint (pass out).</i> 	<p>___ BELLY PAIN:</p> <ul style="list-style-type: none"> • Belly pain is also called abdominal pain. • Many illnesses can cause belly pain and the EMS crew cannot determine the cause of your belly pain. • Take your temperature every 4 hours. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Your pain gets worse or is only in 1 area.</i> • <i>You throw up blood, have blood in your stool, or have black or sticky stools.</i> • <i>You become dizzy or faint</i> • <i>You have a temperature over 101° trouble passing urine, or trouble breathing.</i> 	<p>___ FEVER:</p> <ul style="list-style-type: none"> • ALWAYS take medicines as directed on the label. Tylenol (acetaminophen) and ibuprofen can be taken at the same time. • If you are taking any antibiotics, take them until they are gone, not until you are feeling better. • Drink extra non-caffeinated liquids (1 glass of water, soft drink, or Sports drink per hour of fever for an adult). • If the temperature is above 103°, it can be brought down by sponge bath with room temperature, NOT COLD, water. • Take your temperature every 4 hours. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Temperature is greater than 101° for 24 hours.</i> • <i>A child becomes less active or alert.</i> • <i>You develop a rash.</i> • <i>Your fever does not come down with acetaminophen or ibuprofen.</i>
<p>___ SHORTNESS OF BREATH:</p> <ul style="list-style-type: none"> • Respiratory distress is also known as shortness of breath or difficulty breathing. • There are many causes of respiratory distress. • You should avoid any substance that causes you any difficulty breathing. • If you take medication for difficulty breathing, take your medication as directed. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Temperature is more than 101°</i> • <i>The cough, wheeze, or difficulty breathing become worse or does not improve, even if taking medications.</i> • <i>You have chest pain.</i> • <i>Your sputum (spit) turns color.</i> • <i>You are not able to perform normal activities.</i> 	<p>___ EXTREMITY INJURY:</p> <ul style="list-style-type: none"> • Apply ice on the injured part or area for 15 to 20 minutes each hour for the first 2 days. • Elevate the injured part above the level of the heart as much as possible for the first 2 days to help decrease pain and swelling. • Use the injured part as pain allows. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Temperature above 101°</i> • <i>The bruising, swelling, or pain gets worse despite the treatment listed above.</i> • <i>Any problems listed on the WOUND CARE instructions are noted.</i> • <i>You are not able to move the injured part or if you have numbness or tingling in the injured part.</i> • <i>You are not improving in 2 days or you are not using the injured part in 1 week.</i> 	<p>___ VOMITING/DIARRHEA:</p> <ul style="list-style-type: none"> • Many things can cause vomiting (throwing up). It can occur in anyone and should be watched closely. • Diarrhea can also occur in anyone and can be a reaction to food or infection. • Dehydration (loss of water) can occur with either vomiting or diarrhea. • Drink clear liquids without alcohol (flat soda, Sports drink, or juice) for the first 12 hours. Begin with small sips and slowly increase the amount you drink. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Temperature is greater than 101°</i> • <i>Vomiting or diarrhea lasts longer than 24 hours, you notice blood in the vomit or diarrhea, or you have black or sticky stools.</i> • <i>You cannot keep fluids down or you haven't urinated in 8 hours.</i>
<p>___ WOUND CARE:</p> <ul style="list-style-type: none"> • Wounds include cuts, scraped, bites, abrasions, or puncture wounds. • If the wound begins to bleed, apply pressure over the wound with a clean bandage or cloth and elevate the wound above the heart for 5-10 minutes. • Clean the wound twice daily with soapy water and keep the wound dry. It is safe to shower but do not place the wound in bath or dish water. Remove the bandage prior to showering. • Change the bandage at least daily or when dirty. • You will need a tetanus shot if you have not had one in 10 years. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Fever above 101°</i> • <i>Bruising, swelling, or pain gets worse or bleeding is not controlled as directed above.</i> 	<p>___ HEADACHE:</p> <ul style="list-style-type: none"> • There are many causes of headache. The cause of your headache cannot be determined. • Rest in a quiet, dark room for 20-30 minutes. • Apply ice or heat to areas of pain. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Your headache worsens or does not improve within 24 hours.</i> • <i>Your vision changes or you become sensitive to light.</i> • <i>You develop a fever greater than 101° or have a seizure.</i> • <i>You have a rash.</i> • <i>You have yellow or green discharge from your nose.</i> • <i>Your family cannot awaken you.</i> • <i>You are not acting as you normally do.</i> 	<p>___ LOW BLOOD SUGAR:</p> <ul style="list-style-type: none"> • Today your blood sugar was ____mg/dl. • Taking too much insulin/diabetes medicine, too much exercise, delayed or skipped meals can cause low blood sugar. • Signs and symptoms include shakiness, sweating, irritable, feeling faint, fainting, weakness, sleepiness, confusion, pounding heart. • Test your blood sugar. If it is below 80 you should drink 8 ounces of whole milk, eat a candy bar, or use glucose tablets. Then you should eat a light meal to help keep your blood sugar up. • Be sure to tell your doctor of this event. <p><u>Call a doctor, go to the emergency department, or call 911 immediately if:</u></p> <ul style="list-style-type: none"> • <i>Any new or severe symptoms.</i> • <i>Blood sugar below 60.</i> • <i>Fever above 101°</i>

- Any signs of infection such as redness, puss, red streaks, or a bad smell from the wound.

INSTRUCTIONS

BACK PAIN:

- Apply ice to the painful area to help relieve pain. Apply the ice for no more than 20 minutes every hour. Keep a cloth between the ice bag and your skin. If the ice does not help, try heat in the same way. Be careful not to burn yourself.
- Stay in bed the first 24 hours.
- Begin normal activity when you can do them without causing pain.
- When picking things up, bend at the hips and knees. Never bend from the waist only.

Call a doctor, go to the emergency department, or call 911 immediately if:

- The pain increases or goes down your leg.
- You have trouble urinating or having a bowel movement or lose control of your urine or bowels.
- You have numbness or weakness in your arms, hands, legs, or feet.

HEAD INJURY:

- You may have a headache, nausea, or vomiting after a blow to the head.
- Awaken the individual every 2 hours for the first 24 hours after the injury.
- Ice may be applied to the injured area to decrease pain.
- Drink clear, non-alcoholic liquids for the first 12 hours after the injury.
- Tylenol (acetaminophen or ibuprofen may be used for pain.

Call a doctor, go to the emergency department, or call 911 immediately if:

- The injured person is vomiting all the time not able to be awakened, has trouble walking or using an arm or leg, has a seizure, develops unequal pupils, has a clear or bloody fluid coming from the ears or nose, or has strange behavior.

INSECT BITE/STING:

- A bite or sting typically is a red lump that may have a hole in the center. You may have pain, swelling, and/or a rash. Severe stings may cause a headache and an upset stomach.
- Some people will have an allergic reaction to a bite or sting. Difficulty breathing, throat or tongue swelling, or chest pain are emergencies which require immediate care.
- Elevation of the injured part and ice applied to the area will help decrease pain and swelling.
- Benadryl (diphenhydramine) may be used as directed to control itching and hives.

Call a doctor, go to the emergency department, or call 911 immediately if:

- You develop chest pain, difficulty breathing, or swelling of the tongue or throat.
- The area becomes red, warm, tender, and swelling of the tongue or throat.
- You develop a fever above 101°.

SEIZURES:

- Today you had a seizure
- A seizure can be caused from infection, trauma, or epilepsy.
- If you take medicines to control seizures, take your medication exactly as directed.
- If you had a seizure and are taking your medications, call your doctor. Seizure medicines require you to take them every day to keep the right level in your blood. If you have not taken your seizure medicines in a few days, call your doctor for advice on how much you should take.

Others around you should take you to the emergency department, or call 911 immediately if:

- You have another seizure and it lasts more than 5 minutes.
- You have a fever, neck stiffness, or headache followed by a seizure.
- You do not wake up between seizures.
- You have a temperature above 101°

Others around you should

- Move objects out of your way if you are seizing.
- Not try to restrain you if you are seizing.
- Not put anything into your mouth (you cannot swallow your tongue).

FAINING:

- Today you fainted.
- Many things can cause fainting. Problems with heart rhythms, heart attacks, low blood pressure from bleeding or dehydration, low blood sugar stroke, heat stroke, and head injury are some of the things that cause fainting.
- Fainting can indicate a serious problem. You must see your doctor. Call for an appointment today.
- If you have been vomiting or had diarrhea, refer to that section in these instructions.

Others around you should take you to the emergency department, or call 911 immediately if:

- You faint again
- You have any kind of seizure.
- You have chest pain or a headache
- You have a temperature above 101°
- You throw up blood or stuff that looks like coffee grounds or have black stools.

Call a doctor, go to the emergency department, or call 911 immediately if symptoms persist, worsen or new ones develop.

Title of Policy: <i>Physician on Scene Policy</i>	Policy Number: Ops-122
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To clarify the EMR, EMT, EMT-I/AEMT and/or Pre-hospital RN responsibility to a patient when a physician or nurse appears on the scene and expresses the desire to provide direct patient care.

Policy Statement:

An on-scene physician or nurse does not automatically supersede EMS Personnel authority. Once an approved EMS provider patient relationship is established, written System protocol and standing orders provide the legal basis for all EMS Personnel to function. This authority is considered the delegated practice of the EMS Medical Directors. Patient care cannot be relinquished to another person unless identification and credentials of that individual can be verified and the EMS MD or his/her designee (the on-line Medical Control Physician) approves the request.

Policy:

- a. If a Professional Registered Nurse wishes to participate in patient care at an out-of-hospital scene, the RN may do so ONLY in a first aid capacity. The RN must have licensure from the Illinois Department of Public Health as a Pre-hospital RN to function as an advanced life support provider. Refer to Policy, "Assistance by Non-System Personnel" for further information.
- b. If a professed, duly licensed medical professional (MD/DO – hereinafter collectively referred to as physician) wishes to participate in and/or direct patient care on-scene, EMS Personnel should communicate with Medical Control and inform the on- duty physician/ECRN of the situation.
- c. If the on-scene physician (including the patient's private physician) has properly identified himself/herself and wishes to direct total patient care, approval must be given by the on-line Medical Control physician. The on-scene physician must sign the ambulance report form and personally accompany the patient to the hospital, assuming total patient responsibility.
- d. Given the preceding circumstances, if a physician gives orders, while on-scene or en route, for procedures or treatments that EMS Personnel feels unreasonable, medically inaccurate, and/or not within the EMS Personnel's skill capabilities, refuse to follow such orders and transfer responsibility for the patient's care back to the Resource Hospital Medical Control Physician. EMS Personnel in all circumstances, should avoid any order or procedures emanating from an on-scene physician that would be harmful to the patient.
- e. If an on-scene physician has identified himself/herself, is not the patient's private physician, and obstructs efforts of EMS Personnel to aid a patient for whom they are

called, or who insists on rendering patient care inappropriate to System standards for the circumstance and resists all of your efforts to function appropriately to the point where continued intervention will result in obstruction to rendering good and reasonable patient care, EMS Personnel should:

- i. Communicate the situation to Medical Control via radio or cellular communication
 - ii. One EMS team member should divert the interfering on-scene physician while the other EMS members attend to the patient and attempt to request law enforcement
- f. Upon request by any physician to give orders or directions at the scene of an accident or illness, the EMS crew will:
- i. Inform the physician that they are in direct radio contact with resource hospital physician
 - ii. Inform the physician that they can take orders only from the Resource Hospital physician
 - iii. Inform the physician the procedure for taking over medical control
- g. If the physician at the scene insists on assuming Medical Control, the EMS crew will:
- i. Inform the resource hospital physician of the request
 - ii. Allow the physician at the scene to speak with the resource hospital physician as necessary
 - iii. Follow the directions of the resource hospital physician
- h. Should, at any time, the physician at the scene gives absolutely contraindicated or inappropriate directions or orders which could adversely affect patient care, or refuse to accompany the EMS crew to the hospital, the crew members will:
- i. Immediately re-contact the Resource Hospital physician and inform him/her of the situation.
 - ii. Follow direction and orders of the Resource Hospital physician.
- i. If the on-scene physician is given Medical Control by the Resource Hospital and has produced a valid State of Illinois physician and surgeon's license:
- i. The on-scene physician must accompany the patient to the hospital; and
 - ii. Sign the patient record.

Resources:

Title of Policy: <i>Point-of-Care Glucometer Maintenance and Record Keeping</i>	Policy Number: OPS 123
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

This policy is to ensure the accuracy and reliability of blood glucose point-of-care measurements performed by system-affiliated providers.

Policy Statement:

Since many EMS treatments rely on blood glucose measurements, it is imperative for point-of-care testing devices to be accurate and dependable. To ensure accurate and reliable blood glucose measurements, certain maintenance, training, and records must be maintained by agencies performing these tests.

Policy:

A. Equipment

- a. Lancets shall be auto-disabling, single-use finger stick devices.
- b. At no time shall glucometers be utilized in a matter not in compliance with manufacturer and/or system guidance.
- c. Glucometer strips shall not be utilized on patients for which the manufacturer states an inaccurate reading will result.

B. Training

a. Initial

- i. All candidates for system entry shall be trained by their respective sponsoring agency.
- ii. Verification of this training and competency shall be documented on the system entry form under the “skills” section. This training and verification shall be completed on all makes/models of glucometers in service at the sponsoring agency (“general” training shall not be accepted).
- iii. Candidates shall not be approved for system entry until this training and competency documentation is submitted to and approved by the System.

b. Ongoing

- i. Agencies shall verify *each* provider is competent in performing blood glucose level measurements with all makes/models of glucometer(s) in service at the agency at least once every 12 months.
- ii. This training shall be documented on the system’s *Annual Glucometer Training Log* or other such comparable form that captures the same information. The agency’s chief officer or designated representative must verify with signature the validity of the document and training.
- iii. This training log shall be submitted to the system during the period of annual vehicle inspections.

- iv. If an agency places a new make/model glucometer into service, all personnel shall be immediately re-verified on the new glucometer as otherwise outlined under this subpart.
- c. Procedure
 - i. The System shall provide a general procedure for blood glucose level testing, to be found in the *System Procedure Manual*. This procedure is not intended to be all-encompassing, but rather to incorporate universal guidelines generally applicable to all point-of-care blood glucose level measurements.
 - ii. The agency shall develop an agency-level blood glucose level testing procedure specific for all makes/models of glucometer(s) in use at the agency. This procedure shall be readily available to all agency, System, and regulatory authorities.
- d. Maintenance and Quality Controls
 - i. Glucometers, test strips, test solution, and other related equipment must be stored at all times in accordance with manufacturer specifications.
 - ii. Agencies shall perform all required and recommended manufacturer maintenance and quality control guidelines for all glucometer(s) in use, including but not limited to routine calibration checks.
 - iii. These tasks shall be performed on a timetable established by the glucometer manufacturer, but not less than every month.
 - iv. A calibration test shall be performed on the glucometer anytime it suffers a significant drop, a harsh environmental exposure, or anytime mandated/suggested by the manufacturer.
 - v. This maintenance and quality control activities shall be documented on the system's *Glucometer Maintenance and Quality Control Record* or other such comparable form that captures the same information. The record(s) shall be available upon request of the System or regulatory authorities. A separate log shall be created for each glucometer device in service.

Resources:

1. [Glucometer Training Log](#)
2. [Glucometer Calibration Log](#)

Title of Policy: <i>Power of Attorney for Healthcare</i>	Policy Number: L-108
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Legal	Approvals: MD, System

Background to Policy:

To provide direction to the EMS provider who may encounter a person (other than the patient) expressing treatment, refusal of treatment, and transport wishes in cases where the patient cannot express those wishes.

Policy Statement:

A Power of Attorney for Healthcare acts as an agent for a person who is unable to express decisions regarding healthcare. Within the following guidelines, EMS personnel may honor the wishes of the Power of Attorney for Healthcare.

Policy:

EMS personnel may honor the requests of a person purporting to be the patient's Power of Attorney for Healthcare when:

- A. The patient is unable to express his/her own wishes regarding treatment, transport or refusal of treatment/transport.
- B. EMS personnel are presented with a written Power of Attorney for Healthcare document. The document should list the name and signature of the Power of Attorney for Healthcare, the patient's name and signature, the date the document was signed, and any restriction to the authority of the Power of Attorney for Healthcare.
- C. EMS personnel must inform the Medical Control Physician of the presence of the Power of Attorney for Healthcare, the nature of the Power of Attorney for Healthcare document, the patient's condition (i.e., the inability to express his/her wishes), and the direction of the Power of Attorney for Healthcare. The Medical Control Physician must give direction as to whether to concur with the requests of the Power of Attorney for Healthcare.
- D. EMS personnel may not honor the request of the Power of Attorney for Healthcare to discontinue resuscitative efforts on a patient in cardiac arrest unless a completed DNR form is presented. The Medical Control Physician must be contacted for direction.

Resources:

1. [Illinois Statutory Short Form Power of Attorney for Healthcare](#)

Title of Policy: <i>EMS System Preceptor Policy</i>	Policy Number: E-100
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Education	Approvals: MD, System

Background to Policy:

To identify the responsibilities and qualifications for individuals functioning as EMS preceptors within the OSF Saint James EMS System, including participation in the OSF Saint James John W Albrecht Medical Center Paramedic Program.

Policy Statement:

The field internship component of any initial EMS education program is one of the most important components. It is necessary to ensure that students are given the opportunity to learn and interact with qualified and competent preceptors.

Policy:

A. Responsibilities

- a. Responsible and accountable for decisions made in the field regarding patient care provided by the student
- b. Responsible for orientating, teaching, and supervising student's during their field experiences
- c. Complete the necessary documentation and evaluations regarding the student's field performance at the end of each shift.
- d. Communicate with the OSF Saint James EMS System Education Coordinator/Paramedic Program Director on a monthly basis to provide a comprehensive evaluation and recommendation, either positive or negative, pertaining to each assigned student.
- e. Commit to participate in a minimum of 8 hours' educational time per year in one or more of the following ways
 - i. Perform lectures to EMS students
 - ii. Teach class skill stations
 - iii. Proctor EMS skills testing
 - iv. Teach continuing education lectures
 - v. Proctor continuing education skills testing

B. Qualifications

- a. In order to be considered for the position of System Preceptor, the individual must remain active in the OSF Saint James EMS System and must meet the following criteria
 - i. Maintain a valid license at or above the level being precepted
 - ii. The preceptor shall have practiced at their level of licensure level within the state of Illinois for at least two years.
 - iii. In order to serve as a primary contact preceptor, the candidate must have practiced within the EMS System for two years.

- iv. An individual that has practiced within the system for 1 year may evaluate and precept for procedures.
- v. The preceptor candidate must not be on probation or suspension with the EMS agency they are serving as a preceptor within
- vi. Successfully complete the OSF Saint James EMS System preceptor workshop
- vii. Approval of the OSF Saint James Medical Director and the applicant's agency chief officer
- viii. Demonstrate above average knowledge and skills by achieving a minimum score of 80% on all system written and practical exams
- ix. Maintain all OSF Saint James System requirements for the specific level of licensure
- x. Attend all updates as needed and presented by the OSF Saint James System.

Resources:

Title of Policy: <i>Preparedness to a System-Wide Crisis</i>	Policy Number: D-102
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Disaster/MCI	Approvals: MD, System

Background to Policy:

As a result, dispatch, EMS and emergency department personnel must be cognizant of evolving trends or the influx of patients with similar signs and symptoms. Recognition of an impending or active system-wide crisis will better prepare participating hospitals and local ambulance providers to handle any type of situation.

Policy Statement:

Natural and technological crises may place an intense demand for EMS and emergency department resources on one or more of the EMS agencies and hospitals in the system. The potential exists for these crises to occur or evolve without adequate warning or notification. Such crises may include a heat emergency, communicable disease or influenza epidemic or terrorist act involving a nuclear, chemical or biological agent, which could overload an emergency department's resources.

Policy:

A. Recognition

- EMD Personnel may be made aware of a system wide crisis by increased EMS requests for similar complaints or symptoms or a large number of patients in a single location whether medical complaint or trauma.
- Telemetry personnel may be made aware of a system-wide crisis by communication from the local ambulance provider (i.e., mass casualty incident) or by noting an increased number of emergency departments requesting ambulance diversion. The telemetry personnel should report these occurrences to the attending emergency doctor or charge nurse.
- When participating, hospitals see a rapid or developing increase of patients with similar symptoms, the attending emergency doctor or the charge nurse should contact their Resource Hospital and apprise them of the situation.
- When ambulance providers or their personnel notice that they have an increase of runs with patients complaining of similar signs and symptoms, they should report this information to their Resource Hospital.

B. Notification of Personnel

- The Resource Hospital shall document any calls they receive from their participating hospitals or ambulance providers and identify that they are seeing numerous types of patients complaining of similar types of symptoms. The Resource Hospital should note the time the call is received and seek a detailed account of the situation.
- If the Resource Hospital receives calls or has reason to suspect a potential system-wide crisis, the ECRN will contact the EMS Manager/Coordinator or EMS Medical Director to inform them of the situation. The EMS Manager/Coordinator or EMS Medical Director will contact the local ambulance provider(s) to see if they are seeing an increase in patients with similar types of symptoms.

- The EMS Manager/Coordinator or EMS Medical Director may also contact the Illinois Poison Control Center to see if they are receiving additional calls for similar type symptoms.
- If there appears to be a trend, pre-hospital or hospital, of increased frequency of similar symptoms, the EMS Manager/Coordinator or EMS Medical Director shall page the Emergency Officer for the Illinois Department of Public Health at 1-800-782-7860. In addition, if there is a local health department medical director, that person may also be contacted. Associate, participating and adjoining EMS system hospitals and agencies may be contacted as necessary.
- The Emergency Officer for the Illinois Department of Public Health will contact the Director of Public Health, or his designee, and the Duty Officer with the Illinois Emergency Management Agency. Based on the type and magnitude of the crisis, the Director of Public Health, or his designee, may activate the RHCC, according to the State Medical Disaster Plan.

C. Plan of Action

- Once notified by the Illinois Department of Public Health that there may be a potential for increased utilization of resources, the EMS Manager/Coordinator will contact the participating hospitals and local ambulance providers within the System to inform them of the crisis. The EMS Manager/Coordinator will request that each participating hospital take steps to avoid ambulance diversion and alert them to the possible need of having to mobilize additional staff and resources or activate their internal disaster plans. The EMS Manager/Coordinator may request assistance from the RHCC and/or IDPH. The participating hospitals will also be informed that requests for BLS diversion will not be accepted during the crisis.
- The EMS Manager/Coordinator or most senior EMS person staffing telemetry will monitor transport times, while the local dispatch center that receives 911 calls will monitor ambulance responses. If transport times begin to exceed 10-15 minutes and ambulance response times become excessive as a result of hospitals being on diversion, IDPH Division of EMS will be contacted and will assist in contacting the Emergency Department Charge Nurses and Senior Administrators of the participating hospitals on diversion to advise them to activate their internal disaster plans so that they can rapidly come off diversion. They will be given a specified time frame in which to accomplish this.
- The monitoring of transport and ambulance response times requires frequent communication and close coordination between EMS personnel at the Resource Hospitals, dispatch and the local fire departments.
- During an impending or actual system-wide crisis, the local municipality may request mutual aid, through pre-existing agreements, from the surrounding areas.
- All information shall be recorded on the "System-Wide Crisis Form," developed by the Illinois Department of Public Health which will be available upon request.

D. All Clear

1. The Director of Public Health, or his designee, will contact the Resource Hospital when the response to the crisis appears to be over.

Resources:

1. [Region 2 EMS System Wide Crisis Form](#)

Title of Policy: <i>Region II School Bus Policy</i>	Policy Number: D-104
Effective Date: 01/2007	Review Date: 10/07/2019
Policy Area: Disaster/MCI	Approvals: Region II

Background to Policy:

Incidents involving school buses pose unique challenges to the EMS provider in assuring proper release of uninjured children. Once Medical Control confirms that the minor children are not injured, the custody and responsibility for these children will remain with the responding EMS provider until the children are transferred to parents, legal guardians, school officials or the hospital. If no procedure exists to have children transferred to a parent, legal guardian or school official, then these children will need to be transported to the Hospital.

Policy Statement:

On arrival at the scene, EMS personnel shall determine the category of the incident and request appropriate resources. EMS must also accomplish a complete assessment of the scene to include at least:

- mechanism of injury
- number of patients
- damage to the vehicle
- triage as outlined in the System Plan

Policy:

Once this has been accomplished, then the patients may be assigned to one of the following categories:

CATEGORY A: Significant mechanism of injury (i.e. rollover, high speed impact, intrusion into the bus etc.) –school bus occupancy indicates that at least one child may reasonably be expected to have significant injuries or significant injury is present in one or more children. *All children in this category must be transferred to an appropriate hospital unless a refusal form is signed by a parent or legal guardian.*

CATEGORY B: Suspicious mechanism of injury (i.e. speed of impact, some intrusion into the bus, etc.) –school bus occupancy indicates that at least one child may reasonably be expected to have minor injuries or minor injury in one or more children exists with no obvious mechanism of injury that could reasonably be expected to cause significant injuries. *EMS personnel must complete the EMS School Bus Release form and secure a signature of an appropriate school official.*

CATEGORY C: No obvious mechanism of injury-school bus occupancy indicates no injuries may be present and that the release of uninjured children may be the only EMS need. No injuries are found to be present in any of the children. *EMS personnel must complete the EMS School Bus Release form and secure a signature of an appropriate school official.*

CATEGORY D: If the pediatric patient(s) have special healthcare needs and/or communication difficulties, then all of these patients must be transported to the hospital for evaluation unless approval for release is received from Medical Control or a parent/legal guardian has signed the approved refusal form.

1. After determining the category of the incident, EMS personnel shall determine the extent of EMS involvement and contact Medical Control.
2. Adults, victims 18 years and older, and occupants of other vehicles will be treated or released in accordance with routine System operating procedures.
3. If Medical Control has approved usage of this policy/plan, then each provider will implement their procedure for contacting parents, legal guardians or appropriate school officials to receive custody of uninjured children.
4. The approved regional/System School Bus Release form for school bus incidents must be utilized for all children who will not be transported.
5. Each child transported must have a completed individual run report left at the ED on completion of the call.
6. A run report indicating the nature of the incident, etc., should be completed according to System policy and should include all information regarding the incident including the number of patients released. A copy of the report with the release form or with refusal forms signed by the parents or school officials should be kept on file per System policy.
7. A parent, legal guardian or appropriate school official must be given a copy of the refusal/release form.
8. Any parent or legal guardian who arrives on scene to remove and assume responsibility for their child will be requested to sign an individual refusal form.
9. EMS providers shall use reasonable means to contact parents and/or school officials. This could include use of telephone, cell phone or direct contact by Law enforcement. If contacted by phone, EMS providers shall take reasonable means to confirm the identity and authority of the parent, legal guardian or school official.

10. Once the identity and authority of the parent, legal guardian or school official has been established, the EMS provider may release the child to that individual or alternate transport source. School officials will follow their established program for informing parents or legal guardians regarding the incident.
11. *The health and safety of the child is the primary concern.* It is the responsibility of the EMS provider to assure that the child is returned to the parent or placed on the school's alternate transport vehicle. If the EMS provider on scene determines a child should receive a physician evaluation or be offered medical care, the child *will be transported to the hospital unless* a parent or legal guardian is on scene and consents to refusal.
12. Each prehospital provider agency in the affected System who may likely respond to a school bus incident must contact the school superintendents in their district to obtain the name and title of the "appropriate school official" who may take responsibility for the child on the bus involved in the incident.
13. Copies of documentation must be forwarded to the EMS office for review within 24 hours of the incident or per System policy.
14. A separate refusal or run report will be documented for the driver of the bus. He/she should not be included in the multiple school-bus refusal form.

Resources:

1. [School Bus Refusal Form](#)

Title of Policy: <i>Reporting of Suspected Crimes and Crime Scenes</i>	Policy Number: Ops-123
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

To establish procedures to follow at the scene of a suspected crime to insure proper patient care while preserving the scene.

Policy Statement:

Often EMS Personnel may arrive at the scene of a violent crime before the police arrive. This requires an understanding by the EMS Crew of law enforcement in preserving, collecting and using evidence. Anything at the scene may provide clues and evidence for the police.

Policy:

- a. It is the duty of EMS personnel to notify the local law enforcement agency when it is suspected that the patient receiving treatment by EMS personnel:
 - i. Has any injury resulting from the discharge of a firearm;
 - ii. Has any injury sustained in the commission of or as a victim of a criminal offense;
 - iii. Is a victim of suspected child abuse or neglect;
 - iv. Is a victim of suspected elderly abuse or neglect
- b. Upon arrival at the suspected crime scene, note the following:
 - i. Immediately notify the police or request the dispatch center to do so.
 - ii. If the victim is obviously dead, then he or she should remain undisturbed. Even the position of the body can provide valuable clues.
 - iii. Do not touch, move, or relocate any item at the scene unless absolutely necessary to provide treatment to an injured victim. You should mark the location of any item that must be moved so the police can determine its original position. (Refer to "Interaction of Law Enforcement/Evidence" policy).
 - iv. Do not allow onlookers or other unauthorized personnel on the premises of the crime.
 - v. Observe and note anything unusual, especially if the evidence may not be present when the police arrive. This may include smoke and odors.
 - vi. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt treatment. Remember, your role is to provide emergency care, not law enforcement or detective work.
 - vii. Keep detailed records of the incident including your observations of the victim and the scene of the crime. In many felony cases, EMS personnel are called to testify since they were first on the scene, and lack of records about the case can be professionally embarrassing.
 - viii. Once the police arrive you should leave or at least not hinder their work, however, you should give them any information you believe would be useful.

Title of Policy: <i>Service Animal Policy/Emotional Support Animal</i>	Policy Number: Ops 125
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Operations	Approvals: MD, System

Background to Policy:

The purpose of this policy is to provide direction for the interaction and safe disposition of service animals when their handler is transported by EMS.

Policy Statement:

EMS providers often encounter patients with chronic conditions that necessitate the use of a service animal. This policy outlines guidelines for interaction and safe disposition of service animals when their handler is transported by EMS.

Policy:

1. The Americans with Disabilities Act defines a service animal as:
Service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the handler's disability. Examples of work or tasks include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal's presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks for the purposes of this definition.
2. In addition to dogs, miniature horses may also serve as a service animal under 2011 guidance from the US Department of Justice. Based on the size of the miniature horse, EMS may or may not be able to transport the animal due to size limitations.
3. Providers should not speak to or touch a service animal unless given permission by the handler
4. If the handler is incapacitated and cannot manage the service animal, local law enforcement and animal control should be contacted for assistance
5. If the handler is transported
 - a. Every reasonable effort shall be made to ensure the service animal goes to the hospital
 - i. The first and ideal option would be to have a friend or family member transport the animal to the hospital. Law enforcement may be willing to assist and transport the animal. Consider the use of other agency vehicles e.g. ambulance assist non-transport EMS or command vehicles. The service animal may be transported in the ambulance in the cab area as a first choice and in the patient area as a last resort. Consultation with the handler is strongly encouraged

- b. Notify the receiving hospital that a service animal will be arriving with the patient
6. Refusal to transport the service animal can only be made when the presence of the animal jeopardizes patient and/or crew safety and/or when the presence of the animal significantly impedes or negatively affects patient care. This threat and negative impact must be real and not perceived (such as “sometimes dogs bite” or based upon past experience “another service dog acted up”).
 - a. Refusal to transport a service animal and the reason must be documented in the patient care report along with the disposition actions taken to ensure the service animals safety.
 - b. If the crew or handler refuses the transport of the service animal, the providers shall make every reasonable effort to ensure the animal remains safe, is properly secured, and cared for.

Resources:

1. [EMS and Service Dogs](#)
2. [US DOJ Service Animal Guidance](#)

Title of Policy: Social Media Use	Policy Number: A-107
Effective Date: 8/2019	Review Date: 8/2019
Policy Area: Administration	Approvals: OSF SJEMS EMSMD

I. PURPOSE

The purpose of this policy is to provide guidelines for providers in the OSF Saint James EMS System regarding Internet Communications and Social Media in the context of their functioning in the EMS System.

II. DEFINITION – None.

III. PROCEDURE

- A. Professional standards of conduct apply to all agencies and personnel within the OSF Saint James EMS System, engaging in communication through blogs and social network sites, and other areas.
- B. Everyone should be aware that others, including peers and other agencies both inside and outside the OSF Saint James EMS System may actively be reading what is posted in online forums. In choosing words and content, it is a good practice for everyone to consider that their supervisor, family members of patients and the general public may read their posts. Therefore, everyone needs to exercise good judgment before posting material on internet sites or email. Using a blog or social network site to make negative statements about and/or embarrass the OSF Saint James EMS System, any OSF HealthCare facility, agency or person associated with the OSF Saint James EMS System is inconsistent with our Mission, Values, and standards of conduct.
- C. The OSF Saint James EMS System reserves the right to monitor conduct of our members in regards to social networking, and apply corrective action should it be determined that conduct is inconsistent with our policies.
- D. The following activities are ***Specifically Prohibited*** under this policy:
 1. **Sharing Protected Health Information (PHI). PHI includes, but is not limited to patient's name, address, age, race, extent or nature of illness or injury, hospital destination, crew member names and date, time and location of care.**
 2. **Posting photos, videos, or images of any kind which could potentially identify patients, addresses, or any other PHI.**
 3. **Sharing confidential or proprietary information about OSF Saint James EMS System or our agencies.**
 4. **Postings or other online activities which are inconsistent with or would negatively impact the reputation of the OSF Saint James EMS System or its agencies.**

- 5. Engaging in vulgar or abusive language, personal attacks, or offensive terms targeting groups or individuals within the OSF Saint James EMS System.**
 - 6. Posting statements which may be perceived as derogatory, inflammatory, or disrespectful.**
- E. Posting online comments on third party sites:
1. Everyone should consult with the OSF Saint James EMS System prior to engaging in communication related to OSF HealthCare issues or activities through blogs or comment sections of material posted on the internet.
 2. If communication is done through the internet in regards to OSF HealthCare issues, you must disclose your connection with OSF HealthCare. You should strive for accuracy in your communication. Errors and omissions are poorly reflected upon OSF HealthCare and may present a liability for you or OSF HealthCare.
 3. Everyone should be respectful and professional to everyone in the OSF Saint James EMS System, community partners, co-responders, and patients and avoid using unprofessional online personas.
- F. Personal Blogs and Other Social Networking Content:
1. Where a connection to OSF HealthCare is apparent, everyone should make it clear that they are speaking for themselves and not on behalf of OSF HealthCare. In these circumstances, the following disclaimer is recommended: “the views expressed on this [blog; website] are my own and do not reflect the views of my employer, or the OSF Saint James EMS System.”
 2. Furthermore, employees should consider adding this language in the “about me” section of their profiles.
 3. This disclaimer does not by itself exempt employees from a special responsibility when blogging; employees should remember that their online behavior should still reflect and be consistent with the OSF Saint James EMS System standards of behavior, and each member agency’s standards
- G. OSF Saint James EMS System and Agency Sponsored Sites or Content
1. Posts to sites will be accurate and factual.
 2. Mistakes should be corrected promptly.
 3. When corrections are made, the original post will be preserved for integrity showing by strikethrough what corrections have been made.
 4. All spam and comments off-topic will be deleted.
 5. OSF Saint James EMS System staff will respond to all emails and comments as appropriate.
 6. Whenever possible the OSF Saint James EMS System will link directly to online references and original source materials.

Resources:

Title of Policy: <i>System Entrance Testing</i>	Policy Number: A 111
Effective Date: 01/01/2020	Review Date: 10/2019
Policy Area: Admin	Approvals: MD, System

Background to Policy:

To ensure the protection of patients, Emergency Medical Service (EMS) providers have an ethical and moral responsibility to provide care to all patients to the best of their abilities. In this role, they must demonstrate continued competence.

The OSF Saint James EMS System requires demonstrated knowledge on a written exam for all EMR/EMT/Intermediate/AEMT/Paramedic level personnel entering the system. The OSF Saint James EMS System requires demonstrated competence on a practical competency exam for all Intermediate/AEMT/Paramedic level personnel entering the system.

Policy Statement:

The following will provide guidelines for entry into the OSF Saint James EMS System.

Policy:

A. System Entry Written Exam

- a. All Basic (BLS), Intermediate/AEMT (ILS), and Paramedic (ALS) applicants must pass a written exam prior to approval to function in the OSF Saint James EMS System. Exam questions may cover: OSF Saint James System protocols, policies, and procedures as well as the most current national standard curriculum. In order to pass the written exam, applicants must achieve a score of 80% or higher. The BLS written exam will consist of 50 multiple choice questions. The ILS and ALS written exam will consist of 100 questions. Applicants will have a maximum of three (3) attempts to successfully complete the system entry written exam without the Medical Director's approval. If the applicant fails the first attempt, a second attempt may be scheduled only after a remediation plan, written by the applicant and approved by the OSF Saint James EMS office, is successfully completed. The second attempt will be scheduled as dictated by the remediation plan, but not less than two (2) weeks after the initial attempt. If the applicant fails the second attempt a third attempt may be scheduled only after a remediation plan, written by the applicant and approved by the OSF SJH EMS office, is successfully completed. The third attempt will be scheduled as dictated by the remediation plan, but not less than three (3) weeks after the second attempt. After the third failure of the written exam, any subsequent attempts must be approved in writing by the OSF Saint James Medical Director.

B. System Entry Practical Exam

- a. EMR and BLS applicants must successfully complete a procedure competency exam at their hiring agency. A Procedure Competency Form must be completed by their sponsoring agencies' Training Officer. EMR and BLS providers will not be allowed to function in the system until this form is completed and submitted to the OSF Saint James EMS System Office.
- b. Applicants at the ILS and ALS level must successfully complete a practical competency exam before being approved to function in the system. Each practical exam will consist of two (2) or more scenarios that may be traumatic emergencies, medical emergencies or a combination of both, patients can be single or multiple and of any age ranging from neonate to geriatric. Each scenario will be scored using the National Registry of EMT's assessment skill sheets. In order to pass the practical competency exam, an applicant must score 80% or higher and must not commit a critical failure item. Each scheduled practical exam session will be counted as a single attempt. Applicants will have a maximum of three (3) attempts to successfully complete the system entry practical exam. Any attempts beyond three will require the Medical Director's approval. If the applicant fails the first attempt, a second attempt may be scheduled only after a remediation plan, written by the applicant and approved by the OSF EMS office, is successfully completed. The second attempt will be scheduled as dictated by the remediation plan, but not less than two (2) weeks after the initial attempt. If the applicant fails the second attempt a third attempt may be scheduled only after a remediation plan, written by the applicant and approved by the OSF EMS office, is successfully completed. The third attempt will be scheduled as dictated by the remediation plan, but not less than three (3) weeks after the second attempt. After the third failure of the practical competency exam, any subsequent attempts must be approved in writing by the OSF EMS Medical Director. The applicant will be required to pay a \$75.00 fee to the OSF Saint James EMS System for each attempt after the third attempt. Each attempt will be treated as an independent attempt. At least one different evaluator shall be present at each attempt after the second attempt.

C. Remediation Plan

- a. After a failure of the system entry practical or written exam applicants must complete a remediation plan in order to qualify for a retake. The remediation plan should identify the deficiencies that lead to the failure and articulate steps to be taken to correct the identified deficiencies. Remediation plans will be created by the applicant after consultation with the OSF Saint James EMS System Educator. On the second attempt the remediation plan must be approved by the OSF EMS System Educator. On the third and subsequent attempts the remediation plan must be approved by the OSF EMS System Educator and the OSF Saint James System Manager.

Resources:

1. [System Entry Packet](#)

Title of Policy: <i>System Participation Suspensions</i>	Policy Number: DI-103
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Discipline	Approvals: MD, System

Background to Policy:

1. To ensure the right of due process to all participants within the OSF Saint James EMS System. To allow for internal resolution of problems within the OSF Saint James EMS System primarily with the assurance of further consideration of the matter, if anyone should contest the initial decision and subsequent action.

Policy Statement:

1. The OSF Saint James EMS System is dedicated in providing quality pre-hospital patient care through EMS System personnel whose performance and conduct are satisfactory. The EMS Medical Directors may suspend any System participant, agency or individual, who does not conform to System policy and procedure or protocol.

Policy:

- a. All EMS System personnel are expected to maintain a proper and professional manner in the delivery of patient care. Personnel whose conduct deviates from this will be given an opportunity to correct their conduct. The EMS System Manager/Coordinator will assist in this effort. A conference will be held with the individual; disciplinary action will be taken based on the outcome of the conference, and the nature, seriousness and circumstances surrounding the individual's misconduct.
- b. In case of serious misconduct, the EMS Medical Director may bypass the verbal and/or written warning process and suspend the individual from the EMS System.
- c. The normal progression of disciplinary action shall be as follows:
 - i. **VERBAL WARNINGS** - EMS Medical Director or designee shall inform the individual of reported misconduct, discuss means of correction and inform the individual of the consequences, if the misconduct is not corrected. Documentation of this conference will be placed in the individual's file.
 - ii. **WRITTEN WARNING** - EMS Medical Director or designee shall inform the individual in writing about the misconduct. The individual shall be requested to sign the warning indicating it was received. A conference shall take place between the EMS Medical Director or designee, EMS System Manager/Coordinator and the individual. At that time, the reported misconduct, means of correction and consequences of continued misconduct shall be explained and discussed. Documentation of the written warning and conference shall be placed in the individual's system file indefinitely.
 - iii. **SUSPENSION** - System suspension shall follow the written warning in instances where the individual has failed to correct misconduct. Instances where suspension is the first disciplinary action taken are outlined within this policy.
- d. The EMS Medical Director may suspend from participation within the EMS System or discipline any individual, individual provider or other participant within the EMS System considered not to be meeting the standards of the approved EMS System. Those standards include:

- iv. The EMS System shall designate the Local System Review Board, consisting of at least three members, one of who is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. (Section 3.40(e) of the Act)
- v. The hearing shall commence as soon as possible but at least within 21 days after receipt of a written request. The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the Local System Review Board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the Act and this Part. (Section 3.40(e) of the Act)
- vi. The Local System Review Board shall state in writing its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS Medical Director and the individual, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing.
- vii. The transcripts, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System.
- viii. The EMS Medical Director shall notify the Department, in writing, within five business days after the Board's decision to uphold, modify or reverse the EMS Medical Director's suspension of an individual, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.
- ix. If the Local System Review Board affirms or modifies the EMS Medical Director's suspension order, the individual, individual provider or other participant shall have the opportunity for a review of the Local Board's decision of the State EMS Disciplinary Review Board. (Section 3.40(b) (1) of the Act).
- x. If the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for review of the Local Board's decision by the State EMS Disciplinary Review Board. (Section 3.40(b) (2) the Act)
- xi. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the Local Board's decision or the EMS Medical Director's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed. (Section 3.45(h) of the Act).
- xii. An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information is his or her possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS Medical Director which states the length, terms and basis for the suspension. (Section 3.40(c) of the Act)

Title of Policy: <i>Updates to EMS System Manual</i>	Policy Number: A 112
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

EMS is a fast-evolving practice of medicine. From time to time the OSF Saint James EMS System makes updates to policies and standing medical orders.

Policy Statement:

This policy ensures that system affiliate agencies are informed in a timely fashion of changes to system materials including policies, procedures, and the standing medical orders

Policy:

1. All changes to any of the above mentioned items must be approved by the EMS System Manager/Coordinator and the EMS System Medical Director.
2. Once approved the revision is forwarded to the Region 2 IDPH Regional Emergency Medical Services Coordinator.
3. Once the EMS System has received an approval letter from the Illinois Department of Public Health the EMS System will conduct education through assorted means to assure information has been disseminated. These methods can include in person education, online education, correspondence education, or any other manner determined to be acceptable by the EMS System Medical Director or his designee.
4. The OSF Saint James EMS always displays the most current version of information on its website. <https://www.osfhealthcare.org/saint-james/services/emergency/emergency-medical-services/>

Resources:

Title of Policy: <i>Use of Rescue Task Force in Active Shooter Situations</i>	Policy Number: D-106
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: MCI-Disaster Management	Approvals: MD, System

Background to Policy:

Active shooter situations, are at their most basic level, crime scenes that have injured people in need of treatment, rescue, and expedient evacuation. Each incident is primarily a law enforcement event but requires coordination between law enforcement and EMS. EMS should recognize that law enforcement will initially be sending officers into the impacted area to directly engage the threat and to secure a perimeter. EMS providers should utilize this initial period to begin planning for rapid triage, treatment, and extrication of the wounded.

Policy Statement:

Since the inception of EMS the paradigm for responding to incidents involving active shooters has been to stage in the cold zone away from danger until law enforcement has completely secured the entire facility. With the rise, both in number and profile of these incidents, EMS agencies and providers nationwide have been looking at new ways to respond to these incidents. The Hartford Consensus identifies the importance of initial actions to control hemorrhage as a core requirement in response to active shooter incidents. Experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage. Well documented clinical evidence supports this assertion.

Policy:

- a. Not all agencies within the EMS System will have the resources and support needed to implement the rescue task force concept. EMS agencies are under no requirement to implement a rescue task force procedure. However, agencies who do so are required to do so in compliance with this policy.
- b. All developed rescue task force programs shall be designed with the following core tenants of the Hartford Consensus in mind, easily remembered by the acronym **THREAT**
 - i. Threat Suppression (By law enforcement)
 - ii. Hemorrhage Control
 - iii. Rapid Extrication to Safety
 - iv. Assessment by medical providers
 - v. Transport to definitive care
- c. Agencies wishing to develop a rescue task force for the response to active shooter situations must do so in conjunction with the law enforcement agency having jurisdiction. A memorandum of understanding must be submitted to the EMS office signed by the lead administrators of both the law enforcement and EMS agency. At a minimum it must outline roles and responsibilities of each

- agency will be, a statement that they are supportive of the program, and how law enforcement and EMS will communicate on an incident site.
- d. Agencies wishing to develop a rescue task force must jointly conduct a full-scale exercise with law enforcement authorities prior to implementation of the rescue task force concept. Exercises that have occurred prior to this policies implementation date will count. Full scale exercises shall be conducted at minimum once every four years.
 - e. Agencies wishing to develop a rescue task force must have written policies and procedures in place outlining the purpose and scope of the program. Those policies shall be reviewed by the EMS System prior to implementation.
 - f. Pursuant to the system conceal and carry policy and to 430 ILCS 66/65 EMS providers will not enter an active shooter situation with a firearm. The only exception to this policy is if the EMS provider is also a sworn law enforcement officer.
 - g. EMS providers shall operate in a designated cold or warm zone. EMS providers shall not knowingly enter a hot zone
 - i. **Cold Zone:** the area of an incident free from potential harm and maybe safely used as planning, staging, and treatment without threat.
 - ii. **Warm Zone:** The area of an incident police have cleared, but not yet secured; there is still a minimal risk of harm.
 - iii. **Hot Zone:** The area of an incident police have not yet cleared or secured, and there is still a high potential of harm
 - h. Any EMS provider or team of EMS providers entering a warm zone shall be escorted by a minimum of 2 law enforcement officers. With a preference of additional law enforcement personnel if available.
 - i. If an area that was previously designated as a warm zone becomes a hot zone, EMS providers shall be evacuated at first opportunity with their law enforcement escort, but may be directed to a hard cover location at the discretions of said escort members. This would only be in the event of imminent threat resulting in immediate law enforcement engagement.
 - j. EMS providers shall not enter the scene with the first wave of officers as their primary objective is threat neutralization/isolation.
 - k. EMS providers should utilize any and all protective equipment as prescribed by their agency. Agencies should select protective equipment based on a risk analysis and likelihood of an active shooter event in their jurisdiction. The EMS system does not specify the type of protective equipment that agencies are required to provide outside of the required body substance isolation precautions prescribed by the system infection control plan, and Illinois Department of Public Health regulation.

- l.** EMS providers participating on a rescue task force should have regular training on hemorrhage Control techniques, including the use of tourniquets, pressure dressings, and hemostatic agents (Quick-Clot). ILS/ALS providers should also have regular training on thoracic needle decompression
- m.** The focus of emergency care provided in the warm zone shall focus on bleeding control and basic airway management. It is understood by all parties that medical care in the warm zone will not be as comprehensive as that provided in the cold zone. All medical equipment that will be utilized by rescue task force members shall be approved by the EMS System. Medical care provided in the cold zone will be in accordance with the appropriate MCAEMS SMO/Protocol.

Resources:

1. [National Fire Administration Fire EMS Operational Considerations and Guide for Active Shooter Incidents](#)
2. [The Hartford Consensus III: Implementation of Bleeding Control](#)
3. [EMS Response to Active Shooter/Critical Incidents](#)

Title of Policy: <i>Vehicle Service Advertising</i>	Policy Number: A-108
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Administration	Approvals: MD, System

Background to Policy:

To assure the public is protected against misrepresentation by an EMS Agency Provider.

Policy Statement:

The Illinois Emergency Medical Services Systems Act [P.A. 89-177, (210 ILCS 50/3.85)] mandates any Vehicle Service Provider is prohibited from advertising, identifying its vehicles, or disseminating information in a false or misleading manner concerning the Provider's type and level of vehicles, location, primary service area, response times, level of personnel, licensure status or EMS System participation.

Policy:

- A. No agency, public or private, shall advertise, identify their vehicle as, or disseminate information leading the public to believe that the agency provides a specific level of service unless that agency does in fact provide and is licensed by the Department of Public Health at that specific level of service as defined in the EMS Systems Act.
- B. Penalty. Any person who violates the EMS Systems Act or any rule promulgated pursuant thereto is guilty of a Class C misdemeanor.
- C. A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in such advertisement the hours of operation for those vehicle, if individual vehicles are not available twenty-four (24) hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate twenty-four (24) hours a day.
- D. It is the responsibility of all OSF Saint James EMS System personnel to report such infractions of this section to their EMS Medical Director and/or EMS System Manager/Coordinator.
- E. Agencies that have in-field upgrade capabilities are restricted to advertising the level of service that they can guarantee 24/7/365

Resource

Title of Policy: EMR CE Requirements	Policy Number: C-107
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

The Emergency Medical Responder is required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

PURPOSE

To ensure that all Emergency Medical Responder's operating within the EMS system have the proper amount of CE hours for renewal.

Policy:

Continuing Education Hours:

1. **The Emergency Medical Responder will accumulate 40 hours of continuing education every four years.** It is recommended that 20 hours are completed during the first two years, and the other 20 during the second two years of the license period.
2. It is required that 25% of the total CE hours is obtained from the primary resource hospital.
3. No more than 25% can be in one subject area.
4. The following is required annually as part of CE Hour requirements:
 - a. Healthcare Provider CPR (as recertification is necessary).
 - b. Skill Checks/Competencies; Medical, Trauma, Pediatrics.
 - c. OSHA/Bloodborne Pathogens
 - d. System Review
5. Any CE class that has received a state site code shall be accepted by the EMS system.
6. Up to 8 of the total 40 hours can be obtained through Hospital ED Clinical Time
7. CE hours can also be obtained from completing PEPP, BTLS, or ITLS.
8. **It is the responsibility of the Emergency Medical Responder to keep track of all CE hours during the four year license period**

License Renewal:

1. All Emergency Medical Responder's will renew their license every 4 years.
2. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
3. Emergency Medical Responder's are highly encourage to go on-line as instructed on the Renewal Form to pay the \$20.00 renewal fee and complete the Child Support Statement.
 - a. If a Emergency Medical Responder cannot pay on-line, a \$20.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
4. All Emergency Medical Responder's will route CE record forms to the EMS Office **30 days** prior to expiration date.
5. The EMS Office will verify completion of CE and clinical hours and complete the EMS System Approval in the IDPH database.
6. All records will be kept on file at the EMS Office.

7. An Emergency Medical Responder whose license has expired may, within 60 days after licensure expiration, submit all relicensure material with the \$20 renewal fee as required and a \$50 late fee in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the Emergency Medical Responder, the Department will relicense the Emergency Medical Responder.

NOTE:

Emergency Medical Responder who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may submit an application to the Department for a waiver of these fees on a form prescribed by the Department. (Section 3.60(b)(7) of the Act).

- This “Volunteer License Fee Waiver” application can be found at <http://www.idph.state.il.us/ems/index.htm>
- This application must be sent to the EMS Office with the CE Record Forms

Title of Policy: EMT CE Requirements	Policy Number: C-108
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

The EMT-Basic is required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

PURPOSE

To ensure that all EMT-Basics operating within the EMS system have the proper amount of CE hours for renewal.

Policy

Continuing Education Hours:

9. **The EMT-Basic will accumulate 70 hours of continuing education every four years.** This above the current IDPH requirements.
10. No more than 25% can be in one subject area.
11. The following is required annually as part of CE Hour requirements:
 - a. Healthcare Provider CPR (as recertification is necessary).
 - b. Skill Checks/Competencies- Medical, Trauma, Pediatric
 - c. OSHA/Bloodborne Pathogens
 - d. System Review
12. Up to 20 hours of the total 70 can be obtained from approved EMS internet sites that provide CE hours.
13. Up to 10 hours of the total 70 can be obtained through Hospital Clinical Time in the ED.
14. Any CE class that has received a state site code shall be accepted by the EMS system.
15. **It is the responsibility of the EMT-Basic to keep track of all CE hours during the four year license period.**

License Renewal:

8. All EMT-Basics will renew their license every 4 years.
9. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
10. EMT-Basics are highly encourage to go on-line as instructed on the Renewal Form to pay the \$20.00 renewal fee and complete the Child Support Statement.
 - a. If an EMT-Basic cannot pay on-line, a \$20.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
11. All EMT-Basics will route CE record forms to the EMS Office **30 days** prior to expiration date.
12. The EMS Office will verify completion of CE and clinical hours and complete the EMS System Approval in the IDPH database.
13. All records will be kept on file at the EMS Office.
14. An EMT-Basic whose license has expired may, within 60 days after licensure expiration, submit all re-licensure material with the \$20 renewal fee as required and a \$50 late fee in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the EMT-Basic, the Department will relicense the EMT-Basic.

NOTE:

An EMT who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may submit an application to the Department for waiver of these fees on a form prescribed by the Department. (Section 3.50(d)(9) of the Act).

- This “Volunteer License Fee Waiver” application can be found at <http://www.idph.state.il.us/ems/index.htm>
- This application must be sent to the EMS Office with the CE Record Forms

Title of Policy: EMT- I CE Requirements	Policy Number: C-109
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

The EMT-Intermediate/Advanced is required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

PURPOSE

To ensure that all EMT-Intermediates/Advanced operating within the EMS system have the proper amount of CE hours for renewal.

Policy:

Continuing Education Hours:

16. **The EMT-Intermediate/Advanced will accumulate 80 hours of continuing education every four years.**
17. No more than 25% can be in one subject area.
18. The following is required annually as part of CE Hour requirements:
 - a. Healthcare Provider CPR (as recertification is necessary).
 - b. Skill Checks/Competencies- Medical, Trauma, Pediatrics.
 - c. OSHA/Bloodborne Pathogens
 - d. System Review
19. Current ACLS Certification.
20. Current PALS Certification.
21. Up to 10 hours of the total 80 can be obtained from approved EMS internet sites that provide CE hours.
22. Any CE class that has received a state site code shall be accepted by the EMS system.
23. **It is the responsibility of the EMT-Intermediate/Advanced to keep track of all CE hours during the four year license period.**

License Renewal:

15. All EMT-Intermediates/Advanced will renew their license every 4 years.
16. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
17. EMT-Intermediates/Advanced are highly encourage to go on-line as instructed on the Renewal Form to pay the \$30.00 renewal fee and complete the Child Support Statement.
 - a. If an EMT-Intermediate cannot pay on-line, a \$30.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
18. All EMT-Intermediates/Advanced will route CE record forms to the EMS Office **30 days** prior to expiration date.
19. The EMS Office will verify completion of CE and clinical hours and complete the EMS System Approval in the IDPH database.
20. All records will be kept on file at the EMS Office.
21. An EMT-Intermediate/Advanced whose license has expired may, within 60 days after licensure expiration, submit all re-licensure material with the \$30 renewal fee as required and a \$50 late fee in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and

there is no disciplinary action pending against the EMT-Intermediate/Advanced, the Department will relicense the EMT-Intermediate/Advanced.

NOTE:

An EMT who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may submit an application to the Department for waiver of these fees on a form prescribed by the Department. (Section 3.50(d)(9) of the Act).

- This “Volunteer License Fee Waiver” application can be found at <http://www.idph.state.il.us/ems/index.htm>
- This application must be sent to the EMS Office with the CE Record Forms

Title of Policy: Paramedic CE Requirements	Policy Number: C-110
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

The Paramedic is required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

PURPOSE

To ensure that all Paramedics operating within the EMS system have the proper amount of CE hours for renewal.

Policy:

Continuing Education Hours:

24. **The Paramedic will accumulate 100 hours of continuing education every four years.**
25. No more than 25% can be in one subject area.
26. The following is required annually as part of CE Hour requirements:
 - a. Healthcare Provider CPR (as recertification is necessary).
 - b. Skill Checks/Competencies- Medical, Trauma, Pediatrics.
 - c. OSHA/Bloodborne Pathogens
 - d. System Review
27. **Must be Current with ACLS Certification**
28. **Must be Current with PALS Certification.**
29. **Highly Recommend ITLS Certification**
30. Up to 10 hours of the total 100 can be obtained from approved EMS internet sites that provide CE hours.
31. Any CE class that has received a state site code shall be accepted by the EMS system.
32. **It is the responsibility of the Paramedic to keep track of all CE hours during the four year license period.**

License Renewal:

22. All Paramedics will renew their license every 4 years.
23. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
24. Paramedics are highly encourage to go on-line as instructed on the Renewal Form to pay the \$40.00 renewal fee and complete the Child Support Statement.
 - a. If a paramedic cannot pay on-line, a \$40.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
25. All Paramedics will route CE record forms to the EMS Office **30 days** prior to expiration date.
26. The EMS Office will verify completion of CE and complete the EMS System Approval in the IDPH database.
27. All records will be kept on file at the EMS Office.
28. A Paramedic whose license has expired may, within 60 days after licensure expiration, submit all relicensure material with the \$40 renewal fee as required and a \$50 late fee in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the Paramedic, the Department will relicense the Paramedic.

NOTE:

An EMT who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may submit an application to the Department for waiver of these fees on a form prescribed by the Department. (Section 3.50(d)(9) of the Act).

- This “Volunteer License Fee Waiver” application can be found at <http://www.idph.state.il.us/ems/index.htm>
- This application must be sent to the EMS Office with the CE Record Forms

Title of Policy: PHRN CE Requirements	Policy Number: C-111
Effective Date: 01/01/2020	Review Date: 10/07/2019
Policy Area: Clinical	Approvals: MD, System

Policy Statement:

The PHRN is required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

PURPOSE

To ensure that all PHRN's operating within the EMS system have the proper amount of CE hours for renewal.

Policy:

Continuing Education Hours:

33. **The PHRN will accumulate 100 hours of continuing education every four years** according to IDPH Rules & Regulations Section 515.730(c) . It is recommended that 60 hours are completed during the first two years, and the other 60 during the second two years of the license period.
34. No more than 25% can be in one subject area.
35. The following is required annually as part of CE Hour requirements:
 - a. Healthcare Provider CPR recertification
 - b. Skill Checks every three months.
 - c. OSHA/Bloodborne Pathogens
 - d. System Review
36. **Current ACLS Certification**
37. **Current PALS or Certification.**
38. **Current TNS, TNCC or ITLS Certification**
39. Up to 10 hours of the total 100 can be obtained from approved EMS internet sites that provide CE hours.
40. Any CE class that has received a state site code shall be accepted by the EMS system.
41. **It is the responsibility of the PHRN to keep track of all CE hours during the four year license period.**

License Renewal:

29. All PHRN's will renew their license every 4 years.
30. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
31. PHRN's are highly encourage to go on-line as instructed on the Renewal Form to pay the \$20.00 renewal fee and complete the Child Support Statement.
 - a. If a PHRN cannot pay on-line, a \$20.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
32. All PHRN's will route CE record forms to the EMS Office **30 days** prior to expiration date.
33. The EMS Office will verify completion of CE and clinical hours and complete the EMS System Approval in the IDPH database.
34. All records will be kept on file at the EMS Office.
35. A PHRN whose license has expired may, within 60 days after licensure expiration, submit all relicensure material with the \$20 renewal fee as required and a \$50 late fee in the form of a certified check or money

order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the PHRN, the Department will relicense the PHRN.

NOTE:

An EMT/PHRN who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may submit an application to the Department for waiver of these fees on a form prescribed by the Department. (Section 3.50(d)(9) of the Act).

- This “Volunteer License Fee Waiver” application can be found at <http://www.idph.state.il.us/ems/index.htm>
- This application must be sent to the EMS Office with the CE Record Forms

