Region 1 Emergency Medical Services

Region 1 Bylaws

Region 1 Policies and Procedures

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Appendices

Bylaws: Article 1 – Board Establishment and Member Appointments

ARTICLE I Advisory Board Establishment and Member Appointments

The Illinois Department of Public Health Emergency Medical Services Region 1 Advisory Council (Advisory Council) is established pursuant to Section 3.25, 210 ILCS 50/et.seq of the Emergency Medical Services (EMS) Systems Act and Section 515.210 of the Emergency Medical Services and Trauma Center Code, 77 Illinois Administrative Code Part 515. The Advisory Council is composed of the following members approved by the Director of the Illinois Department of Public Health:

- 4 - One (1) EMS Medical Director from each of the EMS resource hospitals located in Region 1
- 4 - One (1) EMS System Coordinator from each of the EMS resource hospitals located in Region 1
- 3 - One (1) Trauma Medical Director from each of the Trauma Centers located in Region 1
- 3 - One (1) Trauma System Coordinator from each of the Trauma Centers located in Region 1
- 1 - One (1) Associate Hospital representative affiliated with a Region 1 EMS Resource hospital
- 1 - One (1) Participating Hospital representative located in Region 1
- 1 - One (1) representative from the highest volume EMS provider agency
- 4 - One (1) municipal EMS provider representative from each EMS resource hospital located in Region 1
- 4 - One (1) private EMS provider representative from each EMS resource hospital located in Region 1
- 1 - One (1) pediatric champion physician/EDAP representative from the EMS Region 1 PCCC hospital
- 26 - Total representatives as of 10/15/2018

Membership of the Region 1 EMS Advisory Council will be comprised of representatives from outlined agencies or organizations serving residents of Region 1.

1. The agencies or organizations governing body or chief executive will appoint a representative to the council. Each member will have one vote; certain staff and others outlined are non-voting members.

2. Once the initial agency or organization representative is identified as Region 1 EMS Advisory Council member, their membership will be automatically renewed each year.

3. A member's agency or organization by resolution of its governing body or corporation will submit written notice of its intent to withdraw from the Region 1 EMS Advisory Council.

4. The Executive Committee will schedule a meeting to review any application for membership to the Advisory Council and will refer for action all eligible applicants to a regular or special meeting of the full Advisory Council. Advisory Council will define potential value of applying agency to the existing organization. Applications will be acted upon within ninety (90) days of receipt of a request for membership. Applicants will be notified within 10 days of EMS Advisory Council action.

5. Openings due to resignation or removal will be filled as soon as possible as scheduled by the Region 1 EMS Advisory Council Chairperson.

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ARTICLE II Officers

The Region 1 EMS Advisory Council/committees/subcommittees will rotate from its membership, every two years, one chairperson.

1. The Chairperson is a member of all standing committees and is responsible for:
   A. Calling all regular and special meetings of the Region 1 EMS Advisory Council.
   B. Presiding at all regular and special meetings. Robert's Rules of Order will govern the procedures at all meetings of the Region 1 EMS Advisory Council in matters not otherwise governed by these Bylaws.
   C. Appointing all committees, task forces and special study groups.
   D. Working with the EMS Coordinator to prepare meeting agendas.
   E. Representing the Region 1 EMS Advisory Council to other groups and external organizations.
   F. Appointing the chairperson and additional members as needed for all committees.

2. The Region 1 Advisory Council EMS Coordinator is a member of the Region 1 EMS Advisory Council and subcommittees. The Advisory Council EMS Coordinator is responsible for:
   A. Coordinating all meetings of the Region 1 EMS Advisory Council
   B. Participating as an ex-officio member on all committees and subcommittees.
   C. Representing the Region 1 EMS Advisory Council to other groups and external organizations.
   D. Maintaining records of meetings
   E. Providing surveillance of national, state, regional, and local EMS issues, thereby keeping the Region 1 EMS Advisory Council members informed of potential impact.
   F. Assuring accurate recording of minutes from Region 1 EMS Advisory Council or other committee meetings.
   G. Providing other duties as assigned by the Region 1 EMS Advisory Council and endorsed by the Illinois Department of Public Health.

3. The Region 1 EMS Coordinator is a member of the Region 1 EMS Advisory Council and subcommittees. The Region 1 EMS Coordinator will act in an advisory capacity providing guidance and information in all matters related to Region and State items and business.

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ARTICLE III Meetings and Voting

1. The Executive Committee will determine the Schedule of regular Region 1 EMS Advisory Council meetings. The chairperson, the Executive Committee, or a majority of the members expressing their desire to the chairperson in writing may call special meetings of the EMS Advisory Council. EMS Advisory committees, subcommittees, and task forces will meet as needed.
2. Regularly scheduled EMS Advisory Council meetings will be held quarterly. Special meetings of the Region 1 EMS Advisory Council will be held with written notice. The Advisory Council EMS Coordinator will ensure the timely mailing of the notices of Region 1 EMS Advisory Council meetings.
3. For Region 1 EMS Advisory Council meetings and special Region 1 EMS Advisory Council meetings, the agenda and location will be mailed/e-mailed no less than 48 hours in advance of the meeting. The EMS Chair will coordinate the development and distribution of the Region 1 EMS Advisory Council agenda with the Advisory Council EMS Coordinator. Emergency meetings of the Advisory Council may be convened with prior notice as soon as possible.
4. Business will be conducted by a quorum.
5. Except where indicated, the desired method for approving all business actions is through majority of the quorum (26 voting members, quorum is 13). A three-fourths of the quorum of the Council will be required to approve changes to Region 1 EMS Advisory Council membership or bylaws.
6. With advanced notice and approval of the chairperson members may attend via teleconference (or by phone). Should any votes be necessary all attending via teleconference must vote by a call of the roll. Region 1 Executive Council members should attend all meetings in person.
7. Any vote by proxy will be submitted in writing to the chairperson prior to the meeting being convened. The chairperson will notify all in attendance of any proxies presented for that meeting.
8. Executive committee and other sub-committee meetings may be held in closed session to discuss issues, ideas, and concerns.
9. No final action may be taken on public business in a closed session (5 ILCS 120/2).
10. EMS Workforce and Retention Committee:
    a. Will be held at conclusion of Region 1 regular business.
    b. All Region 1 Providers and hospitals are invited to participate. Teleconferencing will be made available.
    c. The purpose is to assess whether there are staffing shortages and the impact of any shortages.
    d. Recommendations to address any staffing shortages.
    e. Minutes will be recorded and provided to the IDPH Region 1 EMS Coordinator.

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ARTICLE IV Standing EMS Advisory Council Committees

Executive Committee

1. The Executive Committee membership will include a Medical Director and EMS Coordinator from each participating EMS System in Region 1.

2. The Executive Committee will, in addition to those activities charged by the Region 1 EMS Advisory Council, be responsible for the following:
    a. Ensuring issues and charges to committees of the Region 1 EMS Advisory Council are addressed in a timely manner and provide monitoring of activities.
    b. Developing and reviewing Region 1 EMS Advisory Council agendas prior to Region 1 EMS Advisory Council meetings.
    c. Reviewing Committee recommendations.
    d. Reviewing and making recommendations on requests for Region 1 EMS Advisory Council membership and membership credentialing.
    e. Serving, with the input of others, as the nominating body for Region 1 EMS Advisory Council Representatives.
    f. Serving as the nominating body for the appointment of Committee chairpersons.
    g. Assigning issues or activities to committees in order to facilitate Region 1 EMS Advisory Council and committee action.
    h. Reporting to the Region 1 EMS Advisory Council, at regular meetings, a summary of previous meetings and activities.
    i. Design and write bylaw requirements for new Standing Committees or Sub-
    j. Committees.
    k. Voting for the Region 1 EMS Executive Committee will be completed by the EMS Medical Directors in person or by proxy. Three-quarters majority of all EMS Medical Directors is required to pass a vote.

3. The Region 1 Quality Assurance Coordination Committee is a Standing Sub-Committee of the Region 1 Executive Committee and will follow the procedures and responsibilities listed in Section C (Complaints) of the Professional Development Policy as well as the process listed below:
    a. The Region 1 Executive Committee rotates chairmanship between Resource Hospitals every two years. The Chairman of the Region 1 Quality Assurance Coordination Committee will rotate every two years, as well.
    b. Sub-Committee members will include all Region 1 EMS Medical Directors and EMS Coordinators.
    c. Agenda items will be sent to the Sub-Committee Chairman prior to the next scheduled meeting.
    d. Minutes of all meetings will be kept by the current Chairman. A recorder of meeting minutes may be present according to the Chairman's preference. All members of the committee will take into account the anonymity of the patient, family, provider, and agency involved. All meeting minutes and outcomes are to be kept confidential.
    e. Meetings will occur quarterly or as called by the Chairman if there are agenda items to be addressed. Meetings may be held in person, virtually, or both. The Sub-Committee Chair or designee will contact meeting participants two weeks prior with the meeting date, time, location, and agenda.
    f. Agenda items before this Sub-Committee may include, but are not limited to:
        1. Any request from a Region 1 EMS Medical Director.
        2. Issues involving Region 1 providers who are part of multiple Region 1 EMS System (example: provider system suspension).
        3. Agencies that are requesting to change from one Region 1 EMS System to another.

4. Provider or patient/family complaints as deemed appropriate for open discussion by a Region 1 EMS Medical Director.
5. Override of Medical Direction.
6. On-duty death of a Region 1 EMS Provider.
7. Mechanical failure/recall of patient care equipment/medication.

g. Sub-Committee members will include all Region 1 EMS Medical Directors and EMS Coordinators, and others as appointed/approved by the chairman for specific situations on a case-by-case basis.

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ARTICLE V Review or Amendment of the Bylaws

Review of these Bylaws should occur as needed, as determined by the Executive Committee of the Region 1 EMS Advisory Council.

Amendments to Bylaws

1. Amendments to these Bylaws may be proposed by any member of the Region 1 EMS Advisory Council. A proposed amendment to these Bylaws must be submitted to the Executive Committee in writing.

2. Amendments to these Bylaws will become effective only after a regular or special meeting scheduled no less than thirty (30) days following the Region 1 EMS Advisory Council meeting where the amendment was introduced.

3. Amendments to the Bylaws must be approved by three-fourths of the quorum of the Region 1 EMS Advisory Council.

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Key Considerations: If there are questions regarding BSI precautions, vaccinations, or proper reporting contact the local hospital, host agency / Department Chief or EMS Officer or the EMS Systems Coordinator at the EMS Resource Hospital. It is imperative that the EMS provider who has a potential exposure report to the receiving hospital's emergency department at the time of exposure. Delay in reporting could result in hospital and staff's inability to attain host blood for testing and effectively provide counseling, intervention or follow-up.

Recommendations:

A. Each hospital has specific procedures for the pre-hospital exposure. Consult with the ED Nurse Manager for specific response to reporting, treatment and follow-up care.
B. If a pre-hospital provider, (EMT, Firefighter, Police Officer, etc), has a significant exposure, (e.g. blood or body fluid on non-intact skin, contact with mucous membranes or a needle stick), they should report to the emergency department who is receiving the patient. The person that has the exposure should notify the charge nurse of the receiving hospital emergency department and advise that a potential significant exposure has occurred.
C. The appropriate hospital, system and department incident reports must be completed. Some departments require additional notification paperwork be completed). Once the appropriate forms are completed, they will be turned into the receiving hospitals Emergency Department Charge Nurse and appropriate agency / department officer.
D. An EMS system form must be completed and returned to the resource hospital of the agency involved (e.g., an exposure happens to an EMT on XYZ department in Anywhere. A form must be filled out for Anywhere Hospital, XYZ department and the EMS Resource Hospital of XYZ department)
E. The appropriate person in the receiving hospitals emergency department will evaluate the exposure to determine if a significant exposure has occurred.
F. If a significant exposure has occurred or is suspected the receiving hospitals Emergency Department Charge Nurse or appropriate designee will implement the hospital specific response procedure. This procedure will include but not be limited to baseline blood test on the EMS provider and host patient, interview and counseling of risks to EMS provider, follow-up information and / or referral which may or may not include prophylaxis.
G. The response action will be documented on the incident report forms and forwarded to the EMS provider, receiving facility infection control provider, provider's department officer (if applicable, and the provider's EMS System Resource Hospital.
H. Follow-up notification of test results is the responsibility of the receiving hospital infectious disease provider. The EMS Systems Coordinator will follow up within 48 hours of receipt of incident report to clarify procedure has been accomplished and notification and follow-up has occurred.
I. If the exposure is identified as non-significant the EMS provider will be advised of same and further testing will per EMS Agency policy. The EMS provider will be counseled on proper use of BSI in the pre-hospital environment.
J. The non-significant exposure will be documented on the incident report and forwarded to the chain of command of the provider and the EMS Resource Hospital System Coordinator.

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Policy: Body Substance Isolation (Universal Precautions

Key Considerations: Assume all patients are carriers of infectious / contagious disease. If a specific contagion is identified respond with addition PPE protection. If disease etiology dictates provide PPE for patient. Consider potential respiratory contagion in a closed ambulance and ventilate accordingly. Consider contagions from bodily fluids, mucous membranes, non-intact skin, body issues, and medications/drugs/illicit substances when handling blood.

GENERAL TREATMENT:

A. Gloves will be worn whenever personnel are in contact with a patient. Consider double gloves when handling blood, body fluids, mucous membranes, non-intact skin, body tissues, and medications/drugs/illicit substances.
B. New gloves should be worn for each patient contact. Hands must be washed (wet or dry wash) after glove removals and between patient contacts.
C. Procedure masks will be worn whenever personnel are in contact with a patient. Consider N-95 masks for high risk patients and/or aerosol generating procedures.
D. If emergency ventilatory support is necessary a resuscitation mask with one-way valve and filter or bag valve mask should be used.
E. Do not recap needles. Promptly place sharps in a designated puncture resistance, protected lid container.
F. Place all soiled linen in a properly marked laundry bag before sending in to laundry or leaving at hospital.
G. Do not launder contaminated clothes with regular laundry. Wash separately then rinse washer with at least a 1-10 bleach solution.
H. Use a solution of 1-part bleach to 10 parts water (or equivalent solution) to clean equipment, clean spills, and decontaminate walls, floors, and other objects soiled with blood or body fluids.
I. If pre-hospital provider has a skin break (cut, abrasion, dermatitis, etc) use gloves and clothing to protect from exposure with blood or body fluids.
J. Keep vaccinations current and have proper annual testing
K. Significant exposure to and possible contamination from blood or body fluids should be reported immediately (ask for receiving hospital's Exposure Report Form).
L. Patients should be asked if they are allergic to latex. Non-latex equipment should be used on all patients that have latex allergies.

HIGH-RISK TREATMENT:

A. A full-face shield and wrap around eye protection or goggles should be worn for respiratory emergencies involving an airway procedure (intubation, suctioning, aerosol treatment, etc) or patient with an active cough from an apparent infectious source.
B. Consider providing the patient with a procedure mask.
C. An impermeable gown should be worn for any situation likely to generate splash/liquid exposures.
D. If possible, isolate the cab of the ambulance during transport.
E. Consider ventilation for aerosol procedures in the ambulance.
F. Include information regarding aerosol procedures for high-risk patients during inbound report. Aerosol procedures may need to be discontinued while transporting the patient through the Emergency Department.
G. Consider the following steps for decontamination of the ambulance following a high-risk transport:
    1. Standard operating procedures for decontaminating the patient care compartment between each patient should include thorough cleaning and disinfecting of all surfaces and reusable patient-care equipment that may have come in contact with the patient or been contaminated during the call (stretcher, floors, walls, monitors, etc.).

2. Wear appropriate PPE while performing decontamination process and ventilate the ambulance when applying the broad-spectrum disinfectant.
3. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
4. All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant in accordance with the product label.
5. Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
6. Follow standard operating procedures for the containment and disposal of used PPE and regulated medical waste.
7. Follow standard operating procedures for containing and laundering used linen. Avoid shaking the linen.

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Policy: Bypass or Resource Limitation Status Review (formerly Ambulance Diversion Status Changes)

Overview:

Guidelines have been established by the Illinois Department of Public Health (IDPH) regarding circumstances in which a hospital may go on bypass/diversion. By incorporating this procedure in the Region 1 Plan, hospitals will not need to establish "Full Bypass" status under certain conditions. Once a peak census is reached, the hospital must have utilized its' surge plan to prevent avoidable diversion status addressing ED, inpatient, and observation/outpatient procedure/surge beds; all reasonable efforts to resolve the essential resource limitation(s) have been addressed.

IDPH will investigate the circumstances that caused a hospital in an EMS System to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable. (Section 3.20(c) of the Act).

The hospital will notify the IDPH Division of Emergency Medical Services, of any bypass/resource limitation decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at https://emresource.juvare.com/login. The hospital will document any inability to access EMResource by contacting IDPH Division of EMS during normal business hours.

During the period of resource limitation, a hospital can respond on a case-by-case basis and thereby divert a provider, through direct communication, only when absolutely necessary.

Policy:

In determining whether a hospital's decision the go on bypass/resource limitation status was reasonable, the Department will consider the following:

1. The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made.
2. Whether an internal disaster, including, but not limited to, a power failure, had occurred in the hospital at the time that the decision to go on bypass was made.
3. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and,
4. The approved hospital protocols for peak census, surge, and bypass and diversion at the time that the decision was made to go on bypass status was made.
5. Bypass status may not be honored or deemed reasonable if three or more hospitals in a geographic area are on bypass status and/or transport time by an ambulance to the nearest facility is identified in the regional bypass plan to exceed 15 minutes.

Hospital diversion should be based on a significant resource limitation and may be categorized as a System of Care (STEMI or Stroke), or other EMS transports. The decision to go on bypass (or resource limitation) status will be based on meeting the following two criteria.

1. Lack of an essential resource for a given type of class of patient (I e, Stroke, STEMI, etc) Examples include, but are not limited to:
    a. No available of monitored beds within traditional patient care and surge patient care areas with appropriate monitoring for patient needs.
    b. Unavailability of trained staff appropriate for patient needs; and/or
    c. No available essential diagnostic and/or intervention equipment or facilities essential for patient needs.

2. All reasonable efforts to resolve the essential resource limitations have been exhausted including, but not limited to:
    a. Consideration for using appropriately monitored beds in other areas of the hospital.
    b. Limitation or cancellation of elective patient procedures and admissions to make available surge patient care space and redeploy clinical staff to surge patients.
    c. Actual and substantial efforts to call in appropriately trained off-duty staff; and,
    d. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.
3. The hospital will do constant monitoring to determine when the bypass condition can be lifted. Such monitoring and decision making will include clinical and administrative personnel with adequate hospital authority. Efforts should be made to resolve issues and come of bypass as soon as such patients can be safely accommodated.

For Trauma Centers Only, the following situations would constitute a reasonable decision to go on bypass status:

1. All staffed operating suites are in use or fully implemented with on-call teams, and at least one or more of the procedures is an operative trauma case.
2. The CAT scan is not working; or
3. You've met the general bypass criteria.

During a declared local or state disaster, hospitals may only go on bypass status if they have received prior approval from IDPH. Hospitals must complete or submit the following prior to seeking approval from IDPH for bypass status:

1. EMResource must reflect current bed status.
2. Peak census policy must have been implemented 3 hours prior to the request for bypass.
3. Hospital and staff surge plans must be implemented.
4. The following hospital information will be provided to IDPH:
    a. Number of hours for in-patient holds waiting for bed placement.
    b. Longest number of hours wait time in the Emergency Department.
    c. Number of patients in waiting area to be seen.
    d. In-house open beds that are not able to be staffed.
    e. Percent of beds occupied by in-patient holds.
    f. Number of potential in-patient discharges.
    g. Number of open ICU beds.
5. The IDPH Regional EMS Coordinator will review the above information along with hospital status in the region and determine whether to approve bypass for 2 hours, 4 hours, or an appropriate length of time as determined by the IDPH Regional EMS Coordinator, or to deny the bypass request. A bypass request may be extended based on continued assessment of the situation, including status of surrounding hospitals, with IDPH Regional EMS Coordinator and communication with the requesting hospital. A hospital may be denied bypass based on regional status or told to come off bypass based if additional hospitals in the geographic area requests bypass.

The Department may impose sanctions, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act. (Section 3.20(c) of the Act).

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Reference: IDPH Administrative Code Section 515.315

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Policy: Concealed Carry of a Firearm

Overview: Illinois has implemented the Firearm Concealed Carry Act allowing registered individuals to possess a concealed firearm on a daily or routine basis. This Policy will be a commonsense guide for the EMS provider in dealing with the firearm during patient care procedures. While it is not an exhaustive list of possible situations, it will give guidance during most situations.

INFORMATION NEEDED

Consider that the safest place for the firearm in any of these situations is in the accompanying holster. EMS providers will now need to ask if the patient is armed before making the decision to start an evaluation. It may be necessary to remind the patient that State law prohibits firearms on a hospital campus. When approaching a scene where the patient may be carrying a concealed handgun, several scenarios are possible and should be handled in one of the following manners:

1. The patient is at their private residence. Ask or assist the patient in removing the firearm and holster as one unit and leave it at the residence in their previously designated location (ideal situation).

2. If law enforcement is at the scene during situations such as a traffic accident or public encounter, have the officer secure and take custody of the firearm.
    a. If the patient is unable to remove the holstered firearm due to significant mechanism of injury and a full body assessment is needed, cut the holster straps and remove the holstered firearm from the patient as a unit and give to law enforcement.
    b. If the holster is contaminated with blood or bodily fluid, have the officer don gloves before touching the holstered firearm. Provide a plastic or biohazard bag if necessary.
    c. If the patient has an altered level of consciousness and is unable to comply with the request to remove the holstered firearm, safely remove the holstered firearm by whatever means necessary (cut holster straps, unbuckle straps, etc.) and give to law enforcement when available, or have the officer assist with safe removal of the firearm. Belligerent, combative, or uncooperative patients that are known to have a firearm should not be approached until law enforcement arrives or the scene is otherwise made safe.

3. If law enforcement is not on scene to take custody of the firearm, place the holstered firearm in the lockable firearm transport (see IDPH recommendation).

4. If the hospital has a secure location, such as a gun safe currently used by law enforcement, place the firearm, holstered if possible, in the gun safe and notify law enforcement or a qualified hospital security agent.

5. Make arrangements for law enforcement to meet the ambulance at the hospital and take custody upon arrival in the ambulance bay or parking area.

6. Women may carry the firearm in a purse rather than a holster. The safest approach is to leave the firearm in the purse, turning it and the contents over to law enforcement to secure the firearm. The purse can be returned to the patient once the firearm is removed and secure.

7. If the patient has the firearm in a pocket without a holster, use extreme caution in retrieving it from the clothing, handling it only by the handle. Never attempt to unload the firearm or handle the trigger area. Avoid trying to manipulate or change the safety on a firearm. Have one crewmember place the gun in a safe or secure location in the home or lockable firearm transport box in the ambulance until law enforcement arrives.

8. If the patient is to be transported by helicopter from the scene or a rendezvous point, leave the firearm with first arriving law enforcement or notify local law enforcement of the situation. Do not send the firearm in the helicopter.

9. It may be considered a refusal of care if a patient will not remove or relinquish their firearm. Contact Medical Direction for any situation of this type.

PRECAUTIONS AND COMMENTS

- If the EMS provider feels threatened or that the scene is unsafe, then follow standard policies and procedures for scene safety.
- EMS providers should never attempt to unload a firearm, regardless of their experience with it.
- Providers should make arrangements with state, county, and local law enforcement to assist with these situations.
- Relinquish firearm only to law enforcement, security personnel, or other qualified person.
- At no time should patient care be compromised in a safe situation due to there being a firearm. This includes transporting to the hospital where law enforcement can rendezvous with EMS to take custody of the firearm.
- Receiving hospitals should allow an ambulance on the premises with a secured firearm to facilitate optimal patient outcomes, as long as arrangements are pending for law enforcement to take custody of the firearm.
- A chain of custody documentation may be necessary to reduce the potential of losing the firearm or ammunition while patient care is being administered. Consult local authorities or your hospital for information regarding chain of custody documentation.

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Policy: Continuing Education

Purpose: To define the requirements for Continuing Education of EMS licensed providers in EMS Region 1. To identify the process of applying for Continuing Education hours in the Region, these hours need to be approved by EMS System and Illinois Department of Public Health.

Required number of hours and renewal process:

1. Region 1 EMS requires the following hours of continuing education to be completed in each 4-year renewal.
    a. 100 hours – Paramedic and PHRN
    b. 80 hours – EMT-Intermediate / Advanced EMT
    c. 60 hours – EMT (includes RN on a volunteer agency functioning at EMT level)
    d. 24 hours – First Responders / Emergency Medical Responders
    e. 48 hours – Emergency Medical Dispatchers
    f. 40 hours – Lead Instructor
2. All provider agencies that have in-house Continuing Education will maintain records that includes the following:
    a. Date
    b. Topic
    c. Site code if required (IDPH or CAPCE)
    d. List of those attending
    e. Total time of education
3. The provider agency will make these records available to their EMS System.
4. Each prehospital provider is responsible for keeping their own records and maintaining a copy of time accrued. The responsibility for completing Illinois Department of Public Health required Continuing Education hours in a timely manner rests fully with the individual.
5. Emergency Medical Responder (EMR), EMT (includes RN on a volunteer agency functioning at the EMT level), Intermediate/Advanced EMT, Paramedic, ECRN, and Prehospital RN providers must submit renewal information to their EMS System. The System will then review Continuing Education for appropriateness and endorse the provider to Illinois Department of Public Health for license renewal. License renewal forms are available at your Systems EMS office.
6. Renewal requests are due at your System EMS office 30 days prior to expiration.
7. Each prehospital provider is responsible to complete the child support and conviction statement, as well as the appropriate fee to IDPH.
8. Requests for extensions will not be considered unless for illness or extreme circumstances.

Approval of Hours:

The EMS Medical Director will determine if a particular didactic Continuing Education program is acceptable for credit within their EMS System. Approval for all hours rests with EMS System.

Required Breakdown of Hours:

Region 1 EMS requires the breakdown of hours in core content areas. The breakdown is as listed in the chart below.

Required Breakdown of Hours in 4 years				
CORE CONTENT	Paramedic/PHRN	I /AEMT	EMT/RN on a volunteer agency functioning at the EMT level	EMR
Preparatory Safety and well-being, Roles & Responsibilities, Prevention, Legal, Ethical, A & P, Medical Terminology, Pharmacology	8	6	5	
Airway Management & Ventilation	12	10	7	2
Patient Assessment Patient Assessment, History Taking, Communication, Documentation	8	6	5	
Trauma MOI, Bleeding, Soft Tissue, Burns, Head, Face, Spine, Thoracic, Abdominal, Musculoskeletal, Environmental	12	10	7	4
Cardiology	16	13	8	4
Medical Respiratory, Nervous System, Endocrine, Immune System, GI, Renal, Toxicology, Infectious Diseases, Psychiatric Disorders, Substance Abuse	20	16	12	4
Special Considerations Obstetrics, Gynecology, Neonatology, Abuse & Assault, Patient with Special Challenges, Chronic Illness Patients	16	13	10	
Operations Crime Scene, Vehicle Operations, Rescue Awareness and Operations, Haz Mat, Tactical EMS, Disaster Preparedness, Triage	4	3	2	
Elective	4	3	4	10
Additional hours may be from any of the topics or educational options				
TOTAL	100	80	60	24

Required Education

The following is a list of required education for each level of EMS provider:

1. First Responder / Emergency Medical Responders:
    a. Current Health Care Provider CPR card (American Heart or Red Cross).
    b. One hour Alzheimer's training.
2. EMT/ RN on a volunteer agency functioning at EMT level in rural areas:
    a. Current Health Care Provider CPR card (American Heart or Red Cross).
    b. One hour Alzheimer's training.
    c. System Competencies – including skills validation and any required System education that may be needed.
3. EMT-I / AEMT (When AEMT Scope of Practice is defined by IDPH requirements for continuing education may change):
    a. Current Health Care Provider CPR card (American Heart or Red Cross).
    b. One hour Alzheimer's training.
    c. ACLS (American Heart).
    d. PALS / PEPP (American Heart or American Academy of Pediatrics).
    e. PHTLS / ITLS / TNCC / TNS or EMS System approved trauma education.
    f. System Competencies – including skills validation and any required System education that may be needed.
4. Paramedic / PHRN:
    a. Current Health Care Provider CPR card (American Heart or Red Cross).
    b. One hour Alzheimer's training.
    c. ACLS (American Heart).
    d. PALS / PEPP (American Heart or American Academy of Pediatrics).
    e. PHTLS / ITLS / TNCC / TNS or EMS System approved trauma education.
    f. System Competencies – including skills validation and any required System education that may be needed.
5. Lead Instructor:
    a. A letter of support or electronic authorization from an EMS MD indicating that the EMS LI has satisfactorily coordinated programs for the EMS System at any time during the four-year period.
    b. Documentation of at least 40 hours of continuing education, of which 20 hours will be related to the development, delivery, and evaluation of education programs.
    c. Documentation of attendance at a Department-approved national EMS education standards update course, if applicable, whenever revisions are made to the nation EMS educational standards.

Note: any equivalent courses to the ones listed in the required education section above must have prior System approval. Some online courses have a certification card that looks equivalent, however, they may not require any skills or testing – these will not be approved.

Standard Documentation

Documentation is required to validate the completion of all continuing education. All continuing education must be approved by the EMS Medical Director. The following should be noted to ensure that credit can be provided.

1. Courses that have an Illinois site code and /or a CAPCE number are approved for credit
2. Course completion cards may be submitted for approved courses.
3. Sign-in rosters for agency in-house training should have the following documented:
    a. Topic
    b. Date / time
    c. Signed by instructor or authorized person
4. Name of participant
5. Number of hours awarded – This needs to be actual hour for hour time, e.g. if a training session was pre-approved for 2 hours but only 1 hour was spent, 1 hour should be awarded.

Illinois Department of Public Health Continuing Educational Relicensure Recommendations
Dated: 10/30/2023 – Modified by Region 1 on January 15, 2024

Continuing education for all EMS clinicians must meet or exceed the criteria listed in the IDPH Rules Section 515.560; 515.570 AEMT and EMT-I CE; 515.580 Paramedic CE; and 515.590 EMS Personnel Licensure Renewals as well as CE that may be mandated by law, rule, or guideline for EMS clinicians.
This Continuing Education (CE) list is NOT intended to be all-inclusive.

Optional/voluntary consideration:

National Continued Competency Program (NCCP) (Required for NREMT recertification): The NCCP has three continuing education (CEU) requirement areas: National, State/Local, and Individual. The NREMT sets the requirements for the National portion. State/Local and individual credits must related to EMS Services or EMS patient care. The national component of the NCCP constitutes 50% of the total recertification requirements. Topics included in the national content reflect current trends in evidence-based medicine, scope of practice changes and position papers from numerous associations involved with EMS research. There is an additional focus on those patient presentations that have a low frequency but high criticality acuity. At least 10% of the National Component must be pediatric-focused content.

National Component Requirements

Expiration dates through Sept. 30, 2025: Download the 2016 NCCP Model (PDF) Expiration dates after March 31, 2026: Download the 2025 NCCP Model (PDF)
(National Continued Competency Program | National Registry of Emergency Medical Technicians (nremt.org)
Courses that cannot be applied towards NREMT recertification requirements include duplicate courses, clinical rotations, EMS instructor courses, management/ leadership courses, performance of duty, preceptor hours, serving as a skill examiner, and volunteer time with agencies.

	Activity	Documentation	Max Hours Recommended	Comments
Initial standardized "Life Support courses (Provider level) (Traditional or adaptive learning approaches)			Hr/Hr to max recommended by sponsoring entity for each course	
Cardiology				
CPR-HCP	CPR for Healthcare Professional	Standard	4 hr	
ACLS	Advanced Cardiac Life Support	Standard	10 hr/course	
Medical				
AMLS	Advanced Medical Life Support	Standard	16	
EMPACT	Emergency Medical Patients: Assessment, Care and Transport	Standard	16	
ASLS	Advanced Stroke Life Support	Standard	8	
ENLS	Emergency Neurological Life Support	Standard	15	
Special Populations				
PALS	Pediatric Advanced Life Support	Standard	12	
APLS	Advanced Pediatric Life Support	Standard	14	
PEARS	Pediatric Emergency, Recognition, and Stabilization	Standard	8	
NRP	Neonatal Resuscitation Program	Standard	8	
PEPP	Pediatric Education for Prehospital Professionals (ALS)	Standard	12	
EPC	Emergency Pediatric Course	Standard	16	
GEMS	Geriatric Education for EMS	Standard	8	
Trauma				
ABLS	Advanced Burn Life Support	Standard	7 hr for live/5 hr online	
ATLS	Advanced Trauma Life Support (ALS)	Standard	16	PM, PHRN, PHAPRN, PHPA
ITLS	International Trauma Life Support	Standard	16	
PHTLS	Prehospital Trauma Life Support	Standard	16	
	Stop the Bleed Course		1.5 hours	
	Tactical Casualty Combat Care – Military Personnel		Hr/Hr	System to review schedule for relevant topics for EMS

Wilderness EMS Training, TEMS			Hr/Hr for EMS content
Initial standardized "Life Support" (Instructor)	Standard	Hr/Hr to max recommended by sponsoring entity	
Standardized "Life Support" courses renewal	Standard	Hr/Hr to max recommended by sponsoring entity	
CPR/ACLS/PALS/NRP frequent competency with rolling renewal via RQI	Standard	Hr/Hr to max recommended by AHA	
ADDITIONAL Sources of Continuing Education			
Attending/Teaching, MIH Community PM, Critical Care PM	Standard	Hr/Hr to max recommended by sponsoring entity	
Pediatric related CE	Standard	At least 10% of total CE hours required	Illinois recommends at least 10% of total required hours in 4 yrs are related to pediatric patients. Topics include: Pediatrics, Neonatology, Gynecology, Obstetrics
Initial courses: Emergency Vehicle Operators	Standard	Hr/hr up to 12 hrs max	
Locally offered CE Examples of approved offerings:	Standard	Hr/hr to max subject hrs	May not exceed 20% of total minimum required hours in one general subject area, e.g., cardiac, trauma, medical, rescue, etc.
Local credentialing (System Entry) activities		Hr/Hr	System to approve
Local orientation/onboarding equipment competency education/labs		Hr/Hr	System to approve
After action reports, debriefings		Hr/Hr	System to approve
Quality improvement case reviews		Hr/Hr	System to approve
Agency-sponsored CE with site codes		Hr/Hr	System to approve
High fidelity simulations/scenarios		Hr/Hr	System to approve
Virtual task trainers and virtual simulations		Hr/Hr	System to approve
Microlearning modules of EBGs with post-test /assessment		Hr/Hr	System to approve
Bloodborne pathogens course in compliance with the 2023 OSHA regulation 29 CFR 1910.1030 Online training acceptable. See https://www.nationaloshafoundation.com/		1 hour/year	
Mandated reporter status: Free online education available from DCFS: See: https://mr.dcfstraining.org/userauth/login!!loginpage.action		2 hours/year	
CHEMPACK Program & the State of Illinois CHEMPACK Plan/EMS Stockpile: Instructional materials available on the IDPH website. See: https://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness.html		1 hour/year	
For license renewals occurring on or after January 1, 2023 EMS personnel must complete at least a one-hour course on the diagnosis, treatment, and care of individuals with Alzheimer's disease or other dementias per license renewal period. https://www.ilga.gov/legislation/publicacts/102/PDF/102-0772.pdf		1 hour in 4 years	This training will include, but not be limited to, assessment and diagnosis, effective communication strategies, and management care and planning. Public Act 102-0772.
Audit of entry level EMT, AEMT, Paramedic Course	Standard	Hr/Hr to max content hours	Unlimited hours if subject matter is at the appropriate level for the participants' license. May not exceed 20% of total required hours in one subject area, e.g. cardiac, trauma rescue, etc.
Author/editor/instructor of educational offerings related to EMS care: * Author of modules/presentations/other media	Signed letter from EMSC or lead	Hr/Hr to max hrs locally allowable	Submit a copy of the article, chapter, or presentation for credit consideration. Submit summary and photo of poster

* Author of journal article, book, chapter(s) * Journal/book reviewer / Textbook editor * Creator of poster presentation / author of an unpublished thesis * Instructor for EMS-related subject at your license level *Preceptor to EMS students/personnel	instructor – see comments		project. Submit evidence of participation as an instructor in the form of student handouts prepared and a brochure or written statement from the course coordinator verifying the topics and hours of participation.
Emergency Preparedness activities include completing FEMA National Incident Management System (NIMS) training, participating in emergency preparedness planning activities, and/or a system-recognized exercise and/or after-action plan	Written statement of participation from EMSC/EMSMD or exercise director	Hr/Hr up to 12 hours (ALS clinician) 10 hrs (AEMT/EMT-I) 8 hrs (EMT)	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.
College courses: health-related courses that relate to the role of an EMS professional (A&P, assessment, physiology, biology, chemistry, microbiology, pharmacology, psychology, sociology, nursing/PA courses, etc.	Syllabus or catalogue description of course and evidence of successful completion (minimum grade of C on official transcript or evidence from school)	Hr/Hr 1 college credit = 8 CEU	May not exceed 20% of total hours for one subject area. Should be considered on a case-by-case basis for any topics in EMS education standards.
Participation/observation in surgery, physical therapy, childbirth, autopsy, etc.	Written statement of participation from: preceptor or physician validating attendance	Hr/Hr up to max of 5 hrs/licensure period	Max 5 hours; must be approved educational experience or include defined educational objectives.
Seminars/Conferences: EMS related education approved by CAPCE or medical or nursing accrediting body.	Copy of agenda/program plus certificate of attendance	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Commercial CE: Electronic digital media, journal articles with publication dates of five years or less prior to the date of CE completion. Approved by CAPCE or medical or nursing accrediting body	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area e.g., cardiac, trauma, rescue, etc.
Trauma Nurse Specialist or TNS Review Courses: May audit for CE with approval of TNS Course Coordinator to ensure space availability.	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area. Course covers multiple areas of A&P, fluid & electrolytes, acid base balance, shock pathophysiology and systems trauma appropriate for PMS, and PHRNS for full credit.
ECRN Course (apart from Life Support courses): May audit for CE with prior approval of course lead instructor to ensure space availability.	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area. Course may cover multiple across the spectrum of EMS appropriate for PMs and PHRNs for full credit
On-line options: Webinars and online offerings with subject matter found in the EMS Education Standards, e.g. sponsored by a governmental agency (infectious diseases, emergency preparedness), legal experts (documentation, HIPAA), organizations or commercial offerings.	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area.

Assigning hours into core content area

All education should be documented into core content areas to ensure proper credit is given. These core content areas are listed in the Required Breakdown Chart above. Some courses or training sessions may fall into several core content areas, hours may be divided into these different areas. The assigning of hours to core content areas is subject to your Systems approval. Following is a list of examples /preapproved assignment of courses:

1. ACLS Renewal – 8 hours in cardiac or 6 hours cardiac 1 hour airway and 1 hour pharmacology
2. PALS Renewal - 8 hours in pediatric or 6 hours pediatric 1 hour airway and 1 hour pharmacology
3. PHTLS Renewal – 8 hours in trauma or 7 hours trauma 1 hour airway
4. CPR Renewal – 4 hours in cardiac or 3 hours cardiac 1 hour airway
5. System annual skills validation cover a variety of topic over the core content areas, they are considered "Wild card" and may be assigned to any of the core content areas.

Original Policy Date: 04/08
Last Revision: 1/24
Reviewed: 11/23

Policy: Controlled Substances – Storage/Security/Wasting

Overview: Controlled substances will be issued to Region 1 EMS Provider Agencies according to the Region 1 Medication and Equipment Exchange Policy. Inventory levels for each ALS vehicle will be according to the Region 1 Medication Restocking Form (Appendix C).

Policy:

Medication Administration: ALS EMS personnel may administer approved controlled substances outside the physical presence of an EMS Medical Director in the course of providing EMS care in compliance with the Region 1 Standing Medical Orders.

1. It is recommended that all controlled substance drawn up into syringes are labeled, if not used immediately, with the drug name, dose withdrawn and the initials of the EMS Provider (or Pharmacy Representative) who drew up the drug.
2. Keep syringes containing controlled substances under the direct control of the person preparing the syringes until administration to the patient.
3. When sequential doses are required from a single syringe, document the doses given as separate entries in the patient care report. The waste of a controlled substance should be witnessed by two advanced personnel (ILS/ALS) Documentation of controlled substance waste should be signed by two ALS personnel. If two ALS personnel are not available to sign the patient care report regarding waste of the controlled substance an ED Nurse will be requested to witness the waste. If the ED Nurse refuses the BLS/AEMT/ILS partner may witness the waste.
4. Document the amount of controlled substance waste (if applicable) in the patient care report including the name of the person who witnessed the waste.

Medication Storage and Security: EMS agencies may store controlled substances in the agency location registered with the DEA, unregistered locations, and in EMS vehicles (as defined below) used by the agency under circumstances that provide for security of the controlled substance consistent with the requirements established by regulations of the Attorney General.

1. EMS vehicles may store controlled substances if they are:
    a. Situated at a registered or designated location of the agency, or
    b. In an emergency, the EMS vehicle used by the agency is:
        i. Traveling from, or returning to, a registered or designated location of the agency in the course of responding to an emergency, or
        ii. Otherwise actively in use by the agency under circumstances that provide for security o the controlled substances consistent with the requirements established by regulations of the Attorney General and Region 1 Standing Medical Orders.
    c. The United States Attorney General must be notified of all unregistered locations at least 30 days before the controlled substances are initially delivered to those locations.
2. ALS agencies may store approved controlled substances in a “drug bag”. The container must be stored separately from non-controlled substance drugs and be secured with a device such as a tamper detectable plastic tie lock. ALS personnel must be in control of the bag at all times when not secured in a locked location on the EMS vehicle or the EMS Agency Station as described below.

3. Controlled substances must be stored in a secure fashion in a "substantially constructed tamper resistant locked cabinet" with 24 hour/day accountability to prevent diversion or tampering. Controlled substances will be stored with the ability to examine for tampering, expiration dates, and inventory counts. EMS Agencies are encouraged to consider, but are not mandated, to use technology such as the CyberLock Access Control System that records all openings of the locked cabinet and creates an audit report to confirm the person who has accessed the controlled substances. Access to EMS vehicles will be limited. They will be occupied or locked and keys removed whenever deployed outside of quarters. EMS quarter will be locked or have secured, limited access.

Additional Security Controls: In order to minimize the opportunities for theft or diversion of controlled substances EMS agencies have an obligation to initiate additional procedures to reduce access by unauthorized persons.

1. Access: The EMS Agency/Registrant must limit access to controlled substances to a minimum number of authorized employees.
    a. Controlled substances may be accessed by ALS EMS personnel. Any other personnel with access must be identified by the agency in writing.
    b. All access will occur in the presence of two authorized personnel. All access will be recorded and witnessed.
2. It is recommended that controlled substance container lock combinations or passcodes upon termination of any employee with knowledge of the combinations.
3. EMS vehicles that are out-of-service will have their controlled substances removed, secured, and accounted for per the agencies' medication management plan. This does not apply to an ambulance that is out-of-service for meals, completing reports, or other duties which prevent temporary response to calls.

Original Policy Date: 06/23
Last Revision:
Reviewed:

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Policy: DNR/POLST/Advanced Directives

Overview: Region 1 Medical Directors have adopted the Illinois Department of Public Health (IDPH) "Uniform Do-Not-Resuscitate (DNR) Advanced Directive" as mandated by (210 ILCS 50/) Emergency Medical Services Act.

This Policy is intended to honor a physician/practitioner order that reflects an individual's wishes about receiving cardiopulmonary resuscitation (CPR). It allows an individual, in consultation with their health-care professional, to make advanced decisions about CPR, in the event the individual's breathing and/or heartbeat stops. When the patient has a valid DNR form, EMS personnel will not institute "Cardiopulmonary Resuscitation". This has been defined by IDPH as various medical procedures, such as chest compressions, electrical shocks, and insertion of a breathing tube, used in an attempt to restart the patient's heart and/or breathing.

The implementation of this Policy references subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65, provides;

"A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform DNR Order or a copy of that form is a valid DNR Order. A health care professional or health care provider, or an employee of a health care professional or health care provider, who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed and act of unprofessional conduct."

"DNR" or Do Not Resuscitate does not allow for the withholding routine treatment from a patient who has a pulse and respiration.

The sections below explain what is on the form.

Advance Directives

IDPH POLST form	**P**ractitioner **O**rders for **L**ife **S**ustaining **T**reatment; provides guidance during life-threatening emergencies. Must be followed by all healthcare providers
Power of Attorney for Healthcare	Names agent: rarely contains directions for authorized practitioner
Mental Health Treatment Declaration	Directions + Agent (for authorized practitioner)
Living Will	Directions for authorized practitioner (NOT EMS)

1. A valid, completed POLST form or previous DNR order does not expire. When a patient completes a new form, the previous form is voided. EMS is not responsible for seeking out other forms- work with the form that is presented as truthful.
2. Original form is NOT necessary- all copies of a valid form are also valid; form color does not matter.
3. **SECTION A**: Orders for Patient in Cardiac Arrest: (follow if patient has NO pulse)
    a. If "YES CPR: Attempt cardiopulmonary resuscitation (CPR)" box is checked, start full resuscitation per SMO. Full treatment (section B) should be selected.
    b. If "NO CPR: Do Not Attempt Resuscitation (DNAR)" box is checked; do not begin CPR.

4. SECTION B explains extent/intensity of treatment for persons found with a pulse and/or breathing.
    a. **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
    b. **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure including (CPAP/BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
    c. **Comfort-Focused Treatment: Primary goal of maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort needs cannot be met in current location.
5. SECTION C: These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]
6. SECTION D: ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)
    a. Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
    b. Trial period for artificial nutrition and hydrations but NO surgically-placed tubes.
    c. No artificial nutrition or hydration desired.
7. COMPONENTS OF A VALID POLST form/ DNR order: Region I recognizes an appropriately executed IDPH POLST form and/or any other written document that has not been revoked; containing at least the following elements:
    a. Patient Name
    b. Resuscitation order (Section A)
    c. Date
    d. Two Signatures (witness signature is no longer required)
        i. Patient or Legal Representative Signature
        ii. Authorized Practitioner Name & Signature (Physician, licensed resident (2nd year or higher), APN, PA)
    e. Out of state DNR/POLST orders should be honored
8. If POLST or DNR form is valid follow orders on form. If form is missing or inappropriately executed, contact Medical Direction for guidance.
9. A patient, POA, or Surrogate that consented to the form may revoke it at any time. A POA or Surrogate should not overturn decisions made, documented, and signed by the patient.
10. If resuscitation begun prior to from presentation, follow form instructions after order validity is confirmed.
11. If orders disputed or questionable contact Medical Direction and explain the situation, follow orders received.

Power of Attorney for Healthcare (POA)/ Living Wills:

If someone presents themselves as having POA to direct medical care for a patient and/or a Living Will is presented, follow these procedures:

1. Living Wills alone may not be honored by EMS personnel.
2. If a Power of Attorney for healthcare document is presented by the agent, confirm that the document is in effect and covers the current situation:
    a. If yes, the agent may consent to or refuse general medical treatment for the patient.
    b. A POA cannot rescind a DNR order consented to by the patient.
    c. A POA may rescind a DNR order for which they or another surrogate provided consent.
    d. If there is any doubt, continue treatment, contact Medical Direction, explain the situation, and follow orders received.
3. Bring any documents received to the hospital.

Hospice patients not in cardiac/respiratory arrest:

1. If patient is registered in a hospice program and has a POLST form completed, follow patient wishes as specified in Box B.
2. Consult with hospice representatives if on scene re: other care options.
3. Contact Medical Direction; communicate patient's status; POLST selection; hospice recommendations; presence of written treatment plans and/or valid DNR orders. Follow Medical Direction orders.
4. If hospice enrollment is confirmed but a POLST form is not on scene, contact Medical Direction. A DNR order should be assumed in these situations; seek Medical Direction approval to withhold resuscitation if cardiorespiratory arrest occurs.
5. See Appendix C – POLST Form

Original Policy Date: 06/16
Last Revision: 06/23
Reviewed: 06/23

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Policy: Emergency Responder Rehabilitation

These guidelines were developed using NFPA 1584 and the FEMA Document as a guideline. Each agency is encouraged to add their own expertise regarding on scene and response operations, to develop a full and working document for their respective agency. See references forms: Rehab Tracking Form.

Determining Need for Rehabilitation on Scene

Each incident is unique, and the Incident Commander must assess whether there may be a need for rehabilitation for responders on-site. Rehabilitation will commence whenever the physical or mental demands of an incident operation or training exercise poses a potential safety or health risk to members as determined by the incident commander (IC). When heat, high humidity, deep standing water, or cold exposure is likely on scene, rehabilitation should generally be initiated as soon as possible with regards to onset of the incident.

Weather conditions are important with regards to environmental safety. The heat stress index should be calculated in warm conditions, and the wind chill index in cold conditions. As humidity and wind play important factors in cooling, it is not sufficient to make rehab deployment decisions based on temperature alone.

Indications for immediate rehabilitation at a working fire scene:

- Heat stress index greater than 89 degrees if turnout gear or protective equipment and any exertion is anticipated.
- Any heat stress index over 105.
- Wind chill under 10 degrees or actual temperature below zero degrees.

Rehabilitation efforts will endeavor to providing the following:

- Relief from climatic conditions.
- Rest and recovery.
- Active and/or passive cooling or warming as needed for incident type and climate conditions.
- Rehydration (fluid replacement, calorie and electrolyte replacement, as appropriate, for longer duration incidents).
- Medical assessment and treatment when indicated per below.
- Member accountability.
- Member release disposition from rehabilitation (reassignment, EMS evaluation, or post-incident recovery).

Crew Guidelines for Rehabilitation:

- Once the Incident Command determines that scene rehabilitation is warranted and it is operational, then all personnel on scene should follow rehab guidelines.
- If at any time, a crewmember feels the need for rehab it should be provided as soon as possible.
- Crews should be sent to rehab based on decreased work capability and fatigue, not only when their air tank is empty.
- Crews should advise their company officers when they believe their level of fatigue or exposure to heat or cold is approaching a level that could negatively affect them, their crew, or the operation in which they are involved.
- Crews will remain aware of the health and safety of other members of their crew.

These criteria are considered maximum guidelines, and crews should routinely be sent to rehab prior to reaching these maximums.

Members are recommended to undergo rehabilitation following the use of a self-contained breathing apparatus (SCBA) or after 40 minutes of extreme work without SCBA (dependent on nature of work, working environment, and climate conditions). Ballistic and Chemical protective apparel is an extreme operation and frequent rehab is also needed.

Rehab Unit Configuration Guidelines

- Distance from working scene enough to allow turn out gear, SCBA or other potentially soiled equipment to be removed:
    - Decontamination strategies should be use prior to personnel entering rehab area.
- Appropriate shelter from conditions.
- Fans and portable heaters as needed.
- Must be free of smoke and apparatus exhaust.
- Size must be large enough for anticipated use.
- A clear entry and exit site must be established.
- Easy and clear access for emergency ambulances must exist.
- Should be staffed with dedicated medical personnel of highest level available.
- The Rehab Manager must have final say as to disposition of individuals in the unit.
- A rehabilitation documentation report may be created and include the following information:
    - Unit number.
    - Member name.
    - Time-in/time-out for members/crews entering or leaving the rehabilitation area.
    - If the member is referred for medical evaluation.
    - Rehabilitation disposition.

ON SCENE MEDICAL TREATMENT

- Emergency medical services (EMS) providers assigned to the rehabilitation group have the authority, as delegated by the incident commander, to use their professional judgement to keep members in rehabilitation or to transport them for further medical evaluation or treatment.
- EMS personnel will evaluate members with symptoms suggestive of a health and/or safety concern:
    - Chest pain, dizziness, shortness of breath, weakness, nausea, or headache.
    - General complaints, such as cramps, aches, and pains.
    - Symptoms of heat- or cold-related stress.
    - Changes in gait, balance, coordination, speech, or behavior.
    - Changes in alertness or orientation to person, place, and time of members.
    - Minimum list of symptoms should not replace good judgement, experience, and training.

Assessment- It is recommended that personnel rest for a minimum of 20 minutes. Additionally, personnel in rehab area should be assessed for physical stress utilizing the following parameters:

- Blood Pressure.
- Pulse.
- Respiratory Rate.
- Temperature: obtain if symptomatic.
- Pulse Oximetry.

Transport to medical facility for any of the following:

- Oral temperature greater than 102°F (38.9°C).
- Oral temperature greater than 101°F (38.3°C) if other symptoms present.
- Irregular pulse.
- Resting pulse greater than 120.
- Systolic BP > 200 after rehab.
- Diastolic pressure > 130 anytime.
- Any signs of dyspnea or hypoxia.
- Any signs of mental status change.

Firefighter may return to the incident if appropriate rehydration has occurred and the following vital sign criteria are met.

- Heart rate < 100
- Systolic BP between 100 and 160
- Diastolic BP < 90
- If temperature elevated and Neurologic Symptoms treat per Hyperthermia SMO, consider IV Fluids, active cooling, and transport to the hospital.
- If temperature low, treat per Hypothermia SMO.
- Transportation to Hospital by EMS Considerations
    - Symptomatic members will be treated/transported as outlined below:
        - Persistent abnormal vital signs despite adequate rehabilitation times.
        - Chest pain.
        - Injuries requiring treatment.
        - Persistent headache, abdominal pain, dizziness, blurred vision, mental status changes, gait instability, nausea, vomiting, or general illness.
        - Any concerning clinical situation of rehab/medical officer.
        - We recommend anyone requiring IV fluids should be transported to hospital.
- Symptomatic members will be treated and transported in accordance with Region 1 SMOs.

- Refusal of Care or Transport to the Hospital:
    - If the department member refuses medical care or transportation, they will be required to sign a medical release waiver.
    - The Incident Commander on scene should be made immediately aware of this situation.
    - The department member should be encouraged to seek medical care.
    - Online medical direction can be consulted immediately for any health concerns.
- Fluids orally should be partially water and partially a commercially made sports drink (ideal mix 50/50) for electrolyte replacement.
    - Fluids should be on ice, so they have a temperature close to 40 degrees in warm environments.
    - Members entering rehabilitation should consume fluids, regardless of thirst, during rehabilitation and be encouraged to continue hydrating after the incident.
    - Members should avoid over hydration, which can lead to hyponatremia.
- Departments should ensure that appropriate calorie and electrolyte replacements are available as indicated.
- When emergency medical care is provided, the incident commander or designee will be notified.

Release from Rehab

- The rehabilitation manager or their designee will determine when a member or company can be as follows:
    - Cleared for further incident assignment or demobilization.
    - Maintained in rehabilitation for further rest and recovery.
    - Transported for more definitive medical evaluation/treatment.
- Members being released from rehabilitation will confirm their accountability with the rehabilitation manager.
- The member should not return to operations in the following conditions:
    - If the member does not feel adequately recovered.
    - If EMS or supervisory staff identifies evidence of medical, psychological, or emotional distress.
    - If the member appears otherwise unable to perform his or her duties.

See Appendix F – Emergency Responder Rehabilitation Form

Post-Incident Recovery

- Personnel and crews released from the incident will follow a demobilization process that includes the following:
  - Communication of post-incident status.
  - Time for post-incident personal hygiene.
  - A plan for station, apparatus, protective clothing, and equipment decontamination.
  - Identification of potentially traumatic events.
  - Completion of exposure reporting as indicated.

Relative Humidity (Percent)	Air Temperature (°F)										
	70	75	80	85	90	95	100	105	110	115	120
	Apparent Temperature (°F)										
0	64	69	73	78	83	87	91	95	99	103	107
10	65	70	75	80	85	90	95	100	105	111	116
20	66	72	77	82	87	93	99	105	112	120	130
30	67	73	78	84	90	96	104	113	123	135	148
40	68	74	79	86	93	101	110	123	137	151	
50	69	75	81	88	96	107	120	135	150		

Temperature (°F)

Wind (mph)	Calm	40	35	30	25	20	15	10	5	0	−5	−10	−15	−20	−25	−30	−35	−40	−45
05		36	31	25	19	13	7	1	−5	−11	−16	−22	−28	−34	−40	−46	−52	−57	−63
10		34	27	21	15	9	3	−4	−10	−16	−22	−28	−35	−41	−47	−53	−59	−66	−72
15		32	25	19	13	6	0	−7	−13	−19	−26	−32	−39	−45	−51	−58	−64	−71	−77
20		30	24	17	11	4	−2	−9	−15	−22	−29	−35	−42	−48	−55	−61	−68	−74	−81
25		29	23	16	9	3	−4	−11	−17	−24	−31	−37	−44	−51	−58	−64	−71	−78	−84
30		28	22	15	8	1	−5	−12	−19	−26	−33	−39	−46	−53	−60	−67	−73	−80	−87
35		28	21	14	7	0	−7	−14	−21	−27	−34	−41	−48	−55	−62	−69	−76	−82	−89
40		27	20	13	6	−1	−8	−15	−22	−29	−36	−43	−50	−57	−64	−71	−78	−84	−91
45		26	19	12	5	−2	−9	−16	−23	−30	−37	−44	−51	−58	−65	−72	−79	−86	−93
50		26	19	12	4	−3	−10	−17	−24	−31	−38	−45	−52	−60	−67	−74	−81	−88	−95
55		25	18	11	4	−3	−11	−18	−25	−32	−39	−46	−54	−61	−68	−75	−82	−89	−97
60		25	17	10	3	−4	−11	−19	−26	−33	−40	−48	−55	−62	−69	−76	−84	−91	−98

Frostbite times: 30 minutes; 10 minutes; 5 minutes

Original Policy Date: 08/07
Last Revision: 06/23
Reviewed: 06/23

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Policy: EMS Patient Care Reports

Purpose: To ensure that all required documentation occurs when services are provided by a Region One EMS provider.

Overview: Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. When a Region 1 EMS provider interacts with a patient, documentation will occur. **It is imperative that written documentation is left at the receiving facility.**

Patient Care Reports:

1. A patient care report (PCR) will be accurately completed for each patient interaction. This includes EMS responses (emergency and non-emergency) in which patient contact is made.
2. All EMS personnel who participate in patient care or assessment will be listed on the patient care report, as well as the interventions or assessments performed.
3. All Non-Transport agencies will complete a Region 1 Short/Non-Transport Form and forward a copy of this patient record to their Resource Hospital within 24 hours.
4. Ideally, a PCR will be completed in its entirety and provided to the receiving facility immediately after transferring care to the ED staff and prior to departing the hospital. The PCR left will be in full compliance with Region 1 policies, IDPH rules and regulations, and NEMSIS rules and regulations.
5. If a PCR cannot be completed prior to departing the ED, then a Region 1 Short/Non-Transport Form (Appendix A) must be fully completed and left with the ED staff.
6. If the Short/Non-Transport Form is utilized the PCR will then be completed and sent (faxed or electronically) within 2 hours of completion of the call.
7. Each agency who utilized the Short/Non-Transport Form must keep a log of when they used it, which patient they used it for, the date of the transport, the time they left the Short Form at the hospital, and the time they submitted the PCR to the hospital. This form will be submitted to the agency's EMS System Coordinator on a monthly basis. See Appendix B.
8. Each Resource Hospital will submit this information to IDPH on a monthly basis including any quality improvement conducted as part of any run report reviews.
9. If an agency repeatedly violates this policy regarding the use of the Short Form the utilization of the Short Form will no longer be an option for that agency. Suspension or termination of use will be determined by the EMSMD for that agency and details will be provided to that agency in writing.

Original Policy Date: 04/08
Last Revision: 09/18
Reviewed: 06/23

Reference: IDPH Administrative Code
Short Form 515.310(k)

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Policy: Inbound Report and Alert Notifications

Overview: Inbound radio reports are utilized to notify receiving facilities about incoming patients. Information conveyed should be concise to facilitate the ED triage/bed assignment process. The abbreviated radio report will provide guidelines on what should be considered "triage essential information." If the patient condition is complex, evolving, or further treatments are requested detailed report format should be utilized.

When the patient condition warrants it, an **alert notification** should be made as soon as possible in order to improve the time to definitive care at the hospital.

A radio report may be in one of the following formats:

- **Heads-up report** – this is an initial report given early in order to give the receiving hospital as much time as possible to prepare for the patient.
- **Abbreviated radio report** – this is the type of report to be used on most routine transports, with the essential triage information.
- **Detailed radio report** – This report type of report should be used when guidance from Medical Direction is needed.

INFORMATION NEEDED

- Age
- Sex
- Complaint/Injury
- SMO being utilized
- Triage category based upon vital signs, LOC and response to treatments.
- Alert notifications in the following critical / time sensitive patients:
  - STEMI
  - Stroke
  - Trauma
  - Burns
  - Unstable Pediatric
  - Sepsis

Alert Notifications

STEMI Alert should be called:

- When the EMS provider identifies a STEMI
- The EMS provider should call in the STEMI Alert and transmit the ECG if possible

Stroke Alert should be called:

- When Stroke Screening checklist/FAST/GFAST Exam is positive
- Give last known well time

Trauma Alert should be called:

- Category I and II Trauma (see In-Field Trauma Triage Criteria)
- Adult Trauma Score of 10 or less or Pediatric Score of 8 or less
- Airway difficulties
- Trauma with altered respiratory rate > 35/ minute or < 12/ minute
- Any trauma patient with signs of hypoperfusion (shock)

Burns Alert should be called:

- Full thickness: ≥ 10% of TBSA
- Partial thickness: ≥ 20% of TBSA.
- Burns of airway, face, eyes, hands, feet or genital area.
- Chemical inhalation or electrical burns.

Unstable Pediatric Alert should be called:

- Altered LOC
- Airway difficulties
- Signs of hypoperfusion (shock)

Sepsis Alert should be called:

- When the Sepsis Screening Tool is positive

Heads-up Radio Report: PROCEDURE

- Transporting unit identification
- Type of patient, any alert notification
- This may be as short as "we have a _____ patient, ETA _____ minutes, details to follow"
- Additional information to follow
- This report may be given by someone other than the providers involved in patient care or very early in patient care so information may be limited.

Abbreviated Radio Report: PROCEDURE

- Transporting unit identification
- Age, sex and complaint
- SMO utilized, treatments given, and response
- Triage category (Red, Yellow or Green)
- ETA

Detailed Radio Report: PROCEDURE

- Identify the ambulance's call letters and level of care of the ambulance (BLS, AEMT, ILS, or ALS)
- Patient's age, sex, and estimated weight
- Chief Complaint
  - Symptoms - degree of distress, level of consciousness
  - Findings from observation of patient and environment
- Vital Signs
  - Pulse - rate, quality, regularity
  - Blood Pressure - auscultated or palpated
  - Respirations - rate, pattern, depth
  - Skin - color, temperature, moisture, turgor, pulse oximeter reading
- Medical History

  S - Symptoms

  A - Allergies

  M - Medications - bring all meds to ED

  P - Past history of pertinent illness/injury

  L - Last oral intake (food or fluid), if known

  E - Events surrounding incident

- Physical examination - ECG findings, Level of Consciousness, Vital Signs, Use AVPU for patients with altered level of consciousness.
- Treatments rendered at time of transmission and response to treatment.
- EMS personnel are to inquire as to any EMS Medical Direction additional orders and/or direction and confirm any orders/direction by voice.
- Provide an ETA to the receiving hospital.

PRECAUTIONS AND COMMENTS

- This Policy is to be used as a guideline. Transporting units may add information that may be pertinent to the triage process ("The patient is on CPAP and is not responding well" "Fall on blood thinners", etc)
- Medical Direction may request additional information.
- The term "radio report" in this Policy is used it include radio and phone report.

Original Policy Date: 06/17
Last Revision: 09/19
Reviewed: 06/23

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Policy: In-Field Termination/Notification of Coroner

Overview:

Special Situations:

A. Patient with DNR/POLST (follow DNR/POLST Policy).
B. Patient with definitive signs of death include at least one of the following:
   - rigor mortis
   - dependent lividity
   - decomposition of body tissues
   - fatal/unsurvivable injury(s)-an injury clearly incompatible with life:
     - decapitation
     - incineration
     - separation of vital internal organs from the body or total destruction of organs
     - gunshot wound to the head that clearly crosses the midline (entrance and exit)
C. Patients meeting the above conditions do not require Medical Direction contact prior to calling Coroner.
D. Patient has a valid DNR/POLST where resuscitation efforts where initiated prior to knowledge of resuscitation status. All providers, when presented with a valid DNR/POLST after initiating CPR, must contact Medical Direction prior to ending resuscitation efforts.
E. Prolonged resuscitation efforts beyond 20 minutes with full ACLS without a return of spontaneous circulation or shockable rhythm and/or capnography has remained below 10 throughout arrest it may be appropriate to terminate in the field.
F. If cardiac arrest is compounded by hypothermia, submersion in cold water, or if there has been transient ROSC or continued shockable rhythm transport is indicated.
G. Correctable causes or special resuscitation circumstances have been considered and addressed.
H. Family requests for termination should be relayed to Medical Direction.
I. Document name and relationship of family member(s) to patient who are present in the patient care report.

Policy:

A. CPR initiated.
B. Airway Management per Airway Management SMO.
C. AED/cardiac monitor applied.
D. AHA Guidelines followed for a minimum of 20 minutes. At 20 minutes consider transporting the patient, continuing treatment, or discontinuing treatment. When termination or transport is being considered:
   - Availability of local resources (e.g., time for coroner to arrive if care is terminated vs time of transport)
   - Trauma codes
   - Scene is unsafe
   - Family members present
   - Age/condition of patient
   - $EtCO_2$
   - Obvious death at crime scene
E. Contact Medical Direction for termination.
F. Any/all equipment that was used to treat the patient such as ET tubes, airway adjuncts, IVs, IOs etc should not be removed from the patient and be left in position that they were in at the time the patient was pronounced.
G. If termination is approved contact Coroner in the county of patient death. The Coroner should be contacted for all out of hospital deaths.
   - Note time of death and confirm signs. Remain on scene until coroner, law enforcement, or other appropriate professional arrives.
   - Do not transport patient who is dead at the scene unless otherwise directed by the coroner.

Original Policy Date: 06/17
Last Revision: 09/19
Reviewed: 06/23

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Policy: Interaction with Law Enforcement on Scene

POLICY: It is clearly understood that the first and foremost duty of law enforcement and EMS personnel is to protect and preserve human life. Pre-hospital providers must ensure that patient care is given the highest priority. In addition, and to the extent possible, this care should be given with consideration to the needs of law enforcement with respect to personnel safety, crime scene management and preservation of evidence. Pre-hospital personnel shall follow the direction of law enforcement with respect to crime scene management. The direction should not prevent nor detract from quality patient care. The following guidelines should be followed:

In all cases where a crime, suicide or self-harm, death, or suspicious fatality has occurred:

A. If police are not on the scene, request their services.
B. Assess dispatch information and the scene to determine if conditions permit safe performance of professional medical duties.
C. If the safety of EMS personnel would be placed in jeopardy, response and treatment and transport may be delayed pending police arrival.
D. Park EMS vehicles with consideration of the crime scene at direction of law enforcement if possible.
E. Do not destroy evidence such as tire tracks, footprints, or broken glass.
   - Consider wearing gloves for all activities at a crime scene including those not directly involved with patient care.
F. Entry to the crime scene should be made with the minimum number of personnel necessary to access and provide care to the patient(s).
G. Entry to and exit from the crime scene should be accomplished by the same route.
H. Do not walk-through fluids (blood) on the floor/ground.
I. Care should be taken not to disturb any physical evidence (including weapons). Do not move or touch anything unless it is necessary to do so for safety and/or patient care.
J. Observe and document any items moved.
K. Notify law enforcement of, and document, any items removed from the scene (impaled object, bottles, and patient belongings).
L. Removal of patient clothing should be kept to a minimum. Clothing removal should be done in a manner which will minimize the loss of physical evidence.
M. Do not cut through suspected bullet or knife holes.
N. Clothing and all personal articles of the patient are to be left in the possession of law enforcement personnel whenever possible.
O. If resuscitation was attempted, all EKG electrodes, defibrillation pads, IVs, IOs, invasive catheters (e.g. chest needles), and advanced airway devices should be left in place.
P. Put wrappers and other disposable "trash", which accumulates as patient care is rendered, in a single site away from the patient and/or potential crime scene evidence. Do not pick up on-scene trash items and discard because evidence may be destroyed. On-scene law enforcement personnel may suggest a site to be used for trash which would be most ideal to maximize preservation of evidence.
Q. Do not clean or disturb a patient's hands when involved with a firearm.
R. Patients who meet the "obvious death" criteria do not require EKG confirmation of asystole, or any manipulation of the body. These include:
   1. rigor mortis
   2. dependent lividity
   3. decomposition
   4. decapitation
   5. incineration
   6. transected torso

S. Patients who meet the criteria for withholding resuscitative efforts should be assessed using the minimum number of EMS personnel. EKG confirmation of asystole, if needed, should be completed with minimal movement of the body.
T. Contacting Medical Direction should be consistent with the In-Field Termination Policy.
U. If obvious death has been presumed by a law enforcement officer, and EMS is present, it is recommended that EMS be involved in the presumption of death. It is important to document the name and badge number of the officer presuming death or limiting access to the scene for patient assessment as the liability for such a decision will rest with him/her, and his/her department.
V. Every effort to cooperate with law enforcement should be made. In the event of a disagreement with law enforcement, EMS personnel should document the problem and refer the matter to their superior for follow-up and/or action. If the disagreement involves, in the opinion of the pre-hospital provider, an issue that will or could result in patient harm, an immediate request for on scene EMS and Law Enforcement supervisory personnel should be made, including consideration for direct medical oversight advice.
W. If EMS personnel discover a crime scene, or are at a crime scene without law enforcement, an immediate request for law enforcement shall be made. Until such time as law enforcement arrives, EMS personnel shall assure their own safety and if possible, attempt to follow the guidelines contained in this document.
X. Laundering of the scene at the completion of the investigation is not routinely in the scope of responsibility for the EMS personnel and therefore these requests should be to the appropriate resources for completion of scene management.
Y. Patients under police custody or who are under arrest should have a law enforcement officer present in the ambulance during EMS transport, but it is acceptable for the officer to follow in his/her vehicle.
Z. Sexual Assault
    1. When possible, transport all victims of a sexual assault to a facility with certified Sexual Assault Nurse Examiners (SANE).
    2. EMS Providers who respond to a call for an alleged sexual assault victim should do a medical screening exam to determine any physical trauma that needs immediate attention. Treat per medical guidelines. The EMS personnel should examine the genitalia only if severe injury is present or suspected.
    3. Patient history should be limited to the elements needed to provide emergency care.
    4. Be cognizant of preserving evidence during the process of patient assessment and care. This should include:
        a) Consider covering the cot with paper chux or sterile burn sheet if possible
        b) Handle clothing as little as possible
        c) Do not clean wounds unless necessary.
        d) Ask the patient not to drink or brush teeth.
        e) Ask the patient to avoid bathing, urinating, defecating, or douching if possible.
        f) Ask the victim not to change clothes or bathe.
        g) Disturb the crime scene as little as possible.

Original Policy Date: 06/17
Last Revision: 09/19
Reviewed: 06/23

Policy: Intercept Criteria

Overview: Abandonment is defined as terminating medical care without legal excuse or turning care over to personnel who do not have training and expertise appropriate for the medical needs of the patient. **If transport time to the receiving hospital is less than the time to complete an ALS intercept initiate rapid BLS/AEMT/ILS transport.**

Advanced level care should be considered according to the following guidelines:

A. **Symptomatic** patient with abnormal vital signs—use assessment skills and common sense. The following guidelines for adults:
   - Pulse < 60 or > 130; or irregularity
   - Respirations <10 or > 28; or irregularity
   - Systolic BP < 90 mmHG or diastolic > 110 mmHG
   - Pulse oximeter reading < 90

B. Any patient with a potentially life-threatening condition which exists or might develop during transport. Examples of situations in which ALS care may be indicated include, but are not limited to:
   - Impending airway compromise
   - Altered mental status and/or unconsciousness
   - Persistent cardiac related chest pain
   - Ongoing seizures
   - Syncope
   - Abdominal pain
   - Shortness of breath unresolved by EMS treatment
   - Signs of impending hypovolemic shock (e.g., GI bleed)
   - Complication of pregnancy or emergency childbirth
   - Significant trauma patient (Category I or II)
   - Overdose/ Poisoning
   - Patient condition warrants advanced prehospital medical care

C. Call for intercept EARLY. NEVER discontinue advanced level care once initiated.

D. **Consider ALS intercept time versus BLS transport**.

Policy:

A. Upon request of BLS ambulance for assistance, an ILS/ALS crew may board the BLS vehicle and begin care of the patient.
B. ILS/ALS equipment must be transferred to the BLS ambulance to render a higher level of care.
C. The ILS/ALS provider will assume responsibility from the EMTs for the care and treatment of the patient.
D. EMTs should assist the ILS/ALS provider enroute and on the scene and work together as a team to provide the best patient care possible.
E. The BLS ambulance will be approved by the Department to function as an ILS/ALS ambulance for the transport.
F. Report to Medical Direction will be the responsibility of the ILS/ALS provider.
G. Separate patient care reports must be completed by the BLS ambulance (for care initiated prior to ILS/ALS arrival) and ILS/ALS (for care initiated upon arrival and patient hand-off by BLS crew).

This policy generally applies for BLS units calling for ALS intercept, however, it may be considered for any higher level of care.

Original Policy Date: 06/17
Last Revision: 06/21
Reviewed: 06/23

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Policy: Interhospital/Interfacility Transport

Overview: Frequently, patients need to be transported between hospitals for higher level of care or more specific care procedures. Patients are to be treated during transport in accordance with existing standing operating procedures and policies & procedures. EMS personal are to maintain ongoing care of the patient until responsibility is assumed by appropriate personnel at the receiving facility.

INFORMATION NEEDED

- Diagnosis of patient that is being transported between facilities.
- Skills required to appropriately care for that patient.
- Additional personnel (i.e. physician, RN, respiratory therapist) required for the transport.
- Medications/ skills that are within the scope of practice of the transporting agency/personnel.

POLICY

- Interhospital / interfacility transports do not routinely need to be approved by Medical Direction because the transferring (sending) hospital physician has developed a treatment plan for the transport. If there are any questions concerning the patient to be transported or concerns over medical care enroute, contact should be established with Medical Direction at the transferring hospital.
- Medical Direction should be contacted in the following circumstances:
  - Change in patient status where guidance by Medical Direction at the transferring hospital is needed.
  - Medical-Legal issues needing immediate clarification and documentation.
  - Concerns between transferring/transporting physician orders and SMOs or policies and procedures.
  - If concerns between the transferring physician orders and the SMOs or policies/procedures cannot be resolved the transporting EMS agency should contact their Region 1 Resource Hospital for clarification.
- Documentation should be followed as per routine SMO for any patient contact by EMS. In addition, document names of transferring and receiving physicians and reasons for transfer.
- Interhospital / interfacility transfer of patients requiring skills for which EMS personal are not trained to perform (excluding home care devices) will require either a registered nurse and/or physician, a certified respiratory therapist, CT Technician, or other appropriate health care provider experienced with the specific skills in question, to be in attendance of the patient throughout the transport.
- An EMS agency/provider may be approved as an Expanded Scope/Critical Care Provider – Tier I, II or III. These agencies/ providers may have additional SMO and policies for interhospital/interfacility transports.

Original Policy Date: 07/04
Last Revision: 06/23
Reviewed: 06/23

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Policy: Latex Allergy/Latex Sensitivities Precautions

Purpose: To provide direction to ensure that the patient with a latex allergy is provided with non-allergic, non-latex equipment and procedures to protect them.

Process:

1. Patient history can note the incidence of latex allergy. Ask the patient history of possible allergies. When verified that the patient has a latex allergy, ask the extent of previous reactions:
    a. Contact dermatitis or local reaction.
    b. Systemic reaction – anaphylaxis.
2. Patients generally at high risk are, but are not limited to:
    a. Spina bifida.
    b. Multiple allergies, especially to bananas or avocados.
    c. Asthma.
    d. Chronic genitourinary problems requiring frequent catheterization.
3. Document allergy as any other allergy and include in the report to the receiving hospital.

Patient:

1. Do not use any product noted to have latex in the content on or around the patient.
2. Use non-latex exam gloves, non-latex tourniquets.
3. Use cloth tape.
4. Use latex-free EKG electrodes.
5. Use latex-free IV tubing, needles, syringes.
6. Use latex-free O2 masks, blood pressure cuffs, stethoscopes.
7. If certain equipment is unavailable, contact Medical Control for suggestions.

Precautions:

1. Do not use any latex product on or around the patient if possible.
2. Keep anaphylaxis medications available. Patients with latex sensitivity should be taken very seriously. These patients can develop anaphylactic reactions very rapidly which can progress to anaphylactic shock within a matter of minutes.
3. Contact Medical Direction as soon as possible for assistance.

When caring for a known latex allergy patient include

1. Use of latex-free supplies.
2. Remove all latex products from patient compartment of ambulance and store in cabinets.
3. Use latex-free equipment or put a barrier between patient and the equipment. Keep all material containing latex away from patient by covering equipment with latex-free material or cloth.
4. Transport with appropriate ventilation if weather or situation permits.
5. Communicate latex sensitivity to the Emergency Department during the course of the radio report.

Original Policy Date: 10/24
Last Revision:
Reviewed:

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Policy: Use of Lights and Sirens

Purpose:

For EMS, the purpose of using lights and sirens is to improve patient outcomes by decreasing the time to care, at the scene, or to arrival at a hospital; however only a small percentage of medical emergencies involve time sensitive conditions in which patients may benefit from lights and siren use.

Process:

The use of lights and sirens should be reduced as much as possible and only reserved for emergency response and emergency transportation. Additionally, training and procedures need to be in place, so when this mode of operation is used it will be done as safely as possible to all drivers and the public.

Each organization should develop and regularly review an emergent driving policy that provides for and enforces safe practices by all drivers. This policy should include a system to monitor the use of lights and siren.

Each organization should provide structured, emergent vehicle operation training prior to allowing personnel to drive the emergency vehicle. Before privileges are granted, drivers should be observed by their leadership.

All responders should have the ability to communicate with one another, and after assessing the patient, they have the ability to downgrade the response.

Driving with due regard for public safety is a critical and expected practice for agencies under our medical direction.

Original Policy Date: 07/23
Last Revision:
Reviewed:

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Policy: Medical Direction

Purpose

To provide a definition of who can provide Medical Direction to Region 1 EMS providers or agencies. This policy does not apply to Interhospital/Interfacility transfers.

Process

1. Region 1 EMS Systems have the responsibility and authority to provide Medical Direction for their providers.
2. Medical Direction is defined as physician (including MD-1) or licensed ECRN.
   a. Physicians may provide direction in the providers' scope of practice.
   b. ECRNs may provide directions as outlined in the Region 1 SMOs.
   c. Should another individual be approved by a receiving hospital to answer the radio/ inbound report they must call the physician or ECRN should orders be necessary or given. This includes Region 1 Associate and/or Participating Hospitals.
3. Region 1 Medical Directors agree on the following:
   a. Medical Direction may come from the EMS System or receiving hospital.
   b. In order for the receiving hospital to function as Medical Direction they must be a Resource, Associate, or Participating that has been approved by their EMS System and IDPH.
   c. All Medical Direction directions must come from a licensed physician or ECRN and be recorded. Recordings are to be stored for a minimum of 365 days or consistent with individual hospital policies, whichever is longer.
4. The Resource Hospital for a provider or agency has the authority to override Medical Direction as needed.
5. Any concerns or conflicts should be referred to the Region 1 Executive Committee.

Original Policy Date: 04/08
Last Revision: 09/18
Reviewed: 06/23

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Policy: Medication and Equipment Exchange

Purpose

To provide instructions for the exchange of medications and equipment at Region 1 Resource Hospitals.

Process

1. Each Region 1 hospital will have their own policy regarding the exchange of medication and equipment for restocking of supplies that are provided to patients during transport to their hospital. This includes all Resource, Associate, and Participating hospitals in the Region.

2. If at all possible, all medications should be replaced using the recommended concentrations on the Region 1 Restocking Form (Appendix D).

3. Medications utilized during transport will be restocked at the receiving hospital. If the medication is not available at the receiving hospital the EMS agency will contact their Resource Hospital for replacement and provide appropriate documentation (patient care report) in order to receive the replacement medication.

4. Any billing for medications or equipment is conducted between the EMS agency and the receiving hospital.

Original Policy Date: 04/08
Last Revision: 09/18
Reviewed: 06/23

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Policy: Patient Disposition and Selection of Receiving Facility and Refusals (formerly Closest Hospital and OB/Gyne Policy)

Overview: It is the purpose of this document to provide guidelines for determining the appropriate transport destination for every patient. Generally, patients should be transported to the closest, most appropriate hospital, utilizing the most appropriate level of care. Patients should not be transported to a more distant facility unless 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 transport to the closer facility.

GUIDELINES:

A. Determination of appropriate hospital should be based on medical benefits and associated risks and should be made in accordance with:

1. Patient Request/Preference
2. Patients' Medical Condition (Stable/Unstable)
3. Capacity of the nearest facility or facility of choice
4. Available resources of the transporting agency
5. Traffic and weather conditions

The patient has the right to make the ultimate decision on hospital destination as long as it is operationally available to the EMS service (a hospital the service would normally be allowed to transport to, that is not on diversion). If patient assessment dictates the patient should go to a different hospital than their original choice, but the patient is able to make decisions and wants to go another facility, attempt to quickly educate the patient regarding the reasons to go to the alternate facility and have the patient sign a Region 1 Refusal Form.

B. Stable Patients

For the purposes of this policy a stable patient is defined as:

1. Patient has apparent decision-making capacity
2. Vital signs within normal limits

If the patient is *stable* and the *medical benefits* to transport to other than the closest appropriate hospital outweigh the *risks* to the patient, the patient may be transported to the requested hospital.

If it is determined that transporting the patient to a more distant medical center does not present undue risk contact the receiving medical center and give them a full report on the patient's condition.

Unless the receiving hospital is on bypass status, it will be assumed that they will have the capacity and willingness to treat such a patient since they will be open to receive any and all ambulance runs.

C. Unstable Patients

If the patient is unstable and refusing to go to the closest appropriate hospital, this will be communicated to the EMSMD or designee at Emergency Department Medical Direction. He/she will evaluate all risks and benefits and direct the EMTs as he/she sees appropriate. Sole responsibility of where the patient is transported rests with the EMSMD or designee through the Emergency Department Medical Direction in such cases. Unstable patient bypasses must be documented on the telemetry log.

D. **Trauma Patients**
Trauma patients should be brought to the closest trauma center based on IDPH and Region I Trauma recommendations.

E. **OB/GYNE Patients** (Illinois Emergency Medical Services Act (210 ILCS 50/3.155a)

1. **Stable:** All pregnant patients (greater than 20 weeks) with a pregnancy related complaint and stable vital signs should be transported to the closest hospital with in-house OB/GYNE services if that facility is a reasonable (as determined by on scene EMS) distance away. This would include labor (not an imminent delivery, contractions greater than five minutes apart, no crowning) vaginal bleeding, pre-eclampsia, etc.
2. **Unstable:** All pregnancies less than 20 weeks, imminent delivery (crowning, contractions less than five minutes apart, etc), eclampsia with active seizing, and unstable vital signs should be transported to the closest facility.

In addition to the specialty care listed above consider the following additional specialty care situations:

1. STEMI Center
2. Comprehensive Stroke Center/Thrombectomy Capable
3. Primary Stroke Center
4. Acute Stroke-Ready Hospital
5. Patient Weight Limitation for CT Scan
6. Burn Capabilities
7. Pediatric Capabilities
8. Sexual Assault
9. Behavioral Health
10. Bariatric Patients

Although Illinois Department of Public Health EMS Rules (515.330 h 5-6) allow for patients to be transported directly to an EMS System approved mental health facility or immediate care Region 1 does not intend to develop policies for these situations at this time.

PROCESS:

Refusal of Treatment by Adult Patients with Decision-Making Capacity

A. Patients have the right to refuse treatment and/or transport.
B. The patient will be informed of the risk of refusal of possibility of deterioration of medical condition up to and including death.
C. Attempt to assess vital signs and SAMPLE history if possible.
D. For high-risk refusals, as defined above:
   - Consider contacting Medical Direction.
   - Attempt to leave patient in care of a responsible party.
   - Provide post refusal instructions as indicated.
   - Inform patient to call back if conditions changes or decision to refuse treatment is reconsidered.
E. Once the allowed assessment is performed, and the patient persists in refusing care and/or transport, the patient will be asked to sign the Region One Prehospital Refusal form (a paper/electronic refusal form approved by the system). The refusal form must also be signed by the EMT and by one other witness (preferably law enforcement or family) if available.
F. Complete patient care report.

Original Policy Date: 07/04
Last Revision: 09/23
Reviewed: 09/23

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Policy: Physician/RN On Scene

Overview: When EMS Provider have established patient contact, "a caregiver/patient" relationship has been established between the patient and EMSMD or designee. If a physician in on-scene they MAY assume responsibility for this patient if the following criteria are satisfied and documented:

- Physician can show a State of Illinois Medical license.
- Physician also produces a picture ID.
- Physician agrees to accompany patient to the hospital in the transporting vehicle.

If any of these criteria are not met and the physician on scene insists on taking control of the situation, contact Medical Direction for physician-to-physician communication. The EMS Provider should employ the following as guidelines in interacting with a physician on the scene:

PHYSICIAN ON SCENE

- Contact the resource hospital as soon as possible. All treatment should be reported over the radio for purposes of documentation.
- When, after consultation with the EMSMD or designee, it is determined that the physician's orders may be harmful to the patient, the EMS Provider will:
  - Explain to the physician on-scene the recognized deviation from SOPs and/or policies and procedures.
  - Immediately put the physician at the scene in contact with Medical Direction.
  - The EMSMD or designee will explain system SOPs and policies and procedures and attempt to reach consensus on patient care. Patient management by the licensed physician to provide supervision and direction throughout the pre-hospital care and transport process will continue until responsibility for care of the patient can be turned over directly to a physician on duty at hospital emergency department.
  - In cases where disagreements cannot be resolved, the EMSMD or designee will assume responsibility for patient care.
- In cases where the patient's personal physician is physically present, Medical Direction should respect the previously established doctor/patient relationship as long as acceptable medical care is being provided.
- Complete the Physician on Scene Form (Appendix G) and submit it to the EMS System Coordinator.

RN or NON-AGENCY EMS PROVIDER ON SCENE

- An RN or non-agency EMS Provider on scene may assist to the level of First Aid. If additional skills are needed (e.g. IV initiation) Medical Direction MUST be contacted for permission to utilize this person in an expanded role.
- An RN or non-agency EMS Provider on scene must provide proof of State of Illinois licensure and a picture ID.
- He/she must agree to follow the directions of the EMSMD or his/her designee.

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Last Revision: 06/17
Reviewed: 06/23

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Prehospital RN (PHRN),
Prehospital Advanced Practice Register Nurse (PHAPRN)
Prehospital Physician Assistant (PHPA):
Education, Certification and Recertification

I. DEFINITIONS

A **Prehospital Registered Nurse (PHRN)** is a registered professional nurse licensed under the Illinois Nursing Act who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to the Act and who is approved by an EMS Medical Director (EMS MD) to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports" (Section 3.80 of the Act). This individual was formerly called a Field RN.

A **Prehospital Advanced Practice Registered Nurse (PHAPRN)** is an advanced practice registered nurse licensed under the Nurse Practice Act who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to this Act, and who has the approval of an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports (Section 3.80 of the Act).

A **Pre-Hospital Physician Assistant (PHPA)** is a physician assistant licensed under the Physician Assistant Practice Act of 1987 who has successfully completed supplemental education in accordance with rules adopted by the Department pursuant to this Act, and who has the approval of an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports (Section 3.80 of the Act).

For the purpose of this policy when PHRN is used, PHAPRN and PHPA will also apply.

II. POLICY

A. All persons that wish to be licensed as a PHRN must demonstrate the same minimum mastery of cognitive objectives and psychomotor skills as set forth in the U.S. National EMS Education Standards for Paramedics.

B. The process of credentialing specifically involves the verification by an EMSMD that the PHRN provider possesses required competencies in the domains of cognitive, affective, and psychomotor abilities.

C. Authorization to practice is a function of state licensure and local credentialing by the EMSMD.

D. Illinois EMS Rules require a PHRN candidate to complete an education curriculum formulated by an EMS System and approved by IDPH, which consists of classroom and practical training for both the adult and pediatric populations, including extrication, telecommunications, and prehospital cardiac and trauma care (Section 3.80(c)(1)(A) of the Act). They must also complete a supervised field internship as authorized by the EMS MD.

III. PROCEDURE

Nurses desiring to be approved as a PHRN will complete the following:

A. Prerequisites

1. Registered nurse with current Illinois license in good standing in accordance with the Illinois Nurse Practice Act (PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (225 ILCS 65/) Nurse Practice Act (225 ILCS 65/Art. 60 heading).
2. Current healthcare provider CPR card through the AHA or a recognized affiliate.
3. Minimum of two-year clinical practice in emergency or critical care nursing; and
    a. Current AHA* - ACLS (or equivalent) provider certification.
    b. Current AHA* - PALS (or equivalent) provider certification.
    c. Current AHA* - BLS (or equivalent) provider certification.
    (*Equivalent AHA course must have written and skills testing component)
    d. Current Trauma provider certification (PHTLS, ITLS, TNS, TNCC).
4. Written approval to ride with for field internship purposes, or evidence of employment by, an approved Region 1 ALS Provider Agency.
5. Liability insurance coverage.
6. Healthcare insurance coverage or signed waiver.
7. System approved drug screening and immunizations.
8. Criminal background check, any potential barrier to licensure or participating in clinical experience must be addressed by Program Director and EMSMD.

B. Didactic component

1. Certain principles required for prehospital ALS practice are not included in an RN's education program, so must be obtained and mastered through the PHRN or a Paramedic course. These topics include, but may not be limited to:
    a. Introduction to EMS; roles and responsibilities of EMS personnel.
    b. Medical/legal issues in EMS; EMS communications.
    c. Documentation using the Prehospital patient care reporting system.
    d. Regional / System Standing Medical Orders.
    e. ALS interventions.
    f. Scene control and patient assessment in the prehospital environment; including specific prehospital stroke, STEMI and trauma assessments.
    g. Application of sensors and interpretation of capnography waveforms and numeric results.
    h. Invasive airway adjuncts and EMS oxygen delivery devices.
    i. Cardiac monitoring (including interpretation of 12-Lead ECGs) and dysrhythmia management; prehospital cardiac arrest management.
    j. Pleural decompression.
    k. Prehospital childbirth, newborn resuscitation.
    l. Ambulance Operations - Hazardous materials awareness; rescue techniques; Patient access and conveyance options; Incident command system and triage.
    m. System policies.

C. Psychomotor component

1. PHRN students must complete all mandatory skill competency labs/exams. Mandatory skill competencies include, but may not be limited to:
    a. Assessment: Adult, pediatric, and infant.
    b. Airway access: Manual opening; NPA, OPA, suction; obstructed airway maneuvers; oral endotracheal, sedation, DSI, in-line, digital intubation; Supraglottic airway, needle and surgical cricothyrotomy.
    c. Oxygen delivery/ventilatory support: Use and maintenance of portable O2 cylinders; NC, NRM, CPAP, BVM; SpO2 and capnography monitoring.
    d. Cardiovascular support: Peripheral venous & intraosseous access; infusions, cardiac monitoring using 3 and 12 leads; cardioversion, defibrillation, transcutaneous pacing; and code management.
    e. Drug administration techniques used in Regional / System SMOs.
    f. Spinal Restriction: KED, helmet removal, splinting techniques: limb splints, traction splints.
    g. Misc.: Capillary glucose monitoring, pleural decompression, use of restraints, etc.

D. Hospital clinical component

All students must complete or show clinical experience / proficiency of all clinical experiences listed in the EMS Systems Paramedic course curriculum. All students requesting credit for prior clinical experiences must request this in writing, any credit may be approved by the EMSMD on a case-by-case determination.

E. Capstone Field Internship

PHRN students will complete the same System prehospital internship requirements as paramedic students with an approved ALS provider.

F. PHRN testing:

Applicants must successfully complete all didactic requirements including paramedic course final written and practical exams.

G. Terminal Competency and PHRN recognition:

1. Applicants must successfully complete all didactic requirements including paramedic course final written and practical exams.
2. Terminal Competency, which indicates readiness to sit for state or national exam, includes:
    a. Completion of the didactic portion of the course.
    b. In-House Clinical completed.
    c. Capstone Field Internship completed.
    d. Letter from Preceptor.
    e. Student reviewed and approved by Program Director and EMS Medical Director.
3. When the above terminal competencies are met the EMSMD will approve the PHRN candidate to take the State / National Assessment Paramedic exam.
4. Successful completion of the State / National Assessment Paramedic exam will constitute a recommendation to license them as a PHRN in Illinois.

H. Records maintenance:

A PHRN will notify their EMS System(s) and IDPH within 30 days after any change in name, affiliation, or address per local policy.

I. 77 Ill Adm.
Code 515.190(c) requires "all licensees and certificate and permit holders under the Act shall report all new felony convictions to the Department within seven days after conviction. Convictions shall be reported by means of a letter to the Department".

J. PHRN recertification:
Recertification is required every four years. A PHRN will maintain their credential in the same manner as a Paramedic.

K. Certificate expiration:
The certificate of a PHRN who has failed to file an application for renewal will terminate on the day following the expiration date shown on the license.

L. Requests for extension:
Recognition as a PHRN may be extended by IDPH only when appropriate documents substantiating hardship is provided in writing accompanied by a recommendation from the EMS MD. To request an extension, complete and submit the IDPH EMT Extension Form to their EMS System office for processing with IDPH.

M. Inactive Status:
Prior to the expiration of the current approval, a PHRN may request to be placed on inactive status. The request will be made in writing on the IDPH Inactive/Reactivation Form. Submit the form to the local Resource Hospital EMSS office for review and processing with IDPH. The form will contain a statement that explains the reasons for requesting inactive status and must be accompanied by the current PHRN license (copies not accepted by IDPH). IDPH will review and grant or deny requests for inactive status. If approved, the nurse may not function as a PHRN.

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Reviewed: 06/23

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Policy: Professional Conduct, Code of Ethics, Complaint Procedure, Good Standing, Social Media, Disciplinary Action, Region 1 QA Coordination Committee, and Resolution of Regional or Inter-System Conflicts

Overview: This policy is intended to be a framework for all licensed EMS Providers to adhere to, regardless of status (student, professional, instructor, or administrator). Region 1 is committed to ensuring that all EMS Providers are committed professionals who the public can rely on during a time of need. The purpose of this policy is to deter licensed EMS Providers misconduct, avoid conflicts of interest, keep honesty in all of their actions, provide for resolving sensitive issues, and make clear that all EMS Providers, regardless of status, will be held accountable for ethical lapses.

Region 1 is committed to providing quality patient care and promoting patient/family satisfaction. EMS Responders at all levels will handle all patient/family complaints consistently and in a timely manner.

Region 1 EMS Responders at all levels will track and trend complaints and grievances. Necessary changes and process improvements will then be implemented under the direction of the Region 1 Resource Hospitals, EMS Medical Directors, and Region 1 Quality Assurance (QA) Coordination Committee.

Complaints can be filed with an individual agency, an EMS System (Resource Hospital), the Region 1 Executive Committee, or Illinois Department of Public Health regarding the behavior and/or actions of EMS Providers who have violated this policy. All complaints received will be investigated per Illinois Department of Public Health Administrative Rule 515.330 g) 4) A-C. The complaint process and form can be found in Appendix K.

Professional Conduct and Code of Ethics for All Licensed EMS Providers:

A. Professional Conduct
   1. **Respect for Human Dignity, Diversity, Inclusion, Cultural Awareness**– The basis of ethical principles and means considers all people as being worthy of high regard and includes respecting the uniqueness of each individual. All people encountered by licensed EMS Providers deserve respect regardless of their socioeconomic and/or financial status and their background regardless of nationality, sex, race, creed, color, or status.
   2. **Maintain Confidentiality** – Every person has the right to privacy. Sensitive information regarding a patients' condition or history should only be provided to medical personnel with an immediate need-to-know. Providers are expected to know Heath Insurance Portability and Accountability (HIPAA) guidelines and abide by HIPAA regulations in their professional practice. All information gathered during any patient encounter by a licensed EMS provider may only be shared to those providers within the continuum of care or with those who have the need to know.
   3. **Professional Competency** – It is the duty of all licensed EMS Providers to provide the best possible care by continuously improving their understanding of the profession, completing continuing education as directed by State, Region, and System policies, maintaining mandatory certifications (such as BLS), and thorough knowledge of all Regional and System Standard Medical Orders (SMOs), guidelines, and resources.
   4. **Safety Awareness and Practice** – It is the responsibility of all licensed EMS Providers to protect the health and well-being of their community, co-workers, family, and self. Licensed EMS Providers should not engage in, attempt to conceal, or attempt or discourage others from disclosing information about situations which may be illegal or harmful to those in their care or community.
   5. **Action Accountability** – It is the responsibility of all licensed EMS Providers to act within their scope of practice and accept responsibility for both satisfactory and unsatisfactory actions. Licensed EMS Providers will not allow personal interests, such as economic gain, recognition, power or promotion, to influence their decisions or advice to others.
   6. **Loyalty and Cooperation** – Licensed EMS Providers demonstrate loyalty to their profession by maintaining confidentiality through restraint from criticism of the public, coworkers and employers, healthcare professionals and agencies in all public forums including social media.

7. Non-retaliation Statement – Licensed EMS Providers may not retaliate, threaten, or punish anyone who, in good faith, engages in protected actions under this policy that include filing or responding to a complaint, serving as a witness in the investigation of a complaint, or serving as an investigator of a complaint. All forms of retaliation are prohibited, including any forms of discipline, reprisal, intimidation, or other form of retaliatory behavior for participating in any activity protected by this policy.
8. Groundless or Malicious Complaint – Filing a groundless or malicious complaint is an abuse of this policy and will be treated as a violation.

B. Code of Ethics:
1. Licensed EMS Providers, agencies, students will adhere to core values, this policy, and codes of ethical conduct that govern the medical, nursing, and EMS professions in the course of their professional EMS duties.
2. Core values of Region 1 licensed EMS Providers includes:
    a. Excellence in providing patient care, educational experiences, exemplary service, and superior clinical practice, quality, and safety.
    b. Commitment to person-centered, efficient, and humanistic care.
    c. Integrity to strive to do the right things in the correct way.
    d. Compassion to care about the well-being of others.
    e. Respect and collaboration for optimal outcomes to deliver optimal outcomes for patients while treating everyone with dignity and respect.
    f. Accountability in taking responsibility for our own actions.
    g. Justice in treating individuals the same.
    h. Professional development in the process of applying and sharing knowledge.
3. Ethical conduct of Region 1 licensed EMS Providers includes:
    a. Tell the truth and model veracity.
    b. Treat other with respect, civility, courtesy, and dignity, and exhibit professional conduct and a cooperative manner at all times.
    c. Work cooperatively and harmoniously with leaders, peers, and educators.
    d. Respect cultural, ethnic, and racial differences and protect the rights, privileges, and beliefs of others to reduce bias and barriers so all operate within a growth mindset within a Culture of Safety and Just Culture.
    e. Avoid threatening, profane, and/or abusive language or actions and refrain from verbal or written communication that defames any person or organization or would be considered harassment.
    f. Address concerns or conflicts with associate in a direct, prompt, yet sensitive manner in an appropriate setting. If this fails, go through proper channels to appropriately resolve the conflict.
4. Examples of prohibited behaviors include, but may not be limited to:
    a. Academic dishonesty in the preparation or completion of education, continuing education, and/or academic assignments. Engagement or assisting in or condoning cheating, plagiarism, or other activities of academic dishonesty.
    b. Fraud, deceit, or misrepresentation in attempting to procure admittance into an EMS System.
    c. Accepting or offered a bribe, kickback, payoff, or other improper incentive or payment to obtain, influence and/or maintain any transaction, obtain or provide a grade or evaluation.
    d. Demonstrated lack of integrity.
    e. Falsified, altered, or participated in the untimely destruction of any EMS-related documents or individual, agency, healthcare facility, or EMS System (Resource Hospital) property.
    f. Engaged in dishonorable, unethical, or unprofessional conduct likely to deceive, defraud, or harm the public. This may include actions that create the potential for harm through negligence or willfulness, providing patient care without proper preparation or authorization, lying, covering up, or failing to report an error in the clinical setting.
    g. Violated rules, regulations, policies, procedures, or behavioral agreements specific to Region 1 EMS providers, agencies, educational programs, or EMS Systems.

h. Presented as unfit for duty or is non-decisional by reason of illness, legal or illegal drug/chemical use, or negligence. Presenting to any workplace or class impaired, intoxicated, or under the influence.
i. Found in procession of, or has used or distributed, an illegal or controlled substance or look-alike drug.
j. Assault and/or battery, hazing, or harassment.

C. Complaint Process

Definitions

Complaints are defined as a verbal or written expression of dissatisfaction regarding care or services provided by Region 1 EMS Providers. An expressed concern may be resolved at the point at which it occurs by the EMS provider. Most complaints have simple solutions that can be promptly addressed and will be considered resolved when the complainant is satisfied with the action taken on their behalf.

Procedures and Responsibilities

Procedure / Duty: Responsible Party

1. Any EMS provider agency who receives a complaint will immediately attempt to resolve the complaint within that provider's role and authority.
2. If the complaint cannot be immediately resolved, the provider agency will escalate the complaint through the appropriate chain of command.
3. The Agency will resolve the complaint or take steps to continue the resolution process with the knowledge and agreement of the patient/family or EMS provider making the complaint.
4. At any time during the complaint resolution process, Region 1 Resource Hospitals, EMS Medical Directors, and Region 1 Quality Assurance Coordination Committee will be available for assistance, advice and/or support.
5. Immediately upon completion of the investigation, the Agency/Provider of the department will communicate all findings and resolutions to Region 1 Resource Hospital utilizing the Patient Complaint Form.
6. All complaints will be logged, analyzed and tracked by Agencies, Region 1 Resource Hospitals, EMS Medical Directors, and Region 1 Quality Assurance Committee.
7. Region 1 Resource Hospitals, EMS Medical Directors, and Region 1 Quality Assurance Coordination Committee will receive reports from Region 1 Agencies within 30 days of the complaint and will be responsible for reviewing and addressing trends and overseeing improvement opportunities.
8. All complaints, investigations, follow-up, tracking, meeting minutes, proceedings, and reports prepared by the Agency/Provider, Region 1 Resource Hospitals, EMS Medical Directors, and Region 1 Quality Assurance Coordination Committee are considered Region 1 information and are privileged and confidential. No information at any time will be released without the written permission of the Region 1 Resource Hospitals, EMS Medical Directors, Quality Assurance Coordination Committee and/or the Legal department.

Forms

All patient complaints or concerns are to be documented utilizing the Request for Clarification Form (Appendix K).

D. Good Standing

An individual (EMD, EMR, EMT, AEMT, ILS, Paramedic, PHRN, ECRN, Critical Care Medic/RN) is deemed to be in Good Standing when they: have successfully completed basic training for licensure, are current with all system required CE, and are under no current disciplinary action. Tier I-III providers must complete annual critical care education (records maintained by individual or agency). ECRNs must complete 8 hours or annual ride time with an ALS System approved provider and the annual SMO test.

Good Standing must be maintained in order to be eligible for: Letters of Good Standing, License Downgrade/ Inactive Status and Re-licensure.

E. Social Media

1. Professional standards of conduct apply to all Region 1 agencies and personnel engaging in communication through blogs and social network (media) sites. Use of e-mail and social media that disclose proprietary or confidential information or create legal liabilities are prohibited.
2. The Region 1 Quality Assurance Coordination Committee reserves the right to monitor social media sites for conduct that is determined to be inconsistent with the Professional Conduct policy and apply corrective action through the appropriate Region 1 Resource Hospital as needed.
3. The following activities are specifically prohibited under this policy:
    a. Posting or mentioning identifiable Region 1 Resource Hospital patient health information (Protected Health Information - PHI) through any variation of social media. This includes, but is not limited to: photos that could identify the patient, the patient's address or location, time and date the care was provided or any other PHI); discussion related to an individual patient's care; and, the patients' hospital destination.
    b. Any misrepresentation that allows a user to gain unauthorized access to a network, application, or site affiliated with Region 1 agencies or personnel.
    c. Communications that are demeaning, defaming, harassing (including sexually), or discriminatory against any Region 1 Resource Hospital, agency, or personnel.
    d. Display of offensive, discriminatory or pornographic material that is inconsistent with the Professional Conduct policy or contributes to an intimidating or hostile environment for all individuals, patients, and providers.
    e. Accessing and/or disclosing PHI or other confidential information that is not within the scope of a Region 1 or Illinois Department of Public Health licensed provider.
4. An individual Region 1 Resource Hospital or agency may request that their agencies and personnel to provide a disclaimer on the agency/personal social media site that "the views expressed on this site are my own and do not reflect the views of my employer or Region 1 Resource Hospital". This disclaimer does not exempt employees from assuring their online behavior represents the Professional Conduct outlined in this policy.

F. Disciplinary Action

1. Parameters for Suspension

   The EMS Medical Director (EMSMD) of any Region 1 EMS System may suspend any individual EMS Personnel, EMS Lead Instructor (LI), individual provider or other participant agency within their EMS System who are not meeting the Program Plan of that approved EMS System following Section 515.420 of the IDPH Administrative Code. A system suspension means the individual(s) or agency will not directly or indirectly participate in the administration of patient care.

   Due process will be afforded prior to suspension unless continued practice would cause imminent harm to patients. Any suspension must be based on one or more of the following:

    a. Failure to meet the education and training requirements as outlined by Illinois Department of Public Health (IDPH) EMS Act or the EMSMD.
    b. Violation of the EMS Act or any rule or regulation under the Act.
    c. Failure to maintain applicable level of proficiency as determined by licensure. This includes remaining current in continuing education requirements.
    d. Failure to comply with the provision of the Region 1 Standing Medical Orders and Policies, SOPs, and/or System Program Standards of Care.

e. During the delivery of emergency care the provider or agency engages in dishonorable, unethical, unprofessional, or criminal conduct that is likely to deceive, defraud, or harm the public.
f. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other recreational/prescribed drugs or stimulants that may adversely affect the delivery, performance, or activities of patients requiring medical care.
g. Intentional falsification of any medical reports or orders or misrepresentations involving medical care. This includes consistent incompletion of required documentation prior to departure from the receiving hospital.
h. Abandonment or neglect of a patient requiring emergency care.
i. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, healthcare facility, institution, or other workplace location.
j. Performing or attempting emergency care, techniques, or procedures without proper permission, licensure, training, or supervision.
k. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin, ability to pay, or sexual orientation/identification.
l. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence, in the delivery of emergency care.
m. Agencies/departments condoning any of the parameters listed (a-l above).
n. Agencies/departments not meeting all system requirements for licensing, stocking, and equipping all transport and non-transport vehicles. All vehicles are subject to random inspection per IDPH guidelines.

2. Procedure for Disciplinary Action

Upon identification of a discrepancy or need for further clarification the individuals/agency will be contacted by the EMSMD or designee. The case or situation will be reviewed and re-education will be completed by the EMS System. If a satisfactory conclusion is reached no further action will be taken. If a satisfactory resolution is unable to be reached one of the disciplinary steps (below) will be taken:

1. Verbal Reprimand: The EMSMD or designee will meet with the individual(s) and a representative from their agency (supervisor, chief, etc.). A formal verbal reprimand will be placed in the individual(s)'s system record and retained for one year. If the issue that led to the verbal reprimand is repeated within that time frame it will be escalated to a written reprimand.
2. Written Reprimand: Gross misconduct is an automatic written reprimand that will be retained in the individual(s)'s system record for two years. The individual(s)'s will not be eligible for a letter of good standing. The EMSMD will meet with the individual(s) and a representative from their agency (EMS Coordinator or Chief) to develop a written plan of corrective action. If the corrective action is not completed or the misconduct is repeated the individual(s) may be subject to system suspension.

3. Procedure for Suspension

a. Any individual(s)/agency deemed to be a threat to public health or safety will be immediately suspended from the EMS System where the infraction occurred.
b. The EMSMD or designee will notify any secondary EMS System where the provider(s) practices (if known).
c. The EMSMD may suspend licensed individuals/agencies from engaging in activities within their EMS System if any of the parameters are not met (Sections A and/or B above).
d. The individual(s)/agency will receive immediate verbal notification of a suspension. A written or electronic notification of suspension will follow within 24 hours and include: reason for suspension, term, length, and date the suspension began.
e. The suspended individual(s)/agency may challenge the suspension and request a hearing with the local EMS System Review Board. If a hearing is desired a written request must be delivered to the EMSMD withing 14 calendar days following the receipt of the written/electronic order of suspension. Failure to request a hearing will constitute a waiver of the local EMS System Review Board.

f. The EMS System will endeavor to schedule a hearing in an expedited manner, but no later than 21 days following the request for a hearing.
g. The EMS System is authorized to seek injunctive relief in circuit court for failure to appear or comply.
h. A hearing may be deferred if a written plan of corrective action is submitted to the EMS System and approved. This will be determined by the EMS System's EMSMD. If the individual(s) challenge the suspension and a hearing is scheduled the suspension will remain in place until the hearing is concluded.
i. The EMS System will designate a local System Review Board in accordance with Section 3.40e of the EMS Act. The purpose of the local System Review Board is to provide a hearing for any individual(s) or entity participating within the System who is suspended from participation by the EMS Medical Director.
    1. The members of the EMS System Review board will be posted in a 24-hour accessible location at the Resource Hospital.
    2. The board will consist of at least three members that include: an Emergency Department Physician (not the EMS Medical Director) with knowledge of EMS, an EMT, and one of the same professional category as the individual(s) provider who has requested the hearing. Additional personnel may be added at the discretion of the EMS System.
j. The EMS System will arrange for a certified shorthand reporter or a method of recording the hearing in order to prepare a transcript of the proceeding. The transcript, all documents or materials received as evidence during the heard, and the local System Review Board's written decision will be retained in the custody of the EMS System. The EMS System will implement the decision of the local System Review Board unless that decision is appealed to the State Emergency Medical Services Review Board in accordance with the EMS Act, Section 3.45 and Section 515.440 of the EMS Administrative Code. The EMS System and appealing individual(s) may be represented by legal counsel but must make notification of their intention to do so at least 14 calendar days in advance in order to allow opposing counsel to be appointed.
k. Any appeal to the State Emergency Medical Services Disciplinary Review Board is the sole responsibility of the suspended individual/agency.
l. The local System Review Board will state, in writing, its decision to affirm, modify, or reverse the suspension order. That decision will be sent via certified mail to the EMS Medical Director and the individual(s)/agency or other participant who requested the hearing within five (5) business days after the conclusion of the hearing.
m. The EMS System will notify the individual(s)/agency, in writing, within five (5) business days of the decision to uphold, modify, or reverse the EMS Medical Director's suspension of an individual(s)/agency. The notice will include a statement detailing the duration and grounds for the suspension.
n. If the local System Review Board affirms or modifies the EMS Medical Director's suspension order, the individual provider(s) or agency have the opportunity for review by the State EMS Disciplinary Review Board (Section 3.40(b)(2) of the EMS Act).
o. If the local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director has the opportunity for review by the State EMS Disciplinary Review Board (Section 3.40(b)(2) of the EMS Act).
p. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Illinois Department of Public Health Division of EMS and Highway Safety within 10 days after receiving the decision of the local EMS System Review Board or the EMS Medical Director's suspension order, whichever is applicable. A copy of the local EMS System Review Board's decision or the suspension order must be enclosed (Section 3.45(h) of the Act).
q. This policy may be modified or amended at any time by the Region 1 EMS Medical Directors without previous notice if it is determined to be in the best interest of the Region 1 EMS Systems. Modifications or Amendments may not take placed during an active investigation at a Region 1 EMS System.

G. Felony Conviction

All EMS licensees convicted of an Illinois Class X, Class 1 or Class 2 felony will be subject to adverse licensure actions under Section 3.50(d)(8) of the Act. Please refer to Administrative Code 515.190(a) for any conviction occurring out of Illinois. Convictions must be reported to the primary/secondary Region 1 EMS System within five (5) days of the conviction and via a letter to Illinois Department of Public Health within seven (7) days of the conviction. Please refer to Administrative Code 515.190 for complete information.

H. Region 1 Quality Assurance Coordination Committee

The Region 1 Quality Assurance Coordination Committee is a Standing Sub-Committee of the Region 1 Executive Committee according to the Region 1 Bylaws, Article 4 and will follow the procedures and responsibilities listed in Section C (above) as well as the process listed below:

1. The Region 1 Executive Committee rotates chairmanship between Resource Hospitals every two years. The Chairman of the Region 1 Quality Assurance Coordination Committee will rotate every two years, as well.
2. Sub-Committee members will include all Region 1 EMS Medical Directors and EMS Coordinators.
3. Agenda items will be sent to the Sub-Committee Chairman prior to the next scheduled meeting.
4. Minutes of all meetings will be kept by the current Chairman. A recorder of meeting minutes may be present according to the Chairman's preference. All Committee members will take into account anonymity of the patient, family, provider, and agency involved All meeting minutes and outcomes are to be kept confidential.
5. Meetings will occur quarterly or as called by the Chairman if there are agenda items to be addressed. Meetings may be held in person, virtually, or both. The Sub-Committee Chair or designee will contact meeting participants two weeks prior with the meeting date, time, location, and agenda.
6. Agenda items before this Sub-Committee may include, but are not limited to:
   c. Any request from a Region 1 EMS Medical Director.
   d. Issues involving Region 1 providers who are part of multiple Region 1 EMS System (example, provider system suspension).
   e. Agencies that are requesting to change from one Region 1 EMS System to another.
   f. Provider or patient/family complaints as deemed appropriate for open discussion by a Region 1 EMS Medical Director.
   g. Override of Medical Direction.
   h. On-duty death of a Region 1 EMS Provider.
   i. Mechanical failure/recall of patient care equipment/medication.
7. Sub-Committee members will include all Region 1 EMS Medical Directors and EMS Coordinators, and others as appointed/approved by the chairman for specific situation on a case-by-case basis.
8. Generally, conflicts are addressed within an EMS agency or EMS System. Should a regional or inter-system conflict occur the following steps should be followed for resolution:
   a. Any Region 1 provider or agency can bring issues to the Region 1 EMS Advisory Council and/or Executive Committee in writing or person.
   b. All relevant information surrounding the issue in dispute is required to be provided to the Council. Issues related to EMS will be reviewed by the Region 1 Executive Committee. Issues related to trauma care may be referred to the Region 1 Trauma Committee, as needed.
   c. After resolution, the Region 1 EMS Executive Committee will respond to the dispute with the involved parties in writing on or before the next scheduled meeting. It is the responsibility of the Council Chairperson to initiate this written response.
   d. If the Region 1 EMS Executive Committee is unable to resolve the issue, the following will be sent to the IDPH Director per Section 515.230 of the Administrative Code:
      1. All relevant information surrounding the issue being disputed.

2. A statement from the Region 1 EMS Executive Committee supporting their position; and the name, phone number, e-mail address, and address of one person who should be contacted if further information is needed.
3. A statement from the Region 1 Trauma Center Medical Director or Trauma Committee, whichever is applicable, supporting their position; and the name, phone number, e-mail address, and address of one person who should be contacted if further information is needed.

e. The IDPH Director will make a determination within 10 working days after receipt of the above information. The determination may be on or the other position or may be another option developed by the IDPH Director.
f. Once the determination is received from the IDPH Director it is the responsibility of the Chairperson of the Region 1 Executive Committee to share the determination with the other Committee members and the involved parties. The determination will be read into the Region 1 Executive Committee meeting minutes for the purpose of documentation of the resolution of the dispute.

I. Documentation of Unusual Occurrences (Sentinel events)

1. Refer to the Region 1 Request for Clarification Form (Appendix K) (formerly titled the Unusual Occurrence Form) in this document.
2. This form should be utilized as an incident report to communicate any of the issues listed below. Submit any report through the usual chain-of-command for your EMS agency or follow the procedure as directed by your EMS Resource Hospital.
3. Possible incidents that should be documented on this form are:
   a. Medication errors
   b. Equipment malfunction
   c. Procedure errors
   d. Deviation from Region 1 SMOs or agency SOPs
   e. Injury of a patient
   f. Injury of an EMS provider
   g. Difficult interaction/communication with another EMS Agency/Law Enforcement Agency
4. Direct any questions to your Region 1 EMS System Coordinator regarding how this form should be utilized.

Original Policy Date: 06/23
Last Revision: 10/24
Reviewed:

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Policy: Protocol for Disbursement of IDPH Department Grants

Purpose

To provide equal opportunity and instructions for application by Region 1 EMS Agencies for EMS Assistance Funds Grants, when available.

Process

1. When EMS Assistance Grants are available the Region 1 EMS Coordinators will forward information to their agencies including all appropriate deadlines and parameters.
2. The EMS Agency will complete the application as defined in 515.3000 of the Administrative Code.
3. Incomplete applications will not be considered.
4. The Region 1 EMS Coordinators, or their designee, prioritize the completed applications.
5. The Chairperson of the Region 1 Executive Committee, or designee, forwards the prioritized list to IDPH in the prescribed manner.
6. When the recipients of the grant are announced the agencies will be notified by IDPH.
7. Questions regarding any agency application should be directed to the agency's EMS System Coordinator.

Original Policy Date: 04/08
Last Revision: 09/18
Reviewed: 06/23

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Policy: Provider Notification of EMAC or NAC Response

Overview: Should a Region 1 EMS agency wish to be deployed for an EMAC/NAC response they must submit a System Modification with their primary Resource Hospital prior to leaving Region 1. The Emergency Management Assistance Compact (EMAC) has been ratified by the United States Congress (PL104-321) and is law in all 50 states, the District of Columbia, Puerto Rico, Guam, the US Virgin Islands, and the Northern Mariana Islands. EMAC allows states to send personnel, equipment, and commodities to other states to help disaster relief during governor-declared states of emergency.

Article V of the EMAC legislation states that any person holding a license issued by any state evidencing the meeting of qualifications for their professional skills will be deemed licensed by the state requesting assistance to render aid involving those skills to meet a declared emergency or disaster. This is subject to potential limitations and conditions of the Governor of the requesting state as prescribed by an executive order. See the full legislation at the following website - https://www.emacweb.org/index.php/learn-about-emac/emac-legislation

The National Advisory Council (NAC) advises the FEMA Administrator on all aspects of emergency management, including preparedness, protection, response, recovery, and mitigation for national disasters, acts of terrorism and other manmade disasters. See more information regarding NAC at this website - https://www.fema.gov/about/offices/national-advisory-council

Policy:

Individual EMS Provider Notification Responsibilities: An individual EMS provider who possesses a current Illinois Department of Public Health license for Emergency Medical Dispatcher, Emergency Medical Responder, Emergency Medical Technician, Paramedic, PHRN (APRN, PHPA), and/or ECRN and who is in good standing must notify their primary Resource Hospital if they are requesting or have been requested to be deployed through EMAC/NAC to a disaster response outside of their primary IDPH designated region or to another area as designated in the EMAC definition above. The provider will complete the "Request for Clarification" form (Appendix J) to their primary Resource Hospital. The provider will not be considered approved for deployment until they receive a copy of the signed approval from their EMS Medical Director / EMS System Coordinator.

Provider Agency Notification Responsibilities: A Region 1 EMS Provider Agency that is in good standing with their Region 1 Resource Hospital must notify their primary Resource Hospital if they are requesting or have been requested to be deployed through EMAC/NAC to a disaster response outside of their primary IDPH designated region or to another area as designated in the EMAC definition above. The provider will complete the "Request for Clarification" form (Appendix J) to their primary Resource Hospital. The Provider Agency must include information related to the licensed vehicle(s) that will be part of the response and a list of all individual providers who will be designated responders as listed in the "Individual EMS Provider Notification" information listed above. The Provider Agency will perform an inspection of the vehicle(s) and include that with other paperwork submitted for approval. The provider agency and their licensed employees will not be considered approved for deployment until they receive a copy of the signed approval from their EMS Medical Director / EMS System Coordinator.

Resource Hospital Responsibilities: When a "Request for Clarification" form is received requesting deployment by an individual EMS Provider or Region 1 EMS Provider Agency for a disaster response through the EMAC/NAC outside the primary IDPH designated region the EMS System Coordinator/EMS Medical Director will immediately verify that all personnel possess active IDPH licenses and all vehicles with requests for deployment have current licenses, an ambulance inspection form is included, and that the agency and/or personnel are all in good standing with their Resource Hospital. If the EMS Medical Director/EMS Coordinator have any questions regarding the form that was submitted they will contact the agency/individual immediately for clarification. The EMS Medical Director/EMS Coordinator will forward all approved requests to the Region 1 EMS Coordinator and contact the Region 1 EMS Coordinator by phone. When the Region 1 EMS Coordinator has acknowledged approval of the request the EMS Medical Director/EMS System Coordinator will contact the EMS Provider/Provider Agency of the approval.

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Policy: Reciprocity

Overview: An EMR, EMT, EMD, A-EMT, EMT-I, or Paramedic who has been trained outside the state of Illinois and who has taken the national Registry exam may apply for reciprocity in Illinois. The EMS system coordinator from the system where with individual was trained needs to submit the necessary documentation to the attention of the Licensure Section at Illinois Department of Public Health / EMS via FAX (217-557-3481) or e-mail dph.emtlic@illinois.gov. The appropriate form can be found at https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/emsreciprocityapplication.pdf

To operate on an EMS System transport or non-transport IDPH licensed vehicle an individual must have a state license in Illinois. **Provisional licensure is not approved in Region 1**, although it is available through IDPH. See Section 515.610 of the IDPH Emergency Medical Services and Trauma Center Code (77 Ill. Adm. Code 515).

With the approval of a Region 1 Resource System and IDPH an alternative to reciprocity may be testing the applicant into the system and completing initial licensure paperwork.

Policy:
Individuals applying for Illinois Reciprocity will complete the following:

5. The applicant will complete the EMS Reciprocity Application as directed.

6. The applicant will attach copies of their NREMT card and state EMS license. A copy of their current American Heart Association Healthcare Provider card and copies of any PALS, ACLS, BLS provider and/or instructor cards, if applicable, should also be attached.

7. The applicant will provide a signed and dated letter from the EMS Medical Director indicating the applicant is in good standing and up to date with continuing education hours in the state where they have been practicing. If the applicant cannot obtain a letter of recommendation please request a waiver of this requirement as described in item 4 below.

8. If the applicant has not functioned at their level of current licensure under the direction of an EMS Medical Director they will need to include a letter stating this information and request that the letter of recommendation be waived. If a waiver is requested and the applicant has held their license for more than six months they will need to provide copies of all continuing education completed during their current license period.

9. Applicants seeking reciprocity in Illinois who are within 60 days of their “out of state” license expiration should renew their current license prior to seeking reciprocity in Illinois.

10. Applications will not be processed if they are incomplete.

11. Fees for applications are included on the application form as well as the address on where to mail the appropriate fee according to the licensure level.

12. After verification, IDPH will mail the Illinois license and the applicant will receive an e-mail from IDPH stated the license has been approved.

Original Policy Date: 06/23
Last Revision:
Reviewed:
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Policy: Relicensure

Overview: Please see the Region 1 Policy for Continuing Education requirements for licensure renewal. This policy provides direction on your responsibilities for completing the relicensure process. If you are a licensed provider in a second Region 1 EMS System, please notify the secondary EMS System Coordinator with all updates or changes to your license including name/address change and relicensure date.

Policy:
Illinois Department of Public Health has a website for License Verification.

There is also an IDPH website that has the forms for Licensure Renewals. They do not accept old forms.

To pay your for your relicensure online or update your address information please use the Internet Explorer or Firefox browser and use this link to Pay Your Renewal or Update Your Address.

If you are requesting a name change or a duplicate license you must contact IDPH at 217-785-2080 or you can email them at DPH.EMTLIC@illinois.gov

Your IDPH license is legal document and should match your legal name on your driver's license. An individual can change their name with IDPH by e-mailing their primary EMS System Coordinator with a copy of their marriage license, divorce decree (front page and name change page only), or court order. The EMS System will file the appropriate paperwork with IDPH. There is no charge for request to change your name unless you want a duplicate copy of your license mailed to you.

A duplicate license request may be necessary if your license has been lost or stolen or for a name change. There is a $10.00 fee if the individual needs a new copy of their license. Follow this link to complete a Request for Duplicate License Certificate.

Other forms available on the IDPH Website include requests for extensions, to become inactive, to be reactivated, and license fee waivers. It is always best to speak with your primary EMS System Coordinator before completing these forms.

1. Other general guidelines for renewing your license include:
2. Ensure your EMS System has your current mailing address and e-mail.
3. Keep copies of your CE for your own records and/or be sure to verify your hours are entered correctly into online programs such as TargetSolutions.
4. If you are keeping details of CE hours, be sure to include the topic(s) covered, IDPH site code, and signatures.
5. IDPH mails out renewal notices with a PIN number 60-90 days prior to renewal. If you do not receive this notice, contact your EMS System Coordinator for a copy.
6. Follow your primary EMS System's rules for contacting your EMS System Coordinator prior to your relicensure.
7. Pay your license fee online to avoid delays caused by mailing a check or money order.
8. When renewing online you will be asked to enter your primary EMS System's Number Code. Go to Illinois EMS System Numbers to get your primary EMS System's four-digit code.
9. Complete the Child Support and Felony conviction statements. Please note: anyone convicted of a felony or delinquent on child support may not be able to complete their renewal online and may need to contact IDPH at the phone number listed above.
10. If you are a licensed provider in a second Region 1 EMS System, please notify the secondary EMS System Coordinator with all updates or changes to your license including name/address change and relicensure date.

Original Policy Date: 06/23
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Policy: Relinquished Newborn

Overview: The Abandoned Newborn Infant Protection Act offers a protected, legal alternative to unsafe infant abandonment. An unharmed newborn, up to 30 days old, may be handed to staff (a person, not a drop box) at a hospital emergency medical care facility, police station, firehouse, college (University police station) or Illinois State Police District Headquarters. No questions need to be answered and there is no fear of prosecution.

Policy:

A. Region 1 EMS Agencies will provide assessment, treatment, and transportation to the nearest hospital for relinquished infants according to the Act named above.

B. Region 1 EMS Agencies will provide the necessary documents to the relinquished parent as specified.

Procedure:

INFANT CARE AND HOSPITAL CONTACT

A. The relinquishing person is presumed to be the infant's biological parent.

B. Assess the infant. Look particularly for any signs of abuse or neglect.

C. Ask the relinquishing parent for the infant's name and date of birth.

D. If the child is presumed to be more than 30 days old, or appears to have been abused or neglected, EMS personnel should proceed as if the child is abused or neglected. Follow the Abuse/Neglect: Child/Domestic Geriatric SMO and file a report with the DCFS.

While this is all that is required under the Act, refusing to take an infant presumed to be older than 30 days or one who is abused or neglected from a parent who wishes to relinquish them could possibly result in harm to the infant. It is in the best interest of the child to accept them and proceed as below.

E. Initiate EMS care that is necessary under implied consent and contact the closest appropriate hospital Medical Control as soon as possible so a physician can take temporary protective custody of the infant.

F. Ensure that the infant is kept warm and transport to the nearest hospital with the infant secured appropriately in an infant car seat or pediatric restraining device.

G. Complete a patient care report on the infant. List the infant's name as "Baby Girl/Boy Doe" if the given name is unknown.

H. Region 1 EMS Systems will honor the intent of the Act to allow for the anonymity of the relinquishing parent. However, nothing in the Act precludes a relinquishing person from providing their identity if the infant is presumed to be 30 days of age or younger and there is no evidence of abuse.
   1. Identity of the infant as relinquished in the comments section of the patient care report but omit any descriptive information regarding the relinquishing individual.
   2. The parent has the right to remain anonymous and to leave the fire station at any time and not be pursued or followed. If abuse or neglect is later suspected, the hospital will report it. The parent will not be prosecuted for relinquishment unless the infant was abused or neglected.
   3. Normal patient confidentiality will surround this process.

COMMUNICATION WITH THE RELINQUISHING PARENT

A. Confirm with relinquishing parent(s) that acceptance of below information is completely voluntarily

B. Additional information including below will be provided at the receiving hospital to relinquishing parent(s):
   1. Adoption Information
   2. Medical Information Exchange Questionnaire
   3. Termination of Parental Rights
   4. Additional counseling resources

C. Inform relinquishing parent of which hospital the infant will be transported to.

   If parent is unwilling to accompany infant to hospital or does not wish to know which hospital infant will be transported to document in PCR .

Resources – Additional resources may be provided at the receiving hospital, if needed.

A. Adoption Agencies in Illinois
B. Birth Parent Information Packet (English)
C. Birth Parent Information Packet (Spanish)

Click here for a copy of the Fire Station Safe Haven Signs Directive.

SAB's crisis line is always open. Please don't hesitate to contact with questions at 888-510-BABY.

Original Policy Date: 06/23
Last Revision:
Reviewed:

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Policy: RN, APRN, and PA at EMT Level

Includes:
Registered Nurse
Prehospital Advanced Practice Register Nurse
Physician Assistant

DEFINITIONS

RN - an RN who may apply to the EMSMD for an exception to the credentialing process in order that the RN may serve as a volunteer and perform the same work as an EMT. This only applies to rural population (5000 or fewer inhabitants).

Advanced Practice RN - an advanced practice RN who may apply to the EMSMD for an exception to the credentialing process in order that the APRN may serve as a volunteer and perform the same work as an EMT. This only applies to rural population (5000 or fewer inhabitants).

Physician Assistant PA - is a physician assistant licensed under the Physician Assistant Practice Act of 1987 who may apply to the EMSMD for an exception to the credentialing process in order that the PA may serve as a volunteer and perform the same work as an EMT. This only applies to rural population (5000 or fewer inhabitants).

For the purpose of this policy when RN is used, APRN and PA will also apply.

POLICY

All persons that wish to function as an RN, APRN or PA must complete the following:

A. Provide the System / EMSMD a valid RN, Advanced Practice RN, or Physician Assistant License.
B. Complete 20 hours of education as outlined in the policy.
C. Complete a minimum of 8 hours of observation ride time as outlined in this policy.

PROCEDURE

RN, APRN or PA desiring to be approved to function at the EMT level will complete the following:

Prerequisites

1. Current Illinois State RN, APRN or PA license in good standing in accordance with the Illinois Nurse Practice Act (PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (225 ILCS 65/) Nurse Practice Act (225 ILCS 65/Art. 60 heading).
2. Current healthcare provider CPR card through the AHA or a recognized affiliate.

Educational component

Educational topics for the RN include, but may not be limited to:

1. Airway management
2. Ambulance operations
3. Ambulance equipment
4. Extrication
5. Telecommunication
6. Prehospital cardiac care
7. Prehospital trauma care

Clinical Component

1. Eight (8) hours of ride time is required. One hour credit will be given for patient transports and 0.5 hour for non-transports where patient assessment is completed. No credit is given for on-call, standby or false alarm.
2. Ambulance equipment – RN must complete an orientation of ambulance equipment. A checklist for this is included in this policy. This checklist may be completed as part of a formal course or with System approval at the individual agency.

Testing

On completion of the educational component the RN must successfully complete a system test.

RN Renewal

1. System renewal is required every four years.
2. RN has the same recertification requirements as an EMT.
3. Other professional continuing education may be used for RN renewal, provided it is relevant and approved by the EMS System.

Sample RN Course Schedule

Session 1 – 4 hours (3.5 hours class / 0.5-hour break)

- Ambulance Operations
  - EMS level, scope & licensure
  - Roles and responsibilities
- EMS Communication
  - Radio
  - Documentation

Session 2 – 4 hours (3.5 hours class / 0.5-hour break)

- Airway Management
  - BVM
  - Oral and nasal airway
  - Supraglottic airways
- Regional SMOs
  - Routine Medical
  - Routine Trauma
  - Routine Pediatric
  - Airway Management - Adult & Pediatric

Session 3 – 4 hours (3.5 hours class / 0.5-hour break)

- Medical and Medications
  - Albuterol & DuoNeb
  - Aspirin
  - Epi Auto Injectors
  - Glucagon
  - Oral Glucose
  - Naloxone
  - Nitroglycerin
  - Ondansetron
  - Diphenhydramine
  - MAD

- Cardiac
- Regional SMOs
    - BLS Medication
    - Chest Pain
    - Resuscitation Checklist – Adult & Pediatric

Session 4 – 4 hours (3.5 hours class / 0.5-hour break)

- Trauma
    - Scene assessment
    - Trauma assessment
    - Spinal Restriction
    - Shock, hemorrhage control & wound packing
- Regional SMOs
    - Routine Trauma Care
    - Spinal Restriction
    - Shock & hemorrhage control
    - Burns

Session 5 – 4 hours (3.5 hours class / 0.5-hour break)

- Splinting
- Trauma packaging
- Review Regional SMO
- System Final Test

Session 6 – 6 hours

- Ambulance equipment
    - Equipment orientation checklist must be completed. This may be completed as part of the course or with System approval at the individual agency.

RN, APRN, PA Orientation Checklist

Equipment Orientation	Date	Preceptor
Ambulance Cab Radio, emergency lights and siren,		
Ambulance Rear Lighting, heat, air, ventilation, fire extinguishers		
Ambulance Cot Secure patient, load, unload, raise, lower, elevate head		
Stair Chair		
Oxygen On-board, portable, spare tanks, change tank, O2 mask, O2 cannulas, CPAP, BVM		
Suction On-board, portable, suction tips		
Airways Orals, nasal, supraglottic		
Monitor / AED Adult & pediatric pads CPR devices if available		
Assessment Equipment Stethoscopes, BP cuffs (all sizes), Pulse Ox, Blood Sugar monitor, flashlights		
Medications Albuterol, DuoNeb, Aspirin, Epi Auto Injectors, Glucagon, Oral Glucose, Naloxone, Nitroglycerin, Ondansetron, Diphenhydramine, MAD, Neb, Syringes & needles, Broselow tape, Med charts		
Immobilization Equipment C-collars, backboard, KED, child car seat		
Splints Traction, other splints – list types		
Trauma supplies Trauma dressings, gauze pads, roller gauze, Vaseline gauze, triangle bandage, tourniquets, tape, burn sheets, bandage shears,		
Other Supplies Cold packs, OB kit, Sterile solutions, emesis basin or bag, bedpan, urinal, restraints		
PPE Equipment Gloves, mask, N95 mask, Eye protection, red bag		

Original Policy Date: 06/23
Last Revision:
Reviewed:

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Policy: School Bus Accident Response/Alternative Transport Vehicle

Purpose:

This policy was developed to assist responders during school bus incidents involving the presence of minors. The goal of this policy is to maximize resources by reducing the number of confirmed uninjured children transported to the hospital. It is recommended that each EMS provider within Region 1 will implement and develop a procedure for releasing uninjured children to a parent, legal guardian, or local school official who is willing and approved to take custody of the children.

Once Medical Direction confirms that minors are not injured, the custody and responsibility for these uninjured children will remain with the responding EMS provider until the children are transferred to parents, legal guardian, school officials or the hospital as outlined in their individual agency procedures.

Level 1 Bus Incident: Significant injuries present in one or more children, or the existence of an obvious mechanism of injury that can be reasonably expected to cause significant injuries. Only a legal guardian can sign a refusal. A school representative is NOT considered a legal guardian in this situation.
Level 2 Bus Incident: Minor injuries present in one or more children with no obvious existence of a mechanism of injury that could reasonably be expected to cause significant injuries. Some on the bus could be transported. All others should have a school representative or legal guardian sign a refusal.
Level 3 Bus Incident: No injuries present in any children and no mechanism that could be reasonably expected to cause injuries. Some on the bus could be transported. All others should have a school representative or legal guardian sign a refusal.
Special Consideration: If the patients have special healthcare needs and / or have communication difficulties, EMS must contact Medical Direction for further directions.

- If EMS Personnel on the scene feel that any child should be offered medical care, need evaluation by a physician or confirmation of custody or responsibility cannot be verified, then the child should be transported to the hospital(s) designated by Medical Direction.
- This policy and procedure only governs the disposition of *uninjured* children. Per Medical Direction, all uninjured children will be discharged to the custody of the appropriate person as outlined in the agency procedure. It is required for the EMS Provider to list the names of the uninjured children with the description of the incident on the System approved patient care run report as well as complete an appropriate release of service form. These reports / forms must then be forwarded to the EMS System Office.
- All such incidents will be reviewed by the EMS System Medical Director, EMS System Coordinator, and the provider agency or agencies involved for each implementation of this procedure.

Process:

A. Once the Level has been determined; approval to implement this policy must be obtained from Medical Direction. All children in a level 1 incident may be transported to hospital(s). Each provider should follow the Region 1 Mass Casualty Incident policy as applicable (see Multiple Patient Refusal Form – Appendix J).
    - If Medical Direction approves implementation of this policy for level 2 or 3 incidents, an appropriate release of service form will be utilized for the children who will not be transported.
    - The provider agency will then transfer the custody of the minor consistent with the Treatment of a Minor policy, to the parents, legal guardians or school officials.
    - The school officials will follow their established procedure for informing parents and /or legal guardians of the crash / accident / incident.
B. Once the decision to implement the uninjured children procedure is approved by Medical Direction, it is the responsibility of the Local School Official with assistance from EMS to direct and confirm that the children are returned to their parents or legal guardians. EMS will complete all appropriate reports and release of services forms (see Multiple Patient Refusal Form – Appendix J). If the school representative is signing the refusal, contact Medical Direction.

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Policy: Special Events

Purpose: A Special Event Form is to be completed as an amendment to an existing EMS System Plan by an ambulance provider who will be providing coverage at a specific event when the coverage will change the normal response pattern of the provider. This form with attachments, if appropriate, should be submitted to the EMS System Office ideally 60 days prior to the event. The form will be filed in the EMS System Office and will be sent to the Illinois Department of Public Health, if requested.

Process: A copy of the Special Events Form and the items required by the EMS System for each level of care can be found on the IDPH Department of EMS website or requested from the EMS System Office, titled **Emergency Medical Services (EMS) Systems Special Events Request Application.**

Special event resources may include:

1. Assist Vehicles included, but not limited to:
   a. Bicycle
   b. Boat
   c. Fire/EMS Apparatus
2. Non-Transport Vehicle
3. Transport Ambulance

The form needs to be completed if an EMS licensed vehicle that is dedicated to a specific event or location and/or temporarily moved out of district for a set period of time or duration of event. This EMS licensed vehicle will not be available to respond to other calls, including those made to 911.

Original Policy Date: 04/08
Last Revision: 09/18
Reviewed: 06/23

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Policy: Student Clinical-Internship Agreement

Overview: Each Region 1 EMS System, as part of its emergency medical services education and training program may offer its students, through a clinical/internship program, the opportunity to receive supplemental clinical experience at other Region 1 EMS facilities.

1. The EMS Systems hope to jointly benefit by improving the students' education through profession preparation.
2. The EMS Systems intent to structure the requirements for an educational internship in such a way as to ensure the safety and well-being of the patients, students, and organizations involved.
3. The use of an EMS System outside Region 1 as a clinical/internship site will be considered on a case-by-case basis by the individual EMS System.

EMS Systems agree to the following:

1. Duties of Supplemental Clinical Experience Facility. The EMS System that receives emergency medical services students, for the purpose of providing to those students a supplemental clinical experience at its facility, from the EMS System at whose facility the students primarily receive instruction and training will:
    a. The liaison between the Supplemental Clinical Experience Facility and the Primary Instructional Facility will be the Lead Instructor for the course unless otherwise designated.
    b. Maintain a curriculum that complies with the National Educational Standards for Emergency Medical Services published by the National Highway Traffic Safety Administration and the testing and licensure requirements of the Illinois Department of Public Health.
    c. Paramedic education follows all guidelines/standards as prescribed by CoAEMSP/CAAHEP accredited programs.
    d. Permit students to use all facilities, equipment, and supplies used in the Supplemental Clinical Experience Facility's ordinary course of business.
    e. Permit students' in-library use of books, periodicals, and other related resources.
    f. Take reasonable steps to provide a safe and healthy work environment in compliance with application State and Federal laws and regulations, and provide a secure area for students' belongings, parking facilities, and food service.
    g. All preceptors will be approved by the EMS System and receive the appropriate training. A certificate of completion of the appropriate training should be on file with the EMS System and available upon request.
    h. Appoint a preceptor who will maintain a record of orientation and complete a student evaluation of performance as requested.
    i. Ensure the cooperation and support of the Supplemental Clinical Experience Facility's staff in assisting instructors and preceptors as supplemental teachers to provide meaningful learning experiences in their areas of expertise.
    j. Allow students access to patients/clients as resources for student learning; provided however, that the Supplemental Clinical Experience Facility will assume ultimate responsibility for the care and service rendered to such patients/clients.
    k. Provide emergency medical care or arrange transportation so that students and faculty may receive such care, if required while students and faculty are on the Supplemental Clinical Experience Facility's premises; provided however, that any costs associated with such emergency medical treatment or transportation will be borne by the students, faculty, and/or their third-party payors.
    l. Ensure that the clinical experience that each student receives is within the scope of practice permitted by that students' emergency medical services curriculum level.

2. Primary Instructional Facility Duties. The Primary Instructional Facility will:
    a. Maintain a curriculum that complies with the National Educational Standards for Emergency Medical Services published by the National Highway Traffic Safety Administration and the testing and licensure requirements of the Illinois Department of Public Health.

b. Ensure the effective flow of communication between instructors, unit managers, and preceptors for the purpose of providing feedback for the improvement through prompt notice to the Supplemental Clinical Experience Facility of irregularities in student evaluation forms.
c. Ensure that students and faculty comply with all applicable Supplemental Clinical Experience Facility policies and procedures.
d. Ensure that students use Supplemental Clinical Experience Faculty's equipment and materials in a manner consistent with standard industry practice.
e. Maintain proof that all students have obtained the following:
    1. TB Test – Testing for tuberculosis is performed through a blood draw or two-step skin test.
    2. Immunizations – per clinical site.
    3. Hepatitis B – the vaccination series is strongly recommended but not required. If you choose not to have this you must sign a waiver.
    4. Urine Drug Screen – Per EMS System the Program Director reserves the right to conduct urine drug screen testing.
    5. Some clinical sites/hospitals may have additional health requirements.
f. Maintain proof that all students have current professional liability insurance (this may be personal or institutional).
g. Complete a background check and notify the Supplemental Clinical Experience Facility of any potential barriers to a student for course completion and/or licensure.
h. Maintain proof to the Supplemental Clinical Experience Facility that all students have health insurance that cover the care and treatment of emergency medical conditions or a signed waiver of responsibility that provides that the student is responsible for any cost associated with care received.
i. Require students to display photo identification of their status as a student at all times while on the Supplemental Clinical Experience Facility premises.
j. Remove, upon request by the Supplemental Clinical Experience Facility:
    i. Any student whose performance is unsatisfactory, in the Supplemental Clinical Experience Facility's sole discretion, after the Supplemental Clinical Experience Facility has given written notice to the student and allowed such student ten (10) days to cure the unsatisfactory condition.
    ii. Any student who knowingly violates any Supplemental Clinical Experience Facility policy or procedure as provided to the Primary Instructional Facility pursuant to Section 2(e) of this Agreement, or
    iii. Any student who, due to a health condition, cannot satisfy the requirements of the internship program.
k. Take reasonable steps to ensure that its employees and agents, in performing the Primary Instructional Facility duties pursuant to the Agreement comply with all Federal and State laws and regulations regarding the confidentiality of protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA).
l. Ensure that all students, prior to beginning clinical education on the Supplemental Clinical Experience Facility premises, satisfactorily complete a life safety training course that includes, at a minimum, lifting and moving, universal precautions, and working with Sharps. Additional requirements for life safety may be required by a clinical site.

Original Policy Date: 04/08
Last Revision: 06/23
Reviewed: 06/23

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Policy: Transfer of Responsibility of Patient Care

Overview: Patients entrust the medical community to care for them to the highest level possible. To that end, this policy is to delineate proper transfer of responsibility of patient care from the prehospital providers to hospital personnel.

INFORMATION NEEDED

1. Level of care patient is currently receiving (BLS/ ALS.)
2. Level of care to which patient is being transferred.

TRANSFER OF RESPONSIBILITY FOR PATIENT CARE

Emergency Department:

A. When a patient is transported to an emergency department, the transporting crew will not leave the patient unattended in the department.
B. Written or verbal acceptance of responsibility for the patient should be obtained.
C. An ALS patient must be turned over to a registered nurse or physician.
D. Care of a BLS patient may be turned over to Emergency Room Technician personnel.
E. If there is a delay in transferring patient care and the patient requires further care (i.e., pain management) contact Medical Direction.

Other Hospital Departments or Medical Facilities (e.g., Nursing Homes):

A. When a patient is transported to a location in a hospital other than the emergency department or to a nursing home or other health care facility, the ambulance crew will remain with the patient until a registered nurse, physician or appropriate healthcare provider accepts responsibility for the patient.
B. Written or verbal acceptance of responsibility for the patient should be obtained.
C. An ALS patient must be turned over to a registered nurse or physician.
D. Care of a BLS patient should be turned over to the highest level of care available.

Transfer of patient care to another prehospital care provider (in a situation other than a disaster or triage situation):

A. When the care of a patient is going to be transferred to another prehospital care provider, the ambulance crew will remain with the patient until the second care provider arrives and accepts responsibility for the care of the patient.
B. Written or verbal acceptance of responsibility for the patient should be obtained.
C. The second provider will not accept responsibility for the patient until the report is given. When care of patient is transferred to another prehospital provider, that provider must be of at least an equal, if not higher, degree of training (e.g., BLS crew must transfer to at least another BLS ambulance; care of the ALS patient may not be transferred to a BLS crew).

INTER-HOSPITAL TRANSFERS:

- If a patient is receiving medications or is connected to medical equipment, and these medications and/or equipment are not within the scope of practice for this System's Emergency Medical Services personnel, a nurse, physician or appropriate healthcare provider must be present on the transfer. A provider is prohibited from transferring such a patient without a nurse, physician or appropriate healthcare provider present during transfer.

PRECAUTIONS AND COMMENTS

- Abandonment is defined as terminating medical care without legal excuse or turning care over to personnel who do not have training and expertise appropriate for the medical needs of the patient.

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Policy: Treatment of Minors

Overview: Under Illinois law, any person under 18 years of age is considered to be a minor and is not able to consent for or refuse emergency medical assessment and/or treatment. In these circumstances, the consent of a parent or legal guardian is required. If, in the opinion of the EMS provider, a delay in obtaining consent would adversely affect the condition of the minor's health, emergency assessment and/or treatment may be rendered under implied consent. The exceptions to this are listed below:

1. Married at the time treatment is rendered.
2. Pregnant at the time treatment is rendered.
3. Requesting treatment for sexual assault or abuse, a sexually transmittable disease, alcohol or drug abuse, or limited out-patient mental health counseling.
4. Member of the United States Armed Services.
5. Emancipated by court order.

Policy:

Parent/Guardian/Surrogate On Scene:

Refusal by an adolescent with decisional capacity to accept recommended assessment, treatment, and/or transportation will be discussed with a parent or other legally responsible adult (guardian or caretaker, including school administrators) with the authority to act on behalf of the parent while EMS personnel are on scene.

If treatment appears necessary the responsible adult should be informed and consent for treatment solicited from them. An adolescent cannot refuse care and/or transportation that is consented to by the parent/guardian/surrogate unless they are emancipated as listed above.

If the assessment/treatment/transportation appears unnecessary the adult may sign the refusal form on behalf of the adolescent.

Parent/Guardian/Surrogate NOT On Scene:

If the parent or a responsible adult is not present EMS personnel may attempt to contact them by phone for consent to assessment, treatment, or refusal unless the delay of care would adversely affect the patient. If the responsible adult is contacted by phone document these conversations in the patient care report.

If EMS is unable to contact a responsible adult and the adolescent appears to be exhibiting rational behavior with decisional capacity and based the EMS assessment there is no apparent illness or injury, and the EMS Provider believes that no foreseeable harm will come to the adolescent as a result of not receiving immediate care and/or transportation, EMS will contact Medical Direction and request authorization to honor the adolescent's refusal of service. The adolescent may then be released to the circumstances in which EMS found them unless releasing the individual would place them at risk of harm.

1. EMS must contact Medical Direction BEFORE the adolescent is released.
2. Medical Direction will consider allowing the adolescent to be released on their own signature. The circumstances of the call must be documented on the patient care report and refusal form and verified by witnesses.
3. EMS may attempt to contact the responsible adult again following assessment, treatment, and/or release. If the responsible adult cannot be reached by phone complete the "Request for Clarification" Form and submit it to your EMS Resource Hospital.

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Policy: Multiple Casualty Incident/Crisis Response/Triage Categorization of Patients

Definition: Multiple Casualty Incident (MCI) is defined as any incident where the number of injured persons exceeds the day-to-day operating capabilities, requiring additional resources, and/or the distribution of patients to multiple hospitals. This will be different for each incident based on time of day, location, resources available, etc.

Recent MCI events have been complicated by victims being transported to local hospitals via unconventional transportation methods. Additionally, victims have self-presented to the geographically closest or most familiar hospital which potentially overwhelms that hospital and makes early notification a high priority.

Scope and Authority:

A. Jurisdictional authority ultimately lies with the primary agency or impacted jurisdiction.
B. Per Illinois Statute (210 ILCS 50/3.30-5, 210 ILCS 50/3.255) the Illinois Department of Public Health (IDPH) has developed a disaster medical plan to assist EMS personnel and healthcare facilities in the mitigation of public health emergencies.
C. Under section 1.5 of the2018 IDPH Emergency Services Function (ESF)-8 plan Mercyhealth has been designated as the Region 1 Regional Hospital Coordinating Center (RHCC).
    1. The RHCC is responsible for coordinating health and medical emergency response for hospitals in Region 1.
    2. The RHCC is to serve as the primary point of contact for communications and coordination of disaster response and maintains a Regional Hospital Disaster Communications Center to assist with coordination of MCI events.

Activation Criteria: This MCI Plan will be activated under the following minimum situations:

An incident with **five** or more patients that are triaged **red (immediate)** – see below.
An incident with more than **ten** patients that require EMS transport **regardless of triage criteria**.
And incident with five or more patients of any category that require special resources to treat or to gain access. Examples include, but are not limited to: o Technical rescue o Hazardous materials response o Enhanced scene security (Active Threat)
Activation of this plan may be considered whenever patient needs exceed local resources or any incident in which the Incident Commander deems appropriate.

MCI Procedure:

Who May Initiate	Any prehospital EMS personnel or command
How to Initiate	Contact Region 1 Hospital Disaster Communications (815-968-2354)
What information should be Provided to Region 1 Hospital Disaster Communications	1. Title or the Unit Number 2. Location of incident 3. An estimated number of patients and triage category (if known) 4. Nature of illness/mechanism of injury 5. Special circumstances (i.e., HazMat, safety hazards, etc.) 6. On scene contact information (if relayed from scene) or scene frequency (if relayed from LOCAL DISPATCH)
How to Cancel/ Demobilize MCI Alert	Contact Region 1 Hospital Disaster Communications (815-968-2354)

After Region 1 Hospital Disaster Communication has been notified they will immediately notify:

A. All local hospitals starting with the geographically closest hospital to obtain bed status. Bed status will be relayed back to scene personnel or LOCAL DISPATCH from Region 1 Hospital Disaster Communication.
B. The Region Hospital Coordinator (RHCC).
    - RHCC will notify individual hospital emergency management coordinators and/or EMS System Coordinators as well as other potential stakeholders.

Patient Triage:

Region I has adopted the START and JumpSTART Triage method as described below. In a disaster situation, one may be working with other providers that utilize different triage systems. It may be helpful to be familiar with some of the more common systems.

START TRIAGE

1. Triage is used to sort patients and resources when the demand for emergency medical services exceeds the immediate capability to deliver that service. The goal of triage is to deliver the most care to the greatest number of patients, and to deliver care to those patients who will benefit most.
2. Triage officers are designated according to the district or county Mass Casualty plan. Illinois EMS Region 1 Trauma Plan utilizes the S.T.A.R.T. triage plan. Casualties are sorted according to the START triage method and tagged:
    - RED: Immediate, life threatening
    - YELLOW: Delayed treatment. These patients are the next priority after patients in the RED category have been treated and/or transported.
    - GREEN: Designates the "walking wounded" or patients with minor injuries.
    - BLACK: Dead, no resuscitation indicated. In mass casualty situations, resuscitation of fatally injured patients may take care away from those who would have a much greater chance of survival. In these situations, no resuscitations should be initiated. Of course, if there is sufficient personnel and equipment, normal protocols for caring for these patients should apply.

GUIDELINES START:

Step 1 - Clear the scene of any walking wounded

Step 2 - Assess ventilation in the remaining patients

No respiratory effort after opening patient's airway- BLACK
Respirations above 30 - RED
Respirations below 30 - continued assessment

Step 3 - Assess perfusion

No radial pulse - RED
Radial pulse present - continued assessment

Step 4 - Assess neurological status

Unconscious or altered level of consciousness - RED

Once the BLACKs, GREENs, and REDs have been designated by the above physical findings - all remaining patients are designated as YELLOW (delayed).

Once the patients have been moved into the various treatment areas immediate re-triage should be accomplished. All BLACK category patients should be confirmed as resources are available.

Variations in Guidelines for Triage of Children - JumpSTART:

Originally used for children under the age of 8 years old but is now used for any victim who appears to be a child.

1. If child was carried off to green area they should be re-evaluated as soon as possible.
2. If child is apneic and has a peripheral pulse provide five rescue breaths.
    a. If this results in spontaneous breathing tag the patient red.
    b. If child remains apneic, tag black.
3. If the respiratory rate is less than 15 or greater than 45 tag the child red.
4. Palpable pulse is a better indicator of perfusion than capillary refill in a child.
5. Neurological status
    a. If patient is alert, responds to verbal stimulus or appropriately responds to painful stimulus tag patient as yellow.
    b. If patient has no response to pain or an inappropriate response to pain tag patient as red.

Patient Distribution and Transport

For the duration of the MCI, Incident Command or designee will:

A. Determine transportation methods and destinations (see Transport Considerations below).
B. Maintain a transportation log of transported patients that includes: triage category, triage tag number (if applicable), patient demographics, destination and transporting agency. (See Annex)

Transport Considerations

A. Whenever possible patients should be transported to the most appropriate hospital taking into consideration relayed bed status and endeavoring to not overload any facility.
B. Transport from scene may not be linear by triage category; i.e. all red, then all yellow, and then all green patients.
C. Patients of different triage categories may be transported in the same unit based on patient condition, crew capability and/or transport unity capabilities and local protocols.
D. During a Multi-Casualty Incident, the maximum number of patients that an ambulance can transport, will be based on the capabilities and space of the occupants and prehospital providers including the ability to safety restrain patients and prehospital providers.

Transport Units

A. Transporting units should provide a brief inbound radio report via MERCI frequency to receiving hospital unless directed. If radio report is performed, the goal is brief communication with only the following information provided:
   - Unit
   - Notification that they are transporting from the MCI
   - ETA
   - Number of/Age/Sex of Patients
   - Triage Category
B. After transporting, the transport unit should return to the scene unless directed otherwise.
C. Transporting units are responsible for necessary documentation for the patients they cared for per local requirements.

Ongoing Communication

Incident Command or designee shall communicate the following information to REGION 1 HOSPITAL DISASTER COMMUNICATIONS (815-968-2354)

A. Updates on total numbers of patients by color coded triage, particularly if different from initial information
B. Any critical information such as contamination from hazardous materials or scene threats which may impact hospital operations
C. Notification that the last critical patient has been transported off scene.
D. Notification that all patients have been transported off scene.

Mass Fatality Incidents

- The local Coroner's Office be notified as early in any mass fatality situation.
- Incidents should be considered potential crime scenes. Prehospital personnel should follow direction of law enforcement with respect to crime scene management. The direction should not prevent nor detract from care.
- The Coroner and Law Enforcement should be responsible for scene and evidence security.

Lightning Strikes - Special Consideration

Consider reverse triage if patient has any signs of life they are likely to recover. They can be treated secondary. Those pulseless/non-breathing should be attended to first, as practical.

Original Policy Date: 04/08 Reviewed: 06/23
Last Revision: 06/23 Return to Bylaws/Policies Table of Contents

Policy: Vehicle Staffing Requirements

Definition: In this policy, as a point of clarification, anywhere the licensure level of EMT is listed the RN functioning at the EMT level in rural areas is included.

Purpose: To identify minimum acceptable staffing patterns for all Region 1 EMS vehicles. To operate on an EMS System transport or non-transport IDPH licensed vehicle an individual must have a state license in Illinois. Provisional licensure is not approved in Region 1. An exception to this licensure requirement is system credentialing to allow registered nurses, physician assistants, and advanced practice nurses to serve as volunteers to perform the same work as EMTs.

Method of Providing EMS Services:

EMS Services in Region 1 may be provided by a variety of methods:

1. Single vehicle response and transport:
   - EMS response and transport is provided by one EMS agency.

2. Dual vehicle response:
   - EMS response includes non-transport and/or transport by:
     1. A single EMS agency
     2. Multiple EMS agencies

3. Level of first response vehicle:
   A. Ambulance Assist Vehicles
      1. Ambulance assist vehicles are dispatched simultaneously with an ambulance to assist with patient care prior to arrival of the ambulance. The vehicle will not be a transport or primary response vehicle. These vehicles will not function as an assist vehicle if staff and equipment are not available.
      2. Emergency Medical Responder ambulance assist vehicle staffed with a minimum of one Emergency Medical Responder (or higher level).
      3. Basic ambulance assist vehicle staffed with a minimum of one EMT (or higher level).
      4. Advanced EMT/ILS ambulance assist vehicle staffed with a minimum of one Intermediate (or higher level).
      5. ALS ambulance assist vehicle staffed with a minimum of one paramedic or one PHRN.
   B. Non-Transport Vehicles
      1. Non-transport vehicles are dispatched prior to the dispatch of the transporting ambulance. These vehicles will be staffed 24-hours per day every day of the year.
      2. Basic ambulance assist vehicle staffed with a minimum of two EMTs (or higher level).
      3. Advanced EMT/ILS ambulance assist vehicle staffed with a minimum of one Intermediate (or higher level) and one EMT level or higher.
      4. ALS ambulance assist vehicle staffed with a minimum of one paramedic or one PHRN and one EMT level or higher.

4. Level of transport vehicle:
   A. Ambulance Basic Life Support:
   All Basic Life Support vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
      1. Minimum requirement - two (2) EMTs or an RN functioning at the EMT level in rural areas licensed appropriately per Illinois Department of Public Health.
      2. Vehicle can be staffed with higher level providers, such as A-EMT/Intermediate, Paramedic, or PHRN, but they cannot function beyond the ambulance license level unless in the situation of Infield Upgrade.

B. Ambulance Intermediate/Advanced EMT:
All Intermediate/Advanced EMT vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
   1. Minimum requirement - one A-EMT/Intermediate and one EMT (or higher level) licensed appropriately per Illinois Department of Public Health.
   2. Vehicle can be staffed with higher level providers, such as A-EMT/Intermediate, Paramedic, or PHRN, but they cannot function beyond the ambulance license level unless in the situation of Infield Upgrade

C. Ambulance Advanced Life Support:
All Advanced Life Support vehicles are to be staffed 24 hours a day, 365 days a year with one of the following (drivers may be used anytime, but not in place of EMT staff):
   1. Minimum requirement – one Paramedic or PHRN and one EMT (or higher level) of any level licensed appropriately per Illinois Department of Public Health.
   2. Vehicle can be staffed with higher level providers, such as Paramedic or PHRN, but they cannot function beyond the ambulance license unless in the situation of Infield Upgrade.

5. In-Field service level upgrade, using advanced level EMS vehicle service providers.
   A. When a lower-level agency calls for an advanced level agency for assistance the advanced level provider may transfer all appropriate equipment and function at the higher level of care.
   B. The advanced level provider/agency will assume primary responsibility for care when they arrive and report is given.
   C. Should the two agencies be in different systems the advanced level provider/agency becomes the primary system for the response.

6. Ambulance service provider and vehicle service provider – rural population:
   A. A rural provider may upgrade as defined by their EMS System and approved by IDPH.
   B. Advanced equipment/medications must be secured per EMS System policies.

7. Alternate Rural Staffing/Alternate Response Authorization:
   A. Providers that serve rural or semi-rural populations of 10,000 or less may be approved by EMS System and IDPH for alternate rural staffing.
   B. If approved for alternate rural staffing, the vehicle may be staffed with one licensed personnel at the level of the vehicle and one EMR.
   C. If approved for alternate rural response an ambulance may respond to the scene with one licensed personnel and they must assure that a second licensed personnel member is on scene or enroute.

8. Currently Region 1 is not approving alternate staffing for private ambulances. Should a private ambulance believe this would benefit their practice they should contact their EMS System Coordinator.

9. Use of mutual aid agreements:
   A. Mutual aid agreements may be agreements between agencies or the formal MABAS agreements.
   B. Mutual aid may be utilized for large events or multiple calls/multiple patients to provide the best patient care.
   C. To function on an EMS vehicle the individual provider should be listed on that agency's roster and approved to function in that agency's EMS System. In unusual or non-typical situations it may be in the patients' best interest to utilize an EMS provider from another agency and/or EMS System. This option should only be utilized in unusual or non-typical situations and the out-of-system provider is responding under a mutual-aid agreement and the EMS provider is in good standing in the neighboring/mutual aid agency and/or EMS System.

10. In the event a caller requests the estimated time of arrival of an emergency vehicle the information will be shared with the caller using the best estimate available.

11. Staffing Waivers:
    A. In the event an EMS Agency believes a staffing waiver may be necessary they should discuss this potential need with their EMS System Coordinator/EMS Medical Director to determine the best course of action.
    B. Staffing Waivers may be approved by the EMS Medical Director. Waivers are completed and sent to Illinois Department of Public Health (on WVRI/95) for final approval. Illinois Department of Public Health will approve the waiver if it determines there is no reduction in the quality of care established by the EMS Act and/or if full compliance with the regulation in the Act at issue would constitute a hardship for the applicant.
    C. Anytime that a service cannot meet its staffing obligation due to extenuating circumstances, please contact the EMS System at once to review the problem and, if applicable, complete a staffing waiver.
    D. Although Illinois Department of Public Health allows for EMR staffing waivers for private ambulance providers (Section 515.830,(k)), Region 1 Medical Directors are not considering requests for these waivers at this time.

12. Vehicle Design:
    In accordance with Section 515.830, Ambulance Licensing Requirements, a) Vehicle Design, 1) Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as Nation Fire Protection Association, Ground Vehicle Standards for Ambulances, the Federal Specifications for the Star of Life Ambulance, or the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle standard for Ambulances.

Original Policy Date: 04/08
Last Revision: 06/23
Reviewed: 06/23

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Policy: Violent Patient Encounters

Overview: Given the dynamics of psychiatric patient encounters and inability to guarantee the safety of responding EMS crews the Region 1 EMS systems issues the following guidance for all Region 1 providers, ECRN staff, and Emergency Department/Hospital Physicians.

Procedure:

1. ECRN/Physician receives telemetry report from responding EMS agency.
2. EMS reports the individual/patient is violent and they are unable to deescalate the situation. Further engagement without police assistance is likely to further degrade the situation.
3. The EMS provider will declare that the scene is "not safe" providing as much detail as possible (armed, barricaded, etc.) in their telemetry report. The ECRN/Physician will read the following statement to the EMS provider:

   "We understand that you are unable to safely access or assess the individual due to their behavior and law enforcement's unwillingness to assist. We are not granting a refusal, but due to the circumstances you've conveyed, we understand there is a significant safety risk to you and are authorizing you to return in service. If the scene is secured, return if requested."

4. Once the police have secured the scene EMS should evaluate the patient as needed.

Original Policy Date: 04/24
Last Revision:
Reviewed:

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Appendix A: Region 1 Short/Non-Transport Form

Region 1- Patient Care Report-Short/Non-Transport Form

Company _____ Unit # _____ Date_____

Receiving Facility_____ Time _____

Patient Name _____

Address: _____

Age _____ DOB_____

Vital Signs: HR_____RR_____B/P_____ O2 Sat_____

Chief complaint /Mechanism of Injury _____

Crew Telephone Contact #_____

Crew Member #1_____

Crew Member #2 _____

LOC
Alert ☐
Verbal ☐
Pain ☐
Unresponsive ☐

Glascow Coma Scale:_____

Lung Sounds
Clear ☐
Bilateral ☐
Wheezes ☐
Rales/Crackles ☐
Ronchi ☐
Diminished ☐

Gluco Check: _____

Treatments
IV/IO Rate _____TKO ☐
Monitor On: Yes ☐ No ☐
Time: _____

12 Lead: Yes ☐ No ☐ Time:_____
STEMI: Yes ☐ No ☐
Transmitted: Yes ☐ Time:_____ No ☐
Interpretation:
NSR ☐ Brady ☐ Tach ☐ Other_____

Stroke Assessment
G - + -
F - + -
A- + -
S- + -
T- _____
Last seen normal

Skin
Normal ☐
Pale ☐
Flushed ☐
Moist ☐
Diaphoretic ☐

Pain
Yes ☐
No ☐
Severity (1-10)
On Arrival_____
At Hospital_____

Oxygen
liters/Minute____
Nasal Cannula ☐
NRB ☐
ETT ☐
King Airway ☐
CPAP ☐

Immobilization
Yes ☐ No ☐
Long Board ☐
Cervical Collar ☐
HIM ☐

Time	BP	Pulse	Resp	02 Sat	Temp

Time	Rhythm	Time	Rhythm

Medications

Med	Time/Dose	Time/Dose	Time/Dose

Defibrillation X_____

Medical History:

Patient's Meds: None ☐

Allergies: None ☐

List:

Other Information:

Final Report Completed-Date _____Time:_____

Final Report Faxed To Rec Hosp. Date _____Time_____

Original-Hospital Photocopy-EMS Agency (Make a copy at the hospital) Region 1 modified June 2019

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Appendix B: Region 1 Short/Non-Transport Form Log

Short Form Utilization Log

Date of Transport	Receiving Hospital	Time Call Ended	Time Report Sent	Comments

Each agency that uses the Short Form must forward this log to their EMS System monthly

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Appendix C: Illinois Department of Public Health POLST Form (Version 220926)

■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*	**ORDERS FOR PATIENT IN CARDIAC ARREST.** Follow if patient has NO pulse.	
	☐ **YES CPR: Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)	☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**
B *Section may be Left Blank*	**ORDERS FOR PATIENT NOT IN CARDIAC ARREST.** Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)	
	☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.	
	☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.	
	☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.	
C *Section may be Left Blank*	**Additional Orders or Instructions.** These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]	
D *Section may be Left Blank*	**ORDERS FOR MEDICALLY ADMINISTERED NUTRITION.** Offer food by mouth if tolerated. (When no selection made, provide standard of care.)	
	☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.	
	☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.	
	☐ No artificial nutrition or hydration desired.	
E *Required*	***Signature of Patient or Legal Representative.*** *(eSigned documents are valid.)*	
	X Printed Name ***(required)***	Date
	Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.* **X**	
	Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care
		☐ Health care surrogate decision maker (See Page 2 for priority list)
F *Required*	***Qualified Health Care Practitioner.*** Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)	
	X Printed Authorized Practitioner Name ***(required)***	Phone
	Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* **X**	Date ***(required)***

■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

THIS PAGE IS OPTIONAL – use for informational purposes		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

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Appendix D: Region 1 Medication Restocking Form

MEDICATIONS: Region I Medication Restocking Form

Patient Name:_____
Account Number:_____
Agency:_____
Ambulance Number:_____
Signature:_____
Resource Hospital Signature: _____

Quantity	Name: Generic	Name: Trade	Strength & unit of use
	Adenosine	Adenocard	6 mg/2 ml Syringe
	Albuterol	Proventil or Ventolin	2.5 mg/3 ml Neb
	Albuterol/Ipratropium	DuoNeb	2.5 mg/0.5 mg/3 ml Neb
NOTE: Carry 2 additional Ipratropium/Albuterol if no Duo-Neb			
	Amiodarone	Cordarone	150 mg/ 3 ml Vial
	Aspirin Chewable		81 mg Tablet
	Atropine Sulfate		1 mg/10 ml Syringe
	Calcium Gluconate		1 gram/10 mL Vial
	D10		50 grams/500ml Bag
	Diphenhydramine	Benadryl	50 mg/ml Vial
	Dopamine	Intropin	400 mg/250 ml Bag
	Epinephrine	Epi Pen	0.3 mg/0.3 ml Auto Injector
	Epinephrine	Epi Pen Jr	0.15 mg/0.3 ml Auto Injector
	Epinephrine	Adrenalin	1 mg/ml Vial
	Epinephrine	Adrenalin	30 mg/30 ml Vial
	Epinephrine	Adrenalin	1 mg/10 ml Syringe
	Etomidate	Amidate	40 mg/20 ml Vial
	Fentanyl	Sublimaze	100 mcg/ml Vial Only
	Furosemide	Lasix	100 mg/10 ml Vial
	Glucagon	GlucaGen	1 mg/ml Vial
	Ipratropium	Atrovent	0.5 mg/2.5 ml Neb
	Ketamine IM	Ketalar	500 mg/5 ml Vial
	Ketamine IV	Ketalar	200 mg/20 ml Vial
	Ketorolac	Toradol	15 mg/ml Vial
	Lidocaine 2%	Xylocaine	100 mg/5 ml Syringe
	Revised 12/2021		
	Version 2021.1		
			Page 2 of 2

Quantity	NAME: Generic	NAME: Trade	Strength and unit of use
	Magnesium Sulfate	$MgSO_4$	2 GM/50 ml
	Methylprednisolone	Solu-Medrol	125 mg/2 ml Act-O-Vial
	Metoprolol Tartrate	Labetalol	5 mg/5ml Vial
	Midazolam	Versed	5 mg/ml Vial
	Morphine Sulfate		10 mg/ml Syringe
	Naloxone	Narcan	2 mg/2 ml Syringe
	Nitroglycerin	Nitrostat	0.4 mg SL Tablet
	Nitro Paste		
	Ondansetron	Zofran	4 mg/2 ml Vial
	Ondansetron	Zofran ODT	4 mg ODT
	Oral Glucose		
	Sodium Bicarbonate	$NaCHO_3$ 8.4%	50 meq/50 ml Syringe
	Sodium Chloride	NaCl 0.9%	10 ml Syringe
	Sodium Chloride	NaCl 0.9%	100 ml Sealed bag
	Sodium Chloride	NaCl 0.9%	1000 ml Bag
	Sodium Chloride	NaCl 0.9%	1000 ml Bag
	Succinylcholine	Anectine	200 mg/10 ml Vial
	Tranexamic Acid (TXA)	Cyklokapron	1000 mg/10 ml Vial
	Mercyhealth Additional Medications		
	Calcium Chloride 10% Solution		1 GM/10 ml preload syringe
	Diltiazem	Cardizem	5 mg/ml – 5 ml vial
	Hydromorphone	Dilaudid	1 mg/ml
	Magnesium Sulfate 50%		5 GM/10 ml preload syringe or 2 GM bags
	Lactated Ringers		1000 cc
	Region 1 Alternative Medications		
	D25/D50	Dextrose 50%	25 g/50 ml syringe
	Diazepam	Valium	10 mg/ 2 ml syringe
	Lorazepam	Ativan	2 mg/ml Vial/Syringe
	Rocuronium	Zemuron	10 mg/ml Vial
	Vecuronium	Norcuron	10 mg Powder Vial

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PHRN Student Clinical Experience Requirements – Credit for Previous Experience

(Template for System)

All students must complete or show clinical experience / proficiency of all clinical experiences listed in the EMS Systems Paramedic course curriculum. All students requesting credit for prior clinical experiences must request this in writing. All credit must be approved by the EMSMD on a case-by-case determination.

Students Name: _____ Date: _____

Course Location: _____ Site Code: _____

System clinical requirements for Paramedic / PHRN course:

1. Emergency department - ____ hours
2. OR (intubation) - _____ hours/ _____ intubations
3. OB - ____ hours
4. Pediatric - ____ hours
5. Intensive Care Unit - ____ hours
6. Respiratory - _____ hours
7. Other _____- _____ hours
8. Capstone Field Internship – ____hours/ ____ ALS runs/ ____BLS runs

I am requesting credit for prior clinical experiences. Attached is documentation stating the requested credit and supporting documentation outlining previous clinical experience / proficiency.

The following credit for previous clinical experience / proficiency has been approved:

_____

_____

_____

_____

_____

_____

EMS Coordinator (signature & date) _____

EMSMD (signature & date) _____

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Appendix F: Region 1 Emergency Responder Rehabilitation Form

Please note: as per the Region 1 Emergency Incident Rehabilitation Policy symptomatic department members will be transported to the hospital.

Emergency Incident Rehabilitation Report

Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ____________
Out										

Incident: ______________________

Location: ______________________

Date: ______________________

Printed name of care provider(s) ______________________ Incident Commander: ______________________

EMS Coordinator Signature: ______________________ Date received: ______________________

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Appendix G: Region 1 Physician On Scene Form

EMS REGION 1

ON-SITE PHYSICIAN RESPONSIBILITY ACKNOWLEDGMENT

Thank you for your offer of assistance. Be advised the attending EMS Region 1 personnel are operating under the authority of Illinois law. No physician or other person may intercede in patient care without the EMS Region 1 Medical Director, or his or her appropriate designee, relinquishing responsibility of the scene or otherwise giving approval in accordance with EMS Region 1 SMOs.

If YOU ARE A PHYSICIAN AND DESIRE TO ACCEPT RESPONSIBILITY FOR AND DIRECTION OF THE CARE OF THE PATIENT(S) AT THE SCENE:

1. You **MUST** show your medical license wallet card to the EMT and state your specialty.

2. You **MUST** accompany any patient whose care you direct to the medical facility in the ambulance or other attending medical vehicle.

3. Your direction of a case **MUST** be approved by the EMS Region 1 Medical Director or his or her appropriate designee.

Please print except for your signature:

I, _____ M.D. / D.O., assume full responsibility for the pre-hospital direction of medical care of the patient(s) identified below during this ambulance call, and I will accompany the patient(s) to the medical facility. I understand that the Region 1 EMS Medical Director, or his or her appropriate designee, retains the right to resume responsibility for the medical care of such patient(s) at his or her discretion in accordance with Region 1 EMS SMOs at any time, and that the care of the patient(s) will be relinquished to the appropriate Region 1 personnel upon arrival at the medical facility.

Patient Identification (*please initial and provide information as appropriate*):

_____ All patients at the scene, **OR**

_____ The following patients: _____

_____

_____

_____ _____/_____/_____

Physician Signature (M.D. / D.O.) Date

Thank you for your interest.

Region 1 EMS Personnel to complete: Date _____/_____/_____ Run Identification _____ EMT Initials _____

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Appendix H: Region 1 Refusal Form

Region One Prehospital Refusal

Date: ___/___/___ Location of Call: _____ Type of Call: _____

Time: _____ Dispatched: _____ Enroute: _____ Arrived: _____ Completed: _____

Agency: _____ Unit #: _____ Call #: _____

Patient Information

Name: _____ Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.: ___/___/___ Age: _____ Gender: ☐ Male ☐ Female

Assessment of Patient

Medical Hx: _____ Allergies: _____

Medications: _____

BP: ____/____ Pulse: _____ Resp.: _____ Skin: _____ Pupils: R-_____ / L-_____ ☐ Refused V/S

Check appropriate response: *Draw an "X" through the most appropriate box – Y is yes and N is no*

Is the patient oriented to: **Person** Y N **Place** Y N **Time** Y N **Situation** Y N

***NOTE: Any "No" answer from above requires contact of Medical Control*

Suspicion of intoxication? Y N

*** NOTE: A "YES" answer requires contact of Medical Control*

Medical Control Contacted? Y N M.D. / ECRN Name: _____

Patient left in care of: _____ Phone Number: (____) _____

Release from Medical Responsibility

I, _____ hereby release the Hospital, EMS System and it's physicians, nurses and employees and the EMS Service and it's EMTs of any responsibility and liability for the worsening of my condition. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibilities in making this decision.

Adult Patient or Guardian initial next to the box(es) with the most appropriate statement(s)

_____ ☐ I do not consider myself to be injured or ill and do not wish to receive medical services, treatment, or transport.
_____ ☐ I have been advised to seek first aid or medical treatment, which I am refusing.
_____ ☐ I have received emergency medical treatment and am now refusing further care or transport to a medical facility.
_____ ☐ I have received emergency medical treatment and am consenting to transport to a medical facility but, I am refusing the following: _____
_____ ☐ I am refusing transport to the nearest hospital.
_____ ☐ I am requesting transport to _____ Hospital. I have been informed that this facility lies outside the responding agency's territorial range of transport. I am refusing transport to a hospital within this territorial range.

RISKS

All refusals of treatment have the inherent risks of threatening the health, medical safety and possible survival of the patient. All transfers have the inherent risks of traffic delays, accidents during transports, inclement weather, rough terrain, and the limitations of equipment and personnel present in the vehicle, all of which may be the potential threat to the health, medical safety and possible survival of the patient. Transfers to a more distant hospital may increase these risks. The following risks have been explained to the patient, the patient's guardian and/or power of attorney for healthcare.

_____ ☐ Deterioration of Medical Condition, up to and including death
_____ ☐ Deterioration of Medical Condition of Pregnant and/or unborn Child/Delivery
_____ ☐ I have received a "Refusal / Discharge Instruction" form.

_____ X _____ ___/___/___
Printed name of patient / person authorized to consent for patient — Signature of patient / person authorized to consent for patient — Date

_____ X _____ ___/___/___
Printed name of witness — Signature of witness — Date

Comments: _____

_____

X _____ X _____
Signature of Crewmember #1/License # — Signature of Crewmember #2 License #

SHMS-7782 11/2017 White: Agency Copy Yellow: EMS Copy Pink: Patient Copy

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Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

• YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.

• IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.

• IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

ABDOMINAL PAIN:

- Abdominal pain is also called belly pain. Many illnesses can cause abdominal pain and it is very difficult for EMS to identify the cause.
- Take your temperature every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Your pain gets worse or is now only in 1 area
- You vomit (throw up) blood or find blood in your bowel movement
- You become dizzy or faint
- Your abdomen becomes distended or swollen
- You have a temperature over 100° F
- You have trouble passing urine
- You have trouble breathing

BACK PAIN:

- Apply heat to the painful area to help relieve pain. You may use a warm heating pad, whirlpool bath, or warm, moist towels for 10 to 20 minutes every hour.
- Stay in bed as much as possible the first 24 hours.
- Begin normal activities 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 or see a physician, go to the emergency department, or call 911 immediately if:
- You have shooting pain into your buttocks, groin, legs, or arms or the pain increases.
- You have trouble urinating or lose control of your stools or urine.
- You have numbness or weakness in your legs, feet, arms, or hands.

FEVER:

- Always take medications as directed. Tylenol and Ibuprofen can be taken at the same time.
- If you are taking antibiotics, take them until they are gone, not until you are feeling better.
- Drink extra liquids (1 glass of water, soft drink or Gatorade per hour of fever for an adult)
- If the temperature is above 103° F, it can be brought down by a sponge bath with room temperature water. Do not use cold water, a fan, or an alcohol bath.
- Temperature should be taken every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F for 24 hours
- A child becomes less active or alert.
- The Temperature does not come down with Acetaminophen (Tylenol) or Ibuprofen with the appropriate dose.

HEAD INJURY:

- Immediately after a blow to the head, nausea, and vomiting may occur.
- Individuals who have sustained a head injury must be checked, and if necessary awakened, every 2 hours for the first 24 hours.
- Ice may be placed on the injured area to decrease pain and swelling.
- Only drink clear liquids such as juices, soft drinks, or water the first 12 hours after injury..
- Acetaminophen (Tylenol) or Ibuprofen only may be used for pain.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- The injured person has persistent vomiting, is 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 which may have a hole in the center. You may have pain, swelling and a rash. Severe stings may cause a headache and an upset stomach (vomiting).
- Some individuals will have an allergic reaction to a bite or sting. Difficulty breathing or chest pain is an emergency requiring medical care.
- Elevation of the injured area and ice (applied to the area 10 to 20 minutes each hour) will decrease pain and swelling.
- Diphenhydramine (Benadryl) may be used as directed to control itching and hives.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- You develop any chest pain or difficulty breathing.
- The area becomes red, warm, tender, and swollen beyond the area of the bite or sting.
- You develop a temperature above 101° F.

RESPIRATORY DISTRESS:

- Respiratory Distress is also known as shortness of breath or difficulty breathing.
- Causes of Respiratory Distress include reactions to pollen, dust, animals, molds, foods, drugs, infections, smoke, and respiratory conditions such as Asthma and COPD. If possible avoid any causes which produce respiratory distress.
- If you have seen a physician for this problem, take all medication's as directed.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- The cough, wheezing, or breathing difficulty becomes worse or does not improve even when taking medications.
- You have Chest Pain.
- Sputum (spit) changes from clear to yellow, green grey, or becomes bloody.
- You are not able to perform normal activities.

EXTREMITY INJURY:

- Extremity Injuries may consist of cuts, scrapes, bruises, sprains, or broken bones (fractures).
- Apply ice on the injury for 15 to 20 minutes each hour for the first 1 to 2 days.
- Elevate the extremity above the heart as possible for the first 48 hours to decrease pain and swelling.
- Use the extremity as pain allows.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- The bruising, swelling, or pain gets worse despite the treatment listed above.
- Any problems listed on the **Wound Care instructions** are noted.
- You are unable to move the extremity or if numbness or tingling is noted.
- You are not improved in 24 to 48 hours or you are not normal in 7 to 10 days.

VOMITING/DIARRHEA:

- Vomiting (throwing up) can be caused by many things. It is common in children, but should be watched closely.
- Diarrhea is most often caused by either a food reaction or infection.
- Dehydration is the most serious problem associated with vomiting or diarrhea.
- Drink clear liquids such as water, apple juice, soft drinks, or Gatorade for the first 12 hours or until things improve. Adults should drink 8 to 12 glasses of fluids per day with diarrhea. Children should drink 1 cup of fluid for each loose bowel movement.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
- Vomiting or Diarrhea lasts longer than 24 hours, gets worse, or blood is noted.
- You cannot keep fluids down or no urination is noted in 8 hours.

WOUND CARE:

- Wounds include cuts, scrapes, bites, abrasions, or puncture wounds.
- If the wound begins to bleed, apply pressure over the wound with a clean bandage and elevate the wound above the heart for 5 to 10 minutes.
- Unless instructed otherwise, clean the wound twice daily with soapy water, and keep the wound dry. It is safe to take a shower but do not place the wound in bath or dish water.
- See a physician for a tetanus shot if it has been 10 years or more since your last one.

Call or see a physician, go to the emergency department, or call 911 immediately if:
- See the **Extremity Injury instructions**.
- Temperature is greater than 101° F.
- Bruising, swelling, or pain gets worse or bleeding is not controlled as directed above.
- Any signs of infection, such as redness, drainage of yellow fluid or pus, red streaks extending from the wound, or a bad smell is noted.

Page 1

Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

• YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.

• IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.

• IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

Chest Pain:

- There are many causes of chest pain.
- Some of the causes include: heart problems, heartburn, esophagus disorders, pneumonia, pleurisy, pulmonary embolism, panic attacks or inflammation in your chest.
- Some of these problems can be serious and life threating.
- Chest Pain should be evaluated by a physician.

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

- If increase in pain or pressure in chest.
- Sweating
- Unexplained weakness, dizziness, lightheadedness
- Shortness of breath
- Nausea or vomiting
- Fast or irregular heart beat

Syncope - Fainting :

- Fainting is a temporary loss of consciousness.
- There are many causes for fainting.
- Fainting usually occurs when your blood pressure drops suddenly and a decrease in blood flow to the brain results.
- Some of the causes include: heart problems, drop in blood sugar, certain medication, emotional distress, standing up too quickly, heat or dehydration.
- Syncope/Fainting should be evaluated by a physician.

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

- Unexplained weakness, dizziness, lightheadedness continues.
- Shortness of breath
- Nausea or vomiting
- Pain or pressure in the chest
- Fast or irregular heart beat

Hypertension – High Blood Pressure:

- High blood pressure is a common condition that may cause health problems, such as heart disease.
- You can have high blood pressure for years without any symptom.
- Uncontrolled high blood pressure increases your risk of serious health problems including heart attack and stroke.
- High blood pressure is generally defined as a pressure over 140/90.
- Have you blood pressure checked regularly and see a physician if it is high.

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

- You have other symptoms such as headache, dizziness, shortness of breath, chest pain or nosebleeds.

Low Blood Sugar:

- Causes of low blood sugar: too little food, too much insulin or diabetes pills and/or more active than usual.
- The onset is often sudden.
- Some Symptoms include: shaky, sweating, fast heartbeat, blurry vision, headache, irritable, weakness or fatigue.
- If you feel like your blood sugar is low, check your blood glucose. If you can't check your glucose, treat anyway.
- Treat by eating glucose tablets, candies, fruit juice or regular soda pop.
- Check blood glucose again.
- Eat something in addition to the sugar. Eat something with protein and/or carbohydrates to last longer.

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

- If symptoms do not improve or stop.

High Blood Sugar:

- Causes of high blood sugar: too much food, too little insulin or diabetes's pills, illness or stress.
- The onset often starts slowly.
- Some Symptoms include: extreme thirst, ,need to urinate often, dry skin, hungry, drowsy, slow healing of wounds.
- Check blood glucose.
- If your blood glucose is higher than your goal and you don't know why call your healthcare provider.

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

- If symptoms do not improve or stop.

Unsafe Situation:

- Are you currently in a relationship / situation where you feel unsafe or threatened?

Information about shelter and alternatives is available 24 hours a day by contacting the Domestic Violence Hotline at:

- **Illinois hotline 877-863-6338**
- **National hotline 800-799-7233 / TTY 800-787-3224**
- **http://www.ilcadv.org/**

Narcan:

- You have received Narcan for an apparent Narcotic overdose. You were unconscious and breathing was compromised. Narcan was administered to save your life.
- **We strongly recommend that you go to the hospital for additional medical care.** The Narcan may wear off before the Narcotic is out of your system. If that happen you could die
- We cannot take you against your will.
- We recommend that you do not do any more drugs or alcohol.

Local Phone Numbers

Refusing against EMS advice:

Patients that have apparent decision making capacities have the right to refuse. We recommend the following:

- You seek medical care.
- You stay with a responsible adult who will observe you and call 911 if needed.
- **Please call 911 or seek medical attention if you change your mind.**

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Appendix J – Region 1 Multiple Patient Prehospital Refusal Form

Region One Multiple Patient Prehospital Refusal Form

Date: ___/___/___ Location of Call: _____

Time: Dispatched: _____ Enroute: _____ Arrived: _____ Completed: _____

Agency: _____Unit #:_____Call #:_____

Type of Incident: _____

_____

Medical Direction Contacted? Y N M.D. / ECRN Name: _____

RELEASE FROM RISKS OF MEDICAL RESPONSIBILITY

I, ***listed below,*** hereby release the Hospital, EMS System and its physicians, nurses, and employees and the EMS agency and its' Personal of any responsibility and liability for the worsening of medical condition of multiple victims involved in this incident. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibility. I acknowledge that all refusals carry the inherent risks of deterioration of medical condition up to and including death.

Print Name	**Signature**	**DOB**
1. _____	_____	_____
Address_____		
2. _____	_____	_____
Address_____		
3. _____	_____	_____
Address_____		
4. _____	_____	_____
Address_____		
5. _____	_____	_____
Address_____		
6. _____	_____	_____
Address_____		
7. _____	_____	_____
Address_____		

_____ _____

Signature of EMS crew #1 **Signature of EMS crew #2**

If School Bus Accident, signature of authorized school designee: _____

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Appendix K – Region 1 Request for Clarification Form (formerly Unusual Occurrence Form)

Region 1 Request for Clarification Form
(formerly Unusual Occurrence Form)

All information contained within this form is private and confidential pursuant to the Illinois Medical Studies Act and is for official use only.

Incident Information:

Date of Report: Date of Incident: Time of Incident:

Incident Location:

Type of Incident (Check all the apply):

☐ Medications ☐ Procedure ☐ Patient Injury ☐ Other Patient Related

☐ Equipment ☐ SMO/SOP Deviation ☐ Provider Injury ☐ ED Staff Related

☐ Communication ☐ Assessment/Intervention ☐ Other Provider Related ☐ Other

Agency / Organization Involved: Receiving Hospital:

EMS Report Number: ECRN Log Number:

EMS System Personnel Involved (List All):

Non-EMS Personnel Involved

Report Initiated By:

Incident Description/Details:

STOP Do not write below this line. For Administrative use only.

EMS System Review:

Disposition:

☐ Unfounded ☐ Re-Education ☐ Verbal Warning ☐ Written Warning ☐ Suspension ☐ Other

Region 1 EMS Coordinator Contacted: ☐ Yes ☐ No Date:

EMS Coordinator Signature: Date:

EMS Medical Director Signature: Date:

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