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East Central Illinois EMS

Section: Introduction

Title: Code of Ethics

Original Policy Date: 10/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish a standard Code of Ethics for all EMS Providers within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

Professional status as an Emergency Medical Services (EMS) Practitioner is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the EMS profession. As an EMS practitioner, I solemnly pledge myself to the following code of professional ethics:

- To conserve life, alleviate suffering, promote health, do no harm, and encourage the quality and equal availability of emergency medical care.
- To provide services based on human need, with compassion and respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status; to not judge the merits of the patient's request for service, nor allow the patient's socioeconomic status to influence our demeanor or the care that we provide.
- To not use professional knowledge and skills in any enterprise detrimental to the public wellbeing.
- To respect and hold in confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.
- To use social media in a responsible and professional manner that does not discredit, dishonor, or embarrass an EMS organization, co-workers, other health care practitioners, patients, individuals or the community at large.
- To maintain professional competence, striving always for clinical excellence in the delivery of patient care.
- To assume responsibility in upholding standards of professional practice and education.
- To assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and to know and uphold the laws which affect the practice of EMS.
- To be aware of and participate in matters of legislation and regulation affecting EMS.

- To work cooperatively with EMS associates and other allied healthcare professionals in the best interest of our patients.
- To refuse participation in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

_____

Originally written by: Charles B.Gillespie, M.D., and adopted by the National Association of Emergency Medical Technicians, 1978.
Revised and adopted by the National Association of Emergency Medical Technicians, June 14, 2013.

IV. RESOURCES – None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

East Central Illinois EMS

Section: Introduction

Page: 1 of 1

Title: Vision Statement

Original Policy Date: 10/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to state the vision statement of the East Central Illinois EMS System.

II. VISION STATEMENT

To be an integrative, High Performance EMS System aligning EMS agencies and providers to meet community-centered needs through Clinical Excellence, Education, Access and Advocacy.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Emergency Medical Services System

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide an overview of the functions of the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

East Central Illinois EMS System was created based on the guidelines of the Illinois Emergency Medical Services Systems Act and complies with all the administrative rules of the Illinois Department of Public Health (IDPH) Emergency Medical Services and Trauma Center Code.

East Central Illinois EMS System was created to:

A. Develop and maintain a system of prehospital medical control to insure a high standard of prehospital care delivery to the citizens of the East Central Illinois EMS service area.
B. Provide for a continuity of prehospital care at the Basic and Advanced Life Support levels for all emergency patients within the East Central Illinois EMS service area in conjunction with state, regional and local standards.
C. Develop treatment protocols and procedures to be used in the East Central Illinois EMS Medical Director's absence and certify that all involved personnel are knowledgeable in emergency care and capable of providing treatment and using communications.
D. Develop lines of cooperative communication between prehospital and hospital providers to facilitate seamless provision of service in the East Central Illinois EMS System service area.
E. Provide training at the Basic and Advanced Life Support levels of emergency care for the purpose of improving and standardizing the quality of prehospital care.
F. Provide training for Emergency Department physicians and Emergency Communication Registered Nurses (ECRN) for the purpose of improving and standardizing the quality of prehospital care.
G. Be responsible for the ongoing education of all East Central Illinois EMS personnel, including coordinating didactic and clinical experience.
H. Be responsible for supervising all personnel participating within East Central Illinois EMS System as described in the System Program Plan.
I. Be responsible for the total management of East Central Illinois EMS System, including enforcement of the System Program Plan by all East Central Illinois EMS System participants.

J. Ensure that a copy of the IDPH application for renewal is provided to any EMS provider within the East Central Illinois EMS System who has not been recommended for relicensure by the East Central Illinois EMS System Medical Director.
K. Monitor, evaluate, review and improve the quality of prehospital care, communication, and transportation at all levels within the East Central Illinois EMS System.
L. Ensure that all Prehospital Care Report forms (including electronic reporting) used by East Central Illinois EMS System providers conform to IDPH standards.
M. Assure standardization and modernization of all patient care equipment, drugs and communication equipment used within the East Central Illinois EMS System.
N. Create and maintain effective lines of communication between all levels of prehospital providers.
O. Develop standardized policies for use by all levels of prehospital providers.

IV. REFERENCES – None.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: EMS Resource Hospital

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Resource Hospital.

II. DEFINITION – None.

III. POLICY

The Resource Hospital has the authority and the responsibility for the planning, development and ongoing operation of the EMS System. This is accomplished through the understanding and commitment of the Senior Leadership team to undertake whatever is necessary to make the East Central Illinois EMS System succeed.

The Resource Hospital shall:

A. Appoint an EMS Medical Director, Alternate EMS Medical Director, EMS Administrative Director, EMS System Coordinator and any additional educational and clerical personnel required. The Resource Hospital provides workspace and materials for these individuals.
B. Support the development of education standards, treatment protocols, procedures, and operational policies for the East Central Illinois EMS System.
C. Educate or coordinate the education of EMS providers at all levels of licensure.
D. Educate or coordinate the education of Emergency Communications Nurses.
E. Provide the training space, materials, and clinical experience opportunities needed to properly educate EMS providers.
F. Assure that relevant data is collected to measure the quality of care provided within the East Central Illinois EMS System, and provides whatever data is required to the Illinois Department of Public Health (IDPH). The Resource Hospital agrees to allow access to all East Central Illinois EMS System records, equipment, and vehicles to IDPH for purposes of inspection, investigation, or site survey.
G. Agree to replace medical supplies and provide for equipment exchange for participating EMS agencies.

REFERENCES

Illinois EMS Act (210 ILCS 50/3.35)

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Associate Hospital

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of Associate Hospitals within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

An "Associate Hospital" in the East Central Illinois EMS System shall provide the same clinical and communications services as the Resource Hospital, but shall not have the primary responsibility for personnel training and System operations. It shall have a basic or comprehensive emergency department with 24-hour physician coverage and a functioning intensive care and/or cardiac care unit. Responsibilities of the Associate Hospital include:

A. Provide prompt exchange for all drugs and all equipment with all pre-hospital care providers participating in the System or other EMS Systems whose ambulances transport to the hospital.
B. Use the standard treatment orders as established by the EMS Resource Hospital;
C. Follow the operational policies and protocols of the EMS System as reflected in the Department approved EMS System Program Plan;
D. Participate in the ongoing training and continuing education of EMS personnel;
E. Meet the Systems educational standards for ECRN's;
F. Collect and provide relevant data as determined by the Resource Hospital & IDPH;
G. Promptly make telemetry tapes, EMS run reports and other data collected to the Resource Hospital and IDPH upon request;
H. Allow the Department prompt access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;
I. Identify the names of the Associate Hospital EMS MD and Associate Hospital EMS System Coordinator and their level of participation in the EMS System;
J. Agree to the requirements set in Section 515.240 Bioterrorism Grants;
K. Have two-way ambulance-to-hospital communications capability on a frequency determined and assigned by the Department;
L. Have two-way hospital-to-hospital communications capability; and
M. Comply with the Resource Hospital's communication plan.

IV. REFERENCES

- Illinois EMS Act
- 77Ill Adm. Code 515.330 (i)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Participating Hospital

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of Participating Hospitals within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

Any hospital located within the geographic service area of East Central Illinois EMS System may commit to being involved in the care and service of the prehospital patient population as a Participating Hospital by agreeing to the following:

A. Provide documentation to substantiate its designated level of care (i.e. standby, basic or comprehensive emergency department).
B. Promptly provide exchange for all drugs and all equipment with all pre-hospital care providers participating in the System or other EMS Systems whose ambulances transport to the hospital;
C. Use the standard treatment orders as established by the EMS Resource Hospital;
D. Follow the operational policies and protocols of the EMS System as reflected in the Department approved EMS System Program Plan;
E. Participate in the ongoing training and continuing education of EMS personnel;
F. Collect and provide relevant data as determined by the Resource Hospital & IDPH;
G. Allow the Department prompt access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;
H. Agree to the requirements set in Section 515.240 Bioterrorism Grants.
I. Have two-way ambulance-to-hospital communications capability on a frequency determined and assigned by the Department
J. Have two-way hospital-to-hospital communications capability; and
K. Comply with the Resource Hospital’s communication plan.

IV. REFERENCES

- Illinois EMS Act
- 77Ill Adm. Code 515.330 (i)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: EMS Medical Director

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Medical Director.

II. DEFINITION – None.

POLICY

The EMS Medical Director is the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System. The East Central Illinois EMS System Medical Director defines the authorized treatments to be performed by all persons who routinely respond to prehospital emergencies and assures the competency of the performance of such acts.

The East Central Illinois EMS System Medical Director must:

A. Be a graduate of an approved, accredited medical school.
B. Be licensed to practice medicine in all of its branches.
C. Be licensed to practice medicine in the State of Illinois.
D. Be certified by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.
E. Have completed an approved residency program in emergency medicine or have extensive critical or emergency care experience.
F. Have completed, within six months of appointment, an IDPH-approved EMS Medical Director's course.
G. Have experience on an EMS vehicle at the highest level available in the system or be willing to make provisions to gain experience in the vehicle.
H. Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system.
I. Have or make provision to gain experience instructing students at a level up to and including Paramedic and Prehospital RN.

The East Central Illinois EMS System Medical Director will be responsible for:

A. Development of standing treatment protocols to be used in the EMS System and ensure that they are being properly followed.
B. Medical oversight for treatment protocols to be used in his/her absence by designated physicians and nurses.
C. Medical oversight for East Central Illinois EMS System policies.
D. Developing lists of medications and equipment to be carried on EMS vehicles of all levels.
E. Being knowledgeable of the State of Illinois EMS Act and its rules and regulations, assuring that the East Central Illinois EMS System conforms to these rules and regulations.
F. Obtaining all necessary IDPH approvals (e.g. waivers, personnel changes, inspections, etc.) for the East Central Illinois EMS System and keeping a current record of all approvals.
G. Developing, coordinating, supervising and participating in EMS education. The East Central Illinois EMS System Medical Director takes part in both initial and continuing education. He or she participates in classroom didactic and clinical experiences in both the hospital and prehospital settings. The East Central Illinois EMS System Medical Director is involved in education of all levels of EMS providers and Emergency Department physicians.
H. Delegating responsibility for communicating to IDPH approval of the licensure and renewal of licensure of EMS personnel. The East Central Illinois EMS System Medical Director also communicates to IDPH any disciplinary action taken which may include recommendation for the removal of EMS licensure.
I. Supervising the quality of care provided by all East Central Illinois EMS System personnel through the monitoring of emergency calls, tape recordings, and report forms
J. Developing a performance improvement program made up of data collection, audits and feedback mechanisms in order to monitor the quality of care provided by all East Central Illinois EMS System personnel.
K. Developing and participating in public relations events representing the East Central Illinois EMS System.
L. Attending appropriate EMS committee meetings at the local, regional, state and national levels.
M. Assuming responsibility of medical control for prehospital care provided by East Central Illinois EMS System personnel.
N. Designating a physician as an Alternate EMS Medical Director to supervise East Central Illinois EMS System in his or her absence.

III. REFERENCES

Illinois EMS Act (210 ILCS 50/3.20)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Alternate EMS Medical Director

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the Alternate East Central Illinois EMS System Medical Director.

II. DEFINITION – None.

III. POLICY

The Alternate East Central Illinois EMS System Medical Director is the physician designated by the East Central Illinois EMS System Medical Director who assumes responsibility for the management of the EMS system in the absence of the East Central Illinois EMS System Medical Director. The Alternate East Central Illinois EMS System Medical Director upholds the authorized treatments performed by all persons who routinely respond to prehospital emergencies and assures the competency of the performance of such acts.

The Alternate East Central Illinois EMS System Medical Director must:

A. Be a graduate of an approved, accredited medical school.
B. Be licensed to practice medicine in all of its branches.
C. Be licensed to practice medicine in the State of Illinois.
D. Have completed an approved residency program in emergency medicine or have extensive critical or emergency care experience.
E. Have experience on an EMS vehicle at the highest level available in the system or be willing to make provisions to gain experience in the vehicle.
F. Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system.
G. Have or make provision to gain experience instructing students at a level up to and including Paramedic and Prehospital RN.

The Alternate East Central Illinois EMS System Medical Director will be responsible for:

A. Enforcing the treatment protocols developed by the East Central Illinois EMS System Medical Director.
B. Enforcing the standard operating policies for the East Central Illinois EMS System.

C. Being knowledgeable of the State of Illinois EMS Act and its rules and regulations, assuring that the East Central Illinois EMS System conforms to these rules and regulations.
D. Assisting with the development, coordination, supervision and participation in EMS education. The Alternate East Central Illinois EMS System Medical Director takes part in both initial and continuing education. He or she participates in classroom didactic and clinical experiences in both the hospital and prehospital settings. The Alternate East Central Illinois EMS Medical Director is involved in education of all levels of EMS provider and Emergency Department Physicians.
E. Assisting with communicating to IDPH the approval of licensure and renewal of licensure of EMS personnel. The Alternate Medical Director also assists with communication to IDPH any disciplinary action taken which may include recommendation for the removal of EMS licensure.
F. Assisting with the supervision of the quality of care provided by all East Central Illinois EMS System personnel, through the monitoring of emergency calls, tape recordings, and report forms.
G. Enforcing the performance improvement program made up of data collection, audits and feedback mechanisms in order to monitor the quality of care provided by all East Central Illinois EMS System personnel.
H. Assisting in the development and participation in public relations events representing the East Central Illinois EMS System.
I. Attending appropriate EMS committee meetings at the local, regional, state and national levels as delegated by the East Central Illinois EMS System Medical Director.
J. Assisting in the responsibility of medical control for prehospital care provided by East Central Illinois EMS System personnel.

IV. REFERENCES

Illinois EMS Act (210 ILCS 50/3.35)

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Associate Hospital EMS Medical Director

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the Associate Hospital EMS Medical Director

II. DEFINITION – None.

POLICY

The Associate Hospital EMS Medical Director is the physician, designated by the Associate Hospital and approved by the East Central Illinois EMS Medical Director, who is responsible for upholding the East Central Illinois EMS System services and programs at the Associate Hospital.

The Associate Hospital EMS Medical Director must:

A. Be a graduate of an approved, accredited medical school.
B. Be licensed to practice medicine in all of its branches.
C. Be licensed to practice medicine in the State of Illinois.
D. Be certified by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.
E. Have completed an approved residency program in emergency medicine or have extensive critical or emergency care experience.
F. Have experience on an EMS vehicle at the highest level available in the system or be willing to make provisions to gain experience in the vehicle.
G. Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system.

The Associate Medical Director will be responsible for:

A. Enforcing the treatment protocols developed by the East Central Illinois EMS System Medical Director.
B. Enforcing the standard operating policies for the East Central Illinois EMS System.

C. Ensuring that all ECRN's and Emergency Department Physicians at the Associate Hospital are knowledgeable on the East Central Illinois EMS System protocols and policies.
D. Being knowledgeable of the State of Illinois EMS Act and its rules and regulations.
E. Assisting the East Central Illinois EMS Medical Director and System Coordinator in Quality Assurance.

REFERENCES

- Illinois EMS Act
- 77Ill Adm. Code 515.320

EMS Medical Director	Date
EMS System Coordinator	Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Page: 1 of 2

Title: EMS Administrative Director

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Administrative Director.

II. DEFINITION – None.

POLICY

The East Central Illinois EMS System Administrative Director is the administrator appointed by the Resource Hospital with the approval of the EMS Medical Director, who is responsible for the administration of the East Central Illinois EMS System.

The East Central Illinois EMS System Administrative Director must:

A. Be knowledgeable in the State of Illinois EMS Act and its rules and regulations.
B. Have a thorough understanding of the Resource Hospital organization and its purpose and function.
C. Be aware of external influences upon the health care industry and the East Central Illinois EMS System.
D. Be knowledgeable regarding the communities encompassed within the East Central Illinois EMS System region, their unique needs and concerns and potential barriers to the provision of quality prehospital care.
E. Be familiar with the organization of the East Central Illinois EMS System regarding its relationship with the communities it serves, to neighboring EMS systems, and to the state of Illinois.

The East Central Illinois EMS System Administrative Director is responsible for:

A. Coordination of hearings in cases of conflict as outlined in the Illinois EMS Systems Act. The East Central Illinois EMS System Administrative Director ensures that these hearings are conducted in accordance with the EMS Systems Act Rules and Regulations.
B. Assisting in the development and/or coordination of administration of the East Central Illinois EMS System in collaboration with the EMS Medical Director and EMS System Coordinator. Administrative duties include:
    1. Preparation and presentation of the East Central Illinois EMS System budget to the Resource Hospital Administration.
    2. Coordination of working relationships and working agreements between the Resource Hospital, participating hospitals and ambulance services.
    3. Assurance of legal compliance of the East Central Illinois EMS System with the State of Illinois EMS Systems Act, its Rules and Regulations and all other applicable laws as mandated by IDPH.
    4. Assurance that the facilities of the Resource Hospital are adequate to support the activities of the East Central Illinois EMS System.
    5. Interpretation and communication of OSF HealthCare policies, objectives, and operational procedures to the East Central Illinois EMS System Medical Director and the East Central Illinois EMS System Coordinator to insure that the East Central Illinois EMS System is appropriately integrated into OSF HealthCare.

REFERENCES

Illinois EMS Act (210 ILCS 50/3.35)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: EMS System Coordinator

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Coordinator.

II. DEFINITION – None.

POLICY

The EMS System Coordinator is the health care professional responsible for planning, coordinating, and organizing the East Central Illinois EMS System services and programs. The EMS System Coordinator is an employee of the East Central Illinois EMS System, and works collaboratively with the East Central Illinois EMS System Medical Director, the East Central Illinois EMS System Administrative Director and the prehospital agencies and providers associated with the East Central Illinois EMS System to insure quality prehospital care for the citizens living in the East Central Illinois EMS System region.

The EMS System Coordinator must:

A. Be licensed to practice as a Registered Nurse or Paramedic in the State of Illinois.
B. Have completed Advanced Cardiac Life Support, Pediatric Advanced Life Support (or
C. Pediatric Emergencies for Prehospital Professionals), International Trauma Life Support (or Trauma Nurse Specialist or Trauma Nurse Core Course), and Basic Life Support at a provider and/or instructor level.
D. Have experience in an EMS vehicle, or be willing to make provisions to gain experience on the vehicle.
E. Be thoroughly knowledgeable about and able to demonstrate all EMS skills at all levels.
F. Have a minimum of five years teaching experience.

The EMS System Coordinator is responsible for:

A. Enforcing the East Central Illinois EMS System treatment protocols as developed by the East Central Illinois EMS System Medical Director.
B. Enforcing standard operating policies for the East Central Illinois EMS System.
C. Periodically inspecting EMS vehicles within the East Central Illinois EMS System at all levels, using equipment and drug checklists developed by the East Central Illinois EMS System Medical Director.
D. Being knowledgeable of the State of Illinois EMS Act and its Rules and Regulations, assuring that the East Central Illinois EMS System conform to those Rules and Regulations.
E. Acting as a liaison between the East Central Illinois EMS System agencies and providers and the Illinois Department of Public Health (IDPH).
F. Acting as a liaison between the East Central Illinois EMS System agencies and providers and the East Central Illinois EMS System Medical Director.
G. Recruiting new agencies to participate in the East Central Illinois EMS System.
H. Obtaining all necessary system approvals from IDPH, and keeping a current record of all current and pending system approvals.
I. Assisting in developing, coordinating, supervising and participating in EMS education. The EMS System Coordinator takes part in both initial and continuing education. He/she participates in classroom didactic and clinical experiences in both the hospital and prehospital settings as needed. The EMS System Coordinator is involved in education of all levels of EMS provider and Emergency Department Physicians.
J. Monitoring quality of care provided by all East Central Illinois EMS System personnel through review of emergency calls, tape recordings, and report forms.
K. Assisting the East Central Illinois EMS System Medical Director with communications to IDPH regarding disciplinary action taken towards EMS personnel and recommendation for removal of licensure.
L. Implementing the performance improvement program, which includes data collection, audits and feedback mechanisms designed to monitor the quality of care provided by all East Central Illinois EMS System personnel.
M. Assisting in the development of and participation in public relations events representing the East Central Illinois EMS System.
N. Attending appropriate EMS committee meetings at the local, regional, state and national levels as delegated by the East Central Illinois EMS System Medical Director.
O. Collaborating with the East Central Illinois EMS System Medical Director and EMS Administrative Director in creating a vision for future development of the East Central Illinois EMS System.

REFERENCES

Illinois EMS Act (210 ILCS 50/3.35)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Associate Hospital EMS System Coordinator

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Associate Hospital EMS Coordinator.

II. DEFINITION – None.

III. POLICY

The Associate Hospital EMS System Coordinator is the healthcare professional (RN or Paramedic), designated by the Associate Hospital and approved by the East Central Illinois EMS Medical Director, who is responsible for upholding the East Central Illinois EMS System services and programs at the Associate Hospital.

The Associate Hospital EMS System Coordinator must:

A. Be licensed to practice as a Registered Nurse or Paramedic in the State of Illinois.
B. Have completed Advanced Cardiac Life Support, Pediatric Advanced Life Support or Pediatric Emergencies for Prehospital Professionals, International Trauma Life Support (or Trauma Nurse Specialist or Trauma Nurse Core Course) and Basic Life Support at a provider and/or instructor level.
C. Have experience in an EMS vehicle, or be willing to make provisions to gain experience on the vehicle.
D. Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system.

The Associate Hospital EMS System Coordinator is responsible for:

A. Enforcing the treatment protocols developed by the East Central Illinois EMS System Medical Director.
B. Enforcing the standard operating policies for the East Central Illinois EMS System.
C. Ensuring that all ECRN's and ED staff at the Associate Hospital are knowledgeable on the East Central Illinois EMS System protocols and policies.
D. Being knowledgeable of the State of Illinois EMS Act and its Rules and Regulations.
E. Assisting the East Central Illinois EMS Medical Director and System Coordinator in Quality Assurance.

IV. REFERENCES

- Illinois EMS Act
- 77Ill Adm. Code 515.320

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: EMS Educator

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of EMS Educators in the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

An EMS Educator is a healthcare professional responsible for providing initial and continuing educational offerings and programs for all levels of providers within the East Central Illinois EMS System. An EMS Educator is an employee of the East Central Illinois EMS System and works collaboratively with the EMS System Coordinator, the East Central Illinois EMS System Lead EMS Educator and the prehospital agencies and providers associated with the East Central Illinois EMS System to ensure that educational needs are met. It is preferred that an EMS Educator in the East Central Illinois EMS System be licensed as a Lead Instructor in the state of Illinois.

An EMS Educator must:

A. Be licensed to practice as a Registered Nurse or an Advanced Life Support EMS Provider in the State of Illinois.
B. Have completed Advanced Cardiac Life Support, Pediatric Advanced Life Support (or Pediatric Emergencies for Prehospital Professionals), International Trauma Life Support (or Trauma Nurse Specialist or Trauma Nurse Core Course) and Basic Life Support at a provider and/or instructor level.
C. Have experience in an EMS vehicle, or be willing to make provisions to gain experience on the vehicle.
D. Be thoroughly knowledgeable about and able to demonstrate all EMS skills at all levels.
E. Have a minimum of two years teaching experience.

An EMS Educator is responsible for:

A. Assisting in developing programs based on the National EMS Education Standards.
B. Enforcing treatment protocols as developed by the East Central Illinois EMS System Medical Director in all education offerings.
C. Enforcing standard operating policies for the East Central Illinois EMS System in all education offerings.

D. Working collaboratively with the EMS System Coordinator to periodically inspect EMS vehicles within the East Central Illinois EMS System at all levels, using equipment and drug checklists developed by the East Central Illinois EMS System Medical Director.
E. Being knowledgeable of the State of Illinois EMS Act and its Rules and Regulations, assuring that the East Central Illinois EMS System education programs conform to those Rules and Regulations.
F. Acting as a liaison between East Central Illinois EMS System agency educators and the East Central Illinois EMS System office.
G. Assisting in the development of an annual calendar of initial education offerings for levels of prehospital providers in the East Central Illinois EMS System.
H. Assisting in the development of an annual calendar of continuing education offerings for all levels of prehospital providers in the East Central Illinois EMS System.
I. Assisting in the development, coordination, and supervision of EMS education. The EMS Educator participates in teaching in both initial and continuing education. He/she participates in classroom didactic and clinical experiences in both the hospital and prehospital settings. The EMS Educator is involved in education of all levels of EMS provider and Emergency Department Physicians.
J. Assisting in the maintenance of records of all education offerings in the East Central Illinois EMS System, and of participation in these offerings by East Central Illinois EMS System personnel.
K. Assisting in the performance improvement program, which includes data collection, audits and feedback mechanisms designed to monitor the quality of care provided by all East Central Illinois EMS System personnel, for the purpose of determining areas of need that can be addressed through education.
L. Assisting in the development of public relations events designed to promote the East Central Illinois EMS System.
M. Attending appropriate EMS committee meetings at the local, regional, state and national levels as delegated by the EMS System Coordinator.
N. Collaborating with the East Central Illinois EMS System Medical Director and EMS System Coordinator in creating a vision for future development of the East Central Illinois EMS System regarding education needs.

IV. REFERENCES – None.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Lead EMS Educator

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the roles and responsibilities of the East Central Illinois EMS System Lead Educator.

II. DEFINITION – None.

III. POLICY

The East Central Illinois EMS System Lead Educator is the health care professional responsible for planning, coordinating, and organizing East Central Illinois EMS System educational offerings and programs. The East Central Illinois EMS System Lead Educator is an employee of the East Central Illinois EMS System, and works collaboratively with the East Central Illinois EMS System Medical Director, the EMS System Coordinator and the prehospital agencies and providers associated with the East Central Illinois EMS System to ensure that education needs are met.

The East Central Illinois EMS System Lead Educator must:

A. Be licensed to practice as a Registered Nurse or Paramedic in the State of Illinois.
B. Be licensed as a Lead Instructor in the state of Illinois.
C. Have completed Advanced Cardiac Life Support, Pediatric Advanced Life Support (or Pediatric Emergencies for Prehospital Professionals), International Trauma Life Support (or Trauma Nurse Specialist or Trauma Nurse Core Course) and Basic Life Support at a provider and/or instructor level.
D. Have experience in an EMS vehicle, or be willing to make provisions to gain experience on the vehicle.
E. Be thoroughly knowledgeable about and able to demonstrate all EMS skills at all levels.
F. Have a minimum of five years teaching experience.

The East Central Illinois EMS System Lead Educator is responsible for:

A. Developing programs based on the National EMS Education Standards.
B. Enforcing East Central Illinois EMS System treatment protocols (as developed by the East Central Illinois EMS System Medical Director) in all education offerings.
C. Enforcing East Central Illinois EMS System standard operating policies in all education offerings.

D. Being knowledgeable of the State of Illinois EMS Act and its Rules and Regulations and assuring that the East Central Illinois EMS System education programs conform to those Rules and Regulations.
E. Acting as a liaison between the East Central Illinois EMS System lead instructors and/or agency educators and the Illinois Department of Public Health (IDPH).
F. Coordinating all educational offerings within the East Central Illinois EMS System.
G. Screening all requests for non-scheduled initial training sessions.
H. Developing an annual calendar of initial education offerings for all levels of prehospital providers in the East Central Illinois EMS System.
I. Developing an annual calendar of continuing education offerings for all levels of prehospital providers in the East Central Illinois EMS System.
J. Developing a corps of reliable and talented instructors to facilitate education within the East Central Illinois EMS System.
K. Developing and coordinating a corps of reliable and talented preceptors to facilitate field clinical education within the East Central Illinois EMS System.
L. Obtaining all necessary approvals for education offerings from IDPH and keeping an accurate record of all current and pending approvals.
M. Developing, coordinating, supervising and participating in EMS education. The EMS Lead Educator takes part in both initial and continuing education. He/she participates in classroom didactic and clinical experiences in both the hospital and prehospital settings. The EMS Lead Educator is involved in education of all levels of EMS provider and Emergency Department Physicians.
N. Maintaining records of all education offerings in the East Central Illinois EMS System, and of participation in these offerings by East Central Illinois EMS System personnel.
O. Coordinating (under the direction of the East Central Illinois EMS System Medical Director) communication to IDPH regarding approval of licensure and license renewal.
P. Assisting with monitoring of quality of care provided by all East Central Illinois EMS System personnel through review of emergency calls, tape recordings, and report forms.
Q. Assisting in the performance improvement program, which includes data collection, audits and feedback mechanisms designed to monitor the quality of care provided by all East Central Illinois EMS System personnel, for the purpose of determining areas of need that can be addressed through education.
R. Assisting in the development of public relations events designed to promote the East Central Illinois EMS System.
S. Attending appropriate EMS committee meetings at the local, regional, state and national levels as delegated by the East Central Illinois EMS System Medical Director.
T. Collaborating with the East Central Illinois EMS System Medical Director and EMS System Coordinator in creating a vision for future development of the East Central Illinois EMS System regarding education needs.

IV. REFERENCES – None.

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Roles and Responsibilities

Title: Region 6 EMS Medical Directors Advisory Committee

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The Regional EMS Advisory Committee is the committee within Region 6 created as directed by the Illinois Emergency Medical Services System Act, to advise the Regional EMS Medical Directors Committee. The Regional EMS Advisory Committee for Region 6 selects the region's representative to the State Emergency Medical Services Advisory Council.

II. DEFINITION – None.

III. POLICY

The East Central Illinois EMS System shall actively participate on the Regional EMS Advisory Committee for Region 6 to assure effective representation of the system.

The Regional EMS Advisory Committee for Region 6 is made up of the following:

A. Region 6 EMS Medical Directors Committee.
B. Chair of the Regional Trauma Committee.
C. EMS System Coordinators from each Resource Hospital within Region 6.
D. One administrative representative from an associate hospital within the region.
E. One administrative representative from a participating hospital within the region.
F. One administrative representative from the vehicle service provider which responds to the highest number of calls for service within the region.
G. One provider from each licensure level practicing within the region.
H. One registered professional nurse currently practicing in an emergency department within the region.
I. An administrative representative from two vehicle service providers (one must be a representative of a private vehicle service provider).
J. IDPH Regional EMS Coordinator (serves as a non-voting member).

Every two years, the members of the Regional EMS Medical Directors Committee shall:

A. Rotate serving as chair of the committee
B. Select the following members of the Advisory Committee:
C. Associate Hospital representative
D. Participating Hospital representative
E. Vehicle service providers which shall send representatives to the advisory committee
F. EMT/Prehospital RN
G. Nurse

IV. REFERENCES

Illinois EMS Act (210 ILCS 50/3.35)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Title: EMS Agency Roles and Responsibilities

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the expectations of EMS agencies serving in the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

Each agency that joins the East Central Illinois EMS System must do the following:

A. Appoint a representative of the agency to attend any scheduled coordinator meetings with the EMS System Coordinator.
B. Maintain all Prehospital Care Records on paper or electronically for a minimum of seven years.
C. Provide updated personnel rosters annually with IDPH inspection or self- inspection. Only EMS providers on the agency roster are permitted to provide patient care for that agency and only at the level of the agency licensure unless an In-Field Service Level Upgrade (see Section 515.833 of the IDPH Administrative Rules) has been approved for the agency.
    1. Rosters should include the following:
        a. provider name
        b. current license level
        c. license number
        d. expiration date
D. Maintain the proper equipment and supplies required by IDPH and the East Central Illinois EMS System.
E. Assist in monitoring quality indicators as established by the East Central Illinois EMS System office.
F. Use the EMS Risk Screen form to communicate all quality concerns to the East Central Illinois EMS System office.
G. Provide agency members with information presented at coordinator meetings and/or obtained from the East Central Illinois EMS System website. Agencies are expected to maintain records indicating transfer of information. These records must be provided on request to the East Central Illinois EMS System office for review.

H. Assure that all agency providers:
    1. Submit all CE records necessary for relicensure to the East Central Illinois EMS System office utilizing NinthBrain at least 30 days prior to date of license expiration.
    2. Complete all required forms for individual license application and renewal as mandated by IDPH.
    3. Be knowledgeable of all policies, procedures and protocols appropriate to licensure.
I. Notify the System in any instance when the agency lacks the appropriately licensed and System-certified personnel to provide 24-hour coverage. Transporting agencies must apply for an ambulance staffing waiver if the agency is aware a staffing shortage is interfering with the ability to provide such coverage.
J. Notify the System anytime an agency is not able to respond to an emergency call due to lack of staffing. The report should also include the name of the agency that was called for mutual aid and responded to the call.
K. Provide the EMS Office with updated copies of FCC Licenses and Mutual Aid Agreements upon expiration.
L. Notify the System of any changes in medical equipment or supplies.
M. Notify the System of any changes in vehicles. Vehicles must be inspected by the System and the appropriate paperwork must be completed prior to the vehicle being placed into service.
N. Notify the System if the agency's role changes in providing EMS.
O. Notify the System if the agency's response area changes.
P. Notify the System if changes occur in communication capacities or equipment.
Q. All agencies and agency personnel are to comply with all of the requirements outlined in HIPAA regulations with regard to protected health information.

IV. RESOURCES – None.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation **Page:** 1 of 2

Title: EMS Providers Joining the System – Initial Credentialing

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish a process for joining the East Central Illinois EMS System as an EMS Provider and to establish requirements for credentialing of new providers within our EMS System.

II. DEFINITION – None.

III. POLICY

System certification is a *privilege* granted by the EMS Medical Director in accordance with the rules and regulations of the Illinois Department of Public Health.

A. All applicants for credentialing in the East Central Illinois EMS System shall complete a system application. Providing false, inaccurate, or misleading information on the system application shall be grounds for immediate termination and/or suspension from the EMS System.

B. EMS providers requesting to function in the East Central Illinois EMS System must meet the system entry requirements.

To obtain BLS privileges, the EMS Provider must:

1. Be a member/employee of an East Central Illinois EMS System agency.
2. Have a valid Illinois EMS license.
3. Have current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.
4. Complete the System Entry Application.
5. Submit a letter of good standing from the provider's current/previous EMS system.

To obtain ILS, ALS, PHRN/PHPA/PHAPRN privileges, the EMS Provider must:

1. Be a member/employee of an East Central Illinois EMS System agency.
2. Have a valid Illinois EMS license.
3. Have current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.
4. Have current certifications in ACLS, PALS or PEPP, and ITLS or PHTLS (PHRN may substitute TNS or TNCC certification).
    a. ACLS and PALS must cover both didactic and psychomotor skills that meet or exceed American Heart Association guidelines.
5. Must complete the Handtevy Pre-Hospital Pediatric Provider Course within six (6) months of system entry.

6. Validation of skills competency by attending an East Central Illinois EMS System Annual Skills Review within three (3) months of system entry.
7. Successful completion of a written protocol exam prior to system entry with a score of 80% or higher.
    a. No more than three (3) attempts, with at least 24 hours between each attempt.
    b. Third attempt failures are handled on a case-by-case basis. A conference will be convened with the EMS Medical Director/designee and the EMS Provider to establish a corrective action plan.
8. Complete the System Entry Application.
9. Submit a letter of good standing from the provider's current/previous EMS System.
10. Meet with the EMS Medical Director for final approval.

To obtain Critical Care (Tier II and III) privileges:

1. See *Critical Care Credentialing* Policy

C. The EMS Medical Director and EMS System Coordinator will review this information prior to giving permission for the provider to function within the system. The provider and the EMS agency director/coordinator will receive confirmation from the East Central Illinois EMS System office once the process is complete and he/she has been approved to participate in patient care.

D. The System Entry Application will be kept on file in the ECIEMS office.

E. Those providers that hold an unencumbered National Registry of Emergency Medical Technicians (NREMT) certification and are seeking IDPH reciprocity must still abide by the entirety of this policy prior to being granted credentials in the East Central Illinois EMS Office.

F. The EMS Medical Director reserves the right to deny System provider status or to place internship & field, skill evaluation requirements on any candidate requesting System certification at any level.

IV. RESOURCES

- System Entry Application
- Critical Care Credentialing Policy

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Page: 1 of 2

Title: Maintenance of Credentials

Original Policy Date: 10/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish mandatory certification requirements for all participants of the East Central Illinois EMS System as an EMS Provider.

II. DEFINITION – None.

III. POLICY

A. All providers must maintain current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines. Providers may NOT function without current CPR certification.

B. EMS providers must meet the following requirements in order to be active within the East Central Illinois EMS System:

To maintain BLS privileges, the EMS Provider must:

1. Be a member/employee of an East Central Illinois EMS System agency.
2. Have a valid Illinois EMS license.
3. Have current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

To maintain ILS, ALS, PHRN/PHPA/PHAPRN privileges, the EMS Provider must:

1. Be a member/employee of an East Central Illinois EMS System agency.
2. Have a valid Illinois EMS license.
3. Have current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.
4. Have current certifications in ACLS, PALS or PEPP, and ITLS or PHTLS (PHRN may substitute TNS or TNCC certification).
    a. ACLS and PALS must cover both didactic and psychomotor skills that meet or exceed American Heart Association guidelines
    b. Providers may NOT function at the Advanced level without current certifications but may continue to function at a Basic level.
5. Attend an ECIEMS annual Skills Review session.
    a. Advanced EMS providers who do not complete a Skills Review by December 31 each year may NOT function at the Advanced level but may continue to function at a Basic level until a Skills Review is completed.

6. Successful completion of an annual written protocol exam with a score of 80% or higher.
    a. No more than three (3) attempts, with at least 24 hours between each attempt.
    b. Third attempt failures are handled on a case-by-case basis. A conference will be convened with the EMS Medical Director/designee and the EMS Provider to establish a corrective action plan.
7. An extension may be requested from the EMS Office for extenuating circumstances such as significant illness or injury, military deployment, etc. that would not permit course participation. Request for extension does NOT guarantee approval.

To maintain Critical Care (Tier II and III) privileges:

1. See *Critical Care Credentialing* Policy

C. The EMS Medical Director reserves the right to deny System provider status or to place internship & field, skill evaluation requirements on any candidate requesting System certification at any level.

IV. RESOURCES

- Critical Care Credentialing Policy

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation **Page:** 1 of 2

Title: Critical Care Credentialing (Tier II & Tier III)

Original Policy Date:	01/2022
Current Effective Date:	01/2024
Last Review Date:	01/2024
Next Required Review Date:	01/2025

I. PURPOSE

To provide credentialing and continuing education requirements for critical care providers in the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

State requirements as outlined in the IDPH Rules and Regulations, 77 Ill Administrative Code Section 515.860 - Critical Care Transport.

1. Initial Advanced Formal Education:
    a. At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education based on nationally recognized program models; and
    b. Demonstrated competencies, as documented by the ECIEMS Medical Director.
2. CE Requirements:
    a. The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;
    b. The following current credentials, as a minimum, shall be maintained: ACLS, PALS or PEPP, ITLS or PHTLS
        i. AC:LS and PALS must cover both didactic and psychomotor skills that meet or exceed American Heart Association guidelines
    c. A minimum of 40 hours of critical care level education shall be completed every four years;
        i. Critical Care agencies within the ECIEMS System shall submit educational plans to the system for approval that will satisfy this requirement utilizing accredited critical care continuing education.
    d. The EMS provider shall maintain documentation of compliance with subsections (f)(2)(B)(i) through (iii) and shall provide documentation to the EMS Resource Hospital upon request; and
    e. Nationally recognized critical care certifications shall be maintained and renewed based on national recertification criteria.
3. Experience:
    a. Minimum of two years of experience functioning in the field at an ALS level for Paramedics and PHRN's/PHPA's/PHAPRN's.

In addition to the state requirements, the East Central Illinois EMS System requires critical care providers to:

1. Satisfy all requirements as outlined in the *EMS Providers Joining the System-Initial Credentialing* and *Maintenance of Credentials* Policies unless otherwise stated in this policy.

2. Maintain the following additional certifications/credentials:
    a. Neonatal Resuscitation Program (NRP)
    b. Advanced Medical Life Support (AMLS)
    c. Pediatric Fundamental Critical Care Support (PFCCS). Must obtain within 12 months of system entry.
    d. Certified Critical Care Paramedic (CCP-C) or Certified Flight Paramedic (FP-C) by the International Board of Specialty Certification (IBSC) and the Board for Critical Care Transport Paramedic Certification (BCCTPC). Must obtain within 12 months of system entry.
        i. PHRN's working as Critical Care Providers in the ECIEMS System shall maintain certification as either a Critical Care Registered Nurse (CCRN), Certified Registered Flight Nurse (CFRN) or Certified Transport Registered Nurse (CTRN).

3. Complete the following skills verification:
    a. A minimum of <u>six</u> adult intubations and <u>six</u> pediatric intubations per calendar year, with a minimum of <u>three</u> intubations per quarter. Must have <u>three</u> adult and <u>three</u> pediatric intubations per six month period.
        i. At the discretion of the medical director, crew may count two simulated intubations per year, but not in consecutive quarters. Simulated intubations must be observed by the medical director.
    b. Attend an ECIEMS annual Skills Review session.
        i. Must pass psychomotor skills verification prior to entry and credentialing as a Critical Care Provider.
        ii. Critical Care Providers who do not complete a Skills Review by December 31 each year may NOT function at the Critical Care level until a Skills Review is completed.
    c. Successful completion of an annual written protocol exam with a score of 80% or higher.
        i. Must pass the written exam prior to entry and credentialing as a Critical Care Provider.
        ii. No more than two (2) attempts, with at least 24 hours between each attempt.
        iii. Failed attempts will meet with the EMS Medical Director/designee to establish a corrective action plan.

All East Central Illinois EMS Critical Care Providers shall comply with the system minimum continuing education standards in accordance with the IDPH requirements.

IV. RESOURCES

- IDPH Rules and Regulations, 77 Ill Administrative Code Section 515.860 - Critical Care Transport
- EMS Providers Joining the System – Initial Credentialing Policy

- Maintenance of Credentials Policy

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Page: 1 of 1

Title: Personnel Records

Original Policy Date: 10/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish that individual participants of the East Central Illinois EMS System are responsible to maintain and update individual continuing education records.

II. DEFINITION – None.

POLICY

A. It is the sole responsibility of the individual EMR, EMD, EMT, AEMT/EMT-I, Paramedic, PHRN/PHPA/PHAPRN and ECRN to:
    1. Maintain and update their continuing education records in Ninth Brain.
    2. Keep current in all required credentials and maintain these records in Ninth Brain.
    3. Advise the EMS Department and IDPH, in writing, regarding any change in demographic information.
B. All initial education records will be kept by the EMS System for seven years.
C. All continuing education records submitted to the EMS System will be kept for seven years.
    1. All continuing education records should be submitted via the Ninth Brain platform.

RESOURCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Page: 1 of 2

Title: Minimum Staffing Requirements

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 08/2023
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to ensure that appropriate staffing levels are maintained by all East Central Illinois EMS System agencies.

II. DEFINITION - None

III. POLICY

Ambulance Staffing

A. All East Central Illinois EMS System **ambulances** shall provide staffing at the following levels unless an Alternate Rural Staffing waiver* has been approved:

1. Each Basic Life Support ambulance shall be staffed by a minimum of one System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN ,PHPA, PHAPN or physician on all responses.
2. Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one System authorized A-EMT, EMT-I, Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses.
3. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one System authorized Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses.

Ambulance Assist Vehicles

B. **Ambulance assistance vehicles** are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. Ambulance assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by the licensure level.

C. All East Central Illinois EMS System **ambulance assistance vehicles** shall provide staffing at the following levels:

1. First Responder assistance vehicles shall be staffed with a minimum of one EMR, EMT, EMT-I, A-EMT, Paramedic, PHRN/PHPA/PHAPRN or physician and shall have all the required equipment.
2. Basic ambulance assistance vehicles shall be staffed with a minimum of one EMT, EMT-I, A-EMT, Paramedic, PHRN/PHPA/PHAPRN or physician and shall have all the required equipment.
3. Intermediate ambulance assistance vehicles shall be staffed with a minimum of one EMT-I, A-EMT, Paramedic, PHRN/PHPA/PHAPRN or physician and shall have all the required equipment.
4. Advanced ambulance assistance vehicles shall be staffed with a minimum of one Paramedic, PHRN/PHPA/PHAPRN or physician and shall have all the required equipment.

D. An EMS provider licensed at a level higher than that of the EMS agency may only perform at the level of the agency licensure unless an In-Field Service Level Upgrade has been approved for the agency (see Section 515.827 and Section 515.833 of the IDPH Administrative Rules).

Alternate Rural Staffing Authorization

A. The EMS MD may approve an alternate rural staffing waiver for:
   a. A Vehicle Service Provider that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers, paid-on-call personnel or a combination to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMS Personnel licensed at or above the level at which the vehicle is licensed, plus one EMR when two licensed EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs, PHPAs, PHAPNs or physicians are not available to respond. (Section 3.85(b)(3) of the Act)

B. Alternate rural staffing models may only be used for 911 responses.

C. The East Central Illinois EMS System has no alternative staffing models for private ambulance providers for interfacility transfers.

IV. RESOURCES

IDPH Administrative Rules Section 515.827
IDPH Administrative Rules Section 515.830
IDPH Administrative Rules Section 515.833

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: System Participation

Page: 1 of 2

Title: In-Field Service Level Upgrade

Original Policy Date: 02/2016
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for an In-Field Service Level Upgrade.

II. DEFINITION – None.

III. POLICY

A. In order for an In-Field Service Level Upgrade to be considered by the East Central Illinois EMS System office, the requesting agency must complete and submit an In Field Service Level Upgrade Application to the EMS System Coordinator addressing the requirements listed in the IDPH Administrative Rules, Section 515.827 Ambulance Assistance Vehicle Provider Upgrades or Section 515.833 In-Field Service Level Upgrade – Rural Population.

B. Any appropriately licensed individual requesting to provide advanced level care (ILS or ALS) must properly test into the East Central Illinois EMS System per policy (refer to "EMS Providers Joining the System"). The test in process will include, but not be limited to, the following:

1. Passing East Central Illinois EMS Protocol Examination with an 80% or higher
2. Successful completion of an Advanced Skills review
3. Meet with the EMS Medical Director

C. All EMS personnel serve at the discretion of the EMS Medical Director. The EMS Medical Director has the authority to initially decline, or revoke the ability to function under their license per the IDPH EMS Act. The EMS Medical Director also retains the right to revoke an agency's In-Field Service Level Upgrade status if indicated.

D. Upon approval of In-Field Service Level Upgrade by the EMS Medical Director, an IDPH EMS System Modification form will be completed and submitted to IDPH for approval. An inspection of the vehicle and/or equipment will also be completed to finalize the process.

E. The agency shall notify the EMS office within 24 hours in the event that they are unable to fulfill the personnel requirement of an already approved in-field service level upgrade. In the event that the advanced providers do not maintain current credentials within the East Central Illinois EMS System, the in-field service level upgrade shall be immediately suspended. In addition, any and all medications outside of the primary level of the agency shall be disposed of or stored in a manner deemed acceptable by the Medical Director.

Equipment

A. All equipment required to function at the advanced upgraded level shall be secured in a locked cabinet only accessible by those approved by the EMS system to function at the level of the upgrade.

B. In the event that an agency holds more than one level of in field upgrade, all equipment shall be separated based on the level of upgrade in a manner acceptable by the Medical Director. (i.e. BLS equipment for BLS providers, ILS equipment for ILS providers and ALS equipment for ALS providers)

C. In-field service level upgrade units will follow the same medication/equipment levels and replenishment procedures as vehicles permanently licensed at that level.

D. Requests for waiver of specific equipment will be considered by the EMS System and IDPH on a case by case basis.

Quality Assurance

A. The provider agency will submit run reports for all In-Field Service Level Upgrade responses to the East Central Illinois EMS System office for review for a minimum of 6 months. Reports may be submitted on a monthly basis. Reports will be reviewed for adherence to the protocols for the upgraded level.

IV. RESOURCES

In Field Service Level Upgrade Application
https://www.ilga.gov/commission/jcar/admincode/077/077005150F08270R.html
https://www.ilga.gov/commission/jcar/admincode/077/077005150F08330R.html

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Page: 1 of 3

Title: Substance Abuse by EMS Provider

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

OSF HealthCare and East Central Illinois EMS are committed to providing an environment free of the negative effects of substance abuse. Substance abuse is strictly prohibited while on duty and while at OSF.

II. DEFINITION – None.

Prohibited Substances - Prescription drugs used inconsistent to the EMS provider/student's legitimate prescription, unauthorized controlled substances or prescription drugs, illegal drugs, marijuana, alcohol, or otherwise lawful substances abused by an EMS provider/student because of the substance's intoxicating effects.

1. **Prohibited Substances** do not include substances which are prescribed to an EMS provider/student and intended to be delivered and administered to the EMS provider/student as a patient under the care of a physician or by an authorized healthcare provider. However, the possession and/or use of such substances must be consistent with the prescription provided to the EMS provider, must comply with OSF's Drug Free Workplace (246) policy, and the EMS provider/student must not be impaired while on duty or on OSF property.

Otherwise lawful substances abused by an EMS provider because of the substance's intoxicating effects include, but are not limited to, lawful substances such as over-the-counter medications, paints, thinners, solvents, etc. that may cause impairment while on duty.

Substance Abuse - The use, possession, or distribution of **Prohibited Substances**.

III. POLICY

A. East Central Illinois EMS System recognizes that safety and productivity is compromised by substance abuse which increases the potential for accidents, substandard performance, and damage to the reputation of OSF HealthCare.

B. Any EMS provider in the East Central Illinois EMS System is prohibited from: a) reporting to duty under the influence of Prohibited Substances, b) distributing Prohibited Substances while on duty, or c) possessing Prohibited Substances while on duty.

C. Any EMS provider who has reason to believe or suspects that use of a substance (prescription or non-prescription) may present a safety risk or may otherwise impair an EMS provider's

conduct and/or performance, must immediately report such substance use to the EMS Medical Director or his/her designee.

D. Any EMS provider suspected of utilizing substances that would jeopardize the safety of themselves, patients, co-workers and/or bystanders, will be deemed “unfit for work” and relieved of duty until the concern is investigated and subject to required drug and/or alcohol testing.

E. Any EMS provider who violates this Substance Abuse policy, except those who self-identify and request assistance as explained below, will be removed from the EMS system. This may be done after only one occurrence and may result in suspension from the EMS system at the discretion of the EMS Medical Director.
    1. Re-credentialing into the EMS system is discretionary and may only be done after the EMS provider has successfully received appropriate treatment, as determined by the EMS Medical Director.

EMS Provider Responsibility

A. East Central Illinois EMS System does not require EMS providers to submit to blood and/or urine testing for Prohibited Substances as a routine part of initial system certification. However, individual EMS agencies may require testing as part of their employment application process.

B. It is the responsibility of the EMS provider to seek help before substance abuse leads to job impairment, poor performance or unsafe behavior while on duty.

Testing Protocol

A. Any EMS provider who violates this policy, or if there is reasonable cause to suspect an EMS provider is under the influence of Prohibited Substances while on duty, will be required to submit to drug and/or alcohol testing.

B. The EMS Medical Director will determine the appropriate screening as part of an investigation.
    1. The cost of this testing will be the EMS provider/student’s responsibility. Disputes related to billing of drug testing should not delay the procedure(s).

C. An EMS provider who refuses to cooperate with required drug and/or alcohol testing, or is caught tampering with or attempting to tamper with his/her test specimen (or the specimen of any other prehospital provider), will be subject to disciplinary action, which may include permanent suspension from the EMS system.

D. If any of the test results are positive (including THC/marijuana metabolites), the EMS Medical Director will interview the EMS provider. The EMS Medical Director will consult with the EMS provider’s agency to determine if referral to an assistance program will occur.

Assistance and Disciplinary Process for Substance Abuse

OSF considers substance abuse and addiction to be a serious health problem warranting appropriate evaluation and treatment. As such, OSF EMS Systems are prepared to assist any EMS provider who has developed dependency on drugs and/or alcohol. The East Central Illinois EMS System, and ultimately our patients, suffer adverse effects of an impaired provider struggling with substance abuse

and addiction. As such, any EMS provider participating in an OSF EMS System who voluntarily requests assistance for issues related to substance abuse or addiction may contact their agency or the EMS Office for further resources and guidance.

A. Any EMS provider who self-identifies prior to being tested or seeks help for substance abuse will be provided resources and guidance on an appropriate assistance program. In this instance, the EMS provider will be suspended from the EMS system while they seek treatment. The EMS provider will be reinstated to the EMS system after successfully receiving appropriate treatment, as determined by the EMS Medical Director.

B. Any EMS provider who violates this policy and/or whose test results are positive will be removed from the EMS system. The EMS Office will assist in providing resources and guidance on an appropriate treatment program. Re-entry into the EMS system is at the discretion of the EMS Medical Director and may only be done after the EMS provider has successfully received appropriate treatment, as determined by the EMS Medical Director.
    1. If the EMS provider refuses to seek treatment, they will be removed from the EMS system.

C. Any EMS provider returning to the EMS system following treatment for substance abuse may be subject to periodic and unannounced drug and/or alcohol testing on a schedule and for a duration established by the EMS Medical Director.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: System Participation

Title: System Corrective Action and Suspension

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide the East Central Illinois EMS System Medical Director and the East Central Illinois EMS System with a consistent means to assure a high standard of prehospital care through the ability to discipline and/or suspend EMS providers and/or EMS agencies who fail to follow the System policies, protocols and procedures while keeping in mind the philosophy of a “Just Culture”.

II. DEFINITION - None

III. POLICY

A. The East Central Illinois EMS System Medical Director may discipline and/or suspend from the East Central Illinois EMS System any EMS provider or EMS agency who fails to meet the standards of the East Central Illinois EMS System, the Illinois EMS Act, and/or the Illinois Department of Public Health (IDPH) EMS Rules and Regulations. Suspensions are handled in accordance with the Illinois EMS Act and IDPH EMS Rules and Regulations.

B. The EMS Medical Director and/or EMS System Coordinator become aware of the potential need for corrective action through verbal or written reports of deviation from policy or protocol, EMS Risk Screens, and/or quality review of patient care reports.

C. A Risk Screen Review Form is used in order to provide a fair and systematic approach and to document the risk level of the issue/ behavior and any corrective action needed. Categories of risk/types of behaviors are as follows:
   a. Normal (Human) Error
   b. At-Risk Behavior
   c. Reckless Behavior

D. The EMS Medical Director (or designee) may meet with the EMS provider, depending on the severity, to discuss the details of the reported misconduct, the means of correction and the consequences if the misconduct is not corrected. In situations where an EMS agency is to receive corrective action, the EMS Medical Director (or designee) meets with the EMS agency coordinator to discuss the details of the reported misconduct, the means of correction and the consequences if the misconduct is not corrected.

E. If the EMS Medical Director (or designee) meets with the EMS provider and/or EMS agency, the EMS provider or EMS agency coordinator shall sign the Risk Screen Review Form. Documentation of the meeting is kept on file in the EMS System office.

F. The East Central Illinois EMS System Medical Director (or designee) has ultimate authority for disciplinary action within the EMS System.

Suspensions:

A. The East Central Illinois EMS System Medical Director may suspend from participation in East Central Illinois EMS System an EMS provider and/or EMS agency who fail to meet the requirements and/or standards of the EMS System Plan. Suspension may be based on one or more of the following:
    1. Failure to meet the education and training requirements prescribed by the Illinois Department of Public Health and the East Central Illinois EMS System.
    2. Violation of the EMS Systems Act and/or IDPH EMS Rules and Regulations.
    3. Failure to maintain proficiency in the licensed level of care.
    4. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the delivery, performance or activities in the care of patients requiring medical care.
    5. Intentional falsification of any medical reports or orders, or making misrepresentations involving patient care.
    6. Abandoning or neglecting a patient requiring care.
    7. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, health care facility, institution or other work place location.
    8. Performing or attempting emergency care, techniques or procedures without proper permission, training or supervision.
    9. Discriminating in rendering emergency care because of race, sex, creed religion, national origin or ability to pay.
    10. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.
    11. Violation of the EMS Standards of Care.
    12. Physical impairment to the extent that the provider cannot physically perform the emergency care and life support functions for which he/she is licensed.
    13. Mental impairment to the extent that the provider cannot exercise the appropriate judgment, skill, and safety required for performing emergency care and life support functions.
    14. Conviction of a felony.
    15. Engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public.

B. East Central Illinois EMS System Participation Suspensions shall fully comply with the Illinois EMS Systems Act [210 ILSC 50] pursuant to Section 515.420 of the Administrative Code [77 Ill Adm. Code 515], as outlined below**:**
    1. An EMS Medical Director may suspend from participation within the System any EMS Personnel, EMS Lead Instructor (LI), individual, individual provider or other participant considered not to be meeting the requirements of the Program Plan of that approved EMS System. (Section 3.40(a) of the Act)

2. Except as allowed in subsection (l), the EMS Medical Director shall provide the individual, individual provider or other participant with a written explanation of the reason for the suspension; the terms, length and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.
3. Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.
4. The EMS System shall designate the local System review board, for the purpose of providing a hearing to any individual or entity participating within the System who is suspended from participation by the EMS Medical Director. (Section 3.40(e) of the Act) The review board will consist of at least three members, one of whom is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. The EMS Medical Director shall prepare and post, in a 24-hour accessible location at the Resource Hospital, the System Review Board List.
5. The hearing shall commence as soon as possible, but at least within 21 days after receipt of a written request. The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing and the local System review board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the local System review board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the Act and this Part. (Section 3.40(e) of the Act)
6. The local System review board shall state in writing its decision to affirm, modify or reverse the suspension order. That decision shall be sent via certified mail or personal service to the EMS Medical Director and the individual, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing.
7. The EMS Medical Director shall notify the Department, in writing, within five business days after the Board's decision to either uphold, modify or reverse the EMS Medical Director's suspension of an individual, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.
8. If the local System review board affirms or modifies the EMS Medical Director's suspension order, the individual, individual provider or other participant shall have the opportunity for a review of the local board's decision of the State EMS Disciplinary Review Board. (Section 3.40(b)(1) of the Act)
9. If the local System review board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for review of the local board's decision by the State EMS Disciplinary Review Board. (Section 3.40(b)(2) of the Act)

10. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the local board's decision or the EMS MD's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed. (Section 3.45(h) of the Act)
11. An EMS Medical Director may immediately suspend an EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, PHRN/PHPA/PHAPRN, LI, or other individual or entity if he or she finds that the continuation in practice by the individual or entity would constitute an imminent danger to the public. The suspended individual or entity shall be issued an immediate verbal notification, followed by a written suspension order by the EMS Medical Director that states the length, terms and basis for the suspension. (Section 3.40(c) of the Act)
    a. Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger, telefax, or other Department-approved electronic communication, a copy of the suspension order and copies of any written materials that relate to the EMS Medical Director's decision to suspend the individual or entity.
    b. Within 24 hours following the commencement of the suspension, the suspended individual or entity may deliver to the Department, by messenger, telefax, or other Department-approved electronic communication, a written response to the suspension order and copies of any written materials that the individual or entity feels are appropriate.
    c. Within 24 hours following receipt of the EMS Medical Director's suspension order or the individual's or entity's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending an opportunity for a hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended individual or entity. The suspension shall remain in effect during this period of review by the Director or the Director's designee. (Section 3.40(c) of the Act)

C. If it is known that the EMS provider has dual participation with another EMS System, ECIEMS shall notify the other EMS System(s) of the EMS providers suspension.

IV. RESOURCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: System Participation

Page: 1 of 3

Title: System Review Board

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide a means within East Central Illinois EMS System to review disputed suspensions.

II. DEFINITION - None

III. POLICY

A. As pursuant to the Illinois EMS Act and Section 515.420 – System Participation Suspensions of the Administrative Code [77 Ill Adm. Code 515]: The Resource Hospital shall designate the local System review board, for the purpose of providing a hearing to any individual or entity participating within the System who is suspended from participation by the EMS MD. (Section 3.40(e) of the Act) The review board will consist of at least three members, one of whom is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. The EMS MD shall prepare and post, in a 24-hour accessible location at the Resource Hospital, the System Review Board List.

B. The Resource Hospital, through the East Central Illinois EMS System Office, designates the members of the System Review Board (See attached).

East Central Illinois EMS System Review Board

Standing Review Board Members

Brandon Bleess, MD (Standing)

Andrew Jones, Paramedic (Standing)

Todd Jones, Paramedic

Ethan Leynes, Paramedic

Mark Ames, EMT-Basic

Misti Trost, EMT-Basic

Lauren Fulton, PHRN

Staci Sutton, ECRN

IV. RESOURCES - None

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office

Section: System Participation

Title: State EMS Disciplinary Review Board

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the process for review by the State EMS Disciplinary Review Board, any suspension of an EMS agency and/or provider in the East Central Illinois EMS System.

II. DEFINITION - None

III. POLICY

A. Any EMS provider and/or agency in the East Central Illinois EMS System who has been suspended by the EMS Medical Director may have his or her case reviewed by the State EMS Disciplinary Review Board. The request for review is submitted in writing to the Chief of IDPH Division of EMS and Highway Safety, within 10 working days after receiving the System Review Board's decision or the East Central Illinois EMS System Medical Director's immediate suspension, (whichever is applicable).
(See the policy entitled System Corrective Action and Suspension)

B. The Governor appoints the State Emergency Medical Review Board (Board). The Board meets regularly on the first Tuesday of every month, unless no requests for review have been submitted. Additional meetings of the Board are scheduled as necessary to ensure that a request for direct review of an immediate suspension order is scheduled within 14 days after IDPH receives the request or as soon thereafter as a quorum are available. The Board meets in Chicago or Springfield, whichever location is closer to the majority of the members or alternates attending the meeting.

C. At its regularly scheduled meetings, the Board reviews requests, which have been received by IDPH at least 10 working days prior to the Board's meeting date. Requests for review received less than 10 working days prior to the scheduled meeting are considered at the Board's next scheduled meeting. Exceptions are requests for direct review of immediate suspension orders, which may be scheduled up to three working days prior to the Board's meeting date.

D. A quorum is required for the Board to meet. A quorum consists of three members or alternates, including the East Central Illinois EMS System Medical Director member, or alternate, and the member or alternate from the same professional category as the subject of the suspension order. At each meeting of the Board, the attending members or alternates select a chairperson to conduct the meeting.

E. Meetings of the Board are conducted in closed session. Department staff may attend for the purpose of providing clerical assistance. No other persons may be in attendance except for the parties to the dispute being reviewed by the Board and their attorneys, unless by request of the Board.

F. The Board reviews the transcript, evidence and written decision of the System Review Board or the written decision and supporting documentation of the East Central Illinois EMS System Medical Director, whichever is applicable. Additional written or verbal testimony or argument offered by the parties to the dispute is considered.

G. At the conclusion of its review, the Board issues its decision and the basis for its decision on a form provided by IDPH. The Board submits to IDPH this form with its written decision along with the record of the System Review Board. IDPH promptly issues a copy of the Board's decision to all affected parties. The Board's decision is binding on all parties.

H. All information relating to the State Emergency Medical Services Disciplinary Review Board or the System Review Board, except for final decisions, is afforded the same status as information provided concerning medical studies. Disclosure of such information to IDPH pursuant to the Act is not considered a violation of the law.

IV. RESOURCES

Illinois EMS Act (210 ILCS 50/3.35)

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: System Participation

Title: Waiver Requests

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the process to request a waiver for staffing or equipment in the event of hardship.

II. DEFINITION - None

III. POLICY

A. If compliance with any of the Illinois Department of Public Health (IDPH) Administrative Rules or the East Central Illinois EMS System policies would result in unreasonable hardship, a provider agency may submit a request to the East Central Illinois EMS System office for a temporary waiver.

B. Any agency requesting a waiver must complete the appropriate waiver request form and return it to the East Central Illinois EMS System office.

C. The waiver request will be reviewed by the EMS Medical Director.

D. Upon approval by the EMS Medical Director, the waiver request will be forwarded to IDPH.

E. Waivers are granted only if there is no reduction in the standard of care.

IV. RESOURCES

IDPH Staffing Waiver Request
IDPH Equipment Waiver Request

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: Medical-Legal

Page: 1 of 3

Title: Abuse

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to identify victims of abuse and provide guidelines for prompt treatment and appropriate referral to support services, for potential victims of abuse, including adults, elder adults, and children.

II. DEFINITION

A. Categories of abuse**:**

1. **Physical Abuse/Neglect**: bodily harm which includes assault, sexual abuse, withholding of care, food and/or medicine.

2. **Psychological abuse:** provoking a fear of violence -- this includes name calling, verbal assaults, or violent behaviors such as hitting inanimate objects (i.e. hitting a wall, breaking windows/furniture, etc.)

III. POLICY

A. Child Abuse or Neglect

1. The alleged victim is a child under the age of 18.

2. All EMS personnel are required by Illinois law (Mandated Reporters) to report any suspicion of child abuse or neglect to the Department of Children and Family Services (DCFS) in accordance with the Abused and Neglected Child Reporting Act

3. Mandated reporters are required to call the Child Abuse Hotline when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. The Hotline worker will determine if the information given by the reporter meets the legal requirements to initiate an investigation. Only one report per ambulance crew needs to be filed.
    a. **DCFS Child Abuse Hotline: 1-800-25-ABUSE (1-800-252-2873)**

4. No assumption should be made that law enforcement or hospital personnel will file a report. In the event there is disagreement between mandatory reporters, the person suspecting the alleged abuse shall complete the necessary reporting requirements.

5. The law does not require certainty. It requires only that there be reasonable cause to believe that a child has been abused and/or neglected. Any person participating in good faith in the making of a report shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions.

B. Elder Abuse and Neglect
    1. All EMS personnel are required by Illinois law (Mandated Reporters) to report any suspicion of elder abuse and/or neglect in accordance with the Elder Abuse and Neglect Act.

    2. Identification of abuse, neglect, self-neglect, or interpersonal violence can occur at any time during the examination, history and physical exam or other assessments performed by members of the prehospital team. This identification can be made in any setting.

    3. If abuse or violence is suspected, it is important to safely isolate the patient (victim) from the alleged perpetrator. Safety of the EMS team must be a first priority.

    4. For those suspected of elder abuse, contact the **Department of Aging, Elder Abuse Hotline, telephone number: 1-800-252-8966** during business hours or **1- 800-279-0400 after 5:00 p.m. or on weekends** to make a report.

C. Long-Term Care Facility Residents Abuse and Neglect
    1. EMS personnel who have identified that a long-term care facility resident is a possible victim of abuse or neglect should report their suspicions to the receiving hospital ED personnel.
        a. **Elder Abuse Hotline for Nursing Home/Extended Care Facility Residents: 1-800-252-4343**

    2. Any mandated reporter having reasonable cause to suspect a resident of a long-term care facility has died as a result of abuse or neglect, shall also immediately notify the appropriate medical examiner or coroner.

D. Reporting of abuse:
   1. All EMS personnel are required under the Illinois EMS ACT to offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse in accordance with the Illinois Domestic Violence Act.
      a. **Illinois Domestic Violence Help Line: 1-877-863-6338**

   2. When evidence of physical injuries exists, law enforcement is notified by the EMS provider. The law enforcement agency notified should be from the residence city or county area in which the patient resides.

   3. For the competent adult patient, when there is evidence of psychological/emotional abuse without physical injuries, law enforcement officials are contacted at the patient's request.

   4. For minors and patients not competent to give consent, when there is evidence of psychological and/or emotional abuse without physical injury, Medical Control and law enforcement officials are notified.

E. All pertinent information will be documented in the prehospital care report.

F. All information obtained during treatment remains confidential.

IV. RESOURCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Title: Advanced Directives and DNR

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to assure consistent guidelines for EMS providers regarding DNR Orders/Illinois POLST Form, Durable Power of Attorney for Health Care, Surrogate Decision Maker and Living Wills

II. DEFINITION

A. **Durable Power of Attorney for Health Care**: a document that permits a person to delegate to another person the power to make any health care decision.

B. **Surrogate Decision Maker**: a person identified by the court to make decisions regarding the foregoing of life sustaining treatment on behalf of a patient who lacks decision making capacity and suffers from a qualifying condition. The surrogate expresses decisions directly to the patient's physician. There are no situations in which a surrogate can directly give instructions to an EMS provider.

C. **Living Wil**l: a witnessed written document voluntarily executed by a person with the proper formalities, instruction the person's physician to withhold or withdraw death delaying procedures in the event that the person is diagnosed as having a terminal condition.

D. **Biological Death**: the cessation of vital processes, resulting in irreversible brain damage, usually following 3-10 minutes of cardiac arrest.

E. **Illinois POLST Form (Practitioner Orders for Life Sustaining Treatment)**: Updated by IDPH to remove "DNR" from the title of the form and from around the form border; care options redefined; modified to align with national POLST standards used in other states. Since the POLST form allows patients to indicate whether they accept or refuse CPR, it is no longer possible to equate the mere existence of the form with a DNR choice.

III. POLICY

A. When EMS Personnel arrive and CPR is not in progress, personnel should initiate Cardiac Arrest Protocol unless:
    1. Death determination criteria are present.
    2. The patient has been pronounced dead by the coroner or the patient's physician.
    3. A valid DNR order/POLST Form is present.
        a. Any POLST form that is formally authorized by a state or territory within the United States such as MOST, POST, MOLST, as well as the National POLST form shall be recognized and honored.

B. A valid Illinois POLST Form should be honored unless compelling circumstances arise and an on-line medical control physician directs EMS personnel to resuscitate.

C. EMS personnel must make a reasonable attempt to verify the identity of the patient (i.e. identification by another person or identification bracelet as seen in long term care facilities) named in the valid DNR order.

D. If at any time it is unclear if this policy applies, begin BLS treatment and contact Medical Control for orders. If communication with Medical Control is impossible, begin treatment per SOPs and transport as soon as possible.

E. Components of a valid Illinois POLST Form:
    1. Patient name; DOB; gender; and address
    2. Section A: **Cardiopulmonary Resuscitation**: must have one of the boxes selected: *"Attempt Resuscitation/CPR"* or *"Do Not Attempt Resuscitation/DNR"*
    3. Section B: **Medical Interventions:** must have one of the boxes selected: *"Full Treatment", "Selective Treatment"* or *"Comfort-Focused Treatment"*
    4. Section C: **Medically Administered Nutrition**: Not-Applicable for EMS
    5. Section D: **Documentation of Discussion:** Signature of Patient or Legal Representative. Witness signature is no longer required to be valid.
    6. Section E: **Signature of Authorized Practitioner**: Name and signature of the authorized practitioner

F. Revocation of a written DNR order/Illinois POLST Form can be made only if:
    1. The order is physically destroyed or verbally rescinded by the physician who wrote the order.
    2. The order is physically destroyed or verbally rescinded by the person who gave written consent to the order.

G. In transporting a patient during a transfer to or from home with a valid DNR order and the patient arrests enroute, contact Medical Control and go to the closest available hospital and do not start resuscitation measures.

H. If transporting a patient during an interhospital transfer with a valid DNR order and the patient arrests enroute, contact Medical Control and go to the closest available hospital and do not start resuscitation measures.

I. In transporting a patient from a long-term care facility with a valid DNR order and the patient arrests enroute, contact Medical Control and continue transport to the hospital and do not start resuscitation measures.

J. If EMS Providers arrive at the scene and the family states that the patient is a hospice patient with a valid DNR order, do not initiate resuscitative measures and contact Medical Control for further orders.
K. On occasion, EMS Personnel may encounter an out-of-state patient with a valid DNR order visiting in the EMS System area. If the DNR order appears to be valid (signed by the patient and physician and has a current date), contact Medical Control for orders.
L. Any other advance directives such as a "Living Will" cannot be honored, followed, or respected by pre-hospital care providers. EMS personnel must contact Medical Control for direction regarding any other type of advanced directive. Full resuscitation should not be withheld during the process of contacting or discussing the situation with medical control.
M. A Durable Power of Attorney for Health Care (DPA) is written document allowing an individual to delegate his or her power to make health care decisions to an appointed agent in the event the individual becomes mentally disabled or incompetent.
    1. The written document must:
        a. Be signed and dated by the individual granting the power.
        b. Name an agent.
        c. Describe health care powers granted to the agent.

    2. A written document does NOT have to be seen; a verbal report from the agent will suffice.

    3. Pre-hospital providers can NOT honor a verbal or written DNR request or order made directly by a surrogate decision maker or any other person, other than the patient's primary care physician. If such a situation is encountered, institute CPR or BLS treatment as indicated by the patient's condition and contact Medical Control for direction.
N. If a patient is found in cardiopulmonary arrest and EMS providers are presented with a Living Will and/or a Durable Power of Attorney for Health Care Agent or Surrogate Decision Maker, CPR must be started and Medical Control contacted immediately for direction.
O. <u>EMS Providers will not be held responsible for determining the validity of a DNR order, Durable Power of Attorney, Surrogate Decision Maker, and/or Living Will.</u> A health care professional or healthcare provider is immune from criminal or civil liability, and cannot be found to have committed an act of unprofessional conduct if, in good faith, and pursuant to reasonable medical standards, death-delaying procedures were withheld or withdrawn.
    1. Subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65: "*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 POLST form, or a copy of that form or a previous version of the uniform form, is valid. 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 cardiopulmonary resuscitation (CPR) or life-sustaining treatment order, Department of Public Health Uniform POLST form, or a previous version of the uniform form 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 an act of unprofessional conduct."

P. Minors: Minors (unless emancipated) cannot execute advance directives. The parent or guardian "stands in place" at all times and can provide consent to written ILLINOIS POLST orders executed by a qualified practitioner. Unless there is a valid written ILLINOIS POLST Order, all minors should be resuscitated.
Q. All paperwork regarding Living Wills and Durable Power of Attorney for Health Care and/or Surrogate Decision Maker must be brought to the receiving facility with the patient.
R. A run report will be filled out on all patients who are not resuscitated in the pre-hospital setting. The reason that the patient was not resuscitated should be documented. DNR patients should also have documentation of why this was a valid DNR. If possible, attach a copy of the DNR order to the run report.
S. On a yearly basis the EMS system will report to IDPH indicating issues or problems which have been identified and the EMS system response.
T. This policy will be distributed to all EMS system agencies and made available to all EMS providers. All EMS providers are responsible for reviewing and implementing this policy.

IV. REFERENCES

Illinois POLST Form

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: Medical-Legal

Title: Assistance by Non-System Personnel

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to clearly delineate the roles of all personnel at the scene to provide the highest quality of patient care.

II. DEFINITION – None.

III. POLICY

A. Only personnel licensed to perform in the prehospital setting and who are members of the East Central Illinois EMS System are allowed to perform advanced patient care at the scene unless approved at the time of service by Medical Control. Advanced patient care includes but is not limited to IV placement, intubation, medication administration, and cardiac pacing.

B. EMS providers who are confronted by individuals wanting to render assistance at the scene of an emergency should use the following guidelines:

1. If assistance is needed, the Senior EMS provider and/or EMS Sector Officer contacts Medical Control to advise of the presence of providers from outside the East Central Illinois EMS System. The Senior EMS provider and/or EMS Sector Officer requests approval from Medical Control for these providers to assist with care appropriate to their licensure.

2. Non-system personnel function under the direction of the Senior EMS provider and/or the EMS Sector Officer at the scene.

3. The Senior EMS provider and/or EMS Sector Officer directs the medical activities and assigns the responsibilities of outside providers at the scene based upon their documented and/or reported level of training and experience.

4. Registered Nurses (RNs) may perform care in the prehospital setting based on the Nurse Practice Act. RNs may be of assistance under the direction of the Senior EMS provider and/or the EMS Sector Officer at the scene. RNs cannot routinely work on an ambulance unless they are licensed as a Prehospital Registered Nurse (PHRN).

5. The Senior EMS provider and/or EMS Sector Officer shall be responsible for keeping Medical Control informed of all treatment being rendered.

6. Medical personnel at the scene function at or below the level of the highest trained EMS provider unit responding to the scene.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Title: Confidentiality

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to ensure consistent instruction to East Central Illinois EMS System providers regarding confidentiality and release of written, verbal, radio and scene information concerning patient care, treatment and/or prognosis.

II. DEFINITION – None.

III. POLICY

A. The Health Information Portability and Accountability Act (HIPAA) privacy rule protects the rights of individuals from the disclosure of protected health information. Inappropriate sharing of confidential information is not tolerated in the East Central EMS System. EMS providers must understand that breech of confidentiality is a serious infraction with legal implications which may result in disciplinary action up to and including system suspension. Any concerns regarding the definitions of protected health information or the application of HIPAA are referred to the HIPPA privacy rule through the Health Information Officer of OSF HealthCare.

B. Reasonable steps should be taken to limit uses and disclosures of protected health information to the minimum amount required to accomplish the intended purpose. Exceptions to the minimum necessary rule include disclosures to a healthcare provider for treatment purposes, disclosures to individuals of their own protected health information; uses or disclosure under authorization; disclosures to the Department of Health and Human Services regarding compliance or enforcement; or uses and disclosures required by law.

C. Every patient has the right to expect both verbal and nonverbal communications and records pertaining to his/her care to be treated as confidential. Therefore, discussion of the patient's prognosis, diagnosis, history, treatment or any portion thereof should occur only in private.

D. EMS Providers may be asked to sign a confidentiality agreement.

1. Written Information
    a. Confidentiality regarding written patient care documentation is governed by the "Need to Know" concept.
    b. Only East Central Illinois EMS providers and hospital staff directly involved in a patient's care or the monitoring of the quality of care are allowed access to a patient's medical records and reports.
    c. Prehospital Patient Care records are kept in secure areas of Emergency Departments, EMS Agencies and the East Central Illinois EMS System Offices following written procedures.
    d. Request for release of all patient care related information, including requests from third party payers, should be directed to the Medical Records Department of the receiving hospital or the transporting agency.
    e. Requests by law enforcement, coroner, fire service or other agencies for patient care reports should be directed to the Medical Records Department of the receiving hospital or the transporting agency. In cases of Triple Zero or refusals, patient care reports may be provided by the EMS agency to the requesting agency. The request for documentation must be in the form of a subpoena or a release of information obtained from the patient or patient's family.

2. Verbal Information
    a. Confidential information should be discussed with other EMS providers only when it is necessary to do so in the provision of EMS care.
    b. EMS providers are not to discuss patients in public areas. Conversations regarding specific patient problems and/or care are inappropriate.
    c. Information regarding the care/hospitalization of a friend or relative cannot be acted upon or passed on unless that information came from an outside source or directly from the patient. An EMS provider who encounters information regarding a friend or relative while on duty as a representative of the East Central Illinois EMS System must keep that information confidential.

3. Radio/Telephone Communication
    a. No patient name will be mentioned in the process of prehospital radio transmissions using the MERCI frequency or MED channels.
    b. When necessary to refer to a patient, references such as, "we have a diabetic patient on North Seventh that we brought in last week" could be used. Patients may be identified by their initials.
    c. Inappropriate patient information regarding diagnosis or prognosis should not be discussed during radio/telephone transmissions.

4. Scene Security
    a. Every effort should be made to maintain the patient's auditory and visual privacy during the treatment at the scene and en route.
    b. EMS providers should limit bystanders at the scene of an emergency. Law enforcement may be called upon to assist in maintaining reasonable distance.

5. Media Communication
    a. Any release of information regarding the patient's illness/injury and/or condition must occur through the receiving facility.
    b. EMS providers may not release patient information to the news media.
    c. Any questions from the media are forwarded by EMS providers to the receiving facility.

E. Any deviation from this policy is grounds for disciplinary action which may include immediate suspension from the system.

F. EMS Providers should report to the EMS System Coordinator any breach or violation of confidentiality as soon as he/she becomes aware of it.

G. EMS Providers and Educators should remove any identifiable information about a patient in cases studies and reports used for educational purposes.

IV. RESOURCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal **Page:** 1 of 4

Title: Consent for Treatment / Transport

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 01/2025

II. PURPOSE

The purpose of this policy is to ensure proper consent for treatment and transport and to provide immediate emergency care as necessary based on the patient's condition.

III. DEFINITIONS

A. None

IV. POLICY

A. Rendering of emergency medical care requires competent consent of the patient/legal guardian regardless of the age of the patient. Every reasonable attempt to obtain consent for treatment must be made before transport. However, at no time should patient care be delayed or jeopardized by trying to obtain consent.
    1. In cases of an emergency and/or consent from a parent or legal guardian cannot be quickly obtained, the EMS provider in either situation must provide treatment and transport to the nearest emergency department.

B. Under Illinois law, a minor is a person who has not attained the age of 18 years.[1] In general, a minor cannot consent to medical treatment, and a parent, guardian, or person *in loco parentis* must consent to the treatment of a minor. However, there are several exceptions that permit a minor to consent for him or herself, and these exceptions depend upon either the minor's legal status or the medical condition or treatment received by the minor.

Exceptions Based on Minor's Legal Status

- **Emancipated minors may consent for their own treatment**: A minor between 16 and 18 years old who presents a court order declaring him or her emancipated[2] may lawfully consent to the performance of healthcare services.[3]
- **Pregnant or married minors may consent for their own treatment**: A pregnant or married minor of any age[4] may lawfully consent to the performance of healthcare services.[3]
- **Minors who are parents may consent for their own treatment**: A minor who is a parent may consent to his or her own health care treatment.[3] However, if the minor's status as a parent ends, then it appears that the minor no longer has authority to consent to his or her own treatment. This could occur if the minor's parental rights were terminated as part of

an adoption proceeding. Minors who are parents may consent to the performance of healthcare services for his or her child.[5]

Exceptions Based on Medical Treatment

- **Medical emergencies**: Emergency medical treatment may be provided to a minor without obtaining parental consent when, in the sole opinion of the provider, obtaining consent is not "reasonably feasible under the circumstances without adversely affecting the condition of the minor's health."[6]
- **Medical treatment/counseling for criminal sexual assault or abuse**: When a minor is a victim of sexual assault or abuse, a provider may furnish healthcare services or counseling related to the diagnosis or treatment of "any disease or injury arising from such offense" without obtaining the consent of the minor's parent or guardian.[7] A minor victim of sexual assault or abuse may consent to such counseling, diagnosis, or treatment.[7] A "provider" includes a hospital, physician, chiropractic physician, optometrist, advanced practice nurse, physician assistant, or other medical personnel.[7] A minor sexual assault survivor may consent to and be provided emergency hospital services, forensic services, and follow-up healthcare without the consent of a parent, guardian, custodian, surrogate, or agent.[8]
- **Sexually transmitted diseases & HIV**: A minor 12 years of age or older who may have come into contact with a sexually transmitted disease ("STD"), including HIV,[9] may consent to STD testing and to healthcare services and/or counseling related to the prevention, diagnosis, or treatment of a STD.[10] Minors 12 years of age[11] or older also have the right to anonymous HIV testing.[12]
- **Drug use or alcohol consumption**: A minor 12 years of age or older who may be determined to be an addict, an alcoholic, or an intoxicated person, or who may have a family member who abuses drugs or alcohol, may consent to healthcare services or counseling related to the prevention, diagnosis, or treatment of drug use or alcohol consumption by the minor or the effects on the minor of drug or alcohol abuse by a member of the minor's family.[13]
- **Outpatient mental health services**: A minor 12 years of age or older may request and receive outpatient counseling or psychotherapy without consent of a parent, guardian, or person in loco parentis.[15]
- **Voluntary inpatient mental health services**: A minor 16 years of age or older may consent to admission to a mental health facility for inpatient services if the minor executes the application for voluntary admission.[16] Unlike outpatient services, providers must immediately inform the minor's parent, guardian, or person in loco parentis of the admission, even if the minor does not consent to the disclosure.[16]
- **Involuntary inpatient mental health services**: A minor may be admitted to a mental health facility upon application by a parent, guardian, or person in loco parentis if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment.[17] A minor 12 years of age or older must be given a copy of the application and his right to object to the admission shall be explained to him in an understandable manner.[18] When the minor objects to his or her admission, the minor must be discharged at the earliest appropriate time, not to exceed 15 days, excluding Saturdays, Sundays and holidays, unless the objection is withdrawn in writing or unless, within that time, a petition for review of the admission is filed with the court.[19]

C. If a minor's condition does not require immediate emergency treatment, and the parents/legal guardians do not consent, EMS providers should advise the parents/legal guardians of the risks involved. A signed release from responsibility must be obtained following the Refusal of Care policy. EMS providers should also notify the proper law enforcement agency or child welfare agency as needed.

D. If the legal guardian refuses to consent to treatment of a minor, and the EMS provider believes that treatment is in the best interest of the child, Medical Control and law enforcement must be contacted. The child may be placed in protective custody by law enforcement.

E. Adults may be legally declared incompetent. In these circumstances, consent must be obtained from their court-appointed legal guardian. Emergency treatment may be provided prior to receiving consent for any condition which poses a threat to life or limb or poses a risk of permanent physical or mental impairment under the doctrine of implied consent.

F. In any circumstance where questions exist regarding consent for treatment, EMS providers should contact Medical Control for direction. These incidents must be reported to the EMS Office via an EMS Risk Screen within 48 hours.

V. REFERENCES

[1] Probate Act of 1975, 755 ILCS 5/11-1.
[2] Emancipation of Minors Act, 750 ILCS 30/1 et seq. The minor claiming to be emancipated must present the court order before non-emergency services are provided, both to verify the minor's status and to ascertain whether there are restrictions on the emancipation, which might limit the minor's ability to consent to medical care.
[3] 410 ILCS 210/1.
[4] Consent by Minors to Medical Procedures Act, 410 ILCS 210/1 et seq.
[5] 410 ILCS 210/2.
[6] 410 ILCS 210/3(a).
[7] 410 ILCS 210/3(b).
[8] Sexual Assault Survivors Emergency Treatment Act, 410 ILCS 70/5(a)-(b); see 410 ILCS 70/1a for definitions of "sexual assault survivor", "forensic services", and "follow-up healthcare".
[9] 77 Ill. Admin. Code 697.20 defines Sexually Transmissible Infection to include HIV.
[10] 410 ILCS 210/4–210/5; 410 ILCS 305/9; 77 Ill. Admin. Code 697.420; 77 Ill Admin. Code 697.140(a)(10).
[11] 77 Ill. Admin. Code 697.120(a) ("No person may order an HIV test without first … receiving the documented informed consent of the subject of the test or the subject's legally authorized representative, except as provided in subsection (b)."). "Legally authorized representative" means an individual who is authorized to consent to HIV testing and/or disclosure of HIV test results and HIV-related information for an individual who is under the age of 12. 77 Ill. Admin. Code 697.20.
[12] 410 ILCS 305/6; 77 Ill. Admin. Code 697.130.
[13] 410 ILCS 210/4.
[14] 410 ILCS 210/4–210/5.
[15] The term "in loco parentis" might include an aunt or uncle or some other adult who does not have legal guardianship but who otherwise stands in the shoes of a parent.

[16] 405 ILCS 5/3-502.
[17] 405 ILCS 5/3-503.
[18] 405 ILCS 5/3-505.
[19] 405 ILCS 5/3-507.

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 3

Title: Crime Scenes

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to ensure proper reporting of suspected crimes, and to establish guidelines for proper management of a crime scene by EMS Personnel.

II. DEFINITION – None.

III. POLICY

A. EMS providers may arrive at the scene of a violent crime before law enforcement. To avoid destroying evidence, EMS providers must understand how law enforcement agencies preserve, collect, and use evidence at a crime scene. Anything at the scene may serve as evidence to law enforcement.

B. Immediately upon identifying a suspected crime scene, EMS providers should take the following steps:

1. Immediately notify law enforcement or call dispatch to do so. Document on the prehospital care report the time law enforcement was notified.

2. If the victim is obviously dead, the body should remain undisturbed. In some circumstances, the victim's body may be moved to gain access for assessment, or to gain access to other living victims.

3. Access to the scene should be restricted to only the personnel required to care for the patient.

4. Do not touch, move or relocate any item at the scene unless it is absolutely necessary to provide treatment to an injured victim. Document the location of any item that is moved, so that law enforcement can determine its original position.

5. Observe and note anything unusual, especially if the evidence may not be around when law enforcement personnel arrive (i.e. smoke or odors).

6. Give immediate care to patients. The possibility of the patient being a crime victim should not delay prompt treatment. The EMS provider’s role is to provide emergency care, not to enforce the law or perform detective work.

7. Keep detailed records of the incident, including observations of the victim and the crime scene. In many felony cases, EMS providers may be called to testify since they were the first on the scene. An incomplete or inaccurate record will hurt credibility.

8. Once the patient is pronounced dead, the body becomes the property of the coroner's office. It may not be touched or altered in any way without authorization from the coroner's office.

9. It is acceptable to share patient care information with appropriate on scene law enforcement.

10. Intravenous lines, endotracheal tubes and all other disposable equipment used, successfully or unsuccessfully, are to remain in place and/or on scene.

11. Disposable items used during resuscitation efforts are to be left in place. Sharps used during the resuscitation should be stored in an appropriate container with the container being left in the area.

12. Once law enforcement personnel arrive, EMS providers should leave the scene as soon as possible to avoid hindering the investigation. Give police any information that might be useful.

13. When documenting projectile wounds, DO NOT indicate whether the wound is an entrance or exit wound. Simply document the size, shape and location of the penetrating wound(s).

C. EMS providers will report required incidents to the appropriate law enforcement agencies in compliance with current state statutes. These incidents include but are not limited to:
    1. Gunshot wounds
    2. Injuries sustained in the commission of or as a result of a criminal event
    3. Stab wounds
    4. Suspected foul play
    5. Assaults
    6. Sexual assault
    7. Motor vehicle accidents
    8. Possible suicided and/or suicide attempts
    9. Child abuse
    10. Elder abuse
    11. Domestic violence
    12. Any other violent crime

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 2

Title: Emotionally Disturbed Patients

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to ensure appropriate patient assessment, management and documentation of care for the emotionally ill patient and/or the patient with an altered mental state.

II. DEFINITION – None.

III. POLICY

A. Patients requesting treatment for an emotional problem, who become emotionally disturbed after initiation of care and/or who have an altered mental state, will be provided medical care according to protocol and degree of illness.

B. Every effort is made to assess any underlying medical cause for the exhibited emotional state.

C. Utilize open-ended questions while interviewing, and do not argue with the patient.

D. Maintain a nonjudgmental attitude when assessing patients with possible behavioral emergencies.

E. All patients are treated with dignity and respect and without underlying prejudice towards their condition.

F. Protective safety devices may be required for the patient who is violent and/or threatening harm to himself/herself or others (See Patient Restraints policy).

G. Determine scene safety. If there is any doubt as to scene safety, request local law enforcement for assistance. Self-defense is of highest priority and may necessitate retreat from the scene.

H. Never leave the patient alone.

I. Be observant of verbal and/or nonverbal clues which may indicate the patient's aggressive or violent mood is escalating. Remove the patient from the agitating situation when possible.

J. Attempt to orient the patient to reality and to persuade the patient to be transported to the hospital so that he/she can receive emergency medical care and mental health services.

K. If persuasion is unsuccessful, contact medical control. The EMS crew will then follow the direction of the medical control physician.

1. If the medical control physician determines the patient cannot understand informed consent for patient care and transportation to the hospital for emergency treatment of a non-psychiatric condition is required to preserve life or prevent serious impairment to health, the physician shall order, against patient will and based upon implied consent, the emergency care and transportation to the hospital.

2. In no way does this mean that the EMS crew is committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of treatment to a hospital against his/her will so that a physician may further evaluate the patient.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Title: Interaction with Law Enforcement

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to delineate functions of law enforcement personnel and EMS providers in the prehospital setting.

II. DEFINITION – None.

III. POLICY

A. The function of law enforcement is to enforce the law. The function of EMS is to provide prehospital emergency care. EMS providers must not hinder law enforcement's ability to enforce the law.

B. In cases where there is a conflict of interest between law enforcement and EMS regarding a police suspect who may be in need of medical attention, EMS providers may request sufficient time to obtain an adequate patient history and perform a physical assessment. EMS providers should convey assessment findings and any need for further medical evaluation and treatment to law enforcement personnel.

C. If a conflict should exist between EMS providers and law enforcement personnel regarding patient treatment, the following guidelines are suggested:

1. Attempt to discuss privately with law enforcement officers an approach to the conflict that satisfies both law enforcement needs and the needs of the patient.

2. Explain to law enforcement officers the patient's history, physical assessment, and need for treatment.

3. Listen with an open mind to law enforcement officers. They also have a duty to perform.

4. If a difference of opinion exists regarding the need for medical treatment, immediately establish EMS telephone or radio contact with Medical Control for further direction.

5. If an agreement cannot be reached regarding the proper handling of the patient, law enforcement requests must be respected. EMS providers should continue to perform treatment allowed by law enforcement officers, and must not leave the patient unless ordered to do so by law enforcement officers.

6. EMS providers are not required to perform services or treatment requested by law enforcement officers that may be potentially harmful to the patient (i.e. drawing of blood alcohol specimens). Law enforcement agents do not have the right to order medical evaluation or treatment of patients.

7. If law enforcement officers place limitations on prehospital evaluation and treatment, EMS providers should advise the patient of those limitations. These limitations should be documented in the prehospital patient care report.

8. Complete an EMS Risk Screen within 24 hours of the incident and forward it to the EMS office for review by the EMS Coordinator and Medical Director. Document all the discussions with law enforcement officers. State facts, not opinions and be as detailed as possible

RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Title: Internet Communications and Social Media

Original Policy Date: 09/2015
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

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

II. DEFINITION – None.

III. POLICY

A. Professional standards of conduct apply to all agencies and personnel within the East Central Illinois EMS System, engaging in communication through blogs and social network sites, and other areas.

B. Everyone should be aware that others, including peers and other agencies both inside and outside the East Central Illinois EMS System may actively be reading what is posted in online forums. In choosing words and content, it is a good practice for everyone to consider that their supervisor, family members of patients and the general public may read their posts. Therefore, everyone needs to exercise good judgment before posting material on internet sites or email. Using a blog or social network site to make negative statements about and/or embarrass the East Central Illinois EMS System, any OSF HealthCare facility, agency or person associated with the East Central Illinois EMS System is inconsistent with our Mission, Values, and standards of conduct.

C. The East Central Illinois EMS System reserves the right to monitor conduct of our members in regards to social networking, and apply corrective action should it be determined that conduct is inconsistent with our policies.

D. The following activities are ***Specifically Prohibited*** under this policy:
   1. Sharing Protected Health Information (PHI). PHI includes, but is not limited to patient's name, address, age, race, extent or nature of illness or injury, hospital destination, crew member names and date, time and location of care.

2. Posting photos, videos, or images of any kind which could potentially identify patients, addresses, or any other PHI.
3. Sharing confidential or proprietary information about East Central Illinois EMS System or our agencies.
4. Postings or other online activities which are inconsistent with or would negatively impact the reputation of the East Central Illinois EMS System or its agencies.
5. Engaging in vulgar or abusive language, personal attacks, or offensive terms targeting groups or individuals within the East Central Illinois EMS System.
6. Posting statements which may be perceived as derogatory, inflammatory, or disrespectful.

E. Posting online comments on third party sites:
   1. Everyone should consult with the East Central Illinois EMS System prior to engaging in communication related to OSF HealthCare issues or activities through blogs or comment sections of material posted on the internet.
   2. If communication is done through the internet in regards to OSF HealthCare issues, you must disclose your connection with OSF HealthCare. You should strive for accuracy in your communication. Errors and omissions are poorly reflected upon OSF HealthCare and may present a liability for you or OSF HealthCare.
   3. Everyone should be respectful and professional to everyone in the East Central Illinois EMS System, community partners, co-responders, and patients and avoid using unprofessional online personas.

F. Personal Blogs and Other Social Networking Content:
   1. Where a connection to OSF HealthCare is apparent, everyone should make it clear that they are speaking for themselves and not on behalf of OSF HealthCare. In these circumstances, the following disclaimer is recommended: “the views expressed on this [blog; website] are my own and do not reflect the views of my employer, or the East Central Illinois EMS System.”
   2. Furthermore, employees should consider adding this language in the “about me” section of their profiles.
   3. This disclaimer does not by itself exempt employees from a special responsibility when blogging; employees should remember that their online behavior should still reflect and be consistent with the East Central Illinois EMS System standards of behavior, and each member agency’s standards

G. East Central Illinois EMS System and Agency Sponsored Sites or Content
   1. Posts to sites will be accurate and factual.
   2. Mistakes should be corrected promptly.
   3. When corrections are made, the original post will be preserved for integrity showing by strikethrough what corrections have been made.
   4. All spam and comments off-topic will be deleted.

5. East Central Illinois EMS System staff will respond to all emails and comments as appropriate.
6. Whenever possible the East Central Illinois EMS System will link directly to online references and original source materials.

IV. REFERENCES – None.

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 2

Title: Notification of the Coroner

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish procedures for how and when to call the coroner.

II. DEFINITION – None.

III. POLICY

A. Illinois State Statute, Chapter 31, Section 10.6, states: “Every law enforcement official, funeral director, ambulance attendant, hospital director or administrator or persons having custody of a body of a deceased person, where the death is one subject to investigation under Chapter 31, the Coroner's Act, shall notify the Coroner or Deputy Coroner promptly.”

B. “No dead body, which may be subject to the terms of the Coroner's Act shall be moved, disturbed, embalmed or removed from the place of death by any person except with the permission of the Coroner/Medical Examiner unless moving the body shall be necessary to protect life, safety or health.”

C. Any person knowingly violating the provisions of this section shall be guilty of a Class A misdemeanor.”

D. Any prehospital death is to be reported to the Coroner immediately. Special circumstances once the coroner is notified include:

1. The body shall not be moved and the scene shall not be disturbed or altered in any way until directed by the coroner. The body may, however, be moved to verify the absence of vital signs, to perform an adequate assessment, or to gain access to a viable patient involved in the same incident.
    a. Do not remove lines or tubes from unsuccessful cardiac arrests.

2. If EMS providers are required to go to another emergency call before the arrival of the coroner, they must do the following:

    a. Leave the body in the care of law enforcement present at the scene, or other medical personnel.
    b. Contact Medical Control regarding the situation and the need to leave, and confirm that the coroner has been notified.

3. In cases in which there are obvious deaths related to a fire, fire service personnel may recognize the obvious deaths and report deaths to the coroner. EMS providers are responsible for confirming that the coroner has been called.

4. In cases in which there are obvious deaths related to a police and/or crime scene, law enforcement personnel may recognize the obvious deaths and report deaths to the coroner. EMS providers are responsible for confirming that the coroner has been called.

E. If a patient is determined to be dead during transport, note the time & location and record this information on the patient care report. Immediately contact the coroner to discuss death jurisdiction. Do not cross county lines with a patient that has been determined to be dead.

F. Refer to the Determination of Death/Withholding Resuscitative Efforts Protocol.

IV. RESOURCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 2

Title: Patient Abandonment

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to assure that patients are not abandoned by EMS providers in the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. Abandonment is defined as termination of a provider/patient relationship without assuring a mechanism for continuation of care. This is assuming, and unless proven otherwise, there exists a need for continued medical care and the patient is accepting the treatment.

B. EMS providers may not leave a patient with whom care has been initiated unless one or more of the following situations exist:

1. The patient or legal guardian refuses treatment and/or transportation. In this instance, EMS providers are referred to the policy on *Refusal of Service*.

2. EMS providers are unable to continue care due to extreme physical exhaustion or injury.

3. Law enforcement, fire service and/or EMS providers determine the scene is not safe and the potential for injury or death to a rescuer exists.

4. The number of patients exceeds the resources immediately available, and EMS providers are involved in triage activities.

5. The patient is in full cardiac arrest, has a valid DNR order physically with the patient, and Medical Control concurs. In this instance, EMS providers are referred to the policy on *Advanced Directives and DNR.*.

6. Medical care and responsibility for the patient is assumed by individuals trained, certified and licensed at a level equal to or higher than that of the initial provider.

7. The patient meets the criteria outlined in the Determination of Death/Withholding Resuscitative Efforts Protocol.

C. If EMS personnel arrive on scene, establish contact and evaluate a patient who then refuses care, the EMS crew shall conduct termination of the patient contact in accordance with the *Refusal of Service* Policy.

D. During the transport of a patient by ambulance, should the EMS crew come across a separate emergency or incident requiring ambulance assistance; the local EMS system will be activated. Crews involved in the treatment and transportation of an emergency patient are not to stop and render care

1. The priority is to the patient onboard the ambulance.

2. In the event you are transporting the patient with more than two (2) appropriately trained prehospital personnel, you may elect to leave one medical attendant at the scene to render care and the other personnel will continue to transport the patient to the receiving facility.

3. In the event there is not a patient onboard the ambulance and an emergency situation is encountered requiring ambulance assistance; the crew may stop and render care. However, the local EMS agency should be activated and their jurisdiction respected.

IV. RESOURCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 2

Title: Patient Restraints

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the use of patient restraints in situations when the patient must be restrained due to posing a risk to himself/herself or others.
.

II. DEFINITION – None.

III. POLICY

A. Attempt to avoid the use of restraints by maintaining a calm, reassuring demeanor and taking all reasonable steps to urge the patient to comply.

B. Restraints shall only be implemented as a last resort by EMS personnel for patients who lack present mental capacity and demonstrate physical resistance or violent behavior that poses an immediate threat to the health and safety of them or others around them.

C. Determine the need for restraint. Criteria for restraint include violence toward personnel or physical resistance to transport by a confused or obtunded patient who must be transported to the hospital.

D. Unless the patient poses an immediate threat to self or others or is suffering from an immediately life-threatening condition, medical control must be contacted prior to the use of restraints or transports of any patient against his/her will.

E. The patient requiring restraint should be safely and humanely restrained. At no time should a patient be struck or managed in such a way as to impose pain. Restrain in a position of comfort and safety. It is very important that restraints not be applied so tightly as to compromise limb circulation. Patients shall not be restrained in the prone position.

F. Law enforcement must be called to manage the situation when danger exists, such as when the patient has a weapon or injury to the patient, bystanders, or personnel is anticipated.
    a. If a patient is restrained by law enforcement with handcuffs or other law enforcement restraint implements, the patient will be accompanied in the ambulance by law enforcement to the hospital to assist with further restraint of the patient or to release the restraints if the patient care is impaired by the devices.

G. It is desirable to have female personnel present when a female patient is being restrained.

H. The patient MUST NOT be left alone after application of restraints.

I. Pulses, movement and sensation of extremities must be checked at least every 15 minutes while the patient is restrained.

J. Document the indications for applying restraints (i.e. presence of self-destructive behavior), prior attempts at less restrictive alternatives (i.e. verbal communication), method of restraint and periodic checks for proper application and patient well-being.

K. Refer to Physical Restraints Procedure.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 2

Title: Physician on Scene

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to clarify the EMS provider's responsibility to a patient when a physician is present at the scene of an emergency and wishes direct or assist patient care

II. DEFINITION – None.

III. POLICY

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

1. If a professed, licensed medical professional (physician) wishes to participate in and/or direct patient care at the scene of an emergency, the Senior EMS provider shall immediately contact Medical Control.

2. If the on-scene physician (including the patient's private physician) has properly identified himself/herself and wishes to direct patient care, he or she must:
    a. Obtain approval from Medical Control, as witnessed by the EMS provider in charge at the scene.
    b. Sign the prehospital care report.
    c. Assume total responsibility for the patient.
    d. Accompany the patient to the hospital.
3. If the on-scene physician obstructs the efforts of the EMS providers to aid the patient, and/or insists on rendering patient care inappropriate to System standards, and/or hinders EMS provider efforts to provide good and reasonable patient care, the EMS providers shall:
    a. Contact Medical Control.
    b. Contact law enforcement for assistance.
    c. Remove the patient from the scene.

4. If a physician gives orders, while on scene or enroute, for procedures or treatments that the EMT/PHRN/PHPA/PHAPRN feels are unreasonable, medically inaccurate, and/or not within the scope of practice of the provider, refuse to follow such orders and establish communication immediately with on-line medical control to clarify further treatment. In all circumstances, the EMS provider shall avoid any order or procedure that would be harmful to the patient

B. When voice communications with on-line Medical Control is not available, the EMS crew is instructed to follow the East Central Illinois EMS System Protocols.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal **Page:** 1 of 2

Title: Prehospital Patient Care Reporting

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

To maintain pertinent Patient Care Report (PCR) information for the purpose of medical/legal records and statistics.

II. DEFINITION - None

III. POLICY

A. A Patient Care Report, in a format approved by the ECIEMS Medical Director, is used by EMS providers to record pertinent patient information. Patient Care Reports are maintained as follows:

1. EMS providers must accurately complete and submit a patient care report for each patient contact or *request* for response.
2. A patient care report is not necessary if the provider is cancelled enroute to the scene however the response and cancellation should be documented in some manner i.e. dispatch center, dispatching software.
3. Receiving facility copies are left with the receiving facility immediately following the call whenever possible. This copy will become part of the patient's permanent medical record.
4. In the event that a patient care run report cannot be completed prior to leaving the facility, then a system approved 'EMS Short Form' must be left with the patient. The patient care run report must be completed and provided to the health care facility as soon as possible, but no later than 2 hours after the patient is left at the receiving facility.
5. Agency copies are maintained by the agency on paper or electronically for a period of not less than seven years.
6. Computer generated records must be in accordance with IDPH guidelines.
7. ECIEMS Medical Director and/or designee(s) shall be granted access to all prehospital patient care reports and data related to patient encounters for continuous monitoring and quality assurance.
8. Provider agencies are responsible for maintaining the accuracy, integrity and security of their data under local, federal and state statutes and system policies.

B. IDPH Rules Section 515.350 DATA COLLECTION AND SUBMISSION; Amended at 42 Ill. Reg. 17632, effective September 20, 2018)

1. A patient care run report shall be completed by each Illinois-licenses transport vehicle service provider for every inter-hospital transport and pre-hospital emergency call, regardless of the ultimate outcome or disposition of the call.

    a. One patient care report shall be provided (paper or electronic) to the receiving hospital emergency department or health care facility before leaving this facility.
    b. Each EMS System shall designate or approve the patient care report to be used by all of its vehicle providers. The report shall contain the minimum requirements listed in Appendix E of the EMS Rules and Regulations.

2. All non-transport vehicle providers shall document all medical care provided and shall submit the documentation to the EMS System within 24 hours. The EMS System shall review all medical care provided by non-transport vehicles and shall provide a report to the Department upon request.

C. Records of EMS radio reports to the receiving hospital are maintained as follows:

1. All radio and cell phone reports from EMS providers to the receiving hospital are recorded on a radio log at the receiving hospital.
2. All calls are recorded at the receiving hospital.
3. All radio logs and recordings are kept by Resource, Associate and Participating Hospitals for a period of not less than seven years.

IV. RESOURCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: Medical-Legal

Title: Refusal of Service

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the use of the East Central Illinois EMS System Refusal Form, in regards to refusal of evaluation, treatment and/or transportation.

II. DEFINITION

A. Competent patient means someone with the legal authority to consent to or refuse care for their own person (not an adult with a guardian or a minor who does not meet one of the exceptions set out below).

B. Decisional patient means one who is able to understand and appreciate the nature and consequences of a medical decision and reach and communicate an informed choice.

C. Competent patient with decisional capacity means that the person has the both the legal authority and actual ability to consent to or refuse treatment.

D. Minor means a person under the age of 18 and under most circumstances may not consent to or refuse treatment.

III. POLICY

REFUSAL PROCEDURE

A. All patients will be offered treatment and transportation to a hospital after attempt to obtain a history and physical, in as much detail as is permitted by the patient.

B. Determine decisional capacity of the patient and reason for refusing care.

C. Document decisional capacity assessments, results of the history and physical exam, clinical symptoms on which need for transport was based, information provided to fully inform the patient of risks, benefits and alternatives as well as the patient's understanding.

D. Complete and review the patient refusal form in its entirety with the patient.
    1. Obtain patient signature and have the patient date the form.
    2. Obtain a witness signature. This should preferably be someone who witnessed your explanation of risks and benefits, heard you advise the patient to receive medical evaluation and treatment, and who watched the patient sign. If no witness is available, a crew member may sign as a last resort. All should be 18 or older, have mental competency and present mental capacity. Write witnesses' address and telephone number on back of refusal form.
    3. If the patient refuses to sign the refusal form, document this on the refusal form as well as in your patient report.

E. Inform the patient to call 911, his/her primary care physician or go to the nearest Emergency Department if symptoms persist or get worse or the patient changes their mind.

F. At no time will EMS professionals mention cost of transport, patient's insurance status, hospital billing or insurance practices, status of system/unit availability, ED wait times, or any other non-clinical subject in an attempt to influence a patient's decision to decline treatment or transport.

COMPETENT DECISIONAL PATIENT

A. When a competent patient with decisional capacity refuses medical assistance or transport, EMS personnel will advise the patient of his/her medical condition and explain why the care and/or transport is indicated. Encourage the patient to consent to treatment and transport.

B. If the patient persists in the refusal of treatment, explain the risks of refusing treatment and document attempts to persuade the patient to accept treatment/transport.

C. Document the patient's ability to comprehend the information provided, including statements made by the patient and confirm that the patient had been fully informed of the risks of refusing care and/or transportation and understood the consequences of the decision.

D. Continually assess the patient's condition as the patient permits. If the patient is decisional, EMS may, but is not required, to contact the Resource or Associate Hospital for assistance. The EMS Medical Director or designee may encourage the patient to comply. If the patient continues to decline treatment/transport, document the refusal, and the call, if made.

INCOMPETENT AND NON-DECISIONAL PATIENT

A patient who is not decisional, lacks the ability to consent to or refuse treatment.

A. Attempt to determine whether the patient's decisional capacity is impaired and consider whether the patient has a condition that might impair capacity such as hypoglycemia, trauma, stroke, dementia, or the presence of alcohol or other substances in the patient's system.

B. These conditions alone do not dictate a conclusion that the patient lacks decisional capacity. The patient must be assessed to determine whether he or she understands the condition, the nature of the medical advice given, and the consequences of refusing to consent to treatment/transport. When the patient's decisional capacity is questioned, or there is evidence of alcohol or drug use, EMS will administer the Quick Confusion Scale on the reverse side of the Refusal form.

C. If EMS personnel determine that the patient lacks decisional capacity, they should attempt to treat the patient and transport with the patient's cooperation.

D. If the patient persists in refusing treatment/transport, or if the patient becomes combative, EMS personnel should request backup from law enforcement and contact the Resource/Associate hospital. EMS personnel should avoid putting themselves in danger, even if doing so may cause a delay in treatment or transport.

E. If law enforcement is on scene, EMS personnel should request assistance in ensuring transport of a non-decisional patient.

F. EMS personnel may employ restraints in an emergency only to protect the patient, EMS Personnel, and others from imminent physical harm. *SEE RESTRAINT POLICY*.

CONTACTING MEDICAL CONTROL

A. Medical control must be contacted when the patient:
   1. Is disoriented to person, time, place, or event.
   2. Is under the age of 18 and not accompanied by parent or guardian.
   3. Is unable to repeat understanding of the medical condition and consequences of treatment refusal.
   4. Is showing obvious life threatening injuries, signs, and symptoms.
   5. Shows evidence of trauma related to significant mechanism of injury.
   6. Receives a score of ≤ 11 on the Quick Confusion Scale.
   7. Has expressed suicidal or homicidal ideation or intention or there is evidence of recent self-harm.
   8. Is under the influence of alcohol or other substances to the point that decision making is impaired.
   9. Refuses transport after EMS has begun treatment.

MINOR PATIENT

A. **A minor cannot generally consent to or refuse treatment**.

   1. The consent of a parent or guardian is required for refusal of treatment for minors. If a parent or guardian is not available to consent and without treatment, the minor's health would be adversely affected, EMS personnel should administer appropriate emergency

treatment and transport. Document efforts to obtain consent. If the minor is refusing or resisting treatment, contact Medical Control, if necessary, contact law enforcement.

2. If a parent or guardian refuses to consent for treatment without which the minor's health would be endangered, EMS personnel will contact law enforcement and Medical Control. Law enforcement or a physician may take or retain temporary protective custody of the child without the consent of the person responsible for the child's welfare. A person taking protective custody of a minor must immediately make every reasonable effort to notify the person responsible for the child's welfare and notify the Department of Children and Family Services.

B. **When a minor may consent to or refuse treatment**.
   1. A person who is under the age of 18 is a minor in Illinois, but may consent to or refuse care as though an adult if the person:
      a. has been emancipated by a court of law[2]
      b. is married
      c. is a parent (father or mother)
      d. is pregnant

C. Any minor parent may consent to or refuse treatment for his/her child. A pregnant minor may consent to the evaluation and/or treatment related to the pregnancy.

IV. RESOURCES – None

[1] 410 ILCS 210/3

[2] 750 ILCS 30/1 applies only to minors between 16-18 years old.

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Medical-Legal

Page: 1 of 3

Title: Relinquished Newborn

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 01/2025

II. PURPOSE

The purpose of this policy is to provide a safe place for a parent who may be considering abandonment of a newborn infant and to ensure East Central Illinois EMS providers are able to respond to situations of infant abandonment in compliance with the Abandoned Newborn Infant Protection Act.

III. DEFINITIONS

A. **Neonate:** means a child who is believed to be 30 days old or less at the time the child is initially relinquished to a hospital, police station, fire station, or emergency medical facility, and who is not an abused or neglected child.

B. **Relinquish**: means to bring a neonate, who a licensed physician reasonably believes is 30 days old or less to a hospital, police station, fire station, emergency medical facility, and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant.

C. **Emergency Medical Professional** includes licensed physicians, and any EMT, AEMT, EMT-I, Paramedic, PHRN, PHPA, and PHAPRN as defined in the EMS Systems Act.

D. **Fire Station**: Means a fire station within the State with at least one staff person.

IV. POLICY

G. The ECIEMS agency will provide assessment, treatment, and transportation to the nearest hospital for relinquished infants according to the above-named Act.
H. The ECIEMS will provide the necessary documents to the relinquishing parent as specified in the above-named Act.

<u>Infant Care and Hospital Contact</u>
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 policy 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 by 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 nearest hospital 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 appropriate 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. The System 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 or neglect:
    1. Identify 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; and
    3. Normal patient confidentiality will surround this process.

Communication with the Relinquishing Parent

A. EMS personnel must offer the relinquishing parent the packet of information (see below) specified in the Act and if possible, verbally inform the parent that:
    1. Their acceptance of the information is completely voluntary.
    2. Completion of the Illinois Adoption Registration form and Medical Information Exchange form is voluntary.
    3. A Denial of Information Exchange form may be completed which would allow the relinquishing parent to remain anonymous to the infant and other parties involved in the infant's subsequent adoption.
    4. The parent may provide medical information only and remain anonymous; and
    5. By relinquishing the infant anonymously, they will have to petition the court to prevent the termination of parental rights and regain custody of the child. This information shall be printed and included in the packet.
    6. If the parent returns within 72 hours to reclaim the infant, they should be told the name and location of the hospital to which the infant was transported.
B. The parent may be unwilling to participate in a discussion. Document on the infant's PCR that the required information was offered to the parent and whether or not it was received. Note: These packets should be available in every fire station.
C. Inform the parent that the fee for filing the application is waived if the medical questionnaire is completed.

Important Documents Needed in the Case of Relinquishment:

- Information Packet (English)
- Information Packet (Spanish)

V. REFERENCES

- https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1459&ChapterID=32
- https://saveabandonedbabies.org/

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 1

Title: Ambulance Estimated Time of Arrival

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide the patient with an opportunity to request another agency for transport, if the initial agency's response time is deemed to be excessive.

II. DEFINITION – None.

III. POLICY

A. The patient calling for EMS response and/or transport may request the estimated time of arrival once the agency dispatcher has been contacted. It is the responsibility of the agency dispatcher to estimate the time of arrival of the responding unit.

B. Emergency Medical Dispatch training includes teaching dispatchers to provide an estimated time of arrival for the responding unit when requested by the patient. Estimated times of arrival must be available for the patient for both emergent and non-emergent situations.

C. After receiving communication of the estimated time of arrival for the transporting ambulance, the patient has the opportunity to request another transport agency.

D. All EMS dispatchers in the East Central Illinois EMS System must abide by this policy.

IV. REFERENCES – None.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: Concealed Weapons

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 01/2025

I. PURPOSE

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

II. DEFINITION

III. POLICY

This policy pertains to all weapons, including, but not limited to firearms, hunting knifes, and electronic weapons.

GENERAL

I. EMS should make every attempt to screen all patients for concealed weapons prior to transport to a medical facility.
J. Emergency responders and healthcare providers should always assume that all firearms are loaded.
K. Under no circumstances should an emergency responder or healthcare worker compromise their safety in regard to these guidelines. When in doubt about a patient with a weapon or the weapon itself, emergency responders and healthcare personnel should contact local law enforcement.
L. No weapon will ever be transported unsecured inside the ambulance whether belonging to the patient or family member. The only exception to this rule will be for conscious and alert on-duty law enforcement personnel.
M. It is not the job of the EMT's or Paramedics to determine if the patient is carrying the weapon legally.
N. Optimally weapons should be safely secured by the patient and/or law enforcement at their residence or appropriately in their vehicle and not be transported with the patient in an emergency response vehicle. The goal is for the EMS provider to minimally handle any weapon
O. Patients with an altered level of consciousness, severe pain, or with difficulties in motor functions should not be encouraged to disarm themselves. An emergency responder or healthcare worker may need to obtain control of the weapon for the safety of responding personnel, the public and the patient. Caution should be used at all times when handling a weapon. Emergency responders and healthcare workers should not attempt to unload a

firearm. Regardless of a person's familiarity with firearms, there is no way to know if the gun is in proper working order.

P. EMS agencies are encouraged to designate themselves as a weapons-free facility. No-carry signage should be clearly posted in emergency squads and EMS facilities. Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles or in hospitals that have declared themselves as no-carry zones.
Q. When a weapon is encountered on a call, the patient care report should include documentation that a weapon was located, type of weapon, how it was recovered, where it was located, what the disposition was, and any actions or comments made to or by the patient.

Conscious Patient Willing to Relinquish a Weapon

A. Patients who are alert and oriented and for whom the emergency response is occurring at their place of residence should be asked to leave their weapons in a secure location at home prior to transport. Patients should be told that EMS vehicles are "no carry zones".
B. Patients for whom the emergency response is occurring away from their residence may relinquish their weapon to law enforcement officer on scene if one is available.
C. If patient is not at their residence or if a law enforcement officer is not available, emergency response personnel should do the following:
    1. Place or have the patient place the weapon into the "Lock Box."
    2. Secure the Lock Box with a numbered security seal and place the Box in a locked cabinet or locked exterior vehicle compartment for transport.
    3. Conduct a thorough secondary survey.
    4. If additional weapons are found, begin again at Step (1). If no additional weapons are found, transport the patient to an appropriate medical facility.
    5. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.

Conscious Patient Unwilling to Relinquish a Weapon

A. Emergency responders should approach an alert and oriented patient in calm discussion about the need to secure the weapon prior to transport. Simple explanations can be given including that these guidelines are in place.
B. Patients that are conscious but have an altered mental status are considered dangerous because they are unable to make sound decisions, therefore they should be disarmed as soon as possible.
C. If the patient continues to refuse to relinquish the weapon, emergency responders may immediately stop the assessment and refuse transporting to a medical facility as the scene is presumed unsafe.
D. EMS Providers should be suspicious of ill or injured patients unwilling to relinquish weapons. Law enforcement may be called to intervene in the situation.
E. If the situation becomes threatening, emergency responders should evacuate the scene to a secure place a safe distance away and notify law enforcement immediately.
F. If emergency responders deem a situation "unsafe" at any time throughout your contact with an individual, you may retreat to a safe place until law enforcement arrives.

Patients with Altered Levels of Consciousness

A. Emergency responders must use extreme caution when approaching patients with altered levels of consciousness.

B. If a weapon is found on a conscious patient with an altered level of consciousness, emergency responders should not attempt to have the patient hand over the weapon on their own. Law enforcement should be called to assist in disarming these patients. If a weapon is removed by a law enforcement officer, the officer will then take custody of the weapon.
C. If the patient is unconscious and requires emergent care but law enforcement is not on the scene, EMS personnel will need to carefully separate the weapon from the patient prior to transport. In a perfect situation a firearm should be removed from the patient while still in the holster. If removing the holster and weapon together jeopardizes the safety of the patient or emergency response personnel, or it is physically impossible to remove the holster and firearm together, the weapon may be removed without the holster. Once removed, emergency response personnel shall:
    1. Handle all weapons carefully.
    2. Place the weapon or weapon-in-the-holster into the Lock Box.
    3. Secure the Lock Box in a locked cabinet or locked exterior vehicle compartment for transport.
    4. Conduct a thorough secondary survey.
    5. If additional weapons are found, begin again at Step (1). If no additional weapons are found, transport the patient to an appropriate medical facility.
    6. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.

Transfer of Weapon at Medical Facility

A. Each hospital will have its own procedure when it comes to dealing with secured weapons that arrive by EMS. If you are unsure of the receiving hospital's policy, please inquire with their staff on your arrival.
B. When transporting a patient notify the receiving facility that security will need to meet you to take control of the patient's personal property and locked in their designated safe location.
C. A "Transfer of Personal Property" form must be completed and signed by all parties.

IV. REFERENCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 13

Title: Critical Care

Original Policy Date: 03/2020
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The East Central Illinois EMS System recognizes the need to transport critically ill and injured patients from outlying hospitals to larger tertiary care centers. Some patients will require additional skills and procedures that paramedics do not normally perform for stabilization during or prior to transport. Some patients will require administration or maintenance of medications not normally carried by Advanced Life Support vehicles. This will outline the requirements for initial training, continuing education, approved additional skills, procedures, medications, quality assurance and improvement.

II. DEFINITION – None.

III. POLICY

This policy assumes that all EMS agencies/providers that provide critical care interfacility/interregional transports have had advanced critical care training for such transports and have been approved by the EMS System Medical Director for critical care transports.

A. An attending physician will authorize or request interfacility transports.

B. The transferring physician will determine the appropriate receiving facility.

C. The transferring physician will receive confirmation of acceptance of the patient from the receiving facility and the receiving physician or physician designee.

D. It is the responsibility of the transferring physician to indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.

E. Prior to the transport, EMS providers must obtain written orders from the transferring physician for all interventions (i.e. fluids, medications, and procedures) being transferred with the patient. These orders shall be written on the “East Central Illinois EMS System EMS Interfacility Transfer Form”. In the event there are no written orders provided by the transferring provider, the EMS providers will default back to the East Central Illinois EMS System Protocols.

F. Any medication and/or procedure not listed in the policies and/or protocols requires Medical Director approval.

G. A Transfer Time-Out shall be conducted for each interfacility transfer prior to initiating transport.

Online Medical Control:

A. Medical Control (MC) may be defined as either the EMS Medical Director (as defined in the *"EMS Medical Director"* Policy), the transferring or receiving physician and as a last resort the ED physician of the transferring or receiving hospital.

B. In any situation that the EMS Provider needs to contact a physician for medical direction they will first attempt to contact the transferring physician or the receiving physician. If unable to reach either one, the EMS MD can be contacted. As a last resort, use on-line medical control at the sending or receiving facility. Any orders from on-line medical control will supersede written orders. Any on-line medical control orders shall be documented in the patient care report.

C. If the EMS Provider is unable to contact the receiving or sending facility, the EMS Provider will follow East Central Illinois EMS System Medical Protocols until contact can be established. In a situation when medical control is unreachable and intervention is necessary, the transport team will divert to the nearest appropriate medical facility.

Considerations for Transport:

A. If the patient is unstable for transport, coordinate with the transferring facility to stabilize the patient to the extent of that facility's capabilities prior to departure. Consider the need for definitive care vs the risk of transport in an unstable condition.

B. Any agency in the East Central Illinois EMS System reserves the right to deny transport under the following conditions:
    1. If providing the Critical Care transport will impede the ability for the agency to provide 911 response within their response area due to staffing or equipment.
    2. If it is deemed the patient is not stable enough for ground transport after consultation with the Medical Director or Medical Control.
    3. If the safety of the patient and crew is at significant risk (i.e. weather, road conditions, violent patient, etc.).
    4. Patients in active labor (when birth is imminent).
    5. Active CPR in progress.

Transferring Documentation / Written Orders:

A. It is the responsibility of the transferring hospital/physician to provide appropriate documentation which includes a transfer form or other documentation indicating compliance with current statutes or laws regarding patient transfers. Included should be patient identifying information (name, address, date of birth, etc.), treatments, test results, preliminary diagnosis, reason for transfer, names of transferring/accepting physicians/institutions, pertinent medical records and orders.

B. Each patient should have a unique set of written orders provided by the transferring physician, specific to the patient's medical condition. The patient will be treated according to those orders. A copy of these written orders shall become part of the Patient Care Report (PCR).

These orders shall be written on the “East Central Illinois EMS System EMS Interfacility Transfer Form”.

C. Any concerns regarding patients written orders should be voiced to the physician caring for the patient (transferring) physician/or the EMS Medical Director or his/her designee prior to transport.

D. Must have name and phone number of the transferring MD as well as the receiving MD readily available in the event you need to contact them for unexpected problems or for clarification to orders provided.

Documentation:

A. All Critical Care transports will have documentation that supports or identifies the trip as being a critical care transport. Documentation, at a minimum, will detail the patient’s chief complaint, reason for the transfer, historical data related to the current problem, pertinent past medical history, medication list, allergy list, and a timed, chronologic description of patient care, medications, vital signs, and changes in patient status with corresponding response of medical crew to the changes. In addition to giving a verbal report to the receiving medical staff, a copy of run report will be left at the receiving facility,faxed or sent electronically shortly thereafter.

Requesting Additional Personnel:

A. When the EMS provider anticipates that they will require more assistance to appropriately care for the patient during transfer, they shall request appropriately trained hospital staff to accompany the patient and assist. The EMS provider must contact the EMS Medical Director or Medical Control for medical direction in all situations where they are not comfortable with the circumstances of the transfer. The transfer will not occur unless the EMS provider and EMS Medical Director and/or Medical Control are confident the personnel and equipment are appropriate for transfer.

B. If at any time a critical care team member feels a treatment plan (i.e. medications, procedures, and interventions) is beyond their skill level or comfort level, DO NOT PROCEED WITH THE TRANSPORT, instead, contact Medical Control and/or your supervisor to discuss your concern and request additional appropriately trained personnel.

Clinical Procedures / Protocols:

A. All current protocols used by East Central Illinois EMS crews to treat patients in the field will also apply to critical care transports if applicable to patient’s condition/situation. In addition, advanced protocols, specific for critical care patients, may apply and be used by the critical care transport team members who are credentialed by the ECIEMS Medical Director and familiar with the procedures listed.

Quality Assurance:

A. The East Central Illinois EMS System will conduct a quality assurance program in accordance with the Illinois Administrative Code, Section 515.860 Critical Care Transport.

B. The critical care transport provider shall submit a written QA plan to the East Central Illinois EMS System for approval. Updates to the QA plan shall be submitted to the EMS system for approval on an as needed basis.

C. The critical care transport provider will provide quarterly reports to the East Central Illinois EMS System evaluating for medical appropriateness and thoroughness of documentation including, but not limited to:
    a. Review of transferring physician orders and evidence of compliance with those orders.
    b. Review of transfer documentation to ensure patient met the criteria for Critical Care Transport as set forth by the East Central Illinois EMS System.
    c. Review of the EMS record assuring documentation of vital signs and frequency, and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed.
    d. Review of the EMS record to ensure proper procedures were followed when approved transport medications for infusion and approved transport equipment were used.
    e. Review of the EMS record for documentation of any side effects/complications including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for these events.
    f. Review of the EMS record for documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions along with rationale and outcome.
    g. Review of the EMS record for any unanticipated change in the management of the patient during transport.
    h. Review of any Medical Control contact for further direction and documentation of any orders given

D. Any unusual occurrences shall promptly be documented and communicated to the East Central Illinois EMS System.

V. IDPH Rules and Regulations, 77 Ill Administrative Code Section 515.860 - Critical Care Transport

A. Critical care transport *may be provided by:*

1. *Department-approved critical care transport providers, not owned or operated by a hospital, utilizing EMT-Paramedics with additional training, nurses, or other qualified health professionals; or*

2. *Hospitals, when utilizing any vehicle service provider or any hospital-owned or operated vehicle service provider. Nothing in* the *Act requires a hospital to use, or to be, a Department-approved critical care transport provider when transporting patients, including those critically injured or ill. Nothing in* the *Act shall restrict or prohibit a hospital from providing, or arranging for, the medically appropriate transport of any patient, as determined by a physician licensed to practice* medicine *in all of its branches, an Advanced Practice Nurse, or a physician assistant.* (Section 3.10(f-5) of the Act)

B. *All critical care transport providers must function within a Department-approved EMS System. Nothing in* this Part *shall restrict a hospital's ability to furnish personnel, equipment, and medical supplies to any vehicle service provider, including a critical care transport provider.* (Section 3.10(g-5) of the Act)

C. For the purposes of this Section, "expanded scope of practice" includes the accepted national curriculum plus additional education, experience and equipment (see Section 515.360) as approved by the Department pursuant to Section 3.55 of the Act. Tier I transports are considered "expanded scope of practice".

D. For the purposes of this Section, CCT plans are defined in three tiers of care. Tier II and Tier III are considered Critical Care Transports.

E. The Department will approve vehicle service providers for CCT when the provider demonstrates compliance with an approved EMS System's CCT program plan for Tier II or Tier III transports. Only Department-approved agencies may advertise as CCT providers.

F. The Department will suspend a vehicle service provider's approval for critical care transport if any part of the provider's QA plan is not followed or if a situation exists that poses a threat to the public health and safety. The Department will provide a notice of suspension of CCT approval and an opportunity for hearing. If the vehicle service provider does not respond to the notice within 10 days after receipt, approval will be revoked.

G. The Director may summarily suspend any licensed provider's authorization to perform CCT under this Part if the Director or designee determines that continued CCT by the provider poses an imminent threat to the health or safety of the public. Any order for suspension will be in writing and effective immediately upon service of the provider or its lawful agent. Any provider served with an order of suspension shall immediately cease accepting all CCT cases and shall have the right to request a hearing if a written request is delivered to the Department within 15 days after receipt of the order of suspension. If a timely request is delivered to the Department, then the Department will endeavor to schedule a hearing in an expedited manor, taking into account equity and the need for evidence and live witnesses at the hearing. The Department is authorized to seek injunctive relief in the circuit court if the Director's order is violated.

Tier I

Tier I provides a level of care for patients who require care beyond the Department-approved Paramedic scope of practice, up to but not including the requirements of Tiers II and III. Tier I transport includes the use of a ventilator, the use of infusion pumps with administration of medication drips, and maintenance of chest tubes.

1. Personnel Staffing and Licensure
    A. Licensure
        i. Licensed Illinois Paramedic or PHRN/PHPA/PHAPRN;
        ii. Scope of practice more comprehensive than the national EMS Scope of practice model approved by the Department in accordance with the EMS System Plan (see Sections 515.310 and 515.330); and
        iii. Approved to practice by the Department in accordance with the EMS System Plan.

    B. Minimum Staffing:
        i. System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN/PHPA/PHAPRN as driver; and
        ii. System authorized expanded scope of practice Paramedic, PHRN/PHPA/PHAPRN or physician who shall remain with the patient at all times.

2. Education, Certification, and Experience
    A. Initial Education: Documentation of initial education and demonstrated competencies of expanded scope of practice knowledge and skills as required by Tier I Level of Care and approved by the Department in accordance with the EMS System Plan.
    B. CE Requirements:
        i. Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed; and
        ii. The EMS vehicle service provider shall maintain documentation of competencies and provide documentation to the EMS Resource Hospital upon request.
    C. Certifications – Tier I personnel shall maintain all renewable critical care certifications and credentials in active status:
        i. Advanced Cardiac Life Support (ACLS);
        ii. Pediatric Education for Pre-Hospital Professionals (PEPP) or Pediatric Advance Life Support (PALS);

iii. International Trauma Life Support (ITLS) or Pre-Hospital Trauma Life Support (PHTLS); and
iv. Any additional educational course work or certifications required by the EMS MD.

D. Experience:
i. Minimum of one year of experience functioning in the field at an ALS level or as a physician in an emergency department; and
ii. Documentation of education and demonstrated competencies of expanded scope of practice knowledge and skills required for Tier I Level of Care, approved by the Department and included in the EMS System plan.

3. Medical Equipment and Supplies
A. Ventilator; and
B. Infusion pumps.

4. Vehicle Standards
A. Any vehicle used for providing expanded scope of practice care shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for expanded scope of practice transport shall be equipped with an onboard alternating current (AC) supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

5. Treatment and Transport Protocols shall address the following:
A. EMS MD or Designee present at established Medical Control;
B. Communication points for contacting System authorized Medical Control and a written Expanded Scope of Practice Standard;
C. Written operating procedures and protocols signed by the EMS MD and approved for use by the Department in accordance with the System Plan; and
D. Use of a ventilator, infusion pumps with administration of medication drips, and maintenance of chest tubes.

6. Quality Assurance Program
A. The Tier I transport provider shall develop a written Quality Assurance (QA) Plan approved by the EMS System and the Department in accordance with subsection (e)(6)(D). The provider shall provide quarterly QA reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
B. The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.
C. An EMS MD or a SEMSV shall oversee the QA Program.
D. The QA Plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
i. Review of transferring physician orders and evidence of compliance with those orders;
ii. Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
iii. Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental

status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;
iv. Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
v. Review of any Medical Control contact for further direction;
vi. Documentation that any unusual occurrences were promptly communicated to the EMS System; and
vii. A root cause analysis of any event or care inconsistent with standards. The EMS System educator shall assess and carry out a corrective action plan.

E. The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

Tier II

Tier II provides a level of care for patients who require care beyond the Department-approved national EMS scope of practice model and expanded scope of practice ALS (Paramedic) transport program, and who require formal advanced education for ALS Paramedic staff. Tier II transport includes the use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines; accessing central lines; medication-assisted intubation; patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

1. Personnel Staffing and Licensure
   A. Licensure – Licensed Illinois Paramedic or PHRN/PHPA/PHAPRN:
      i. Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier I Level as approved by the Department; and
      ii. Approved to practice by the EMS System and the Department in accordance with the EMS System Plan.

   B. Minimum Staffing;
      i. System authorized Paramedic or PHRN/PHPA/PHAPRN ; and
      ii. System authorized Paramedic, PHRN or physician who is critical care prepared, who shall remain with the patient at all times.

2. Education, Certification and Experience
   A. Initial Advanced Formal Education:
      i. At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education based on nationally recognized program models; and
      ii. Demonstrated competencies, as documented by the EMS MD or SEMSV MD and approved by the Department.

   B. CE Requirements:
      i. The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;
      ii. The following current credentials, as a minimum, shall be maintained: ACLS, PEPP or PALS, ITLS or PHTLS;
         a. *In addition, the East Central Illinois EMS System requires:*
            i. *Neonatal Resuscitation Program (NRP)*

ii. *Advanced Medical Life Support (AMLS)*
iii. *Pediatric Fundamental Critical Care Support (PFCCS). Must obtain within 12 months of joining the system.*
iv. *Certified Critical Care Paramedic (CCP-C) or Certified Flight Paramedic (FP-C) by the International Board of Specialty Certification (IBSC) and the Board for Critical Care Transport Paramedic Certification (BCCTPC). Must obtain within 12 months of joining the system.*

iii. A minimum of 40 hours of critical care level education shall be completed every four years;
iv. The EMS provider shall maintain documentation of compliance with subsections (f)(2)(B)(i) through (iii) and shall provide documentation to the EMS Resource Hospital upon request; and
v. Nationally recognized critical care certifications shall be maintained and renewed based on national recertification criteria.

C. Experience – Minimum of two years experience functioning in the field at an ALS level for paramedic and PHRNs/PHPA's/PHAPRN's and one year experience in an emergency department for physicians.

3. Medical Equipment and Supplies
   A. Ventilator; and
   B. Infusion pumps.

4. Vehicle Standards
   A. Any vehicle used for providing critical care transport shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

5. Treatment and Transport Protocols shall address the following:
   A. EMS MD or designee present at established Medical Control communication points and a written Expanded Scope of Practice Standard Operating Procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;
   B. The use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines, accessing central lines, and medication-assisted intubation; and
   C. Patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

6. Quality Assurance Program
    A. The Tier II transport provider shall develop a written QA plan approved by the EMS System and the Department in accordance with subsection (f)(6)(D). The participating provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
    B. The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.
    C. An EMS MD or SEMSV MD shall oversee the QA program.
    D. The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
        i. Review of transferring physician orders and evidence of compliance with those orders;
        ii. Documentation of vital signs and frequency, and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
        iii. Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;
        iv. Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
        v. Review of any Medical Control contact for further direction;
        vi. Documentation that unusual occurrences were promptly communicated to the EMS System; and
        vii. A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.

    E. The QA Plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

TIER III

Tier III provides the highest level of ground transport care for patients who require nursing level treatment modalities and interventions.

1. Minimum Personnel Staffing and Licensure
    A. EMT, A-EMT, EMT-I or Paramedic (as driver); and
    B. Two critical care prepared providers, who shall remain with the patient at all times:
        i. Paramedic or PHRN/PHPA/PHAPRN; and
        ii. RN or PHRN/PHPA/PHAPRN.

2. Education, Certification, and Experience: Paramedic or PHRN
    A. Initial Advanced Formal Education
        i. Approval to practice by EMS System and the Department in accordance with the EMS Program Plan;
        ii. At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education nationally recognized program models; and
        iii. Demonstrated competencies, as documented by EMS MD and SEMSV MD and approved by the Department; and

iv. Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier II levels as approved by the Department.

B. CE Requirements
   i. The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;
   ii. The following valid credentials, at a minimum, shall be maintained: ACLS, PEPPO or PALS, ITLS or PHTLS;
   iii. A minimum of 40 hours of critical care level CE shall be completed every four years;
   iv. The EMS provider shall maintain documentation of compliance with subsection (g)(2)(B)(i) and shall provide documentation to the EMS Resource Hospital upon request; and
   v. Nationally recognized critical certifications shall be maintained and renewed based on national recertification criteria.

C. Experience
   i. Minimum of two years experience functioning in the field at an ALS level;
   ii. Documented demonstrated competencies; and
   iii. Completion of annual competencies of expanded scope knowledge, equipment and procedures.

3. Education, Certification and Experience – Registered Nurse:
   A. CE Requirements
      i. A minimum of 48 hours of critical care level education shall be completed every four years;
      ii. The EMS provider shall maintain documentation of compliance with subsection (g)(3)(A)(i) and shall provide documentation to the EMS Resource Hospital upon request; and
      iii. Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed.

   B. Certifications
      Tier III personnel shall maintain the following renewable critical care certifications and credentials in active status:
      i. ACLS;
      ii. PALS, PEPP or ENPC;
      iii. ITLS, PHTLS, TNCC or TNS; and
      iv. ECRN or equivalent.

   C. Advanced Certification Preferred but not Required
      i. Certified Emergency Nurse (CEN);
      ii. Critical Care Registered Nurse (CCRN);
      iii. Critical Care Emergency Medical Technician-Paramedic (CCEMT-P);
      iv. Certified Registered Flight Nurse (CFRN); and
      v. Certified Transport Registered Nurse (CTRN).

   D. Experience
      i. Two years of experience with demonstrated competency in a critical care setting; and

ii. Documented demonstrated EMS System competencies.

4. Medical Equipment and Supplies
   A. Tier III transport requires nursing level treatment modalities and interventions as agreed upon by the sending physician and the accepting physician at the receiving facility. If either physician is not available for consult, the EMS MD or SEMSV MD or designee shall direct care.

5. Vehicular Standards
   A. Any vehicle used for providing CCT shall comply, at a minimum, with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

6. Treatment and Transport Protocols shall address the following:
   A. Paramedic or PHRN/PHPA/PHAPRN: EMS MD or designee present at established Medical Control communication points and written Critical Care Standard Operating procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;

   B. Registered Nurse: The provider's EMS MD or SEMSV Critical Care MD may establish standing medical orders for nursing personnel, or the RN may be approved to accept orders from the sending physician or receiving physician.

7. Quality Assurance Program
   A. The Tier III transport provider shall have a written QA plan approved by the EMS System and the Department, in accordance with subsection (g)(7)(D). The provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
   B. The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.
   C. An EMS MD or SEMSV MD shall oversee the QA program.
   D. The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
      i. Review of transferring physician orders and evidence of compliance with those orders;
      ii. Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
      iii. Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status or changes in neurological examination, and evidence that interventions were appropriate for those events;
      iv. Documentation of any unanticipated discontinuation of a catheter or rate

adjustments of infusions, along with rationale and outcome;
v. Review of any medical control contact for further direction;
vi. Prompt communication of unusual occurrences to the EMS System;
vii. A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.

E. The QA plan will be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).

VI. REFERENCES – None.

- IDPH Administrative Rules, 77 Ill Administrative Code Section 515.860 – Critical Care Transport
- ECIEMS Interfacility Transfer Form

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: Operations

Page: 1 of 2

Title: Disaster Deployment

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 08/2024

VII. PURPOSE

The purpose of this policy is to provide guidelines for disaster deployment of an ambulance.

VIII. POLICY

Prior to deployment, the provider MUST get approval from the EMS Medical Director and IDPH.

Complete the IDPH *System Modification Form* and send it to the EMS office for appropriate signatures.

1. Tip: Do NOT fill in the “Requested Level” box.
2. Tip: In the Comment Box of the System Modification Form indicate the following:
   a. What vehicle is deploying
   b. Where you are deploying
   c. Why you are deploying
   d. Names and license numbers of crew members deploying
   e. Anticipated length of stay

A. The EMS Medical Director will send the request to IDPH.
B. Once the System Modification Form has been approved by IDPH, the vehicle(s) and crew may deploy.

Upon returning from disaster deployment, the provider MUST get approval from the EMS Medical Director and IDPH before the deployed vehicle can return to service within the response area.

A. Complete the IDPH *System Modification Form* and send it to the EMS office for appropriate signatures.
   1. Tip: Do NOT fill in the “Requested Level” box.
   2. Tip: In the Comment Box of the System Modification Form indicate the following:
      a. What vehicle was deployed
      b. Where you were deployed
      c. Why you were deployed
      d. Names and license numbers of crew members deployed
      e. Date you initially deployed
      f. Any unfavorable conditions to the vehicle
B. The EMS Medical Director will send the request to IDPH.
C. The EMS System or Regional EMS Coordinator may at any time request an inspection to be completed on the deployed vehicle by means of self-inspection, system inspection or IDPH inspection before the vehicle can return to service.

D. Once the System Modification Form has been approved by IDPH, the vehicle(s) may return to service within the response area.

IX. REFERENCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 7

Title: EMS Controlled Substances

Original Policy Date: 05/2016
Current Effective Date: 01/2024
Last Review Date: 05/2023
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of the Controlled Substance Policy is to provide guidelines for the security, storage, administration, documentation and replacement of controlled substances for the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. All drugs approved for distribution to EMS agencies and administration to EMS patients shall be procured, deployed, stored, inventoried, clinically administered, documented, restocked, and records kept in compliance with laws, rules, regulations, and policies and procedures that govern EMS drug oversight and administration.

EMS Agency Liability

A. EMS agencies under the EMS MD's supervision, are liable for ensuring the proper use, maintenance, reporting, and security of controlled sustances used by the agency. Before the Protecting Patient Access to Emergency Medications Act (PPAEMA), liability regarding use of controlled substances by an EMS agency was placed on the DEA-registered medical director or the hospital overseeing the agency.
B. A registered emergency medical services agency, under the supervision of a medical director, shall be responsible for ensuring that:
    1. all emergency medical services professionals who administer controlled substances using the sytem's registration act in accordance with the requirements of this policy and all other applicable policies;
    2. all emergency medical services personnel licensed, credentialed, and authorized to access or handle controlled substances are educated and competent in established policies, procedures, and regulatory requirements.
    3. the recordkeeping requirements are met in accordance with this policy;
    4. the applicable physical security requirements established by regulation of the Attorney General are complied with wherever controlled substances are stored by the agency in accordance with the storage subsection;

Storage and Accountability

A. All controlled substances shall be kept in a drug box/bag or cabinet within the ambulance and secured with a numbered tamper-proof tag labeled with the earliest expiration date. Tag numbers are to be recorded on the **Controlled Substance Daily Security Log.**
    1. Out-of-Service: EMS vehicles that are out-of-service (inoperable, not available for current operation, no crew available, not functional) shall have their controlled substances removed, secured appropriately and accounted for per the "Non Full-Time Agencies" section. This does not apply to an ambulance that is OOS secondary to the crew having lunch, completing reports or other duties, which prevent temporary response to calls.

B. When the crew is not physically inside the unit, controlled substances will be secured on the apparatus by locking all exterior doors or compartments. The crew members assigned to that unit are the only personnel authorized to unlock the unit.

C. Once a drug box/bag is opened, it should remain on the advanced provider's person until it is secured with a new numbered tamper-proof tag.

D. At the beginning of each shift, two (2) advanced EMS providers (Paramedic, EMT-Intermediate or PHRN/PHPA/PHAPRN) will verify that the numbered tags are secure and match the number recorded on the **Controlled Substance Daily Security Log** and/or the last entry on the **Controlled Substance Administration Log**. Upon verification, both EMS providers must sign the log.
    1. If the numbered tag is not intact or cannot be verified, a complete inventory must be taken immediately and a supervisor notified. An East Central Illinois EMS Risk Screen must be completed and submitted to the EMS System Coordinator within 24 hours of the finding.
    2. The **Controlled Substance Daily Security Log** will be changed at the end of each month. Thus, a new log will be started on the 1st day of each month.

E. Controlled substances shall be inspected once a month with a supervisor and advanced provider (Paramedic, EMT-Intermediate, or PHRN/PHPA/PHAPRN). The inspection is documented on the **Controlled Substance Monthly Inventory Log**. If no discrepancies are found, the drug box/bag is secured with a new numbered tamper-proof tag labeled with the earliest expiration date and the log is signed and witnessed. *The old tag number and new tag number should also be recorded on the **Controlled Substance Administration Log** and labeled as "Monthly Inventory".*
    1. Any discrepancies (missing medications, broken seals, unverified lock number, etc.) must be reported to a supervisor immediately. An East Central Illinois EMS Risk Screen must be completed and submitted to the EMS System Coordinator within 24 hours of the finding.

F. The **Controlled Substance Monthly Inventory Log,** completed **Controlled Substance Daily Security Logs** and applicable Patient Care Report (PCR)/EMS Short Form for that month shall be submitted to the EMS System Coordinator on a monthly basis.

G. Controlled substances shall be available for inspection by IDPH, East Central Illinois EMS Office, or any other authorized individual announced or unannounced.

Patient Administration and Documentation

A. Advanced providers (Paramedic, EMT-Intermediate or PHRN/PHPA/PHAPRN) may only administer a controlled substance in accordance with the East Central Illinois EMS System treatment protocol(s) and/or a direct order from an on-line medical control physician.

B. When a controlled substance is administered in patient care, the Patient Care Report (PCR) will contain at a minimum in relation to the controlled substance:
   1. Date of administration
   2. Time of administration
   3. Patient name
   4. Patient address
   5. Reason for administration / Medical condition being treated
   6. Physician name (if administered by on-line medical control order)
   7. Medication name
   8. Medication strength
   9. Dosage form
   10. Quantity administered and route
   11. Quantity wasted
   12. Name of employee performing the administering/wastage
   13. Name of RN witnessing any wastage

C. Each usage of a controlled substance shall be documented on the **Controlled Substance Administration Log**. All items on the log must be completed.

Controlled Substance Exchange and Replacement

A. All controlled substances utilized in prehospital patient care will be exchanged on a 1:1 basis. An EMS Short Form or Patient Care Report (PCR) is required at the time of replacement in order to replace or exchange any medications.

B. For portions of controlled substances not given, the unused portion will be discarded in the presence of both the paramedic and an Emergency Department nurse. Discarded or wasted medication shall be documented on the **Controlled Substance Administration Log** and signed by advanced provider (paramedic, EMT-Intermediate or PHRN/PHPA/PHAPRN) and an Emergency Department nurse.

C. Controlled substances should be replaced by the hospital pharmacy. In the event that the pharmacy is closed, the controlled substance will be replaced in the Emergency Department by an RN.

    1. The ED RN will enter restock as “EMS” Ambulance “#”, patient last name in pyxis. Example – “EMS PRO 8987, Smith”

D. After use of controlled substances in the field, the EMS provider will bring the empty vial to the receiving hospitals for resupplying.

E. The **Controlled Substance Administration Log** must be completed in its entirety and contain the minimum information:
    1. Date and Time of Administration
    2. Run/Incident Number
    3. Patient’s name
    4. Medication, Dose Administered, Waste Amount and Total Dose (Amount administered + Amount Wasted)
    5. Tag Number(s)
    6. Signature of the RN witnessing the wastage of the used medication and resupplying the medication and the advanced EMS provider (Paramedic, EMT-Intermediate and PHRN/PHPA/PHAPRN) accepting the medication.
    7. Any amount of a controlled substance that is not used or broken shall be wasted by the advanced EMS provider (EMT-P or EMT-I) and witnessed by the RN personnel and documented on the log sheet.

F. After restocking a controlled substance, the drug box/bag must be secured with a new RED numbered tamper-proof tag labeled with the earliest expiration date and the new tag number recorded on the **Controlled Substance Administration Log.**

G. A DEA 222 Form will be filled out for all Schedule 2 controlled substances dispensed.

*** When replacement is not feasible (i.e patient is transported to a non-associated hospital or unit has to respond to emergency call prior to replacement) receiving facility should witness wastage and narcotic box/bag should be sealed with deficient YELLOW numbered tamper-proof tag.

<u>Non-Transporting Agencies</u>

A. All controlled substances administered by non-transporting agencies should be administered as outlined under “Patient Administration and Documentation”.

B. For portions of controlled substances not given by non-transporting agencies, the unused portion will be discarded in the presence of both the non-transporting advanced provider and the transporting advanced provider once arriving on scene. The **Controlled Substance Administration Log** must be filled out.

C. After the witness of wastage, the non-transport advanced provider will place the empty syringe/cartridges/ampule back in to the drug box/bag and drug box/bag must be secured with a new YELLOW numbered tamper-proof tag. (Yellow Tag = Deficient Narcotic Bag)

D. The non-transporting agency will then take the deficient narcotic box/bag to pharmacy for replacement within 48 hours and will fill out the line below the patient that the controlled substance was used for, stating "Pharmacy Resupply", documenting the deficient tag number and the new tag number on the **Controlled Substance Administration Log**.

Non Full-Time Agencies

A. Agencies that do not have full time staff and are not able to perform the daily security checks of controlled substances should perform at minimum weekly security checks with two (2) advanced EMS providers (Paramedic, EMT-Intermediate or PHRN/PHPA/PHAPRN) and document this on the **Controlled Substance Daily Security Log.**

Responsibilities of the Resource and Associate Hospitals

A. The Resource and Associate Hospitals will accept any excess controlled substances from the EMS providers and dispose of such substances according to appropriate hospital and DEA policy. The hospitals, upon proof of use, will then replace the controlled substance used by the ALS/ILS provider.

Hospital Owned Ambulance Services

A. Those ambulance services that are owned or directly affiliated with Participating Hospitals shall be allowed to use their own internal medication replacement policies that have been developed in conjunction with Participating Hospitals after they have been approved by the EMS Medical Director. Those ambulance services must still use the standardized Controlled Substance Logs (i.e. **Controlled Substance Daily Security Log, Controlled Substance Administration Log, Controlled Substance Monthly Inventory Log**).

Restock Inventory **(Requires Special Approval by ECIEMS Medical Director)**

A. Those EMS agencies in the East Central Illinois EMS System who are not able to get their medications restocked at an approved EMS System Hospital may request to keep an inventory of controlled substances at a mutually agreed upon location in order to more efficiently restock apparatus inventory.
    1. ECIEMS Agencies may NOT keep an inventory of controlled substances at their stations unless specifically approved by the ECIEMS Medical Director and all applicable forms and licenses are obtained.

B. Controlled substances will be kept at an agreed upon secured location within the agency's station.

1. The controlled substances will be kept in a locked, electronic safe such as the Knox DrugBox, or similar safe, in order for the ECIEMS Office to remotely audit its user's access.
2. The safe shall be kept inside of a secured room that is able to be locked 24/7.
3. The names of those agency personnel who will have access to the controlled substance safe shall be submitted to the East Central Illinois EMS Office.

C. The par levels for controlled substances kept within the secured safe shall be dictated by the ECIEMS Medical Director.

D. Restocking of the restock inventory shall be done through an approved ECIEMS System Hospital Pharmacy in conjunction with ECIEMS Office.
   1. A DEA 222 Form will be filled out for all Schedule 2 controlled substances dispensed.

E. A **Controlled Substance Daily Security Log** shall be filled out on a daily basis recording the numbered tamper-proof tag for the controlled substance inventory kept in the safe.

F. Controlled substances shall be inspected once a month with two authorized personnel. The inspection is documented on the **Controlled Substance Monthly Inventory Log**. If no discrepancies are found, the controlled substances are secured with a new numbered tamper-proof tag labeled with the earliest expiration date and the log is signed and witnessed.
   1. Any discrepancies (missing medications, broken seals, unverified lock number, etc.) must be reported to the East Central Illinois EMS Office immediately. In addition, an East Central Illinois EMS Risk Screen must be completed and submitted to the EMS System Coordinator within 24 hours of the finding.

G. The East Central Illinois EMS System Medical Director or their designee reserves the right to inspect the controlled substances, announced or unannounced.

<u>East Central Illinois EMS System Record Keeping</u>

A. Per DEA policy, all records related to controlled substances must be maintained and be available for inspection for a minimum of **<u>two</u>** years

*** RED Tag → Full/Restocked narcotic box/bag
YELLOW Tag → Deficient/Used narcotic box/bag

REFERENCES – None

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: EMS Medication Exchange and Replacement Policy

Original Policy Date: 05/2016
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of the EMS Medication Exchange and Replacement Policy is to provide guidelines for the exchange and replacement of expired, soon-to-be expired, damaged or medications used in refusal of service.

II. DEFINITION – None.

III. POLICY

Medication Exchange and Replacement

A. All medications utilized in prehospital patient care will be exchanged on a 1:1 basis. An EMS Short Form or Patient Care Report (PCR) is required at the time of replacement in order to replace or exchange any medications.

B. All medications will be replaced by the hospital pharmacy. In the event that the pharmacy is closed, the medication will be replaced in the Emergency Department by an RN.

Soon-to-be Expired/Damaged Medications

A. All drugs, according to FDA, are dated with an expiration date on the outside of the box. If dated with month and year only, the drug will expire on the last day of indicated month. (For example, 10/05 will expire 10/31/05.)

B. In order to replace soon-to-be expired or damaged medications through the pharmacy prior to the expiration date, the **Expired/Replacement Medication Request Form** must be completed and faxed to the EMS office for approval at least 24 hours prior to pick-up.

C. Once approved by the EMS office, the form will be forwarded to the pharmacy and the agency will be notified.

D. When picking up medication from the pharmacy, you will be asked to present an agency issued ID.

E. Expired medications must be brought with and given to the pharmacy at time of pick-up.

Refusal of Service

A. When there are medications used for prehospital care of a patient and the patient is a documented refusal of service, the following procedure must be followed:
    1. Fax a copy of the Prehospital Run Report or EMS Short Form and a completed **Expired/Replacement Medication Request Form** to the pharmacy indicating the medications used.
    2. Medications may be exchanged on a 1:1 basis at the expense of the EMS agency and must be exchanged by the pharmacy only**.**

IV. REFERENCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: High Performance CPR

Original Policy Date: 07/2016
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

To improve the overall survival rate of sudden out-of-hospital cardiac arrest patients within the East Central Illinois EMS System. Research indicates that High Performance CPR (HP CPR) along with Code Resource Management (CRM) can save lives. In order to have effective HP CPR ALL involved must work as team. This systematic change in treatment and management of cardiac arrest patients is based on research and practices being used in many other high performance EMS systems across the county. Minimal breaks in compressions, full chest recoil, adequate compression depth, and adequate compression rate are all components of CPR that can increase survival from cardiac arrest. Together, these components combine to create high performance CPR (HP CPR).

II. DEFINITION – None.

III. POLICY

A. Effective Compressions

1. CPR should be initiated immediately upon identification of cardiac arrest as long as the scene is safe.
2. Compressors should be rotated **every 2 minutes.**
3. Ideally, one compressor is on each side of the patient's chest (one person compressing and the other person ready to start)
4. Maintain compression depth of **at least 2 inches.**
5. Compression should allow for complete chest recoil/decompression between compressions (50% Compression / 50% Decompression).
6. Compressor shall also rotate when a decrease in ETCO2 is observed.

B. Continuous Compressions

1. Compressions at a rate of **100-120 per minute** for 2 minutes (use of a metronome is recommended).
   (Compression Fraction > 60%)
2. Do NOT interrupt chest compressions during the 2 minute cycle for ANY reason.
3. Treatments such as ventilations, IV/IO access, or intubation shall be done while CPR is ongoing.
4. After completion of a two-minute cycle, a phase to assess pulses and/or defibrillate will be limited to <10 seconds.

C. Defibrillation

1. Turn on the AED/monitor as soon as cardiac arrest is confirmed.
2. Chest compressions should NOT be interrupted to remove clothing or place defibrillation pads.
3. Compressions should continue during charging of the AED; pausing only for analysis and shock delivery.
4. Compressors will hover over the patient with hands ready during defibrillation so compressions can start IMMEDIATELY after a defibrillation.
5. NO PULSE CHECKS AFTER SHOCKS.
6. Manual Defibrillator
    a. Charge to appropriate energy level as the end of the compression cycle nears (approx. 1 minute and 45 seconds into a two-minute cycle).
    b. At the end of the two-minute cycle, the patient will be cleared, the rhythm will be interpreted rapidly and then the patient will either be defibrillated or the defibrillator energy will be cancelled.
    c. This sequence must be performed **within 10 seconds.**
    d. Rhythm interpretation will not occur after a shock, but only after the two-minute cycle of CPR is performed.

D. Ventilations

1. Once an advanced airway is in place, ventilations will be performed WITHOUT STOPPING chest compression.
2. Once an advanced airway is in place, ventilations will be asynchronous with compressions during the recoil phase (**1 ventilation for every 10 compressions** which equates to about **1 ventilations every 6 seconds**).
3. Compressions should NOT be interrupted to place an advanced airway.

E. Mechanical CPR Devices

******Mechanical CPR devices should be used in accordance with the devices specific instructions.

1. Per AHA 2015 manual chest compression remain the standard of care for the treatment of cardiac arrest.
2. Mechanical CPR devices may be reasonable alternative to conventional CPR in specific settings where delivery of high-quality manual compressions may be challenging or dangerous for the provider:
    a. Limited rescuers available
    b. Prolonged CPR
    c. CPR during hypothermic cardiac arrest
    d. CPR in a moving ambulance
3. Placement of mechanical CPR device should not create excessive interruptions in compressions.
4. Mechanical CPR devices should be deployed by providers who have received proper training on the device and a trained provider should accompany any patient who the device is being used on for the duration of transport.
5. Upon arrival at the hospital, the mechanical CPR device should be left in place and active until the receiving ED staff advises otherwise.
6. Impedance Threshold Devices (ITD) should only be considered when using mechanical CPR devices that are capable of doing active compression-decompression CPR.

F. Advanced Life Support

1. ALS providers will address manual defibrillation, IV/IO access medication administration and advanced airway placement, as indicated.
   *** However, intubation is no longer a primary focus of cardiac arrest management and any advanced airway intervention should NOT interrupt chest compressions
2. Capnography should be utilized to optimize CPR performance and evaluation of ROSC.
   a. EtCO2 > 10 mm Hg is indicative of quality CPR.
   b. Abrupt sustained increase in EtCO2 is indicative of potential ROSC.

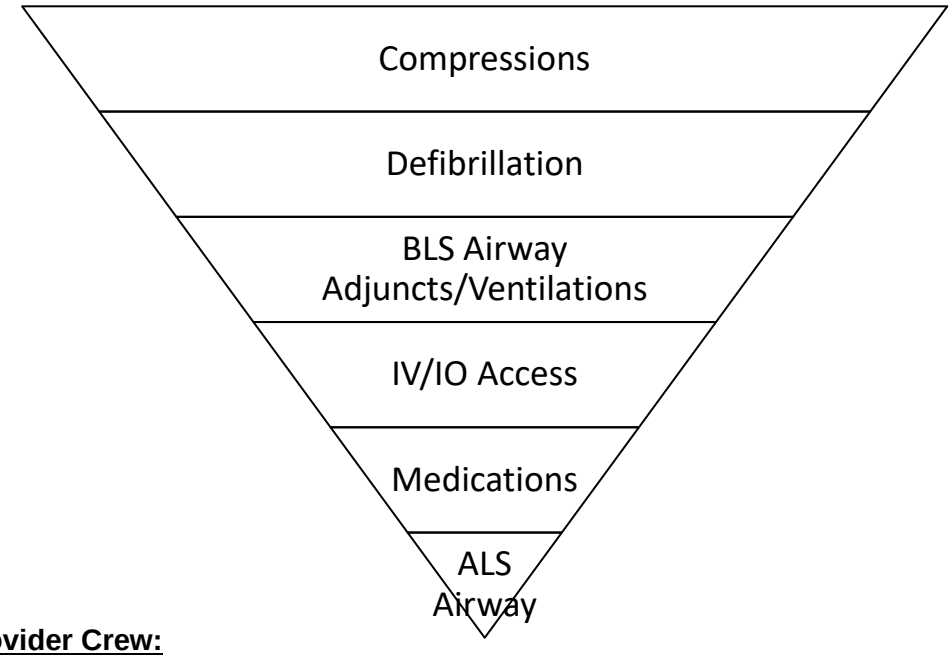
G. Return of Spontaneous Circulation (ROSC)

1. Refer to RETURN OF SPONTANEOUS CIRCULATION Protocol

H. Transport Considerations

1. Medical Cardiac Arrests generally do not benefit from “load-n-go” situations.
2. Patient’s best chance of survival is obtaining ROSC on scene (working where found).
3. Consider “load-n-go” for traumatic arrests.
4. Transport rapidly after obtaining ROSC, and after prolonged resuscitation for persistent V-fib/Pulseless V-Tach.

Crews should coordinate their duties keeping the call priorities in mind. Intervention priorities are (in order of highest to lowest):



2 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Ventilate, attach/operate AED/Defibrillator, assume crew leader responsibilities.
(providers rotate positions every two minutes)

***Roles remain the same even if providers are ALS equipped*

3 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Crew Leader, attach/operate AED/defibrillator
Provider 3 – Ventilate
(Providers 1 and 3 rotate every two minutes)

***Roles remain the same even if providers are ALS equipped*

4 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Attach/operate AED/Defibrillator
Provider 3 – Ventilate
Provider 4 – Crew Leader *(Preferably ALS)*
(Providers 1, 2, and 3 rotate every two minutes)

***Once first two roles have begun treatment, ALS providers will establish IV/IO and administer medications*

Greater Than 4 Providers:

Utilize the same initial assignments as the four provider crew. The crew leader will assign additional roles such as informing the family of patient status, gathering patient information, and documenting the medical interventions performed on the call. If resources allow, rotate additional providers to do chest compressions to achieve optimal performance.

Positions for 6-Person High-Performance Teams*

Leadership Roles

Team Leader

- **Every resuscitation team must have a defined leader**
- Assigns roles to team members
- Makes treatment decisions†
- Provides feedback to the rest of the team as needed
- Assumes responsibility for roles not defined

IV/IO/Medications†

- An ALS provider role
- Initiates IV/IO access
- Administer medications

Timer/Recorder

- Records the time of interventions and medications (and announces when these are next due)
- Records the frequency and duration of interruptions in compressions
- Communicates these to the Team Leader (and the rest of the team)

Resuscitation Triangle Roles

Compressor

- Assesses the patient
- Performs compressions according to local protocols
- Rotates every 2 minutes or earlier if fatigued

Monitor/Defibrillator/CPR Coach

- Brings and operates the AED/monitor/defibrillator and acts as the CPR Coach if designated
- If a monitor is present, places it in position where it can be seen by the Team Leader (and most of the team)

Airway

- Opens the airway
- Provides bag-mask ventilation
- Inserts airway adjuncts as appropriate†

The team owns the code. No team member leaves the triangle except to rotate compressors or to protect his or her safety.

*This is a suggested team formation. Roles may be adapted to local protocol.
†Roles and tasks are performed by advanced providers.

IV. REFERENCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: Immunization/Vaccination Administration Policy

Original Policy Date: 01/2022
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

To allow EMS agencies to administer vaccinations to persons 6 years of age and older on an as needed basis for the health and wellness of their personnel and to assist local health officials with vaccine administration during a declared public health emergency. Only those EMS providers/agencies approved by the EMS Medical Director may administer vaccinations.

II. DEFINITION – None.

III. POLICY

A. Prerequisites
1. Illinois licensed AEMT's, EMT-Intermediates, Paramedics and PHRN's/PHPA's/PHAPRN's who are members in good standing with the East Central Illinois EMS System.
2. Successful completion of the EMS Vaccination/Immunization education module, including skill validation.
3. Final approval from the EMS Medical Director. A list of approved providers will be kept on file in the EMS System office.

B. Education
1. One (1) hour EMS Vaccination/Immunization education module
2. Intramuscular injection skill validation
3. "Just In Time" refresher training specific to the vaccine to be administered
4. Annual continuing education

C. Vaccinations covered in this plan:
1. Influenza
2. Coronavirus (COVID-19)

D. Personal Protective Equipment Needed:
1. Surgical facemask
2. Eye protection
3. Disposable gloves

E. Communication
   1. EMS agencies/providers must provide the following information to the East Central Illinois EMS System before administering vaccines:
      a. Type of vaccine to be administered
      b. Location where the vaccine will be administered (i.e. home agency, hospital, community setting)
      c. Date and time when the vaccine(s) will be administered
   2. Complete an IDPH Special Event Form and submit to the EMS office.

F. Storage and Handling
   1. Follow specific manufacturer recommendations.

G. Vaccine Waste and Disposal
   1. The healthcare provider in possession of the vaccine is responsible for its proper disposal. Vaccines should not be flushed down the toilet, poured down the drain, dispensed into the sink, or put in the regular trash.

H. Quality Assurance:
   1. The EMS system and EMS agency will retain a record of all instances where EMS personnel are used for the administration of vaccines.
   2. All required documentation for the specific vaccine must be completed.
   3. All adverse events shall be recorded in writing using the Vaccine Adverse Event Reporting System (VAERS) form and VAERS web site at www.vaers.hhs.gov or by calling 1-800-822-7967. All adverse events will be reviewed by the EMS Medical Director.
   4. If emergency patient care is required, EMS providers will follow the EMS System protocols. A patient care report must be completed if emergency patient care is provided.

IV. RESOURCES

ECIEMS Protocol: *Immunization/Vaccination Administration*
CDC References:
https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html
https://www.cdc.gov/vaccines/hcp/admin/document-vaccines.html
Screening Form Examples:
COVID-19 Vaccine Screening Form:
https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf
General Vaccine Screening Forms: https://www.cdc.gov/vaccines/hcp/admin/screening.html
VIS/EUA Fact Sheets
COVID-19 EUA Fact Sheet
https://www.cdc.gov/vaccines/covid-19/eua/index.html
Influenza Vaccine Information Statement
Inactivated: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html
Live, Intranasal: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.html

Current VIS's: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: Infection Control

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish guidelines to prevent the transmission of communicable diseases in the prehospital environment.

II. DEFINITION – None.

III. POLICY

EMS Providers are responsible for providing care to patients while following precautions for exposure to communicable diseases and/or body substances. Because EMS Providers have a higher than normal risk of exposure to body substances and communicable diseases the following precautions are recommended:

A. Hand washing: Regardless of the use of gloves, all EMS Providers wash their hands before and after patient contact. Each ambulance is recommended to carry alcohol-based foam/liquid for immediate cleansing in the case of direct body substance exposure to the skin.

B. General Body Substance Isolation (BSI)
   1. Gloves are to be worn when there may be contact with body substances from a patient. Any open wounds or dermatitis on the skin of EMS Providers should be covered with a sealed moisture proof substance.
   2. Safety glasses and goggles should be used whenever there may be splattering of body substances.
   3. Masks should be worn when there is risk of contact with body substances on mucus membranes (i.e. intubation, suctioning, major facial trauma).
   4. NIOSH-APPROVED N-95 masks (such as a HEPA mask) should be worn whenever there is direct contact with a patient who is known or suspected to have a transmissible respiratory disease (i.e. tuberculosis).
   5. Only NIOSH-APPROVED N-95 masks which have been fit-tested for EMS providers prior to use are recommended.
   6. Patients with a productive cough and known or suspected transmissible respiratory disease should wear a mask during transport.

C. Cardiopulmonary Resuscitation: Disposable resuscitation masks with one-way valves are carried by all EMS agencies/providers and are easily retrievable when the need arises. NO EMS PROVIDERS SHALL PERFORM UNPROTECTED MOUTH-TO-MOUTH RESUSCITATION.

D. Pregnant EMS Providers: Due to the risk to the fetus, pregnant EMS Providers must be especially familiar with and strictly adhere to the precautions outlined in this policy.

E. Needles, Syringes and Sharps: Contaminated needles, syringes and other medical sharps are disposed of in a rigid puncture resistant container. Full containers are brought to an East Central Illinois EMS facility Emergency Department for proper disposal.

F. Body Wastes: Body substances collected in the course of providing patient care (i.e. urine, emesis, suction bottle contents) are placed in a biohazard bag, sealed and left at a designated location at the receiving hospital.

G. Linens and Clothing: Linens soiled with body substances are placed in leak proof bags. Laundering of linens is done per individual EMS agency arrangements. EMS provider uniforms soiled with body substances must be changed as soon as possible for clean clothing. Soiled clothing is cleaned according to OSHA guidelines.

H. Ambulances and Equipment:
   1. Gloves should be worn throughout the cleaning process.
   2. Ambulances, cots and all non-disposable equipment should be cleaned with an approved disinfectant after each patient use. Additional sanitation with a 1:10 bleach solution may be used as needed.
   3. Laryngoscope blades are to be cleaned and soaked for 15-20 minutes in an approved disinfectant solution, then rinsed and air-dried.

Significant Exposure to Body Substances and/or Communicable Disease

A significant exposure to a body substance and/or communicable disease is defined as:

A. Body substance contact:
   1. Via a percutaneous puncture by a contaminated needle or other sharps;
   2. On a provider's mucous membranes (eyes, nose, mouth);
   3. On a provider's non-intact skin.

B. Exposure to one of the diseases listed in the policy on Communicable Disease Notification.

Any EMS provider with a significant exposure will take the following steps:

A. Immediately clean the area with soap and water and/or alcohol-based foam/liquid. Irrigation is recommended for eye exposure.

B. Report to an appropriate facility (Emergency Department, Occupational Health, or other approved facility) for evaluation. Register under Worker's Compensation for your provider agency. If the provider is unsure whether or not the exposure was significant, he or she may contact an East Central Illinois EMS associated ED and talk with the physician or triage nurse on duty.

C. Complete an East Central Illinois EMS System Risk Screen, and return the form or fax it to the EMS office within 24 hours of the exposure.

D. The EMS provider will be contacted by the appropriate person at the treating facility (Occupational Health, Emergency Department, Infection Control office) when lab results are available, and will be given follow-up instructions.

E. The EMS provider will contact the East Central Illinois EMS office when all follow-up is completed to allow completion of the Risk Screen.

F. The East Central Illinois Risk Screen forms are considered confidential and will be kept in a secure location in the EMS office.

Exposure to Communicable Disease Notification

A. If a patient is transported by an EMS agency/provider, and during the normal course of medical events is diagnosed as having a communicable disease, the treating facility is required to notify the EMS agency/provider and the EMS office in writing within 72 hours.

B. EMS providers who are exposed to patients with any of the following diseases are required to be notified:

1. Rubella
2. Measles
3. Tuberculosis
4. Meningitis or meningococcemia
5. Mumps
6. Chicken pox
7. Herpes simplex
8. Diphtheria
9. Human Rabies
10. Anthrax
11. Cholera
12. Plague
13. Poliomyelitis
14. Hepatitis B
15. Louse borne typhus
16. Smallpox
17. Hepatitis non A/non B

18. Acquired Immunodeficiency Syndrome (AIDS)
19. AIDS related complex (ARC)
20. Human Immunodeficiency Virus (HIV) Infection

C. The written notification which is sent to the EMS agency/provider includes the following information:
    1. The names of prehospital providers as listed on the prehospital care record.
    2. The patient's diagnosed disease.
    3. The date that the patient was transported.
    4. A statement that this information is to be confidential.

IV. REFERENCES – East Central EMS Risk Screen

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 4

Title: Intercepts

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for a system-wide tiered response process to increase the survival rate of critically ill or injured patients.

II. DEFINITION – None.

III. POLICY

A. All non-transport agencies that identify patients in need of emergency medical care must notify a transport agency immediately.

B. Intermediate and Basic Life Support agencies that encounter a patient who requires medical care at a higher level of care must call for an intercept as soon as the need is recognized. In calling for an intercept, agencies shall abide by the following guidelines:

1. The EMS agency shall follow the East Central Illinois EMS System Intercept Criteria Protocol.

2. The EMS provider with the higher level of medical training takes whatever medical equipment is deemed necessary and boards the unit of the agency with the lesser medical training for the duration of the transport. Areas that might be left without EMS provider services in their response areas may alter this procedure via System waiver.

3. The EMS provider with the highest level of medical training is responsible for the care of the patient.

1. Activation of an intercept must meet the following standards:
2. The initial EMS providers must arrive on the scene and assess the mechanism of injury/illness. Mutual aid agreements with Advanced Life Support Providers may supersede this.
3. The initial EMS providers must assess the patient and identify the adopted criteria for activation of an intercept.
4. The initial EMS providers must estimate scene time. Initial EMS providers who have extended scene times with a critical patient must activate an intercept with an ALS agency.
5. A critical patient is one whose medical treatment may be enhanced with advanced care.
6. Ambulances and intercept vehicles contact each other by MERCI or other predetermined frequency to arrange a rendezvous site.
7. Pertinent patient care information is transmitted to the intercepting EMS providers prior to the rendezvous, including chief complaint, level of consciousness and respiratory status.

IV. REFERENCES – None.

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 4

Title: Interfacility Transfers (Region 6 Policy)

Original Policy Date: 04/2005
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide consistent guidelines to Region 6 EMS agencies/providers and hospital personnel for interfacility/interregional transports.

II. DEFINITION – None.

III. POLICY

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

A. An attending physician, Emergency Department physician, or physician designee will authorize or request interfacility transports.

B. The transferring physician or physician designee will determine the appropriate receiving facility.

C. The transferring physician or physician designee will receive confirmation of acceptance of the patient from the receiving facility and the receiving physician or physician designee.

D. It is the responsibility of the transferring physician or physician designee to indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.

E. EMS agencies providing interfacility transports may only function to their level of licensure as defined by the National EMS Education Standards and Department regulations unless otherwise stated in this policy.

F. Any patient requiring care at a level higher than the highest level of prehospital care provider available must be transported with an RN or other appropriate professional personnel.

G. Prior to the transport, EMS providers must obtain written orders from the transferring physician or physician designee for all fluids and/or medications being transferred with the patient. EMS providers may only administer/monitor fluids and medications listed within this policy and the East Central Illinois EMS System Protocols. These orders shall be written on the “East Central Illinois EMS System EMS Interfacility Transfer Form”. In the event there are no written orders provided by the transferring provider, the EMS providers will default back to the East Central Illinois EMS System Protocols.

H. A *Transfer Time-Out* shall be conducted for each interfacility transfer prior to initiating transport.

Online Medical Control:

A. Medical Control (MC) may be defined as either the EMS Medical Director, the transferring or receiving MD and as a last resort the ED physician of the transferring or receiving hospital.

B. In any situation that the EMS Provider needs to contact a physician for medical direction they will first attempt to contact the transferring MD or the receiving MD. If unable to reach either one, the EMS MD can be contacted. As a last resort, use on-line medical control at the sending or receiving facility. Any orders from on-line medical control will supersede written orders.

C. If the EMS Provider is unable to contact the receiving or sending facility, the EMS Provider will follow East Central Illinois EMS Protocols until contact can be established. In a situation when medical control is unreachable and intervention is necessary, the transport team will divert to the nearest appropriate medical facility.

Considerations for Transport:

A. Any East Central Illinois EMS agency reserves the right to deny transport under the following conditions:

1. If providing the interfacility transport will impede the ability for the agency to provide 911 response within their response area due to staffing or equipment.
2. If it is deemed the patient is not stable enough for ground transport after consultation with the Medical Director or Medical Control.
3. If the safety of the patient and crew is at significant risk (i.e. weather, road conditions, violent patient, etc.).
4. Patients in active labor (when birth is imminent).
5. Active CPR in progress.

Requesting Additional Personnel:

A. When the EMS provider anticipates that they will require more assistance to appropriately care for the patient during transfer, they shall request the transferring physician/health care provider to provide appropriately trained hospital staff to accompany the patient and assist. The EMS provider must contact Medical Control for medical direction in all situations where they are not comfortable with the circumstances of the transfer. **The transfer will not occur unless the EMS provider and MC are confident the personnel and equipment are appropriate for transfer.**

Levels of EMS Interfacility Transports:

Basic Life Support (BLS) interfacility transport
Minimum staffing: 2 EMT-Basic providers
Includes basic airway management, cardiopulmonary resuscitation including the use of AED's, basic shock management and control of bleeding, basic fracture management and medications within the ECIEMS BLS protocols:

Basic providers may also transport patients with the following:

Foley catheters
Gastric devices (i.e., NG tubes, G tubes, ostomy equipment)
Saline locks
Wound drains
Clamped Vascular devices (i.e., Central lines, Groshong catheters, PIC lines)*
***May not be accessed by Basic providers**

Intermediate Life Support (ILS) interfacility transport
Minimum staffing: 1 EMT-Intermediate and 1 EMT-Basic
Includes all BLS services, cardiac monitoring, IV cannulation/fluid therapy, advanced airway management and medications within the ECIEMS ILS protocols:

ILS providers may also transport patients with the following:
CPAP / BiPAP
IV infusion pumps

Advanced Life Support (ALS) interfacility transport
Minimum staffing: 1 EMT-Paramedic or Prehospital RN and 1EMT-Basic
Includes all BLS and ILS services, cardiac monitoring (including cardiac pacing, manual defibrillation, and cardioversion) and administration/monitoring of medications within the ECIEMS ALS protocols:

The following additional fluids and medications may also be transported by ALS providers:

All crystalloid and colloid solutions
Acetadote
Blood and Blood products **(already initiated)**
IIb/IIIa glycoprotein inhibitors
(Aggrastat, Reopro, Integrilin)
Antibiotics
Atenolol
Calcium Chloride
Calcium Gluconate
Cardene **(drip only)**
Dexamethasone sodium phosphate
Diazepam
Dobutamine
Fentanyl drip
Fosphenytoin
Heparin drip
Hydralazine
Hydrocortisone sodium succinate
Hydroxyzine
Insulin Drip **(non-titratable)**
Isoproteronol
Ketorolac
Labetalol **(drip only)**
Levophed
Lorazepam
Mannitol
Metoprolol **(drip only)**
Nifedipine **(tabs)**
Nitroglycerine drip
Oxytocin
Octreotide
Phenobarbital **(drip only)**
Potassium **(no faster than 10 mEq/hr)**
Pralidoxime chloride
Propanolol **(drip only)**
Protonix
Racemic epinephrine
Sodium nitroprusside
Vitamin K **(already initiated)**

ALS providers may also transport patients with the following:

Pain medication pumps
Femoral artery sheaths
Chest tubes; with written physician orders. If mechanical suction, the amount of mechanical suction must be specified. Refer to "CHEST TUBE MANAGEMENT" in Procedures.

Paramedics may perform interfacility transports of chronic tracheostomy ventilator patients, who have been on ventilator for at least 30 days and are considered medically stable by the requesting provider, using their current home settings and home vent machine. For these stable chronic vent trips a standard two-person ambulance crew, with a single ALS provider in back with the patient is acceptable.

For all patients with newer ventilators and either ETI or trach, or for unstable chronic vent patients, additional advanced staff are required for the transport. This should be either an RT or an RN with critical care experience whenever possible. If utilization of hospital staff to fill this role is not possible, a critical care EMS transport service should then be contacted to perform the transport.

Only in extenuating circumstances when all other options are exhausted may the transport of a ventilator patient be completed with a team consisting of two ALS providers in the back plus an EMT-B or higher licensed driver. All such extenuating circumstance situations must be approved by the ALS agency's manager staff, with medical director consultation as needed.

Approved High-Flow Nasal Cannula devices may be transported by ALS providers that have undergone appropriate training on the equipment, if there are no critical care transport units available. Prior to transport, providers must ensure:

- Adequate battery supply for equipment
- Adequate ambulance oxygen supply
    - Calculate oxygen cylinder duration based on current patient oxygen requirements. https://opencriticalcare.org/oxygen-supply-demand-calculator/

Tank Duration = $\frac{\text{(tank pressure in PSI – 200)x cylinder conversion factor}}{\text{Flow rate in LPM}}$

Cylinder Size	Conversion Factor
D	**0.16**
M	**1.56**
G	**2.41**

- Appropriately trained personnel for equipment
- Safely and securely mounted in ambulance

***If not listed above or in the ECIEMS protocols, a Registered Nurse is required to accompany the patient during transfer/transport.**

IV. REFERENCES – None.

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 1

Title: Line of Duty Death Notification

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 08/2024

II. PURPOSE

Unfortunately, line of duty deaths of EMS providers are on the rise. It is necessary to notify the Illinois Department of Public Health when a licensed EMS provider is killed in the line of duty.

III. DEFINITIONS

B. None

IV. POLICY

B. Any EMS agency that suffers a line of duty death of a licensed EMS provider should notify the EMS System as soon as practical.
C. The EMS System Coordinator will notify the IDPH Regional EMS Coordinator and the IDPH Division Chief of EMS and Highway Safety.
D. If the EMS System Coordinator becomes aware of a line of duty death through unofficial means, they will verify the information and then notify the appropriate IDPH personnel.

V. REFERENCES - None

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 2

Title: Minimum Equipment/Supplies and Medications

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 08/2024

VI. PURPOSE

The purpose of this policy is to define the minimum equipment/supplies and medication requirements for IDPH licensed EMS vehicles in the East Central Illinois EMS System.

VII. POLICY

A. All East Central Illinois EMS agencies must maintain response vehicles in a manner that will limit mechanical breakdown, provide a clean environment, and be engineered for compliance with OSHA standards. Agencies must also have minimum medications, equipment and supplies as specified by IDPH and the EMS System. Every effort should be made to obtain and use latex-free supplies. If a product contains latex Do NOT use without covering equipment or patient.

B. EMS agencies shall notify the EMS Office of any new or replacement vehicles (including temporary loaner vehicles). The EMS office will submit the information to IDPH and arrange for a vehicle inspection, if needed.

C. Non-transport vehicles shall be equipped and stocked in accordance with the IDPH Non-Transport Vehicle Inspection Form and the ECIEMS Inspection Form (level specific).

D. Transport vehicles shall be equipped and stocked in accordance with the IDPH Ambulance Inspection Form and the ECIEMS Inspection Form (level specific).

E. Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as National 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 (Section 515.830).

F. A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, if the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred (Section 515.830).

G. The addition of new equipment not listed on the IDPH Inspection Form or an ECIEMS Inspection form requires approval by the EMS Medical Director. In addition, the EMS Medical Director must be notified of and approve any change in AEDs or cardiac monitoring equipment.

H. IDPH inspection forms may be found on the IDPH website: https://dph.illinois.gov/topics-services/emergency-preparedness-response/ems/provider-vehicle-licensing.html or the East Central Illinois EMS website: https://www.osfhealthcare.org/ems/eciems/forms/

I. East Central Illinois EMS System level specific as well as combined level inspection forms may be found at: https://www.osfhealthcare.org/ems/eciems/forms/

J. The following form is a combination of the IDPH inspection forms and the ECIEMS inspection forms (non-transport and transport) and may be used for routine vehicle equipment checks. This form should not be used for annual IDPH inspections.

VIII. REFERENCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 1

Title: Mutual Aid Agreements

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide consistent guidelines and minimum expectations for mutual aid situations.

II. DEFINITION – None.

III. POLICY

A. All EMS agencies in the East Central Illinois EMS System, both transport and non-transport, must maintain current Mutual Aid Agreements to ensure adequate coverage of their service area at all times.

B. Non-transport agencies must have current Mutual Aid Agreements with transporting agencies. These must be reviewed every two years.

C. When additional resources are required by an EMS agency, Mutual Aid EMS agencies are contacted for assistance.

IV. REFERENCES – None.

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 2

Title: Nearest Facility Bypass

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 06/2023
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to identify circumstances in which bypassing the nearest facility would be acceptable for Region 6 EMS Participants.

II. DEFINITION – None.

III. POLICY

Communication:

A. EMS providers at the point of patient contact will initiate communications with the EMS system hospital. The hospital initiating the bypass or EMS personnel involved will contact the receiving facility to relay the patient assessment findings.

Patient Care Practice:

A. Prehospital patient care will be provided to all adult and pediatric patients in accordance with East Central Illinois EMS System's protocols specific to the provider's level of licensure and appropriate for the patient as determined through patient assessment findings. EMS patients may only be transported to an emergency department classified as comprehensive under the Illinois Hospital Licensing Act.

Transport of Patients with Special Needs/Requests:

A. Patient care circumstances may indicate the need to bypass the nearest hospital in order to manage the needs of the patient based on the presenting assessment. Situations involving special needs may include, but are not limited to:
    1. Specialized services (i.e. Trauma, STEMI, Stroke, OB)
    2. Patient request for transport to a specific health care facility

B. The decision to approve or deny a transport rests with the East Central Illinois EMS System Medical Director or his/her designee responsible for the online medical direction of the call.
    1. Severity of patient condition
    2. Time and distance factors which may affect patient outcome
    3. Regional bypass guidelines (i.e. Trauma, STEMI, Stroke, OB)
    4. Patient's medical decision making capacity.

System By-pass/Diversion:

A. Transfer patterns are considered in the notification of EMS agencies when a bypass/diversion situation exists. Neighboring hospitals which may be impacted by the situation will also be notified. There are specific instances where bypass/diversion may not be possible:
    1. The patient is critical and unable to tolerate transport to a more distant comprehensive medical facility.
    2. The patient refuses transport to another medical facility.
    3. OB emergencies

Quality Assurance/Continuous Quality Improvement:

A. Patient care issues related to inter-system or inter-region transports will be directed to the EMS provider's EMS System for follow-up. Unresolved issues will be managed in accordance with System and Regional conflict resolution policies.

REFERENCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 2

Title: Patient Interactions

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to define who is responsible for patient care in the prehospital setting within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. Whoever is deemed in charge of patient care directs patient care in accordance with East Central Illinois EMS Protocols, Procedures, and East Central Illinois EMS System policies. Patient care responsibility shall be determined as follows:

1. The EMS provider with the highest level of licensure is in charge of patient care in the prehospital setting.
2. If two or more providers have the same level of licensure, the provider with the most experience at that licensure level is in charge of patient care.
3. If two prehospital providers have equal licensure and experience, then the first to make patient contact is in charge of patient care.
4. For the purposes of determining responsibility for patient care at the scene, the following chain of command is used:
    i. Paramedic/Prehospital RN
    ii. AEMT/Intermediate
    iii. Basic
    iv. Emergency Medical Responder

B. Access to the patient and performance of medical care shall be at the direction of the prehospital EMS provider in charge at the scene. This policy is subject to change with regard to the restrictions encountered in a Major EMS Incident.

C. The EMT in charge at the scene can only provide care at the level of licensure of the agency that the EMT represents on that call.

D. If a controversy and/or a disagreement as to protocol or policy arises and Medical Control cannot be contacted for guidance, the EMS provider in charge at the scene takes responsibility for making the final decision.

E. The EMS provider in charge at the scene delegates patient care in the field, and is responsible for the decisions made in delegation.

F. The EMS provider's duty to perform all services and all patient care decisions are to be made without unlawful discrimination (i.e. race, color, age, religion, gender, ethnic background or sexual orientation).

IV. REFERENCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: Patient Transport / Selection of Receiving Facility

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 08/2024

II. PURPOSE

The purpose of this policy is to assure that patients treated within the East Central Illinois EMS System are transported to the appropriate receiving facility.

III. POLICY

A. A person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center, STEMI center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital 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 more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal. (Section 3.20(c)(5) of the Act).

B. The **nearest hospital** is defined as the hospital which is closest to the point of patient contact as determined by travel time and which operates a comprehensive emergency department at the minimum level recognized by the System in its EMS System Program Plan.

C. When a patient is not taken to the nearest appropriate facility, the EMS provider must document the reason on the prehospital run report form. Acceptable reasons for not taking the patient to the closest appropriate facility include:

1. Bypass criteria (i.e., Trauma, STEMI, Stroke, OB - *See Nearest Facility Bypass policy)*
2. Diversion to another facility by Medical Control
3. Major EMS Incident
4. Patient/legal guardian's choice

Patient Hospital Preference

A. A patient/legal guardian has the right to make an informed decision to be transported to the facility of his/her choice.

B. If a patient/legal guardian refuses to be transported to the nearest appropriate facility, the patient/legal guardian should be informed of the risk associated with not being transported to the nearest appropriate facility. Once all risks have been explained, and the patient or the patient's legal guardian demonstrates complete understanding of those risks, the patient should be transported to the facility of choice.

C. If EMS providers determine that the patient/legal guardian's choice of facility would be detrimental to the well-being of the patient or would take the provider agency out of its response area for an extended period, the EMS providers must contact Medical Control.

D. If it is deemed transport to the patient's choice of facility will be detrimental or could possibly incur harm to the patient a refusal of service must be filled out **AGAINST MEDICAL ADVICE**.

E. If the patient continues to refuse transport to the closest appropriate facility, EMS providers must follow these guidelines:

1. Make sure the patient/legal guardian is notified of and understands the risks and benefits of their decision to be transported to a facility other than the closest appropriate facility.

2. Document the patient/legal guardian's refusal of transport to the closest appropriate facility.

3. Remain with the patient at the scene until additional EMS Providers are available to cover the EMS agency's primary response area as listed in the provider's EMS System Plan.

4. The patient is cared for at the highest level of care required to meet his/her needs. The level of care is not diminished due to his/her refusal to be transported to the closest appropriate facility. If the level of care required by the patient is higher than that available by the responding providers, an ALS Intercept is required. *(See Intercept policy).*

Alternative Destination Transports

A. Illinois Administrative Rules allow EMS personnel to conduct assessments of patients with low acuity medical conditions and provide alternative pathways of care other than transport to a hospital-based ED. This may include transport to a licensed healthcare facility such as a licensed mental/behavioral health care facility, licensed drug treatment center, or licensed emergency care center based on System policy. **None of these options currently exist in the East Central Illinois EMS System.**

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 2

Title: Physician Response Vehicle

Original Policy Date: 01/2016
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the East Central Illinois EMS Physician Response Vehicle, utilized by the EMS Medical director or their designee.

II. DEFINITION - None

III. POLICY

The East Central Illinois EMS Physician Response Vehicle (PRV), local call sign – 8950, is intended to enhance patient care and provide education and quality assurance/improvement to the field EMS crews.

A. CRITERIA:

1. The PRV will be staffed by the EMS Medical Director, Associate EMS Medical Director or physician designee that is board certified or board eligible in emergency medicine as appointed by the EMS Medical Director.
2. The PRV will be operated on an as needed basis or may be staffed by the EMS Medical Director or Associate EMS Medical Director as available.
3. The PRV is intended to supplement and not replace EMS field response.
4. Once on scene, the physician should operate under the existing on-scene Incident Command System, however will provide direct On-Line Medical Control.
5. Considerations for requesting a physician response include, but are not limited to:
    a. Critical care that may be beneficial for the patient exceeds the capabilities of on-scene paramedic personnel.
    b. Provide on-scene medical direction at large scale incidents (MCIs, prolonged incidents, etc.)
    c. To provide surgical intervention for patients that would be considered medically salvageable if entrapment, etc. were mitigated.
    d. Other situations where the EMS crew on scene or Incident Commander determines an on-scene physician would be of value.

B. DISPATCH/RESPONSE:

1. To request the East Central Illinois EMS Physician Response Vehicle, the EMS crew/Incident Commander shall contact AMT East Dispatch via radio or by calling (217)337-2911.
2. If the EMS Medical Director or designee is able to respond he/she will contact the requesting EMS crew via radio to advise them that the Physician Response Vehicle is enroute and the estimated time of arrival (ETA).
3. The responding physician shall maintain communication with both AMT East Dispatch and the appropriate county dispatch for the responding agency.
4. The EMS Medical Director and/or designee may travel to any scene where any system participant is providing any medical care in order to assess, oversee and/or direct the medical care provided by any EMS System participant(s). All system participants shall immediately cooperate with and immediately facilitate all such efforts and actions by the EMS Medical Director and/or designee.
5. Lights and sirens will be used by the Physician Response Vehicle when responding to emergencies only in accordance with Illinois law governing emergency response vehicles.

IV. RESOURCES - None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office

Section: Operations

Title: Prehospital Transfer of Care from Higher Level Provider to Lower Level Provider

Original Policy Date: 10/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. POLICY STATEMENT

The "hand-off" or transfer of patients, between EMS providers, particularly between Advanced Life Support (ALS) to Intermediate Life Support (ILS) or Basic Life Support (BLS) represents one of the most important elements of successful pre-hospital patient care.

II. PURPOSE

The purpose of this policy is to provide guidelines for the safe transfer of care from a non-transport on-scene paramedic to an ILS or BLS staffed transport ambulance.

III. DEFINITION – None.

IV. POLICY

A. Criteria for transfer of care from ALS to ILS or BLS must include:
1. The ILS or BLS level provider must agree to the transfer of care.
2. Prior to the transfer of care, a history and physical examination (H&P) must be performed by the ALS provider. This H&P must be documented and the higher level provider must affix their signature to the report. This H&P may be documented on the patient care record of the transporting unit, or on a separate PCR. If documented on a separate PCR, the H&P must be forwarded to the receiving medical facility.
3. With any transfer of care, the provider transferring care must interface directly with the receiving provider and ensure all pertinent information is conveyed.
4. Patent airway, maintained without assistance or adjuncts.
5. Patient appears hemodynamically stable with medical complaints or injuries that could be cared for at the ILS or BLS level.
6. GCS ≥ 14.
7. No mechanism of injury that would warrant a trauma alert or activation.
8. No cardiac, respiratory, or neurological complaints that may warrant ALS intervention.
9. No patient may be transferred to ILS or BLS once an ALS intervention has been initiated.
10. Before transferring care to the ILS or BLS transport ambulance, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition.
11. Any level of provider accepting transfer of patient care must be continuously alert for changes in patient condition and be prepared to provide immediate medical intervention and potentially call for an ALS intercept.

B. Documentation:
    1. Both the transferring and receiving providers shall document the transfer of care in their Patient Care Report (PCR). The ALS Provider will complete an independent PCR which will include the completed H&P from (A-2) and will identify the receiving transport ambulance.
    2. ALS transferring unit is identified on the BLS PCR.

C. The responsibility of transfer of care lies with the ALS provider. If the ILS or BLS provider is not comfortable accepting responsibility for primary care and the providers cannot agree, contact Medical Control for further direction and resolution.

V. REFERENCES – None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Page: 1 of 2

Title: School Bus Incidents
(Region 6 Policy)

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

This policy governs the handling of school bus accidents/incidents involving the presence of minors. This policy is based on the Region 6 School Bus Incident policy. The goal of this policy is to eliminate the transport of uninjured children/students to the hospital and to reduce EMS scene time and utilization of resources

II. DEFINITION – None.

III. POLICY

Each ambulance service provider within East Central Illinois EMS System shall follow this procedure in coordination with school officials.

A. Determine the category of the accident/incident:
   1. Category 1 bus accident/incident: significant injuries present in one or more children/students, or there is a documented mechanism of injury and/or extent of damage to the vehicle that could reasonably be expected to cause significant injuries.

   2. Category 2 bus accident/incident: minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students are also present.

   3. Category 3 bus accident/incident: no injuries present in any children/students and no significant mechanism of injury present.

B. Determine if implementation of this policy is appropriate.
   1. Category 2 or 3 bus accident/incident: Implement the School Bus Incident Policy.

   2. Category 1 bus accident/incident: Do Not implement the School Bus Incident Policy. Follow East Central Illinois EMS Protocols as necessary to transport children/students to the hospital.

C. Contact medical control and advise of the existence of a Category 2 or 3 bus accident/incident. Determine if a scene discharge of uninjured children/students by the Emergency Department physician in charge of the call is appropriate.

D. Children/students determined to be injured by exam and/or complaint shall be treated and transported by EMS personnel. All children/students with special healthcare needs and/or communication difficulties shall be transported to the hospital.

E. Contact school officials. It will be the responsibility of the school officials to inform the parents/legal guardians of the accident/incident.

F. This procedure may include the option of the ambulance service provider escorting the bus back to the school of origin or other appropriate destination.

G. Medical Control, after consulting with scene personnel, may discharge the uninjured children/students to the care of the ambulance service provider, who then will release the children to parents/legal guardians or school officials.

H. Authorized school representatives shall utilize the School Bus Incident log and sign the log sheet. The school representative's signature indicates acceptance of responsibility for the children/students after medical clearance by the EMS personnel. The school representatives will then follow their own policies, which shall include informing the parents/legal guardians in regard to the accident/incident.

I. Any child/student having reached the age of 18 years or older and any adult non-student present on the bus will initial the log sheet adjacent to their name when in agreement that they have suffered no injury and are not requesting medical care and/or transport to the hospital.

J. Complete one (1) prehospital care report form in addition to the School Bus Incident log.

This policy addresses discharge disposition of uninjured children/students only, thus no individual release/AMA signatures are necessary. An isolated abrasion or superficial wound can be regarded as uninjured should the EMS personnel and medical control concur.

This policy is also applicable for school/student incidents not involving a bus if deemed appropriate by the responding EMS agency and evaluated and executed in a like manner.

IV. REFERENCES

-School Bus Incident Log

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

SCHOOL BUS INCIDENT LOG

(page 1 of ___)

Date: **Time:**	**Location:**	**District name:**	**Bus number:**

Run Report #:	**Total # persons:**	**# transported:**	**# not transported:**

Adult name (non-student)	**Age**	**Initials**

Child/student name	**Age**	**Initials**

The children/students listed above have been determined to be uninjured. Medical control has been contacted and approved release to the custody of school officials or parent/legal guardian or to self if age 18 or older.

_____ _____

(Name of Ambulance service provider) (Name of Authorized School Rep.)

_____ _____

(Signature) (Date) (Signature) (Date)

SCHOOL BUS INCIDENT LOG

(page ___ of ___)

Child/student name	Age	Initials

The children/students listed above have been determined to be uninjured. Medical control has been contacted and approved release to the custody of school officials or parent/legal guardian or to self if age 18 or older.

_____ _____

(Name of Ambulance service provider) (Name of Authorized School Rep.)

_____ _____

(Signature) (Date) (Signature) (Date)

Section: Operations **Page:** 1 of 2

Title: System Wide Crisis

Original Policy Date: 01/2024
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to describe the actions to take during a system wide crisis.

II. DEFINITION – None.

III. POLICY

Natural, man-made and/or technological crises may place an intense demand for EMS and Emergency Department resources on one or more of the EMS agencies and hospitals in the East Central Illinois EMS System. The potential exists for these crises to occur or evolve without adequate warning or notification. Such crises may include an environmental emergency, communicable disease or epidemic/pandemic or a terrorist act involving a nuclear, chemical, or biological agent which could overload an EMS agency's and Emergency Department's resources. As a result, Dispatch, EMS, and Emergency Department personnel must be cognizant of evolving trends or the influx of patients with similar signs and symptoms. Recognition of an impending or active system-wide crisis will better prepare system EMS agencies and hospitals to handle any type of situation.

A. Recognition
   1. Telemetry personnel may be made aware of a system-wide crisis by communication from the local ambulance provider (i.e., mass casualty incident) or by noting an increasing number of emergency departments requesting ambulance diversions. The telemetry personnel should report these occurrences to the attending emergency doctor or charge nurse.
   2. When participating hospitals see a rapid or developing increase of patients with similar symptoms, the attending emergency doctor or the charge nurse should contact their Resource Hospital and apprise them of the situation.
   3. When ambulance providers or their personnel notice that they have an increase of runs with patients complaining of similar signs and symptoms, they should report this information to their Resource Hospital.

B. Notification of Personnel
   1. The Resource Hospital shall document any calls they receive from their participating hospitals or ambulance providers and identify that they are seeing numerous patients complaining of similar types of symptoms. The Resource Hospital should note the time the call is received and seek a detailed account of the situation.
   2. If the Resource Hospital Receives calls from two participating hospitals or has reason to suspect a potential system-wide crisis, the telemetry nurse will page the EMS Coordinator or

EMS Medical Director to inform them of the situation. The EMS Coordinator or EMS Medical Director will contact the local ambulance provider to see if they are seeing an increase in patients with similar types of symptoms.

3. The EMS Coordinator or EMS Medical Director may also contact the Illinois Poison Control Center to see if they are receiving additional calls for similar type symptoms.
4. If there appears to be a trend, prehospital or hospital, of increased frequency of similar symptoms the EMS Coordinator or EMS Medical Director shall page the Emergency Officer for the Illinois Department of Public Health at 1-800-782- 7860. In addition, if there is a local health department medical director, that person may also be contacted.
5. The emergency officer for the Illinois Department of Public Health will contact the Director of Public Health, or his designee, and the Duty Officer with the Illinois Emergency Management Agency. Based on the type and magnitude of the crisis, the Director of Public Health, or his designee, may activate the Disaster POD, according to the Emergency Medical Disaster Plan.

C. Plan of Action

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

D. All Clear

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

IV. **REFERENCES -None.**

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Title: Transport of Law Enforcement Animals

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 01/2025

II. PURPOSE

The purpose of this policy is to provide guidelines for the ability of ECIEMS agencies to transport a police dog injured in the line of duty.

III. DEFINITION

C. **Police Dog**: A dog owned or used by a law enforcement department or agency during the department or agency's work, including a search and rescue dog, service, accelerant detection canine, or other dog that is in use by a county, municipal, or State law enforcement agency. (Illinois Public Act 100-0108; HB2661)

IV. POLICY

B. In accordance with the Illinois Department of Public Health Rules and Regulations, Section 515.550 Scope of Practice – Licensed EMT and Paramedic as well as Illinois EMS Act, ECIEMS agencies may transport a police dog injured in the line of duty to a veterinary clinic or similar facility if there are no persons requiring any medication attention or transport at that time.
C. All sick and injured human patients remain the priority of EMS personnel within the ECIEMS System.
    1. All human patients must be transported and/or appropriately dispositioned prior to providing any care to police dogs, irrespective of the injuries or condition of either the human or the police dog.
    2. The human patient always has priority and will be treated and transported first.

D. Most police dogs are appropriate to be transported exclusively by their dog handler's police vehicle.
E. Due to the protective instincts of these animals, it is recommended that the animal be transported with a handler who is familiar with the commands with which the dog was trained.
F. Due to the protective instincts of these animals, the animal should be transported with a muzzle, to protect EMS providers from the possibility of being bitten.

V. REFERENCES - None

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.

Title: Transport of Service/Support Animals

Original Policy Date: 08/2023
Current Effective Date: 08/2023
Last Review Date:
Next Required Review Date: 01/2025

VI. PURPOSE

The purpose of this policy is to ensure compliance with state and federal laws related to service animals while promoting a safe environment for service animals, handlers, patients, and pre-hospital providers.

VII. DEFINITION

D. **Service Animal**: Any dog or miniature horse[2] that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The task(s) performed by a service animal is directly related to the individual's disability.
   1. Emotional support animals, comfort animals, and therapy dogs are not service animals under Title II and Title III of the ADA.
   2. Under Title II and III of the ADA, service animals are limited to dogs. However, entities must make reasonable modifications in policies to allow individuals with disabilities to use miniature horses if they have been individually trained to do work or perform tasks for individuals with disabilities.
      a. Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds
      b. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

VIII. POLICY

G. If EMS is transporting a patient to the hospital, they may bring the patient's service animal in the ambulance. According to the Americans with Disability Act (ADA), beginning on March 15, 2001, only dogs are recognized as service animals. Ambulances are only required to accommodate service dogs, and ambulance crews can legally deny transporting all other types of animals.

H. When a service animal's trained purpose is not readily apparent, an EMS crew can only ask the following questions regarding a service dog:

1. Is the dog a service animal that is required because of a disability?
2. What work or task has the dog been trained to perform?

Crews cannot ask about the person's disability, request medical documentation, or ask that the dog demonstrate its ability to perform the work or task.

I. Crews may not require documentation as proof that the dog has been trained, certified, or licensed before accepting it as a legitimate service animal.
J. Service animals are not required to wear a vest or any other identifier indicating it is a service animal.
K. EMS providers are not responsible for care, comfort or securing of the service dog in the ambulance. Unless a specific location is required for the dog's work, the service dog should be kept in a location in the ambulance (chosen by the EMS personnel) where they will not interfere with medical care or pose a danger to personnel or the patient.
L. Care and behavior management of the service animal is solely the responsibility of the handler.
M. EMS providers should alert the ED before arrival that a service animal is accompanying the patient. Upon arrival at the hospital, the service dog can accompany the patient into the ED. Service dogs are allowed in areas of the hospital where the general public travels. Hospital staff are not responsible for the care of the animal.
N. Once patient care has been turned over, the crew is responsible for cleaning/decontaminating their ambulance according to their department policy and procedures. Some form of documentation should be noted regarding the cleaning of the ambulance.

IX. REFERENCES

- https://ag.state.il.us/rights/servanimals.html
- http://www.ada.gov/cguide.htm.
- https://www.ada.gov/resources/service-animals-2010-requirements/
- OSF HealthCare Policy on Service Animals

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Operations

Title: Use of Aeromedical Resources

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the appropriate use of aeromedical resources.

II. DEFINITION – None.

III. POLICY

Aeromedical transport offers many critically ill or injured patients rapid transport to specialized centers. However, it is inherently more dangerous and expensive for providers and patients. It must be used responsibly. The EMS Office encourages aeromedical unitization in appropriate circumstances.

A. Aeromedical resources may be utilized in the following situations:
   1. When emergency personnel determine that the time needed to transport a patient by ground to an appropriate facility poses a threat to the patient's survival and recovery;
   2. When weather, road, or traffic conditions would seriously delay the patient's access to ALS care;
   3. When critical care personnel and equipment are needed to adequately care for a patient during transport.

B. General Guidelines:
   1. In general, when the transport of a seriously injured trauma patient will take more than 30 minutes by ground ambulance to the nearest appropriate Trauma Center, aeromedical resources should be considered.
   2. Patient transportation via ground ambulance should not be delayed to wait for helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance, then transportation should be initiated by ground ambulance.
   3. Helicopter transport may NOT be appropriate for patients in cardiac arrest.
   4. Personnel at the scene shall notify their dispatcher if aeromedical resources are needed.
   5. If aeromedical resources are dispatched, an ALS ground unit shall be dispatched at the same time (if not already on scene or enroute).
   6. Medical Control must be kept informed of any situation in which aeromedical resources are used.

C. Safety precautions:
1. Never allow ground personnel to approach the helicopter unless requested to do so by the pilot or flight crew.
2. The pilot and/or flight crew will determine which personnel are absolutely necessary to assist with loading and unloading of patients.
3. Secure any loose clothing or items that could be blown about by rotor wash, such as blankets, pillows and sheets.
4. Allow no smoking.
5. After the aircraft is parked, move to the front beyond the perimeter of the main rotor blades and wait for a signal from the pilot.
6. Approach the helicopter in a crouched position, staying within view of the pilot or other crew members.
7. Never approach the rear of the aircraft.
8. Long objects should be carried horizontally and no more than waist high.
9. All IVs should be placed in pressure bags and secured to the patient.
10. Depart the helicopter from the front and within view of the pilot.

IV. REFERENCES - None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Communication

Page: 1 of 2

Title: EMS Provider Protocol Usage

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline how protocols shall be used by providers within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. The East Central Illinois EMS System Medical Director have developed protocols and procedures with respect to the current, nationally recommended treatment modalities for use by prehospital personnel.

B. All protocols have two types of treatment modalities that may be performed by EMS providers -- those that can be performed independent of medical control, and those that require communication with medical control. The two types of treatment modalities are separated by a broken line (-------).

C. Protocols have been developed for the First Responder/Emergency Medical Responder, EMT-Basic, EMT-Intermediate, and EMT-Paramedic levels.

D. When initiating patient care, EMS providers may utilize the protocols and procedures appropriate to their level of licensure.

E. When using system protocols and procedures, EMS providers may perform all modalities listed above the broken line before contacting medical control.

F. EMS providers must contact medical control before performing procedures listed below the broken line.

G. The emergency department physician assuming medical control may, at his or her discretion, allow EMS providers to perform the modalities listed below the broken line.

H. EMS providers may perform the modalities listed below the broken line without medical control authorization only if telephone or radio contact with medical control cannot be established.

I. In any situation where EMS providers perform modalities below the broken line without contacting Medical Control, an EMS Risk Screen (“Risk Screens/ Reporting of Problems”) must be completed and forwarded to the East Central Illinois EMS System Office.

IV. RESOURCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Communication

Page: 1 of 2

Title: EMS System Updates

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for the timely communication of East Central Illinois EMS System policy, protocol and procedure updates, and the availability of education/training materials to agencies and members.

II. DEFINITION – None.

III. POLICY

A. All East Central Illinois EMS System agencies will have access to policies, protocols and procedures. Agencies will receive notification of updates and/or revisions via e-mail as they occur. Updates will also be posted to the East Central Illinois EMS System website.

B. Individual East Central Illinois EMS System members will have access to the *"East Central Illinois EMS"* mobile protocol app.

C. Individual East Central Illinois EMS System members may contact their Agency Coordinator or the East Central Illinois EMS System office to make arrangements to review the manual or make copies.

D. Notification of in-service training regarding policy, protocol, and procedure changes is communicated through established channels (i.e. Agency Coordinator meetings, Ninth Brain, e-mail, direct and telephone communications, website, etc.).

E. Information regarding educational classes and monthly continuing education are available on Ninth Brain or by contacting the East Central Illinois EMS System office. *East Central Illinois EMS System members may utilize the educational resources within the East Central Illinois EMS System office with assistance of the staff.*

I. RESOURCES: None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Communication **Page:** 1 of 3

Title: General Communication Policy

Original Policy Date: 11/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish a communication system for the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. The East Central Illinois EMS System communication system utilizes the following to interface with ambulances, hospitals, and existing systems:

1. Resource Hospital (OSF HealthCare Heart of Mary Medical Center): Cellular and VHF communications as well as *Twiage EMS* mobile app.
2. Associate Hospital: Cellular and VHF communications as well as *Twiage EMS* mobile app.
3. Participating Hospitals: VHF communications.
4. Radio and phone consoles at OSF HealthCare Heart of Mary Medical Center and OSF HealthCare Sacred Heart Medical Center are equipped with recorders that automatically record any communications.
5. All EMS telecommunication equipment within the East Central Illinois EMS System must be configured to allow the EMS Medical Director or designee, to monitor all ambulance-to-hospital and hospital-to-ambulance communications within the system.

B. All telecommunication equipment must be maintained to minimize breakdowns. Resource/Associate Hospital telecommunications operating personnel are to contact a repair person immediately should a breakdown occur.

C. Resource Telephone Numbers:
   1. OSF HealthCare Heart of Mary Medical Center:
      a. Primary: (217) 337-2197

D. Operation Control Point
   1. Communications will be answered promptly by an ECRN or Emergency Physician. The ECRN or Emergency Physician shall answer as follows:
      a. Identify Hospital's name.

b. Repeat the transmitting unit's call letters.
c. Give orders/directions promptly and courteously.
d. Keep communications to a minimum.
e. Do not voice names of EMS personnel or patients.
f. Call ED physician to the operational control point (radio) per ECRN policy.
g. End taped communication with date, time, and call letters

E. Pre-hospital Communications
1. Communications will be transmitted to medical control as soon as feasible utilizing the following:
a. Identify Hospital's name.
b. State unit identifier (call letters) and level of care.
c. Give BRIEF report to include only necessary information.
d. Be courteous and professional at all times.
e. Repeat all orders to the ECRN or MD.
f. Do not voice names of EMS personnel or patients.
g. Voice ETA and identify receiving facility.
h. Advise medical control of re-contact number if situation warrants.
i. End taped communications with unit identifier.

F. ALS communications should occur utilizing the *Twiage EMS* mobile app or on the ALS phone when possible.

G. BLS communications should occur utilizing the *Twiage EMS* mobile app or on the VHF (MERCI) radio or BLS cellular phone when possible.

H. All communications must be documented completely and accurately by the hospital ECRN or MD.

IV. RESOURCES – None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Communication

Page: 1 of 2

Title: Medical Control

Original Policy Date: 11/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish a mechanism for prehospital providers to be able to seek advice from the EMS Medical Director or designee. On-line Medical Control is utilized to involve the expertise of an Emergency Medical Physician in the treatment plans and decisions involving patient care in the prehospital setting.

II. DEFINITION – None.

III. POLICY

A. All personnel functioning in the System do so under the authority of the Illinois Department of Public Health and the EMS Medical Director.

B. In the absence of the EMS Medical Director, the physician staffing the ED at OSF HealthCare Heart of Mary Medical Center shall be considered Medical Control for the East Central Illinois EMS System.

C. All East Central Illinois EMS System personnel must be familiar with the field operations, treatment, and operational protocols, and all equipment used in the performance of these tasks.

D. All personnel in the East Central Illinois EMS System must meet the requirements of the System and be approved by the EMS Medical Director.

E. Only the EMS Medical Director and/or an approved designee, including physicians and ECRNs in the ED of the Resource Hospital or Associate Hospital may give patient treatment orders over VHF (MERCI), UHF, telephone, or *Twiage EMS* mobile app to field personnel.

F. Incoming telemetry calls will usually be answered by an Emergency Communications Registered Nurse (or ECRN). The ECRN may request Medical Control from an ED Physician if orders or consultation are needed.
    a. Pre-hospital personnel in need of on-line Medical Control shall notify the ECRN the need to speak to an ED Physician at the initiation of the report.

G. Once the EMS Medical Director or the Medical Control Physician designee has arrived at the radio, the ECRN and physician shall continue to utilize the field treatment protocols as a patient treatment guide during the EMS call.
    1. Only the EMS Medical Director or Medical Control Physician can initiate orders outside of the pre-hospital SOGs. These orders should be clearly documented on the radio log at the hospital.

H. In the event that physician authorization is required, the name of the physician shall be documented with the order in the log book. It is suggested that the EMS crew ask for and document the name of the ED physician providing the order.

I. Treatment protocols are to be considered the standing orders of the EMS Medical Director and are to be followed by field personnel whenever contact with the resource hospital is impossible, or where a delay in patient treatment would be of harm to the patient.

J. In the event the prehospital provider is not able to get in contact with Medical Control, despite multiple attempts via radio or telephone, the EMS provider will initiate the appropriate protocol and/or may perform the modalities listed *below the line* without Medical Control authorization.
    1. In any situation where prehospital providers are unable to contact Medical Control and perform modalities below the broken line without contacting Medical Control, an EMS Risk Screen must be completed and forwarded to the EMS Office within 24 hours.

K. The Associate Hospital is authorized to provide orders only:
    1. For patients being transported to the Associate Hospital, or
    2. In the event of communication failure with the Resource Hospital.

L. In the event that the Medical Director or designee responds to the scene in the Physician Response Vehicle, they shall provide direct On-Line Medical Control.

IV. RESOURCES – None

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Communication

Page: 1 of 3

Title: Resource Hospital Override of Orders

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

II. PURPOSE

The purpose of this policy is to establish a procedure to contact the Resource Hospital Medical Control to qualify orders from any other source other than the Resource Hospital.

II. DEFINITION – None.

III. POLICY

A. To allow prehospital providers to contact the East Central Illinois EMS System Resource Hospital if, in the judgment of the provider, orders for patient treatment:

1. Vary significantly from the provider's protocols and/or policies.
2. Could result in unreasonable or medically inaccurate treatment causing potential harm to the patient.
3. Could result in undue delay in initiating transport of a critically ill patient.
4. When there is no response from the Associate Hospital after three attempts to contact.

B. This pertains to:

1. Orders for patient care given by the Associate Hospital during transport to the Associate Hospital.
2. Orders for patient care given by any hospital for inter-facility transfers.

IV. PROCEDURE

A. Clarify the order.

1. Advise the Physician/ECRN issuing the order that the order is not allowed or deviates significantly from approved protocols.

2. Advise the Physician/ECRN that you will contact the East Central Illinois EMS System Resource Hospital for guidance/orders.

B. After medical control guidance has been completed:

1. For patients being transported to the Associate Hospital, the Resource Hospital Medical Control Physician should notify the Associate Hospital Medical Control physician that an override was initiated and completed. All pertinent information shall be conveyed to the Associate Hospital medical control regarding an update on the patient's medical status and the pre-hospital treatment rendered. The Associate Hospital shall be given an Estimated Time of Arrival of the patient to their facility.

2. For patients requiring inter-facility transfer, the Resource Hospital Medical Control Physician should discuss the patient's management with the transferring physician and determine an appropriate course of action. Note that it is the responsibility of the transferring physician to determine a suitable destination facility and arrange accordingly, not that of the Medical Control physician.

C. Only those physicians listed below may grant or deny a request for Resource Hospital Medical Control Override:

1. EMS Medical Director.
2. Associate/Alternate EMS Medical Director.
3. On-duty Emergency Department Physician at OSF HealthCare Heart of Mary Medical Center.

D. Any override of medical orders shall be submitted in writing by the prehospital provider via the EMS Risk Screen Form, and promptly forward to the EMS Office.

E. In the unlikely event that further consultation is needed, the EMS Medical Director (or their Alternate when they are unavailable) may be contacted. Final authority rests with the EMS Medical Director on all matters.

V. RESOURCES – None

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Continuing Education

Title: EMS Continuing Education Requirements (Region 6 Policy)

Original Policy Date: 12/2000
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

To provide continuing education requirements for license renewal to Region 6 EMS providers at all levels.

II. DEFINITION – None.

III. POLICY

Emergency Medical Responder

A. Minimum **24 hours** of continuing education per licensure period
B. May not exceed 20% of total hours for one subject area
C. Current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines

Emergency Medical Technician (EMT) - Basic

A. Minimum **80 hours** of continuing education per licensure period
B. May not exceed 20% of total hours for one subject area
C. Current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines

Advanced EMT/EMT-Intermediate

A. Minimum **100 hours** of continuing education per licensure period
    1. Included in the 100 hours:
        a. Attend an Advanced Skill Review annually
        b. Maintain current ACLS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines
        c. Maintain current PALS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines or PEPP certification
        d. Maintain current ITLS or PHTLS certification as per system requirement
B. May not exceed 20% of total hours for one subject area
C. Current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines

Paramedic

A. Minimum **120 hours** of continuing education per licensure period
    1. Included in the 120 hours:
        a. Attend an Advanced Skill Review annually
        b. Maintain current ACLS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines
        c. Maintain current PALS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines or PEPP certification
        d. Maintain current ITLS or PHTLS certification as per system requirement
B. May not exceed 20% of total hours for one subject area
C. Current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines

Prehospital Registered Nurse

A. Minimum **120 hours** of continuing education per licensure period
    1. Included in the 120 hours:
        a. Attend an Advanced Skill Review annually
        b. Maintain current ACLS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines
        c. Maintain current PALS certification that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines or PEPP or ENPC certification
        d. Maintain current ITLS, PHTLS, TNS or TNCC certification as per system requirement
B. May not exceed 20% of total hours for one subject area
C. Current certification in CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines
D. Is a Registered Professional Nurse in accordance with the Nursing and Advanced Practice Nursing Act

Core Content hours

Content Category	EMR	EMT	AEMT / Intermediate	Paramedic / PHRN/PHPA/PHARPN
Preparatory	2 hours / 4 years	6 hours / 4 years	6 hours / 4 years	8 hours / 4 years
Airway Management / Ventilation	2 hours / 4 years	10 hours / 4 years	12 hours / 4 years	12 hours / 4 years
Patient Assessment	2 hours / 4 years	6 hours / 4 years	6 hours / 4 years	8 hours / 4 years
Trauma	3 hours / 4 years	10 hours / 4 years	12 hours / 4 years	12 hours / 4 years
Cardiology	2 hours / 4 years	6 hours / 4 years	16 hours / 4 years	16 hours / 4 years
Medical	5 hours / 4 years	12 hours / 4 years	16 hours / 4 years	20 hours / 4 years
Special Populations	4 hours / 4 years	12 hours / 4 years	12 hours / 4 years	16 hours / 4 years
Geriatrics	1 hours / 4 years	4 hours / 4 years	4 hours / 4 years	4 hours / 4 years
Operations	1 hours / 4 years	4 hours / 4 years	4 hours / 4 years	4 hours / 4 years
Other Misc. Education	2 hours / 4 years	10 hours / 4 years	12 hours / 4 years	20 hours / 4 years
Total	**24 hours / 4 years**	**80 hours / 4 years**	**100 hours / 4 years**	**120 hours / 4 years**

Emergency Communications Registered Nurse

A. Minimum **32 hours** of continuing education per licensure period
B. Is a Registered Professional Nurse in accordance with the Nursing and Advanced Practice Nursing Act

EMS Lead Instructor

A. Minimum **40 hours** of continuing education **per licensure period of which 20 hours shall be related to the development, delivery and evaluation of education programs.**
B. Attendance at a Department-approved curriculum review course, if applicable
C. A letter of support from an EMS Medical Director indicating that the EMS Lead Instructor has satisfactorily coordinated programs for the EMS System at any time during the four-year period.

Emergency Medical Dispatcher

A. Minimum **12 hours annually** of medical dispatch continuing education

IV. RESOURCES

- **Refer to Illinois Department of Public Health Rules and Regulations, Section 515.590 EMT License Renewals, for complete requirements.**
- **Refer to the 'Core Content Hours" section for a breakdown by content category.**

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Illinois Department of Public Health
Division of EMS & Highway Safety
www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems

Emergency Medical Systems
Continuing Education Relicensure Recommendations

This Continuing Education (CE) list is NOT intended to be all-inclusive and should be considered as CE Recommendations ONLY. A wide variety of educational programs, seminars, online offerings, and workshops that are not listed below may also meet the intent of national standards for EMS continuing education.

Standard Documentation required to validate completion for all CE in Illinois: CE certificate, course card, or sign-in roster signed by instructor or authorizing person to include: name of participant; date; times; topic(s); number of CE hours awarded; and Illinois site code, CECBEMS, and/or medical or nursing accrediting body number. All CE hours awarded must be approved by the EMS Medical Director.

Calculating hours for AEMT/EMT-I and EMT: The hours listed in this document are for Paramedics (based on 100 hours in 4 years).
AEMT and EMT-I: Multiply required hours for Paramedics by 0.8 (80 hours in 4 years). **EMT:** Multiply required hours for Paramedics by 0.6 (60 hours in 4 years).
NOTE: EMS personnel should verify the continuing education requirements within their EMS System(s). EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

Activity	Documentation	Hours Recommended	Comment
Initial education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation and course schedule	Hr/Hr up to 16 hours for each course	
Advanced Trauma Life Support, Teaching EMS-related courses/ CE, Wilderness EMS Training, TEMS, MIH Community PM, Critical Care PM	Standard documentation and course schedule	Hr/Hr for EMS content of course	May not exceed 20% of total hours for one subject area. Educators may not get credit for presenting the same topic/lecture multiple times. Up to 50% of total hours may be earned by teaching participants at a lower level of licensure. Should be considered on a case by case basis for any topics in EMS education standards
Refresher/renewal education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation and course schedule	Hr/Hr up to 8 hours	
EMTs: PEPP (BLS) course	Standard documentation and course schedule	Hr/Hr up to 8 hours	
Pediatric related CE	Standard documentation and course schedule	Hr/Hr up to 16 hours max	Pediatric education now has much greater emphasis than in the 1998 DOT curriculum. Illinois recommends 16 hours in 4 yrs. Topics include: Pediatrics, Neonatology, Gynecology and Obstetrics.
Initial courses: CPR Instructor, Emergency Vehicle Operators course, Emergency Medical Dispatch course	Standard documentation and course schedule	Hr/Hr up to 12 hours max	
Locally offered CE programs	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Audit of entry level EMT, AEMT, Paramedic courses	Standard documentation	Hr/Hr to max content hours	Unlimited hours if subject matter is at the appropriate level for the participant's license. May not exceed 20% of total required hours in one subject area, e.g., cardiac, trauma, rescue, etc.

Activity	Documentation	Hours Recommended	Comment
Clinical preceptor or evaluator	Signed letter from EMS Coordinator or lead instructor	Hr/Hr to max hours allowable	May not exceed 20% of total minimum required CE hours.
Emergency Preparedness	Written statement of participation from EMSC/EMS MD or exercise director.	Hr/Hr up to 12 hours (Paramedic/PHRN) 10 hours (EMT-I) 8 hours (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.)	Catalog description of course and evidence of successful completion through minimum grade of C (official transcripts 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: clinical unit leader, preceptor or physician validating attendance	Hr/Hr up to max of 5 hours	Max 5 hours must be part of an approved educational experience or include defined educational objectives.
Seminars/Conferences: EMS related education approved by CECBEMS or medical or nursing accrediting body	Copy of agenda/program plus certificate of attendance	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Commercial CE: Electronic digital media (e.g. videotapes/CDs), journal articles with publication dates of 5 years or less prior to the date of CE completion. Approved by CECBEMS or medical or nursing accrediting body	Standard documentation	Hr/Hr to max content hours	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 prior approval of TNS Course Coordinator to ensure space availability	Standard documentation	Hr/Hr to max content hours	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 documentation	Hr/Hr to max content hours	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 on-line 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 documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area,

The below table outlines Illinois recommendations of Core Content breakdown during each relicensure period for Paramedics (hours for AEMT, EMT-I and EMT should be calculated accordingly).
Note: EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements as outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

CORE CONTENT	*ILLINOIS RECOMMENDED HOURS*	*CORE CONTENT*	*ILLINOIS RECOMMENDED HOURS*
Preparatory	8 hours in 4 years	Medical	20 hours in 4 years
Airway Management & Ventilation	12 hours in 4 years	Special Considerations (Neonatology, Pediatrics, Gynecology, Obstetrics)	16 hours in 4 years
Patient Assessment	8 hours in 4 years	Geriatrics	4 hours in 4 years
Trauma	12 hours in 4 years	Operations	4 hours in 4 years
Cardiology	16 hours in 4 years		
		TOTAL	**100 hours in 4 years**

Section: Continuing Education **Page:** 1 of 3

Title: Sources of Continuing Education

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide East Central Illinois EMS System members with information on continuing education sources.

II. DEFINITION – None.

III. POLICY

A. Auditing Initial EMS Education Courses

1. EMS providers may attend regularly scheduled EMS Initial Education courses to obtain continuing education hours. Because these EMS providers are not regular members of the course, this is referred to as auditing. All Initial Education courses have a separate site code number assigned for continuing education. Awarding of continuing education hours is the responsibility of the Lead Instructor.
2. EMS Lead Instructors are encouraged to make the syllabi for EMS Initial Education courses available for posting to all ECIEMS agencies. If an EMS provider wishes to audit a particular course, he or she must contact the Lead Instructor for permission to attend all sessions or specific sessions of the course. EMS providers receive hour-for-hour continuing education credit for attending EMS Initial Education courses.
3. EMS providers who participate as "patients" for practical skills assessment stations in an EMS course will receive hour-for-hour continuing education credit for time spent in the station.

B. Continuing Education Credit for Academic Courses

1. EMS providers are encouraged by ECIEMS to further their education by attending institutions of higher education. Health-related, college-level courses are evaluated individually by the ECIEMS Medical Director and/or the ECIEMS System Coordinator for content and to determine if the course is applicable to EMS. College courses that are deemed appropriate for EMS continuing education (i.e. science courses, nursing courses) are awarded eight (8) continuing education credit hours for every course credit hour.
2. College courses may make up no more than 50 percent of the total required continuing education hours.

C. Continuing Education Credit for Teaching EMS Courses

1. EMS instructors in ECIEMS may be awarded continuing education credit for teaching EMS or other healthcare-related courses. Hour-for-hour continuing education is awarded for teaching any of the following:
    a. Initial EMS education didactic and/or practical skills.
    b. EMS continuing education didactic and/or practical skills.
    c. Nationally recognized courses (i.e. CPR, ACLS, PALS, PEPP, ITLS, AMLS, etc.)
2. Teaching EMS courses may make up no more than 50 percent of the total required continuing education hours.

D. Nationally Recognized Courses

1. ECIEMS requires providers to maintain certification in specific nationally recognized courses to remain active in the system. ECIEMS provides opportunities for EMS providers to attend these courses. These courses include but are not limited to:
    a. American Heart Association Basic Life Support (BLS)
    b. American Heart Association Advanced Cardiac Life Support (ACLS)
    c. American Heart Association Pediatric Advanced Life Support (PALS)
    d. Pediatric Education for Prehospital Professionals (PEPP).
    e. International Trauma Life Support (ITLS)
    f. Advanced Medical Life Support (AMLS)

Individuals requesting to take recertification courses in a nationally recognized course offered at ECIEMS must have current certification or certification that has been expired no more than 60 days from the expiration of the current certification. Individuals will be required to bring a copy of their current certification to the course with them.

IV. REFERENCES – IDPH EMS Continuing Education Relicensure Recommendations

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: EMS Licensing

Page: 1 of 2

Title: EMS Provider License Renewal

Original Policy Date: 12/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to outline the steps for renewing an EMS provider license through the East Central Illinois EMS System Office.

II. DEFINITION – None.

III. POLICY

A. The EMS provider is responsible for completing and documenting the required number of continuing education hours (See Region 6 EMS Education Requirements).

B. IDPH will send a renewal notice approximately 60 days prior to license expiration date. Included in the notice is the IDPH website for license renewal and a unique PIN number.

C. EMS License renewal is a 2 step process:
   1. Step 1: Log on to the IDPH website to answer the questions regarding felony conviction and child support and to pay the license renewal fee, if applicable. If paying the licensing fee by certified check or money order, the EMS Renewal Notice must be completed and sent with the payment by US mail.

   2. Step 2: Ensure all credentials and continuing education hours are up-to-date in the NinthBrain Suite software. This must be completed at least 30 days prior to the license expiration date.

D. The EMS office will review the CE hours and approve the license renewal in the IDPH database.

E. A new EMS license is mailed to the EMS provider once all license renewal requirements have been completed.

IV. REFERENCES - Region 6 EMS Continuing Education Requirements

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: EMS Licensing **Page:** 1 of 2

Title: Fee Waivers

Original Policy Date: 12/2017
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to establish a process for EMS providers to request a waiver of the EMS licensure fees.

II. DEFINITION – None.

III. POLICY

A. EMS providers who serve exclusively as volunteers for units of local government or not-for-profit organizations that serve an area with a population base of less than 5,000 may apply for a waiver of licensure fees. To apply for a fee waiver:
   1. Obtain the EMS License Fee Waiver application from the IDPH website or the East Central Illinois EMS office.
   2. Complete the application and return to the EMS System office for the EMS System Coordinator's signature.
   3. Waiver requests must be submitted to the EMS System office at least 30 days prior to the expiration date on the license to ensure timely license renewal.
   4. The EMS System office will submit the waiver request to IDPH.

IV. REFERENCES – IDPH EMS License Fee Waiver Request

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: EMS Licensing **Page:** 1 of 1

Title: Lapsed/Expired License

Original Policy Date: 12/2000
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for obtaining an EMS license once the current license has lapsed or expired.

II. DEFINITION – None.

III. POLICY

A. The license of an EMS Provider who has failed to file a completed application for renewal on time shall be invalid on the day following the expiration date shown on the license. EMS Providers shall not function on an expired license.

B. EMS Providers whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and no disciplinary actions are pending against the EMS Provider, IDPH will relicense the EMS Provider.

C. Any EMS Provider whose license has expired for a period of more than 60 days shall be required to complete an EMS training program, pass any required exam, and pay any required fees for initial EMS licensure.

IV. REFERENCES – IDPH Administrative Rules, Section 515.590 EMS Personnel License Renewals

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: EMS Licensing

Title: Inactivation/Reactivation of EMS License

Original Policy Date: 12/2000
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to ensure a mechanism for requesting inactivation/reactivation of an EMS license.

II. DEFINITION – None.

III. POLICY

Inactive Status

A. An EMS provider may request to be placed on inactive status prior to the expiration of the current license by providing the following to the EMS System office:
   1. A written request for inactive status addressed to the East Central Illinois EMS System Medical Director
   2. A completed IDPH Inactive Status form
   3. Original EMS license (both wall certificate and wallet card)

B. All relicensure requirements must be met by the date of the application for inactive status.

C. The EMS Provider shall not function at any level during inactive status.

Reactivation of Status

A. An EMS provider who is on inactive status may request reactivation of status by providing the following to the EMS System office:
   1. A written request to the East Central Illinois EMS Medical Director for reactivation of status
   2. A completed IDPH Reactivation Request form.

B. The East Central Illinois EMS System Medical Director submits the form and includes a statement that the provider has been examined (physically and mentally) and found capable of functioning within the EMS system and that all system continuing education requirements have been met for reactivation.

C. If the inactive status was based on a temporary disability, the East Central Illinois EMS System Medical Director verifies that the EMS provider is no longer disabled.

D. EMS Personnel whose inactive status period exceeds 48 months shall pass an IDPH approved licensure examination for the requested level of license upon recommendation of the EMS Medical Director.

IV. REFERENCES - IDPH Inactive and Reactivation Requests; Maintenance of Credentials Policy

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: EMS Licensing

Page: 1 of 2

Title: Voluntary Reduction in License Level

Original Policy Date: 12/2000
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide guidelines for changes in EMS level of licensure.

II. DEFINITION – None.

III. POLICY

A. At any time prior to the expiration of the current license, an EMT, A-EMT, EMT-I or Paramedic may downgrade to EMT or EMR status for the remainder of the license period. The EMT, A-EMT, EMT-I or Paramedic shall make this request in writing to the EMS MD of his or her System of primary affiliation along with a signed renewal notice and his or her original EMS license and duplicate license fee. The EMS MD or designee shall verify that the license is current with CE hours and forward the approved applications to the Department. To relicense at the EMT or EMR level, the individual must meet the relicensure requirements for that downgraded level.

B. EMS Personnel who have downgraded to EMT, A-EMT or EMT-I status may subsequently upgrade to his or her original level of licensure held at the time of the downgrade upon the recommendation of an EMS MD who has verified that the individual's knowledge and psychomotor skills are at the level of the licensure being requested. The individual shall complete any education or testing deemed necessary by the EMS MD for resuming A-EMT, EMT-I or Paramedic activities and submit a duplicate license fee. EMS Personnel cannot upgrade from the EMR level.

IV. REFERENCES – IDPH Administrative Rules, Section 515.590 EMS Personnel License Renewals

_____ _____
EMS Medical Director Date

_____ _____
EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Quality

Title: Quality Assurance/Quality Improvement Plan

Original Policy Date: 10/2023
Current Effective Date: 10/2023
Last Review Date:
Next Required Review Date: 01/2025

V. PURPOSE

A. EMS is a constantly evolving and dynamic field. To ensure that patients receive the best care, it is imperative to routinely re-evaluate standards of care, develop strategies for implementation of new policies and procedures, and identify our strengths and weaknesses in meeting those standards.
B. The mission of EMS is to provide timely and appropriate emergency medical care and transportation of the ill and injured, which requires consistent on-going evaluation of both organizational efficiency and operational quality. To achieve this end, EMS agencies should embrace the following fundamental principles:
    1. EMS agencies can and must be improved.
    2. It is the responsibility of every provider to participate in the effort to improve EMS.
    3. The foundation of EMS Quality Assurance (QA)/Quality Improvement (QI) begins at the agency level.
    4. There must be a commitment to quality care by the governing body of each EMS agency.
C. EMS providers and agencies must be willing and able to engage in QA/QI activities, as do all other healthcare professionals, to ensure that patients receive timely medical care from well-trained and competent individuals.
D. All Quality Assurance / Quality Improvement programs should be designed to objectively, systematically and continuously monitor, assess and when indicated improve the quality of care provided by individual providers and the agencies themselves. All QA/QI programs should be set up as learning, non-punitive programs. The objectives should include the following:
    1. Strive to improve EMS with monitoring of care and overall ambulance operations so that outstanding care can be honored, and challenges addressed.
    2. Provide a program for constructive feedback to EMS providers of all levels.
    3. Recognize trends in patient care that are in need of improvement and recommending and / or providing education to facilitate system and provider improvement.
    4. Recognition of outstanding care and operations.
    5. Focus on the process to improve outcomes, not the outcomes of individual calls themselves.

VI. DEFINITION

A. Quality Assurance can be defined as the planned systemic and structred evaluation necessary to ensure confidence that quality clinical care is delivered and is consistent with standards set

by IDPH and the local EMS system. Quality assurance runction s to ensure compliance with protocols or policies.

B. Quality Improvement is the intentional process of making system-level changes in clinical processes with a continuous reassessment to improve the delivery of high-quality prehospital care. Quality improvement, by nature, is designed to improve a problem or process.

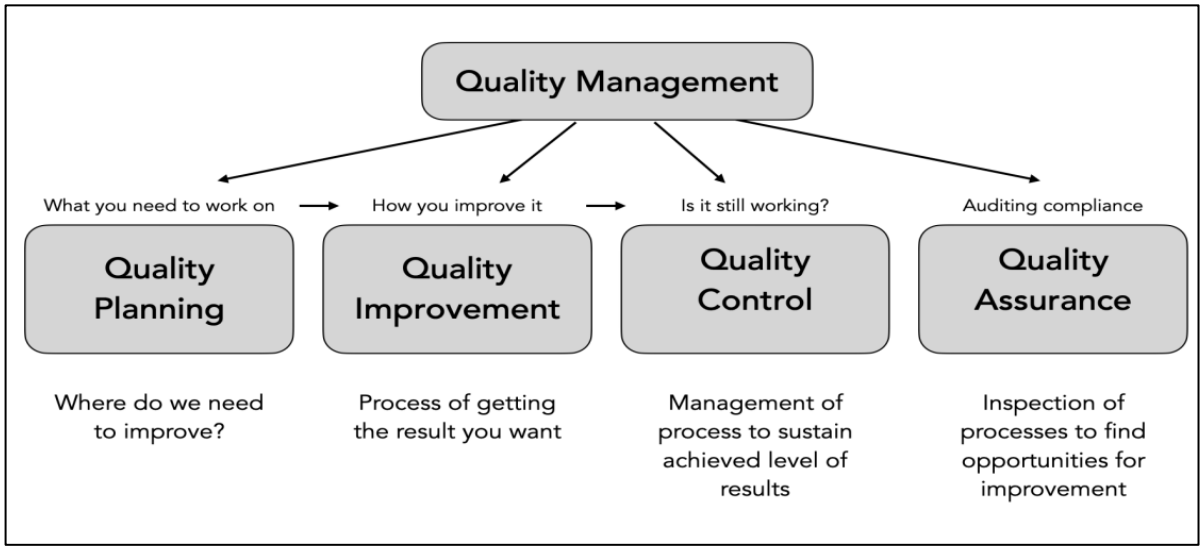


Figure 1: Outline of Quality Management (NYS DOH 2007)

VII. POLICY

D. Current QA/QI practices in our system vary from simple resolution of complaints to structured reviews of clinical care and skills gathered from PCRs.
E. All QA/QI work done in the East Central Illinois EMS System shall be considered confidential under the Illinois Medical Studies Act, 735 ILCS 5/8-2101.
F. QA/QI activities are comprehensive in scope and encompass many strategies. They utilize several approaches and models of problem-solving and analysis. These activities, while distinct, are inter-related and address clinical and system issues from three perspectives:
    i. Prospective: Working proactively to mitigate issues before they occur.
        1. This is accomplished through standardized protocols, establishment of time standards, etc.
    ii. Concurrent: Assessing issues and addressing them as they happen.
        1. This is accomplished through real-time review of processes through on-line medical control, ED observation, field observation, etc.
    iii. Retrospective: Examining the data collected to provide additional insight into the efficacy, effectiveness and efficiency of the EMS System.
        1. This is accomplished through PCR review, risk screens, patient complaints, etc.
G. QA/QI activities may include but are not limited to:
    i. Provider Recognition: QA/QI programs should regularly recognize the efforts made by individuals and agencies, which promote high-quality patient care.
    ii. Data Collection and Analysis: The collection of data allows the QA/QI team to identify the frequency, trends, improvements, declines and other areas that are actionable.
    iii. Customer Satisfaction: Surveying customers is similar to being graded on performance.

iv. Patient Care Report (PCR) Reviews: PCRs are a valuable source of information on the quality of patient care delivery.
v. Skill Maintenance: QA/QI analysis can identify skills or procedures that are deficient or not performed regularly. These skills should receive performance review and testing.
vi. Continuing Education (CE): CE covers regulatory and mandated training.
vii. Establishing Quality Peer Groups: Quality peer groups are designed to balance the judgment of any QA/QI decision. A peer group of providers using their best judgment allows for better acceptance.
viii. Protocol and Procedure Review: Regular timely review of treatment protocols is imperative. Review is important to update medical procedures and apply new rules and regulations that may affect treatments.
ix. Quality Meetings: Quality meetings are held to communicate the findings and plans of the various activities to other providers in the system. Meetings work towards improving the system of patient care.
x. Generating Activity Reports: Activity reports are summaries of various measurable events that can be based on individual provider agencies or the entire EMS system. These reports can be used to establish trends, consistencies and rates of proficiency. These reports can help to establish training needs or identify the need for system changes.
xi. Internship Programs: An internship program is a plan to orient a new provider to the methods and standard operating procedures of a service program. Experienced preceptors and/or training officers serve to facilitate and monitor this process.
xii. Development of Standards: Standards are generalized characteristics that should be met on all calls. Standards keep providers focused on basic principles of customer service.
xiii. Benchmarking: Benchmarking is a comparison of a system's performance statistics against the nationally established performance levels.
xiv. EMS Event Review Process: Issues or concerns can come from a variety of sources and may be clinical, operational or both. EMS events are to be reviewed and the characteristics of the events are measured and analyzed for improvement of the EMS system.
xv. Equipment/Technology Evaluation: QA/QI plays an important role in creating processes to objectively evaluate and analyze new equipment and technology.

H. The following, at a minimum, will be reviewed by the East Central Illinois EMS System:
i. Random QA/QI
    1. Cases will be pulled at random from each transport agency throughout the year. Patient Care Reports will be reviewed for compliance with System, Region and State regulations regarding documentation and patient care.
ii. Public Request
    a. Cases will be reviewed when the public reports a concern to the ECIEMS System.
iii. Agency Request
    a. Cases will be reviewed when an agency reports a concern to the ECIEMS System.
iv. RN / MD Request
    a. Cases will be reviewed when an RN / MD reports a concern to the ECIEMS System.
v. High Risk
    a. The following cases will be reviewed by the ECIEMS System as the occur:

i. Cardiac Arrest/Determination of Death/Termination of Resuscitation
ii. Intubation
iii. Cricothyrotomy
iv. Childbirth / Delivery
v. Use of restraints
vi. Use of Ketamine

vi. Additional QA/QI activities can be conducted at the discretion of the ECIEMS Medical Director.

I. The ECIEMS System will pick yearly core quality measures to monitor based off of national standards (i.e., NEMSQA Measures).

J. Participation at all levels within the East Central Illinois EMS System is required to meet this goal.

i. Resource Hospital
1. Coordinate all QA/QI activities within the system.
2. Provide continuing education.
3. Report all system data to the state as required by Illinois Department of Public Health.

ii. Associate Hospital / Participating Hospital
1. On a monthly basis, review telemetry log sheets.
2. Participate in QA/QI activities as required by the ECIEMS System.
3. Coordinate with the ECIEMS System, the investigation and resolution of all prehospital concerns relating to their respective hospital. Report legal/ethical prehospital provider concerns to the ECIEMS System.
4. Assure that the physicians and nurses are informed of any changes to the protocols, procedures and/or policies within the ECIEMS System.

iii. System Agencies
1. Provide the ECIEMS Medical Director and/or designee(s) access to Patient Care Reports and data related to patient encounters for continuous monitoring and quality assurance. (IDPH Rule 515.350)
2. All non-transport agencies shall document all medical care provided and submit the documentation to the ECIEMS System within 24 hours. The EMS System shall review all medical care provided by non-transport vehicles and provide a report to the Department upon request. (IDPH Rule 515.350)
3. Review Patient Care Reports for accuracy and deficiencies and follow-up with individual prehospital providers as necessary.
4. Ensure all Patient Care Reports are completed on time in accordance with system policies and IDPH EMS Rules and Regulations.
5. Participate in yearly ambulance inspections.
6. Ensure agency complies with applicable policies, rules and laws related to controlled substances.
7. Maintains and ensures proper equipment and supplies on EMS licensed vehicles.
8. Ensure proper staffing with qualified personnel at all times and notify the ECIEMS System of any changes.
9. Prepare written reports as required by IDPH and ECIEMS System for QA/QI purposes.
10. Participate in System-wide QA/QI data collection projects as designated by the ECIEMS System.

iv. Prehospital Providers
1. Ensure all Patient Care Reports are completed on time in accordance with system policies and IDPH EMS Rules and Regulations.

2. Ensure completion of all ECIEMS System requirements for continuing education.
3. Report any problems, concerns, adverse events or near-misses that occur to the ECIEMS System utilizing the ECIEMS Risk Screen form.

IV. REFERENCES

- New York State Department of Health: Bureau of Emergency Medical Services and Trauma Systems. (2007) NYS Quality Improvement for Prehospital Clinicians: The New York State Manual. https://www.health.ny.gov/professionals/ems/pdf/quality_improvement_for_prehospital_providers.pdf
- Medical Studies Act, 735 ILCS 5/8-2101 to 8-2105 (2017)
- 77Ill Adm. Code 515.350

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Quality Improvement

Title: Risk Screens/Reporting of Problems

Original Policy Date: 01/1999
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The purpose of this policy is to provide a mechanism for hospital and prehospital personnel to address problems, concerns or near misses that may arise during the provision of prehospital care within the East Central Illinois EMS System.

The East Central Illinois EMS System is committed to building, maintaining and supporting a "Just Culture". It is a culture in which errors, near misses, adverse events, unsafe conditions and system problems can be easily reported without retaliation, and are seen as a means to identify system and behavior changes that will improve the safety and quality of care and service we deliver. A "Just Culture" environment will encourage and empower each ECIEMS provider to take part in improving the quality of care and services within our EMS System.

II. DEFINITION – None.

III. POLICY

A. Prehospital and hospital personnel shall complete an EMS Risk Screen whenever an EMS System related problem, adverse event or near miss occurs. When completing the EMS Risk Screen, hospital and prehospital personnel shall describe the specific problem or issue, using a brief objective summary with supporting documentation as needed.

B. All information on the EMS Risk Screen is confidential and protected from legal discovery. The EMS Risk Screen is for quality assurance purposes only.

C. All EMS Risk Screens shall be reviewed by the East Central Illinois EMS Medical Director, the East Central Illinois System Coordinator, and/ or the appointed personnel from the East Central Illinois EMS office. Findings shall be documented on the Risk Screen Review Form.

D. A Risk Screen Review Form is used in order to provide a fair and systematic approach for reviewing events and to document the risk level of the issue/ behavior and any corrective action needed. Categories of risk/types of behaviors are as follows:
    1. Normal (Human) Error
    2. At-Risk Behavior
    3. Reckless Behavior

E. "Just Culture" principles will be applied when reviewing Risk Screens, when applicable, utilizing a "Just Culture" algorithm.

F. If needed, corrective action will be documented on the Risk Screen Review Form or attached as appropriate.

G. All Risk Screens will be logged to monitor reoccurrence of the same problem and the following will be submitted to IDPH on a monthly basis:
   1. Number of EMS patient care complaints, including a brief synopsis of the issue
   2. Outcome of the system investigation
   3. Names and licenses of the EMS personnel involved in sustained allegations.

H. The East Central Illinois EMS System Medical Director and/or the System Coordinator will determine the initial action to be taken and who will be responsible for resolution of the problem.

I. Situations that require the East Central Illinois EMS System Medical Director intervention include (but are not limited to):
   1. Equipment or vehicle failure
   2. Delay in response or transport of patient
   3. Inappropriate procedure or equipment for restraining a patient
   4. Injury to patient or property
   5. Deviation from East Central Illinois EMS System protocols or
   6. Personal safety issues
   7. Quality of care issues involving another agency
   8. Patient pick-up/drop-off issues
   9. Refusals
   10. Significant exposure
   11. Any situations, conditions, or events which could adversely affect a patient, prehospital care provider or the East Central Illinois EMS System

IV. REFERENCES

- East Central Illinois EMS System Risk Screen
- East Central Illinois EMS System Risk Screen Review Form

_____ _____

EMS Medical Director Date

_____ _____

EMS System Coordinator Date

NOTE: Policies with original signatures are on file in the EMS office.

Section: Quality Improvement

Title: Just Culture

Original Policy Date: 01/2022
Current Effective Date: 01/2024
Last Review Date: 01/2024
Next Required Review Date: 01/2025

I. PURPOSE

The East Central Illinois EMS System is committed to building, maintaining and supporting a "Just Culture". A "Just Culture" is one where accountability is fairly balanced between the ECIEMS System and the individual prehospital providers. It is a culture in which errors, near misses, adverse events, unsafe conditions and system problems can be easily reported without retaliation, and are seen as a means to identify system and behavior changes that will improve the safety and quality of care and service we deliver. A "Just Culture" environment will encourage and empower each ECIEMS provider to take part in improving the quality of care and services within our EMS System.

A "Just Culture" describes three duties, all of which should be familiar to anyone working in EMS:

1. The duty to **act** (produce an outcome).
2. The duty to **follow a procedural rule**.
3. The duty to **avoid causing unjustifiable risk or harm**.

II. DEFINITION –

A. **Adverse Event –** An adverse event is any unintended event that interrupts services, causes or has the potential to cause an injury or illness and/or damage to persons, property, other assets and/or the natural environment. A patient safety event that resulted in harm to a patient.

B. **Near Miss –** A near miss is an incident or unsafe condition with the potential for injury, damage, or harm that is resolved before having actual impact. A "close call". A patient safety event that did not reach the patient.

C. **Human Error –** Human error describes inadvertent actions in which there is general agreement that the individual should have done something other than what he or she did, and the action(s) inadvertently caused (or could have caused) an undesirable outcome.

D. **At-risk Behavior –** At-risk behavior describes situations in which an individual makes a choice to engage in a behavior out of a belief that the risk is insignificant, or out of the mistaken belief that the behavior is otherwise justified.

E. **Reckless Behavior –** Reckless behavior describes a behavioral choice to consciously disregard a substantial and unjustifiable risk.

III. POLICY

A. A “Just Culture” is a balance between human and system accountability. It recognizes that adverse events and unanticipated outcomes are often the result of a complex array of contributing factors, including failures of process or equipment as well as human factors. Not all errors are random occurrences or the result of failures of practitioners to perform as expected. To foster this culture ECIEMS will utilize a fair and systematic approach that balances a non-punitive learning environment with the equally important need of accountability.

B. “Just Culture” principles will be applied whenever there is an opportunity to assess the behavior or performance of a member of the ECIEMS System.

C. Responses to errors, near misses and adverse events will be influenced by the individual’s behavioral choices, not the outcome of the event.

D. Providers will not be punished or retaliated against for reporting errors, near misses, adverse events, system problems, safety or quality concerns.

E. When indicated, ECIEMS System members will be held accountable and appropriate corrective action taken. Actions will be consistent with the “Just Culture” principles and in accordance with the ECIEMS *System Corrective Action and Suspension Policy*.

F. All types of error hold equal importance in a “Just Culture”, not just those with poor outcomes. Error identification and reporting are encouraged to provide opportunities for staff education and system redesign.

G. The “Just Culture” algorithm should be used as a guide to help ensure appropriate application of “Just Culture” principles and aid in determining the right course of action when there has been an error, near miss, adverse event or unexpected outcome. It is intended to help understand an individual’s actions, motives, and choices at the time of an incident and categorize these into one of the three types of behaviors described in a “Just Culture”.
    1. Human Error
    2. At-risk Behavior
    3. Reckless Behavior

RESOURCES

Strategy for a National EMS Safety Culture: National Highway Traffic Safety Administration, et al., October 13, 2013
NAEMT Position Statement (2012): “Just Culture” in EMS
ACEP Policy Statement (2014): A Culture of Safety in EMS Systems
National Patient Safety Foundation: “A Just Culture Tool”

EMS Medical Director _____ Date _____

EMS System Coordinator _____ Date _____

NOTE: Policies with original signatures are on file in the EMS office.