

# OSF Saint James John W Albrecht Medical Center EMS System Policies

0257

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<b>Title of Policy: System Contact Information</b>	<b>Policy Number: A100</b>
<b>Effective Date: 08/01/2023</b>	<b>Review Date: 08/01/2023</b>
<b>Policy Area: Administration</b>	<b>Approvals: EMS system, EMS MD</b>

**Rule: Section 515.330 EMS System Program Plan, sections a-e**

**I. OSF Saint James John W Albrecht Medical Center 0257**

**2500 W Reynolds**

**Pontiac, IL 61764**

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## II. System EMS Transport Providers

Service	Level	Address	Email Contact
Allen Twnshp Fire Dept.	BLS	102 South Lincoln Street, Ransom	<a href="mailto:atfpd.ems@gmail.com">atfpd.ems@gmail.com</a>
Benson	BLS	418 Front St Benson IL 61516	<a href="mailto:stephsamuelson@hotmail.com">stephsamuelson@hotmail.com</a>
Eastern Marshall County EMS	BLS/ALS Field Upgrade	Wenona IL 12hrs Toluca IL 12hrs	<a href="mailto:easternmarshallcounty@gmail.com">easternmarshallcounty@gmail.com</a>
Minonk Ambulance Service	BLS/ALS Field Upgrade	636 S Jefferson St. Minonk IL 61760	<a href="mailto:minems2011@gmail.com">minems2011@gmail.com</a>
Odell EMS	BLS	210 S Front St, Odell, IL 60460	<a href="mailto:millsy@mchsi.com">millsy@mchsi.com</a>
Pontiac Fire Dept.	ALS, BLS	413 N Mill St. Pontiac IL 61764	<a href="mailto:Jacob.campbell@pontiac.org">Jacob.campbell@pontiac.org</a>
Saunemin Fire Dept.	BLS	56 Center St. Saunemin IL	<a href="mailto:saufire@yahoo.com">saufire@yahoo.com</a>
SELCAS	ALS	310 W Locust Fairbury IL 61739	<a href="mailto:Selcas6721@gmail.com">Selcas6721@gmail.com</a>
Eagle Ambulance	BLS	24457 W Eames St, Channahon, IL	

## III. Non-Transport Providers

Service	Level	Address	Email
SELCAS - Chatsworth	EMR	32654 E 830 N Rd, Chatsworth, IL 60921	<a href="mailto:Selcas6721@gmail.com">Selcas6721@gmail.com</a>
Cornell Fire Dept	EMR	406 W Main, Cornell, IL 61319	<a href="mailto:josh@tsctruck.com">josh@tsctruck.com</a>
Dana Fire	EMR/BLS Upgrade	115 W Washington St, Dana, IL 61321	<a href="mailto:mikebeckett1980@gmail.com">mikebeckett1980@gmail.com</a>
Forrest/Strawn Fire Dept	EMR/BLS Upgrade	706 N Center St, Forrest, IL 61741	<a href="mailto:bri.edelman95@gmail.com">bri.edelman95@gmail.com</a>

Service	Level	Address	Email
Flanagan Fire Dept	EMR/BLS/ALS Field Upgrade	103 E South ST Flanagan IL 61740	<a href="mailto:ryan.m.schladenhauffen@osfhealthcare.org">ryan.m.schladenhauffen@osfhealthcare.org</a>
Kempton Fire Dept	EMR	210 First Street, Kempton, IL, 60946	<a href="mailto:english6@frontiernet.net">english6@frontiernet.net</a>
Long Point Fire Dept	EMR	302 Market St, Long Point, IL 61333	<a href="mailto:longpointfire@gmail.com">longpointfire@gmail.com</a>
Pontiac Fire Dept.	BLS/ALS Engine	413 N Mill St. Pontiac IL 61764	<a href="mailto:Jacob.campbell@pontiac.org">Jacob.campbell@pontiac.org</a>
SELCAS - Chenoa	EMR		<a href="mailto:Selcas6721@gmail.com">Selcas6721@gmail.com</a>
Varona-Kinsman Fire Dept	EMR/BLS Upgrade	429 Division Street, Verona IL	<a href="mailto:veronakinsmanfiredepartment@gmail.com">veronakinsmanfiredepartment@gmail.com</a>
Toluca Fire Dept.	EMR/BLS Upgrade	322 West Railroad Avenue, Toluca, IL 61369	<a href="mailto:jcstase@gmail.com">jcstase@gmail.com</a>

#### IV. Industrial Providers

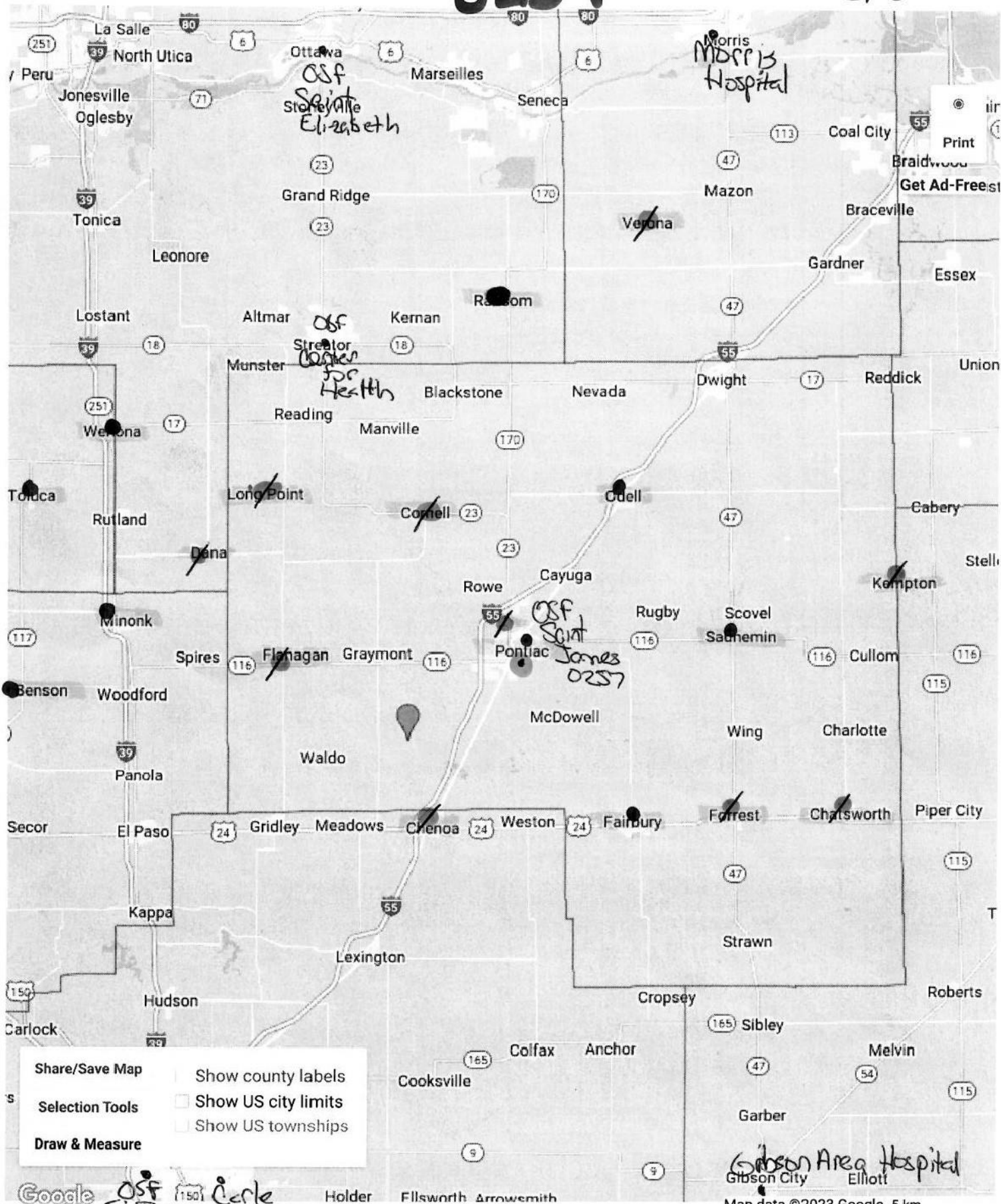
Service	Level	Address	Email
Caterpillar Inc.	EMR	1300 4h Park Rd, Pontiac, IL 61764	<a href="mailto:tricia.ruthe@cat.com">tricia.ruthe@cat.com</a>

#### V. 911 Telecommunications

Service	Level	Address	Email
Vermillion Valley Regional Communications Joint Authority (V-COM)	EMD	844 W Lincoln Pontiac IL 61764	<a href="mailto:sarah.bohm@vcom911.com">sarah.bohm@vcom911.com</a>



●EAGLE-



Gibson Area Hospital  
Gibson City Elliott

Map data ©2023 Google 5 km

<b>Title of Policy:</b> <i>911 Emergency Calls Initiated from Hospitals</i>	<b>Policy Number:</b> O100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> ILS/ALS Intercept Policy	<b>Policy Number:</b> O110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> ILS/ALS Intercept Policy	<b>Policy Number:</b> O110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- Regardless of response jurisdiction, if two different agencies with differing levels of care are dispatched to and arrive on the scene of an emergency, the agency with the highest licensure level shall assume control of the patient(s).

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

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

#### **C. Transfer of care**

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

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

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

<b>Title of Policy:</b> Ambulance Licensing Requirements	<b>Policy Number:</b> L100
<b>Effective Date:</b> 01/20/2023	<b>Review Date:</b> 12/10/2022
<b>Policy Area:</b> Licensing	<b>Approvals:</b> MD, System

**EMS Rules: Section 515.830 Ambulance Licensing Requirements**

1. 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.
2. *A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, as long as 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 3.85(b)(8) of the Act)

**I. Policy**

**A. OSF Saint James EMS System requires all transport, non-transport and Ambulance assist vehicles to carry the IDPH and system approved supplies and equipment at a minimum. ( see supply list)**

1. BLS Supplies/Equipment- complies with IDPH regulations.
2. ALS Supplies/Equipment- shall be in adherence of the EMS system requirements.

**B. All vehicles Must be inspected annually**

1. 3. Provide proof of insurance

**C. All new vehicles will have an initial inspection and then followed up with annually.**

**D. All transport units will:**

1. Have approved bi-annual inspections completed by an approved DOT inspector
2. Be up to date with title and license fee's (plates)
3. Provide proof of insurance

**II. BLS/ALS supplies and equipment Minimums for Transport and Non-transport**

Item	Non-Transport					Transport		
	EMR	BLS	ILS	ALS-Engine	ALS-Intercept	BLS	ILS	ALS
<b><i>Patient Transport Equipment</i></b>								
Wheeled Cot w/Straps						1	1	1
Three-Point Fastner for cot						1	1	1
Secondary stretcher w/straps						1	1	1
<b><i>Oxygen Supplies/Equipment</i></b>								
Adult Nasal Cannula	1	2	2	2	2	2	2	2
Adult Non-Rebreather	1	2	2	2	2	2	2	2
BVM-Adult	1	1	1	1	2	2	2	2
BVM-Child	1	1	1	1	2	2	2	2
BVM-Infant	1	1	1	1	2	2	2	2
Child size Nasal Cannula	1	1	1	1	2	2	2	2
Child size Non-Rebreather	1	1	1	1	2	2	2	2
Infant Oxygen Mask	1	1	1	1	2	2	2	2
Nebulizer		1	1	1	2	2	2	2
<b><i>Airway/Suction Equipment</i></b>								
1000ml Suction Container						2	2	2
CPAP Device (at least 2 sizes) each		1	1	1	1	1	1	1
ET Stylets			2	2	2		2	2
ET Tube Holder (Adult & Ped) each			1	1	1		1	1
ET Tube Introducer (Bougie)			1	1	1		1	1
ET tubes (2.0-9.0) include 0.5 sizes, each			1	1	1		1	1
Igel Size 1 21.29			1	1	1		1	1
Igel Size 1.5 21.29			1	1	1		1	1
Igel Size 2 21.29			1	1	1		1	1
Igel Size 2.5 21.29			1	1	1		1	1
Igel Size 3 21.29	1	1	1	1	1	1	1	1
Igel Size 4 21.29	1	1	1	1	1	1	1	1
Igel Size 5 21.29	1	1	1	1	1	1	1	1
Laryngoscope Blade (1-4) each			1	1	1		1	1
Laryngoscope Handle Adult			1	1	1		1	1
Lubricant Jelly	2	2	2	2	2	2	2	2
Nasopharyngeal Airway 12-34f	1	1	1	1	1	1	1	1
Onboard Suction						1	1	1
Oropharyngeal Airway (00-5)	1	1	1	1	1	1	1	1
Portable Suction (or Manual)	1	1	1	1	1	1	1	1
Semi-Rigid Suction Tip (Yankauer)	1	1	2	2	2	3	3	3
Suction Cath (6-18f) each						2	2	2
Suction Cath (6-8,10-12,14-18 1 per range)	1	1	1	1	1			
Suction Tubing (if battery device carried)	1	1	1	1	1	2	2	2
Syringe Catheter tip (60mL)				1	1			1

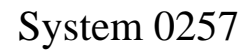
Item	Non-Transport					Transport		
	EMR	BLS	ILS	ALS-Engine	ALS-Intercept	BLS	ILS	ALS
Quick Trach 2				1	1			1
Laryngoscope Spare Batteries			1	1	1		1	1
Oro-Naso Gastric Tube 3.30ea				1	2			2
Decompression needle 16/14				2	2			2
Video Laryngoscope				1	1			1
Video Laryngoscope Blade (Adult Sizes)				1	1			1
<i>Cardiac/Resuscitation</i>								
Adult Pads (AED Compatible)	1	1	1	1	1	2	2	2
AED w/ Pediatric and Adult Capabilities	1	1						
Cardiac Monitor (12 lead Capable)			1	1	1	1	1	1
EKG Electrodes			24	24	36	36	36	36
Pediatric Pads (or w/ Ped Key)	1	1	1	1	1	1	1	1
Razor	1	1	1	1	1	1	1	1
<i>Extraction/Immobilization/Splinting</i>								
C-Collar Adjustable Adult	2	2	2	2	2	3	3	3
C-Collar Adjustable Pediatric	1	1	2	2	2	3	3	3
Extremity Splint - Adult Long	1	1	1	1	1	2	2	2
Extremity Splint - Adult Short	1	1	1	1	1	2	2	2
Extremity Splint - Ped Long	1	1	1	1	1	2	2	2
Extremity Splint - Ped Short	1	1	1	1	1	2	2	2
Goggles						Enough for crew		
Long Spine Board	1	1	1	1		1	1	1
Restraints (sets each)						2	2	2
Short Spine Board or KED Device						1	1	1
Traction Splint-Adult						1	1	1
Traction Splint-Pediatric						1	1	1
Wrecking Bar						1	1	1
<i>Assessment Equipment</i>								
BP Cuff - Adult	1	1	1	1	1	1	1	1
BP Cuff - Child	1	1	1	1	1	1	1	1
BP Cuff - Infant	1	1	1	1	1	1	1	1
BP Cuff - Large Adult					1	1	1	1
Electric Clock w/ Sweep Hand						1	1	1
Pen light	1	1	1	1	1	1	1	1
Pulse Oximeter w/ Adult & Ped probes	1	1	1	1	1	1	1	1
Stethoscope	1	1	1	1	1	2	2	2
Glucometer (incl. Test strips)	1	1	1	1	1	1	1	1
Thermometer (incl. probe covers)	1	1	1	1	1	1	1	1







	Non-Transport					Transport		
Item	EMR	BLS	ILS	ALS-Engine	ALS-Intercept	BLS	ILS	ALS
<i>IV/ Medication Administration Equip.</i>								
Blood Tubes (assorted colors) each				1	1		1	1
EZ-IO Drill			1	1	1		1	1
EZ-IO Needle Adult Blue				1	2		2	2
EZ-IO Needle Bariatric Yellow			1	1	2		2	2
EZ-IO Needle Pediatric Pink				1	2		2	2
Filter Tubing				1	1			1
IV Arm Board				1	1		1	1
IV Cath 14g			2	2	3		3	3
IV Cath 16g			2	2	3		3	3
IV Cath 18g			3	3	4		4	4
IV Cath 20g			3	3	4		4	4
IV Cath 22g			2	2	2		2	2
IV Hand Board			1	1	1		1	1
IV Pump					1			1
IV Pump Tubing					2			2
MAD Device	2	2	2	2	2	2	2	2
Needle 18-21g (1.5"-2") each								
Needle 25-27g (1")								
Needle Filter		1	1	1	1	1	1	1
Syringe 12 ml or larger								
Syringes 1cc		2	2	2	2	2	2	2
Syringes 3cc			2	2	2	2	2	2
Syringes 5cc/10cc			2	2	2	2	2	2
Tubing - Blood			1	1	1		1	1
Tubing - Macro 10gtts			2	2	4		4	4
Tubing - Micro 60gtts			2	2	2		2	2
Venous Tourniquet			4	4	4		4	4
<i>Optional Equipment</i>								
Pelvic Binder								
<i>PPE Equipment</i>								
Bio-hazard Isolation Bag	1	1	1	1	1	1	1	1
Disposable Gloves (assorted sizes)	Enough for each crew member							
Face Mask/Eye Protection	2	2	2	2	2	2	2	2
Gown	2	2	2	2	2	Enough for crew		

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Item	Non-Transport					Transport		
	EMR	BLS	ILS	ALS-Engine	ALS-Intercept	BLS	ILS	ALS
Adenosine 6mg/2mL			2	2	2		2	2
Adenosine 12mg			2	2	2		2	2
Albuterol 2.5mg/3mL		2	2	2	2	3	3	3
Amiodarone 150mg/3mL			4	4	4		8	8
Aspirin (81mg tab)	36	36	36	36	36	36	36	36
Atropine 1mg/10mL			3	3	5		5	5
Dextrose 10% 250mL bag			1	1	2		2	2
Diphenhydramine 50mg/1mL			1	1	2		2	2
Diphenhydramine 25mg Tab		8	8	8	8	8	8	8
Epinephrine 1:1,000 1mg vial (IM approved)		1	1	1	1	1	1	1
Epinephrine 1:10,000 1mg/10mL Syrg.			5	5	10		10	10
Amiodarone Drip premix 250ml								1
Glucagon 1mg/1mL		1	1	1	2	2	2	2
Acetaminophen tab 500MG		16	16	16	16	16	16	16
Ipratropium 0.5mg/2.5mL		3	3	3	3	3	3	3
Lactated Ringers 1000mL			4	4	4		6	6
Levophed 4mg					2			2
Lidocaine 100mg/5mL			1	1	1		1	1
Magnesium Sulfate 5g/10mL				2	2			2
Methylprednisolone 125mg/2mL				1	2			2
Narcan 2mg/2mL	2	3	3	3	3	3	3	3
Nitroglycerin (Tab or Spray) 0.4mg Bottle		1	1	1	1	1	1	1
Nitroglycerin 50mg/250mL Bottle					1			1
Nitroglycerin Paste w/ Paper		1	1	1	1	1	1	1
Normal Saline 0.9% 100 mL				1	2			2
Normal Saline 0.9% 250ml				1	2			2
Normal Saline 0.9% 1000ml				1	1			1
Ondansetron 4mg ODT		2	2	2	2	4	4	4
Ondansetron 4mg Vial			1	1	2		2	2
Oral Glucose (15g tube)	2	2	2	2	2	2	2	2
Sodium Bicarbonate 50mEq/50mL				1	1			1
Tranexamic Acid 1000mg/10mL				1	1			1
<b>Controlled Medication</b>			Exact Requirement			Exact Requirement		
Fentanyl 100mcg/2mL			100mcg		200mcg		200 mcg	
Ketamine 500mg/5mL				1	1			1
Haladol				1	1			2
Etomidate				2	2			2
succinylcholine				2	2			2
Midazolam 5mg/5mL			2	2	4		2	4
Rocuronium 50mg/5mL				1	1			1

**Approved Equipment List**

<b>Tourniquets</b>
Combat Application Tourniquet
SOF-T Tourniquet
SAM XT

<b>Blind Insertion Airway Device</b>
i-Gel Airway

<b>Cric Equipment</b>
<ol style="list-style-type: none"> <li>1. Quick Trach 2 Adult and peds</li> <li>2. Surgical Control Cryc Kit</li> </ol>

<b>Needle Decompression Device</b>
Turkel Needle
Spear Needle - North American Rescue
Russel PneumoFix Decompression Needle -12g

<b>Video Laryngoscope</b>
C-Mac Video Laryngoscope
GlideScope
IntubBrite Video
King Vision
Eagle Vision
McGrath Mac
Rusch Airtraq

<b>Chest Seal</b>
HyFin
SAM Chest Seal
Halo Chest Seal
Asherman Chest Seal

<b>Pelvic Binder</b>
Sam Pelvic Sling
TPOD

<b>Title of Policy:</b> <i>Abuse of Controlled Substances by System Personnel</i>	<b>Policy Number:</b> D100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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



<b>Title of Policy:</b> <i>Aeromedical Resources Guidelines</i>	<b>Policy Number:</b> O120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy:

Aeromedical resources should be used in the following situations.

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

### Dispatch Standby Criteria

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

### General Guidelines and Considerations

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

not already on scene or enroute).

<b>Title of Policy:</b> <i>Aeromedical Resources Guidelines</i>	<b>Policy Number:</b> O120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

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

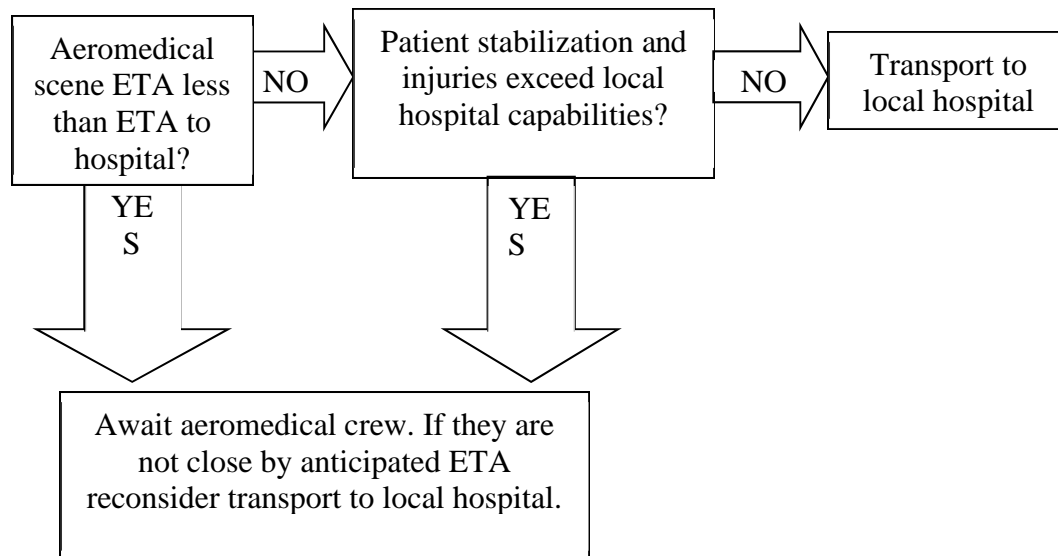
#### **Landing Zone Safety Precautions**

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



<b>Title of Policy:</b> <i>Aeromedical Resources Guideline</i>	<b>Policy Number:</b> O120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

### Aeromedical Consideration Algorithm



<b>Title of Policy:</b> <i>Agency Inspection</i>	<b>Policy Number:</b> L110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Licensure	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Assistance by Non-System Personnel</i>	<b>Policy Number:</b> O130
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

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

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

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

<b>Title of Policy: <i>Authority of the Associate EMS Medical Director</i></b>	<b>Policy Number: A110</b>
<b>Effective Date: 10/07/2019</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Administration</b>	<b>Approvals: MD, System</b>

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy: Bi-Annual Skill Checks</b>	<b>Policy Number: E100</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

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

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

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

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

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

## **PURPOSE**

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

## Policy:

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

<b>Title of Policy:</b> <i>BLS IM Injection Program</i>	<b>Policy Number:</b> O140
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### 1. Notification

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

### 2. Training

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

### 3. Prescription

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

### 4. Equipment

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

<b>Title of Policy:</b> <i>Cardiac Monitor and AED on Emergency Vehicles</i>	<b>Policy Number:</b> O150
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD. System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy: Cardiac Resuscitation vs. Cease Efforts and Coroner Notifications</b>	<b>Policy Number: O160</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Operations</b>	<b>Approvals: MD, System</b>

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### A. Resuscitation vs. Recognition of Death

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

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

### B. Guidelines for determining resuscitation efforts or ceasing efforts:

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

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

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



<b>Title of Policy: Cardiac Resuscitation vs. Cease Efforts and Coroner Notifications</b>	<b>Policy Number: O160</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Operations</b>	<b>Approvals: MD, System</b>

**D. Signs of death are notably evident:**

- Confirm no Blood Pressure, respirations, or EKG activity
- **Contact Medical Control**
- Receive direction to notify Coroner

**E. Upon EMS arrival, CPR is in progress:**

- Continue CPR
- Determine if life signs are present
- **Contact Medical Control**
- Continue resuscitative measures as directed

**F. Special circumstance where prolonged resuscitation efforts are indicated:**

- Hypothermia
- Pediatric patients
- Treatable contributing factors

<b>Title of Policy: Coroner Notifications</b>	<b>Policy Number: O170</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Operations</b>	<b>Approvals: MD, System</b>

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### A. Recognition of Death

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

### B. Notification Requirements and Procedures

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

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

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

#### 1. ACCIDENTAL DEATHS

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

<b>Title of Policy: Coroner Notifications</b>	<b>Policy Number: O170</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Operations</b>	<b>Approvals: MD, System</b>

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

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

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

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

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

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

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

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

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

<b>Title of Policy: Coroner Notifications</b>	<b>Policy Number: O170</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Operations</b>	<b>Approvals: MD, System</b>

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

<b>Title of Policy:</b> <i>Code of Conduct</i>	<b>Policy Number:</b> D110
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

## Background to Policy:

EMS providers must always maintain a high ethical and professional standard.

## Policy Statement:

Emergency Medical Service Providers must continually maintain high ethical and professional standards. We have been entrusted to serve the public with complete integrity. Failure to uphold these standards puts patients, the community, and the profession of EMS at risk of losing public trust. We must continually uphold ourselves and other responders to the highest of standards.

## Policy:

- A. EMS responders work under the license and at the privileges granted by the EMS System Medical Director. As such, the EMS responder represents the Medical Director and the EMS System while performing their EMS duties.
- B. EMS responders are expected to represent the EMS System, the Medical Director, and their agencies in a professional manner at all times.
- C. Providers are expected to act in the following manner when working with patients, patient's family and friends, bystanders, other responders, hospital staff and physicians.
  - a. Treat every person they come in contact with while on duty with dignity, respect, and empathy
  - b. Speak to all persons in a professional and respectful manner
  - c. Treat all patients free of discrimination or bias
  - d. Protect the dignity of the patient and their rights as guaranteed by local, state and federal laws.
  - e. Treat all patients within established written protocol and policy, providing appropriate, timely, and accurate interventions.
  - f. Uses medically appropriate clinical judgement for the benefit of the patient.
  - g. Never withhold appropriate and necessary care to patients in need.
  - h. Protects the privacy of all patients including materials and information written, orally given, electronic and/or digitally received.
  - i. Represent the System, their Agency, and the profession of EMS with the highest professional standards
  - j. Maintain professional knowledge and competencies as required by the system, the state, and any applicable Federal standards.
  - k. Function free from being chemically impaired.
  - l. Speaks truthfully and with integrity in all situations
  - m. Ensure complete, thorough, and accurate information in written documentation.
  - n. Never use their position to endanger, abuse
  - o. Ensures that fellow Emergency Medical Services providers abide by these standards and reports violations in a timely manner

<b>Title of Policy:</b> <i>Code of Conduct</i>	<b>Policy Number:</b> D110
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

D. Violations of these standards will be treated under the System Suspension Policy.

E. EMS System providers charged with a Felony whether on duty or off duty will be system suspended pending outcome and resolution of their charges.

F. It is the responsibility of the agency and EMS providers to report violations of this policy or if an EMS provider is charged with a felony.

<b>Title of Policy:</b> <i>Communications Etiquette</i>	<b>Policy Number:</b> O180
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Communications Recording Procedures</i>	<b>Policy Number:</b> O190
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

The following guidelines have been established to assist the ECRN or the Medical Control Physician in the proper procedure of recording all in-bound, pre-hospital patient care information. The purpose for recording all calls is two-fold. First, is to seek Continuous Quality Improvement through retrospective evaluation of out-of-hospital care and secondly, to validate patient care in cases of litigation. Communications is recorded through Carepoint system 24/7, 365 day per year. All recordings are kept via the cloud in compliance with EMS Act standards.

## Policy:

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



<b>Title of Policy:</b> <i>Conceal Carry Policy</i>	<b>Policy Number:</b> O200
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Policy Statement:

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

## Policy:

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

## Applicable Scenarios

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

<b>Title of Policy:</b> <i>Conceal Carry Policy</i>	<b>Policy Number:</b> O200
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**General Guidelines**

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

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

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19. Any street, driveway, parking area, property, building, or facility, owned, leased, controlled, or used by a nuclear energy, storage, weapons, or development site or facility regulated by the federal Nuclear Regulatory Commission. The licensee shall not under any circumstance store a firearm or ammunition in his or her vehicle or in a compartment or container within a vehicle located anywhere in or on the street, driveway, parking area, property, building, or facility described in this paragraph.

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

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

#### **Conscious Patient Willing to Relinquish a Weapon**

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

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

#### **Conscious Patient Unwilling to Relinquish a Weapon**

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

#### **Patients with Altered Levels of Consciousness**

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

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

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

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

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

**Patients Transported via Emergency Responders to a Medical Facility**

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

**Lock Box**

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



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

#### **Activities Which Shall Result in Immediate Licensure Suspension**

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

<b>Title of Policy:</b> <i>Consent for Treatment of Minors</i>	<b>Policy Number:</b> LE100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### DEFINITIONS:

EMERGENCY:	A medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Illinois EMS Systems Act [210 ILCS 50] Section 3.5)
MINOR:	A minor is anyone under the age of 18. The parent or legal guardian of a minor may consent to treatment on the minor. The parent or guardian need not be 18 years of age or older to consent. (Illinois Revised Statutes Chapter 111, Section 4502)
IMPLIED CONSENT:	Situations involving an unconscious patient where care is initiated under the premise that the patient would desire such care if they were conscious and able to make the decision. In the case of a minor, if a parent or legal guardian is not present, care and transportation is given on a basis of <u>Implied Consent</u> .

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

<b>Title of Policy:</b> <i>Consent for Treatment of Minors</i>	<b>Policy Number:</b> LE100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

E. When faced with a questionable consent problem, in all cases, contact Medical Control.

F. Exceptions based on minor's legal status are as follows:

1. **Emancipated (1), Pregnant or Married Minors may consent for their own treatment:**

A minor between the age of 16 and 18 years old who presents a court order declaring him or her emancipated, or a pregnant or married minor of any age, may lawfully consent to the performance of any medical or surgical procedure. (2)

2. **Minors who are parents may consent for their own treatment:** A minor who is a parent may lawfully consent to his or her own health care treatment. (3) But, if the minor's status as a parent ends, for example, if the minor gives up his or her child for adoption, then it would appear the minor no longer has authority to consent to his or her own treatment.

3. **Minors who are parents may consent for their child's treatment:** Any parent, including a parent who is a minor, regardless of age, may consent to health care on behalf of his or her child. (4) This provision applies to parents who are divorced or separated; either parent may consent for the child, so long as the divorce decree or custody order does not state otherwise. The hospital does not have an obligation to investigate the terms of the divorce decree or custody order. In most cases, it is sufficient if a parent is present and seeking care for his or her child.

4. **Inpatient Mental Health Services:** A minor 16 of age or older may consent to admission to a mental health facility for inpatient services if the minor himself executes the application for voluntary admission. Unlike outpatient services, providers must immediately inform the minor's parent, guardian or person in *loco parentis* (5) of the admission, even if the minor does not consent to the disclosure. (6)

5. **Birth Control Services:** Birth control services and information may be rendered by doctors licensed in Illinois to any minor: (1) Who is married, (2) Who is a parent, (3) Who is pregnant, (4) Who has the consent of his parent or legal guardian; or (5) If the failure to provide such services creates a serious health hazard; or (6) If the minor is referred for such services by a physician, clergyman or a planned parenthood agency.

6. **Temporary Custody:** If a physician has taken temporary protective custody of an abused or neglected child at a hospital, he/she shall immediately notify DCFS and make every reasonable effort to notify the person responsible for the child's welfare. He/she shall also notify the person in charge of the hospital and shall become responsible for the further care of the child in the hospital or similar institution under the direction of DCFS.

7. **Emancipated Minors:** Emancipation does not arise solely because a minor is living or acting independently of his/her parent; this is a legal procedure requiring a court petition. A minor may be completely or partially emancipated; a copy of the court emancipation order must be reviewed to determine if the minor has authority to consent to his/her own treatment.

G. Exceptions based on minor's medical treatment are as follows:

1. Emergency medical treatment may be provided to a minor without parental consent when, in the opinion of the provider, obtaining consent is not "reasonably feasible under the circumstances without adversely affecting the condition of the minor's health." A "provider" includes a physician, dentist, hospital, physician assistant or advanced practice nurse.
2. Any minor who is a victim of sexual assault or abuse may consent to medical care or counseling related to the diagnosis or treatment of "any disease or injury arising from such offence."
3. A minor 12 years or older may consent to treatment or counseling related to the diagnosis and treatment of a sexually transmitted disease. Unless the minor consents, providers cannot seek the

<b>Title of Policy:</b> <i>Consent for Treatment of Minors</i>	<b>Policy Number:</b> LE100
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<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

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

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

#### H. Refusal of Transport after Emergency Treatment

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

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

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

## Resources:

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

<b>Title of Policy:</b> <i>Continuous Quality Improvement Policy</i>	<b>Policy Number:</b> A120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Administration	<b>Approvals:</b> MD, System

## Policy Statement:

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

### PURPOSE

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

## Policy:

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

<b>Title of Policy:</b> <i>Continuous Quality Improvement Policy</i>	<b>Policy Number:</b> A120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Administration	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> Corrective coaching/DISCIPLINARY ACTION	<b>Policy Number:</b> D120
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> /08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

EMS Rules Section 515.420 System Participation Suspensions Amended at 42 Ill. Reg. 17632, effective September 20, 2018)

**I. Philosophy and purpose**

- A. The OSF SAINT JAMES EMS believes in uncompromising legal and ethical behavior based on the standards and codes of EMS professional conduct and the laws of our community, state, and country. EMS personnel have the opportunity to participate in a worthy, purposeful, and progressive profession. This opportunity is not without obligation. The viability of the profession rests on the integrity as well as the capability of its members.
- B. Further, we are dedicated to excellence as our basic performance standard. We affirm that all tasks and services provided in the context of EMS care shall be delivered in a consistently superior manner. Working together, we will approach everything we do as an opportunity for continuous quality improvement.

**II. Possible outcomes for a complaint investigation or behavior infraction**

- A. **Non-sustained/no action:** Evidence was insufficient to prove or disprove the complaint.
- B. **Sustained:** Complaint was supported by sufficient evidence to justify disciplinary action. Determine if human error or willful defiance.
- C. **Unfounded/Not involved:** Means the facts revealed by the investigation did not support the complaint (e.g., the complained-of conduct did not occur).
- D. **Exonerated:** Means the complained-of conduct occurred, but the accused individual's actions were deemed proper, within guidelines, or had mitigating circumstances that vacate disciplinary action.

**III. Possible disciplinary actions stratified by their seriousness**

Corrective action is generally progressive in the OSF Saint James EMS System. The purpose of disciplinary action is to provide feedback and coaching that encourages accountability and behavior that reflects System values and standards. In each instance, the corrective action is to be fair, just, and in proportion to the seriousness of the violation. In addition, feedback is to be communicated privately, out of sight and sound of peers or co-workers, and delivered in a timely manner. For more severe offenses, the disciplinary process may begin with a final written warning, suspension, or dismissal.

A. **Verbal warning** and remediation plan

B. **Written warning** with corrective coaching/action plan: If the violation would not warrant immediate suspension, the EMSC/educator will work with the involved parties to design a corrective action plan that will require ongoing assessment and monitoring of behavior/performance.

C. **Final written warning** with a corrective action plan as above that may include restriction of practice and/or suspension recommended to IDPH, and with the caveat that serious consequences to licensure/practice will result if prohibited behaviors are repeated.

D. **Recommendation to take action on the individual's EMS license**

- IV. Grounds for corrective coaching and/or disciplinary action in the OSF SAINT JAMES EMS System.** The EMS Medical Director (EMS MD) may choose to invoke corrective coaching or disciplinary action against any individual or individual provider or other participant considered to be in violation of the EMS Act or other statutes governing EMS personnel and/or any Rule promulgated under those Acts and/or failure to comply with the provisions of the System's Program Plan approved by IDPH which may include violation of the System's standards of care. Examples may include but not be limited to the following:



<b>Title of Policy:</b> Corrective coaching/DISCIPLINARY ACTION	<b>Policy Number:</b> D120
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

- A. Failure to meet education requirements prescribed by statute, Rule, or EMS MD;
- B. All forms of academic misconduct including but not limited to cheating, fabrication, plagiarism, or academic dishonesty.
- C. Selling, posting, or distributing EMS educational materials, QI documents, videos, or audio recordings that are the intellectual property of the EMS System unless authorized in advance by the EMS MD or EMS System Manager in writing
- D. Failure to maintain proficiency in the provision of basic, intermediate or advanced life support services prescribed by IDPH and/or the EMS MD;
- E. Any EMS personnel, who, during the provision of emergency services or while acting as a student or an agent of an EMS agency or hospital, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;
- F. Impaired behavior, 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 or performance of activities in the care of patients requiring EMS interventions. ("adversely affect" means anything which could harm the patient or treatment that is administered improperly);
- G. Unlawful manufacture, distribution, dispensing, possession, use, or sale of, or the attempted manufacture, distribution, dispensing, or sale of controlled substances, identified in federal and state law or regulations.
- H. Unauthorized use or removal of controlled substances, drugs, supplies, or equipment from any ambulance, health care facility, institution or other work place location;
- I. Intentional falsification of any medical reports/orders, or making misrepresentations involving personal affiliation with a healthcare agency or scope of practice during pt care;
- J. Forgery, alteration, or misuse of any System document, record, key, or electronic device.
- K. Theft of, conversion of, destruction of, or damage to any EMS property, or any property of others while acting as a student/agent of the System, or possession of any property when the individual had knowledge or reasonably should have had knowledge that it was stolen;
- L. Theft or abuse of EMS electronic resources such as computers and electronic communications devices, facilities, systems, and services. Abuses include (but are not limited to) unauthorized entry, use, transfer, or tampering with the communications of others; interference with the work of others and with the operation of computer and electronic communications facilities, systems, and services; or copyright infringement (for example, the illegal file-sharing of copyrighted materials);
- M. Unauthorized entry to, possession of, receipt of, or use of any EMS services; equipment; resources; or properties.
- N. The System member is physically impaired to the extent that he or she cannot physically perform EMS duties for which he or she is licensed, as verified by a physician, unless the person is on inactive status pursuant to IDPH regulations;
- O. The System member is mentally impaired to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless that person is on inactive status pursuant to IDPH regulations and is not determined to be impaired a result of a medical condition;
- P. Abandoning or neglecting a patient during the provision of emergency care.
- Q. Performing or attempting emergency care, techniques or procedures without proper permission, licensure, education or supervision;



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<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

- R. Discriminating in rendering emergency care because of race, sex, creed, religion, national origin, medical condition, sexual orientation, or ability to pay;
- S. Physical abuse including but not limited to sexual assault, sex offenses, and other physical assault; threats of violence; or other conduct that threatens the health or safety of any person that occurs while a student and/or in the line of duty;
- T. Stalking behavior in which a System student or member repeatedly engages in a course of conduct directed at another student or agent of the System and makes a credible threat with the intent to place that person in reasonable fear for his or her safety, or the safety of his or her family; where the threat is reasonably determined by the System to seriously alarm, torment, or terrorize the person; and where the threat is additionally determined by the System to serve no legitimate purpose.
- U. Harassment by a student or System member in the line of duty: Harassment may include: a) the use, display, or other demonstration of words, gestures, imagery, or physical materials, or the engagement in any form of bodily conduct, on the basis of race, color, national or ethnic origin, sex, religion, age, sexual orientation, or physical or mental disability, that has the effect of creating a hostile and intimidating environment sufficiently severe or pervasive to substantially impair a reasonable person's participation in program activities, or use of program facilities; b) must target a specific person or persons; and c) must be addressed directly to that person or persons. Sexual harassment means unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature that occurs while a student and/or in the line of duty;
- V. Obstruction or disruption of teaching, research, administration, disciplinary procedures, or other System activities.
- W. Illegal possession, use, storage, or manufacture of explosives, firebombs, firearms or other weapons or other destructive devices while a student or acting as an agent of the System;
- X. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care;
- Y. Behavior of the System participant of a nature that could cause foreseeable danger to himself/herself or the public; or
- Z. The System participant, while not in violation of any of the above, has consistently and repeatedly, during the provision of emergency care, acted in such a way as to reflect discredit upon the EMS System, their employer, and/or IDPH.

#### **V. IMMEDIATE SUSPENSION OF PRIVILEGES**

- A. The EMS MD may issue an immediate suspension if he finds that the information in his possession indicates that continued EMS practice by the individual, individual provider, or participant would constitute a foreseeable, imminent danger to the public. The suspended individual, individual provider, or participant shall be issued a verbal notice of Immediate Suspension followed by a written suspension order to the EMT or other provider by which the EMS MD states the length, terms and basis for the suspension. Verbal notice shall be communicated to the individual and to the highest-ranking on-duty officer or administrator of the agency employing the suspended individual at the time of the incident.
- B. Documentation in the individual's or individual provider's EMS file shall include all salient facts leading to the suspension.
- C. Within 24 hours following the commencement of the suspension, the EMS MD shall deliver to IDPH, by e-mail, messenger, or telefax, a copy of the suspension order and copies of any written materials that relate to the decision to suspend the individual or individual provider.

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- D. Within 24 hours following the commencement of the suspension, the suspended individual or individual provider may deliver to IDPH by e-mail, messenger, or telefax, a written response to the suspension order and copies of any written materials that the individual or individual provider believes relates to that response.
- E. Within 24 hours of receipt of the EMS MD's suspension order or the written response, whichever is later, the Director or Director's designee shall determine whether the suspension should be stayed pending the individual's or individual provider's opportunity for hearing or review in accordance with the EMS Act, or whether the suspension should continue during the course of that hearing or review. IDPH shall issue this determination to the EMS MD, who shall immediately notify the suspended EMT or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.
- F. Upon issuance of a suspension order for reasons directly related to medical care, the EMS MD shall provide notice to the individual or individual provider that they have the opportunity for a hearing before the local System Review Board, or they may elect to bypass the local Review Board and seek direct review of the suspension order by the State EMS Disciplinary Review Board in accordance with the EMS Act and Rules.
- G. If the local Review Board affirms or modifies the EMS MD's suspension order, the individual or individual provider shall have the opportunity to appeal the local Board's decision to the State EMS Disciplinary Review Board, pursuant to the EMS Act.
- H. If the local Review Board reverses or modifies the EMS MD's suspension order, the EMS MD shall have the opportunity to appeal the local Board's decision to the State EMS Disciplinary Review Board, pursuant to the EMS Act.

#### **VI. ADMINISTRATIVE SUSPENSION OF SYSTEM PRIVILEGES**

- A. For suspensions that do not include a finding of a foreseeable risk to the public, the EMS MD shall invoke an Administrative suspension of practice privileges in OSF SAINT JAMES EMS by issuing a written notice to the individual or individual provider which includes a statement describing the reason(s) for the suspension (taken from the grounds listed in Section II of this policy), the terms, length, and condition of the suspension, corrective action that could avert a suspension if applicable, the effective date unless a hearing is requested, and the procedure for requesting a hearing.
- B. The written intent to suspend notice shall be sent to the individual by e-mail or personal service and to the EMS agency employing the suspended individual by e-mail, fax, or personal service.
- C. Documentation in the individual's or individual provider's EMS file shall include all salient facts leading to the suspension.
- D. Reinstatement: An administrative suspension shall remain in place until the Resource Hospital receives reliable evidence that the deficiency has been corrected.

#### **VII. Notification of other EMS Systems**

- A. If a suspended EMS practitioner is known to have dual participation with another EMS System; that System shall be notified in writing via email when a notice of suspension and reinstatement is issued. activities, participates in causing the damages or costs to the program.

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**VIII. Recovery of damages**

Students or system members who have been found to have stolen or damaged System or hospital property shall be required to provide reimbursement for expenses incurred by the program or other parties resulting from the person's infraction. Such reimbursement may take the form of monetary payment or appropriate service to repair or otherwise compensate for damages to program property or equipment. Restitution may be imposed on any student or System member who alone, or through group activities, participates in causing the damages or costs to the program.

**IX. Posting disciplinary action in academic transcripts or EMS personnel file**

When a student or System member is subject to disciplinary action, a notation that discipline was imposed must be placed on the academic transcript or in the EMS personnel file. If disciplinary action consisted of sanctions less than suspension or dismissal, such notations may be removed after one year if no further action has been necessary. If disciplinary action resulted in suspension, the notation shall remain in the file until the next licensure cycle. If disciplinary action resulted in dismissal, the investigation record and record of dismissal shall permanently remain in the EMS file.

**X. Expungement of the record**

If, as a result of an official appeal, it is determined that the individual was improperly disciplined, the System shall, if requested by the individual, have the record of the hearing sealed, and have any reference to the disciplinary process removed from the individual's EMS record. In such case, the record of the hearing may be used only in connection with legal proceedings. The EMS MD or designee also may take other reasonable actions to ensure that the status of the individual's relationship to the System shall not be adversely affected.

**XI. Responsibility for policy enforcement**

The EMS MD has the final authority and responsibility for implementing this policy and administering discipline even if other System agents become the instrument of enforcement.

<b>Title of Policy:</b> Crisis Response Plan	<b>Policy Number:</b> O210
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Definition of an actual or potential system crisis**

**A.** OSF SAINT JAMES EMS defines an EMS crisis as any time the System is faced with a crucial or decisive point or situation wherein conditions are unstable and business as usual would either be impossible, unlikely, or ineffective.

**B.** Examples may include, but are not limited to the following:

1. EMS Agencies and/or hospitals are threatened or impacted by patients due to trauma or disease that could reflect an impending epidemic or public health crisis, loss of public utilities, large losses to property, or disruptions to communication networks or transportation mechanisms creating a resource limitation that does or could impair EMS response;
2. When two hospitals servicing the same EMS provider agencies have simultaneously activated their Peak Census response plan or bypass status and/or two or more hospitals simultaneously on bypass will cause other hospitals to reach Peak Census or declare Bypass status.
3. Large crowd events have a moderate to high likelihood of volatile public responses with the potential for multiple casualties (demonstrations, special events with celebrities, national/international or political figures attending).

**II. POLICY**

**A.** OSF SAINT JAMES EMS shall take all reasonable precautions to safeguard the safety and welfare of System members and to meet the emergency healthcare needs of the public served by our members to the best of our ability based on available resources.

**B.** Situations may occur that would threaten or impair our ability to provide care within the standards that regulate usual and customary operations. We recommend that all System members establish or maintain internal policies that would specify their actions to prevent, contain, and respond to crisis situations. Despite prior planning, unforeseen events may require unconventional responses based on the exigency of the circumstances.

**C.** When situations are anticipated or evolve that threaten the ability to provide emergency medical response as specified in usual and customary EMS operations, and policies already in place are not providing a framework for response (i.e., Bypass policy, disaster plan), this policy shall be enacted.

**III. PROCEDURE****A. EARLY SURVEILLANCE ALERT and CONTACTS**

1. The following clues suggest a bioterrorism event

a. An unusual clustering of patients presenting with similar signs or symptoms

- (1) Sepsis
- (2) Pneumonia
- (3) Flaccid muscle paralysis
- (4) GI illness
- (5) Bleeding disorders
- (6) Severe flu-like symptoms
- (7) Rash
- (8) Encephalitis/meningitis



<b>Title of Policy:</b> Disinfection and Decontamination (EMS)	<b>Policy Number:</b> O220
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## PURPOSE

This policy describes the decontamination procedures of equipment and clothing. This procedure outlines cleaning and disinfecting procedures for emergency medical equipment that may be contaminated with potentially infectious agents.

## POLICY

It is imperative that all members properly clean and disinfect reusable equipment to minimize the possibility of infection during emergency treatment. Cleaning and disinfecting decrease the likelihood of infections by reducing the amount of disease-causing organisms on equipment. Cleaning is defined as the removal of all foreign materials from objects. Equipment for invasive procedures that require sterilization should not be used by the agency, but instead must provide comparable equipment that is single use only. These items will be disposed of after each use as if they were contaminated waste. All stations shall have a designated decontamination area. This area will be used only for disinfecting contaminated equipment. Cleaning infected equipment in this area will assure isolation of potential infectious agents. All Agencies will provide and have on hand cleaning solutions and necessary cleaning tools.

## Contaminated Equipment Transport

Before transporting contaminated equipment from a scene or hospital to a designated cleaning area, these items shall be placed in a red biohazard bag. If the item is too large for the bag, care should be taken to make certain the item does not cause secondary contamination of equipment or supplies.

## Equipment Disinfecting

Equipment that has been contaminated by blood or Other Potentially Infectious Materials (OPIM) shall be decontaminated through cleaning and disinfecting, or disposed of as contaminated waste. Members decontaminating and disinfecting equipment shall wear appropriate PPE and use disposable paper towels to remove gross contaminants. Anything used to clean blood or OPIM shall be disposed of as if it were contaminated waste. Follow the manufacturer directions on cleaning solution container for disinfection / decontamination procedures.

If any medical equipment is contaminated with a patient's blood or OPIM, it must be decontaminated after use. Gross Decontamination shall be accomplished by utilizing appropriate cleaning solutions with an approved water based disinfection solution, and allowed to dry for a minimum of 5 minutes. This process will inactivate microorganisms such as HIV, HBV, Tuberculosis, and MRSA.

All EMS equipment shall be checked daily for cleanliness and operational readiness. Items that come into contact with patients will be given special attention in order to have them as clean as possible prior to use.

<b>Title of Policy:</b> Disinfection and Decontamination <b>Policy Number:</b> (EMS)	
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b>	<b>Approvals: MD, System</b>

## Disposable Equipment

The medical equipment identified below that requires sterilization and will be disposed of as contaminated waste. The following list includes some of the equipment available that are disposable due to the difficulty of decontamination required:

- Suction canisters/catheters/tubing.
- Head immobilizer/C-collars.
- Oxygen masks, cannulas, nebulizers, BVM's.
- Cricothyrotomy kits.
- OB kits
- Gloves, masks, sleeves.
- Intubation tubes, OPA's, NPA's.
- IV catheters, IO catheters, IV tubing, IV fluids.
- Bandaging materials, burn sheets.

## Uniform Disinfection

Clothing that has been contaminated with blood or OPIM needs to be cleaned as follows:

- Contaminated clothing, including turnouts, will be changed as soon as possible, and washed in detergent and warm water as recommended by the manufacturer.
- Contaminated uniform clothing will be washed at the fire station. Contaminated uniforms will be placed in a plastic bag to prevent any cross contamination of other uniforms, washed separately, and the washing machine should be rinsed with a cup of bleach after clothing is removed from machine. The department does not recommend the laundering of contaminated clothing at home.
- Uniform Boots or shoes should be scrubbed with soap and hot water to remove contaminants. Wash the soles of footwear after the medical incident or as soon as possible, if contaminated with blood or OPIM. Uniform boots utilized on medical calls should not be worn in the station. Use of alternative footwear is highly recommended while in station between incidents.

## Hand Washing

The Center for Disease Control (CDC) states that "hand washing before and after contact with patients is the single most important means of preventing the spread of infection." Washing your hands after encountering each patient is a must. Use soap and water, or approved waterless hand sanitizer available on all apparatus and vehicles when other wash facilities are not available. The CDC recommends that hand washing take a minimum of 30 seconds to properly rid the hands of protein matter, blood, secretions, and other contaminants picked up while handling patients. Vigorous scrubbing is essential. The following is the suggested method for hand washing:

- Wet hands up to 2-3" above wrists.
- Apply hand-cleaning agent. Various agents and soaps are furnished for station use.



<b>Title of Policy:</b> Disinfection and Decontamination (EMS)	<b>Policy Number:</b> O220
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- Rub hands vigorously to work up lather.
- Using rotating motion, apply friction to all surfaces of hands and wrists, including backs of hands, between fingers, and around and under nails. Interlace fingers and rub up and down; continue for 15 seconds.
- Holding hands downward, rinse thoroughly, allowing the water to drop off fingertips.
- Repeat procedure, dry hands thoroughly with a paper towel.
- Turn off faucet using a clean paper towel so as not to re-contaminate your hands on the dirty faucet handle.

## Hand Sanitizers

The CDC recommends the use of an alcohol based hand rub for decontaminating hands when soap and water hand washing is not available. It is recommended that personnel utilize the approved hand sanitizer and skin protectant, to kill germs on their skin and to provide additional protection against disease causing germs. Bottles of hand sanitizer will be placed in each apparatus and automatic dispensing units are strategically placed in stations for convenient use.

## Apparatus

An apparatus that has been contaminated by blood or OPIM shall be decontaminated through cleaning and disinfecting. Environmental surfaces that have become soiled with blood or OPIM must be cleaned and disinfected using appropriate cleaning solution wipes. Gloves shall be worn when decontaminating ambulances. After gross decontamination, in units equipped with UVC systems, members should allow UVC decontamination system to run for a full cycle before returning to service. Any surface that shows signs of contamination should be immediately disinfected and decontaminated. If a mop is used in the process, the mop head should be disposed of or soaked in a solution of bleach and water, 1:9, for at least an hour. In addition to the decontamination of apparatus "as needed", all ambulances will be thoroughly disinfected and decontaminated on a regular basis.

## Ultraviolet C (UVC)

Ambulance Decontamination System (ADS) UVCADS utilizes a narrow spectrum of light that has been proven effective in the control of Bacteria, virus, spores, and yeast. Any agencies using this device shall follow manufacturers directions and guidelines.



<b>Title of Policy:</b> DRUG/Pharmacologic MANAGEMENT: Approval / Issuing / Storage / Exchange / Disposal/ Reporting	<b>Policy Number:</b> MM100
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

## I. POLICY

- A.** The OSF Saint James EMS System is committed to the safe and secure stocking, storage, administration, documentation, disposal, replacement, and reporting of sentinel events relative to EMS drugs, pharmacologics, and medical supplies.
- B.** The EMS Program Plan shall contain a list of all drugs and equipment required for each type of System vehicle and procedures for obtaining initial stock and replacements at SJWAMC.
- C.** Drug/Pharmacologic and Supplies Management policies are approved and implemented by the OSF Saint James EMS Medical Director (EMS MD) and monitored in cooperation with System members.
- D.** Drugs and pharmacologics stocked for EMS use shall be of suitable quality, quantity, concentration, and formulation for approved routes of administration per the SOPs and Drug & Supply List. Only those drugs and pharmacologics listed in the SOPs, the System Drug and Supply List, and/or approved by the EMS MD in written format shall be carried on EMS vehicles and given by OSF Saint James EMS personnel.
- E.** The EMS MD has the overall responsibility for ensuring that systems in place for the safe and secure handling of drugs and pharmacologics are followed.
1. Hospitals and EMS providers must comply with all federal, state, and local laws rules, and guidelines regulating the provision, storage, exchange, and inventory management of drugs and medical supplies, including the laws relating to the handling of controlled substances.
  2. Hospitals and EMS providers shall take all reasonable precautions to mitigate risks to patients and staff arising from the use of drugs/pharmacologics, medical supplies & equipment including but not limited to the safe use and security of those items.
  3. Medications and pharmacologics shall be issued and stored in their original manufacturer's packaging or if reformulation is necessary, in packaging produced and labeled by a hospital pharmacist.
  4. Provider Chiefs/Administrators or their designees are responsible and accountable for the day to day safe and secure handling of drugs and pharmacologics within the operational environment of their agency and must ensure that staff understand and are competent to carry out the duties described in this policy.
  5. EMS personnel must maintain their competency in the management of drugs and pharmacologics and to ensure their familiarity with and compliance with changes to therapeutic guidelines as they are adopted in the SOPs.

<b>Title of Policy:</b> DRUG/Pharmacologic MANAGEMENT: Approval / Issuing / Storage / Exchange / Disposal/ Reporting	<b>Policy Number:</b> MM100
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

## II. APPROVING NEW DRUGS AND SUPPLIES

A. Inclusion of any new drug, supply, solution or equipment on the Standard Drug and Supply List shall be a collaborative process between hospital and prehospital System members unless based on his or her prerogative alone. the EMS MD believes there are unusual and compelling medical reasons for requiring a product

B. New products being considered for use in the OSF Saint James EMS System will usually go through the following process prior to being added to the Standard Drug and Supply List:

1. Review by the EMS MD to determine if further evaluation or consideration is warranted or approved. If the EMS MD rejects the product for prehospital use in this System, the investigation process stops at this point.
  2. If the EMS MD approves the product for further review, the manufacturer/distributor shall be directed to the training committee to discuss the merits of the item with potential users.
  3. The training committee will provide feedback on the strengths and perceived limitations of a product and may decide to conduct field-testing with the prior authorization of the EMS MD.
  4. After evaluation and/or field-testing, the results shall be shared with the Provider and hospital EMS Coordinators/Educators for further discussion and recommendations to the EMS MD.
  5. The System is committed to responsible stewardship and agrees that any product purchase that would impact the capital budgets of providers or hospitals shall be brought to the Chiefs/Administrators PRIOR to making a decision for approval or developing a timeline for compliance.
  6. The EMS System Manager will file a System plan amendment with IDPH.
- C. All drugs and equipment not included in the current National EMS Education Standards and National EMS Scope of Practice Model must be approved by IDPH in accordance with the EMS Rules before being used by the System.
1. IDPH shall either approve the drug and/or equipment, approve the drug and/or equipment on a conditional basis, or disapprove the drug and/or equipment. IDPH's decision shall be based on a review and evaluation of the documentation submitted, the application of technical and medical knowledge and expertise; consideration of relevant literature and published studies on the subject; and whether the drug and/or equipment has been reviewed or tested in the field. The IDPH Director may seek the recommendations of medical specialists and/or other professional consultants to determine whether to approve or disapprove the specific drug(s) or equipment.

<b>Title of Policy:</b> DRUG/Pharmacologic MANAGEMENT: Approval / Issuing / Storage / Exchange / Disposal/ Reporting	<b>Policy Number:</b> MM100
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

D. The EMS MD or designee will ensure the creation of educational materials, mandatory implementation of the education, and documented competency of all users prior to implementing the new drug/pharmacologic.

### III. ISSUING NEW DRUGS AND SUPPLIES

A. All new products that are consumable, patient exchange items and added to the System Drug and Supply List and/or initial stock issued to a new EMS vehicle are provided by the hospital to which the Provider agency is assigned on the System organizational chart. The cost of the initial inventory will be sustained by system hospitals. All durable medical goods (non-exchange items) will be purchased by the EMS providers.

B. The Resource hospital EMS MD (or designee) is responsible for communicating to the Chiefs/Administrators and Hospital and Provider EMS Coordinators (PEMSCs) the name, approved manufacturer(s), type of packaging, amount and cost of product(s) to be added along with a compliance date.

C. An EMS MD shall not approve EMS personnel to use new drugs or equipment unless that individual has completed an approved education program and has demonstrated the required competencies and met the performance standards to use that drug or equipment safely and effectively (EMS Rules).

D. An EMS MD is not required to provide new drug or equipment training to System EMS personnel who will not be using the new drugs or equipment.

E. Provider Chiefs/Administrators or their designees are accountable for ensuring that all EMS vehicles are appropriately stocked by compliance dates or a waiver request must be submitted to the Resource Hospital EMS office and approved prior to the compliance date.

F. Provider Chiefs/Administrators or their designees are responsible for notifying their assigned educator of all proposed vehicle additions at least three months prior to their implementation to allow for appropriate inventory and budgetary planning for initial stocking. **(When possible.)**

### IV. EMS DRUG/PHARMACOLOGIC/SUPPLY STORAGE and SECURITY at System HOSPITAL

A. All drugs and supplies available for EMS exchange shall be stored by hospital in a "reasonably secure" manner to prevent diversion or tampering with the products. They shall be inspected to ensure the appropriateness of the drug/concentration/packaging, integrity of the packaging, to ensure that they are not near their expiration date (The Joint Commission [TJC

<b>Title of Policy:</b> DRUG/Pharmacologic MANAGEMENT: Approval / Issuing / Storage / Exchange / Disposal/ Reporting	<b>Policy Number:</b> MM100
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

B. All Controlled Substances must be secured and managed in compliance with DEA laws and regulations. See Controlled Substance policy.

C. Other drugs and products must be kept in areas that are not readily accessible to the public and/or easily removed by visitors. All areas restricted to authorized hospital personnel only are considered “secure” areas. Non-controlled substance drugs stored in these areas do not need to be locked (TJC).

D. The security of EMS Medications should be addressed in a hospital’s security management plan (JC standard EC.1.4). As part of this plan, theft, pilferage and tampering should be reported. If medication security becomes a problem, it is expected that the hospital take additional steps to prevent it.

E. If using an Automated Dispensing Machine (e.g. Pyxis, etc), the machine is not a medical control system, but rather a tool that is part of the medication control system. Hospitals must ensure that the proper medication control systems (designed to prevent medication related sentinel events) are still in place when these machines are used.

## **V. DRUG/PHARMACOLOGIC/SUPPLY STORAGE and SECURITY at EMS AGENCIES**

A. Drugs and pharmacologics shall be stored per the manufacturer’s recommendations in a safe environment, and in an area that is not accessible by the public from the time of receipt to the point of use or disposal.

B. EMS personnel are personally responsible for the security of all drugs and pharmacologics while they are in their possession (chain of custody). This includes but is not limited to ensuring that ambulances are locked when out of ambulance quarters and not occupied by EMS personnel.

C. EMS vehicles should be inventoried daily, but at least monthly, to ensure that drugs and pharmacologics are of suitable quality, quantity, sterility, concentration, formulation and within expiration dates.

D. It is recommended that stock with expiration dates be rotated from reserve and non-transport to front line vehicles within 90 days of expiration to encourage use prior to expiration dates.

E. **Provider EMS Coordinators shall make random**, unannounced checks of each vehicle within their agency plan at least every six months to ensure compliance with this policy. A record book must be kept at the agency including the identity of the person conducting the checks and retained for a period of two years from the date of the last entry.

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**F. CLIMATE CONTROL**

1. Any place where medications are stored shall be sufficiently climate-controlled so that the medications and solutions are kept within the temperature range recommended by the manufacturer.
2. Standards for medications are set by the United States Pharmacopeial Convention Inc. (USP), a nongovernmental entity that establishes standards intended to ensure the quality of medicines and other healthcare technologies. The role of USP and its “National Formulary” (USP-NF) is recognized under the Federal Food, Drug and Cosmetic Act, including their authority to prescribe the packaging, storage, and distribution of medications.
3. Most medications used by EMS are intended for storage at “controlled room temperature”. “A temperature maintained thermostatically that encompasses the usual and customary working environment of 20°-25° C (68°-77° F) that results in a mean kinetic temperature calculated to be not more than 25° C; and that allows for excursions between 15°-30° C (59°-86° F) that are experienced in pharmacies, hospitals, and warehouses. Provided the mean kinetic temperature remains in the allowed range, transient spikes up to 40° C are permitted, as long as they do not exceed 24 hours. Spikes above 40° C may be permitted if the manufacturer so instructs. Articles may be labeled for storage at “controlled room temperature” or at up to 25° C (86° F), or other wording based on the same mean kinetic temperature. The mean kinetic temperature is a calculated value that may be used as an isothermal storage temperature that simulates the non-isothermal effects of storage temperature variations.

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#### Medication Recommended Storage Temperature

Adenosine 15° - 30° C (59°-86° F); Do not refrigerate
Albuterol sulfate 2° - 25° C (36°-77° F)
Amiodarone Controlled room temp 25° C (77° F);
Atropine 15° - 30° C (59°-86° F)
Diphenhydramine 15° - 30° C (59°-86° F); protect from freezing
Epinephrine 1:1,000 15° - 30° C (59°-86° F);
Epinephrine 1:10,000 15° - 30° C (59°-86° F);
Etomidate 20 to 25°C (68 to 77°F)
Glucagon Controlled room temp 20°-25° C (68°-77° F)
Haldol 15°-30°C (59° 86°F)
Ipratropium 2° - 25° C (36°-77° F)
Ketamine 20°C to 25°C (68°F to 77°F)
Lidocaine 2% 2° - 25° C (36°-77° F)
Magnesium 15° - 30° C (59°-86° F); protect from freezing
Midazolam 15° - 30° C (59°-86° F);
Naloxone Controlled room temp -15° - 30° C (59°-86° F);
Nitro Tab <b>20 and 25 degrees C (68 and 77 degrees F)</b>
Nitro Drip
Norepinephrine (Levoquin) 20°C to 25°C (68°F to 77°F)
Ondansetron (Zofran) 20 to 25°C (68° to 77°F)
Fentanyl 20 to 25°C (68 to 77°F)
Rocuronium 2° to 8°C (36° to 46°F)
Sodium bicarb 15° - 30° C (59°-86° F);
Succinylcholine 2 °C to 8 °C (36 °F to 46 °F)
Transexamin Acid TXA 59 and 86°F
Normal Saline/ Lactated Ringers/ D10W -The expiration dating is based on stability data generated from product samples stored at the equivalent of a constant 25°C (77° F). While stored under labeled conditions, our product remains pharmaceutically acceptable. Prolonged storage at higher temperatures may accelerate concentration and pH changes in the final product (Baxter)

**4.** tems requiring warming (at least 1 bag 1000 mL NS) must be stored in a heating unit, solely for that purpose. Temperatures of warming units/drawers must be recorded daily by a designated person within the agency. We do not recommend heating IV solutions in a microwave oven.

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Warming recommendations for intravenous (IV) solutions in plastic bags:

- IV solutions of volumes 150 mL or greater should be warmed in their plastic overpouches to temperatures not exceeding 40°C (104°F), and for a period no longer than 14 days.
- Label bags with warming expiration date before placing in the warmer.
- Once the VIAFLEX plastic containers have been in the warming cabinet for their maximum time period, remove the container from the warming cabinet and identify as having been warmed. They should not be subsequently returned to the warmer.
- They may continue to be used until the labeled expiration date from the manufacturer provided they have not been warmed more than once (Baxter, 2015).

Note: Intentional warming of IV containers does not affect the sterility of those containers and the solutions they contain. IV containers are terminally sterilized at higher temperatures and container seals are able to withstand those temperatures. Unless the container has been breached during shipping, handling, or storage, the solution remains sterile throughout its life. Clinicians must check the integrity of all of containers prior to use, whether intentionally warmed or not. The warming temperatures listed in this policy are provided only as a guideline to insure the chemical stability of the warmed products (Baxter, 2015).

#### 5. Recommended Practice from USP-NF Chapter

- a. Monitor and verify temperature profiles to compare with established limits, especially on hot summer days and cold winter days.
- b. On-board cabinets must be insulated and should use active heating and cooling if necessitated by the local climate.
- c. Consider using insulated portable carrying cases and, when they are not in use, keep them inside or in a climate-controlled cabinet to maintain controlled room temperature.
- d. Consider using portable cases exclusively, instead of on-board cabinets, to facilitate rotation. Time-temperature indicators can be used to monitor temperature exposures of the portable case's entire contents.
- e. Consider using time-temperature indicators to monitor individual medication packages, especially for environmentally sensitive and thermally sensitive preparations.
- f. All medications should be protected from excessive heat (40° C+). Some medications may need to be stored in a cold and/or dry place, and "environmentally sensitive" medications should not be stored on EMS vehicles unless the storage cabinet is temperature-controlled or individual time-temperature indicators are attached to each medication package.



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**g.** Consider stock rotation on a schedule based on local climate, perhaps every three days or so. The stock should be rotated into a climate controlled environment. Stock rotation may be especially necessary for environmentally sensitive preparations.

**h.** Consider temperature exposures when parking ambulances. Park in heated and air-conditioned garages if possible. When parking outside, attempt to park in the shade.

**i. Note:** Because the USP classifies this chapter as general information, it does not view compliance as mandatory. The recommendations are offered to guide EMS agencies in efforts to ensure stability of medications and identify practices that will help achieve that goal.

## **VI. DRUG/SUPPLY REPLACEMENT-EXCHANGE**

**A.** EMS drugs shall only be replenished from EMS inventories. If EMS supplies are depleted, replenishment shall be requested from the Pharmacy Department or alternative/equivalent drugs/supplies only as approved by the EMS MD shall be substituted. Replenishment items shall generally not be taken from ED stock as dose/concentrations may be inconsistent with EMS requirements.

**B.** EMS medications and supplies shall not be replenished directly through an undocumented handoff from the Pharmacy Department. All exchanges shall be made through a formal and documented request per hospital policy.

### **C. REPLACEMENT from AUTOMATED DISPENSING DEVICE**

**1.** Hospitals must adhere to internal policies and TJC standards with respect to dispensing ambulance supplies.

**2.** All medication use standards apply to drugs obtained via an automated dispensing device to the same extent as medications dispensed via the traditional unit-dose drug distribution system or floor stock (TJC).

**3.** IDPH has long approved the use of automated dispensing machines for EMS drugs as long as the hospital has a policy on using these machines for controlled dispensing of supplies and drugs (Leslee Stein-Spencer letter to EMS Coordinators, 3/2/01).

**4.** Drugs kept in an automated dispensing machine are considered secure as long as access is limited to those people with a password and those people with a password are limited to those who have a need for access to the medications (nurse, pharmacy technician, pharmacists, physicians, paramedics) (TJC).

Hospital that use automated dispensing machines need to determine back-up systems and downtime procedures for the distribution of medications if the machine breaks, power fails, or electronic programming is off line (TJC).



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**D. Stocking under the Office of Inspector General (OIG) Safe Harbor Regulations**

1. SJJWAMC agrees to abide by the System's policies regarding the issuing and exchange of drugs for items on the OSF Saint James EMS System Drug List to all prehospital providers participating in the System or other EMS Systems whose ambulances transport to them on an equal basis (Section 3.20(b) of the EMS Act) in one or more of three categories:

- a. All ambulance providers;
- b. All non-profit and State or local government ambulance service providers (including, but not limited to municipal and volunteer ambulance services providers); or
- c. All non-charging providers (typically volunteer providers) (OIG Rule).

2. A receiving facility can offer restocking to more than one category, and can offer a different restocking program to each category that it restocks, so long as the restocking is uniform within each category (OIG Rule).

3. Except for government-mandated or fair market value restocking protected restocking arrangements must be conducted in an open and public manner. A restocking arrangement will be considered to be conducted publicly if: (i) A disclosure notice is posted conspicuously in the receiving facility's ED or other location where ambulance providers deliver patients that outlines the terms of the restocking program and copies are available to the public upon request (subject to reasonable photocopying charges) (see sample disclosure form); or (ii) The restocking program operates in accordance with a plan or protocol of general application promulgated by an EMS Council or comparable organization (with copies available to the public upon request). OSF Saint James EMS system policy satisfies this requirement.

4. Fair market value restocking: This category protects restocking arrangements where an ambulance provider pays the receiving facility fair market value based on an arm-length transaction, for restocked medical supplies (including linens). The final OIG rule does not include the resale of drugs in this category.

- a. The restocking must be at fair market value, and
- b. Payment arrangements must be commercially reasonable and made in advance.

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**E.** Either the hospital or the ambulance provider must maintain records of restocked items and make the records available to the Dept. of Health and Human Services upon request (OIG).

**F.** All billing or claims submission by the receiving facility, ambulance provider or first responder for replenished drugs and medical supplies used in connection with the transport of a Federal health care program beneficiary must comply with all applicable Federal health care program payment and coverage rules and regulations.

**G.** Compliance will be determined separately for the receiving facility and the ambulance provider (and first responder) as long as the receiving facility; ambulance provider (or first responder) refrains from doing anything that would impede the other party or parties from meeting their obligations.

**H.** Conditions applicable to all safe harbor restocking arrangements

**1. Appropriate billing of Federal health care programs:** All Federal health care programs must be billed appropriately. The ambulance provider and the hospital may not both bill for the same restocked drug or supply. This includes submitting claims for bad debt.

**2. Documentation requirements:** Either the hospital or the ambulance provider may generate the necessary documentation so long as the other party receives and maintains a copy of it for 5 years. The prehospital patient care report is sufficient to satisfy this requirement if it (i) identifies the drugs and supplies used on the patient and subsequently restocked and (ii) a copy of the report is filed with the receiving facility within a reasonable amount of time. An exchange of linens will be presumed to occur with each run, absent documentation to the contrary.

**3. No ties to referrals:** Restocking arrangements are prohibited that are conditioned on, or otherwise take into account, the volume or value of any referrals or other business generated between the parties for which payment may be made in whole or in part by a Federal health care program (other than delivery to the receiving facility of the patient for whom the drugs and medical supplies are restocked).

**4. Compliance with all other applicable laws:** Both receiving facilities and the ambulance provider must comply with all Federal, State, and local laws regulating ambulance services including, but not limited to, emergency services, and the provision of drugs and medical supplies, including, but not limited to, laws relating to the handling of controlled substances (OIG Rule).

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<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

**VII. Medication administration errors -See Reportable incidents policy****VIII. PROPER DISPOSAL of unused non-controlled substance drugs/pharmacologics**

- A. Drugs/pharmacologics removed from their container/packaging, drawn up into a syringe, or engaged (preload) for potential use on a patient and not (fully) administered must be appropriately wasted and discarded at the hospital and presented for exchange.
- B. This may be done by disposing of all non-controlled substance medications and supplies in the EMS Pyxis disposal drawer and/or in compliance with individual hospital policies. They shall not be placed on top of EMS Pyxis machines. Controlled substance disposal is addressed in System policy Controlled Substances.
- C. Expired medications shall not be put back into active EMS vehicle stock.

**IX. Recalled and medications unsuitable for use**

- A. Immediately pull from use.
- B. If possible, pull suitable drug from reserve vehicles to ensure adequate supply on front-line ambulances.
- C. Store in a locked space until returned to the hospital for exchange.

**X. Out of date medications/supplies**

- A. Stock shall be regularly inspected and rotated to ensure that they have not expired.
- B. See policy Drug Replacement: Soon to expire, outdated, or damaged
- C. The FDA, IDPH, and/or the EMS MD may grant authorization to use drugs after their expiration date in crisis situations of shortages without approved alternatives.

**XI. Lost, non-exchanged, misused, or damaged drugs/pharmacologics**

- A. The loss or suspected loss or misuse of any drug or pharmacologic must be reported according to the Reportable Incidents Policy within the same shift of the discovery.
- B. Any drug/supply that is lost, stolen, damaged or not replaced at the time of use will be the fiscal responsibility of the Provider Agency to replace. Provider agencies should contact their System hospital to arrange for dispensing of replacement prescription drug products under these circumstances. They may replace other consumable supplies at the System hospital or per their own internal policies.
- C. EMS providers shall be charged the fair market value for replenishing drugs or supplies that cannot be connected to a particular patient use. Commercially reasonable and appropriate payment arrangements must be made in advance. Nonprofit receiving hospitals may sell to nonprofit ambulance providers at cost (OIG).

<b>Title of Policy:</b> <i>Duty to Perform all Services Without Discrimination</i>	<b>Policy Number:</b> LE110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Emergency Vehicle Response Greater Than Eight Minutes</i>	<b>Policy Number:</b> M230
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operation	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

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

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

<b>Title of Policy:</b> <i>Emotionally Disturbed Patient</i>	<b>Policy Number:</b> LE120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

**Background to Policy:**

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

**Policy Statement:**

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

Policy:

**DEFINITIONS:**

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

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

**Procedures:**

- A. Attempt to orient the patient to reality and to persuade this person to be transported to the hospital so that he/she can get emergency medical care and mental health services.
- B. If persuasion is unsuccessful, contact Medical Control and relay with history and/or have the Medical Control Physician talk with patient. The EMS crew will then follow the direction of the Medical Control Physician.
- C. NOTIFY THE APPROPRIATE LAW ENFORCEMENT AGENCY TO RESPOND.
- D. If the Medical Control Physician determines the patient cannot understand EXPRESSED CONSENT for patient care and transportation to the hospital and emergency treatment is required to preserve life or prevent serious impairment to health, the Physician shall order, against patient will, and based upon IMPLIED CONSENT the emergency care and transportation to the hospital.
- E. IN NO WAY does this mean that the EMS crew are committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of mental health treatment to a hospital against his/her will so that a physician may further evaluate said patient.
- F. If patient requires restraints, EMS personnel shall use all the force reasonably required to restrain the patient. “Reasonable force” depends on the degree of resistance on part of the patient.
- G. If patient runs from EMS, this matter should be left to law enforcement personnel.

<b>Title of Policy: EMS Clinical Hours</b>	<b>Policy Number: E110</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

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

<b>Title of Policy:</b> <i>EMS Controlled Substances</i>	<b>Policy Number:</b> MM110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

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

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



<b>Title of Policy:</b> EMS <i>Controlled Substances</i>	<b>Policy Number:</b> 110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

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

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

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

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

<b>Title of Policy:</b> <i>EMS Medication Replacement</i>	<b>Policy Number:</b> MM120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Medication Management	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>EMS Quality Council</i>	<b>Policy Number:</b> E120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Education	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>EMS Quality Council</i>	<b>Policy Number:</b> E120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Education	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> EMS Staffing Requirements during Conventional, Contingent, and Crisis operations; EMT-EMR staffing waiver	<b>Policy Number:</b> O230
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**I. Requirements while operating under Conventional capacity: Personnel and staffing**

- A.** It is assumed through this section that the spaces, staff, and supplies used are consistent with usual and customary daily practices within the System fully meeting all laws, rules, guidelines, policies and procedures.
- B.** Each EMS provider agency that operates an emergency transport vehicle shall ensure through written agreement with the EMS System that the agency providing emergency care at the scene and en-route to a hospital meets or exceeds the requirements of the IDPH Rules and System Policy. (Section 515.830 of the EMS Rules Amended at 42 Ill. Reg. 17632, effective September 20, 2018 amended by emergency rulemaking at 46 Ill. Reg. 1173, effective December 27, 2021, for a maximum of 150 days) and System policy.

**Levels of acuity:** Source document: National EMS Core Content: An acuity level is essential for identifying care priorities in the EMS setting. They are coded to NEMSIS standards and should be documented as such in the ePCR. Critical pts are TIMESENSITIVE with black box notations throughout the SOPs.

**Critical:** Symptoms of a life threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further airway, respiratory, hemodynamic and/or neurologic instability.

**Emergent:** Symptoms of illness or injury that may progress in severity or result in complications w/ a high probability for morbidity if treatment is not begun quickly. These may be identified as time-sensitive on a case by case basis.

**Lower Acuity:** Symptoms of an illness or injury that have a low probability of progression to more serious disease or development of complications.

- C. OSF Saint James EMS Policy:** Patients requiring ALS services and determined to be critical, emergent, and/or unstable, as defined by IDPH, the EMS Act and/or Rules, and System SOPs and/or policy, will be cared for by a minimum of two licensed EMS personnel with ALS privileges when possible (paramedic, Pre-hospital RN [PHRN], Pre-hospital Advanced Practice RN [PHAPRN,] or Pre-Hospital Physician Assistant [PHPA]) with OSF Saint James EMS privileges awarded through the full System entry credentialing process unless an exemption applies or a variance has been granted by the EMS MD.
- D.** Patient requiring ALS services who are stable and determined to be of a lower acuity rating shall be cared for by one licensed ALS practitioner and one other EMT with OSF Saint James EMS privileges awarded through the full System entry credentialing process.
- E.** All patients requiring Basic Life Support services as defined by IDPH, the EMS Act and/or Rules, and System SOPs and/or policy will be cared for by a minimum of two licensed EMTs or EMS practitioners with a higher level of licensure with OSF SAINT JAMES EMS privileges while at the scene and en-route to the receiving destination.

<b>Title of Policy:</b> EMS Staffing Requirements during Conventional, Contingent, and Crisis operations; EMT-EMR staffing waiver	<b>Policy Number:</b> O230
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- F. This policy is driven by the level of care required by the patient, not the level at which a vehicle is licensed. Agencies have options for how they will get adequately licensed individuals and/or vehicles licensed and stocked at the ALS level to the scene if ALS care is required. It also only pertains to an agency's first response capabilities within their primary response area as identified in their EMS System Plan agreement. It DOES NOT pertain to second simultaneous calls requiring dispatch of reserve vehicles or mutual aid companies. The System expects EMS agencies to dispatch the highest level of care available once all primary response transport vehicles are committed, pending a request for mutual aid.
- G. All mutual aid ALS transport vehicles sent by OSF Saint James EMS Provider agencies to other OSF SAINT JAMES EMS agencies will be staffed with at least one licensed ALS personnel.
- H. At the time of application for initial or renewal licensure, the applicant or licensee shall submit to IDPH and the System for approval a list containing the anticipated hours of operation for each vehicle covered by the license.
1. A current roster shall also be submitted, which lists the EMTs, paramedics, PHRNs, PHAPRNs, PHPAs, and/or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license level, license number, expiration date, and contact information (e-mail address or phone number) and shall state whether such person is generally scheduled to be on site or on call.
  2. An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift. (EMS Rules Section 515.830(k2A)).
- I. **Special Considerations under Conventional Capacity**
1. Private ambulance EMS personnel in need of ALS assistance may do one of the following:
    - a. Weigh the risk/benefit to the patient of waiting for a mutual aid ALS team or rapidly transporting to the nearest hospital for care. Call OLMC for a determination.
  2. **Rural Staffing** - The Illinois Department of Public Health allows providers to petition for a waiver if unreasonable hardship results from compliance requirements of the EMS Act or its Rules and Regulations or System Program Plan.
    - a. Must serve a population of less than 7500 people
    - b. An explanation as to why the waiver is necessary.
    - c. A written description of the alternate means of handling of the matter.
    - d. A projected target date and action plan of correction for compliance with the requirement in petition to be waived.
    - e. Will allow the agency to respond with at least one licensed provider to the level of the vehicle license and a EMR.
  3. **SEE INFIELD Upgrade policy**

<b>Title of Policy:</b> EMS Staffing Requirements during Conventional, Contingent, and Crisis operations; EMT-EMR staffing waiver	<b>Policy Number:</b> O230
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4. Transfer of care from one agency to another: Any EMS Agency assuming responsibility for a patient from another agency must receive a verbal handover report from personnel who are relinquishing responsibility for the patient noting the chief complaint, presenting S&S, vital signs, any treatment rendered, and the patient's responses. The originally responding agency must complete a PCR documenting the assessments and care provided up to the time of patient transfer and forward a copy of their complete PCR to the receiving hospital within two hours.

**A. Temporary staffing resources and CONTINGENCY practice privileges:**

1. OSF SAINT JAMES EMS agencies may immediately share licensed EMS practitioners in good standing with other OSF EMS agencies with no additional requirements other than to notify the Resource Hospital and to activate them within their agency's ESO roster so they are accurately noted on the ePCR.
2. OSF SAINT JAMES EMS agencies may temporarily use licensed PMs in good standing working for EMS agencies in Region 2. These ALS practitioners may petition for temporary Contingency EMS Privileges by providing written recommendation from their current EMS MD to the Resource Hospital stating that they are qualified and in good standing to practice at the Paramedic level. They shall be added temporarily to the agency's ESO Roster so they can be listed on the ePCR. See limitations of Contingency Practice Privileges below.
3. Agencies who are hiring licensed ALS practitioners from outside of Region 2 during Contingency Operation and suspension of System Entry testing may petition for Contingency practice privileges after the licensee opens a file and submits required documents per usual System Entry processes, submits a letter of good standing from the current EMS System, and submits the SOP and Policy Manual Self-assessments scored as acceptable.
4. IDPH shall permit immediate reciprocity to all EMS personnel from other states who hold an unencumbered National Registry of Emergency Medical Technicians certification for EMTs, AEMTs, or Paramedics, allowing such individuals to operate in an EMS System under a provisional system status until an Illinois license is issued:
  - a. To operate on an EMS System transport or non-transport IDPH licensed Vehicle under provisional system status, an individual must have applied for licensure with the Department and meet all requirements under the Act. All Dept-required application materials for submission must be provided to the EMS System for review prior to system provisional reciprocity approval.
  - b. The EMS System has the responsibility for validating National Registry Certification of each individual.
  - c. An individual with a Class X, Class 1 or Class 2 felony conviction or out-of-state equivalent offense, as described in Section 515.190, is not eligible for provisional system status.

*(Source: Amended by emergency rulemaking at 46 Ill. Reg. 1173, effective December 27, 2021, for a maximum of 150 days)*



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<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

5. **Contingency privileges are temporary** and shall only be awarded while Contingency operation continues. These individuals shall serve in a support role alongside at least one other licensed ALS practitioner with full OSF SAINT JAMES EMS privileges. They shall not perform assessments or procedures using devices or equipment for which they have not been educated, competencied, or credentialed. When the state of Contingency is lifted, those hired by OSF SAINT JAMES EMS Agencies must complete the full System Entry testing and credentialing process per System Policy.

## II. **CRISIS CAPACITY STAFFING**

- A. Staffing shortages already exist, and crisis strategies are used in order to continue operations at a safe level. Staffing, equipment, and supply resources are insufficient even after adaptations and allowances made for Contingency capacity. Crisis operation provides for the best proportionate response possible in the setting of severe resource limitations, catastrophic disease, or disaster given the circumstances and resources available. It allows the flexibility to improvise, loosens usual requirements, and balances risk against benefit to provide the greatest good for the greatest number (Utilitarianism). The System must make known to IDPH and all its member dispatch centers, Provider Agencies; and Hospitals that it is operating under CRISIS capacity standards of care.
- B. Source authority: Temporary Waiver for Certain Requirements for EMT and Paramedics Pursuant to authority granted to IDPH by 210 ILCS 50/3.185, the Department will consider a special temporary waiver for certain requirements for EMT and Paramedic Licensure for applicants whose IDPH issued EMS license is expired for less than 60 months, as of 3/23/20.
- C. If the nature of the emergency makes operating at minimum IDPH staffing levels impossible, the EMS MD will consider declaring a state of CRISIS CAPACITY. This declaration must be submitted to IDPH if it is anticipated to last longer than 72 hours. An agency's crisis capacity staffing plan must be submitted to the Resource Hospital who will also forward to the IDPH Regional EMS Coordinator (REMSC).
- D. No Crisis Capacity staffing plan will be granted for longer than 90 days without a re-evaluation of the request.
- E. If Crisis Capacity staffing is invoked, a QA process must be put in place by the System to have the Agency evaluate at least five calls during the duration of the request to ensure there were no preventable deficiencies in care due to the staffing change. This information shall be provided to and retained by the System and made available to IDPH upon request.
- F. **Options to support staffing during Crisis Capacity operation**
1. Submit a waiver to the Resource Hospital to allow one licensed practitioner at the level of care required by the patient and consistent with the drugs and supplies available on the vehicle and one other individual to drive the ambulance with CPR certification. If approved, the System will forward to the REMSC for approval.
  2. Currently licensed EMS practitioners and ECRNs and currently credentialed MILITARY Medics may petition the System for temporary CRISIS privileges by forwarding a copy of a photo ID, their current license and a letter of good standing from their current EMS System or Commanding Officer to the EMS Administrative Director. If approved, no further actions are needed for temporary Crisis Privileges.



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3. CRISIS privileges are temporary and shall only be awarded while CRISIS operations continue. Whenever possible, these individuals shall serve in a support role alongside at least one other licensed practitioner with full OSF SAINT JAMES EMS privileges. They shall not perform assessments or procedures using devices or equipment for which they have not been educated, competencies, or credentialed. When the state of CRISIS is lifted, those who wish to retain OSF SAINT JAMES EMS privileges must complete the full System Entry testing and credentialing process per System Policy.
4. Per IDPH authorization, the System shall create an educational and testing plan for reinstating retired or expired EMS practitioners to attain temporarily Crisis EMS privileges to work in the System per the following restrictions.
  - a. **General requirements for all special licensees issued under this temporary special waiver:**
    - (1). The applicant's IDPH EMS license has been expired for less than 60 months, and must have been in good standing at the time it expired, i.e. not suspended or revoked.
    - (2) The applicant must not have been suspended from any Illinois EMS system as of the IDPH license expiration date.
    - (3) The applicant must hold current CPR for healthcare provider certification from the AHA.
    - (4) Any licensee granted a temporary license under this special waiver shall only practice with another System-approved licensee with full practice privileges at or above the level of the licensee. Two licensees granted a temporary (Crisis) license under this special waiver shall not practice together and must be paired with a System approved licensee with full practice privileges.
    - (5) The applicant must submit a written application for the level of license sought, which may be downloaded from the Department's website at:  
<http://www.dph.illinois.gov/topics-services/emergencypreparedness-response/ems>.  
The application must demonstrate and comply with all of the following for the level of license sought:
      - (a) For applicants seeking a paramedic license, the applicant must demonstrate all of the following:
        - (i) That the applicant has either: (i) Completed all CE as required by the EMS MD OR (ii) successfully completed an EMS System exam demonstrating competence with all current Paramedic protocols required with respect to the EMS System in which the applicant seeks to practice.
        - (ii) Regardless of (i) and (ii) above, the applicant must also have the written recommendation from a current Illinois EMS System MD stating that the applicant is: (i) qualified to practice at the Paramedic level; and (ii) will be accepted into that EMS MD's EMS system.
      - (b) For applicants seeking to practice at the EMT level:
        - (i) That the applicant has either: (i) Completed all Continuing Medical Education as currently required by the EMS System; OR (i) successfully completed an EMS System examination demonstrating competence with all current EMT protocols required with respect to the EMS System in

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which the applicant seeks to practice, and

(ii) Regardless of (i) and (ii) above, the applicant must also have the written recommendation from a current Illinois EMS System MD stating that the applicant: (i) is qualified to practice at the EMT level;

(6) For licenses expired less than 60 months as of 3/23/20:

(a) The applicant must submit a complete application for the level of license sought; demonstrate successful completion of system entrance requirements to function at the level of the expired license, e.g. expired Paramedic successfully completes system entrance requirements for the ALS level, may function at the PM level.

(b) If they cannot successfully complete the system entrance exam for the level of licensure requested, then may function at the level of entrance requirements they can successfully pass, e.g. a person with an expired Paramedic license can only successfully complete the EMT entrance requirements, then may only function at the EMT level.

(c) All temporary licenses for those reinstating their status under this special waiver (EMT and Paramedic) shall automatically expire 6 months after being issued. License renewal shall require full compliance with all: IDPH and EMS system requirements.

b. The EMS MD is responsible for all approvals and at what level they may function.

c. OSF Paramedic students in SJJWAMC program who are already employees of an ALS Provider Agency within the OSF SAINT JAMES EMS may be given Crisis ALS privileges if they have been declared competent by completing EMS Field Internship.

d. "Function" requirements: Expired and student EMS personnel may only function with a licensed EMS practitioner at or above the level of licensure that they are seeking as approved by the EMSMD

e. Required documentation:

(1) System plan amendment presented to IDPH for approval

(2) System submits a roster with names of expired licensed personnel who successfully complete the system entrance requirements.

(3) The roster will include:

(a) Name of expired licensee, expired license number, phone number, social security#, level of function approved by EMS system for this individual, and date approved

(b) Name of student, class site code, phone number, social security # level of function approved by EMS system for this individual and date approved

(c) Name, system number, EMS MD signature

#### IV. Alternative Staffing for Private Ambulance Providers, Excluding Local Government Employers

A. An ambulance provider may request approval from IDPH to use an alternative staffing model for interfacility transfers for a maximum of one year in accordance with the requirements for Vehicle Service Providers in 210 ILCS 50/3.85 of the Act and may be renewed annually.

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<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

1. An ambulance provider requesting alternative staffing for BLS ambulance(s) for interfacility transfers will provide the following to IDPH:
  - a. Assurance that an EMT will remain with the patient at all times and an EMR will act as driver.
  - b. Certificate of completion of a defensive driver course for the EMR and validation that the EMT has one year of pre-hospital experience.
  - c. A system plan modification form stating this type of transport will only be for identified interfacility transports or medical appointments excluding dialysis.
  - d. Dispatch protocols for properly screening and assessing patients appropriate for transports utilizing the alternative staffing models.
  - e. A quality assurance plan which must include monthly review of dispatch screening and outcome.
2. The EMSMD and the Department shall not approve any request for out of state deployment for any EMS provider utilizing an alternative staffing model.
3. The System modification form and program plan shall be submitted to the EMSMD for approval and forwarded to the REMSC for review and approval. The provider shall not implement the alternative staffing plan until approval by the EMSMD and the Department.
  - a. OSF Saint James System must develop an EMS Workforce Development and Retention Committee. The Committee shall be representative of the following:
    - (1) At least one individual representing each private ambulance provider.
    - (2) At least one individual representing each municipal provider;
    - (3) Two individuals representing the Associate Hospitals
    - (4) Two individuals representing the Participating Hospitals
    - (5) One individual representing the Resource Hospital; and
    - (6) The EMS System Medical Director
  - b. **The committee shall:**
    - (1) Assess whether there are EMS staffing shortages within the System and the impact of any staffing shortage on response times and other relevant metrics.
    - (2) Develop recommendations to address such staffing shortages, including, but not limited to, alternative staffing models including the use of EMRs.
  - c. The EMSMD shall submit a final report to the Department along with any proposed system modifications to address the staffing shortages of the System.
  - d. Under the approval of the EMSMD, private ambulance providers may submit a plan for alternative staffing models.
    - (1) The alternative staffing model would include expanded scopes of practice as determined by the EMSMD and approved by the Department.
    - (2) This may include the use of an EMR at the BLS, AEMT/ILS, or ALS levels of care.
    - (3) If an EMSMD proposes an expansion of the scope of practice for EMRs, such expansion shall not exceed the education standards prescribed by IDPH.
    - (4) No expanded scopes of practice for EMTs or EMRs are needed in the OSF SAINT JAMES EMS at the present time.
  - e. The alternative staffing plan shall be renewed annually if the following criteria are met:
    - (1) All system modification forms and supportive planning documentation are submitted,

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validated, and approved by the EMSMD who shall submit to the Department for final approval.

(2) All plans must demonstrate that personnel will meet the training and education requirements as determined by IDPH for expanding the scope of practice for EMRs, testing to assure knowledge and skill validation, and a quality assurance plan for monitoring transports utilizing alternative staffing models that include EMRs.

(3) This plan shall be submitted to the REMSC for review and approval.

(4) This plan shall not be implemented without Department approval, which shall not be unreasonably withheld.

- V. **Requirements for EMS** personnel who have identified an EMS system as secondary
- Providers of any level shall declare a primary system in which they operate in more than 50% of their EMS response.
  - The primary system will be responsible for the providers re-licensure every four years.
  - Providers will follow all protocols and policies of the EMS system the service they work for is affiliated with.
  - All areas of education and disciplinary actions will be communicated between the primary and secondary systems of the provider.

<b>Title of Policy:</b> <i>EMS System Incident Report</i>	<b>Policy Number:</b> A130
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Administration	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

***EMS System Review Form***

Date of Occurrence: \_\_\_\_\_ Time of Occurrence: \_\_\_\_\_ Date of Report: \_\_\_\_\_  
EMS Service: \_\_\_\_\_ Run Number: \_\_\_\_\_

***Type of Occurrence:***

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

***Description of Occurrence:***

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Review of Occurrence:*** ☐ EMS Office ☐ Service

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Recommendations:***

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

***Copies To:*** ☐ Service ☐ EMS Office ☐ PMD ☐ Files

<b>Title of Policy:</b> <i>Encountering a Scene While Already Having a Patient</i>	<b>Policy Number:</b> 240
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> EPCR Documentation, Short Form Mandatory reporting of certain events	<b>Policy Number:</b> DOC100
<b>Effective Date:</b> 10/01/2019	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Documentation	<b>Approvals:</b> MD, System

**EMS Rules: Section 515.350 Data Collection and Submission, Short Form Amended**

- I. To insure appropriate documentation of all patient encounters by pre-hospital personnel who are affiliates of the OSF Saint James EMS system. Documentation of all patient encounters is essential for record keeping and essential to the continuum of care.
- II. **Policy EPCR's, Short forms**
  - A. **All agencies** must complete a report for **all** encounters or calls for emergency/non-emergency response. **Lead provider** on the call should be the person completing the report.
  - B. Report shall be completed using system approved software or forms.
  - C. ESO Software, provided by the EMS system
  - D. All transport agencies must report data to the state database in the NEMSIS version in effect at the time
  - E. Reports are to be completed and distributed as soon as possible after the call. If a sufficient reason exists to delay completion of the report immediately after the call, the report must be completed and distributed to the receiving facility within 2 hours of the patient arriving at the receiving facility.
  - F. Ideally reports should be left with the receiving hospital immediately after completion of the call. In the event that the reports cannot be left, they must be transmitted by facsimile to the receiving hospital within 2 hours (**Ambulance Short form/notes should be left with all patient transports unless full electronic report is left initially.**)
  - G. **SHORT FORM POLICY**
    1. All Ambulance Short forms (Notes) must contain the following elements:
      - a. Complete Patient Demographics ( Name, address, DOB, Parents name is minor)
      - b. Pertinent patient history, meds and allergies
      - c. Complete vitals/treatment performed
      - d. Short narrative or bullet points with circumstances of the call
    2. Within two hours of the completion of the call, the full EPCR **MUST** be submitted via fax, email or in person to the receiving hospital, EMS system and downloaded to IDPH.
    3. EPCR's must include as integrated or attached the short form, pertinent EKG's, refusals and stroke forms if separate from EPCR.



<b>Title of Policy:</b> EPCR Documentation, Short Form Mandatory reporting of certain events	<b>Policy Number:</b> DOC100
<b>Effective Date:</b>	<b>Review Date:</b>
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4. Failure to comply will result in the following:

- a. 1<sup>st</sup> offense – Notification and education of Section 515.350.
- b. 2<sup>nd</sup> offense – WRITTEN WARNING TO THE AGENCY
- c. 3<sup>rd</sup> offense – **Monetary fine of \$250.00**
- d. **Each offense after will be System fine to agency of \$250.00.**

- H. Agencies and or personnel that fail to meet the requirements of items C and/or D above will be reported to the Medical Director who will take action as is deemed appropriate to insure reports are completed and transmitted in a timely manner
- I. Agencies must be sure to have all patient demographics, reason for call, narrative, times of call.
- J. **All EKG's, paper notes, refusal forms should be uploaded to the electronic report if system is not automatically doing so.**

**III. Mandated Reporting**

EMS providers are required to submit mandatory reports on certain calls. Policy Statement: Mandatory reports are used for quality improvement purposes and to ensure that any high-risk procedures are being performed within system standards. These reports are not used for punitive matters, but rather to ensure all patients are receiving appropriate care.

**A. Reports could be flagged in ESO for Medical Review.**

**B. The following events are required reports:**

- a. Pre-Hospital Delivery
- b. Pre-Hospital Return of Spontaneous Circulation
- c. Pediatric Cardiac Arrest
- d. Utilization of RSI Intubation
- e. Utilization of Chemical Restraint Protocol (Ketamine)
- f. USE of Bipap
- g. Care withheld due to POLST
- h. Failure to report may result in disciplinary action**

**IV. UNDER NO CIRCUMSTANCES SHOULD ANY FORMS, NOTES OR WRITTEN INFORMATION BE REMOVED OR TAKEN FROM FIRE/EMS STATIONS. ALL REPORTS ARE TO BE COMPLETED AT OR IN AGENCY PROPERTY.**

**A. Violation of this policy is subject to disciplinary actions due to the possibility of HIPPA violation to both the provider, agency, and system.**

<b>Title of Policy:</b> <i>Healthcare professional on scene</i>	<b>Policy Number:</b> O250
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Background to Policy:**

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

**Policy Statement:**

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

**Policy:**

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

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

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

<b>Title of Policy:</b> Hospital Resource Limitation/Bypass - <i>Diversion to a Hospital, Trauma Center, or Regional Trauma Center Other Than the Nearest Hospital</i>	<b>Policy Number:</b> O260
<b>Effective Date:</b> 09/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Resources to this policy:** IDPH EMS Rules 515.315 and 515.330 at Emergency amendment at 46 Ill. Reg. 17682, effective October 23, 2022, for a maximum of 150 days)

### Section 515.330 EMS System Program Plan

m) Written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, STEMI center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, which provide that 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 StrokeReady 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) The bypass status policy shall include criteria to address how the hospital will manage pre-hospital patients with life threatening conditions within the hospital's then-current capabilities while the hospital is on bypass status. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:

- 1) There are no critical or monitored beds available in the hospital; or
- 2) An internal disaster occurs in the hospital; (Example, a power failure, flood, fire, or active shooter incident resulting in hospital lockdown at the time that the decision to go on bypass status was made.

**OSF Saint James EMS System Plan:** Inter-system/Inter-region transports; Bypass/Diversion

#### I. DEFINITIONS

- A. "Nearest hospital" is the hospital which is closest to the scene of the emergency as determined by travel time, and which operates a full-time emergency department at the minimum level recognized by the System in its Department approved Program Plan.
- B. "Nearest Trauma Center" is either the nearest Level I or Level II Trauma Center that can be reached within 15 minutes by ground travel time from the scene of the emergency as defined by Trauma Triage Guidelines in the SOPs. In the event that a specialty care unit is unavailable, the ED of that institution shall be regarded as a functioning comprehensive ED without any specialty care back-up capabilities (e.g., burn unit, spinal cord unit, hyperbaric chamber, Level I Trauma Center).
- C. Comprehensive Stroke Center or CSC – a hospital that has been certified and has been designated as a Comprehensive Stroke Center under Subpart K. (Section 3.116 of the Act)
- D. Primary Stroke Center or PSC – a hospital that has been certified by a Departmentapproved, nationally recognized certifying body and designated as a Primary Stroke Center by the Department. (Section 3.116 of the Act)
- E. "Hospital bypass"
  1. Requests for bypass must only be made based on IDPH criteria after a decision has been reached by medical, nursing and administrative representatives with the authority to make such a request.
  2. An appropriately declared and reported bypass status will usually result in EMS patients being taken to a hospital other than the one on bypass unless an exception applies; see Section VI.

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**II. PURPOSE / POLICY STATEMENTS**

- 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) or (iii) another healthcare facility can provide appropriate medical treatment for that person. CAPITALIZATION indicates statutory language
- B. The purpose of this policy is to provide background and practice guidelines for OSF hospitals, provider Agencies and EMS personnel during crisis situations and/or when hospital resources are severely limited and Bypass status has been approved and declared.
- C. OSF Saint James shall make every reasonable effort to prevent declaring bypass status. Bypass status should only be declared in compliance with the EMS Act and Rules and IDPH and Region2 recommendations after the hospital has exhausted all internal mechanisms to relieve the limitation of resources, mitigate internal service disruptions or resolve threats/hazards requiring them to go on lockdown status (See E. below).
- D. Each hospital shall have a policy addressing Peak Census/Surge procedures. This policy shall:
1. Delineate procedures for the hospital to follow when faced with a potential or declared resource limitation that would help them to avoid bypass status.
  3. Include a list of Providers and their current contact information who customarily transport to that hospital.
- F. All reasonable efforts to resolve the essential resource limitation(s) shall be exhausted, including:
1. Considering appropriately monitored beds in other areas of the hospital;
  2. Limitation or cancellation of elective pt procedures and admissions to available surge pt care space and redeploy clinical staff to surge patients.
  3. Actual and substantial efforts to call in appropriately trained, off-duty-staff; and
  4. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment/or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.
- G. If bypass is granted/declared, the hospital shall monitor their situation carefully to determine the earliest possible time when the bypass status/lockdown can be lifted.
- H. Under EMTALA provisions, OSF Saint James may not divert a patient without a medical screening exam once on their campus

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**III. Section 515.315 Bypass or Resource Limitation Status IDPH Review**

- A. The Department shall investigate the circumstances that caused a hospital in an EMS System to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable. (Section 3.20(c) of the Act)
- B. The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass/resource limitation decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at <https://emresource.juvare.com/login> . The hospital shall document any inability to access EMResource by contacting IDPH Division of EMS during normal business hours.
- C. In determining whether a hospital's decision to go on bypass/resource limitation status was reasonable, the Department shall consider the following:
  1. The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;
  2. Whether an internal disaster, including, but not limited to, a power failure, had occurred in the hospital at the time that the decision to go on bypass status was made;
  3. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and
  4. The approved hospital protocols for peak census, surge, and bypass and diversion at the time that the decision to go on bypass status was made, provided that the Protocols include subsections (c)(1), (2) and (3).
  5. Bypass status may not be honored or deemed reasonable if three or more hospitals in a geographic area are on bypass status and/or transport time by an ambulance to the nearest facility is identified in the regional bypass plan to exceed 35 minutes
- D. Hospital diversion should be based on a significant resource limitation and may be categorized as a System of Care (STEMI or Stroke), or other EMS transports. The decision to go on bypass (or resource limitation) status shall be based on meeting the following two criteria, and compliance with Subsection (c) (3).
  1. Lack of an essential resource for a given type or class of patient (i.e. Stroke, STEMI, etc.) Examples include, but are not limited to:
    - a. No available or monitored beds within traditional patient care and surge patient care areas with appropriate monitoring for patient needs;
    - b. Unavailability of trained staff appropriate for patient needs; and/or
    - c. No available essential diagnostic and/or intervention equipment or facilities essential for patient needs.
  2. All reasonable efforts to resolve the essential resource limitations(s) have been exhausted including, but not limited to:
    - a. Consideration for using appropriately monitored beds in other areas of the hospital;





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- G. The Department may impose sanctions, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act. (Section 3.20(c) of the Act)
- H. Each EMS System shall develop a policy addressing response to a system-wide crisis. (Source: Emergency amendment at 46 Ill. Reg. 17682, effective October 23, 2022, for a maximum of 150 days)

#### IV. PROCEDURE: PHASE I: PRIOR TO REQUESTING BYPASS (IDPH & OSF Policy recommendations)

- A. "Peak Census" occurs when a specific hospital is experiencing near capacity census with limited access to inpatient beds, monitors, critical care equipment, support resources and staffing which impact the management of patient care. The hospital surge capacity plan may have implemented patient admission to overflow space, which in turn provides a strain on available support resources and staffing.
- B. When resource limitations meet a hospital's tipping point, they shall implement their Peak Census/surge plan and update their status into the Illinois EMResource application, accessed at <https://emresource.juware.com/login> to reflect Peak Census/Surge Status.
- C. IDPH suggests that the following core group should be consulted when a hospital is on peak census status and/or is contemplating the need for bypass:
  1. President and/or administrator on call; CNO or designee
  2. Directors/Managers of housekeeping, admitting, laboratory and transportation services
  3. Nurse and physician directors of inpatient units Hospitals are directed to the IDPH model policy for options to avoid bypass, procedures for advance admission of a pt to an inpatient area, and the five tier bed monitoring and utilization process. They are encouraged to expedite discharges; open boarding beds or overflow units, rapidly clean and prepare beds for incoming pts; and consider cancelling non-emergent surgeries and/or admissions.
- D. Before a decision is made to request Bypass status, the stricken hospital shall review the Illinois EMResource application to determine if neighboring hospitals are also on the highest levels of peak census or bypass, ED-to-ED communication shall evaluate the possible area-wide consequences of a pending "Bypass" request.
- E. EDs of stricken hospitals considering the need to request Bypass Status shall notify their EMS Manager/Coordinator and discuss the IDPH-recognized grounds for bypass. The System Manager shall consider the need to implement the System Crisis Response plan based on the nature and extent of System-wide resource limitations.

#### V. PROCEDURE Phase II: Requesting BYPASS STATUS – OSF Saint James John W Albrecht Medical Center Critical Capacity/Bypass Worksheet

- A. System hospital must follow IDPH Rules and EMS System/Region 2 guidelines with respect to requesting and reporting bypass status.
- B. Gather the information on the Critical Capacity/Bypass worksheet to provide justification for bypass status. (Max 2 hours for non-internal disasters)
- C. If bypass is being considered, contact the following to discuss your facility's situation:



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Region 2 Emergency Preparedness: Jonathan Quast (RHCC Coord) 309-683-8365 \*RHCC will review need for bypass and review EMResource for potential impact.

If supported, will be given direction to contact IDPH for approval IDPH Region 2 EMSC: IDPH Region2 EMSC: Mike Epping, Email the Bypass Worksheet to: [mike.epping@illinois.gov](mailto:mike.epping@illinois.gov) Then call his Cell: **NOTIFICATION** procedures:

1. If IDPH grants approval for bypass: Enter the change in hospital status in <https://emresource.juware.com/login>
2. The hospital declaring bypass shall notify all surrounding hospitals that could be impacted by a bypass declaration and EMS agencies that normally transport to that facility through their dispatch centers or numbers provided by the agencies. This may be accomplished by phone or through a mass notification system if the process has been proven to be a reliable means of communication. Notification must include the hospital's name, reason for bypass, and estimated duration. If on lockdown, be very clear that NO PATIENTS are to be transported to that hospital.
3. EMS AGENCIES are responsible for keeping their personnel informed regarding Bypass Patient Redistribution plans. Provider agency policies shall specifying their way of complying with this requirement.
4. Upon notification of another hospital's bypass status, the ED charge nurse shall notify appropriate persons within their facility (based on hospital policy) regarding the potential for ED volume increases.
5. It is expected that the hospital on bypass will return to normal operations ASAP. They should reevaluate their status at least every four hours or more frequently if the resource limitation necessitating bypass has been resolved.
6. Notification of BYPASS CANCELLATION shall be promptly entered into <https://emresource.juware.com> and communicated to all impacted hospitals and EMS agencies using the same notification methods used to declare bypass status.
7. Hospitals shall notify their EMSC when the Internal Peak Census/Surge plan is deactivated. Hospital EMSCs shall notify the Resource Hospital EMS System Manager to cancel the System Crisis Response activation that involved their facility.

**VI. On-line medical control (OLMC) during Bypass declarations** EMS personnel shall follow usual and customary OLMC call patterns. Contact OSF Saint James Medical Control EVEN IF THAT HOSPITAL IS ON BYPASS. They will let you know if the patient will be accepted by them or routed to another facility. Requests for transport to a facility other than the predetermined destination hospital outlined in the Patient Redistribution Plan require OLMC contact PRIOR TO leaving the scene.

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**VII. Patient distribution plan** - pre-established transport destinations for EMS agencies impacted by a hospital's bypass declaration.

### Situations which may result in a hospital receiving patients while on bypass

- A. The patient is unstable and unable to tolerate transport to a more distant comprehensive medical facility. Risks to a pt resulting from a longer transport time are judged to be greater than the benefits of transporting to a nearer hospital on bypass as long as that hospital still has a functioning Emergency Department.
- B. Unstable patients with an immediately life-threatening condition whose "LAST CLEAR CHANCE" of survival lies in an EXPEDITIOUS emergency evaluation or resuscitative intervention are NOT TO BE DIVERTED and must be accepted by the closest appropriate ED regardless of Peak Census, Surge, or Bypass status unless an internal hospital disaster is occurring and/or the hospital is on lock-down.
- C. UNSTABLE for the purposes of this policy is defined as: Symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." This includes, but may not be limited to the following:
  1. Persistently compromised airway/ventilations despite EMS interventions; and/or
  2. Severe vascular injury with uncontrolled hemorrhage; cardiac arrest
  3. Others as listed below
- D. Specific patients:
  1. ACUTE STROKE: Transport to the closest appropriate Stroke Center regardless of peak census, surge or bypass status unless their CT scanner is unavailable, an internal hospital disaster is occurring, and/or they are on lock-down.
  2. PREGNANT PATIENTS in ACTIVE LABOR or with OB COMPLICATIONS: Transport to the **closest hospital with an OB unit** regardless of peak census, surge, or bypass status unless an internal hospital disaster is occurring and/or they are on lock-down.
  3. **Unstable PEDIATRIC PATIENTS:** Transport to the nearest EDAP regardless of peak census, surge, or bypass status unless an internal hospital disaster is occurring and/or the hospital is on lock-down.
  4. **MEDIUM or LARGE SCALE MULTIPLE PATIENT INCIDENTS:** Bypass status is vacated unless an internal disaster is occurring and/or the hospital is on lock-down.
- E. **Multiple hospitals simultaneously on bypass in the same geographic area**
  1. Bypass status may not be honored or deemed reasonable if multiple hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility identified in the regional bypass plan exceeds 15 minutes (IDPH rules)
  2. When two hospitals servicing the same EMS provider agencies have simultaneously declared bypass and/or two or more hospitals simultaneously on bypass will cause other hospitals to reach the highest level of Peak Census or declare Bypass status, the

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Resource Hospital shall call or page the System EMS Manager. If he or she fails to respond within 5 minutes, call the EMS MD (see below). They shall determine if the situation necessitates activation of the System's Crisis Response policy.

<b>Andrew Larsen</b>	<b>(815)848-6565 (Cell)</b>
<b>Michael Daley</b>	<b>(646)942-8789 (Cell)</b>

1. Hospitals on bypass may be required to accept BLS patients to avert a System Crisis situation.
2. If three or more hospitals are simultaneously on bypass and are adversely impacting patient transports, the EMS MD or EMS System Manager will consult with the IDPH Regional EMSC. If transport time by ambulance to the next nearest approved healthcare facility exceeds 15 minutes, the hospital on bypass may be required to accept select ALS patients except in situations of internal disaster or lockdown.

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## APPENDIX

**EMTALA** (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd) Provisions

x The definition of a hospital campus at 42 CFR 413.65(a)(2) means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis.

x Per 42 CFR 489.24(b), "Hospital property" means the entire main hospital campus, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. Also, per the American Disabilities Act (ADA), hospital campuses must be accessible to individuals with disabilities.

x In addition, we know that, during the COVID-19 PHE, non-hospital properties, such as hotels, dormitories, and field hospitals at parks, are becoming extensions of hospitals, otherwise known as temporary expansion sites. This is permissible under the section 1135 waiver of the provider-based regulations at 42 CFR § 413.65 and certain requirements under the Medicare conditions of participation at 42 CFR § 482.41 and § 485.623. See description of Temporary Expansion Locations at <https://www.cms.gov/files/document/covid-hospitals.pdf>.

x If an ambulance arrives on any portion of a hospital's "campus" or "property", all EDs must conduct a medical screening examination for those patients and provide emergency stabilization to the best of their ability under the conditions. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.

x EMTALA defines an emergency medical condition as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

x The decision to admit, discharge, or transfer a patient, once stabilized, is the responsibility of the emergency physician treating the patient. Any diversions of patients that occur when the facility is not on bypass status shall be reasonable, appropriate, and compliant with Federal, state, and local laws and protocols.

x The transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

x Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

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## **Criteria for Resource Limitation**

**All confirmed or suspected STEMI's identified by EMS providers or the OSF Saint James EMS ED Physician, will be diverted to the closest appropriate facility with a Cardiac Cath lab.**

**If a hospital has declared bypass due to a CT scanner resource limitation – DO NOT transport patients with the following to their location:**

### **Indications for HEAD CT:**

- x Acute head injury; suspected intracranial hematoma (epidural, subdural)
- x Suspected stroke, TIA, subarachnoid hemorrhage

### **Indications for SPINE CT:**

- X Acute spine trauma (injury within previous 48 hours) where there is a higher than average likelihood of fracture or dislocation, bulging or herniated disc, or mechanical instability of the spine that requires spine motion restriction. Pt may c/o midline spine pain, have visible injury, or findings of neuro loss or deficit.

### **Indications for CHEST CT**

- x Chest trauma with possible pneumothorax, hemothorax, rib fractures and flail segments, pulmonary contusion, disruption to the thoracic aorta, diaphragmatic rupture

### **ABDOMINAL/PELVIC CT**

- x Acute abdominal/pelvic trauma
- x Kidney and bladder trauma
- x Possible Abdominal Aortic Aneurysm (AAA)

OSF Saint James John W Albrecht Medical Center

## PRE-ALERT BYPASS FORM

DECISION MAKERS		
ED Physician:	Admin on Call:	
Admin Supervisor:	Time called:	Present # in ED:

ED ASSESSMENT	
# Patients on cardiac monitors:	# Open monitored beds:
# Admits/Transfers holding for critical care or monitored beds:	

INTERNAL ASSESSMENT: get from Admin Supervisor	
No monitored beds in house? [ ] Yes [ ] No Internal disaster in hospital? [ ] Yes [ ] No Special procedures down? [ ] Yes [ ] No	Other reason for considering bypass:
Current census:	Step-down: ICU: House:
Estimate # of in-house critical and/or monitored beds that could be available in next 2 hours:	
Peak Census procedure completed <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXTERNAL ASSESSMENT: check impact on other area hospitals if we go on bypass: use direct dial phone	
OSF St. Joseph Medical Center 309-661-5111	Time: RN:
ED status: Open/ Limited/ Full	Comments:
Carle BroMenn 309-268-5130	Time: RN:
ED status: Open/ Limited/ Full	Comments:
OSF Center for Health 815-673-2311	
ED status: Open/ Limited/ Full	Comments:

NOTIFICATIONS (FYI): may be contacted after decision is made		
	Time called:	Responded:
	Time called:	Responded:
	Time called:	Responded:

DECISION(S) MADE		
Monitor situation	Time began:	Time ended:
Enact hospital Peak Census Plan	Time began:	Time ended:
Initiate Bypass	Time began:	Time ended:

**If decision is made to go on BYPASS; Initiate Bypass Notification Worksheet**

**OSF Saint James John W Albrecht Medical Center**

## BYPASS Worksheet

<b>Date:</b>		<b>Date:</b>
Time declared:		Bypass decision authorized by: (Name & title)
Reason(s) for bypass: <input type="checkbox"/> No critical or monitored beds available in hospital, including ED  <input type="checkbox"/> Internal/external disaster  <input type="checkbox"/> Special procedure/CT down  <input type="checkbox"/> General bypass criteria (above)		
Surrounding hospitals <input type="checkbox"/> Yes notified: <input type="checkbox"/> No		
IDPH notified on web-site <input type="checkbox"/> Yes <input type="checkbox"/> No		if no, how was IDPH notified?
EMS Providers notified <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date canceled:		Time canceled:

Notify	Number	Initiated	Update	Canceled
<b>VCOM- 911</b> <i>PFD, SELCAS, Odell, Saunemin, Dwight,</i>	<b>815-842-0911</b>			
<b>MetCom 911</b> <i>Gridley</i>	<b>(309) 888-5030</b>			
<b>Woodcom-</b> <i>Minonk, Benson</i>	<b>309-467-2375</b>			
<b>Marshall County 911</b> <i>Eastern Marshall County Amb.</i>	<b><u>(309) 246-2115</u></b>			
<b>Riverside Ambulance</b>	<b>815-935-4359</b>			
<b>Streator Fire</b>	<b>(815) 672-2266</b>			

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<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

**References:** Public Act 094-0865 that amends the EMS Act and others with respect to DNR orders; EMS Rules; Section 515.380 (Sept 18, 2008); Public Act 096-0765 The Health Care Surrogate Act (1/1/10); Illinois POLST form updated May 2016; Public Act 099-0328 The Illinois Power of Attorney Act (1/1/16). Disclaimer: If Federal or State laws that impact Advance Directives and/or ILLINOIS POLST orders change prior to this policy being amended or they appear to be inconsistent or in conflict with any provisions of this policy, the statutory language or State Directives shall prevail.

## **I. POLICY**

- A.** Resuscitation shall be attempted on all patients in cardiac and/or respiratory arrest, except in those situation described in this policy.
- B.** “Emergency medical services should be available to all persons in need, including terminally ill patients who (may or may not) need to be transported to the hospital for palliative care. Prehospital care providers require a means to honor patient directives to limit intubation and avoid application of cardiopulmonary resuscitation (CPR). Requests to limit resuscitation will confront the provider in many forms. Written Do-not-resuscitate (DNR) orders, living wills, clear and unequivocal family requests, and a relative’s impulsively expressed reservations about life support will be encountered. Acceptable directives must guarantee that withholding resuscitation would reflect the informed wishes of competent patients” (NAEMSP, 1993).
- C.** Decisional adults have the right to make decisions regarding their healthcare. Illinois courts have ruled that this right should not be lost when a person becomes unable to make their own decisions. Decisional adults may accept or refuse medical care after they have been informed about treatment alternatives and the risks and benefits of each alternative. The law requires that they be informed of the availability of advance directives to help ensure that their wishes are carried out even if they are no longer capable of making or communicating their decisions.
- D.** The decision to accept and/or withhold resuscitative and/or life-sustaining interventions is the result of a responsible medical, legal, and ethical process with respect for the patient's right to privacy and self-determination. It is acceptable to withhold or withdraw resuscitative and/or life sustaining interventions in the event a patient is terminally ill, when death will occur in a reasonably short period of time, or for whom treatment would be virtually futile or prolong the act of dying and the patient has a valid IDPH POLST form. These patients are in the process of dying and DO NOT meet the criteria listed in the Triple Zero Policy.
- E.** A valid ILLINOIS POLST Form should be honored unless compelling circumstances arise, and an on-line medical control (OLMC) physician directs EMS personnel to resuscitate.
- F.** An ILLINOIS POLST Form does not mean the abandonment of appropriate care that the patient perceives as desirable. All patients are to receive medical care as indicated on the form, and required by their condition per SOP and/or OLMC.
- G.** If at any time it is unclear if this policy applies, begin BLS treatment and contact OLMC for orders. If communication with OLMC is impossible, begin treatment per SOPs and transport as soon as possible.



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- II. Circumstances under which resuscitation may be WITHHELD and/or WITHDRAWN**
- A.** The patient has been declared dead by a coroner, medical examiner, or a physician.
  - B.** There are explicit signs of long-term biological death (Triple zero).
    - 1. These signs include decapitation, thoracic/abdominal transection, rigor mortis without profound hypothermia, profound dependent lividity, decomposition, frozen state, or other signs that establish long-term biological death
    - 2. For such patients, follow the **EMS Cardiac Resuscitation vs. Cease Efforts** policy and thoroughly document the surrounding circumstances and the signs of biological death on the EMS patient care report.
    - 3. If required, notify the coroner or Medical Examiner's office according to System Policy:
    - 4. If there is any question regarding the appropriateness of withholding or withdrawing medical care in such circumstances, begin treatment and contact OLMC immediately for orders.
  - C. When instructed by an OLMC physician to withhold or withdraw medical care.**
    - 1. In certain circumstances, a medical control physician can order further treatment to be withdrawn or withheld from a patient. This may occur, for example, when the patient remains in persistent monitored asystole after resuscitation per SOP or a question arises as to whether the patient's care is governed by an Illinois POLST form or other valid DNR order. Medical control should be notified and, depending on the circumstances, may order further treatment withheld or withdrawn.
    - 2. In these situations, thoroughly document the circumstances surrounding the call, describe the treatment withheld or withdrawn, along with the name of the medical control physician, and the time resuscitation was discontinued.
  - D. When presented with a valid Illinois POLST form.**
- III. ILLINOIS POLST Form and Orders**
- A.** The Illinois POLST form can be used to create a practitioner generated order that reflects an individual's wishes about receiving cardiopulmonary resuscitation (CPR) and other treatments such as medical interventions and artificial administered nutrition. It allows an individual, in consultation with his or her health care practitioner, to make advance decisions about CPR and other care wishes.
  - B.** The following EMS System members are authorized to honor a valid ILLINOIS POLST order: EMT; Paramedic; Prehospital RN; ECRN; ED physicians.
  - C.** The 2016 POLST form is the 6th edition in a series of IDPH DNR / POLST forms:
    - 1. 2000: 1st Illinois out of hospital DNR "orange form." Only for EMS, the DNR order had to be rewritten at each new facility.
    - 2. 2005: IDPH Uniform DNR Order form - applied to all facilities and a patient only needed one form.
    - 3. 2006: Some facilities confused if form had to be used for every in-hospital DNR order (it did not), so it was renamed the IDPH Uniform DNR Advance Directive.
    - 4. 2013: Still called the IDPH DNR Advance Directive, but used the shorthand POLST since it used the POLST "paradigm" for life-threatening emergencies but required a physician's signature.
    - 5. 2015 IDPH DNR/POLST form. POLST redefined to stand for "Practitioner Orders for Life-Sustaining Treatment" and expanded the types of practitioners that could authorize an order.

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6. 2016 Illinois POLST: Updated by IDPH in May 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.
7. Validity of form editions: Some persons may still have older versions of the form. A valid, completed form does not expire. When a new form is created, it voids past forms. Follow instructions on the form with the most recent date. EMS is not responsible for investigating the presence of other forms or validating the accuracy of the form presented - assume the form presented is truthful.
8. **FORM IS VOLUNTARY:** This form cannot be required of any patient, and is completely voluntary.
9. Intended population: Persons of any age for whom death within the next year would not be unexpected. This includes those with advanced illness or frailty. An ILLINOIS POLST form is NOT intended for persons with chronic, stable disability. Such individuals should not be mistaken for having an end-of-life illness. An ILLINOIS POLST form would only be appropriate if their health deteriorates such that death within a year would not be unexpected.
10. **PURPOSE:** Designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care. It allows them to choose all possible life-sustaining treatment, limited life sustaining interventions, or comfort care only. Comfort measures are always provided no matter what other choices patients make.
11. When to complete: ILLINOIS POLST forms are completed after patients discuss their preferences with health care practitioner who can explain to them what may happen if different treatments are tried. The form serves as a guide for these discussions related to each person's unique medical condition and goals.
12. The completed form is an actionable medical order: Health care providers and professionals are required by law to honor treatment choices shown on a ILLINOIS POLST form. It provides an immediate guide for EMS and hospital staff about whether to even begin resuscitative and/or life-supporting care.
13. The Form should travel with patient at all times: The form is intended to be honored across various settings, including hospitals, nursing homes, licensed long-term care facilities, with hospice and home-care patients, and by EMS personnel.
14. Original or copy: The person does NOT need the original form – all copies of a valid form are also valid. It may be printed on any color paper.
15. **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 for EMS purposes.
    - a. Applies if patient is found in respiratory/cardiac arrest
    - b. If "Attempt Resuscitation" box is checked, EMS does NOT need to look at any other parts of the form. Initiate Resuscitation per SOP.
    - c. If "DNR" box is checked, do not begin CPR.
    - d. Why use the form to request CPR?

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- (1) Persons with advanced age or disabilities may be concerned they will not receive the same emergency services as younger or nondisabled persons, despite having a good quality of life
- (2) A person may have created a ILLINOIS POLST form declining CPR during a period of serious illness, but if they recover or go into remission, may now wish CPR.

### 3. Section B:

- a.** Full treatment: This is for “pre-arrest” patients. It is anticipated that this person would end up in cardiac arrest if nothing was done. This section tells healthcare workers how aggressively the patient wishes to be treated.
- b.** Selective Treatment: Example: patient with heart failure having severe shortness of breath. They may want a trial period of CPAP/BiPAP but do not want to be intubated. They may be far more comfortable if noninvasive pressure support ventilations and/or appropriate positioning to relieve their distress. King LTD, LMA, Combitube are all examples of advanced airways that the patient generally intends to refuse if this box is marked.
- c.** Comfort-focused treatment: Example: hospice patient. “Please keep me out of pain but let me die at home.” One of the problems that EMS personnel face is being called to a home because the family does not know what to do when the patient deteriorates and end of life appears imminent. EMS responds and the family requests help, but they do not know what that help should be. EMS usually has to transport the patient even though patient’s wish is to not be transported. There is now a caveat written into the form that states, “Transfer to hospital only if comfort needs cannot be met in current location.”

### 4. Section C: Medically Administered Nutrition: N/A for EMS

- a.** Not typically relevant for EMS personnel
- b.** Provides clear direction to avoid contested care as happened in Terri Schiavo case in Florida
- c.** For patients with TPN/tube feedings needing transport, contact OLMC.

### 5. Section D: Documentation of Discussion: Consent from Patient or Legal Representative.

#### Evidence of consent by one of the following:

- a.** Signature of the patient
- b.** Signature of person legally authorized to act on that person’s behalf such the Individual’s legal guardian, agent under a power of attorney for health care or a surrogate decision maker. Priority order under Surrogate Act
- (1) Patient’s guardian of person
  - (2) Patient’s spouse or partner of a registered civil union
  - (3) Adult child (
  - 4) Parent
  - (5) Adult sibling
  - (6) Adult grandchild
  - (7) A close friend of the patient (8) Patient’s guardian of the estate

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c. A parent or legal guardian typically may consent to a DNR order for a minor.

Emancipated minors may consent to a DNR order.

d. Signature of ONE witness 18 years of age or older, who attests that the individual, other person, guardian, agent, or surrogate (1) has had an opportunity to read the form; and (2) has signed the form or acknowledged his or her signature or mark on the form in the witness's presence. The only restriction is that the witness cannot be the "Primary Care Giver". The primary care giver is the practitioner that is directing the patient's care. All other medical personnel are carrying out the practitioners orders so can witness the form if needed. Witnesses may be a family member, friend, health-care worker or other competent adult.

6. Section E: Signature of Practitioner: Name and signature of the authorized practitioner. Practitioners authorized to sign form: Physicians, Advance Practice Nurses (APNs), Physician Assistants (PAs), medical residents ( $\geq$  2nd year). Temporary verbal orders signed by an RN are acceptable.

**Effective date: The validity of an order will not expire unless modified or revoked at any time by the maker.**

7. All other information is optional.

8. If any of the required elements are missing or not completed in compliance with the Act, the order IS NOT VALID for EMS use. Call OLMC for direction. The order IS valid if the back or second page of the form has not been completed.

9. Elements present in another format: If presented with a document that contains all the mandatory elements, but it is written on something other than the IDPH ILLINOIS POLST Form, contact OLMC for orders.

10. No verbal DNR orders will be honored by EMS personnel unless the patient's personal practitioner or coroner/medical examiner is present and has declared the patient dead. Document this information in the comments section on the patient care report.

#### **M. IMPLEMENTING an ILLINOIS POLST ORDER**

1. Assess the patient to determine their medical condition and need to have the Order invoked. If the patient has an intervening condition causing death that is not related to the terminal illness or condition, e.g., choking or trauma, begin care per SOP.

2. Make a reasonable attempt to verify the identity of the patient named in the ILLINOIS POLST form, e.g., identification by another person or I.D.

3. Determine if the ILLINOIS POLST order contains all of the required elements. If not, begin resuscitation. "A health care provider may presume, in the absence of knowledge to the contrary, that a completed Illinois POLST form or a copy of that form indicating Do NOT attempt resuscitation is a valid DNR Order". If there is any doubt as to the validity of a DNR order, begin BLS treatment and contact OLMC as soon as possible.

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4. Document the circumstances surrounding the use of the form and attach a copy to the EMS patient care report left at the receiving facility if possible. If impossible, record the following information from the ILLINOIS POLST form in the comments section of the PCR: practitioner's name; the effective date of the order; the name of the one giving consent and their relationship to the patient, if known; and the name of the witness. Include the nature of the terminal illness and the person who presented the order to EMS responders.

5. If resuscitation is already in process when a ILLINOIS POLST order is produced that indicates Do Not Resuscitate, temporarily continue resuscitation, confirm that all required elements are present, and contact OLMC for instructions. Medical control should authorize cessation of all resuscitation.

6. If death occurs during transport and a valid ILLINOIS POLST order was produced that indicates Do Not Resuscitate, honor the Order and contact OLMC for further instructions.

7. If a person on the scene disputes an ILLINOIS POLST order: Determine if they have durable power of attorney for healthcare for the individual and if they had provided consent to the ILLINOIS POLST order as the designated surrogate.

a. If yes, this person has a duty to base decisions on the patient's values and wishes and they may revoke the order.

b. If no, contact OLMC immediately and inform them of the dispute. Family members or significant others who do not have the designation of agent or surrogate have no standing to overrule the ILLINOIS POLST Order. Follow the direction of OLMC in situations of dispute.

8. If appropriate, notify the coroner/medical examiner according to System Policy

#### **N. Voiding or revoking a ILLINOIS POLST form**

1. An ILLINOIS POLST form can be revoked or changed by a patient with decisional capacity or the agent that consented to the order at any time.

2. Changing, modifying or revising an ILLINOIS POLST form requires completion of a new form.

3. Draw a line through sections A and B and write "VOID" in large letters if any ILLINOIS POLST form is replaced or becomes invalid.

4. Beneath the written "VOID" write in the date of change and re-sign.

5. If included in an electronic medical record, follow all voiding procedures of the facility.

#### **O. Professional immunity for implementing a DNR order:**

Subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65, provides: "A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform DNR Order or a copy of that form is a valid DNR Order. A health care professional or health care provider, or an employee of a health care professional or health care provider, who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

#### **IV. DURABLE POWER of ATTORNEY (POA) for HEALTH CARE Designation**

A. Since 1987, Illinois law has allowed persons to appoint an "agent" or "attorney in fact" to act on their behalf in making medical care decisions for them (principal) in the event that they are unable to make their own medical decisions.

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- B.** An agent can be anyone other than the patient's physician and is appointed by the patient via a document called a "Durable Power of Attorney for Health Care". One does not need an attorney to execute this form, nor does it have to be notarized. The Illinois Durable Power of Attorney Act recognizes the right of individuals to control all aspect of their personal care and medical treatment including the right to decline medical treatment or to direct that it be withdrawn, even if refusal of care will result in death.
- C.** The Act states that the right of an individual to decide about their personal care overrides the obligation of the physician and other health care providers to render care or to preserve life and health. The power given to the agent may be as broad or narrow as the patient wishes. The standard form grants the agent medical decision-making power that the patient may limit. The law does not require use of this particular form.
- D.** Other than withholding resuscitation, a POA may make choices re: refusal of treatment or hospital preference.
- E.** The POA's ability to make decisions can be designated to begin at any time the patient chooses. They do not have to be in a terminal condition, unlike a Living Will.
- F.** If both documents are executed, a Durable Power of Attorney supersedes a Living Will.
- G.** Generally, a POA has no authority if the patient is alert and is able to communicate their wishes: If the patient is alert and consents to treatment, continue to treat them, even if thereafter they are unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.
- H. If someone claims to hold a POA for healthcare decisions, follow these guidelines:**
- 1.** Begin treatment of the patient per SOPs. Immediately inform OLMC that a health care agent for the patient is present. Follow all orders of the OLMC physician, even if such orders contradict the instructions being given by the "agent".
  - 2.** As soon as is practical, ask the agent for the Illinois Statutory POA for Health Care form (2016). The form should be complete, including:
    - a.** Patient's (principal's) name and address;
    - b.** Agent's name and address;
    - c.** Date of execution;
    - d.** Effective date of Power of Attorney (may not be mandated by Ill. law);
    - e.** Powers granted to the agent;
    - f.** Date Power of Attorney terminates (may not be mandated);
    - g.** Signature of the patient (principal);
    - h.** Signature of a witness; and
    - i.** Specimen signatures of the agent (not mandated by Illinois Law).
  - 3.** Examine the form to see if it is complete. Ask the agent to verify his/her signature. Review the form to see what medical authority has been given to the agent. Ask the agent to point out the language that confirms that the Power is in effect and that it covers the situation at hand.
    - a.** If form is incomplete, agent's authority to make decisions is not recognized.
    - b.** If the form is complete, notify OLMC about the presence of a health care agent on scene and follow the instructions of the agent unless instructed otherwise by medical control.



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**c. EXCEPTION: EMS cannot honor a verbal or written DNR request or order made directly by a surrogate decision maker or POA for healthcare agent.** Agents can provide consent to a DNR order, but the order, itself, must be authorized by a qualified practitioner. The practitioner is responsible for determining if a POA agent, surrogate decision maker or other person has proper authority to give consent to the ILLINOIS POLST order.

**4.** Document the names of the patient and agent and powers given to the agent on the patient care report. Bring the POA form to the hospital if the patient is transported.

**5.** If there is any doubt as to the identity of the agent, the validity of the document, the extent of the authority of the agent, or if communications with OLMC cannot be established, continue **treatment per SOP and/or OLMC and transport ASAP.**

#### **V. LIVING WILLS AND PATIENT SURROGATES**

**A.** Illinois law has allowed terminally ill patients to instruct their physician, either directly with a Living Will (since 1983), or indirectly through a patient surrogate (since 1991), on their treatment in near-death situations.

**B.** A Living Will is a declaration to a physician and does not go into effect until the person who makes it is in a terminal condition. A terminal condition is defined as "an incurable and irreversible condition which is such that death is imminent and the application of death delaying procedures serves only to prolong the dying process." In order to create a Living Will, the author must be a competent adult and the document must be witnessed.

**C.** The Health Care Surrogate Act is enacted when an adult or minor: (1) lacks decisional capacity; (2) has a qualifying condition; and (3) has no Living Will or POA for Health Care.

**1.** Implementation of this act falls on the physician who must declare that the patient lacks decision-making capacity. The attending physician needs at least one physician consult who agrees that the patient has a qualifying condition. The surrogate is then nominated by the primary physician in the order of priority set by the law.

**2.** Prehospital providers shall not follow the instructions contained in a Living Will or given by any person purporting to be a surrogate for the patient unless affirmed by a medical control physician.

**VI. 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.

**VII. QUALITY IMPROVEMENT:** The System will review patient care reports where medical care has been withheld or withdrawn pursuant to a ILLINOIS POLST order through the PBPI process.

**VIII. EDUCATION:** System personnel will receive continuing education concerning the provision of these policies as changes in the law or System policy require or in response to sentinel events which reveal learning opportunities. Information shall be disseminated on the System website or through the In-Station continuing education program and to ECRNs through EMS CE at their hospitals.

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**IX. Other resources** relative to the governing provisions of law: Nursing Home Care Act Emergency Medical Services (EMS) Systems Act Hospital Licensing Act Illinois Living Will Act Health Care Surrogate Act Mental Health Treatment Preference Declaration Act Illinois Power of Attorney Act

For more information about the Illinois POLST form, or to download a Form, log onto  
<http://www.idph.state.il.us/public/books/advin.htm>



<b>Title of Policy:</b> <i>Infection Control/PPE</i>	<b>Policy Number:</b> IC100
<b>Effective Date:</b> 03/01/2020	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Infection Control	<b>Approvals:</b> MD, EMS sys

**Background to Policy:**

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

**Policy Statement:**

The following best practices are for the use of protective equipment; the cleaning and disinfecting techniques that have been established in accordance with the Centers for Disease Control. **Providers should wear the appropriate PPE on every patient encounter.** Type of PPE will be at the discretion of the provider.

**Policy:**

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

<b>Title of Policy:</b> <i>Infection Control/PPE</i>	<b>Policy Number:</b> IC100
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Infection Control	<b>Approvals:</b> MD, EMS sys

- v. Before reporting for duty, cover any cuts, abrasions, or insect bites with a dressing.

**c. Needles and Syringes**

- vi. Needles should be disposed of in a red biohazard, rigid, puncture-resistant container kept inside the back compartment of the ambulance. Needles should never be recapped or intentionally bent or broken. Also, a needle cutting device should not be used. There are new products on the market that employ a guard that automatically locks into place around the needle as you withdraw in from the patient. Your local ambulance distributor should be contacted for purchase of those devices.

**d. Cleansing of Ambulance and Equipment**

- vii. The ambulance and equipment used should be cleansed with a 1:10 bleach solution after each patient use or other commercially available cleaning solution approved for biohazards. Appropriate personal protective equipment should be used when cleaning any contaminated surface.

**e. Soiled Clothing**

- viii. According to the Center for Disease Control, they recommend the following: Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage. If hot water is used, linen should be washed with detergent in water at least 71° C (160°F) for 25 minutes. If low-temperature water (70°C [158°F]) in the laundry cycle is used, chemicals suitable for low-temperature washing at properly used concentration should be used.

**f. Masks**

- ix. Masks should be worn whenever there is direct contact with a patient that has a transmissible respiratory disease. Masks must also be worn when there is a risk of blood or body fluid splashing onto mucous membranes, such as when intubating or suctioning a patient, or when you are caring for a patient with major bleeding.

**g. Protective Eye Wear**

- x. Use of glasses or goggles is recommended when there may be splattering of blood or bodily fluids.

**h. Gloves**

- xi. Gloves should be utilized when there will be contact with blood or other body fluids from a patient. Any open cut or any skin dermatitis that leaves skin open (i.e., eczema, psoriasis) on pre-hospital care personnel should be covered with a sealed moisture proof covering. These precautions should be taken before the EMT leaves the ambulance to care for a patient.

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**i. Cardiopulmonary Resuscitation**

xii. Disposable resuscitating masks and one-way airways should be carried in all ambulances and easily retrievable when the need arises. **No one** should be administering unprotected mouth-to-mouth resuscitation.

xiii. Guidelines for Use of Protective Gear during CPR:

1. Gloves: The following types of gloves must be available to pre-hospital personnel

a. Heavy duty leather gloves for performing light extrication or assist with Extrication tasks.

b. Medical-grade gloves for patient care procedures that require dexterity and sensitivity but may involve contamination of the hands with blood or body fluids. Procedures may include IV insertions, dressing and splinting open injuries, and establishing airways.

2. Hepa Mask

a. If EMS personnel believe that blood or body fluids might be splashed in their face, they should utilize a medical-grade face mask.

3. Eye Protection

a. Plastic goggles are available for situations in which blood or body fluids could be splashed into the eyes, of such a design that allows clear vision and does not obstruct peripheral vision.

4. Airway management

a. Respiratory assist devices should be utilized whenever possible and are to be of a disposable type only.

**j. Sharps**

iii. Special care should be taken when handling sharp needles, objects, and glass. Needles should not be recapped, bent or broken. Needles and other sharp objects should be disposed of properly in the heavy puncture-proof plastic containers in the ambulance.

**k. Hand washing**

xiv. Hands are to be thoroughly washed after each patient transport and as soon as patient care allows. In the field, waterless hand cleaners and alcohol are available for hand washing; hands are to be thoroughly cleaned with soap and water as soon as the necessary facilities are available.

**l. Cleaning Procedures**

xv. Non-critical types of equipment such as spinal immobilization devices, stretchers, blood pressure cuffs, stethoscopes, etc. are to be thoroughly cleaned with hot water and disinfectant detergents, such as a 1:10 dilution of bleach.

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- xvi. Critical items that come in contact with mucous membranes but are not disposable, such as laryngoscope blades require high level disinfection with a Cidex or 70% Isopropyl alcohol solution for at least thirty (30) minutes.
- xvii. **Always wear gloves when cleaning and disinfecting pre-hospital equipment.**
- xviii. **Interior of Transport Vehicles**
  - 1. For the interior of transport vehicles, routine and consistent cleaning procedures with detergent disinfectants and hot water will provide adequate decontamination. The use of bleach is not recommended since repeated applications corrode metal and may damage some equipment.
- xix. **Care of Clothing**
  - 1. Routine laundering practices are adequate to decontaminate clothing that is soiled with blood or body fluids, utilizing hot water (106°F) and detergent.
  - 2. Routine laundering practices are adequate to decontaminate clothing that is soiled with blood or body fluids, utilizing hot water (106°F) and detergent.
- m. **Ineffective Procedures**
  - xx. All disinfectants require a clean surface before they can work.
  - xxi. The spraying of disinfectants is not recommended. Sprays are applied unevenly so that the amount sprayed may not disinfect the area adequately. Spray disinfectants can cause electrical equipment to malfunction.
- n. **Types of Disinfectants and Antiseptics:**
  - xxii. **Commercial available biohazard substance cleaning substances.**
  - xxiii. **Bleach**
    - 1. Uses
      - a. As a powerful anti-microbial agent, bleach is recommended for cleaning up fresh un-dried blood spills or surfaces that are difficult to clean. Good disinfectant for plastic materials.
    - 2. Concentration
      - a. 1:10 dilution (5000ppm) = 1 cup of bleach to 9 cups water (slightly more than ½ gallon).
    - 3. Contact time
      - a. Thirty (30) minutes.
    - 4. Precautions
      - a. Highly corrosive to metal even at low concentrations. Can hamper the function of electrical connections and electronic equipment. Can decolorize fabrics. Undiluted and 1:10 dilutions can cause eye, skin and respiratory irritations.

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**xxiv. Alcohol, 70% Isopropyl****1. Uses**

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

**2. Contact time**

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

**3. Precautions**

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

**xxv. Glutaraldehyde, 2%****1. Uses**

- a. Powerful disinfectant; can kill bacteria, fungi, viruses. Most commonly utilized for respiratory equipment disinfection. Can work in the presence of blood and dirt. Acid Glutaraldehyde does not corrode metal; most brands will not affect plastic or rubber.

**1. Contact time**

- b. Ten (10) to thirty (30) minutes for high-level disinfection.

**2. Precautions**

- c. Alkalized Glutaraldehyde will corrode and stain high-carbon metals such as stainless steel and leave residue on same. Unstable, expensive products that must be mixed freshly with each use to maximize effectiveness. Must never be used to disinfect environmental surfaces. Can cause burns on human skin and mucous membranes and are eye and respiratory irritants.

**xxvi. Hydrogen Peroxide****1. Uses**

- a. Good for dissolving dried blood and body fluids from the surfaces of equipment. Can be used as a skin and oral antiseptic.

**2. Concentration**

- a. 3%

**3. Contact time**

- a. Reacts immediately upon contact.

**4. Precautions**

- a. A 3% solution is not considered a disinfectant, so cleaning and decontamination are still required.

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**xxvii. Iodophors**

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

**xxviii. Phenolic and Quaternary Ammonium Compounds**

1. Uses
  - a. Common classes of hospital environmental disinfectants.
2. Concentration
  - a. See manufacturers' recommendation.
3. Contact time
  - a. See manufacturers' recommendation
4. Precautions
  - a. Should not be used to disinfect equipment; leave ionic residues; if used consistently for routine cleaning, these compounds must be stripped periodically from all surfaces. Affect the function of electrical and electronic equipment. Must be used exactly in accordance with label instructions. Material Safety Data Sheets should be obtained for these products.

**xxix. Detergent Disinfectants**

1. Uses
  - a. For cleaning and decontaminating environmental surfaces, non-critical equipment and laundering. Available in grocery stores. The words "disinfectant" and "detergent" are clearly visible on the label. Registered with the EPA because they are labeled as disinfectants.
2. Concentration
  - a. See label instructions.
3. Contact time
  - a. See label instructions.
4. Precautions
  - a. See label instructions.

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- b. Should not be used to disinfect equipment; leave ionic residues; if used consistently for routine cleaning, these compounds must be stripped periodically from all surfaces. Affect the function of electrical and electronic equipment. Must be used exactly in accordance with label instructions. Material Safety Data Sheets should be obtained for these products.

**iii. Detergent Disinfectants**

**1. Uses**

- a. For cleaning and decontaminating environmental surfaces, non-critical equipment and laundering. Available in grocery stores. The words “disinfectant” and “detergent” are clearly visible on the label. Registered with the EPA because they are labeled as disinfectants.

**2. Concentration**

- a. See label instructions.

**3. Contact time**

- a. See label instructions.

**4. Precautions**

- a. See label instructions.

**iv. Detergent Disinfectants**

**1. Uses**

- a. For cleaning and decontaminating environmental surfaces, non-critical equipment and laundering. Available in grocery stores. The words “disinfectant” and “detergent” are clearly visible on the label. Registered with the EPA because they are labeled as disinfectants.

**2. Concentration**

- a. See label instructions.

**3. Contact time**

- a. See label instructions.

**4. Precautions**

- a. See label instructions.

**o. Significant Exposure**

- v. **Definition:** Significant Exposure means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that resulted from the performance as an EMS provider.

**vi. Classifications of EMS Providers**

- 1. EMS Students
- 2. First Responders, EMT-B, EMT-I, EMT-P

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3. Other ambulance service personnel

vii. **Procedure for Exposure Incident**

1. Any EMS Students or EMS Systems member with significant exposure in the clinical setting (i.e. Emergency Department, ALS Unit...) must report the incident to their educational supervisor and the EMS System office.
2. Any EMT or other ambulance service/rescue personnel with significant exposure shall report the incident immediately to their agency supervisor, Director, Chief or Command Officer. The Individual must comply with the guidelines of their agency's "Exposure Control Program".
3. Complete a detailed incident report including, but not limited to the following:
  - a. Documentation of the route(s) of exposure, and the circumstance under which the exposure incident occurred;
  - b. Identification and documentation of the source individual.
4. Seek treatment at the emergency department of the hospital clinical site or where the source individual was transported, if transported to an emergency department.
5. If the patient was not transported to an emergency department, treatment should be sought at a local emergency department. NOTE: ***An EMS employer may require an individual to seek medical attention at a medical facility contracted with the EMS Agency to provide such services that is not an emergency department.***
6. Complete follow-up care as directed.

## Resources:

2. [https://www.ems.gov/pdf/workforce/Guide\\_Infection\\_Prevention\\_EMS.pdf](https://www.ems.gov/pdf/workforce/Guide_Infection_Prevention_EMS.pdf)
3. <http://www.emsworld.com/article/10322573/best-practices-infection-control>
4. <http://centegra.org/wp-content/uploads/2013/06/Infection-Control-Guidance-for-EMS-Providers.pdf>



<b>Title of Policy:</b> <i>In Field Service Level Upgrade (Only applies to agencies serving &lt;7500 people)</i>	<b>Policy Number:</b> O270
<b>Effective Date:</b> 09/2015	<b>Review Date:</b> 10/2022
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

### Security

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

<b>Title of Policy:</b> <i>In Field Service Level Upgrade (Only applies to agencies serving &lt;7500 people)</i>	<b>Policy Number:</b> O270
<b>Effective Date:</b> 09/2015	<b>Review Date:</b> 10/2022
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Equipment**

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

**Quality Improvement**

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

**Personnel**

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

**Special Considerations**

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

<b>Title of Policy:</b> <i>Interaction with Law Enforcement/Evidence</i>	<b>Policy Number:</b> O280
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2022
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### a. Arrival at the scene

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

### b. Treatment

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

<b>Title of Policy:</b> <i>Interaction with Law Enforcement/Evidence</i>	<b>Policy Number:</b> O280
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2022
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> <i>Interfacility/Interregional Transport Policy</i>	<b>Policy Number:</b> O290
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Background to Policy:**

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

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

**Policy Statement:**

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

**Policy:**

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

**\*\*\*\*\* Patients receiving narcotics prior to transfer MUST have Cardiac/Respiratory monitoring during transport. If the patient is serious enough to need pain management prior to, during, after transport, then patient must go by ALS Ambulance with Paramedic Provider attending.**

<b>Title of Policy:</b> <i>Interfacility/Interregional Transport Policy</i>	<b>Policy Number:</b> O290
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

#### **Levels of EMS providers:**

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

Minimum staffing: 2 EMT-Basic providers

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

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

#### **Fluids and Medication list:**

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

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

Foley catheters

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

Wound drains

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

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

BiPAP/Cpap- if trained

Morphine drips on pumps – if trained

Gravity Chest Tubes –

IV infusion pumps – if trained

Pain medication pumps-if trained

Portable ventilators-if trained

Chest tubes attached to suction

Nitroglycerin drips on pumps- if trained

Heparin drips on pumps - if trained

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 1: Request for Clarification (RFC); complaint investigation	<b>Policy Number:</b> D130
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

- I. Definition:** "Complaint" "means a report of an alleged violation of the Act or this Part by any System Participants or providers covered under the Act, or members of the public. Complaints shall be defined as problems related to the care and treatment of a patient" (Amended at 42 Ill. Reg. 17632, effective September 20, 2018).

## II. PURPOSE

**A.** A standardized mechanism to request clarification, report an occurrence, or report a complaint is intended to reduce morbidity and mortality and to improve the quality of patient care. All RFC activities and complaint investigation files fall under the auspices of continuous quality improvement and are thus protected under the Medical Studies Act [735 ILCS 5/8-2101].

**B.** While this policy provides a means for System members to report an occurrence, seek clarification, or report a complaint and for System representatives to document the results of their investigation and to report recommendations, it is not intended to replace face-to-face communication and the immediate resolution of a conflict.

## III. Initiate a Request for Clarification Form or file a complaint if one of the following occurs:

- A.** One party believes that a discrepancy exists between EMS standards of practice and EMS practitioner actions and/or OLMC orders. Either party may request a review of the run events for clarification as to compliance with standards.
- B.** Interference at the scene hampered EMS personnel in the performance of their duties.
- C.** A patient injury was sustained after the establishment of an EMS-patient relationship either during the course of treatment at the scene or during transport. If this injury was caused by a medical device malfunction, see Policy *Medical device failure* for further instructions.
- D.** An EMS team member was injured during the course of treatment at the scene or during transport. If this injury was caused by a medical device malfunction, see Policy *Medical device failure* for further instructions.
- E.** There is a question of missing valuables.
- F.** There is an indication of impaired behavior exhibited by EMS personnel. See **Policy I-4.**
- G.** The quality or nature of radio/phone communication is questioned.
- H.** An incident adversely affects or threatens to affect patient, personnel, or public relations.
- I.** There are multiple sustained complaints relative to non-compliance with standards.

## IV. Initiating an RFC

- A.** Consider if the incident also falls under the Reportable Incidents policy (R-7) If so, immediately report by telephone to the EMS MD or his designee to
1. avert an anticipated adverse outcome or occurrence.
  2. reduce or eliminate an impairment of services.
  3. reduce or eliminate a delay of service.
- B.** RFCs shall be initiated by the person(s) seeking review of an incident or clarification in writing.



<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 1: Request for Clarification (RFC); complaint investigation	<b>Policy Number:</b> D130
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

**C.** The original RFC form should be forwarded within 24 hours of the occurrence to the EMS Coordinator (EMSC) at OSF Saint James. A copy should be kept at the initiating person's Agency.

**D.** Upon receipt of an RFC, the EMSC/educator will conduct an investigation, obtain all records and/or data necessary to evaluate the situation and communicate their findings/ recommendations to the person(s) originating the RFC or complaint within five business days. EMSCs/educators may choose to use the attached RFC investigation form.

**E. Complain investigation:**

1. **Gather the facts.** Talk with all involved parties and get their statements. If there are witnesses to an occurrence, record their names and affiliations.
2. **Consult documents, laws, rules, and policies** that define standards of care, expected behaviors, and codes of conduct.
3. **Consider the nature of the infraction:**
  - a. Duty to avoid causing an unjustifiable risk or harm: "Don't do" allegation. Did the behavior cause a substantial and unjustifiable risk of harm for the safety of others?
  - b. Duty to follow procedural rule(s): Was the act or omission not aligned with program values or standards? Did the individual believe their act or omission was justified or insignificant?
  - c. Duty to produce an outcome: "What to do" allegation ("Expected behavior and by when" violation)
4. **Consider:** Was the duty known to the individual? Was it possible to produce the duty?
5. **Mitigating circumstances:** Factors relating to an allegation that do not bear on the question of culpability but are considered when determining the outcome and recommended actions. Was the alleged behavior culturally normalized (normalization of deviance)? Did the social benefit exceed the risk? Was there an explainable cause?
6. **Conduct a meeting** with the involved parties in a private space with program representative(s) and witnesses.
7. **Documentation:** All RFC and QI/complaint investigation forms shall be documented completely. DO NOT record any assumptions or opinions. Include only direct observations and substantiated facts as outlined on the form.

**F. Possible outcome recommendation of the investigation**

1. **Non-sustained/no action:** Evidence was insufficient to prove or disprove the complaint or allegation.
2. **Sustained:** Complaint or allegation was supported by sufficient evidence to justify disciplinary action. Determine if human error, at-risk behavior, or reckless behavior with or without willful defiance.
3. **Unfounded/not involved:** means the facts did not support the complaint or allegation (e.g., the complained-of conduct did not occur) or the individual was not involved in the incident (specify which one).
4. **Exonerated:** Means the complained-of conduct occurred, but the actions were deemed proper, within guidelines, or had mitigating circumstances that vacate disciplinary action.



<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 1: Request for Clarification (RFC); complaint investigation	<b>Policy Number:</b> D130
<b>Effective Date:</b>	<b>Review Date:</b>
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**G. Make a nature of error determination**

1. **Human error:** Unintentional mistake; requires remediation
2. **At-risk behavior:** Behaviors that individuals engage in, knowing on some level that it could risk safety. Requires corrective coaching.
3. **Reckless behavior/willful defiance:** conscious disregard for a substantial and unjustifiable risk. Disciplinary action warranted.

**H. If sustained, recommend possible consequences/disciplinary action**

1. **Verbal warning and remediation plan**
2. **Written warning with corrective coaching/action plan:** If the violation would not warrant immediate suspension, the EMSC/educator will work with the involved parties to design a corrective action plan that will require ongoing assessment and monitoring of behavior/performance approved by the System Manager.
3. **Final written warning** with a corrective action plan as above that may include restriction of practice and/or suspension recommended to IDPH, and with the caveat that serious consequences to licensure/practice will result if prohibited behaviors are repeated.
4. **Recommendation to take action on the individual's EMS license**

**I. Form processing:** A copy of the completed RFC and/or investigation form along with blinded copies of the ePCR and Communication Log (if patient-related) is to be sent to the EMS System Manager. A record of RFCs/QI reviews/complaints and their dispositions or recommendations shall be kept at the OSF Saint James EMS office. If the report sustains a complaint against any System member, a copy of the completed investigation form shall also be forwarded to the EMSC/educator who holds that individual's active EMS file.

## V. Reporting a complaint to IDPH

**A.** A person who believes that the Act or this Part may have been violated may submit a complaint by means of a telephone call, letter, fax, or in person. An oral complaint will be reduced to writing by the Department. The complainant is requested to supply the following information concerning the allegation:

1. Date and time or shift of occurrence;
2. Names of the patient, EMS personnel, entities, and other persons involved;
3. Relationship of the complainant to the patient or to the provider;
4. Condition and status of the patient;
5. Details of the situation; and
6. The name of the facility where the patient was taken.

**B.** All complaints shall be submitted to the Department's Central Complaint Registry or to the EMS MD. *Complaint registry hotline: 1-800-252-4343.* Complaints received by the EMS MD or Trauma Center MD shall be forwarded to the Department's Central Complaint Registry within five working days after receipt of the complaint. The substance of the complaint shall be provided in writing to the System participant or provider no earlier than at the commencement of an on-site investigation pursuant to subsection (e).

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 1: Request for Clarification (RFC); complaint investigation	<b>Policy Number:</b> D130
<b>Effective Date:</b>	<b>Review Date:</b>
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**C.** The Department and the EMS MD shall not disclose the name of the complainant unless the complainant consents in writing to the disclosure.

**D.** The Department may conduct a joint investigation with the EMS MD, EMS System Manager if a death or serious injury has occurred or there is imminent risk of death or serious injury, or if the complaint alleges action or conditions that could result in a denial, non-renewal, suspension, or revocation of licensure or designation. If the complaint alleges a violation by the EMS MD, System Manager, EMS Coordinator the Department shall conduct the investigation. If the complaint alleges a violation that would not result in licensure or designation action, the Department shall forward the complaint to the EMS MD for review and investigation. The EMS MD may request the Department's assistance at any time during an investigation. In the case of a complaint between EMS Systems, the Department will be involved as mediator or lead investigator.

**E.** The EMS MD shall forward the results of the investigation and any disciplinary action resulting from a complaint to the Department. Documentation of the investigation shall be retained at the hospital in accordance with EMS System improvement policies and shall be available to the Department upon request. The investigation file shall be considered privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101].

**F.** Based on the information submitted by the complainant and the results of the investigation conducted in accordance with subsection (e), the Department will determine whether the Act or this Part is being or has been violated. The Department will review and consider any information submitted by the System participant or provider in response to an investigation.

**G.** The Department will have final authority in the disposition of a complaint. Complaints shall be classified as "violation", "no violation", or "undetermined".

**H.** The Department will inform the complainant and the System Participant or provider of the complaint results (i.e., whether the complaint was found to be a violation, no violation, or undetermined) within 20 days after its determination. **I.** The EMS System shall have a policy in place requiring compliance with this Section.

**J.** An EMS System participant or provider who is dissatisfied with the determination or investigation by the Department may request reconsideration by the Department.

**K.** The investigative files of the EMS System and the Department shall be privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101], except that the Department and the involved EMS System may share information. The Department's final determination shall be public information subject to FOIA. (Source: Amended at 42 Ill. Reg. 17632, effective September 20, 2018)

**L.** The EMS MD shall be responsible for developing or approving a system form and submitting the following to the Department on a monthly basis:

1. Number of EMS patient care complaints including a brief synopsis of the issue;
2. Outcome of the system investigation; and
3. Names and license of the EMS personnel involved for sustained allegations. (515.330 EMS System Program Plan EMERGENCY rules 12-27-21)

**VI.** For repeated occurrences, a meeting will be requested with the parties involved, the Provider, EMS System Manager, and the EMS Coordinator/educator for re-education.

**VII.** All participants are entitled to full due process according to the grievance policies G-1 through G-3.

**Request for Clarification**

Date of occurrence:	Time of occurrence:		
Prehospital Provider:	Hospital:		
Patient initials (if applicable):	Patient age/Gender (if applicable):		
Persons involved in occurrence or requesting clarification:			
<b>Nature of Request/Occurrence: (Check all that apply)</b>			
<input type="checkbox"/> EMS Provider-related	<input type="checkbox"/> Deviations from SOPs	<input type="checkbox"/> Deviation from Policy	<input type="checkbox"/> E.D. Staff-related
<input type="checkbox"/> Equipment-related	<input type="checkbox"/> Patient-related	<input type="checkbox"/> Communications related	<input type="checkbox"/> Education-related
<input type="checkbox"/> Request clarification/review of incident		<input type="checkbox"/> Request review of patient outcome	

**Situation/Occurrence Facts:**

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Occurrence Reported To: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

**Action taken/feedback given at the time of the occurrence:**

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Forward to EMS Coordinator or System Manager

**Statement of investigation/clarification/recommended outcome by Hospital EMS Coordinator:**

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Statement of investigation/resolution by Resource Hospital (if necessary)**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

cc: Originator of Report; Provider Agency; Hospital EMS File

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 2 LOCAL SYSTEM REVIEW BOARD	<b>Policy Number:</b> D140
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

**Reference:** EMS Act (Section 3.40); EMS Rules Section 515.420 (a)-(k) Sept. 20, 2018. Board list options attached:  
Updated 3-10-22

## **I. POLICY**

Any individual, individual provider, or other participant suspended from participation by the EMS MD pursuant to the EMS Act, the EMS Rules or System Policy D-1, may request a hearing before a Local System Review Board prior to the terms of the suspension being implemented unless the nature of the allegation is so egregious that an Immediate Suspension is deemed necessary by the EMS MD. (See Policy D-1; System Participant Suspensions).

## **II. PROCEDURE**

### **A. REQUEST FOR A HEARING:**

Upon receipt of a Notice of Suspension the individual, individual provider or participant shall have 15 days to request a hearing before the Local System Review Board. This request shall be made in writing, via certified mail or personal service, to the EMS MD. Failure to submit a request in writing to the EMS MD within 15 days after the suspension notice has been received shall constitute a waiver of the right to a System Review Board hearing and the decision by the EMS MD shall be considered binding.

### **B. COMPOSITION OF THE SYSTEM REVIEW BOARD**

*The Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an ED physician with knowledge of EMS, and two who are of the same professional category as the individual, individual provider or other participant requesting the hearing. (Section 3.40(e) of the Act) The EMS MD shall prepare and post the Review Board list in a 24 hour accessible location on the System website. The list for the OSF Saint James EMS is located appended to this policy and is also available by contacting the EMS office.*

### **C. CONVENING A BOARD:**

The hearing shall commence as soon as possible but at least within 21 days after receipt of a written request for a hearing.

### **D. FAIR AND OBJECTIVE HEARING CONDUCTED UNDER ESTABLISHED RULES**

A hearing held by the System need not be formal in legal terms, nor need it adhere to established rules of evidence. The hearing shall be conducted in a fair and impartial manner under procedures outlined below:

- 1. Option of representation:** Each party to the proceedings shall have the right to select a person to represent him or her and be present at the hearing at his or her own expense. Any rights of participation, review or commentary extended to the Counsel for the EMS System will be similarly extended to the same degree to Counsel for the suspended participant.
- 2. Questioning by panel members:** At the hearing, the suspended participant will present his or her case before the Board. The Board will direct questions to all concerned parties in order to gather all of the facts and pertinent information.

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 2 LOCAL SYSTEM REVIEW BOARD	<b>Policy Number:</b> D140
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**3. Submission of evidence:** The Board shall review and consider any testimony and documentation related to the issue at hand which is offered by either party to the suspension issue. Only current allegations may be presented unless previous information illustrates a pattern of behavior or practice. The suspended participant shall have the right to submit evidence explaining or refuting the charges as well as the right to cross-examine the witnesses.

**4. Record of the proceedings:** The EMS MD shall arrange for a certified shorthand reporter to make a stenographic record of the hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during such hearing, and the System Review Board's written decision shall be retained in the custody of the EMS System (Resource Hospital).

**5. Open vs. closed hearing:** The suspended individual or individual provider and the EMS MD will be allowed to listen to all testimony but will not be allowed admittance to the discussion and decision process of the Board. However, they may be present after the decision is reached and the Board's recommendations are announced, if the decision can be reached immediately.

**6. Times when witnesses may be present:** Witnesses may only be present during their testimony or when making their statement, and shall be instructed not to discuss the situation with any other witnesses.

**7. Confidentiality of Board proceedings:** All information relating to the Board, except final decisions, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure. Disclosure of such information to IDPH pursuant to the EMS Act shall not be considered a violation of Article VIII, Part 21 of the Code of Civil Procedure.

**E. TIMELY, FAIR DECISION BASED ON THE EVIDENCE**

The Board shall state in writing its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS MD and the individual, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing detailing the Board's findings for each charge or issue and citing the evidence to support their decision.

**F. BINDING NATURE OF BOARD'S DECISIONS:**

*The System shall implement a decision of the Local System Review Board unless that decision has been appealed to the State EMS Disciplinary Review Board in accordance with the EMS Act and the Rules (Section 3.40(e) of the Act*

**G. NOTICE to IDPH:**

The EMS MD shall notify IDPH, in writing, within five business days after the board's decision to uphold, modify or reverse the EMS MD's suspension order of an individual, individual provider or participant has been received. The notice shall include a statement detailing the duration and grounds for the suspension.

**H. APPEAL**

**1.** If the Local System Review Board affirms or modifies the EMS MD's suspension order, the individual, individual provider or other participant shall have the opportunity for a review of the Local Board's decision by the State EMS Disciplinary Review Board pursuant to Section 3.40(b)(1) of the Act.

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 2 LOCAL SYSTEM REVIEW BOARD	<b>Policy Number:</b> D140
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2. If the Local System Review Board reverses or modifies the EMS MD's suspension order, the EMS MD shall have the opportunity for a review of the local Board's decision by the State EMS Disciplinary Review Board, pursuant to Section 3.40(b)(2) of the EMS Act.

3. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the IDPH Division of EMS and HW 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).

**III. A suspension (other than an immediate suspension) shall commence only upon the occurrence of one of the following:**

- A.** The System member or provider has waived the opportunity for a hearing before the local system review Board; or
- B.** The suspension order has been affirmed or modified by the local Board and the individual or individual provider has waived the opportunity for review by the State Disciplinary Review Board; or
- C.** The suspension order has been affirmed or modified by the local Board, and the local Board's decision has been affirmed or modified by the State Board.

*Note:* A recommendation to the Department by the EMS MD to deny, suspend, or revoke the license of a participant within the OSF Saint James EMS System is not subject to the provisions of the Suspension subpart of the Rules unless such recommendation forms the basis for suspension pursuant to the EMS Rules.

<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 3 STATE DISCIPLINARY REVIEW BOARD	<b>Policy Number:</b> D150
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

**Reference:** IDPH EMS Rules Section 515.440: State EMS Disciplinary Review Board (June 25, 1998)

- I. **Function of the State EMS Disciplinary Review Board:** To review and affirm, reverse, or modify an EMS Medical Director's (EMS MD's) orders to suspend an EMT or other individual provider from participating within an EMS System.
- II. **Opportunity to request a hearing**
  - A. Any individual, individual provider, or other participant who received an immediate suspension from the EMS MD may request the State Board to reverse or modify the suspension order.
  - B. An individual, individual provider or other participant who received a non-immediate suspension order from an EMS MD which was affirmed or modified by a Local System Review Board, may request the Board to reverse or modify the local Board's decision.
  - C. An EMS MD whose suspension order was reversed or modified by a local System Review Board may request the Board to reverse or modify the local Board's decision.
  - D. Such a request shall be made in writing to the Chief of the Department's Division of EMS and Highway Safety, within 10 days after either receiving the local Board's decision or the EMS Medical Director's suspension order. A copy of the EMS MD's written suspension order and/or the Board's decision shall be enclosed.
- III. **Composition of the State Review Board:** The Governor shall appoint a State EMS Disciplinary Review Board, composed of an EMS MD, an EMS System Coordinator, an EMT-P, an EMT-B, and the following members, who shall only review cases in which a party is from the same professional category: a PHRN, an ECRN, a TNS, an EMT-I, a representative from a public vehicle service provider, and an emergency physician who monitors telecommunications from and gives voice orders to EMS personnel.
- IV. **Convening a Board**
  - A. The Board shall meet on the first Tuesday of every month, unless no requests for review have been submitted. Additional meetings of the Board shall be scheduled as necessary to insure that a request for direct review of an immediate suspension order is scheduled within 14 days after the Department receives the request for review or as soon thereafter as a quorum is available. The Board shall meet in Chicago or Springfield, whichever location is closer to the majority of the members or alternates attending the meeting. At its regularly scheduled meetings, the Board shall review requests which have been received by IDPH at least 10 working days prior to the Board's meeting date. Requests for review which are received less than 10 working days prior to a scheduled meeting shall be considered at the Board's next scheduled meeting, except that the requests for direct review of an immediate suspension order may be scheduled up to 3 working days prior to the Board's meeting date (Section 3.45(i) of the Act).
  - B. A quorum shall be required for the Board to meet, which shall consist of 3 members or alternates, including the EMS MD Board 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 members or alternates present shall select a Chairperson to conduct the meeting.



<b>Title of Policy:</b> GRIEVANCE RECOURSE STEP 3 STATE DISCIPLINARY REVIEW BOARD	<b>Policy Number:</b> D150
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Discipline	<b>Approvals:</b> MD, System

**C. Board deliberations**

1. The Board shall deliberate decisions in closed session. IDPH staff may attend for the purpose of providing clerical assistance, but 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.
2. The Board shall review the transcripts, evidence and written decision of the local review board or the written decision and supporting documentation of the EMS MD, whichever is applicable, along with any additional written or verbal testimony or argument offered by the parties to the dispute.
3. At the conclusion of its review, the Board shall issue its decision and the basis for its decision on a form provided by the Department, and shall submit to the Department its written decision together with the record of the Local System Review Board. The Department shall promptly issue a copy of the Board's decision to all affected parties.

**V. Binding nature of the Board's decision: The Board's decision shall be binding on all parties.**



<b>Title of Policy:</b> Latex Free Supplies Allergies (EMS)	<b>Policy Number:</b> O300
<b>Effective Date:</b> 10/1/2015	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## PURPOSE

A latex allergy is recognized as a significant problem for specific patients and healthcare workers. There are two (2) types:

- **Systemic** – Immediate reaction (within 15 minutes). Symptoms include generalized rash, wheezing, dyspnea, laryngeal edema, bronchospasm, tachycardia, angioedema, hypotension, and cardiac arrest.
- **Delayed** – Delayed reaction (6 to 48 hours). Symptoms include contact dermatitis such as local itching, edema, erythema (redness), blisters, drying patches, crushing & thickening of the skin, and dermatitis that spreads beyond the skin initially exposed to the latex. Persons at risk include patients with spina bifida, patients with urogenital abnormalities, workers with industrial exposures to latex, healthcare workers, persons with multiple surgeries, persons with frequent urinary procedures and persons with a history of predisposition to allergies.

## POLICY

All EMS providers should try to obtain latex free supplies/equipment for patient use. For times when this is not applicable, the agencies and providers should try to mitigate the possible contamination to patient.

### Suspected Latex Allergy

1. Assess for suspected latex sensitivity by asking the following:  
*“Do you react to rubber bands or balloons? Describe.”*
2. Initiate interventions for Known Latex Sensitivity if the latex sensitivity screen response suggests a latex hypersensitivity.
3. Notify the receiving hospital of suspected latex hypersensitivity.
4. Follow orders as per the Allergic/Anaphylactic Reaction Protocol.

### Known Latex Allergy

1. Obtain a patient history and ask the patient to describe their symptoms of latex hypersensitivity.
2. Monitor the following signs and symptoms:
  - Itching eyes
  - Feeling of faintness
  - Hypotension
  - Bronchospasm/Wheezing
  - Nausea/Vomiting
  - Abdominal cramping
  - Facial edema
  - Flushing
  - Urticaria
  - Shortness of breath

<b>Title of Policy:</b> Latex Free Supplies Allergies (EMS)	<b>Policy Number:</b> O300
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- Generalized itching
- Tachycardia
- Feeling of impending doom

3. Notify the receiving hospital of known latex sensitivity.
4. Follow orders as per the Allergic/Anaphylactic Reaction Protocol.
5. Remove all loose latex items (e.g. gloves, tourniquets, etc.) and place in a closed compartment or exterior storage panel.
6. Utilize available latex-free supplies when preparing to care for or transport the latex-sensitive patient. The latex-free supplies must be on the ambulance (or other apparatus) and readily available.
7. Cover the mattress of the cot with a sheet so that no areas of the mattress are exposed.
8. DO NOT administer any medications through latex IV ports.
9. Wrap all tubing containing latex in kling before coming into contact with the patient (e.g. stethoscope tubing, BP cuff tubing, etc.).

<b>Title of Policy:</b> <i>Licensure Reinstatement Policy</i>	<b>Policy Number:</b> L120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Licensure	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Licensure Reinstatement Policy</i>	<b>Policy Number:</b> L120
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Licensure	<b>Approvals:</b> MD, System

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

## Resources:

1. [IDPH 515.640 Reinstatement](#)

<b>Title of Policy:</b> <i>Line of Duty Death</i>	<b>Policy Number:</b> O310
<b>Effective Date:</b> 06/01/2016	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Background to Policy:**

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

**Policy Statement:**

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

**Policy:**

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

<b>Title of Policy:</b> <i>Mass Casualty Incident Policy</i> (Crisis response and medical surge policy)	<b>Policy Number:</b> O320
<b>Effective Date:</b> 10/7/2020	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**I. General Policy**

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

**II. Command and Control**

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

**III. Responsibilities**

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

<b>Title of Policy:</b> <i>Mass Casualty Incident Policy</i> (Crisis response and medical surge policy)	<b>Policy Number:</b> O320
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**B. Triage**

1. The immediate area where rescue operations and initial patient evaluation is being performed. Multiple triage teams may be necessary depending on the magnitude of the incident. Responsibilities include:
  - a) Identify and prioritize mitigation of scene hazards
  - b) Identify and categorize patients on scene using the START triage system
  - c) Manage the disposition of victims who are obviously deceased

**B. Treatment/Casualty Collection Point (CCP)**

1. An area located a safe convenient distance from the triage area where victims are taken for pre transport stabilization. Secondary and ongoing triage shall be performed in this area. This team can be divided by patient triage category IE Red, Yellow, Green Responsibilities include:
  - a) Secondary and ongoing triage
  - b) Pre transport treatment and packaging
  - c) Determine the level and type of transportation required and communicate this information to the transport team leader.
  - d) Supervise the delivery of patients to the transport area

**C. Staging**

1. An area where personnel, ambulances and fire apparatus report to prior to being assigned. The level and number of staging areas will be determined by the size and magnitude of the incident.  
Responsibilities include:
  - a) Determine the level of staging
  - b) Maintain a record of the names of all personnel deployed at the incident and record the amount and type of equipment managed by staging
  - c) Maintain a reserve of at least one ambulance, and a sufficient number of other resources as may be required
  - d) Request and deploy additional resources as needed

**D. Transport**

1. A separate area adjacent to the treatment area where the packaged patient is assigned to an ambulance for transportation to a medical facility Responsibilities include:
  - a) Ensure a communications link is established and maintained with the Resource Hospital
  - b) Notify Resource Hospital of the types and numbers of casualties including any special hazards e.g. hazardous materials
  - c) Obtain the patient's hospital destination from Medical Control and write the destination on the patients triage tag

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- d) Assign and arrange patient transportation using the patient's triage category and Resource Hospital assignment as indicated on the triage tags
- e) Maintain a record of the patients transported and their respective destinations
- f) Keep staging informed of estimated transport needs

#### **IV. Operational Phase**

**A.** To achieve maximum effectiveness and efficiency certain objectives must be met with each response. These objectives are outlined below and later described as operational phases. These phases are not intended to be a "step by step" requirement. These phases describe a flow of operational objectives or events that should be met to help ensure the best possible management of a mass casualty incident.

- 1. Initial agency response
- 2. Establishment of incident command
- 3. Scene report
- 4. MCI declaration
- 5. Secondary response
- 6. Continued incident management
- 7. Release/ termination
- 8. Incident documentation/ review

**B. Phase 1- Initial agency response**

- 1. Upon receipt of a call for service by the agency's dispatch center, the primary jurisdiction shall be dispatched and provided all pertinent call information in accordance with established protocols and policies. The primary agency responding, based on dispatch information may declare a MCI or choose to wait until a scene assessment has been made.

**C. Phase 2 - Establishment of command**

- 1. Incident command shall be established by the first arriving unit. This person will remain in command until relieved by a person of higher rank, training, and or experience. Regardless of **who the incident commander is they should not be directly involved in patient care or triage**

**D. Phase 3 - Scene report**

- 1. As soon as the pertinent information is collected the following information should be communicated to the agency's dispatch center
  - a) Location of incident ( to become incident name)
  - b) Type of incident
  - c) Hazards
  - d) Casualty Estimates
  - e) Primary casualty types
  - f) Initial access
  - g) MCI declaration



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**E. Phase 4 - MCI declaration**

1. Once it has been determined that the incident meets the definition of a MCI as defined by this policy the incident commander will ensure the resource hospital and EMS system Manager/coordinator are notified. The agency's dispatch center will dispatch resources as requested by the incident commander following the agencies EMS run cards.

**F. Phase 5 - Secondary response**

The secondary response is defined as the units responding per run card assignments or special call by the incident commander. Responding units shall report to the designated staging area or assignment. Personnel shall stay with their unit and maintain crew integrity with exception made for incoming command staff requested to assist in unified command or To achieve maximum effectiveness and efficiency certain objectives must be met with each response. These objectives are outlined below and later described as operational phases. These phases are not intended to be a "step by step" requirement. These phases describe a flow of operational objectives or events that should be met to help ensure the best possible management of a mass casualty incident.

1. Initial agency response
2. Establishment of incident command
3. Scene report
4. MCI declaration
5. Secondary response
6. Continued incident management
7. Release/ termination
8. Incident documentation/ review

**G. Phase 1- Initial agency response**

1. Upon receipt of a call for service by the agency's dispatch center, the primary jurisdiction shall be dispatched and provided all pertinent call information in accordance with established protocols and policies. The primary agency responding, based on dispatch information may declare a MCI or choose to wait until a scene assessment has been made.

**H. Phase 2 - Establishment of command**

1. Incident command shall be established by the first arriving unit. This person will remain in command until relieved by a person of higher rank, training, and or experience. Regardless of who the incident commander is they should not be directly involved in patient care or triage

**I. Phase 3 - Scene report**

1. As soon as the pertinent information is collected the following information should be communicated to the agency's dispatch center
  - a) Location of incident ( to become incident name)
  - b) Type of incident
  - c) Hazards
  - d)

<b>Title of Policy:</b> <i>Mass Casualty Incident Policy</i> (Crisis response and medical surge policy)	<b>Policy Number:</b> O320
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- e) Casualty Estimates
- f) Primary casualty types
- g) Initial access
- h) MCI declaration

**J. Phase 4 - MCI declaration**

1. Once it has been determined that the incident meets the definition of a MCI as defined by this policy the incident commander will ensure the resource hospital and EMS system Manager/coordinator are notified. The agency's dispatch center will dispatch resources as requested by the incident commander following the agencies EMS run cards.

**K. Phase 5 - Secondary response**

1. The secondary response is defined as the units responding per run card assignments or special call by the incident commander. Responding units shall report to the designated staging area or assignment. Personnel shall stay with their unit and maintain crew integrity with exception made for incoming command staff requested to assist in unified command or to staff a position in the command structure. Responders are not to report on scene and begin an operation without being properly assigned and accounted for. Freelancing will hinder the effectiveness of the operation and put responders or other victims at risk.

**L. Phase 6 - Continued incident management**

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

**M. Phase 7 – Release / termination**

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

**N. Phase 8 Incident documentation / review**

1. Incident documentation will be coordinated through the EMS office. The primary responding agency will be responsible for overall documentation. Each responding unit will be responsible for the documentation of the patients they transport.
2. After every MCI a review shall be conducted. These reviews will be used solely to address the effectiveness of the system and modify the system or components as needed. The review can also identify objectives regarding MCI operations. Each participating agency (inclusive of law enforcement, dispatch, hospitals etc.) will be asked to be represented in the review.

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**V. Operational considerations****A. Triage**

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

**B. Treatment**

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

**C. Transport**

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

**D. Patient tracking**

1. Transport leader
  - a) The transportation leader on scene is responsible for ensuring that patient data including triage tag number, name (if available) triage category, transporting unit and destinations is recorded and that the information is accurate and current
2. Transport unit
  - a) The transport unit is responsible for ensuring that patient data including triage tag number, name (if available) triage category, assessment, care provided and destination is documented

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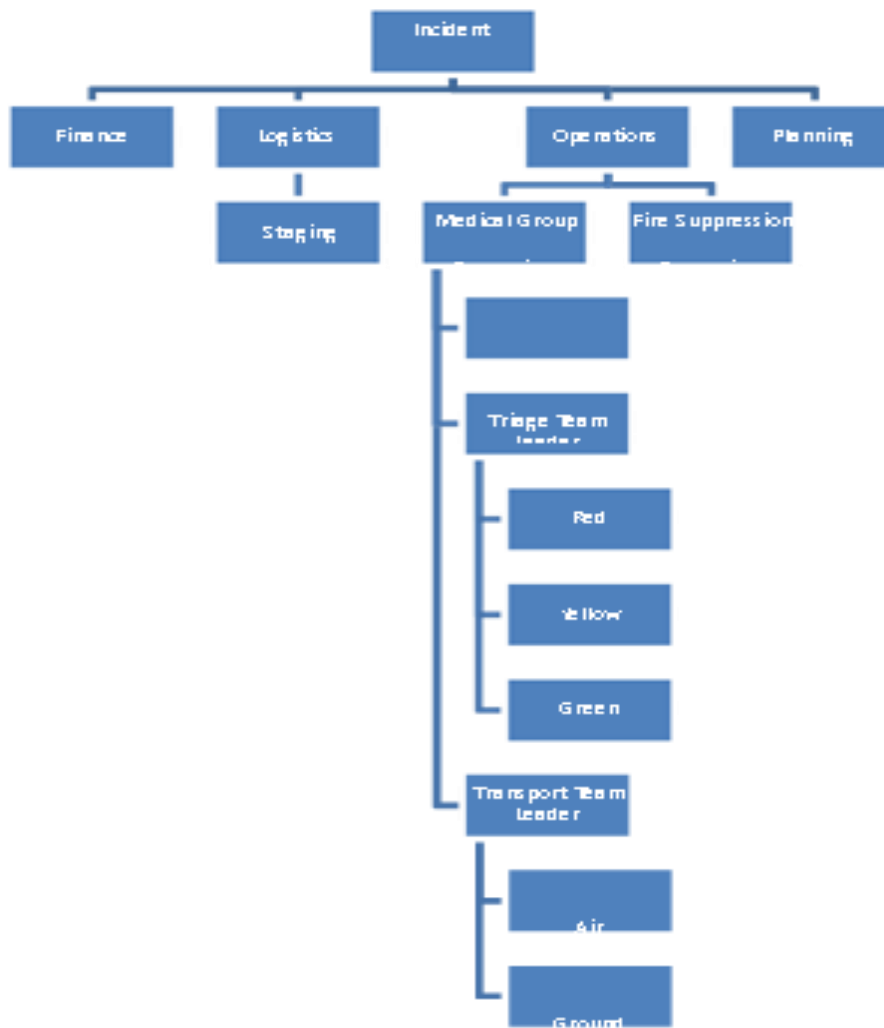
**E. Responding transport units**

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

**VI. Agency requirements**

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

## VII. Sample Organization Chart



<b>Title of Policy:</b> <i>Medical Control- Operational Control Point</i>	<b>Policy Number:</b> CON100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Communications	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Medical Control- Operational Control Point</i>	<b>Policy Number:</b> CON100
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Communications	<b>Approvals:</b> MD, System

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

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

### Resources:

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

<b>Title of Policy:</b> <i>MERCI Radio Operations</i>	<b>Policy Number:</b> CON110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Communications	<b>Approvals:</b> MD, System

## Policy Background:

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

## Policy Statement:

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

## Policy:

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



<b>Title of Policy:</b> Medical Device Failure/Malfunction	<b>Policy Number:</b> LE140
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## I. LEGISLATIVE MANDATE

- A. Medical device reporting (MDR) is intended to help the U.S. Food and Drug Administration (FDA) identify medical device problems that pose a threat to public health and safety.
- B. On December 11, 1995, the Food and Drug Administration (FDA) issued its final rule on medical device reporting (FedRegist 1995 Dec. 11; 60[237]:63578-606) under the Safe Medical Devices Act (1990). This rule expanded the existing requirements for medical device reporting, record keeping, confidentiality, mandatory forms, coding manuals, written policies and procedures, and includes new definitions.
- C. Under the Safe Medical Devices Act of 1990 (SMDA) and the FDA Modernization Act of 1997 (FDAMA), mandatory reporters are required to report to FDA and/or the device manufacturer certain adverse events and/or product problems involving medical devices. Device-related incidents that must be reported include deaths and serious injuries and illnesses.
- D. In addition, the FDA also encourages health care professionals, patients, caregivers and consumers to submit voluntary reports about serious adverse events that may be associated with a medical device, as well as use errors, product quality issues, and therapeutic failures. These reports, along with data from other sources, can provide critical information that helps improve patient safety.
- E. Mandatory reports are to be made as soon as practicable but no later than 10 work days after the user facility becomes aware of a reportable event. Reports of death must be submitted directly to FDA, and a copy of the report must be sent to the manufacturer, if known. Reports of serious illness or serious injury must be submitted to the manufacturer or, if the manufacturer is unknown, to FDA. In addition, user facilities must provide an annual summary of their mandatory device-related event reports to FDA.
- F. All mandatory reporter agencies must develop and implement a written MDR program. The program should assign responsibility for reporting, identify tasks to be assigned, outline documentation requirements, and detail the flow of information.
- G. Penalties for non-compliance: Failure to comply with FDA medical device reporting (MDR) requirements can result in hefty penalties (e.g., civil money penalties of \$15,000 for each violation, up to a maximum of \$1 million for all violations adjudicated in a single proceeding), civil injunctions, or criminal prosecutions.

## II. DEFINITIONS

- A. Caused or contributed: A death or serious injury was or may have been attributed to a medical device, or a medical device was or may have been a factor in a death or serious injury.
- B. Medical device: any instrument, apparatus, or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body. This includes disposable and non-disposable products such as catheters, laryngoscope blades, patient restraints and syringes.
- C. Serious injury: An injury or illness that is life-threatening; results in permanent impairment of a body function or permanent damage to a body structure; or necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure

<b>Title of Policy:</b> Medical Device Failure/Malfunction	<b>Policy Number:</b> LE140
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

### III. POLICY

A. The OSF Saint James EMS System embraces a culture of safety. This includes a reporting culture in which there is an emphasis on all members reporting incidents that could have or did impact worker/patient safety and/or patient care and a just culture where there is an emphasis on trust where members are encouraged to report without fear of retaliation.

B. EMS personnel must submit a report as soon as practical but no longer than 10 work days after they receive or otherwise become aware of information, from any source, that reasonably suggests that a device, drug, or ambulance did not function/operate as intended (malfunction and/or failure) and:

1. did not affect patient care;
2. affected patient care but caused no harm; or
3. affected patient care and may have caused or contributed to harm including serious injury or death. This includes, but is not limited to, events occurring as a result of user error and ambulance crashes within the line of duty.

C. Deaths must be reported to the FDA and the manufacturer, if known. Serious injuries must be reported to the manufacturer or to the FDA if manufacturer is unknown.

D. In any situation involving a medical device failure or malfunction, immediate steps shall be taken to ensure the health and safety of the patient and the healthcare providers.

E. Immediate action shall be taken to preserve the medical device as it was at the time of the occurrence, to document the condition/status of the device pending an inspection and report by the manufacturer.

### IV. PROCEDURE — all malfunctions and/or failures while caring for a patient

A. Actions at the time of malfunction:

1. Attend to the medical and safety needs of the patient or the injured parties, removing them from the area if necessary and treating per SOPs.
2. Immediately remove the malfunctioning device from active service. DO NOT toss any part into the trash. Preserve the device precisely as it was at the time of the malfunction/failure, including attachments and/or disposable items. Do not change any settings or disconnect any attachments. Save all parts if an item breaks into pieces. Return to Agency's Provider EMS Coordinator for analysis by the manufacturer.
3. Document objective, pertinent information regarding the patient's condition, description of the event, and medical interventions taken on the patient care report.
4. DO NOT make any reference to the fact that an incident report was completed on the patient care report.
5. DO NOT make any judgments or conclusions regarding the cause of the occurrence on the patient care report.

<b>Title of Policy:</b> Medical Device Failure/Malfunction	<b>Policy Number:</b> LE140
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**B. NOTIFICATIONS and Communication** - Documentation requirements

1. Contact immediate supervisor as soon as patient safety and care is ensured.
2. NOTIFICATION TO EMS MD
  - a. These are all reportable incidents. The EMS MD must be notified each time there is a device malfunction/failure/ambulance crash in the line of EMS duty.
  - b. If malfunction caused or contributed to a death or serious injury to patient or crew: Contact EMS MD immediately (1) Dr. Michael Daley; cell: (646)942-8789 (2) If EMS MD is not reachable within 30 minutes, page the EMS System Manager at (815)848-6565
  - c. All others: Contact EMS MD by e-mail ([michael.n.daley@osfhealthcare.org](mailto:michael.n.daley@osfhealthcare.org) )
3. Complete the Medical Device/Ambulance Malfunction/Failure Report appended to this policy whenever they are aware of information, from any source, that reasonably suggests that a device, drug, or ambulance has or may have malfunctioned or failed whether or not it involved patient care or an injury. If patient involved: Complete report as soon as patient care is appropriately transferred to the receiving hospital. Be as specific as possible.

**C. Investigation / evaluation**

1. EMS Agency: Complete a thorough investigation of the occurrence, interviewing all crew present at the time of the incident and the patient, if necessary.
  - a. Pull all manufacturers' product specifications, preventive maintenance records and repair records for review during the investigation.
  - b. Contact the manufacturer's representative or contracted service agreement agency to perform an inspection.
  - c. Complete a thorough inspection of the device in accordance with manufacturer's specifications and document in accordance with EMS Agency policy.
  - d. Photographs may be taken of the device, drug, or ambulance if they would enhance the written description.
  - e. Append the manufacturer's analysis to the Medical Device Failure/ Malfunction Report as soon as it is received.
  - f. Forward the preliminary report to the OSF Saint James EMS office within 72 hours of the event. Fax: 815-842-4995 or send an electronic copy to [Andrew.r.larsen@osfhealthcare.org](mailto:Andrew.r.larsen@osfhealthcare.org) who shall forward to the EMS MD.
2. EMS System
  - a. The System must track all incidents of malfunction/failure to perform an informed risk/benefit analysis prior to determining if a product should be recalled from System use.
  - b. The System will maintain records of MDR events and correspond with manufacturers as EMS MD deems necessary.
  - c. The device shall only be returned to service upon approval of the EMS MD.

<b>Title of Policy:</b> Medical Device Failure/Malfunction	<b>Policy Number:</b> LE140
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

**D. Records retention**

1. Providers must establish and maintain Medical Device Reporting (MDR) event files that contain information related to the adverse event, documentation of deliberations and decision-making processes, copies of forms, and other information submitted to the manufacturer, FDA and others.
2. These records must be retained in an MDR event file for a period of two years.
3. FDA employees are permitted to access, copy, and verify the records in the MDR event file.

**V. FDA Reporting – See end of policy for details**

- A. If it is determined by the EMS MD that the medical device caused or contributed to a patient or healthcare worker's death or resulted in serious illness or injury, a report must be submitted to the FDA Med Watch VOLUNTARY reporting of adverse events form 3500 (12- 11) or the FDA Med Watch MANDATORY reporting of adverse events form 3500A.
- B. These reports are to be made as soon as practical, but not later than 10 working days after the provider becomes aware of the information. A provider "becomes aware" when medical personnel or employees acquire such information about a reportable event.
- C. For assistance in completing FDA form 3500 A, contact the EMS System Manager for full instructions and a list of codes
- D. If there is any dispute regarding the cause of the equipment failure or malfunction, a review panel comprised of at least the crew members present at the time of the occurrence, the Chief or his designee, the EMS MD and a Biomedical Engineering manager shall meet to review the details of the occurrence and make a determination if the medical device caused or contributed to a patient's death, serious illness or injury.
- E. Semiannual reports or electronic equivalents must be submitted by the EMS Agency to the FDA by January 1 for reports made July through December, and by July 1 for reports made January through June of each year. If no reports are submitted to either the FDA or a manufacturer during these six month time periods, no semiannual report is required.

**VI. Ambulance malfunction/failure/crash in the line of duty**

- A. If at any time an ambulance is unexpectedly taken out of service and unable to complete a run, either enroute to or during a call due to malfunction/failure or crash, notify the EMS MD per this policy and complete the Equipment Malfunction/Failure form as soon after the event as possible and forward to the NWC EMS Office on the same shift as the incident occurrence. Review of these incidences is considered continuous quality improvement, and, as such is protected under the Medical Studies Act.
- B. In all cases of ambulance malfunction/failure enroute to a call, a second ambulance or licensed EMS non-transport vehicle shall be called that can arrive within normal response times under Illinois law to begin care. If an ambulance or licensed EMS non-transport vehicle cannot respond within 6 minutes in their primary service area for a 9-1-1 call, the provider agency must attempt to notify the person requesting aid and inform them of the anticipated delay.

<b>Title of Policy:</b> Medical Device Failure/Malfunction	<b>Policy Number:</b> LE140
<b>Effective Date:</b>	<b>Review Date:</b>
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## FDA information

**Mandatory Medical Device Reporting Requirements:** The Medical Device Reporting (MDR) regulation (21 CFR 803) contains mandatory requirements for manufacturers, importers, and device user facilities to report certain device-related adverse events and product problems to the FDA.

**Voluntary Medical Device Reporting:** The FDA encourages healthcare professionals, patients, caregivers and consumers to submit voluntary reports of significant adverse events or product problems with medical products to MedWatch, the FDA's Safety Information and Adverse Event Reporting Program or through the MedWatcher mobile app.

### How to Report a Medical Device Problem:

Medical device reports are submitted to the FDA by mandatory reporters (manufacturers, importers and device user facilities) and voluntary reporters (health care professionals, patients, caregivers and consumers).

**Mandatory Reporting for Manufacturers, Importers and Device User Facilities (Form FDA 3500A):** Find information and instructions for mandatory device reporting at:

- Reporting Medical Device Adverse Events for Manufacturers, Importers and Device User Facilities
- Instructions for Completing Form FDA 3500A
- eMDR- Electronic Medical Device Reporting
- Draft Guidance for Industry and Food and Drug Administration Staff: Medical Device Reporting for Manufacturers
- FDA Guidance: Medical Device Reporting for User Facilities (PDF Only) (PDF - 313KB)
- For Questions about Medical Device Reporting, including interpretation of MDR policy: Call: (301) 796-6670
- Email: [MDRPolicy@fda.hhs.gov](mailto:MDRPolicy@fda.hhs.gov)

Title of Policy: Missed Call by Primary Agency	<b>Policy Number: DOC110</b>
Effective Date: 01/01/2020	<b>Review Date: 10/07/2019</b>
Policy Area: Documentation	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

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

<b>Title of Policy:</b> Mutual Aide Services	<b>Policy Number:</b> O330
<b>Effective Date:</b> 05/17/17	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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



<b>Title of Policy:</b> <i>Notification of Ambulance Personnel of Exposure to Communicable Disease</i>	<b>Policy Number:</b> IC110
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Infection Control	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

## Resources:

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



<b>Title of Policy:</b> <i>Patient Abandonment vs. Prudent Use of EMS Personnel</i>	<b>Policy Number:</b> LE150
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD/System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Patient Abandonment vs. Prudent Use of EMS Personnel</i>	<b>Policy Number:</b> LE150
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD/System

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

<b>Title of Policy:</b> <i>Patient Confidentiality/Release of Information</i>	<b>Policy Number:</b> A140
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Administration	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

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

## 2. Verbal

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

## 3. Radio

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

## D. Scene

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

<b>Title of Policy:</b> <i>Patient Hospital Preference</i> (Behavioral Health Center, Appropriate Facility)	<b>Policy Number:</b> O340
<b>Effective Date:</b> 08/01/2023	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Background to Policy:**

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

**Policy Statement:**

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

**Alternative destination Transports:**

OSF Saint James EMS believes that most patients should be transported to the closest **appropriate** facility. The patient with legal and decisional capability should also have the right to determine where they want to go for Emergency treatment. Illinois Emergency rules allow EMS personnel to conduct assessment of patients with low acuity medical conditions and provide alternative pathways of care other than transport to a hospital based ED- department or stand alone ED. This may include a licensed behavioral health center or drug rehab center. **At this time, none of those options exist but we are looking into options and opportunities.**

**DEFINITIONS:**

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

**EMTALA -** Patients who present off hospital grounds and are transported by a hospital-owned or operated ambulance are considered to have presented to the hospital's emergency department and must undergo routine medical screening examination and stabilization as outlined by EMTALA regulations. Before 2003, EMS systems that were owned and operated by a hospital were required under EMTALA laws to transport all patients to their specific hospital to discourage the practice of only carrying insured patients to that hospital. However, given the possibility that the hospital tied with the hospital-based EMS system may not have specialty services that may be required to stabilize and treat the patient, an EMTALA revision was implemented that allowed hospital-based EMS systems to transport a patient to a different hospital if the area protocols require transport to another hospital. Indications for transport to a different hospital include the following [see CMS.gov Emergency Medical Treatment and Labor Act (EMTALA) Interim Guidance, 2003]:

<b>Title of Policy:</b> <i>Patient Hospital Preference</i> (Behavioral Health Center, Appropriate Facility)	<b>Policy Number:</b> O340
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The patient is experiencing a time-critical condition that the specific hospital does not provide service for (i.e., no cardiac catheterization capabilities for STEMI)

**If the patient is stable but requires particular subspecialty care that is not present at the hospital tied with the hospital-based EMS system, the patient may be transported to the "closest most appropriate facility" (i.e., the patient has a pregnancy-related issue, and the specific hospital does not have obstetrics services)**

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

#### INFORMED

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

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

In the pre-hospital setting, EMS providers are not obligated to obtain consent at the same degree as within a health care facility. The patient must only verbally agree or at least not object to the general nature of the treatment.

**STABILIZED -** In respect to a patient with an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer, (as defined in this part), of an individual to a medical facility other than the nearest appropriate facility.

**A. Patient choice** and medical urgency should be the guiding principles to EMS personnel as to where each ambulance case is delivered. However, it is inherent that each patient has the right to make an informed decision, provide Informed Consent, as to which hospital they are transported to within the service area of the ambulance agency as defined by the EMS System Plan.

**B. NO EMERGENCY PATIENT** of any EMS agency affiliated with the OSF Saint James EMS System shall be transported to a medical facility which is not within the service area of said EMS agency without first being STABILIZED and approved by the Medical Control Physician.

**C. ALL EMS AGENCIES PARTICIPATING IN THE OSF Saint James EMS SYSTEM ARE REQUIRED TO COMPLY WITH EMTALA AS DEFINED IN THIS PART.**

- If transport to the EMS agency's own hospital bypasses the closest hospital or trauma center; the receiving hospital has no EMTALA transfer issue, but the hospital directing the transport (which may be a different hospital) must still comply with the EMS System Bypass/Diversion policy.

<b>Title of Policy:</b> <i>Patient Hospital Preference</i> <b>(Behavioral Health Center, Appropriate Facility)</b>	<b>Policy Number:</b> O340
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- If a patient is transported to the closest hospital or trauma center but that is not the hospital that operates the ambulance service:
  - The hospital giving medical direction has no EMS System bypass/diversion issue, but the EMS agency's own hospital must still handle it as a EMTALA transfer issue.
- D. Should the patient refuse to be transported to the nearest appropriate facility, the patient should be advised of the risk, if any, associated with not being transported to the nearest appropriate hospital. Once risk factors have been explained, the patient's decision should be honored unless superseded by the Medical **Control Physician** (in compliance with this part), by the **Trauma Policy/ or Bypass/Diversion Policy**.
- E. All **TRAUMA** patients shall be subject to the Field Triage of the Trauma Patient policy, as well as the Illinois Department of Public Health Rules and Regulations, Section 515. Appendix C, "Minimum Trauma Field Triage Criteria".

Patient hospital preference should be documented on the EMS EPCR



<b>Title of Policy:</b> <i>Patient Restraints</i>	<b>Policy Number:</b> O350
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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



**Saint James-John W. Albrecht Medical Center****System 0257**

<b>Title of Policy:</b> <i>Patient Restraints</i>	<b>Policy Number:</b> O350
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

- k. Restraints must periodically be checked for proper application (i.e., adequate circulation to limbs, with documentation in the Patient Care Report that these periodic checks were conducted at least every five minutes).
- k. A patient under arrest by a law enforcement agency must first be restrained with hand-cuffs. Restraint and/or transport of a patient to a hospital by EMS personnel who is under arrest but has not been restrained initially with hand-cuffs by law enforcement ARE NOT TO BE RESTRAINED

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

- l. Documentation Requirements

- i. Indication for using restraints (i.e., presence of self-destructive behavior, danger to others, meets criteria for implied consent, under arrest by law enforcement).
  - ii. Prior attempts at less restrictive alternatives (i.e., verbal communication).
  - iii. Periodic checks for proper application.

- m. Avoiding Injury

- i. Keep at a safe distance whenever possible.
  - ii. Expect the unexpected.
  - iii. Never turn your back to the patient.
  - iv. Watch out for the patient's head; the patient can and will bite.
  - v. Remove any sharp objects from the patient's immediate environment.
  - vi. Never restrain a patient face down.
  - vii. Never restrain the legs to the arms.
  - viii. Assess for digital circulation every five minutes after restraint application.

<b>Title of Policy:</b> <i>Patient Right of Refusal</i>	<b>Policy Number:</b> LE160
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## Policy Statement:

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

## Policy:

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

**Minor** – Any person under 18 years of age.

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

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

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

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

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

<b>Title of Policy:</b> <i>Patient Right of Refusal</i>	<b>Policy Number:</b> LE160
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
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**Pre-hospital personnel allowed to obtain refusals;**

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

**High risk patients include, but not limited to:**

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

**Low risk patients:**

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

**Who May Refuse Care**

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

<b>Title of Policy:</b> <i>Patient Right of Refusal</i>	<b>Policy Number:</b> LE160
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**3. Guardian**

**a.** A legal guardian is one who is appointed by a court to act as “guardian of person” of an individual who has been found by a court to be incapacitated.

**b.** Legal guardian may also be appointed in lieu of parents for a minor

**c.** If a person indicates they are a legal guardian to the patient, attempt to obtain documentation of this fact (court order, etc.) and attach to trip sheet. If no such documentation is available, you may obtain refusal signature from the guardian as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the legal guardian of the patient.

**4. Health Care Agent (Attorney in Fact)**

**a.** A person appointed by the patient in a durable power of attorney document may refuse care of behalf of the patient if the power of attorney contains such authorization.

**b.** Attempt to obtain a copy of the durable power of attorney document to attach to the trip sheet. If no such documentation is available, you may obtain refusal signature from the health care agent (“attorney in fact”) as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the health care agent or “attorney in fact” of the patient.

## Procedure:

**A.** All patients will be offered treatment and transportation to a hospital after an accurate patient assessment has been conducted to include: patient’s complaint, history and objective findings, and patient’s ability to make sound decisions.

**B.** Determine decisional competency of the patient and the reason for refusing care. (Complete the Informed Decision Making Form) Providers should assess three major areas prior to permitting a patient to refuse care and/or transportation:

**1. Legal Competence**

**a.** Assure that patient is at least 18 years of age

**b.** Or, if a minor, patient may refuse care if he or she is a 17 year old high school graduate, is married, or is currently or has ever been pregnant.

**c.** Patients subject to court decree of incapacity are not legally competent to refuse care.

<b>Title of Policy:</b> <i>Patient Right of Refusal</i>	<b>Policy Number:</b> LE160
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
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2. Mental Competence
  - a. Start with the presumption that all patients are mentally competent unless your assessment clearly indicates otherwise.
  - b. Complete the Decisional Capacity/Risk Checklist**
- C. Explain to the patient the risk associated with their decision to refuse treatment and transportation.
- D. Inform the patient they may contact EMS if they change their mind
- E. Advise the patient to seek medical care, i.e. go to a hospital, doctor's office, clinic, etc.
- F. High risk patients:
  1. Establish voice contact via MERCI radio or cellular telemetry with Medical Control and relay the patient's complaint, history, complete assessment and vital signs. Clearly state that the patient refuses treatment and transport.

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

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

2. After receiving concurrence by Medical Control to accept refusal, complete the Release of Medical Responsibility Form (example pp.46-47) and have the patient sign the form. If a minor, this form must be signed by a legal guardian. **MINORS CANNOT REFUSE CARE AND TRANSPORTATION TO THE HOSPITAL!**
  3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.
- G. Low risk patients
1. EMR's/BLS will establish contact with Medical Control and follow the recommendations of the Physician or ECRN.
  2. Paramedic pre-hospital personnel will complete the Release of Medical Responsibility form and reasonably assure the patient understands the refusal
  3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.

<b>Title of Policy:</b> <i>Patient Right of Refusal</i>	<b>Policy Number:</b> LE160
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

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

#### Bypass or Diversion of a Hospital

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

#### Refusal of Transport after Emergency Treatment

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

#### NOTE:

1. **False calls or other “third party” calls where the person states they did not call for EMS assistance, the EMS provider does not need to obtain a written refusal. An EMS report still needs to be completed by the EMS provider for the emergency response.**
2. **Calls for assistance for transfer, where no mechanism of injury exists, the EMS provider does not need to obtain a full written refusal (e.g. transfer from chair to bed, transfer from car to home), but should complete the top half of the refusal form and obtain signature on 911 calls. An EMS report still needs to be completed by**



**Saint James-John W. Albrecht Medical Center**  
the EMS provider for the emergency response.

System 0257

**EMS SYSTEM 0257 REFUSAL FORM**

Agency Name: \_\_\_\_\_  
Date/Time of Call: \_\_\_\_\_  
Reason for Call: \_\_\_\_\_ ☐ Lift Assist Only/No Patient Injury

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Chief Complaint:**

BP	Pulse	Resp.	O2 Sat	Blood Glucose
----	-------	-------	--------	---------------

Decisional Capacity/Risk Checklist Completed: ☐ Yes ☐ NO EMT Initials \_\_\_\_\_

Medical Control Contacted: ☐ Yes ☐ NO EMT Initials \_\_\_\_\_

**SECTION B: ASSESSMENT/TREATMENT REFUSED (Check all the apply)**

- ☐ Patient deemed competent, accept the following pre-hospital care: yet refuses transport. (list care below)

- Patient deemed competent, accepts ambulance transportation, but refuses the following pre-hospital care

(Check all that apply)

- ☐ Oxygen      ☐ Physical Exam      ☐ IV access      ☐ Spinal Precautions      ☐ EKG applied  
☐ Vital Sign assessment   ☐ Medication      LSB  
☒ **Other**      ☐ Spinal Precautions C-Collar

**SECTION C: PATIENT/GUARDIAN/POWER OF ATTORNEY HAD BEEN ADVISED**

1. EMS explained the potential known and unknown problems including, but not limited to:

### Death or Permanent Disability

\*Patient is able to verbalize understanding of their clinical situation. ☐ Yes ☐ No *If NO is marked Medical Control needs to be contacted*

2. EMS explained potential for fatal or permanently disabling consequences including, but not limited to:

### Death or Permanent Disability

\* Patient is able to verbalize understanding of risks. ☐ Yes ☐ No *If No is marked Medical Control needs to be contacted.*

- ☐ Advised patient to seek care with an Emergency Department or physician as soon as possible.
- ☐ Advised the patient to call 9-1-1 or their local EMS if their condition changes or they change their mind regarding care and transport.

3. What is patient's plan to seek further medical evaluation?

**SECTION D: PATIENT SIGNATURE** *(This section to be completed by the patient or patient representative)*

I (we), the undersigned, hereby certify that I (we) refuse ☐ recommend oral treatment and/ or ☐ ambulance transportation to the appropriate hospital emergency department for ☐ myself ☐ minor less than 18 or ☐ Other

I (we) having been so advised by Ambulance Medical Personnel that treatment or transportation is recommended, hereby accept all responsibility connected with my (our) refusal and release the Ambulance Company, their employees, medical personnel, administrative and executive officers from any and all liability or claims resulting from any such refusal of treatment and/or transportation. **Instruction form provided to patient** ☐ YES ☐ NO

TRANSPORTATION INFORMATION FORM PROVIDED TO PATIENTS ON 12/2/15 BY		
SIGNATURE	PRINTED NAME	DATE
EMT On Representative		
WITNESS		
EMT/Paramedic		



NWC EMSS DECISIONAL CAPACITY/RISK CHECKLIST (Rev. 1-21-22)						
Pt. name			DOB		Gender	
Witness name			Has pt been declared legally incompetent?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Chief complaint			Has pt been declared an emancipated minor?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Law enforcement	<input type="checkbox"/> Requested & provided assistance <input type="checkbox"/> Requested; denied assistance <input type="checkbox"/> Not requested		Did EMS have access to the patient?			<input type="checkbox"/> Yes
			<input type="checkbox"/> No; pt. refused			<input type="checkbox"/> No; scene deemed unsafe for EMS
<b>Decisional capacity assessment:</b> If any of the below are abnormal or impaired, attempt to assess and document whether changes are new to patient's baseline or features of chronic illness; and how grossly abnormal EMS interprets the exam findings to be.			WNL	Abn./impaired new	Abn./impaired chronic	
Alertness: GCS: E          V          M			Total GCS:			
Orientation (person, place, time, situation): Answers accurately: Name, location, age, month; situation			X (1-4):			
Speech: Rate, volume, articulation, content (Note abnormality in narrative)						
Affect: Mood/emotional response (sad, depressed, flat, anxious, irritable, angry, elated, inappropriate, and incongruent with speech content) (Note abnormality in narrative)						
Behavior: Quiet, restless, inattention, hyperactivity, compulsions, agitated, violent? (Note abnormality)						
Cognition: Thought processes - Confusion, delirium, delusions, hallucinations, phobias? (Note abnormality)						
Memory: Immediate, recent, remote (amnesia/dementia?) (Note abnormality in narrative)						
Insight: Can pt articulate lucid and logical implications and consequences to their choices? (Note abnormality)						
EMS personnel impression of decisional capacity based on their assessment:						
Physical exam findings						
<input type="checkbox"/> VS - BP: <input type="checkbox"/> SpO <sub>2</sub> <input type="checkbox"/> ETCO <sub>2</sub> <input type="checkbox"/> Glucose <input type="checkbox"/> ECG						
BALANCE/Coordination – Ataxia (upper or lower extremities); tremors    EYES: Nystagmus						
Based on the suicide screen; does the patient pose an imminent risk to self?			Y		N	
Based on the EMS risk assessment; does the pt pose an imminent risk to others?			Y		N	
HPI/PMH	<input type="checkbox"/> Denies PMH <input type="checkbox"/> Unable to obtain PMH <input type="checkbox"/> A: Alcohol and drugs/toxins (substance use disorder); ACS/HF, arrhythmias, anticoagulation <input type="checkbox"/> E: Endocrine/exocrine, particularly thyroid/liver/adrenal dx; electrolyte/fluid imbalances; ECG: dysrhythmias/prolonged QT <input type="checkbox"/> I: Insulin disorders: hypoglycemia; DKA/HHS <input type="checkbox"/> O: O <sub>2</sub> deficit (hypoxia), opiates, overdose, occult blood loss (GI/GU) <input type="checkbox"/> U: Uremia; other renal causes including hypertensive problems <input type="checkbox"/> T: (recent) Trauma, temperature changes <input type="checkbox"/> I: Infections, neurologic and systemic (sepsis); infarction <input type="checkbox"/> P: Psychological*; massive pulmonary embolism <input type="checkbox"/> S: Space occupying lesions (epi or subdural, subarachnoid hemorrhage, tumors); stroke, shock (hypotension), seizures <input type="checkbox"/> Neuro: delirium, dementia (Alzheimer's dx), developmental impairment, autism, Parkinson's disease, migraine or other headaches <input type="checkbox"/> Metabolic: acidosis (✓ ETCO <sub>2</sub> ), vitamin/dietary deficiencies; eating disorders *Psych/behavioral: anxiety disorders, mood disorder, PTSD, mental health crisis; personality and bipolar disorders; psychosis.					
	<b>EMS CARE</b> Did patient receive any of the following from EMS? <input type="checkbox"/> Verbal de-escalation <input type="checkbox"/> Physical restraint <input type="checkbox"/> Medication sedation    If yes, explain in narrative. <input type="checkbox"/> Ongoing monitoring of VS and oximetry every 5 minutes after EMS interventions <input type="checkbox"/> Any untoward events after restraint or sedation? If yes, explain in narrative.					
<b>Pts may not dissent to care/transport IF:</b> EMS has access to the pt + they lack legal or decisional capacity; and/or pose an imminent risk to self, others, or cannot care for self; and/or as long as they remain severely hypoxic (SpO <sub>2</sub> < 90%), hypoglycemic, hypotensive, or hypercarbic after care. Transport under implied consent (emergency doctrine).						
Disposition						
<input type="checkbox"/> Treat/transport w/ express consent <input type="checkbox"/> Treat/transport w/ implied consent <input type="checkbox"/> Decisional pt refused care/transport <input type="checkbox"/> No care d/t EMS safety concerns						

**Caveats on contested collaborative care decisions/EMS safety issues:**

- Non-medical persons cannot compel EMS practitioners to provide or withhold any EMS care.
- EMS personnel have no duty to place themselves at risk of harm in the absence of law enforcement assistance and protection.
- OLMC cannot compel EMS to act in a way that subjects them to risk of harm – which may mean leaving a high risk patient at the scene when EMS access has been denied, law enforcement declines to assist, and/or there is reason to believe the pt may have access to lethal weapons.

EMS shall not seek OLMC approval of a refusal in these instances. Rather, they shall report the following:

We are on the scene with a person who has denied us access to provide a reasonable assessment and law enforcement has declined to intervene; OR we have determined that this person has legal and decisional capacity and they appear to pose no imminent risk to themselves or others and declines to be transported at the present time. They have been informed of the benefits of treatment/transport, given disclosure of the risks of refusing care, and also informed of alternatives for their care. They persist in declining our assistance. We are therefore leaving them in the environment in which they were found.



# INSTRUCTIONS

## VERSAL INSTRUCTIONS:

change your mind or your condition becomes worse and you decide to accept treatment and transport by Emergency Medical Services, please do not hesitate us back or seek other medical care.

time you take a medicine and become short of breath, start wheezing, get hives or a rash, or have an unexpected reaction, call 9-1-1 or your local emergency r immediately. ALWAYS take medicine as directed on the label. NEVER take someone else's prescription medication.

### EST PAIN:

re many causes of chest pain. The cause of test pain cannot be determined. activity that increases your pain. smoke, QUIT! eep breaths each hour even if it hurts. take medicines for chest pain, take your ne as directed.

ctor, go to the emergency department, or immediately if:

*ain worsens with activity.  
velop difficulty breathing.  
velop cough, chills, fever, upset stomach,  
er, jaw, or back pain, throw up blood, see  
n your urine, fever greater than 101°  
ive blood come up when you cough.  
velop black or sticky stools  
int (pass out).*

### BELLY PAIN:

- Belly pain is also called abdominal pain.
- Many illnesses can cause belly pain and the EMS crew cannot determine the cause of your belly pain.
- Take your temperature every 4 hours.

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

- *Your pain gets worse or is only in 1 area.*
- *You throw up blood, have blood in your stool, or have black or sticky stools.*
- *You become dizzy or faint*
- *You have a temperature over 101 ° trouble passing urine, or trouble breathing.*

### FEVER:

- ALWAYS take medicines as directed on the label. Tylenol (acetaminophen) and ibuprofen can be taken at the same time.
- If you are taking any antibiotics, take them until they are gone, not until you are feeling better.
- Drink extra non-caffeinated liquids (1 glass of water, soft drink, or Sports drink per hour of fever for an adult).
- If the temperature is above 103°, it can be brought down by sponge bath with room temperature, NOT COLD, water.
- Take your temperature every 4 hours.

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

- *Temperature is greater than 101 ° for 24 hours.*
- *A child becomes less active or alert.*
- *You develop a rash.*
- *Your fever does not come down with acetaminophen or ibuprofen.*

### ORTNESS OF BREATH:

atory distress is also known as shortness of or difficulty breathing. re many causes of respiratory distress. ould avoid any substance that causes you iculty breathing. take medication for difficulty breathing, our medication as directed.

ctor, go to the emergency department, or immediately if:

*ature is more than 101°  
ugh, wheeze, or difficulty breathing  
e worse or does not improve, even if taking  
tions.  
ive chest pain.  
putum (spit) turns color.  
e not able to perform normal activities.*

### EXTREMITY INJURY:

- Apply ice on the injured part or area for 15 to 20 minutes each hour for the first 2 days.
- Elevate the injured part above the level of the heart as much as possible for the first 2 days to help decrease pain and swelling.
- Use the injured part as pain allows.

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

- *Temperature above 101°*
- *The bruising, swelling, or pain gets worse despite the treatment listed above.*
- *Any problems listed on the WOUND CARE instructions are noted.*
- *You are not able to move the injured part or if you have numbness or tingling in the injured part.*
- *You are not improving in 2 days or you are not using the injured part in 1 week.*

### VOMITING/DIARRHEA:

- Many things can cause vomiting (throwing up). It can occur in anyone and should be watched closely.
- Diarrhea can also occur in anyone and can be a reaction to food or infection.
- Dehydration (loss of water) can occur with either vomiting or diarrhea.
- Drink clear liquids without alcohol (flat soda, Sports drink, or juice) for the first 12 hours. Begin with small sips and slowly increase the amount you drink.

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

- *Temperature is greater than 101°*
- *Vomiting or diarrhea lasts longer than 24 hours, you notice blood in the vomit or diarrhea, or you have black or sticky stools.*
- *You cannot keep fluids down or you haven't urinated in 8 hours.*

### UND CARE:

ls include cuts, scraped, bites, abrasions, or re wounds. ound begins to bleed, apply pressure over und with a clean bandage or cloth and the wound above the heart for 5-10 s. he wound twice daily with soapy water and e wound dry. It is safe to shower but do not he wound in bath or dish water. Remove the e prior to showering. e the bandage at least daily or when dirty. ill need a tetanus shot if you have not had 10 years.

ctor, go to the emergency department, or immediately if:

*above 101°  
ing, swelling, or pain gets worse or bleeding  
controlled as directed above.  
gns of infection such as redness, puss, red  
, or a bad smell from the wound.*

### HEADACHE:

- There are many causes of headache. The cause of your headache cannot be determined.
- Rest in a quiet, dark room for 20-30 minutes.
- Apply ice or heat to areas of pain.

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

- *Your headache worsens or does not improve within 24 hours.*
- *Your vision changes or you become sensitive to light.*
- *You develop a fever greater than 101° or have a seizure.*
- *You have a rash.*
- *You have yellow or green discharge from your nose.*
- *Your family cannot awaken you.*
- *You are not acting as you normally do.*

### LOW BLOOD SUGAR:

- Today your blood sugar was \_\_\_\_mg/dl.
- Taking too much insulin/diabetes medicine, too much exercise, delayed or skipped meals can cause low blood sugar.
- Signs and symptoms include shakiness, sweating, irritable, feeling faint, fainting, weakness, sleepiness, confusion, pounding heart.
- Test your blood sugar. If it is below 80 you should drink 8 ounces of whole milk, eat a candy bar, or use glucose tablets. Then you should eat a light meal to help keep your blood sugar up.
- Be sure to tell your doctor of this event.

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

- *Any new or severe symptoms.*
- *Blood sugar below 60.*
- *Fever above 101°*

**BACK PAIN:**

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

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

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

**HEAD INJURY:**

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

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

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

**INSECT BITE/STING:**

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

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

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

**SEIZURES:**

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

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

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

**Others around you should**

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

**FAINTING:**

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

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

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

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

<b>Title of Policy:</b> <i>Point-of-Care Glucometer Maintenance and Record Keeping</i>	<b>Policy Number:</b> O360
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### A. Equipment

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

### B. Training

#### a. Initial

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

#### b. Ongoing

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

<b>Title of Policy:</b> <i>Point-of-Care Glucometer Maintenance and Record Keeping</i>	<b>Policy Number:</b> O360
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> <i>Region II School Bus Policy</i>	<b>Policy Number:</b> O370
<b>Effective Date:</b> 01/2007	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> Region II

## Background to Policy:

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

## Policy Statement:

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

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

## Policy:

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

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

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

<b>Title of Policy:</b> <i>Region II School Bus Policy</i>	<b>Policy Number:</b> O370
<b>Effective Date:</b> 01/2007	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> Region II

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

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

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

<b>Title of Policy:</b> <i>Region II School Bus Policy</i>	<b>Policy Number:</b> O360
<b>Effective Date:</b> 01/2007	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> Region II

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



Saint James-John W. Albrecht Medical Center

System 0257

**School Bus Crash  
EMS MULTIPLE CASUALTY RELEASE FORM**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Run/Incident Number: \_\_\_\_\_

Agency: \_\_\_\_\_ Unit Number: \_\_\_\_\_

Location: \_\_\_\_\_ Number of Victims: \_\_\_\_\_

Description of Incident: \_\_\_\_\_

School District: \_\_\_\_\_ Bus Company: \_\_\_\_\_

Bus Driver: \_\_\_\_\_ School Official: \_\_\_\_\_

The following children were involved in the above school bus incident. They have been medically triaged by EMS personnel and no obvious or apparent injuries were found. The school official signing this form assumes responsibility for the children and is advised the evaluation the children received is not a substitute for medical evaluation by a doctor. The school official was instructed to CALL 911 if there is any change in any of the children that may raise any suspicion of potential injury.

	Name (Print)	DOB/Age
Child #1	_____	_____
Child #2	_____	_____
Child #3	_____	_____
Child #4	_____	_____
Child #5	_____	_____
Child #6	_____	_____
Child #7	_____	_____
Child #8	_____	_____
Child #9	_____	_____
Child #10	_____	_____

**Signatures**

School Official: \_\_\_\_\_

EMS Crew: \_\_\_\_\_

EMS Crew: \_\_\_\_\_



<b>Title of Policy: Relinquished Newborn, Infant SAFE HAVEN</b>	<b>Policy Number: LE170</b>
<b>Effective Date: 10/7/2020</b>	<b>Review Date: 08/01/2023</b>
<b>Policy Area: Legal</b>	<b>Approvals: MD, System</b>

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

For a full-text copy of the law go to: <https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1459&ChapterID=32>

## I. DEFINITIONS

- A. Neonate:** means a child who, a licensed physician reasonably believes is 30 days old or less, at the time the child is initially relinquished to a hospital, police station, fire station, 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, TNS, and Prehospital registered nurse as defined in the EMS Systems Act.
- D. Fire/Ambulance Station:** Means a fire/ambulance station within the State with at least one staff person.

## II. POLICY

- A.** The OSF Saint James EMS Agency will provide assessment, treatment, and transportation to the nearest hospital for relinquished infants according to the above named Act.
- B.** The OSF Saint James EMS Agency will provide the necessary documents to the relinquishing parent as specified in the above named Act.

## III. PROCEDURE - INFANT CARE AND HOSPITAL CONTACT

- A.** The relinquishing person is presumed to be the infant's biological parent.
- B.** Assess the infant. Look particularly for any signs of abuse or neglect.
- C.** Ask the relinquishing parent for the infant's name and date of birth.
- D.** If the child is presumed to be more than 30 days old, or appears to have been abused or neglected, EMS personnel should proceed as if the child is abused or neglected. Follow the Child Abuse SOP. Suspected child abuse and neglect policy and file a report with the DCFS Central Registry. While this is all that is required under the Act, refusing to take an infant presumed to be older than 30 days or one who is abused or neglected from a parent who wishes to relinquish them could possibly result in harm to the infant. It is in the best interest of the child to accept them and proceed as below.
- E.** Initiate EMS care that is necessary per SOP under implied consent and contact the nearest System hospital over the UHF radio/cellular or landline phone as soon as possible so a physician can take temporary protective custody of the infant.

<b>Title of Policy: Relinquished Newborn, Infant SAFE HAVEN</b>	<b>Policy Number: LE170</b>
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area: Legal</b>	<b>Approvals: MD, System</b>

F. Ensure that the infant is kept warm and transport to the nearest System 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.

#### **IV. PROCEDURE: COMMUNICATION WITH THE RELINQUISHING PARENT**

A. EMS personnel must offer the relinquishing parent the packet of information 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 in order 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.

<b>Title of Policy: Relinquished Newborn, Infant SAFE HAVEN</b>	<b>Policy Number: LE170</b>
<b>Effective Date:</b>	<b>Review Date:</b>
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**D. RESOURCES**

1. <https://saveabandonedbabies.org/fire-station-protocol/>
2. Illinois Adoption Registry and Medical Information Exchange Brochure:  
<https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/adoptapp.pdf>
3. Important Documents needed in the case of a relinquishment:
  - [AdoptionAgencies – Save Abandoned Babies](#)
  - [SAB-Info-Packet-for-Birthparents-2017.pdf \(saveabandonedbabies.org\)](#)

**V. IMMUNITY** (Section 27): A hospital, fire station, or emergency medical facility, and any personnel of a hospital, fire station, or emergency medical facility, are immune from criminal or civil liability for acting in good faith in accordance with the Act. Nothing in the Act limits liability for negligence for care and medical treatment.

**VI. EVALUATION (Section 65)**

A. IDPH shall collect and analyze information regarding the relinquishment of newborn infants and placement of children under the Act. Fire stations, emergency medical facilities, and medical professionals accepting and providing services to a newborn infant under the Act shall report to the Department data necessary for the Department to evaluate and determine the effect of this Act in the prevention of injury or death of newborn infants. Child-placing agencies shall report to the Department data necessary to evaluate and determine the effectiveness of these agencies in providing child protective and child welfare services to newborn infants relinquished under the Act.

B. The information collected from Fire stations shall include but need not be limited to: the number of newborn infants relinquished and the services provided to relinquished newborns.

<b>Title of Policy:</b> <i>Reporting of Suspected Crimes and Crime Scenes</i>	<b>Policy Number:</b> LE180
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## Background to Policy

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Service Animal Policy/Emotional Support Animal</i>	<b>Policy Number:</b> OP370
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Service Animal Policy/Emotional Support Animal</i>	<b>Policy Number:</b> O370
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

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

## Resources:

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

<b>Title of Policy: Social Media Use</b>	<b>Policy Number: A150</b>
<b>Effective Date: 8/2019</b>	<b>Review Date: 8/2019</b>
<b>Policy Area: Administration</b>	<b>Approvals: OSF SJEMS EMSMD</b>

## **I. PURPOSE**

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

## **II. DEFINITION – None.**

## **III. PROCEDURE**

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

<b>Title of Policy: Social Media Use</b>	<b>Policy Number: A150</b>
<b>Effective Date: 8/2019</b>	<b>Review Date: 8/2019</b>
<b>Policy Area: Administration</b>	<b>Approvals: OSF SJEMS EMSMD</b>

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



<b>Title of Policy:</b> <i>EMS System Preceptor Policy</i>	<b>Policy Number:</b> E-130
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Education	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

### A. Responsibilities

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

### B. Qualifications

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

<b>Title of Policy:</b> <i>EMS System Preceptor Policy</i>	<b>Policy Number:</b> E-130
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Education	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> <i>Transport of Law Enforcement K-9's</i>	<b>Policy Number:</b> O380
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Transport of Law Enforcement K-9's</i>	<b>Policy Number:</b> 0380
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

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

<b>Title of Policy:</b> <i>Updates to EMS System Manual</i>	<b>Policy Number:</b> A160
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Administration	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Use of Rescue Task Force in Active Shooter Situations</i>	<b>Policy Number:</b> O390
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

<b>Title of Policy:</b> <i>Use of Rescue Task Force in Active Shooter Situations</i>	<b>Policy Number:</b> O390
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

agency will be, a statement that they are supportive of the program, and how law enforcement and EMS will communicate on an incident site.

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

<b>Title of Policy:</b> <i>Use of Rescue Task Force in Active Shooter Situations</i>	<b>Policy Number:</b> O390
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- k. EMS providers should utilize any and all protective equipment as prescribed by their agency. Agencies should select protective equipment based on a risk analysis and likelihood of an active shooter event in their jurisdiction. The EMS system does not specify the type of protective equipment that agencies are required to provide outside of the required body substance isolation precautions prescribed by the system infection control plan, and Illinois Department of Public Health regulation.
- l. EMS providers participating on a rescue task force should have regular training on hemorrhage Control techniques, including the use of tourniquets, pressure dressings, and hemostatic agents (Quick-Clot). ILS/ALS providers should also have regular training on thoracic needle decompression
- m. The focus of emergency care provided in the warm zone shall focus on bleeding control and basic airway management. It is understood by all parties that medical care in the warm zone will not be as comprehensive as that provided in the cold zone. All medical equipment that will be utilized by rescue task force members shall be approved by the EMS System. Medical care provided in the cold zone will be in accordance with the appropriate MCAEMS SMO/Protocol.

## Resources:

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



<b>Title of Policy:</b> <i>Vehicle Service Advertising</i>	<b>Policy Number:</b> LE180
<b>Effective Date:</b> 01/01/2020	<b>Review Date:</b> 10/07/2019
<b>Policy Area:</b> Legal	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy Statement:

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

## Policy:

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

Agencies that have in-field upgrade capabilities are restricted to advertising the level of service that they can guarantee 24/7/365

<b>Title of Policy:</b> <i>Violence, Abuse</i>	<b>Policy Number:</b> DOC160
<b>Effective Date:</b> 8/2019	<b>Review Date:</b> 08/01/2023
<b>Policy Area:</b> Documentation	<b>Approvals:</b> MD, System

## Background to Policy:

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

## Policy statement

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

## Policy:

DEFINITION- Domestic Violence

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

### ILLINOIS STATE LAW

#### ABUSE and NEGLECT REPORTING; DOMESTIC VIOLENCE REFERRALS

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

<b>Title of Policy:</b> <i>Violence, Abuse</i>	<b>Policy Number:</b> DOC160
<b>Effective Date:</b> 8/2019	<b>Review Date:</b> 8/1/2023
<b>Policy Area:</b> Documentation	<b>Approvals:</b> MD, System

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

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

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

**Resources:**

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

<b>Title of Policy: EMR CE Requirements</b>	<b>Policy Number: E200</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

### Continuing Education Hours:

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

### License Renewal:

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

**Saint James-John W. Albrecht Medical Center****System 0257**

<b>Title of Policy: EMR CE Requirements</b>	<b>Policy Number: E200</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

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

**NOTE:**

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

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

<b>Title of Policy: EMT CE Requirements</b>	<b>Policy Number: E210</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy

### Continuing Education Hours:

- 1. The EMT-Basic will accumulate 60 hours of continuing education every four years.** This above the current IDPH requirements.
- No more than 25% can be in one subject area.
- The following is required annually as part of CE Hour requirements:
  - Healthcare Provider CPR (as recertification is necessary).
  - Skill Checks/Competencies- Medical, Trauma, Pediatric
  - OSHA/Bloodborne Pathogens
  - System Review
- Up to 20 hours of the total 60 can be obtained from approved EMS internet sites that provide CE hours.
- Up to 10 hours of the total 60 can be obtained through Hospital Clinical Time in the ED.
- Any CE class that has received a state site code shall be accepted by the EMS system.
- 7. It is the responsibility of the EMT-Basic to keep track of all CE hours during the four year license period.**

### License Renewal:

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

<b>Title of Policy: EMT CE Requirements</b>	<b>Policy Number: E210</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

**NOTE:**

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

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

<b>Title of Policy: EMT- I CE Requirements</b>	<b>Policy Number: E230</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

### Continuing Education Hours:

**The EMT-Intermediate/Advanced will accumulate 70 hrs of continuing education every four years.**

1. No more than 25% can be in one subject area.
2. The following is required annually as part of CE Hour requirements:
  - i. Healthcare Provider CPR (as recertification is necessary).
  - ii. Skill Checks/Competencies- Medical, Trauma, Pediatrics.
  - iii. OSHA/Bloodborne Pathogens
  - iv. System Review
3. Current ACLS Certification.
4. Current PALS Certification.
5. Up to 10 hours of the total 70 can be obtained from approved EMS internet sites that provide CE hours.
6. Any CE class that has received a state site code shall be accepted by the EMS system.
7. **It is the responsibility of the EMT-Intermediate/Advanced to keep track of all CE hours during the four year license period.**

### License Renewal:

1. All EMT-Intermediates/Advanced will renew their license every 4 years.
2. IDPH will send out the Renewal Notice/ Child Support Statement form prior to expiration date.
3. EMT-Intermediates/Advanced are highly encourage to go on-line as instructed on the Renewal Form to pay the \$30.00 renewal fee and complete the Child Support Statement.
  - a. If an EMT-Intermediate cannot pay on-line, a \$30.00 money order or cashier's check along with the Renewal Form/Child Support Statement must be sent to IDPH at the address listed on the form **30 days** prior to expiration.
4. All EMT-Intermediates/Advanced will route CE record forms to the EMS Office **30 days** prior to expiration date.
5. The EMS Office will verify completion of CE and clinical hours and complete the EMS System Approval in the IDPH database.
6. All records will be kept Ninthbrain online



<b>Title of Policy: EMT- I CE Requirements</b>	<b>Policy Number: E230</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

7. EMT-Intermediate/Advanced whose license has expired may, within 60 days after licensure expiration, submit all re-licensure material with the \$30 renewal fee as required and a \$50 late fee in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the EMT-Intermediate/Advanced, the Department will relicense the EMT-Intermediate/Advanced.

**NOTE:**

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

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

<b>Title of Policy: Paramedic CE Requirements</b>	<b>Policy Number: E240</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

### Continuing Education Hours:

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

### License Renewal:

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

<b>Title of Policy: Paramedic CE Requirements</b>	<b>Policy Number: E240</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

**NOTE:**

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

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

<b>Title of Policy: PHRN CE Requirements</b>	<b>Policy Number: E250</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

## Policy Statement:

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

### PURPOSE

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

## Policy:

### Continuing Education Hours:

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

### License Renewal:

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

**Saint James-John W. Albrecht Medical Center****System 0257**

<b>Title of Policy: PHRN CE Requirements</b>	<b>Policy Number: E250</b>
<b>Effective Date: 01/01/2020</b>	<b>Review Date: 10/07/2019</b>
<b>Policy Area: Education</b>	<b>Approvals: MD, System</b>

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

**NOTE:**

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

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

<b>Title of Policy:</b> Fire Ground Rehab Guidelines	<b>Policy Number:</b> O400
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Background:** Fire rehab is a coordinated plan to ensure firefighters, who encounter extremes of temperature, exposure, and exertion, do not develop significant illnesses related to exertion or exposure. Fire rehab can vary from simple temperature management and oral rehydration to aggressive medical treatments and transport to a higher level of care. Fire rehab is continually evolving as our understanding of physiologic responses to exertion and exposure change, technologies evolve, and risk tolerance adjusts.

**Policy:**

Rehabilitation of personnel at emergency scenes and training exercises. It will ensure that members who might be suffering the effects of metabolic heat buildup, dehydration, physical exertion, and/or extreme weather receive evaluation and rehabilitation during emergency operations or at training sessions.

**GUIDELINES:**

1. Rehabilitation should commence when fire/emergency operations and/or training exercises pose the risk of members exceeding a safe level of physical or mental endurance.
2. Rehabilitation should be established for large-scale incidents, long duration, extreme temperatures and / or physically demanding incidents.
3. The Incident Commander (IC) may establish rehabilitation setup according to the circumstances of the incident. The rehabilitation process may include the following;

- Rest and recovery
- Rehydration (fluid replacement)
- Active and/or passive cooling or warming as needed for the incident type and climatic conditions
- Medical monitoring
- EMS treatment in accordance with local protocols
- Relief from extreme climatic conditions (heat, cold, wind, rain)
- Calorie and electrolyte replacement
- Accountability
- Release

4. **ROLES AND RESPONSIBILITIES:** Incident Commander (or their designee) is responsible for considering the following:
  1. Include rehabilitation in incident/event size-up.
  2. Establishing a rehabilitation group to reduce adverse physical effects on firefighters while operating during fire/emergencies, training exercises, and extreme weather conditions.
  3. Designating and assigning a supervisor/officer to manage rehabilitation. The IC should assume the responsibility if not delegated.
  4. Ensure enough resources are assigned to rehabilitation if created.
  5. Ensure EMS personnel are available for emergency medical care of firefighters as required. BLS should be the minimum level of care; ALS may be needed and is preferred when it is available.

<b>Title of Policy:</b> Fire Ground Rehab Guidelines	<b>Policy Number:</b> O400
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Rehabilitation Officer should be responsible for the following:**

1. Don the rehabilitation officer vest.
2. Whenever possible, select a location for rehabilitation with the following site characteristics:
  - Large enough to accommodate the number of personnel expected (including EMS personnel for medical monitoring), with a separate area for members to remove personal protective equipment
  - Accessible for an ambulance and EMS personnel should emergency medical care be required
  - Removed from hazardous atmospheres including apparatus exhaust fumes, smoke, and toxins often encountered on the incident scene
  - Away from patient treatment/triage areas
  - Shade in summer and protection from inclement weather at other times
  - Access to a water supply (bottled or running) to provide for hydration and active cooling
  - Away from spectators and media
3. Ensure personnel in rehabilitation “dress down” (when appropriate) by removing their bunker coats, helmets, hoods, and opening their bunker pants to promote cooling (prior to entering the rehab area).
4. Make available the suggested resources for rehabilitation including the following:
  - Shelter from the elements (cold, heat, wind, rain, etc.) if needed
  - Potable drinking water for hydration
  - Sports drinks (appropriate electrolyte and caloric replacements) for long duration incidents (working for more than one hour)
  - Active cooling where required
  - Medical monitoring equipment (chairs to rest on, blood pressure cuffs, stethoscopes, check sheets,
  - Food where required and a means to wash or clean hands and face prior to eating
  - Blankets and warm, dry clothing for winter months
  - Bathroom facilities where required
5. Monitor the time personnel are in rehabilitation to ensure they receive at least 10 minutes to 20 minutes of rest.
6. Ensure personnel rehydrate themselves.
7. Ensure personnel are provided with a means to be actively cooled where required.
8. Always maintain accountability and remain within rehabilitation (Individual Rehab Report).
9. Document members entering or leaving rehabilitation.
10. Inform the incident commander, accountability officer (resource status unit), and EMS personnel if a member requires transportation to and treatment at a medical facility.
11. Serve as a liaison with EMS personnel.

**Company officers should be responsible for the following:**

1. Be familiar with the signs and symptoms of heat stress and cold stress.
2. Monitor the company members for signs of heat stress and cold stress.
3. Notify the IC when stressed members require relief, rotation, or reassignment according to conditions.
4. Provide access to rehabilitation for company members as needed.
5. Ensure that the company is properly checked in with the rehabilitation manager and accountability officer (resource unit), and that the company remains intact.

<b>Title of Policy:</b> Fire Ground Rehab Guidelines	<b>Policy Number:</b> O400
<b>Effective Date:</b>	<b>Review Date:</b>
<b>Policy Area:</b> Operations	<b>Approvals:</b> MD, System

**Crew members** should be responsible for the following:

1. Be familiar with the signs and symptoms of heat and cold stress.
2. Maintain awareness of themselves and company members for signs and symptoms of heat stress and cold stress.
3. Promptly inform the company officer when members require rehabilitation and/or relief from assigned duties.
4. Maintain unit integrity.

**EMS personnel** should be responsible for the following:

1. Report to the IC and obtain the rehabilitation requirements.
2. Coordinate with the rehabilitation manager.
3. Identify the EMS personnel requirements.
4. Check vital signs, monitor for heat/cold stress and signs of medical issues.
5. Document medical monitoring (Individual Rehab Report)
6. Provide emergency medical care and transportation to medical facilities as required.
7. Inform the IC and the rehabilitation manager when personnel require transportation to and treatment at a medical facility.
8. Document emergency medical care provided.

## 5. PROCEDURES:

1. All personnel should maintain hydration on an ongoing basis (pre-incident, incident, post-incident).
2. Members may be sent to rehabilitation as required.
3. All members should be sent to rehabilitation following the use of
  - two 30-minute or 45-minute SCBA cylinders
  - one 60-minute SCBA cylinder
  - 45-60 minutes of intense work without SCBA
  - Shorter times might be considered during extreme weather conditions
4. Active cooling (e.g., wet towels, forearm immersion, misting fans) should be applied where temperatures, conditions, and/or workload create the potential for heat stress.
5. In hot, humid conditions, a minimum of 10 minutes (20 minutes is preferable) of active cooling should be applied following the use of the second and each subsequent SCBA cylinder.
6. Personnel in rehabilitation should rest for at least 10 minutes to 20 minutes prior to being reassigned or released.
7. The following vital signs should be obtained;
  - Heart rate
  - Respiratory rate
  - Blood pressure
  - Pulse-Ox
  - Temperature (if capable)
8. Members exposed to fire smoke should be assessed for CO poisoning.
9. EMS personnel should provide medical monitoring and emergency medical care as per medical protocol.



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10. If a member is demonstrating abnormal vital signs, he or she should be monitored frequently during rehabilitation.
11. Personnel who are weak or fatigued with pale clammy skin, low blood pressure, nausea, headache, or dizziness should be assessed by EMS personnel.
12. Personnel may be transported to a medical facility for treatment if they are experiencing
  - chest pain
  - shortness of breath
  - dizziness
  - nausea
  - Altered mental status
  - If after 30 minutes vital signs are above limits
13. Personnel transported to a medical facility for treatment should be accompanied and attended to by a department representative. (Notify Incident Commander immediately)
14. Members should drink water during rehabilitation (12 – 32 oz / 20-minute break). After the first hour, a sports drink containing electrolytes may be provided. (Soda and caffeinated and carbonated beverages should be avoided)
15. Nutritional snacks or meals should be provided as required during longer duration incidents.
16. No tobacco use should be permitted in or near the rehabilitation area.
17. The member should not return to operations if
  - He or she does not feel adequately rested
  - If EMS or supervisory staff present see evidence of medical, psychological, or emotional distress
  - If the member appears otherwise unable to safely perform his or her duties
18. Release from Rehab will be determined by one of the following
  - Cleared for duty
  - Sent to a medical facility for more definitive medical evaluation/treatment
19. Where transport or care is provided, a Patient Care Report (PCR) should be generated and a copy placed in the member's employee health record. (Notify the Incident Commander Immediately)
20. For any ongoing event with high potential for injury to public safety personnel consider requesting a physician to the scene

**Fire Ground Rehab MEDICAL MONITORING**

Time entering rehab: \_\_\_\_\_

Date: \_\_\_\_\_

Firefighter Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Alert and oriented, normal gait, clear speech?** Yes / No

**Skin evaluation:** Normal , Pale , Flushed , Ashen , Cyanotic ,Clammy , Dry , Moist , Wet ,

**Cooling Provided:** List type and duration: \_\_\_\_\_

Time	BP	HR	RR	Temp (oral)	Oral fluid consumed (ml)	IV fluids provided (ml)

**Transport to medical facility for any of the following:**

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

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

- Heart rate < 100 Systolic
- BP between 100 and 160 Diastolic BP < 90
- Oral temperature < 99.5°F (37.5°C)