



Operations/Legal Protocols

All guidelines and information contained herein is intended solely for the use within the St. John's Hospital EMS System. No other set of guidelines or any other system's protocols, policies, or procedures shall supersede the guidelines set forth in the manual or be utilized in place of the manual by any provider in the St. John's Hospital EMS System without explicit approval of the St. John's Hospital EMS Medical Director.

EMS Medical Director
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Table of Contents

EMS System Hospitals	3
LEVELS OF PREHOSPITAL CARE	4-6
PROVIDER RESPONSIBILITIES	7-23
AGENCY RESPONSIBILITIES	7-9
PROFESSIONAL CONDUCT CODE OF ETHICS	10-12
AGENCY COMPLIANCE WAIVER POLICY	13
AGENCY ADVERTISING POLICY	14
SYSTEM CERTIFICATION POLICY	15-18
RE-LICENSE POLICY	19-23
EMS License Renewal Request	24
EMS COMMUNICATIONS & DOCUMENTATION	25-35
OFF-LINE MEDICAL CONTROL POLICY	25
ON-LINE MEDICAL CONTROL POLICY	26-28
RADIO COMMUNICATIONS PROTOCOL	29
PATIENT RIGHT OF REFUSAL POLICY	30
INCIDENT REPORTING POLICY	31-32
EMS PATIENT CARE REPORTING POLICY	33
PATIENT CONFIDENTIALITY & RELEASE OF INFORMATION POLICY	34-35
GENERAL PATIENT ASSESSMENT & MANAGEMENT/EMS OPERATIONS	36-49
PATIENT DESTINATION POLICY	36-37
TRANSFER & TERMINATION OF CARE POLICY	38-39
TRANSITION OF PATIENT CARE POLICY	40
INTERCEPT POLICY	41-42
CORONER NOTIFICATION POLICY	43
REPORTING AND CONTROL OF SUSPECTED CRIME SCENE POLICY	44
PHYSICIANS ON SCENE POLICY	45
REGION 3 BUS POLICY	46-49
WELL-BEING OF THE EMS PROVIDER	50-57
INFECTIOUS DISEASE CONTROL POLICY	50-52
LATEX ALLERGY POLICY	53-54
SUBSTANCE ABUSE POLICY	55-56
CRITICAL INCIDENT STRESS MANAGEMENT (CISM) TEAM PROCEDURE	57
EMS SUPPLIES	58-64
EMS EQUIPMENT & SUPPLIES POLICY	58
EMR Medication List	59
BLS MEDICATIONS LIST	60
ILS MEDICATIONS LIST	61
ALS MEDICATIONS LIST	62
CONTROLLED SUBSTANCE POLICY	63-64
DRUG SHORTAGE POLICY	65

St. John's Hospital EMS System
Springfield Area Mobile Intensive Care (SAMIC)

Resources Hospital

St. John's Hospital
EMS Office 217-525-5645

Cellular Telemetry
217-753-0016 or 217-753-1089

Associate Hospitals

St. Francis Hospital, Litchfield
St. Anthony's Memorial Hospital, Effingham
Mason District Hospital, Havana

Participating Hospital

Hillsboro Area Hospital, Hillsboro

Levels of Prehospital Care EMS Services

First Responder Services defines a preliminary level of prehospital emergency care as outlined in the First Responder National Curriculum of the National Highway Transportation Safety Administration and any modification to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. First Responder care includes: ***CPR, AED services, monitoring vital signs, administration of oxygen, bleeding control, and use of Narcan.***

Basic Life Support (BLS) Services defines a level of prehospital and inter-hospital medical services as outlined in the Basic Life Support National Curriculum of the National Highway Transportation Safety Administration and any modification to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. BLS emergency and non-emergency care includes: ***Basic airway management, CPR, AED services, control of shock & bleeding and splinting of fractures.*** BLS services may be enhanced with the administration of System-approved medications and the Combi-tube or KING Airways.

Intermediate Life Support (ILS) Services defines a level of pre hospital and interhospital medical services as outlined in the Intermediate Life Support National Curriculum of the National Highway Transportation Safety Administration and any modifications to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. ILS emergency and non-emergency care includes: ***Basic life support care, intravenous fluid therapy, oral intubation, EKG interpretation, 12-lead acquisition, Adult EZ-IO, defibrillation procedures and administration of System-approved medications.***

Advanced Life Support (ALS) Services defines a level of prehospital and inter-hospital medical services as outlined in the Paramedic Life Support National Curriculum of the National Highway Transportation Safety Administration and any modifications to that curriculum specified in the EMS Act. ALS emergency and non-emergency care includes: ***Basic and intermediate life support care, ACLS electrocardiography and resuscitation techniques, administration of medications, drugs & solutions, use of adjunctive medical devices, CPAP, chest decompression and intraosseous access.***

Levels of Prehospital Care

Prehospital Personnel

1. A currently licensed EMR, EMT-B, EMT-I, EMT-P or PHRN may perform emergency and non-emergency medical services as defined in the EMS Act and in accordance with his or her level of education, training and licensure. Prehospital personnel must uphold the standards of performance and conduct prescribed by the Department (IDPH) in rules adopted pursuant to the Act and the requirements of the EMS System in which he or she practices, as contained in the approved System Program Plan.
2. A person currently licensed as an EMT-B, EMT-I or EMT-P may only use their EMT license in prehospital/inter-hospital emergency care settings or non-emergency medical transport situations under the written directions of the EMS Medical Director.
3. **First Responder -Defibrillator (EMR):** Provides care consistent with the definition of a First Responder service and within the context of Standing Medical Orders (SMOs) or Standard Operating Procedures (SOPs). First Responder care should be focused on assessing the situation and establishing initial care.

First Responders who provide medical care in the St. John's Hospital EMS System must be trained in the use of an AED and hold a *First Responder/Defibrillator (EMR)* recognition card from the Illinois Department of Public Health (IDPH). Each agency is responsible for downloading a code summary and forwarding that information to the receiving hospital (along with the PCR).

4. **Emergency Medical Technician -Basic (EMT -B):** Provides care consistent with the definition of a BLS service and within the context of SMOs or SOPs. This may include interventions involving airway access/maintenance, ventilatory support, oxygen delivery, bleeding control, spinal immobilization and splinting isolated fractures.

EMT -B attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation.

In addition, EMT-Bs may assist the patient in self-administering prescribed Nitroglycerin (NTG), Proventil (Albuterol) or an Epi-Pen pending an ALS response. EMT-Bs who are System-certified and functioning with an approved B-Med agency may carry and administer various approved medications and the Combi-tube or KING Airway.

AEDs are required on BLS vehicles officially incorporated into the EMS System Plan. Each agency is responsible for downloading a code summary and forwarding that information to the receiving hospital (along with the PCR).

Levels of Prehospital Care *Prehospital Personnel*

5. **Emergency Medical Technician -Intermediate (EMT-I):** Provides care consistent with the definition of an ILS service and within the context of SMOs or SOPs. This may include all BLS skills, along with intravenous fluid therapy, oral intubation, EKG interpretation, 12-lead acquisition, defibrillation procedures, Adult EZ-IO and administration of System-approved medications. EMT-I, (Advanced EMT) attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation.
6. **Emergency Medical Technician -Paramedic (EMT-P):** Provides care consistent with the definition of an ALS service and within the context of SMOs or SOPs. This includes all BLS and ILS skills, advanced EKG skills with prompt intervention using Advanced Cardiac Life Support (ACLS), administration of System-approved medications & IV solutions, proper use of System-approved adjunctive medical devices (e.g. CPAP) and performance of advanced medical procedures (e.g. needle chest decompression and intraosseous access). The patient's condition and chief complaint determine the necessity and extent of ALS care rendered. Consideration should be given to the proximity of the receiving hospital. The EMT -P level may be enhanced to include selected critical care medications and skills for inter-facility transfers.
7. **Prehospital RN (PHRN):** The Illinois EMS Act (1995) defines a PHRN as "a registered professional nurse licensed under the Illinois Nursing Act of 1987 who has successfully completed supplemental education in accordance with rules adopted by the Department (IDPH) pursuant to the Act, and who is approved by an EMS Medical Director to practice within an EMS System as emergency medical services personnel for Prehospital and inter-hospital emergency care and non-emergency medical transports".

NOTE: Prehospital personnel are required to provide copies of their IDPH license and all certifications to both the agency and the EMS System. A new copy must be submitted to the EMS Office and to any agency with whom the provider is currently functioning when the license or certification is renewed.

It is the agency's and individual licensee responsibility to track expiration dates, to ensure that the appropriate documentation is in the agency personnel file and to ensure that copies have been provided to the EMS Office prior to the license or certification expiration. If the appropriate documents are not on file, the provider will not be allowed to function in the System.

Agency Responsibilities Policy

Listed below is a summary of the important responsibilities of the provider agencies that are in the St. John's Hospital EMS System. This list is based on the System manuals and IDPH rules and regulations. These responsibilities are categorized into four major areas:

Operational Requirements, Notification Requirements, Training & Education Requirements and Additional Reports and Records Requirements. Some items have been repeated to stress the importance of compliance.

Operational Responsibilities

1. A provider agency must comply with minimum staffing requirements for the level and type of vehicle. Staffing patterns must be in accordance with the provider's approved system plan and in compliance with Section 515.830(f).
2. No agency shall employ or permit any member or employee to perform services for which he or she is not licensed, certified or otherwise authorized to perform (Section 515.170).
3. Agencies that utilize First Responders and Emergency Medical Dispatchers shall cooperate with the System and The Department in developing and implementing the program (Section 515.170).
4. A provider agency must comply with the Ambulance Report Form Requirements Policy, including Prehospital patient care reports, refusal forms and any other required documentation.
5. Agencies with controlled substances must abide by all provisions of the Controlled Substance Policy including: *maintaining a security log, maintaining a Controlled Substance Usage Form and reporting any discrepancies to the EMS Office.*
6. Notify the EMS Office of any incident or unusual occurrence which could or did adversely affect the patient, co-worker or the System within 24 hours via incident report form.

Notification Requirements

An agency participating as an EMS provider in the St. John's Hospital EMS System must notify the Resource Hospital, (St. John's Hospital), of the following:

1. Notify the System in **any** instance when the agency lacks the appropriately licensed and System-certified personnel to provide 24-hour coverage. Transporting agencies must apply for an ambulance staffing waiver if the agency is aware a staffing shortage is interfering with the ability to provide such coverage.
2. Notify the System of agency personnel changes and updates **within 10 days**. **This includes addition of new personnel and resignations of existing personnel.**

Rosters must include: *Name/level of provider, license number, expiration date, current address, phone number, date of birth, and B-med certification status.*

3. Notify the System anytime an agency is not able to respond to an emergency call due to lack of staffing. The report should also include the name of the agency that was called for mutual aid and responded to the call.
4. Notify the System of **any** incident, via incident report within 24 hours, which could or did adversely affect the patient, co-worker or the System.
5. Provide the EMS Office with updated copies of FCC Licenses and Mutual Aid Agreements upon expiration.
6. Notify the System of any changes in medical equipment or supplies.
7. Notify the System of any changes in vehicles. Vehicles must be inspected by the System and the appropriate paperwork must be completed **prior** to the vehicle being placed into service.
8. Notify the System if the agency's role changes in providing EMS.
9. Notify the System if the agency's response area changes.
10. Notify the System if changes occur in communication capacities or equipment.

Training and Education Responsibilities

1. Twenty-five percent (25%) of all EMT continuing education must be obtained through classes taught or sponsored by the Resource Hospital, St. John's Hospital.
2. Appoint a training officer. The EMS training officer ideally should be an IDPH Lead Instructor. The training officer must provide the EMS Office with their contact information..
3. Develop a training plan which meets the requirements for re-licensure and System certification as detailed in the *Continuing Education and Re-licensure Requirements Policy*.
4. Submit the agency's training plan (along with a current roster) annually to the EMS Office for System and Department (IDPH) approval. The applications are due by October 1, for the following training year.
5. Any changes made to an approved training application must be communicated to the EMS Office prior to the training.
6. Maintain sign-in rosters for all training conducted and provide participants with certification of attendance.
7. Conduct System mandatory training annually as per EMS Office notification.

Additional Reports and Records Responsibilities

1. Comply with St. John's Hospital EMS System Quality Assurance Plan, including agency self-review, submission of incident reports, submission of patient care reports, maintain controlled substance security logs and usage tracking forms. Logs must be made available upon request of EMS Office personnel.
2. Maintain glucometer logs. Testing should be done a minimum of once per week, any time a new bottle of strips is put into service and any time the glucometer is dropped. Glucometer logs should be kept in the ambulance (or other vehicle) and must be made available upon request of EMS Office personnel.
3. All agencies and agency personnel are to comply with all of the requirements outlined in HIP AA regulations with regard to protected health information.

NOTE: Prehospital personnel are required to provide copies of their IDPH license and all certifications to both the agency and the EMS Office and to any agency with whom the provider is currently functioning when the license or certification is renewed.

If the appropriate documents are not on file, the provider will not be allowed to function in the system.

Professional Conduct & Code of Ethics Policy

The following are guidelines for interaction with patients, other caregivers and the community:

- **Respect for Human Dignity** -Respect all patients regardless of socioeconomic status, race, belief systems, financial status or background. Dignity includes greeting, conversing, respectful mannerisms, and protecting physical privacy.
- **Maintain Confidentiality** -Respect every person's right to privacy. Sensitive information regarding a patient's condition or history should only be provided to medical personnel involved in the patient's care, with an immediate need-to-know. Sensitive information regarding our profession may only be provided to those with a right to know. This includes no electronic dissemination or publication of information referencing patients or calls.
- **Professional Competency** -Provide the patient with the best possible care by continuously improving your knowledge base, skills, and maintaining continuing education and required certifications. Protect the patient from incompetent care by knowing the standard of care and being able to identify those who do not.
- **Safety Awareness & Practice** -Protect the health and well-being of the patient, yourself, your co-workers and the community by constantly following safety guidelines, principles and practices.
- **Accountability for Your Actions** -Act within the scope of your practice and training, realize your individual limitations, and accept responsibility for both satisfactory and unsatisfactory actions.
- **Loyalty & Cooperation** -Demonstrate devotion to your profession by promoting professional image through competency and efficiency and honesty. Strive to improve morale when possible and refrain from publicly criticizing.
- **Personal Conduct** -Demonstrate professionalism by maintaining high moral and ethical standards, and by maintaining good personal hygiene. Do not participate in behavior that would discredit you, your co-workers and the profession.

Professional Conduct & Code of Ethics Policy

Code of Ethics

(Applies to ALL Prehospital providers)

Professional status as an Emergency Medical Technician is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician.

As an Emergency Medical Technician, I solemnly pledge myself to the following code of professional ethics:

- A fundamental responsibility of the EMT is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.
- The EMT provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color or status.
- The EMT does not use professional knowledge and skills in any enterprise detrimental to the public well-being.
- The EMT respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
- The EMT, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the EMT has the never-ending responsibility to work with concerned citizens and other healthcare professionals in promoting a high standard of emergency medical care to all people.
- The EMT shall maintain professional competence and demonstrate concern for the competence of other members of the EMS healthcare team.
- An EMT assumes responsibility in defining and upholding standards of professional practice and education.
- The EMT assumes responsibility for individual professional actions and judgment, both in all aspects of emergency functions, and knows and upholds the laws which affect the practice of the EMT.
- An EMT has the responsibility to be aware of and participate in matters of legislation affecting the EMS System.
- The EMT, or groups of EMTs, who advertise professional service, does so in conformity with the dignity of the profession.
- The EMT has an obligation to protect the public by not delegating to a person less qualified, any

service which requires the professional competence of an EMT.

- The EMT will work harmoniously with and sustain confidence in EMT associates, the nurses, the physicians, and other members of the EMS healthcare team.
- The EMT refuses to participate in unethical procedures and assumes responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Agency Compliance Waiver Policy

If compliance with IDPH Rules and Regulations of the St. John's Hospital EMS System Policies results in unreasonable hardship, the EMS provider agency shall petition the St. John's Hospital EMS System and IDPH for a temporary rule waiver.

The format shall be as follows for policy or equipment issues:

Part 1- Cover letter, to include: *agency name, IDPH agency number, agency official(s), agency designated contact person, telephone number, statement of the problem and proposed waiver.*

Part 2- *Explanation of why the waiver is needed.*

Part 3- Explanation of how the modification will relieve problems that would be created by compliance with the rule or policy as written.

Part 4- Statement of and justification for the time period (maximum 1 year) of which the modifications will be necessary. The section must also include a chronological plan for meeting total compliance requirements.

For Staffing Waivers

Agencies that have staffing issues must submit the IDPH EMS Staffing Waiver Application. The staffing waiver may be obtained on the IDPH EMS website or by contacting the EMS Office.

All waiver requests should be submitted to the St. John's Hospital EMS System Medical Director for review and approval.

Agency Advertising Policy

EMS agencies are expected to advertise in a responsible manner and in accordance with applicable legislation to assure the public is protected against misrepresentation.

No agency (public or private) shall advertise or identify their vehicle or agency as an EMS life support provider unless the agency does, in fact, provide service as defined in the EMS Act and has been approved by IDPH.

No agency (public or private) shall disseminate information leading the public to believe that the agency provides EMS life support services unless the agency does, in fact, provide services as defined in the EMS Act and has been approved by IDPH.

Any person (or persons) who violate the EMS Act, or any rule promulgated pursuant there to, is guilty of a Class C misdemeanor.

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 vehicles, 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.

It is the responsibility of all St. John's Hospital EMS System personnel to report such infractions

System Certification Policy

It is the responsibility of the Resource Hospital to confirm the credentials of the System's EMS providers. System certification is a *privilege* granted by the EMS Medical Director in accordance with the rules and regulations of the Illinois Department of Public Health.

System Certification Process

1. A System applicant must hold a State of Illinois license or be eligible for State licensure. EMS providers transferring in from another system or state must have all clinical and internship requirements completed prior to System certification. *Transferring into the St. John's Hospital EMS System to complete internship requirements of an EMT training program is prohibited.*
2. The System applicant must be a member of or in the process of applying for employment with a St. John's Hospital EMS System provider agency. The System agency must inform the EMS Office of the applicant's potential for hire or membership to their agency.
3. A *Pre-Certification Application* must be completed and submitted to the EMS Office.
4. The System applicant must also submit copies of the following:
 - IDPH (FR-D, EMT, Intermediate, Paramedic, or PHRN)
 - National Registry certification (if applicable)
 - ACLS (Intermediate, Paramedic)
 - PHTLS, **TECC** or ITLS (Intermediate, Paramedic)
 - PEPP or PALS (Intermediate, Paramedic)
 - CPR {AHA Healthcare Provider OR American Red Cross} (FR-D, EMT, Intermediate, Paramedic or PHRN)
 - Letter of good standing from current EMS System
5. Upon System review of the *Pre-Certification Application*, EMS Office personnel will determine if the candidate can sit for the system examination.
6. The System applicant must pass the appropriate St. John's Hospital EMS System Protocol Exam with a score of 80% or higher. The applicant may retake the exam with the approval of the EMS Medical Director. A maximum of two (2) retakes are permitted.
7. Satisfactory completion of a **90-day** probationary period is required once System certification is granted.
8. The EMS Medical Director reserves the right to deny System provider status or to place internship & field skill evaluation requirements on any candidate requesting System certification at any level.

Note: St. John's Hospital EMS System applicants from another system or state have a "grace period" to obtain PEPP or PALS. All other certifications must be current.

Maintaining System Certification

First Responder / Defibrillator (EMR)

- ALL First Responders providing EMS care must upgrade to and maintain FR-D status.
- Current AHA Healthcare Provider or ARC Professional Rescuer CPR card
- Active Member of a St. John's Hospital EMS System Agency

EMT-Basic (EMT-B)

- Current AHA Healthcare Provider or ARC Professional Rescuer CPR card
- Successfully complete periodic System protocol testing and skills evaluation
- Active Member of a St. John's Hospital EMS System Agency

EMT-Intermediate (EMT-I), EMT-Paramedic (EMT-P)

- Current AHA Healthcare Provider or ARC Professional Rescuer CPR card
- ITLS, TECC or PHTLS
- PEPP or PALS
- ACLS
- Active Member of a St. John's Hospital EMS System Agency

- Successfully complete periodic System protocol testing and skills evaluation

Prehospital RN (PHRN)

- Current AHA Healthcare Provider or ARC Professional Rescuer CPR card
- ITLS, TECC PHTLS or TNS
- PEPP or PALS
- ACLS
- Active Member of a St. John's Hospital EMS System Agency

- Successfully complete periodic System protocol testing and skills evaluation

Maintaining of current certifications and tracking of expiration dates is ultimately the responsibility of the individual provider. Agency training officers will be *assisting* with monitoring these certifications and reporting to the EMS Office. However, these individuals are not *responsible* for any certifications other than their own.

Failure to maintain *current* certification in ACLS, ITLS/PHTLS, PEPP/PALS, CPR or any other System certification may result in **suspension** of the individual in violation if an extension has not been applied for and granted through the EMS Office. In either case, **the individual will be required to take a full provider course in the lapsed certification and will NOT be allowed to simply take a refresher course for certification.** Suspended individuals will remain on suspension until proof of current certification is presented to the EMS Office.

System Resignation/Termination

A System participant may resign from the System by submitting a written resignation to the EMS Medical Director.

A System participant who resigns from or is terminated by a System provider agency has a 60-day grace period to re-establish membership/active status with another System provider agency. If the participant does not do this within the 60-day time period, then the individual's System certification will be terminated.

An EMS provider requesting to re-certify in the St. John's Hospital EMS System will be required to repeat the process for initial certification.

Provider Status

Active Provider -A EMR, EMT or PHRN is considered an active provider if he/she:

- Is System-certified at the level of his/her IDPH licensure level.
- Is active and functions at his/her certification level with a St. John's Hospital EMS System agency providing the same level of service.
- Maintains all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.

Sub-certified Provider -An EMT is considered to be a sub-certified provider if he/she:

- Is System-certified at a level other than his/her IDPH licensure level.
- Is active and functions as a provider with a St. John's Hospital EMS System agency at a level of service other than his/her IDPH licensure level.
- Maintains all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.

RESTRICTIONS:

- A sub-certified EMS provider may only function within the scope of practice of the individual's System certification and the provider level of the EMS agency.

- A sub-certified EMS provider is **prohibited** from performing skills the individual is not *System-certified* to perform regardless of the IDPH licensure level.
- A sub-certified provider is restricted to identifying himself/herself as a provider at his/her level of System certification when functioning with a St. John's Hospital EMS System agency (this includes uniform patches and name tags).
- A sub-certified provider shall apply for *independent* re-licensure if System certifications are not met for the IDPH licensure level.

Inactive (Non-participating) Provider -An EMT is considered to be inactive if he/she:

- Was previously system-certified but has not functioned with a St. John's Hospital EMS System agency for greater than 90 days.
- Maintains IDPH continuing education requirements.

RESTRICTIONS:

- An inactive provider is **prohibited** from identifying himself/herself as an EMS provider in the St. John's Hospital EMS System.
- An inactive provider is **prohibited** from performing skills or providing care that he/she is not System-certified to perform.
- An inactive provider must apply for independent re-licensure with IDPH.

Re-Licensure Requirements Policy

1. To be re-licensed as an EMS provider, the licensee shall submit the required documentation for renewal with the Resource Hospital (EMS Office) at least 60 days prior to the license expiration date. **Failure to complete continuing education requirements and/or failure to submit the appropriate documentation to the EMS Office at least 60 days prior to the license expiration date may result in delay or denial of re-licensure. The licensee will be responsible for any late fees or class fees incurred as a result.**
2. The EMS Office will review the re-licensure applicant's continuing education records. If the individual has met all requirements for re-licensure and approval is given by the EMS Medical Director, the EMS Office will submit a renewal request to IDPH.
3. A licensee who has not been recommended for re-licensure by the EMS Medical Director will be instructed to submit a request for independent renewal directly to IDPH. The EMS Office will assist the licensee in securing the appropriate renewal form.
4. IDPH requires the licensee to certify on the Renewal Notice (Child Support/Personal History Statement), **under penalty of perjury**, that he or she is not more than 30 days delinquent in complying with a child support order and previous felon status (Section 10-65(c) of the Illinois Administrative Procedure Act [5 ILCS 100/1065(c)]). The provider's social security number must be provided as well.
5. The license of an EMS provider shall terminate on the day following the expiration date shown on the license. **An EMS provider may NOT function in the St. John's Hospital EMS System until a copy of a current license is on file in the EMS Office.**
6. An EMS provider whose license has expired may, within 60 days after license expiration, submit all re-licensure material and a fee of \$50.00 in the form of a *certified check* or *money order* made payable to IDPH (Note: personal checks, cash or credit cards will NOT be accepted). **Do Not** send payment to the St. John's Hospital EMS Office! If all continuing education and System requirements have been met and there is no disciplinary action pending against the EMS provider, the Department may re-license the EMS provider.
7. **Any EMS provider whose license has expired for a period of more than 60 days and less than 36 months may be allowed reinstatement which includes retest for their license renewal (written and skills test) after a review of the situation by the Medical Director and IDPH. This only applies to a State of Illinois license for EMT (Section 3.50(d)(5) of the Illinois Administrative Procedure Act [5 ILCS 100/3.5(d)(5)]).**

****NOTE:** Failure to re-license at any level does not "automatically" drop a provider to a lower level of certification (e.g. An EMT does not automatically become a First Responder, etc.). Once a provider's license has expired, he or she is no longer an EMS provider at ANY level and cannot provide medical care in the System or the State.

8. Requests for extensions or inactive status must be submitted on the proper IDPH form and forwarded to the EMS Office at least 60 days prior to expiration. Extensions are granted only in very limited circumstances and are handled on a case by case basis. **NOTE:** The EMS Medical Director may mandate additional CEU requirements during the extension period.

9. At any time **prior to the expiration of the current license**, an EMT -I or EMT-P may revert to the EMT-B status for the remainder of the license period. The EMT-I or EMT-P must make this request in writing to the EMS Medical Director & the Department and must submit their original current EMT-I or EMT-P license to the Department. To re-license at the EMT-B level, the provider must meet all of the EMT-B requirements for re-licensure.
10. At any time **prior to the expiration of the current license**, an EMT -B may revert to the First Responder/Defibrillator (FR-D) status for the remainder of the license period. The EMT-B must make this request in writing to the EMS Medical Director & the Department and must submit their original current EMT-B license to the Department. To re-license at the FR-D level, the provider must meet all of the FR-D requirements for re-licensure.
11. The provider must submit a copy of their new IDPH license to their agency(s) and to the EMS Office. Failure to do so will result in ineligibility to function in the System.

General Continuing Education Requirements

St. John's Hospital EMS System requires:

1. Twenty-five percent (25%) of the didactic continuing education hours required for re-licensure (as an EMS provider, at any level in the St. John's Hospital EMS System) must be earned through attendance at System-taught courses or System approved courses (such as System approved agency CE classes, SIU School of Medicine or the Southern Illinois Trauma System), courses sponsored by the St. John's Hospital EMS Office or courses taught by a System-approved instructor.
2. No more than seventy-five percent (75%) of the continuing education hours required for re-licensure will consist of hours obtained from the same site code.
3. No more than twenty-five percent (25%) of the continuing education hours required for re-licensure will consist of any single subject area (*i.e.* shock, diabetic emergencies, etc.).
4. EMS providers (all levels) must attend at least one (1) continuing education program that reviews St. John's Hospital EMS System and Regional Policies, Standing Medical Orders and Operating Procedures as part of the four-year, 25% St. John's Hospital EMS System continuing education requirements. Such review will also be required with protocol updates.
5. No more than fifty percent (50%) of on-line CE will be accepted for re-licensure.
6. EMS continuing education credits must have an *approved* IDPH site code or be approved by the St. John's Hospital EMS Medical Director.
7. Continuing education credits approved for EMS Systems within IDPH EMS Region 3 will be accepted by the St. John's Hospital EMS System.
8. Prior approval must be obtained from the EMS Medical Director for continuing education programs from other IDPH regions or from other states, including national symposiums.

Summary of Re-licensure Requirements

Emergency Medical Dispatcher (EMD)

- A minimum of forty-eight (48) hours of continuing education that review the core EMD curriculum and includes review of SJH EMS System protocols.
- The dispatch certification-training program recognized by the local Emergency Telephone System Board (ETSB) may have specific requirements for re-certification. Dispatch personnel should consult the local ETSB for recertification. Dispatch personnel should consult the local ETSB for specific guidelines.

First Responder/Defibrillator (FR-D)

- A minimum of twenty-four (24) hours of continuing education that review the core First Responder curriculum and includes review of SJH EMS System protocols.
- Current *CPR/AED* certification {American Heart Association (AHA) Healthcare Provider or ARC Professional Rescuer CPR card}
- Functioning within a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"

EMT-Basic (EMT-B)

- A minimum of sixty (60) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses St. John's Hospital EMS System Protocols
- Current *CPR/AED* certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card}
- Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"
- Must meet St. John's Hospital EMS System certification (provider status) requirements to be recommended for relicensure by the EMS Medical Director

EMT-Intermediate (EMT-I)

- A minimum of eighty (80) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses St. John's Hospital EMS System Protocols
- Current *CPR/AED* certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card}
- Current certification in International Trauma Life Support (ITLS) or Prehospital Trauma Life Support (PHTLS).
- Current certification in Advanced Cardiac Life Support (ACLS)
- Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS)

- Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"
- Must meet St. John's Hospital EMS System certification (provider status) requirements to be recommended for relicensure by the EMS Medical Director

EMT -Paramedic (EMT-P)

- A minimum of one hundred (100) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses St. John's Hospital EMS System Protocols
- Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card}
- Current certification in International Trauma Life Support (ITLS) or Prehospital Trauma Life Support (PHTLS) or Tactical Emergency Combat Care (TECC).
- Current certification in Advanced Cardiac Life Support (ACLS)
- Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS)
- Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"
- Must meet St. John's Hospital EMS System certification (provider status) requirements to be recommended for relicensure by the EMS Medical Director

Prehospital RN (PHRN)

- A minimum of one hundred twenty (100) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses St. John's Hospital EMS System Protocols
- Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card}
- Current certification in International Trauma Life Support (ITLS), Prehospital Trauma Life Support (PHTLS), Trauma Nurse Core Curriculum (TNCC) or Trauma Nurse Specialist (TNS)
- Current certification in Advanced Cardiac Life Support (ACLS)
- Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS)
- Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"
- Must meet St. John's Hospital EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

Emergency Communications RN (ECRN)

- A minimum of thirty-two (32) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses **Current CPR/AED certification** {AHA Healthcare Provider or ARC Professional Rescuer CPR card}
- Current certification in International Trauma Life Support (ITLS), Prehospital Trauma Life Support (PHTLS), Trauma Nurse Specialist (TNS), or Trauma Nurse Core Curriculum (TNCC)
- Current certification in Advanced Cardiac Life Support (ACLS)
- Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS)
- Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the St. John's Hospital EMS System Medical Director"
- Must meet St. John's Hospital EMS System certification (provider status) requirements to be recommended for relicensure by the EMS Medical Director



EMS License Renewal Request

Name (as written on license): _____

License Held: _____ License Number: _____ Expiration Date: _____

Agency: _____

Category	FR/ EMR	Lead Instructor	EMT-B	EMT-I	EMT-P/PHRN
Airway Including: skills labs	2	4	4	8	10
Breathing, Patient Assessment	3	6	6	8	8
Circulation, Trauma, Shock/Resuscitation, Pathophysiology	8	12	18	24	32
Disability, Medical, Behavioral, OB/infant/Children	6	12	14	18	18
Environment, Preparations /Operations, Special Population, Pharmacology	5	6	10	14	16
Subtotal	24	40	52	72	84
Open topics	-	-	8	8	16
Total	-	-	60	80	100

Documentation Required

- CPR for Healthcare Provider

Intermediate/ Paramedic/ PHRN/ECRN

- ACLS
- PHTLS, ITLS, TNS, TECC or TNCC
- PEPP, PALS or ENPC

EMS Office

- Renewal received in EMS Office Date: _____ By: _____
- Renewal approved and processed Date: _____ By: _____
- Verify license printed with IDPH Date: _____ By: _____
- Issue affecting renewal: _____

Additional Information/ Requirements

- Lead Instructor 40 hours and
Course Evaluations
- ECRN 32 hours
- EMD 48 hours

Off-Line Medical Control, Standing Medical Orders & Protocols Policy

The Prehospital Care Manual, as developed by the EMS Medical Director, reflects nationally recommended treatment modalities for providing patient care in the prehospital setting. This Prehospital Care Manual, containing Standing Medical Orders, Protocols, Policies & Procedures, is intended to establish the standard of care which is expected of the St. John's Hospital EMS System provider.

1. Standing Medical Orders, Protocols, Policies & Procedures contained in this Prehospital Care Manual are the written, established standard of care to be followed by all members of the St. John's Hospital EMS System for treatment of the acutely ill or injured patient.
2. The EMS provider will initiate patient care under these guidelines and contact Base Station Medical Control in a timely manner for consultation regarding treatment not specifically covered by standing orders, in addition to those protocols that specify online physician's order. Diligent effort must be made to contact Medical Control in a timely manner via cellular telemetry, landline phone or VHF MERCI radio. Delay or failure to contact Medical Control for required on-line orders is a quality assurance indicator.
3. These Standing Medical Orders will be utilized as Off-Line Medical Control under the following circumstances:
 - For conditions covered by this protocol manual.
 - In the event communication cannot be established or is disrupted between the Prehospital provider and Medical Control.
 - In the event that establishing communications would cause an inadvisable delay in care that would increase life threat to the patient.
 - In the event the Medical Control physician is not immediately available for communication.
 - In the event of a disaster situation, where an immediate action to preserve and save lives supersedes the need to communicate with hospital-based personnel, or where such communication is not required by the disaster protocol.
4. Inability to contact Medical Control should not delay patient transport or the provision of life-saving therapies. Patient destination and transport decisions are set forth in these Standing Medical Orders / Protocols.

|

On-Line Medical Control Policy

On-line Medical Control is designed to provide immediate medical direction and consultation to the Prehospital EMS provider in accordance with established patient treatment guidelines and policies in this manual.

On-line Medical Control is utilized to involve the expertise of an Emergency Medical Physician in the treatment plans and decisions involving patient care in the Prehospital setting.

1. EMS communications requiring on-line contact with a base station physician shall be conducted using cellular telemetry.
2. Incoming telemetry calls will usually be answered by an Emergency Communications Registered Nurse (or ECRN). The ECRN may request Medical Control from a ED Physician if orders or consultation are needed.
3. *Pre-hospital personnel in need of on-line Medical Control shall notify the ECRN the need to speak to a ED Physician at the initiation of the report.*
4. Use of telemetry is required for patient care requiring interventions beyond the *Routine BLS, ILS or ALS* standing medical orders. Situations requiring Medical Control contact include, but are not limited to:
 - Any time an order is specifically required for BLS, ILS or ALS medications as outlined in the protocol.
 - Any time orders are needed for certain defined *procedures*.
 - Any instance an EMS provider desires *physician involvement*.
 - Any situation that involves *bypassing* a closer hospital.
 - Anytime an EMS provider feels a *deferral* is warranted.
 - Anytime a Field Training Instructor (FTI) feels a student needs to further develop communication skills.
 - **When a pre-hospital 12-Lead EKG is acquired that shows wide-complex tachycardia or consultation is needed regarding an EKG.**
 - Circumstances involving a Death on Scene (DOS) or cases involving advanced directives (DNR et al).
 - High risk refusals (*see item #8 of this policy*).
 - *First Responder* low risk refusals (*see item #9 of this policy*).
 - Use of restraints (including handcuffs).
5. **"Telemetry"** calls include all medical complaints requiring Medical Control contact, refusals, traumas and consultations.
6. **"Trauma Traffic"** includes calls that are related to injuries or mechanisms of injury that meet (or potentially meet) *Minimum Trauma Field Triage Criteria* (see *Critical Trauma Procedure*). Trauma traffic does not include refusals (including accident refusals).
7. **"MERCİ"** calls are made via MERCİ radio and called directly to the receiving hospital (or in cases where telemetry communication is not possible and consult with a physician is

necessary). MERCI communication is adequate for patient care that does not require interventions beyond *Routine BLS, ILS or ALS Care*. Specifically, patients that have received only oxygen, monitor, IV and/or medications without the need for additional orders or in cases where Medical Control contact is not required.

- If MERCI traffic prevents contact with the receiving hospital, the Resource Hospital (St. John's Hospital) may be contacted for assistance in proper routing of communications.
 - If the receiving hospital deems that further care is necessary or requests additional interventions be performed, the EMS provider should contact Medical Control. Only Medical Control (ED Physician or ECRN) at the resource hospital (SJH) may give orders.
 - If the receiving hospital requests discontinuation of treatment established by the prehospital provider, Medical Control contact should be established.
8. **High Risk Refusals** require Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High risk refusals involve cases where the patient's condition may warrant delivery of care in accordance with implied consent of the *Emergency Doctrine* or other statutory provision. High risk refusals include, but are not limited to:
- Head injury (based on mechanism or signs & symptoms)
 - Presence of alcohol and/or drugs
 - Anytime medications are given and patient refuses transport
 - Significant mechanism of injury (e.g. rollover MVA)
 - Altered level of consciousness or impaired judgment
 - Minors (17 years old or younger, regardless of injury or illness)
 - Situations that involve bypassing a closer hospital
 - Paramedic initiated refusals (patient wants to be transported but the paramedic feels it is unnecessary).
9. **Low Risk Refusals** do not require Medical Control consultation (for BLS, ILS & ALS levels) if the prehospital provider determines that the patient meets the *Low Risk Criteria* and there is no doubt that the patient understands the risk of refusal. The patient cannot be impaired and must be able to consent to the refusal. Medical Control should be contacted if there are any concerns about the patient's ability to refuse. **Low risk** refusals may include:
- Slow speed auto accidents with no intrusion into patient compartment, low mechanism of injury, and no patient injury beyond minor scrapes and bruises.
 - Fall from standing without other medical conditions and no extreme of age.
 - Isolated injuries not related to an auto accident or other significant mechanism of injury
 - False calls or "third party" calls where no illness, injury or mechanism of injury is apparent.
 - Lifting assistance or "public assist" calls (for which EMS is called for assistance in moving a patient from chair to bed, floor to bed, car to home, etc.). This assumes the EMS agency is routinely called to assist this patient, the patient is assessed to ensure there is no complaint or injury and there has been no significant change in the patient's condition. EMS crews must complete a patient care report indicating all assessment findings and assistance rendered.
10. **If the EMS provider has not been able to contact Medical Control** via cellular telemetry, telephone or MERCI radio, the EMS provider will initiate the appropriate protocol(s). Upon arrival at the receiving hospital, an incident report must be completed and forwarded to the EMS Office within 24 hours of the occurrence. This report should document all aspects of the run with

specific details of the radio/communications failure and initiation of the St. John's Hospital EMS System *Standing Medical Orders and Standard Operating Procedures*.

11. First Responders may handle **low risk** refusals only (as defined above). **Under no circumstance should a First Responder take a *high risk* refusal.**

Radio Communications Protocol

Radio communications is a vital component of prehospital care. Information reported should be concise and provide an accurate description of the patient's condition as well as treatment rendered. Therefore, **a complete patient assessment and set of vital signs should be completed prior to contacting Medical Control or the receiving hospital.**

Regardless of the destination, **early** and **timely** notification of Medical Control or the receiving hospital is essential for prompt care to be delivered by all involved.

Components of the Patient

1. Unit identification
2. Destination & ETA
3. **Age/sex**
4. **Chief complaint**
5. **Assessment (General appearance, degree of distress & level of consciousness)**
6. **Vital signs:**
 - Blood pressure (**auscultated** *or palpated if unable to auscultate)
 - Pulse (rate, quality, regularity)
 - Respirations (rate, pattern, depth)
 - Pulse oximetry, if indicated
 - Pupils (size & reactivity)
 - Skin (color, temperature, moisture)
7. Pertinent physical examination findings
8. SAMPLE History
9. Treatment rendered and patient response to treatment

NOTE: Items underlined should be transmitted without delay.

If Medical Control contact is necessary to obtain physician orders (where indicated by protocol), diligent attempts must be made to establish base station contact via:

1. Cellular telemetry to 217-753-0016 or 217-753-1089
2. Telephone landline direct to 217-525-5610
3. MERCI radio

If unable to establish contact, then initiate protocol. If Medical Control contact is not necessary, contact the receiving hospital via MERCI

Patient Right of Refusal Policy

A patient may refuse medical help and/or transportation. Once the patient has received treatment, he/she may refuse to be transported if he/she does not appear to be a threat to themselves or others, **Any person refusing treatment must be informed of the risks of not receiving emergency medical care and/or transportation.** NOTE: Family members cannot refuse transportation of a patient to a hospital unless they can produce a copy of a *Durable Power of Attorney for Healthcare*.

Refusal process

1. Assure an accurate patient assessment has been conducted to include the patient's chief complaint, history, objective findings and the patient's ability to make sound decisions.
2. Explain to the patient the risk associated with his/her decision to refuse treatment and transportation.
3. Secure Medical Control approval of **high risk refusals** (low risk refusals for First Responders) in accordance with the *Online Medical Control Policy*.
4. Complete the *Against Medical Advice/Refusal Form* and have the patient sign the form. If the patient is a minor, this form should be signed by a legal guardian or *Durable Power of Attorney for Healthcare*. NOTE: Parental refusals may be accepted by voice contact with the parent (i.e. by telephone) if the EMS provider has made reasonable effort to confirm the identity of the parent and the form may be signed by an adult witness on scene. This should be clearly documented on the refusal form and in the patient care report.
5. If available, it is preferable to have a police officer at the scene act as the witness. If a police officer is not present, any other bystander may act as a witness. However, his/her name, address & telephone number should be obtained and documented.
6. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and refuses to sign the release, clearly document the patient's refusal to sign the report. Also, have the entire crew witness the statement and have an additional witness sign your statement, preferably a police officer. Include the officer's badge number and contact Medical Control.
7. The top (white) original of the *AMA/Refusal Form* is maintained by the agency securing the refusal. The copy is forwarded to the EMS Office with the appropriate copies of the patient care report. The patient is provided with the copy of the *AMA/Refusal Form*.

Incident Reporting Policy

Prehospital care providers shall complete a St. John's Hospital EMS System (or the individual agency) *Incident Report Form* whenever a System related issue occurs. In order to properly assess the situation and determine a solution to the issue, the following information needs to be provided on the form:

1. Date of occurrence
2. Time the incident occurred
3. Location of the incident
4. Description of the events
5. Personnel involved
6. Agency and/or institution involved
7. Copy of the patient care record and/or any other related documents

Incident Report Process

1. All incident report forms shall be given to the EMS provider's immediate supervisor, training officer, or quality assurance coordinator who will assess the incident and will forward the report to the St. John's Hospital EMS System Coordinator.
2. The EMS Coordinator will review the incident and notify the EMS Medical Director and the appropriate course of action will be determined.
3. The EMS provider originating the report will be notified of the resolution.

Incident Report Indicators

Situations requiring EMS Office notification include: (see form)

- "Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or the System."
- Any deviation from St. John's Hospital EMS System policies, procedures or protocols.
- **Medication errors**
- **Treatment errors**
- Delays in patient care or scene response
- Operating on protocol when Medical Control contact was indicated but unavailable
- Violence toward EMS providers that results in injury or prevents the provider from delivering appropriate patient care
- Equipment failure (e.g. cardiac monitor, glucometer)
- Inappropriate Medical Control orders
- Repeated concerns/conflicts between agencies, provider/physician or provider/hospital conflicts
- Patterns of job performance that indicate skill decay or knowledge deficiencies affecting patient care

Situations subject to review and resolution at the agency level include:

- Conflicts between employees
- Conflicts between agencies (that do not impact patient care)
- Operational errors (that do not impact patient care)
- Behavioral issues (that do not impact patient care)

THE FOLLOWING INFORMATION
IS CONFIDENTIAL AND PROTECTED
FROM DISCLOSURE UNDER THE
MEDICAL STUDIES ACT



SAMIC EMS QUALITY ASSURANCE COMPLAINT/UNUSUAL OCCURANCE REPORT

Date:

Date of Incident:

Run Report #:

Patient Name:

Complainant:

Follow-up Address/Phone:

Notified by:

Person Reporting Complaint:

Nature of Complaint: (Briefly summarize complaint or occurrence, give dates, personnel involved, attach letter of complaint or concern, EMS run charts and any other supporting documentation.)

Complaint against: Person Agency Other (specify) _____

Category:

- | | |
|--|--|
| <input type="checkbox"/> Medication error or discrepancy | <input type="checkbox"/> Treatment/protocol |
| <input type="checkbox"/> Transport problem | <input type="checkbox"/> Response/Scene time |
| <input type="checkbox"/> Attitude/Behavior | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Other (specify) _____ | |

Referred to: EMS Coordinator EMS Med Director SJH Admin
 Risk Management IDPH EMS EMS Educator

Complaint Investigation: (Briefly describe findings attach supporting documentation.)

Action Taken: Remediation Personnel Action Suspension
 Policy revision Other(specify) _____

Letter to: Complainant EMT EMS Agency IDPH
 Other (specify) _____

Copies to: EMSMD IDPH SJH Admin Other(specify) _____

Date Closed ___/___/___

Operations/Medical Legal

3/2017

EMS Patient Care Reports Policy

Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. It is imperative that written documentation is left with the patient at the receiving facility.

Patient Care Reports

1. All EMS providers/agencies involved must complete a patient care report for each patient contact or *request* for response (e.g. agency is cancelled en route to a call then a "cancelled call" chart must be completed).
2. Ideally, a patient care report will be completed in its entirety and provided to the receiving hospital's Emergency Department immediately after transferring care to the ED staff and prior to departing the hospital.
3. If the Patient Care Reports (PCR) cannot be completed prior to departing the ED, then a St. John's Hospital EMS System provider must ensure that the receiving nurse assumes care and has been given verbal of all patient care rendered by the EMS provider. The patient care report should then be completed and faxed to the ED as soon as possible after the call (within the shift).
4. Documentation must be completed on System approved forms and/or System approved electronic reporting systems.
5. Failure to leave written documentation will be reported to the EMS Office by ED personnel. Agencies and/or personnel failing to comply with documentation requirements will be reported to the EMS Medical Director and corrective action may be taken to assure documentation policies and procedures are followed.
6. Non-transport agencies must complete patient care documentation immediately following the call.
7. Copies of all patient care reports must be provided to the EMS Office.

Patient Confidentiality & Release of Information Policy

All St. John's Hospital EMS System personnel are exposed to or engaged in the collection, handling, documentation or distribution of patient information. Therefore, all EMS personnel are responsible for the protection of this information.

Unnecessary sharing of confidential information will not be tolerated. EMS personnel must understand that breach of confidentiality is a serious issue that carries legal implications due to laws governing privacy (HIPAA). Corrective action **will** be taken including System suspension or termination.

Confidential Information Guidelines

1. Written and Electronic Documentation

- a) Confidentiality is governed by the "*need to know*" concept.
- b) Only St. John's Hospital EMS System personnel and hospital medical staff directly involved in a patient's care or personnel involved in the quality assurance process are allowed access to the patient's medical records and reports. Authorized medical records and billing personnel are allowed access to the patient's medical records and reports in accordance with hospital and EMS provider policies.
- c) Requests for release of patient care related information (from third party payers, law enforcement personnel, the coroner, fire department or other agencies) should be directed to the EMS agency's medical records department.

2. Verbal Reports

- a) St. John's Hospital EMS System personnel are **not** to discuss specific patients in public areas.
- b) EMS providers should not discuss any confidential information regarding patient care with friends and relatives or friends and relatives of the patient. This includes hospitalization of a patient and/or the patient's condition.
- c) Information gained from chart or case reviews for the purpose of education, research, quality improvement or quality assurance is considered confidential.
* E.O.

3. Radio Communications

- a) No patient name will be mentioned in the process of prehospital radio transmissions utilizing MERCI radio.

- b) Customarily, when calling in a "direct admit" the patient's initials can be included in the radio report. This is necessary for identification and is acceptable to transmit.
- c) Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.

4. Communication at the Scene

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

Patient Destination Policy

Patients should be transported to the closest appropriate hospital. A patient (or the patient's *Power of Attorney for Healthcare*) does have the right to make an informed decision to be transported to a hospital of choice. This decision should be respected unless the risk of transporting to a more distant hospital outweighs the medical benefits of transporting to the closest hospital.

*A trauma patient may benefit from transport directly to the closest appropriate **Trauma Center** rather than the closest geographically located hospital.*

*A STEMI patient may benefit from transport directly to a hospital with a **cardiac catheterization lab**.*

*A Stroke patient may benefit from transport to a **Comprehensive Stroke Center** or a **Primary Stroke Center with Endovascular Capabilities Per Region 3 Policy***

Patient Hospital Preference Guidelines

Bypassing the nearest hospital to respect the patient's hospital choice is a decision based on medical benefits and associated risks and should be made in accordance with:

1. Urgency of care and risk factors based on:
 - Mechanism of injury (physiologic factors)
 - Perfusion status and assessment findings (anatomical factors)
 - Transport distance and time (environmental factors)
2. Medical Control consultation
3. Capacity of the nearest facility or facility of choice
4. Available resources of the transporting agency
5. Traffic and weather conditions

The patient's hospital preference may be honored if:

- There are no identifiable risk factors.
- The patient has a secure airway.
- The patient is hemodynamically stable.
- The patient has been advised of the closer hospital.
- Medical Control approves.

The EMS provider will explain the benefits versus the risks of transport to a more distant hospital and contact Medical Control for approval. The patient (or representative) must sign a St. John's Hospital EMS System *AMA/Refusal Form* documenting that the patient understands the risks.

No transporting service shall bypass a hospital in order to meet an ALS intercept unless approved by Medical Control.

Patients may be transported to the hospital of choice within the city limits of Springfield without contacting Medical Control for approval as differences in transport times is negligible.

Trauma Patient Guidelines

All **trauma patients** fall under the American College of Surgeons *Field Triage Decision Scheme*. Any trauma patient who meets the ACS Field Triage Guidelines shall be transported to the Level 1 Trauma Center unless otherwise directed by Medical Control.

- If a patient is unconscious and meets ACS Field Triage guidelines for trauma, the patient will be taken to the highest level trauma center available.
- If a patient has an altered level of consciousness and meets ACS Field Triage guidelines for trauma, the patient will be taken to the highest level trauma center available.
- If a patient is alert and oriented to person, place & time with stable vital signs, and does not meet potential trauma criteria based on mechanism of injury the patient may be taken to the hospital of his/her choice in accordance with *Patient Hospital Preference Guidelines*.
- If a family member or any other person is at the Scene of an emergency and can readily prove Durable Power of Attorney for Healthcare, he/she can request that the patient be transported to a specific hospital in accordance with Patient Hospital Preference Guidelines.
- If a parent requests that a child (less than 18 years of age) who meets ACS Field Triage guidelines be taken to a specific hospital, Medical Control must be contacted for the final decision.

Transfer and Termination of Patient Care Policy

Patient abandonment occurs when there is termination of the caregiver/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 the treatment.

EMS personnel must not leave or terminate care of a patient if a need exists for continuing medical care that must be provided by a knowledgeable, skilled and licensed EMS provider **unless** one or more of the following conditions exist:

1. Appropriate receiving hospital personnel assume medical care and responsibility for the patient.
2. The patient or legal guardian refuses EMS care and transportation (In this instance, follow the procedure as outlined in the *Patient Right of Refusal Policy*).
3. EMS personnel are physically unable to continue care of the patient due to exhaustion or injury.
4. When law enforcement personnel, fire officials or the EMS crew determine the scene to be unsafe and immediate threat to life or injury hazards exist.
5. The patient has been determined to be dead and all policies and procedures related to death cases have been followed.
6. If Medical Control concurs with a DNR order.
7. Whenever specifically requested to leave the scene due to an overbearing need (e.g. disasters, triage prioritization).
8. Medical care and responsibility for the patient is assumed by comparably trained, certified and licensed personnel in accordance with applicable policies.

If EMS personnel arrive on scene, establish contact and evaluate a patient who then refuses care, the EMS crew shall conduct termination of the patient contact in accordance with the *Patient Right of Refusal Policy* and *On-Line Medical Control Policy*.

EMS personnel may leave the scene of an illness or injury incident, where initial care has been provided to the patient and the **only** responsibility remaining for the EMS crew is transportation of the patient or securing a signed refusal, if the following conditions exist:

1. Delay in transportation of another patient (i.e. trauma patient) from the same incident would threaten life or limb.
2. An occurrence of a more serious nature elsewhere necessitates life-saving intervention that could be provided by the EMS crew (and without consequence to the original patient).
3. More appropriate or prudent transportation is available.
4. Definitive arrangement for the transfer of care and transportation of the initial patient to other appropriate EMS personnel must be made prior to the departure of the EMS crew. The alternate arrangements should, in no way, jeopardize the well-being of the initial patient.

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

The priority is to the patient onboard the ambulance.

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

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

Transition of Care Policy

A smooth transition of care between EMS providers is essential for optimum patient care. First Responder and BLS non-transport crews routinely transfer care to transporting EMS providers. The transfer of advanced procedures presents unique concerns for both the EMS provider relinquishing patient care as well as the EMS provider assuming patient care. A smooth transition between providers is essential for good patient care. Cooperation between all EMS personnel is encouraged and expected.

Patient Care Transition Procedure

1. EMS providers arriving at the scene of a call shall initiate care in accordance with the guidelines provided in this manual. The EMS provider must maintain a constant awareness as to what would be the best course of action for optimum and compassionate patient care. *Focus should be placed on conducting a thorough patient assessment and providing adequate BLS care.* The benefit of remaining on scene to establish specific treatments versus prompt transport to a definitive care facility should be a consideration of each patient contact.
2. Once on scene, the EMS transporting agency shall, in conjunction with Medical Control, be the on-scene authority having jurisdiction in the determination of the patient care plan. The rank or seniority of a *non-transport provider* shall not supersede the authority vested in the transporting EMS provider by the EMS Medical Director.
3. Upon the arrival of the transporting agency, the non-transport provider should provide a detailed verbal report to the transporting provider and then **immediately transfer care to the transporting provider**. The non-transport provider may continue the establishment of BLS/ILSI ALS procedures with the concurrence of the transporting provider.
4. The transport provider should obtain report from the non-transport provider and conduct a thorough patient assessment. Treatment initiated by the non-transport provider should be taken into consideration in determining subsequent patient care steps.
5. If the provider has initiated advanced procedures, then the transport provider should verify the integrity of the procedure prior to utilizing it for further treatment (*e.g.* verify patency of peripheral IVs and ETTs should be checked for proper placement). *Transporting crews shall not arbitrarily avoid the use of (or discontinue) an advanced procedure established by non-transport personnel.* Rationale for discontinuing an established procedure should be documented on the patient care report.
6. Properly licensed and System-certified providers may be utilized to establish ILS/ALS procedures with the concurrence of the transporting provider. EMS personnel are encouraged to use all responders for efficiency in coordinating patient care.

Intercept Protocol

To improve access to Advanced Life Support in the more rural communities the EMS System Intercept Protocol should service as a guide to pre-establish procedures and work to minimize the amount of possible variables when a Basic Life Support ambulance needs assistance from an Advanced Life Support Ambulance from another geographic area. The goal should always be to provide ALS care to the patient who need ALS care in the most expeditious manner.

Dispatch Initiated Intercept

1. At the point of 911 EMD all calls prioritized as Charlie, Delta, and Echo will have ALS automatically requested from the 911 center taking the call. This dispatch should come secondary to dispatching the local unit, but in the most time efficient manner possible.
 - a. As areas needing ALS assistance are situated geographically between two or more hospitals, the 911 dispatcher is to ask patient what destination city they want to be transported to. The 911 center taking the call should then contact the 911 center in the destination location to request an intercept. The request should also include identifying the call sign of both ambulances involved in the intercept, radio frequency that will be used, and patient chief complaint. Updates may need to be provided.
 - b. If patient destination is not known, the closest 911 dispatch center with ALS ambulances services should be contacted. This should be predetermined.
 - i. ALS unit origin does not dictate patient destination. Transport units must be informed as to 24/7 capabilities of all area hospitals.
2. The BLS and ALS units must communicate via radio frequency regarding patient status and rendezvous location as soon as possible.
 - a. Radio frequency should be predetermined.
3. Rendezvous location should be off main roadways and, if at all possible, a parking lot or secondary road.
 - a. EMS providers functioning on roadways are required to meet the CFR655 (F) requirements by wearing high visibility, breakaway safety vests.
4. Patient transport/transfer
 - a. Patient care should be of the upmost priority in making decisions about which vehicle will provide transport of the patient.
 - i. The ALS ambulance, in cooperation with Medical Control, will have the ultimate authority regarding patient care decisions.
 - b. In order to address as many potential agencies as possible, intercept agreements should be pre-established between all possible agencies in the geographic area.
 - c. The decision as to whether the BLS rig can return to service should be a team decision based upon each patient situation. If needed, both rigs can be taken out of service to provide enough providers for patient care.
 - d. Should the BLS unit be returned to service, every reasonable attempt to resupply the BLS unit should be made by the ALS unit.

BLS/ILS Request for Intercept

At any time ALS can be requested based on BLS assessment or change in patient condition. In order to request that intercept

1. The BLS unit should contact their dispatching 911 center (or the center in their destination city if unable to reach their own dispatch 911 center).
 - a. Reason for request
 - b. Patient requested destination
 - c. Route of travel

- d. 911 dispatch centers should proceed with request in the same manner as if requesting based on 911 call information.
2. Both agencies should work to achieve radio communication as soon as possible.
 - a. Communication between the BLS and the ALS unit should occur prior to ALS unit arrival.
3. Patient intercept should follow the process outlined for EMD initiated dispatch.
4. Any time a BLS unit is transporting a patient with lights and siren it must be to intercept with an ALS unit.

ALS Transfer of Care to ILS/BLS

1. Should ALS arrive on scene and feel that the patient may be appropriate for (ILS) BLS care
 - a. Patient assessment must be completed and communicated to Medical Control by the senior most ALS provider of the transport unit.
 - b. ALS, ILS/BLS and Medical Control must agree that the lower level of care meets all of the patients needs.
 - c. Situations that cannot be transported by a lower level of care include
 - i. Any suspected cardiac complaint
 - ii. Respiratory distress not relieved by a single nebulizer
 - iii. Patients meeting trauma declaration criteria
 - iv. Patients with uncontrolled pain
 - v. Post-ictal seizure patients
 - vi. Imminent childbirth
 - vii. Any situation where medications were given that are not in BLS/ILS protocol
 - d. Both agencies should complete all appropriate patient documentation.

Discrepancies

Should initial units arrive and find a situation different than that which they were dispatched for, the update should be communicated to the dispatching agency and highest level of providers so to make the best use of available resources. Unless in a situation where the patient(s) are signing refusals, once initiated, the ALS unit must assess the patient. At no time should units not on scene be making decisions that supersede the decisions made by Emergency Medical Dispatch. Disagreements regarding response should be handled at an administrative level. Agencies that represent specific geographic areas must identify if they will or will not provide intercept services.

Coroner Notification Policy

In accordance with Section 10.6, Chapter 31 of the Illinois Revised Statutes -Coroners:

1. Every law enforcement official, funeral director, ambulance attendant, hospital director of administration or person having custody of the body of a deceased person, where the death is one subjected to investigation under Section 10 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 notify the coroner promptly shall be guilty of a Class A misdemeanor, unless such person has reasonable cause to believe that the coroner had already been notified.
2. Deaths that are subject to coroner investigation include:
 - Accidental deaths of any type or cause
 - Homicidal deaths
 - Suicidal deaths
 - Abortions -criminal or self-induced maternal or fetal deaths
 - 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 a place of employment, or any deaths under unknown circumstances may ultimately be the subject of investigation.
3. The coroner (or his/her designee) should be provided the following information:
 - Your name
 - Your EMS service
 - Location of the body or death
 - Phone number and/or radio frequency you are available on
 - Brief explanation of the situation
4. Once this information has been provided, wait for the coroner (or his/her designee) to arrive for further instructions. EMS crews may clear the scene if law enforcement is on the scene and no other emergency exists.
5. Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified.
6. If a patient is determined to be dead during transport, note the time & location and record this information on the patient care report. Immediately contact the coroner to discuss death jurisdiction. Do not cross county lines with a patient that has been determined to be dead.

Reporting and Control of Suspected Crime Scenes Policy

EMS providers should be aware of law enforcement's concern for preserving, collecting and using evidence. Anything at the scene may provide clues and evidence for the police.

1. Immediately notify law enforcement of any suspected crime scene (this does not necessarily include petty crimes or traffic violations).
2. If the victim is obviously dead, then he or she should remain undisturbed if at all possible.
3. Do not touch, move or relocate any item at the scene unless absolutely necessary to provide treatment to an injured, viable victim. Mark the location of any item that must be moved so the police can determine its original position.
4. Restrict access to the scene of onlookers or other unauthorized personnel on the premises of the crime.
5. Observe and note anything unusual (e.g. smoke, odors, or weapons), especially if the evidence may not be present when law enforcement arrives.
6. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt care to the patient. Remember that your role is to provide emergency care, not law enforcement.
7. Keep detailed records of the incident, including your observations of the victim and the scene of the crime. Lack of records about the case can be professionally embarrassing if called to testify.

Physician (or Other Medical Professional) On Scene Policy

Only personnel licensed to perform care in the prehospital setting and certified in the St. John's Hospital EMS System are allowed to provide advanced patient care (e.g. intubation, IV access, medication administration, pacing, etc.) at the scene unless approved by Medical Control.

An on-scene physician (or other medical professional) does **not** automatically supersede the EMS provider's authority. Patient care shall not be relinquished to another person or provider unless approved by the EMS Medical Director or Medical Control.

1. If a professed, duly licensed medical professional (e.g. physician, nurse, or dentist) wishes to participate in and/or direct patient care on scene, the EMS provider should contact Medical Control and inform the base station physician of the situation.
2. If the medical professional on scene (including the patient's primary care physician) has properly identified himself/herself and wishes to direct patient care, approval must be granted by the Medical Control Physician prior to EMS personnel carrying out the on-scene medical professional's requests or orders. If care is relinquished to the professional on scene, he/she **must** accompany the patient to the hospital. This procedure should be explained to the provider prior to contacting Medical Control.
3. If an on-scene physician orders procedures or treatments that the EMS provider believes to be unreasonable, medically inaccurate, and/or outside the EMS provider's standard of care, the EMT should refuse to follow such orders and re-establish contact with Medical Control. In all circumstances, the EMS provider shall avoid any order or procedure that would be harmful to the patient.
4. If an on-scene medical professional (or any person *claiming* to be a healthcare provider) is obstructing EMS efforts or is substantially compromising patient care, the EMS provider should redirect the interfering person, request law enforcement assistance and communicate the situation to Medical Control.
5. If EMS personnel or nursing staff from another system or jurisdiction (other than a requested intercept or mutual aid) are at the scene and request to provide or assist with patient care, excuse them from the scene if their assistance is not needed. If assistance is needed, these personnel may provide assistance with the supervision of the agency having jurisdiction of the scene. St. John's Hospital EMS System policies, procedures and protocols must be followed regardless of the assisting EMS personnel's authorized level of care.

SCHOOL BUS INCIDENT

Region 3 Policy

I. PURPOSE:

This policy governs the handling of school bus accidents/incidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with System's policies including mass casualties. The goal of this policy is to eliminate the transport of uninjured children/students to the hospital and to reduce EMS scene time and utilization of resources.

Each ambulance service provider within the System is required to design and implement a procedure for discharging uninjured children/students to their parents/legal guardians or to local school officials. Such procedures will facilitate transferring custody of uninjured children/students to the parents/legal guardians or school officials consistent with System and Regional policies. It is recommended that these policies be developed in coordination with school officials and provider's legal counsel.

II. PROCEDURE

- A. Determine the category of the accident/incident
 1. **Category I bus accident/incident** – significant injuries present in one or more children/students or there is a documented mechanism of injury that could reasonably be expected to cause significant injuries.
 2. **Category II bus accident/ incident** – minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students also present.
 3. **Category III bus accident/ incident** - no injuries present in any children/students and no significant mechanism of injury present.
- B. **Category II or III bus accident/ incident. Do not implement this policy if the accident/ incident is a Category I bus accident/ incident** – follow multiple victim and disaster preparedness policies for all Category I bus accident/ incidents, and transport all children/students to the hospital.
 - A. Contact medical control, advise of the existence of a Category II or III bus accident/ incident and determine if a scene discharge of uninjured children/students by the emergency department physician in charge of the call is appropriate.
 - B. Injured children/ students by exam and/or complaint are treated and transported as deemed necessary and appropriate by EMS personnel or at the request of the child/student.
 - C. Implement provider procedures for contacting school officials or parents/ legal guardians to receive custody of the uninjured children/students consistent with Region III policy. Procedure may include option of ambulance service provider escorting bus, if operable, back to school of origin or other appropriate destination.
 - D. Medical Control, after consulting with scene personnel, will discharge the uninjured children/students to the custody of the ambulance service provider who then will transfer

the custody of the children/students, consistent with appropriate department and regional policies and procedures, to parents/ legal guardians or school officials.

- E. Authorized school representatives will sign the log sheet indicating acceptance of responsibility for the children/students after medical clearance by the EMS personnel finding NO evidence of injury. The school representative will then follow their own policies to include informing the parents/ legal guardians as regards the accident/ incident.
- F. Any child/student having reached the age of 18 or older and any adult non-student present on the bus will initial the log sheet adjacent to their name and address when in agreement that they have suffered no injury and are not requesting medical care and/or transport to the hospital.
- G. Complete one Prehospital Care Report Form in addition to the School Bus Incident Form.

This policy addresses discharge disposition of uninjured children/students only. Thus, no release/AMA signatures are necessary. An isolated abrasion/ superficial wound can be regarded as uninjured should the EMS personnel, medical control, and the child/student all concur.

This policy is also applicable for school/student incidents not involving a bus if deemed appropriate by the responding EMS Agency and evaluated and executed in a like manner.

SCHOOL BUS INCIDENT Log

All individuals on the bus age 18 and older should initial in the indicated space adjacent to their name when uninjured. Parent/legal guardian should initial in the indicated space adjacent to their child's name when uninjured. Initials indicate agreement that no injury has been suffered and no transportation is required to the hospital.

Date:	Location:	District Name:	Bus Number:
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Run Report #	Dept. Alarm #:	Total # of Persons	# transported	# not transported:
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Adult Name (Non-student)	Function	Address & Telephone	Initials

Child/student name	Age	Address & Telephone	Initials if age > 18 Or parent/guardian

release to the custody of school officials (or parent /legal guardian) or to self if age 18 or older.

Name of (EMS) Ambulance Service Provider

Date Signature

Name of School authorized representative

Date Signature

Notice of Emergency Medical Services Response to a Minor

DATE:

FROM: (Chief or President of Provider Agency)
(Provider Agency)
(Address)
(Phone number to contact)

CHILD'S NAME:

Members of our Emergency Medical Services agency were called to evaluate your son/daughter/ward today as a result of a bus collision/incident.

After responding to the above incident, we evaluated the child. Based on our assessment and statements made by the child, it was determined that he or she did not require emergency care and/or transportation to an emergency department at that time.

Whereas your child is a minor, it is our duty to inform you of this incident so that an informed decision can be made as to whether follow-up evaluation with a physician is desired.

The child was released to a designated school representative who accepted further responsibility for him or her.

If you wish additional information, please contact our agency at the above phone number.

Infectious Disease Control Policy

The following procedure has been established in accordance with the Illinois State Statutes, Centers for Disease Control recommendations and OSHA standards. All St. John's Hospital EMS System agencies should have a specific exposure control program and post exposure plan.

Protective Measures

1. Utilization of body substance isolation gear during all patient contacts is an effective means of avoiding exposure to body fluids. EMS personnel should don protective gear prior to entering a scene or situation that may increase the risk of exposure to body fluids or other infectious agents.
2. Thorough hand washing should be accomplished immediately after each patient contact or handling of potential infectious vectors.
3. EMS personnel should consult their agency's exposure control program for specific guidelines in the type of protective gear to be worn.

Exposure

1. An exposure incident has occurred when, as a result of the performance of an EMS provider's duty, the provider's eyes, mouth, mucous membrane or area of non-intact skin has come in contact with body fluids or other potentially infectious vector. This includes parenteral contact with blood or other potentially infectious materials.
2. If EMS personnel treating and/or transporting a patient are directly exposed to a patient's body fluids or infectious vector, the provider(s) should immediately report the incident. This includes notifying the EMS provider's supervisor and following post exposure procedures.

Post Exposure Management

After an exposure has occurred:

1. Thoroughly cleanse the exposed area with soap and water immediately.
2. The eyes and/or mouth of the provider should be thoroughly rinsed with water if exposed.
3. Immediately seek treatment at the emergency department where the source patient was transported. If the source patient was not transported to an emergency department, treatment should be sought at a local hospital (emergency department).
4. Complete applicable *Communicable Disease Incident Form*. The completed form should be left with the emergency department charge nurse. The charge nurse will forward the form to EMS Office within 24 hours. The EMS provider should also provide a copy to his/her supervisor.
5. A request should be made for consent to test the source patient's blood for HBV/HCV/HIV infectivity. Testing is not necessary if the source patient is known to be infected with HBV or HIV.

6. Results of tests performed on the source patient shall be made available to the exposed EMS provider's private or occupational physician while maintaining confidentiality of all persons involved.
7. The EMS provider should follow-up with his/her private or occupational physician and the provider should be advised of available post-exposure counseling.
8. All findings or diagnosis shall remain confidential.

Questions concerning exposure control program requirements or post exposure procedures should be directed to the EMS provider's supervisor, training officer or infection control department.

Notification of EMS Personnel Exposed to Communicable Disease

1. If a patient is suspected to have, or is diagnosed with a reportable communicable disease, a copy of the ambulance patient care report will be forwarded to Infection Control Department as soon as possible by the receiving hospital emergency department supervisor.
2. The Infection Control Department will maintain a log and file. If any patients treated and/or transported by EMS providers are diagnosed as having one of the specified diseases, the designated EMS provider(s) will be notified by the Infection Control Department/EMS Office within seventy-two (72) hours after the confirmed diagnosis is known.
3. Specified diseases requiring notification of EMS personnel by the Infection Control Department include:
 - Acquired Immunodeficiency Syndrome (AIDS)*
 - AIDS-Related Complex (ARC) *
 - Anthrax
 - Chickenpox
 - Cholera
 - Diphtheria
 - Hepatitis B
 - Hepatitis non-A, non-B
 - Herpes simplex Human Immunodeficiency Virus (HIV) infection*
 - Measles
 - Meningococcal infections
 - Mumps
 - Plague
 - Polio
 - Rabies (human)
 - Rubella
 - Severe Acute Respiratory Syndrome (SARS)
 - Smallpox
 - Tuberculosis (TB)
 - Typhus

*For confirmed diagnosis of AIDS or HIV, the letter of notification will not be sent unless emergency personnel indicate

that they may have had blood or body substance exposure.

4. When a hospital patient with a listed communicable disease is to be transported by ambulance personnel, the hospital staff sending the patient shall inform the ambulance personnel of any precautions to be taken to protect against exposure to disease. If a significant exposure occurs, the ambulance personnel shall immediately report the incident as indicated above.
5. The *Hospital Licensing Act* requires any information received in the notification process be handled in accordance with confidentiality policies and procedures.

Latex Allergy Policy

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.

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
 - 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.).

Substance Abuse Policy

The St. John's Hospital EMS System considers substance abuse (drug and/or alcohol dependency) to be a health problem and will assist any System provider who becomes dependent on drugs and/or alcohol. The System, and ultimately our patients, will suffer the adverse effects of having a prehospital care provider whose work performance and attendance are below acceptable standards. Any employee whose substance abuse problems jeopardize the safety of patients, co-workers or bystanders shall be deemed "unfit to work". Any prehospital care provider involved in the St. John's Hospital EMS System who voluntarily requests assistance with a personal substance abuse problem will be referred to the EMS Medical Director for assessment and referral for treatment when necessary.

Testing for Drugs & Alcohol

The St. John's Hospital EMS System does not require employees to submit to blood and/or urine testing for drugs and/or alcohol as a routine part of their employment physical examination. However, individual agencies may require testing as part of the application process.

Any prehospital care provider may contact the EMS Medical Director (or his/her designee) if he/she has reasonable cause to suspect that a co-worker is under the influence of drugs and/or alcohol while on duty. The EMS Medical Director may choose to require the System provider to submit to a blood alcohol test and/or blood/urine toxicology screening. The cost of this testing procedure may be billed to the provider's agency, or in the case of a student, the requesting agency. Disputes related to billing of drug testing should not delay the procedure(s).

1. If a System provider who is required to submit to testing for drugs and/or alcohol refuses to cooperate, he/she will be subject to disciplinary action for insubordination (up to and including termination from the System).
2. Anyone caught tampering with, or attempting to tamper with his/her test specimen (or the specimen of any other prehospital care provider) will be subject to immediate termination from the System.
3. If any of the test results are positive, the EMS Medical Director will interview the provider. The EMS Medical Director will consult with the provider's agency to determine if referral to an assistance program shall occur.
 - The **first** occurrence will result in a referral of the prehospital care provider to the appropriate assistance program and the provider will be subject to disciplinary action as determined by the EMS Medical Director in consultation with the provider's agency/employer.
 - The **second** occurrence will result in disciplinary action as determined by the EMS Medical Director in consultation with the provider's agency/employer and may result in suspension of the provider's license and/or System certification.
 - The progress of employees with substance abuse problems who have been referred to an assistance program will be closely monitored by their agency/employer and the EMS

Medical Director. The provider must successfully complete the entire required rehabilitative program and maintain the preventative course of conduct prescribed by the assistance program. He/she must attend the appropriate after-care program(s) and provide verification of compliance with the program requirements, including additional drug testing as determined by the EMS Medical Director and the agency/employer.

4. If the test results are negative, a conference with the EMS Medical Director and the provider's agency/employer will be held to determine what future action, if any, will be taken.
5. If the prehospital care provider refuses to correct his/her health problems, he/she shall be subject to disciplinary action that pertains to all System providers who cannot, or are not, performing their job duties and responsibilities at acceptable levels.

The use, sale, purchase, transfer, theft or possession of an illegal drug is a violation of the law. *Illegal drug* means any drug which is (a) not legally obtainable or (b) legally obtainable but has not been legally obtained. The term *illegal drug* includes prescription drugs not legally obtained and prescription drugs legally obtained but not being used for prescribed purposes. Anyone in violation will be referred to law enforcement, licensing and/or credentialing agencies when appropriate.

Critical Incident Stress Management (CISM) Team Procedure

There are certain emergencies that may have a lasting emotional effect on EMS personnel. These include emergencies involving children, co-workers, familiar or particularly close persons, multiple death situations and disaster incidents. The *Critical Incident Stress Management Team* is an important resource in assisting EMS personnel in coping with stressful experiences.

1. EMS providers of the St. John's Hospital EMS System involved in an unusually stressful incident can contact the *Critical Incident Stress Management Team*.
2. The CISM Team members have specialized training in providing pre-incident education, on scene support services, defusing, demobilization, formal debriefings, one-on-one debriefings, follow-up services and specialty briefings.
3. Debriefings and stress management services are most effective when conducted within 72 hours of the incident.
4. The CISM Team Coordinator may be reached by contacting the Central Illinois Team at 217-333-8911

EMS Equipment & Supplies Policy

St. John's Hospital EMS System providers must maintain response vehicles in a manner that will limit mechanical breakdown, provide a clean environment and be engineered for compliance with OSHA standards. Providers must also have minimum equipment and supplies specified by IDPH and the EMS Medical Director.

1. EMS providers shall notify the EMS Office and IDPH of any new or replacement vehicles (including temporary loaner vehicles).
2. Initial response vehicles (First Responder and BLS Non-transport units) shall be equipped and stocked in accordance with the IDPH *Non-Transport Vehicle Inspection Form*.
3. Ambulance (transporting) vehicles must meet general standards as specified on the IDPH *Ambulance Inspection Form* and be in compliance with DOT Standard KKK-A-1822D.
4. BLS transporting vehicles shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *St. John's Hospital EMS System Agency Supply List*.
5. ILS providers shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *St. John's Hospital EMS System Agency Supply List* and *Additional ILS Equipment List*.
6. ALS providers shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *St. John's Hospital EMS System Agency Supply List* and *Additional ALS Equipment List*.
7. The addition of new equipment not listed on a specific EMS provider level checklist **requires approval by the EMS Medical Director**. In addition, the EMS Medical Director must be notified of and approve any change in AEDs or cardiac monitoring equipment as well as any changes in communications equipment that may affect Base Station communications.

First Responder Medication

Narcan	2mg/mL pre-filled
Syringes/needles/	Atomizer 3ml syringe

BLS Medication List

*Denotes BLS transport agencies only

<i>Unit Stock</i>	<i>Medication</i>	<i>Supplied</i>	<i>Expiration Date(s)</i>
2	Albuterol (Proventil)	2.5mg/3mL unit dose	1. 2.
4	Aspirin (ASA)	4-81mg chewable tablets	1. 2. 3. 4.
1	Epinephrine 1:1,000	1ml/1cc vial or ampule	
1	Glucagon	1mg & diluent unit dose	
1	Nitroglycerin (NTG)	1 bottle -0.4mg	
3	Oral Glucose	15g tube	1. 2. 3.
1	Narcan	2mg/mL pre-filled	
2	*Ondansetron (Zofran)	4mg ODT tab	
3	Needles/syringes Atomizer	1-1cc syringe, 2-3cc syringes	

ILS Medications

Unit Stock	Medication	Supplied
3	Adenocard (Adenosine)	6mg/2mL vial
2	Albuterol (Proventil)	2.5mg/3mL unit dose
1	Aspirin (ASA)	4-81mg chewable tablets
3	Atropine	1mg/10mL pre-filled syringe
6	Epinephrine 1:10,000	1mg/10mL pre-filled syringe
1	Epinephrine 1:1,000	1mg/1mL vial or ampule
2	Glucagon	1mg & diluent unit dose
2	Amiodarone	300 Mg vial
2	Narcan(Naloxone)	2mg/2mL ampule
1	Nitroglycerin (NTG)	1 bottle -0.4mg
2	Ondansetron (Zofran)	4mg ODT tab
<i>Controlled Substance Container</i>		
2	Versed (Midazolam)	10mg/2mL vial

2- D10W and assorted needles, syringes and Atomizer

ALS Medication List

Unit Stock	Medication	Supplied
3	Adenocard	6mg/2mL vial
2	Albuterol	2.5mg/3mL unit dose
1	Amiodorone	150mg/3mL with 100mL D5W for infusion
1	Aspirin (ASA)	4- 81mg Chewable tablets
3	Atropine	1mg/10mL pre-filled syringe
2	Atrovent (Ipratropium)	0.5mg/2.5mL unit dose
2	Benadryl (Diphenhydramine)	50mg/1mL pre-filled syringe
1	Dopamine	400mg/250mL D5W
2	Epinephrine 1:1000	1mg/1mL ampule
6	Epinephrine 1:10,000	1mg/10mL pre-filled syringe
1	Glucagon	1mg & diluent unit dose
1	Lidocaine	100mg/5mL pre-filled syringe
2	Narcan (Naloxone)	2mg/2mL ampule
1	Nitroglycerin (NTG)	1 bottle-0.4mg
2	Ondansetron (Zofran)	4mg ODT tab
2	Plavix	600 mg
3	Amiodarone	150 mg vial
2	Sodium Bicarbonate	50mEq/50L pre-filled syringe
2	D10W	250ml IV
	<i>Controlled Substances</i>	
1	Fentanyl	100mcg/2mL vial
2	Morphine	4mg/1mL tubex
1	Versed (Midazolam)	10mg/2mL vial
Assorted	Syringes, needles, Atomizer	3-1cc, 3-3cc, 2-5cc, 2-10cc

Controlled Substance Policy

The St. John's Hospital EMS System recognizes the importance of medications carried on the ambulances in relationship to patient care. It is also important to understand the risks involving the potential abuse and addiction of controlled substances and to have tracking mechanisms in place.

1. All controlled substances will be kept inside each ambulance/apparatus within the drug box (preferably) or designated cabinet.
2. At the beginning of a shift, the on-coming paramedic (or intermediate at the ILS level) will verify that the controlled substance tag is secure and the tag number is to be verified with the log.
3. After assuring the tag is intact and the number corresponds with the log, the paramedic must sign the controlled substance shift log.
4. If the tag is **not** intact or the number is not verifiable, a complete inventory should be taken immediately, a supervisor shall be notified and an incident report will be completed and forwarded to the St. John's Hospital EMS Office.
5. Controlled substances shall be available for inspection by IDPH, St. John's Hospital EMS office, or any other authorized individual.
6. Each usage of a controlled substance must be documented on the proper "Controlled Substance Usage Form". All of the following information is to be completed:
 - Date of administration
 - Time of administration
 - Old tag number
 - New tag number
 - FIN & Destination
 - Drug & dose given
 - Drug amount wasted
 - Total amount of drug
 - Paramedic signature (or intermediate signature at the ILS level)
 - Witness signature (RN or MD at the receiving hospital)
7. The controlled substances shall be inspected once a month. This inspection will be documented with the old and new tag number. Any discrepancies (e.g. missing medication, broken seals, etc.) should be reported to a supervisor immediately. If no problems are found, the log will be signed and witnessed.
8. By signing the log (at ALS agencies), the paramedic is ensuring that the following controlled substances are secure:
 - 1-Fentanyl 100mcg/2mL vial
 - 2 -Morphine 4mg/1mL tubex
 - 2 -Versed 5mg/5mL vial

9. By signing the log (at the ILS level), the intermediate is ensuring that the following controlled substance is secure:
 - 2 -Versed 5 mg/5 mL vial
10. Any controlled substance that has not been administered must be properly disposed of. The amount wasted must be noted on the log and witnessed by a nurse or physician at the receiving hospital.
11. Controlled substances (e.g. Fentanyl, Morphine, Versed) should be restocked at the receiving hospital if possible. The EMS agency may be billed for restocked controlled substances.
12. At the end of each shift, the paramedic (or intermediate at the ILS level) will verify that the controlled substance tag is secure and the tag number matches the log. Any new tag number must be documented on the log.
13. The controlled substance shift log form will be changed at the end of each month. Thus, a new log will be started on the 1st day of each month.

Drug Shortage Policy

Due to the demand, expirations and other limiting factors, drug shortages seem to be a reality of the medical world in which we function. While seeking other supply options should always be explored there are times when shortages of desired medications cannot be alleviated and alternatives must be used. It would be impossible to plan for all possible shortages within this protocol manual. Instead providers must be ever aware that this issue exists and be attentive that attempts to address such shortages may be more or less obvious to providers. Therefore, providers must always be alert when pulling medications and verify the **six rights** before administering any medication. The following steps shall be followed:

1. In the event of a known or anticipated shortage the pharmacy will contact the EMS Office with the drug affected by the shortage and anticipated time frame of the shortage. A staff pharmacist and the EMS Medical Director will discuss the situation and develop a plan for responding to the shortage. This plan could include:
 - a. Changing the concentration of a drug that is already used by EMS. (I.e. EMS carries Morphine 4mg/4mL but instead will be given 10mg/10mL.)
 - b. Using a different concentration such that the drug will be given differently. (I.e. Dextrose 50% is not available but D10W will be given to be infused over 15 minutes.)
 - c. Using an alternative drug that can be reconstituted to make the unavailable drug. (i.e. Giving Epi 1:1,000 and 10 mL of Normal Saline with directions for making Epi 1:10,000)
 - d. Giving a replacement drug. (I.e. Lidocaine is not available but Amiodarone is. Amiodarone is provided with training given to all affected agencies.)
 - e. Not replacing a drug that is affected by shortage. (I.e. Narcan is affected by shortage; but no suitable replacement is available. Treatment would need to proceed to next step in protocol sequence.)
2. This plan will be communicated to all affected agencies and include any necessary training information.
3. This plan will be communicated to all affiliated hospital pharmacies.
4. Notice will be posted at the Pyxis where EMS providers obtain their medications.
5. When the shortage is over notice will be given to all affected agencies and previously posted, notices will be removed from the refill areas.