HSHS
St. John's
SAMIC EMS

# Prehospital Policies, Guidelines, and Procedures

January 2019

# Protocol Introduction

Welcome to the revitalized edition of the SAMIC EMS System protocols. We hope the following changes will allow for easier navigation through the protocols. We now utilize a four digit numbering system to quickly identify protocol type and age group. The tens and ones places XX__ indicate the individual protocol of that section. The hundreds place X_XX will have a 1 for adult protocols and a 2 for pediatric protocols. The pediatric protocols are mixed though out but colored for quick identification. The thousands place _XXX indicates the protocol section; see the table of contents for familiarization of the layout.

The process for following the appropriate protocol should begin at the lowest level of care regardless of the level of the provider. Therefore, paramedics should begin with the EMR care and work towards the bottom. If you are directed to a different protocol, you should begin at the EMR level and work to your level of care.

You will notice medications may not always have the routes of administration listed. This was intentional so those medications indicated can be given based on the provider's scope of practice rather than the level of care in the protocol. Appropriate routes are listed in **Drug Administration Routes 9500**.

HSHS St. John's SAMIC EMS

# POLICY 0002

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# System Hospitals

**Resource Hospital**

HSHS St. John's Hospital

EMS Office 217-525-5645

MICU Line 217-753-0016 or 217-753-1089

**Associate Hospitals**

HSHS St. Francis Hospital, Litchfield, IL

HSHS St. Anthony's Memorial Hospital, Effingham, IL

Mason District Hospital, Havana, IL

**Participating Hospital**

Hillsboro Area Hospital, Hillsboro, IL

# Scope of Practice

| | EMR | EMT | ILS | ALS |
|---|---|---|---|---|
| **Monitoring** | | | | |
| Blood Glucose Monitor | X | X | X | X |
| Pulse Oximetry | X | X | X | X |
| Capnography Monitoring | | X | X | X |
| Blood Chemistry Analysis | | | X | X |
| ECG Rhythm and 12 Lead ECG interpretation | | | X | X |
| **Airway/Ventilatory Management Oxygen Delivery** | | | | |
| Positioning | X | X | X | X |
| OPA/NPA | X | X | X | X |
| Obstructed Airway Maneuvers | X | X | X | X |
| Oral Suctioning | X | X | X | X |
| Tracheal-bronchial suctioning | | X | X | X |
| Stoma Suctioning | | X | X | X |
| Oxygen Administration NC, NRM, BVM, | X | X | X | X |
| Blind Insertion Airway Device | | X | X | X |
| Occlusive Dressing to Chest Wall Injury | X | X | X | X |
| Magill Forceps for Airway Foreign Body Removal | | | X | X |
| Intubation – Adult and Pediatric | | | X | X |
| CPAP and PEEP | | X | X | X |
| Needle/Surgical Cricothyrotomy | | | | X |
| Needle Decompression | | | X | X |
| Use of Transport Ventilators | | | | CCP |
| **Circulatory/Cardiac Management, Vascular Access** | | | | |
| High Quality CPR | X | X | X | X |
| Mechanical CPR Device | X | X | X | X |
| Bleeding Control – Elevation, Pressure, Tourniquet, Hemostatic Agents | X | X | X | X |
| AED Use | X | X | X | X |
| Application of ECG Monitor Including 12/15 Lead Acquisition and Transmission | | X | X | X |
| ECG and 12/15 Lead Interpretation | | | X | X |
| Spiking IV Bag, Priming Tubing for Access | | X | X | X |
| Manual Defibrillation | | | X | X |
| Synchronized Cardioversion | | | X | X |
| Transcutaneous Pacing | | | X | X |
| IV Access – Adult and Pediatric | | | X | X |
| IO Access – Adult and Pediatric | | | X | X |

| | EMR | EMT | ILS | ALS |
|---|---|---|---|---|
| EJ Access – Adult and Pediatric | | | | X |
| Central Line/Fistula Access | | | | X |
| **Psychomotor Skill** | | | | |
| Backboard Use | X | X | X | X |
| C-Collar Application | X | X | X | X |
| Monitoring OG/NG Tube Already Placed | | X | X | X |
| Selective Spinal Precautions | | X | X | X |
| Splinting/Bandaging | X | X | X | X |
| Vaginal Delivery | X | X | X | X |
| Limb Restraints | X | X | X | X |
| Eye Irrigation with Morgan Lens | | | | X |
| Assess JVD and Pulsations | | | X | X |
| Temperature Management in ROSC Patients | | | X | X |
| Burn Care | X | X | X | X |
| Protective Equipment Removal | | X | X | X |
| Monitoring Urinary Catheter Already Placed | | | X | X |
| **Medication Routes** | | | | |
| Oral | X | X | X | X |
| Oral Disintegrating Tablet | | X | X | X |
| Sublingual | | X | X | X |
| Inhalation | X | X | X | X |
| Intranasal | X | X | X | X |
| Intramuscular | Auto | X | X | X |
| Intravenous | | | X | X |
| Intraosseous | | | X | X |

# Scope of EMS Service

Revised: 10/18

**Policy:**

Provide the basis for the provision of Emergency Medical Services in the Springfield Area Mobile Intensive Care (SAMIC) EMS System.

**Special Instructions:**

- When functioning as a prehospital care provider in the SAMIC EMS System, you are expected to meet particular patient care standards and administrative requirements. These patient care expectations can be simply explained as the "Standard of Care."
- Realistically, your patient care standards are compared to other prehospital care providers who are expected to conform and perform with a reasonable level of skill, knowledge, and competence.
- The policies, procedures, and standard medical orders are to serve as guidelines for prehospital personnel and are derived from current National Standard Curricula for Emergency Medical Responder, EMT, EMT-Intermediate, Advanced EMT, EMT-Paramedic, and EMS Instructor; national and/or state recognized standards for care (i.e., ACLS, BLS, PALS, BTLS, EMSC, etc.), Illinois EMS System Act, Illinois EMS and Trauma Center Code, and the policies and procedures for HSHS St. John's Hospital.
- Any deviation from an approved standing medical order, policy, or procedures should be submitted to the EMS Medical Director or designee, in writing, within 24 hours of the occurrence for review.

HSHS St. John's SAMIC EMS

# POLICY 0012

## EMS Medical Director Responsibilities

Revised: 10/18

**Policy:**

Provide for the overall medical control management of the Springfield Area Mobile intensive Care (SAMIC) EMS System.

**Special Instructions:**

- Fulfill the role of EMS Medical Director as outlined in the EMS Systems Act (210 ILCS 50) and the EMS and Trauma Center Code (77 Ill. Adm. Code 515).
- Ensure the Department access to all records, equipment and vehicles under the authority of the EMSMD during any Department inspection, investigation or site survey.
- Work in cooperation with the EMS Administrative Director and the EMS Facilitator regarding the supervision of all personnel participating within the System, as described in the System Program Plan.
- Work in cooperation with the EMS Facilitator and EMS Educator regarding the educational needs of all system personnel including coordinating didactic and clinical experience.
- Develop written standing orders (treatment protocols, standard operating procedures) to be used in the EMS MD's absence and certify that all involved personnel will be knowledgeable in emergency care and capable of providing treatment and using communications equipment once the program is operational.

HSHS St. John's SAMIC EMS

# POLICY 0013

## Assistant EMS Medical Director Responsibilities

Revised: 10/18

**Policy:**

Provide for the overall medical control management of the Springfield Area Mobile Intensive Care (SAMIC) EMS System in the absence of the EMS Medical Director.

**Special Instructions:**

- Fulfill the role of EMS Administrative Director as outlined in the EMS Systems Act (210 ILCS 50) and the EMS and Trauma Center Code (77 Ill. Adm. Code 515).
- Ensure the Department access to all records, equipment and vehicles under the authority of the EMS System during any Department inspection, investigation or site survey.
- Work in cooperation with the EMS Medical Director and the EMS Facilitator regarding the supervision of all personnel participating within the System, as described in the System Program Plan.
- Work in cooperation with the SAMIC EMS System, HSHS St. John's Hospital and the Illinois Department of Public Health regarding EMS issues.

# EMS Administrative Director Responsibilities

Revised: 10/18

**Policy:**

Provide for the overall management of the Springfield Area Mobile Intensive Care (SAMIC) EMS System and its role within HSHS St. John's Hospital.

**Special Instructions:**

- Fulfill the role of EMS Administrative Director as outlined in the EMS Systems Act (210 ILCS 50) and the EMS and Trauma Center Code (77 Ill. Adm. Code 515).
- Ensure the Department access to all records, equipment and vehicles under the authority of the EMS System during any Department inspection, investigation or site survey.
- Work in cooperation with the EMS Medical Director and the EMS Facilitator regarding the supervision of all personnel participating within the System, as described in the System Program Plan.
- Work in cooperation with the SAMIC EMS System, HSHS St. John's Hospital and the Illinois Department of Public Health regarding EMS issues.

# EMS System Coordinator Responsibilities

Revised: 10/18

**Policy:**

Provide for the management and coordination of the Springfield Area Mobile Intensive Care (SAMIC) EMS System.

**Special Instructions:**

- Fulfill the role of EMS System Coordinator as outlined in the EMS Systems Act (210 ILCS 50) and the EMS and Trauma Center Code (77 Ill. Adm. Code 515).
- Perform duties as outlined in the HSHS St. John's Hospital EMS Facilitator job description.
- Ensure the Department access to all records, equipment and vehicles under the authority of the EMS System during any Department inspection, investigation or site survey.
- Work in cooperation with the EMS Administrative Director and the EMS Medical Director regarding the supervision of all personnel participating within the System, as described in the System Program Plan.
- Work in cooperation with the EMS Medical Director and EMS Educator regarding the educational needs of all system personnel including coordinating didactic and clinical experience.

# Methods of Providing EMS Services

Revised: 10/18

**Policy:**

Provide the public with the appropriate prehospital care through the dispatching of the proper response and transport vehicles. Make provisions for mutual aid response when assistance is needed.

**PROCEDURE:**

- Single vehicle response and transport.
  - For all routine transfers and non-emergency BLS calls, an ambulance meeting at least BLS personnel and equipment requirements will be dispatched by the appropriate agency.
    - If a BLS or ILS ambulance finds that ALS care is needed, an ALS unit will be dispatched.
  - If additional assistance is found to be needed by the responding ambulance, they will notify their appropriate dispatcher, who will in turn notify the appropriate agency for assistance.
- Dual vehicle response and transport.
  - For all emergency calls, an ambulance meeting at least BLS personnel and equipment requirements will be dispatched by the appropriate agency.
  - For all emergency calls, the appropriate non-transporting agency will be notified to provide initial response and/or support to the transporting agency.
  - For all emergency calls in which the patient requires an advanced level of care, the appropriate ALS agency shall be notified.
  - Responding agencies should work in cooperation for the benefit of the patient(s) and provide the most appropriate level of care available
- Level of first response vehicle.
  - Any agency responding to a non-emergency or emergency call will provide at least emergency medical responder level of care.
  - For all emergency calls in which the patient requires an advanced level of care, the appropriate ALS agency shall be notified.
  - Responding agencies should work in cooperation for the benefit of the patient(s) and provide the most appropriate level of care available
- Level of transport vehicle.
  - Routine transfer and non-emergency calls will be dispatched to an ambulance functioning at least to the BLS level for treatment and transport.
    - If a BLS or ILS ambulance finds that ALS care is needed, an ALS unit will be dispatched.
  - Emergency calls will be dispatched to an ambulance functioning at least to the highest level of care available.

    - If a BLS or ILS ambulance finds that ALS care is needed, an ALS unit will be dispatched.
  - Responding agencies should work in cooperation for the benefit of the patient(s) and provide the most appropriate level of care available.
- Mutual Aid agreements.
  - Transporting agencies should have a mutual aid agreement(s) or policy provisions for covering their response area when their primary unit is on a call.
  - Non-transporting agencies must have a mutual aid agreement(s) with a transporting agency (ies).
- Caller notification.
  - Callers will be advised of the approximate response times for the first response units and the transporting ambulance if this information is requested by the caller.

HSHS St. John's SAMIC EMS

# POLICY 0017

## EMS System Manual Distribution and Updates

Revised: 10/18

**Policy:**

Provide a means for the distribution of the SAMIC EMS System Manual, Regional EMS Manual/Procedures, and their subsequent updates.

**Procedure:**

- All participants in the SAMIC EMS System will receive a copy of the Medical-Legal, Operation, and Education policies, and Standing Medical Orders appropriate to the participant's licensed level of care.
- System Manual updates will be distributed to participants in the System as appropriate for the type of update. Minor updates will be included in the *The Run Report*, a monthly newsletter published by the EMS Department.
- In-services will be provided to assist in the distribution of updated information, skills, and Standing Medical Orders, as appropriate.
- Information on Regional issues relevant to the participating agencies and personnel will be distributed through in-services, direct communications, and/or the SAMIC Run Report.

HSHS St. John's SAMIC EMS

# POLICY 0018

## Medication and Equipment Replacement

Revised: 10/18

**Policy:**

Provide for the replacement of medications and disposable equipment utilized during the rendering of patient care by participants in the SAMIC EMS System.

**Procedure:**

- The Resource, Affiliate, and Participating hospitals in the SAMIC EMS System agree to exchange medications and equipment with pre-hospital providers participating in this EMS System or other EMS System where ambulances transport to our facility.
- Non-transporting agencies should be able to obtain replacement for standard disposable items from the transporting agency.
- Transporting agencies should be able to obtain replacement for standard disposable items from the receiving facility.

**Medication Replacement:**

- Associate Hospitals in the SAMIC EMS System will replace used or outdated medications according to their current hospital pharmacy department policy on replacement of prehospital medications.
- When a used or outdated medication box is brought to the St. John's Hospital Emergency Department medications will be replaced according to the current policy posted on replacement of EMS medications in the EMS restocking room.

# Minimum Vehicle Staffing

Revised: 10/18

**Policy:**

Provide quality prehospital care through the appropriate staffing of both transport and non-transporting vehicles participating in the SAMIC EMS System.

**Procedure:**

Transporting agencies

- Each Basic Life Support ambulance shall be staffed by a minimum of one System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician on all responses.

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

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

Non-transporting Agencies

- ALS Non-Transport Vehicles shall have a minimum of either one System authorized Paramedic or one PHRN and one additional System authorized A-EMT, EMT-I, EMT or physician, and shall have all of the required equipment.

- ILS Non-Transport Vehicles shall have a minimum of either one System authorized A-EMT, EMT-I, Paramedic or PHRN and one additional System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN or physician and shall have the required equipment.

- BLS Non-Transport vehicles shall be staffed by one System authorized EMT, A-EMT, EMT-I, Paramedic or physician on all responses and shall have all of the required equipment.

# Professional Conduct / Code of Ethics

Revised: 10/18

**Policy:**

Professional status as an EMT-Basic, EMT-Intermediate, EMT-Paramedic or Prehospital RN 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 services.

**Procedure:**

- A fundamental responsibility 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.
- Provide services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status.
- Do not use professional knowledge and skills in any enterprise detrimental to the public wellbeing.
- Respect and hold in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
- As a citizen, understand and uphold the law and perform the duties of citizenship; as a professional, you have a never ending responsibility to work with concerned citizens and other health professionals in promoting a high standard of emergency medical care to all people.
- Maintain professional competence and demonstrate concern for the competence of other members of the emergency medical services health care team.
- Assume responsibility in defining and upholding standards of professional practice and education.
- Assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws which affect the practice of emergency medical services.
- Has the responsibility to be aware of and participate in matters of legislation affecting emergency medical services.
- Adhere to standards of personal ethics which reflect credit upon the profession.
- If you or your group advertises emergency medical services, do so in conformity with the dignity of the profession.
- Have an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of and EMT-B, EMT-I, EMT-P, or Prehospital RN.
- Work harmoniously with and sustain confidence in emergency medical services personnel, the nursing personnel, the physician, and other members of the emergency medical services health care team.

- Refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

HSHS St. John's SAMIC EMS

# POLICY 0021

## In-Field Service Level Upgrade

Revised: 10/18

**Policy:**

Optimize patient outcomes by providing the highest level of care available to those patients who warrant such higher level care.

**Procedure:**

- When EMS personnel respond to a medical or traumatically injured patient, the responding personnel should begin thinking that an intercept of a higher level of care may be of benefit to the patient.

- When a patient's condition warrants a higher level of care and an advanced level is available, the more advanced agency shall be called immediately for assistance.

- Patient conditions that are likely to benefit from advanced care include, but are not limited, to:
  - Trauma patients entrapped with extended extrication
  - Patients with compromised or obstructed airway
  - Patients exhibiting signs of hypoxemia (respiratory distress, restlessness, cyanosis, altered mental status, etc.)
  - Cardiac arrest
  - Unstable cardiac rhythms
  - Chest pain unresolved with oxygen or nitroglycerin
  - Patients exhibiting signs of decompensating shock (B/P <100 systolic, diaphoresis, altered mental status, tachypnea, etc.)
  - Unconscious patients
  - Pediatric cases with any of the above
  - Any case deemed by the responding agency or Medical Control as beneficial to patient outcome

- When determining the need for a higher level of care, consideration should be given to the following:
  - Transport time to the receiving hospital
  - Rendezvous site
  - Availability of resources
  - Interventions needed (i.e., defibrillation, airway management, medications, etc.)

- Decisions for or against requesting a higher level of care should be based on the patient's best interests. Better to err on the side of the patient.

- It is the responsibility of the responding agency to request response of the higher level of care when the patient's condition warrants.

- Additionally, the receiving and/or treating hospital may, based upon the initial provider's assessment, initiate the dispatching of a higher level of care.

- Through coordination via communications with the appropriate dispatching entities, the initial responding agency and the higher level agency will rendezvous at a reasonable and safe location.

- Pertinent patient information should be transmitted to the intercepting agency prior to the rendezvous.

- Transfer of care

  - Safety will be emphasized throughout the intercept and transfer of care.
  - Patient transport should not be unreasonably delayed.
  - If at all possible, the patient should not be transferred from ambulance-to-ambulance except for extenuating circumstances.
  - The higher level personnel with proper equipment shall board the transporting vehicle and oversee patient care with the assistance of the requesting agency's personnel.
  - The transporting ambulance will, at that point, become temporarily, and only during the duration of the transport, a higher level of care vehicle.

HSHS St. John's SAMIC EMS

# POLICY 0022

## Resource Hospital Override

Revised: 10/18

**Policy:**

Provide a mechanism for protection and a mode of documentation to assure that any suspected infectious disease contamination is properly documented and any required follow-up is completed.

**Procedure:**

- Overrides should only occur when the Resource Hospital may have additional information regarding the patient's care or where the procedure or medication ordered by the managing hospital may potentially harm the patient and there needs to be clarification or modification of those orders.
- Upon detection of a possible situation that might require the override of the managing hospital, immediate communications between the Resource and managing hospitals ER physicians shall be conducted.
- If clarification of the medication or treatment is obtained, the managing hospital ER physician will clarify the questioned situation and continue to manage the patient's prehospital care.
- If there is a disagreement between the managing hospital ER physician and the Resource Hospital ER physician, the Resource Hospital's ER physician opinion and recommendation will prevail.
- If there are prevailing disagreements and ongoing prehospital care issues that are not resolved by the physician-to-physician communication, immediately contact the EMS Medical Director or designee to settle the matter.
- All instances of Resource Hospital overrides or intervention must be reported by the Resource and managing hospitals to the EMS Medical Director within forty-eight hours of the incident.
- Prehospital care personnel are ultimately responsible for following the orders of the Resource Hospital's ER physician.

# POLICY 0023

## Infection Control

Revised: 10/18

**Policy:**

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

**Procedure:**

**Protective Measures**

- 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.
- Thorough hand washing should be accomplished immediately after each patient contact or handling of potential infectious vectors.
- EMS personnel should consult their agency's exposure control program for specific guidelines in the type of protective gear to be worn.

**Exposure**

- 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.
- 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:

- Thoroughly cleanse the exposed area with soap and water immediately.

- The eyes and/or mouth of the provider should be thoroughly rinsed with water if exposed.

- 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).

- 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.

- A request should be made for consent to test the source patient's blood for HBVIHCV/HIV infectivity. Testing is not necessary if the source patient is known to be infected with HBV or HIV.

- 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.

- The EMS provider should follow-up with his/her private or occupational physician and the provider should be advised of available post-exposure counseling.

- 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**

- 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.

- 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.

- 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.

- 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.

- The *Hospital Licensing Act* requires any information received in the notification process be handled in accordance with confidentiality policies and procedures.

HSHS St. John's SAMIC EMS

# POLICY 0024

## Problem Resolution

Revised: 10/18

**Policy:**

Provide a mechanism for the identification, investigation, review, and resolution of occurrences or problems within the SAMIC EMS System.

**Procedure:**

- Situations involving a medication or other treatment affecting the immediate patient care shall be verbally reported to the receiving hospital as soon as identified. A written report on the situation, meeting the below criteria, will be forwarded to the EMS Medical Director or EMS Facilitator within 24 hours of the event.
- Situations involving non-immediate patient care issues or deviation for approved policies and/or procedures shall be reported, in writing, to the EMS Medical Director or EMS Facilitator within 24 hours of the event.
- Other situations which EMS personnel or agencies feel should be brought to the attention of the EMS Director and/or EMS Facilitator shall be reported, in writing, to the EMS Medical Director or EMS Facilitator.
- All situations reported shall be in writing and consist of at least the following:
  - date/time of the event/occurrence
  - location where event occurred
  - personnel and/or agencies involved
  - detailed description of the event
  - any other information that may be pertinent (ePCR number, statements, etc.)
- The EMS Medical Director, EMS Facilitator, or designee will investigate and/or review the situation/event and determine what corrective action(s), if any, is necessary. Information regarding the event, investigation, and/or review is confidential and protected under the Medical Studies Act. Information on the event shall remain on file in the SAMIC EMS Office.

HSHS St. John's SAMIC EMS

# POLICY 0025

## ILS/ALS Assessment of Patient being Treated by BLS

Revised: 10/18

**Policy:**

Provide a mechanism for the continuity of care between BLS, ILS, and ALS personnel.

**Procedure:**

- Always keep the "best interest of the patient" in mind. The continuity of care must continue without interruption.
- EMS personnel shall maintain professionalism when dealing with multiple agencies and different levels of personnel.
- ILS and ALS personnel should include the assessment and/or treatment rendered by BLS personnel as part of total patient care.
- ILS and ALS personnel should work with the BLS personnel in understanding the patient care situation while avoiding the appearance of conflicts.
- Any conflict between BLS, ILS, and ALS personnel should not be brought to light in front of the patient, family, bystanders, etc., however, should be later addressed between personnel, agencies, or the EMS System. Any specific problems may be brought to the attention of the EMS Medical Director and/or EMS Facilitator utilizing the Problem Resolution policy.

HSHS St. John's SAMIC EMS

# POLICY 0026

## Physician Direction and Voice Orders

Revised: 10/18

**Policy:**

Provide a mechanism for the direction of patient care in the prehospital setting.

**Procedure:**

- All EMS personnel should remember that they are part of the healthcare team. Prehospital personnel are the eyes, ears, and hands of the ER personnel. Prehospital care may only be rendered under the license of the EMS Medical Director through verbal or written standing medical orders
- All EMS personnel participating in SAMIC may follow the written standing medical orders as included in the approved Program Plan/System Manual (except where contact with the hospital is required prior to a specific treatment) for patients presenting with the appropriate signs and/or symptoms.
    - Associate Hospitals may require prior contact for any prehospital treatment. Such policies should be outlined in hospital directives and distributed to those agencies that routinely transport to that facility.
- In addition to those situations specified in the written standing medical orders where contact with the hospital is required prior to the treatment, EMS personnel may contact the Resource, Affiliate, or Participating Hospital at any time for review of assessment and treatment direction.
- The voice order(s) of the ER physician, either directly or through the ECRN, shall supersede those written standing medical orders.
- Conflicts between verbal orders and standing medical orders may be resolved following the Resource Hospital Override Policy.

# ECRN Contacting ER Physician

Revised: 10/18

**Policy:**

Provide a mechanism for the Emergency Communication Registered Nurse to function under the direction of the ER physician.

**Procedure:**

- All ECRNs should remember that they are part of the healthcare team. Prehospital care may only be rendered under the license of the EMS Medical Director through verbal or written standing medical orders.
- All ECRNs participating in SAMIC may follow the written standing medical orders as included in the approved Program Plan/System Manual for patients presenting with the appropriate signs and/or symptoms.
    - Associate Hospitals may require more direct ER physician involvement in prehospital patient care decisions. Such policies should be outlined in hospital directives and distributed to those ECRNs functioning with that hospital.
- The voice order(s) of the ER physician, ECRN, shall supersede those written standing medical orders. The ECRN may request such orders from the ER physician.
- Conflicts between verbal orders of the ER physician or ECRN and standing medical orders may be resolved following the Problem Resolution policy.

HSHS St. John's SAMIC EMS

# POLICY 0028

## Continuous Quality Improvement Plan

Revised: 10/18

**Policy:**

Provide a means of quality patient care through monitoring, reviewing, data collection, interaction with EMS personnel, and participation in various regional, state, and national EMS activities.

**Procedure:**

- Continuous quality improvement activities include, but are not be limited to, the following.
    - Review of the Illinois Prehospital Care Report form data and utilization of collected data in overall quality improvement.
    - Announced and/or unannounced visits with participating agencies within the System. Information from these visits will be reviewed for appropriate recommendations.
    - Prehospital care providers may be monitored in the field setting. The EMS System representative conducting the monitoring will complete a written evaluation and discuss it with the prehospital provider. This evaluation will become part of their permanent file in the EMS office. Major concerns will be brought to the attention of the prehospital care provider's agency and the EMS Medical Director.
    - Retrospective audits on selected topics will be done on a periodic basis. These results may be reported to the participating agencies and/or included in case review sessions.
    - Investigation and follow through on any problematic situation or complaint.

# Discipline and Suspension

Revised: 10/18

**Policy:**

Assure due process is provided to all prehospital and hospital personnel participating in the SAMIC EMS System.

**Procedure:**

- The EMS Medical Director may suspend form participation within the SAMIC EMS System any individual, provider agency, or other participant considered not to be meeting the requirement of the approved program plan.
- Except in situations of immediate suspension, the EMS Medical Director shall provide the individual, provider agency, or other participant with a written explanation of the reason for the suspension; the terms, length, and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. Such notice shall be delivered in person or by certified mail.
- The suspended party may request a hearing by the Local System Review Board within 15 days of the date on the suspension notice. Such requests must be in writing to the EMS Medical Director or EMS Facilitator.
- Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.
- The SAMIC EMS System shall designate the Local System Review Board, consisting of at least three members, one of whom is an emergency Department physician with knowledge of EMS, one of whom is an EMT, and one of whom is of the same professional category as the individual, provider agency, or other participant requesting the hearing.
- The hearing shall commence as soon as possible, but at least within 21 days after receipt of a written request. The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing, and the Local System Review Board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the Local System Review Board unless that decision has been appealed to the State EMS Disciplinary Review Board in Accordance with the EMS Systems Act and EMS and Trauma Center Code.
- The Local System Review Board shall state, in writing, its decision to affirm, modify, or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS Medical Director and the individual, provider agency, or other participant who requested the hearing within five business days after the conclusion of the hearing.
- The transcripts, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System.

- The EMS Medical Director shall notify the Department, in writing, within five business days after the Board's decision to uphold, modify, or reverse the EMS Medical Director's suspension of an individual, provider agency, or other participant. The notice shall include a statement detailing the duration and grounds for the suspension.
- If the Local System Review Board affirms or modifies the EMS Medical Director's suspension order, the individual, provider agency, or other participant shall have the opportunity for a review of the Local System Review Board's decision by the State EMS Disciplinary Review Board.
- If the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for a review of the Local System Review Board's decision by the State EMS Disciplinary Review Board.
- Requests for review by the State EMS Disciplinary Review Board shall be submitted, in writing, to the Chief of the Department's Division of EMS and Highway Safety, within 10 days after receiving the Local System Review Board's decision or the EMS Medical Director's suspension order, whichever is applicable. A copy of the Local System Review Board's decision or suspension order shall be included with the request.
- An EMS Medical Director may immediately suspend an individual, provider agency, or other participant if he/she finds that the information in his/her possession indicates that the continuation in practice by an individual, provider agency, or other participant would constitute an imminent danger to the public. The suspended party shall be issued an immediate verbal notification followed by a written suspension order to the party by the EMS Medical Directors which states the length, terms, and basis for suspension.
- Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger, in person, or telex, a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the individual, provider agency, or other participant.
- Within 24 hours following the commencement of the suspension, the suspended party may deliver to the Department, by messenger, in person, or telex, a written response to the suspension order and copies of any written materials which the party feels relate to that response.
- Within 24 hours following receipt of the EMS Medical Director's suspension order or the suspended party's written response, whichever is later, the Director or designee shall determine whether the suspension should be stayed pending the suspended party's opportunity for hearing or review in accordance with the EMS System Act, or whether the suspension should continue during the course of that hearing or review. The Director or designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended individual, provider agency, or other participant. The suspension shall remain in effect during this period of review by the Director or designee.

Revised: 10/18

**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.

**Procedure:**

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 hislher 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).
    - 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).
    - 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.
    - 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.
- 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.
- 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.

HSHS St. John's SAMIC EMS

# POLICY 0031

## Criminal Conviction

Revised: 10/18

**Policy:**

Provide for the safety and wellbeing of the population served by the SAMIC EMS System.

**Procedure:**

- Prehospital personnel who have been convicted of an offense of the Criminal Code, Wrongs to Children Act, Controlled Substances Act, or other felony charges must submit a written statement to the EMS Medical Director containing when the offense occurred, the circumstances surrounding the offense, information regarding sentence and status of sentence, and any other pertinent information.
- The EMS Medical Director will review the information and render a decision as to the personnel's ability to function in or continue to function in the System.

HSHS St. John's SAMIC EMS

# POLICY 0032

## Hospital Bypass or Diversion

Revised: 10/18

**Policy:**

Provide for the continuity of patient care when circumstances result in the bypass or diversion from a hospital participating in the SAMIC EMS System.

**Procedure:**

- In the event the Administrative Disaster Team determines the hospital should go on "bypass status" due to a disaster situation or limited resources, the Administrative Disaster Team, or designee shall notify the Director of Emergency & Special Care and the EMS Facilitator, or designee.
- The Administrative Disaster Team, or designee, shall make such notification to outside organizations specific to the situation (e.g., Red Cross, Salvation Army, Blood Bank, etc.).
- The EMS Facilitator, or designee, shall notify
  - Springfield Ambulance Companies
  - Springfield Fire Department
  - Springfield Police Department
  - Participating agencies within our System that may be effected
  - Other EMS Systems that may be effected by such bypass status
- Such notification shall include, but not limited to, the following
  - Notification of "bypass status"
  - Estimated length of bypass
  - Alternate access to facility, if appropriate
  - Alternate methods of communications, if appropriate
  - Other information approved by the Administrative Disaster Team for the situation
- Upon termination of the "bypass status" by the Administrative Disaster Team, the EMS Facilitator, or designee, shall notify all parties previously notified that the "bypass status" has been lifted and to resume normal operations.

- Notification shall be made to the Illinois Department of Public Health, Division of Emergency Medical Services, during the next business day following any bypass or resource limitation decision. This notification may be faxed.

ASSOCIATE AND/OR PARTICIPATING HOSPITALS

- In the event the Administrator or designee determines the hospital should go on "bypass status" due to a disaster situation or limited resources, the Administrator or designee shall notify the appropriate parties as stated in their emergency preparedness plan.
- The hospital shall make such notification to outside organizations specific to the situation (e.g., Red Cross, Salvation Army, Blood Bank, etc.).
- The Associate Hospital EMS Coordinator or designee, shall notify
  - Local Ambulance Services
  - Appropriate fire and police departments
  - Other hospital that may be effected by the bypass/diversion of patients,.
  - SAMIC EMS Medical Director or designee
- Such notification shall include, but not limited to, the following
  - Notification of "bypass status"
  - Estimated length of bypass
  - Alternate access to facility, if appropriate
  - Alternate methods of communications, if appropriate
  - Other information approved by the Administrator or designee for the situation
- Upon termination of the "bypass status" by the Administrator or designee, shall notify all parties previously notified that the "bypass status" has been lifted and to resume normal operations.
- Notification shall be made to the Illinois Department of Public Health, Division of Emergency Medical Services and SAMIC EMS System office during the next business day following any bypass or resource limitation decision. This notification may be faxed

Revised: 10/18

**Policy:**

Provide appropriate documentation of patient care to demonstrate the continuity of care and provide information for medical-legal purposes, continuous quality improvement activities, research, and other appropriate uses for the data collected.

**Procedure:**

**NON-TRANSPORTING AGENCIES**

- All agencies must complete either the SAMIC non-transporting report form or a System-approved form containing at least the same information.
- Completed run forms should be submitted to the SAMIC EMS office as soon as possible after the call.
- Distribution of the copies are as follows:
    - Original - receiving hospital for patient record
    - First copy - agency records
    - Second copy - SAMIC EMS office
- Consistent failure to complete run forms on a repetitive basis by agencies or personnel within the System will be cause for consideration of suspension proceedings by the EMS Medical Director.

**TRANSPORTING AGENCIES**

- An electronic patient care report must be completed for all runs.
- All agencies must complete the designated report form preferably **before leaving the receiving hospital**, but not more than **twenty-four (24) hours** after the call.
- Inability to complete the patient care report within the appropriate times will be investigated to see if sufficient reason exists to delay completion of the forms. If such a reason does not exist, agencies and/or personnel in a delinquent status will be reported to the EMS Medical Director, who will take action as is deemed appropriate to insure the forms are immediately completed and accorded to the EMS office.
- Consistent failure to complete the Illinois Prehospital Care Report form on a repetitive basis by agencies or personnel within the System will cause consideration for initiation of suspension proceedings by the EMS Medical Director.

# POLICY 0034

## Agency Responsibilities

Revised: 10/18

**Policy:**

Provide a summary of the important responsibilities of the provider agencies that are in the HSHS St. John's Hospital EMS System.

**Procedure:**

**Operational Responsibilities**

- The 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).
- No agency shall employ or permit any member or employee to perform services for which the provider is not licensed, certified, or otherwise authorized to perform.
- Agencies must comply with **0033 – Patient Care Report Policy**.
- Agencies with controlled substances must abide by all provisions of **0056 – Controlled Substance Policy.**
- Provide updated copies of FCC Licenses and Mutual Aid Agreements upon expiration.

**Notification Requirements**

Any agency participating as an EMS provider in the HSHS St. John's Hospital EMS System must notify the EMS office of the following:

- 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.
- Any personnel changes and updates within ten days. This includes addition of new personnel and resignations of existing personnel. Roster changes must include the following:
    - Name
    - Address
    - Phone Number
    - Date of Birth
    - License Number
    - Expiration date
- Any time 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.
- Any incident or unusual occurrence which could have or did adversely affect the patient or EMS provider in the system within 24 hours via the Incident Report Form.

- Any changes in medical equipment or supplies.
- Any changes in vehicles. Vehicles must be inspected by the system and IDPH. The appropriate paperwork must be completed prior to the vehicle being placed into service.
- Any change in the agency's role in providing EMS.
- Any change to the agency's response area.
- Any changes occur in communication capacity or equipment.

**Training and Education Responsibilities**

- Twenty-five percent of all EMT continuing education must be obtained through classes taught or sponsored by the Resource Hospital, HSHS St. John's Hospital.
- 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.
- Develop a training plan which meets the requirements for re-licensure and System certification as detailed in the **0038 – Re-licensure Requirements Policy.**
- 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.
- Any changes made to an approved training application must be communicated to the EMS Office prior to the training.
- Maintain sign-in rosters for all training conducted and provide participants with certification of attendance.
- Conduct System mandatory training annually as per EMS Office notification.

**Additional Reports and Records Responsibilities**

- Comply with HSHS 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.
- 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.
- All agencies and agency personnel are to comply with all of the requirements outlined in HIPAA regulations with regard to protected health information.

HSHS St. John's SAMIC EMS

# POLICY 0035

## Agency Compliance Waiver

Revised: 10/18

**Policy:**

Provide a layout for agencies with unreasonable hardship to request a waiver from HSHS St. John's Hospital EMS Office and IDPH.

**Procedure:**

**For Policy and Equipment Issues:**

- A cover letter to include: agency name, IDPH provider number, agency official(s), designated contact person and telephone number, statement of the problem and proposed waiver.
- Explanation of why the waiver is needed.
- Explanation of how the modification will relive problems that would be created by compliance with the rule or policy as written.
- Statement of and justification for the time period of which the modifications will be necessary. This section must also include a chronological plan for meeting total compliance requirements. The maximum time period allowed for modifications is one year.

**For Staffing Waivers:**

- Complete the IDPH EMS Staffing Waiver Application.

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

HSHS St. John's SAMIC EMS

# POLICY 0036

## Agency Advertising

Revised: 10/18

**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.

**Procedure:**

- **No agency** 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** 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 HSHS St. John's Hospital EMS System personnel to report such infractions

# System Certification

Revised: 10/18

**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.

**Procedure:**

- 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.
- The System applicant must be a member of or in the process of applying for employment with a HSHS 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.
- A system application must be completed and submitted to the EMS Office.
- The System applicant must also submit copies of all required documents for their level of licensure.
- Upon System review of the system application, EMS Office personnel will determine if the candidate can sit for the system examination.
- The System applicant must pass the appropriate HSHS 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.
- Satisfactory completion of a **90-day** probationary period is required once system certification is granted.
- 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.

**Maintaining System Certification**

In order to maintain active status within the HSHS St. John's Hospital EMS System, providers must maintain the appropriate requirements as noted below.

| | ECRN | EMD | EMR | EMT | AEMT | Intermediate | Paramedic | PHRN |
|---|---|---|---|---|---|---|---|---|
| **Continuing Education Hours** | **32** | **48** | **24** | **60** | **80** | **80** | **100** | **100** |
| **SAMIC Agency Affiliation** | | X | X | X | X | X | X | X |
| **System Testing and Skill Evaluation** | X | X | X | X | X | X | X | X |
| **CPR Card** | X | X | X | X | X | X | X | X |
| **ACLS** | X | | | | X | X | X | X |
| **PALS or PEPP** | X | | | | X | X | X | X |
| **PHTLS, ITLS, TECC, TCCC, TNCC or TNS** | X | | | | X | X | X | X |

- 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 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.

- After 60 days, any EMS provider requesting to re-certify in the HSHS St. John's Hospital EMS System will be required to repeat the process for initial certification.

HSHS St. John's SAMIC EMS

# POLICY 0038

## Re-licensure Requirements

Revised: 10/18

**Policy:**

Provide expectations for providers regarding license renewal.

**Procedure:**

- To be re-licensed as an EMS provider, the licensee shall submit the required documentation for renewal to HSHS St. John's 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.**

- 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.

- 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.

- 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.

- 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.

- 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 HSHS 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.

- 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 lOO/3.5(d)(5)]).

- 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.

- 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.

- At any time **prior to the expiration of the current license**, an Intermediate or Paramedic may revert to EMT status for the remainder of the license period. The provider must make this request in writing to the EMS Medical Director and the Department and must submit their original current 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.

- At any time **prior to the expiration of the current license**, an EMT -B may revert to the Emergency Medical Responder 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 EMR level, the provider must meet all of the EMR requirements for re-licensure.

- 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:

- Twenty-five percent of the didactic continuing education hours required for re-licensure must be earned through attendance at system-taught courses, system approved courses, courses sponsored by the HSHS St. John's Hospital EMS

Office or courses taught by a System-approved instructor.

- No more than seventy-five percent of the continuing education hours required for re-licensure will consist of hours obtained from the same site code.
- No more than twenty-five percent of the continuing education hours required for re-licensure will consist of any single subject area.
- EMS providers must attend at least one (1) continuing education program that reviews HSHS St. John's Hospital EMS System Policies, Guidelines, and Procedures as part of the four-year continuing education requirements. Such review will also be required with protocol updates.
- No more than fifty percent of on-line CE will be accepted for re-licensure.
- EMS continuing education credits must have an approved IDPH site code or be approved by the HSHS St. John's Hospital EMS Medical Director.
- Continuing education credits approved for EMS Systems within IDPH EMS Region 3 will be accepted by the HSHS St. John's Hospital EMS System.
- 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**

EMS providers must meet the requirements noted below.

| | ECRN | EMD | EMR | EMT | AEMT | Intermediate | Paramedic | PHRN |
|---|---|---|---|---|---|---|---|---|
| **Continuing Education Hours** | 32 | 48 | 24 | 60 | 80 | 80 | 100 | 100 |
| **SAMIC Agency Affiliation** | | X | X | X | X | X | X | X |
| **System Testing and Skill Evaluation** | X | X | X | X | X | X | X | X |
| **CPR Card** | X | X | X | X | X | X | X | X |
| **ACLS** | X | | | | X | X | X | X |
| **PALS or PEPP** | X | | | | X | X | X | X |
| **PHTLS, ITLS, TECC, TCCC, TNCC or TNS** | X | | | | X | X | X | X |

- 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 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.

- After 60 days, any EMS provider requesting to re-certify in the HSHS St. John's Hospital EMS System will be required to repeat the process for initial certification.

# Off-Line Medical Control

Revised: 10/18

**Policy:**

**Establish the standard of care which is expected of the HSHS St. John's Hospital EMS System Provider.**

**Procedure:**

- 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 HSHS St. John's Hospital EMS System for treatment of the acutely ill or injured patient.
- 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.
- 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.

- 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

Revised: 10/18

**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.

**Procedure:**

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.

- EMS communications requiring on-line contact with a base station physician shall be conducted using cellular telemetry.
- Incoming telemetry calls will usually be answered by an Emergency Communications Registered Nurse (ECRN). The ECRN may request Medical Control from an ED Physician if orders or consultation are needed.
- Pre-hospital personnel in need of on-line Medical Control shall notify the ECRN the need to speak to an ED Physician at the initiation of the report.
- 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 or cases involving advanced directives.
    - High risk refusals
    - First Responder low risk refusals.
    - Use of restraints (including handcuffs).
    - Trauma cases or potential trauma cases.

- "Telemetry" calls include all medical complaints requiring Medical Control contact, refusals, traumas and consultations.

- MERCI calls are made via MERCI 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, HSHS 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 HSHS St. John's Hospital may give orders.
  - If the receiving hospital requests discontinuation of treatment established by the prehospital provider, Medical Control contact should be established.

- 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).

- 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.

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

- 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.

HSHS St. John's SAMIC EMS

# POLICY 0041

## Radio Communications

Revised: 10/18

**Policy:**

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.

**Procedure:**

- 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 Report
  - Unit identification
  - **Special Alert (STEMI, Stroke, Trauma, Cardiac Arrest, or Sepsis)**
  - Destination & ETA
  - **Age/sex**
  - **Chief complaint**
  - **Assessment (General appearance, degree of distress & level of consciousness)**
  - **Vital signs:**
    - Blood pressure
    - Pulse (rate, quality, regularity)
    - Respirations (rate, pattern, depth)
    - Pulse oximetry, if indicated
    - Pupils (size & reactivity)
    - Skin (color, temperature, moisture)
    - Pertinent physical examination findings
    - SAMPLE History
    - Treatment rendered and patient response to treatment
- Bold items 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:
- Cellular telemetry to 217-753-0016 or 217-753-1089
- Telephone landline direct to 217-525-5610
- 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 to Refuse

Revised: 10/18

**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.

**Procedure:**

- 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.
- Explain to the patient the risk associated with his/her decision to refuse treatment and transportation.
- Secure Medical Control approval of high risk refusals (low risk refusals for First Responders) in accordance with the Online Medical Control Policy.
- 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.
- 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.
- 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.
- 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.

HSHS St. John's SAMIC EMS

# POLICY 0043

## Incident Reporting

Revised: 10/18

**Policy:**

Prehospital care providers shall complete a HSHS St. John's Hospital EMS System Incident Report Form whenever a System related issue occurs.

**Procedure:**

- In order to properly assess the situation and determine a solution to the issue, the following information needs to be provided on the form:
  - Date of occurrence
  - Time the incident occurred
  - Location of the incident
  - Description of the events
  - Personnel involved
  - Agency and/or institution involved
  - Copy of the patient care record and/or any other related documents

Incident Report Process

- 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.
- The EMS Coordinator will review the incident and notify the EMS Medical Director and the appropriate course of action will be determined.
- The EMS provider originating the report will be notified of the resolution.

Incident Report Indicators

- Situations requiring EMS Office notification include:
- 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 HSHS 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)

# Patient Confidentiality and Release of Information

Revised: 10/18

**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.

**Procedure:**

- Confidentiality is governed by the "need to know" concept.
- 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.
- 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.
- St. John's Hospital EMS System personnel are not to discuss specific patients in public areas.
- 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. Information gained from chart or case reviews for the purpose of education, research, quality improvement or quality assurance is considered confidential.
- No patient name will be mentioned in the process of prehospital radio transmissions utilizing MERCI radio.
- 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.
- Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.
- Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and en route.
- EMS personnel should limit bystanders at the scene of an emergency. Law enforcement personnel may be called upon to assist in maintaining bystanders at a reasonable distance.

# Patient Destination

Revised: 10/18

**Policy:**

Patients should be transported to the closest appropriate hospital. A patient or designee 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.

**Procedure:**

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.

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:
    - 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)
    - Medical Control consultation
    - Capacity of the nearest facility or facility of choice
    - Available resources of the transporting agency
    - 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 15 miles without contacting Medical Control for approval.

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.

HSHS St. John's SAMIC EMS

# POLICY 0046

## Transfer and Termination of Patient Care

Revised: 10/18

**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.

**Procedure:**

- 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:
    - Appropriate receiving hospital personnel assume medical care and responsibility for the patient.
    - 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).
    - EMS personnel are physically unable to continue care of the patient due to exhaustion or injury.
    - 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.
    - The patient has been determined to be dead and all policies and procedures related to death cases have been followed.
    - If Medical Control concurs with a DNR order.
    - Whenever specifically requested to leave the scene due to an overbearing need (e.g. disasters, triage prioritization).
    - 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:
    - Delay in transportation of another patient (i.e. trauma patient) from the

same incident would threaten life or limb.
    - 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).
    - More appropriate or prudent transportation is available.
- 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

Revised: 10/18

**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.

**Procedure:**

- 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.
- 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.
- 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/ILS/ALS procedures with the concurrence of the transporting provider.
- 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.
- 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.
- 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.

Revised: 10/18

**Policy:**

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.

**Procedure:**

**Dispatch Initiated Intercept**

- 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.
    - 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.
    - If patient destination is not known, the closest 911 dispatch center with ALS ambulances services should be contacted. This should be predetermined.
        - ALS unit origin does not dictate patient destination. Transport units must be informed as to 24/7 capabilities of all area hospitals.
- The BLS and ALS units must communicate via radio frequency regarding patient status and rendezvous location as soon as possible.
    - Radio frequency should be predetermined.
- Rendezvous location should be off main roadways and, if at all possible, a parking lot or secondary road.
    - EMS providers functioning on roadways are required to meet the CFR655 (F) requirements by wearing high visibility, breakaway safety vests.
- Patient transport/transfer
    - Patient care should be of the upmost priority in making decisions about which vehicle will provide transport of the patient.
        - The ALS ambulance, in cooperation with Medical Control, will have the ultimate authority regarding patient care decisions.
    - In order to address as many potential agencies as possible, intercept agreements should be pre-established between all possible agencies in the geographic area.

- 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.
- 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

- 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.
  - Reason for request
  - Patient requested destination
  - Route of travel
  - 911 dispatch centers should proceed with request in the same manner as if requesting based on 911 call information.
- Both agencies should work to achieve radio communication as soon as possible.
  - Communication between the BLS and the ALS unit should occur prior to ALS unit arrival.
- Patient intercept should follow the process outlined for EMD initiated dispatch.
- 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

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

Revised: 10/18

**Policy:**

**Procedure:**

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

- 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.

- 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.

- 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

- 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.

- Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified.

- 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.

# Crime Scene Control and Reporting

Revised: 10/18

**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.

**Procedure:**

- Immediately notify law enforcement of any suspected crime scene (this does not necessarily include petty crimes or traffic violations).
- If the victim is obviously dead, then he or she should remain undisturbed if at all possible.
- 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.
- Restrict access to the scene of onlookers or other unauthorized personnel on the premises of the crime.
- Observe and note anything unusual (*e.g.* smoke, odors, or weapons), especially if the evidence may not be present when law enforcement arrives.
- 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.
- 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.

# Medical Professional on Scene

Revised: 10/18

**Policy:**

Only personnel licensed to perform care in the prehospital setting and certified in the HSHS 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.

**Procedure:**

- 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.
- 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.
- 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.
- 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.
- 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.
- 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. HSHS 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

Revised: 10/18

**Policy:**

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.

**Procedure:**

- Determine the category of the accident/incident
  - **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.
  - **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.
  - **Category III** bus accident/ incident – no injuries present in any children/students and no significant mechanism of injury present.

- 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.
  - 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.
  - 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.
  - 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.
    - 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.
    - 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.
    - 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.
    - 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.

# Latex Allergy

Revised: 10/18

**Policy:**

**Procedure:**

A latex allergy is recognized as a significant problem for specific patients and healthcare workers. There are two 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**

- Assess for suspected latex sensitivity by asking the following: "Do you react to rubber bands or balloons? Describe."

- Initiate interventions for Known Latex Sensitivity if the latex sensitivity screen response suggests a latex hypersensitivity.

- Notify the receiving hospital of suspected latex hypersensitivity.

- Follow orders as per the Allergic/Anaphylactic Reaction Protocol.

**Known Latex Allergy**

- Obtain a patient history and ask the patient to describe their symptoms of latex hypersensitivity.

- 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

- Notify the receiving hospital of known latex sensitivity.

- Follow orders as per the Allergic/Anaphylactic Reaction Protocol.

- Remove all loose latex items (e.g. gloves, tourniquets, etc.) and place in a closed compartment or exterior storage panel.

- 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.

- Cover the mattress of the cot with a sheet so that no areas of the mattress are exposed.

- DO NOT administer any medications through latex IV ports.

- Wrap all tubing containing latex in kling before coming into contact with the patient (e.g. stethoscope tubing, BP cuff tubing, etc.).

HSHS St. John's SAMIC EMS

# POLICY 0054

## Critical Incident Stress Management

Revised: 10/18

**Policy:**

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.

**Procedure:**

- EMS providers of the HSHS St. John's Hospital EMS System involved in an unusually stressful incident can contact the Critical Incident Stress Management Team.
- 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.
- Debriefings and stress management services are most effective when conducted around 72 hours of the incident.
- The CISM Team Coordinator may be reached by contacting the Central Illinois Team at 217-333-8911.

HSHS St. John's SAMIC EMS

# POLICY 0055

## EMS Equipment and Supplies

Revised: 10/18

**Policy:**

HSHS 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.

**Procedure:**

- EMS providers shall notify the EMS Office and IDPH of any new or replacement vehicles (including temporary loaner vehicles).
- 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.
- 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.
- 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 HSHS St. John's Hospital EMS System Agency Supply List.
- 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 HSHS St. John's Hospital EMS System Agency Supply List and Additional ILS Equipment List.
- 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 HSHS St. John's Hospital EMS System Agency Supply List and Additional ALS Equipment List.
- 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.

# Controlled Substance Policy

Revised: 10/18

**Policy:**

The HSHS 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.

**Procedure:**

- All controlled substances will be kept inside each ambulance/apparatus within the drug box (preferably) or designated cabinet.
- 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.
- After assuring the tag is intact and the number corresponds with the log, the paramedic must sign the controlled substance shift log.
- 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.
- Controlled substances shall be available for inspection by IDPH, St. John's Hospital EMS office, or any other authorized individual.
- 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)

- 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.
- 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.
- 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.

- 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.
- 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.

# Medication Shortage

Revised: 10/18

**Procedure:**

- Due to the demand, expirations and other limiting factions, 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:
    - 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:
    - 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.)
    - 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.)
    - Using an alternative drug that can be 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 I: 10,000)
    - Giving a replacement drug. (I.e. Lidocaine is not available but Amiodarone is. Amiodarone is provided with training given to all affected agencies.)
    - 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.)

- This plan will be communicated to all affected agencies and include any necessary training information.
- This plan will be communicated to all affiliated hospital pharmacies.
- Notice will be posted at the Pyxis where EMS providers obtain their medications.
- When the shortage is over notice will be given to all affected agencies and previously posted, notices will be removed from the refill areas.

HSHS St. John's SAMIC EMS

# POLICY 0058

## Resuscitation vs. Cease Efforts

Revised: 10/18

**Withholding Resuscitation:**

- EMS providers are responsible to make every effort to preserve life. In the absence of an advanced directive, resuscitative measures shall be attempted if there is any chance that life exists.
- When EMS providers arrive on scene and discover the patient is pulseless and apneic and CPR is not in progress; chest compressions at minimum must be initiated unless one or more of the following conditions exist:
    - Obvious sign of biological death:
        i. Decapitation
        ii. Rigor mortis without hypothermia
        iii. Liver mortis, dependent lividity
        iv. Obvious mortal wounds with no signs of life
        v. Decomposition
        vi. Incineration
        vii. Frozen state
        viii. Trauma where CPR is impossible
    - Death has been declared by patient's physician or the coroner.
- EMS provider should notify the coroner and law enforcement.
- If none of the above conditions are met. EMS must begin CPR and follow the appropriate protocol.
- If a valid DNR order is present follow **Policy 0059 – Do Not Resuscitate**.

**Termination of Resuscitation:**

- Provide care based on appropriate protocol.
- Contact **Medical Control** and explain events. Report treatment and response.
- Consider:
    - Adult is normothermic and experienced an arrest unwitnessed by bystanders or ems;
    - No bystander CPR was provided;
    - The patient has remained in continuous monitored asystole or cardiac arrest with a non-shockable rhythm with no ROSC after full ALS resuscitation in the field for at least 30 minutes;
    - No AED or defibrillator shocks have been delivered for at least 30 minutes;
    - Capnography has remained ≤10 after 20 minutes.
    - There are no reversible causes of cardiac arrest identified.
- The physician may give the order to discontinue medical treatment if determined to be appropriate.
- Document time the resuscitation was terminated.

# Do Not Resuscitate

Revised: 10/18

**Procedure:**

- Any EMS provider who is actively participating in SAMIC EMS System may honor, follow, and respect a valid DNR. **Medical Control** must be contacted in all cases involving a DNR.
- EMS personnel must make every effort to correctly identify the patient and correct documentation.
- Once EMS providers arrive on scene and identify a patient in cardiac arrest and no efforts have been started and a valid DNR is present, EMS must contact **Medical Control** while performing CPR until an order for cease efforts is given.
- Once EMS providers arrive on scene and identify a patient in cardiac arrest with efforts ongoing, the EMS provider should:
    - Determine if patient has a pulse and respirations. If no respirations and no pulse are present. Contact **Medical Control** for cease efforts.
    - If patient has a pulse and/or respirations, treat per the appropriate protocol.
    - EMS providers may encounter State of Illinois DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM. EMS providers may have specific medical interventions they can and cannot perform as noted on the form.
- Any other advanced directives of living will cannot be honored, followed, and respected by pre-hospital care providers. EMS providers must contact **Medical Control** for direction regarding any other type of advanced directive. Resuscitation should not be withheld during the process of contacting or discussing the situation with the on-line **Medical Control** physician.
- A Durable Power of Attorney for Healthcare is an agent who has been delegated by the patient to make any healthcare decisions (including the withholding or withdrawal of life-sustaining treatment) which the patient is unable to make. When a patient's surrogate decision-maker is present or has been contacted by prehospital personnel and they direct that resuscitative efforts not be instituted:
    - As the Durable Power of Attorney for Healthcare agent to provide positive identification, to see the document, and ask the agent to point out the language that confirms that the patient's medical or mental condition complies with the document designating the Durable Power of Attorney for Healthcare.
    - The Durable Power of Attorney for Healthcare agent or a surrogate decision-maker can provide consent to a DNR order, but the order itself must be written by a physician.

  - An EMS provider cannot honor a verbal or written DNR request/order made directly by a Durable Power of Attorney for Healthcare agent, surrogate decision-maker or any person other than a physician. If such situation is encountered, contact **Medical Control** for direction.

- Revocation of a written DNR order is accomplished when the DNR order is physically destroyed or verbally rescinded by the physician who signed the order and/or the person who gave consent to the order.

- Prehospital care providers have a duty to act and provide care in the best interest of the patient. This requires the provision of full medical and resuscitative interventions when medically indicated and not contraindicated by the wishes of the patient.

- When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear unclear (i.e. upset family members, disagreement regarding DNR order, etc.), EMS personnel should provide assessment, initiate resuscitative measures and contact Medical Control for further direction.

- If EMS personnel encounter a patient with a valid DNR from a long-term care facility, hospice, during an inter-hospital transfer or when transporting to or from home and the patient arrests en route, do not initiate resuscitative measures and contact **Medical Control** for orders.

- If EMS personnel arrive at the scene and the family states that the patient is a hospice patient with a valid DNR order, do not initiate resuscitative measures and contact **Medical Control** for orders.

- On occasion, EMS personnel may encounter an out-of-town patient with a valid DNR order visiting in the HSHS St. John's Hospital EMS System area. If the DNR order appears to be valid (signed by the patient and physician), contact **Medical Control** for orders.

- The coroner will be notified of any patient or family wishes that there is to be tissue donation in cases where the patient is not transported to the hospital.

- The **Medical Control** physician's responsibility is to make reasonable effort to confirm the DNR order is valid and order resuscitative measures within the directives of the DNR order.

- Appropriate patient care reports will be completed on all patients who are not resuscitated in the prehospital setting. A copy of the DNR form should be retained and attached as supporting documentation to the prehospital care report form.

- All HSHS St. John's Hospital EMS System personnel are to submit an incident report to the EMS Coordinator and the EMS Medical Director regarding any difficulties experienced with DNR situations. These cases will be evaluated on an individual basis.

- Ask the patient's family to produce an actual copy of the DNR/Advanced Directives. Family members will often identify themselves as Power of Attorney when in fact; they are solely Power of Attorney for Finance.

- Power of Attorney for Finance does not convey authority for healthcare decisions. Only a valid Durable Power of Attorney for Healthcare conveys authority for healthcare decisions.

# Petitioning an Emotionally Disturbed Patient

Revised: 10/18

**Procedure:**

- EMS providers should consider the mental health needs of a patient who appears emotionally or mentally incapacitated. This involves cases that the EMS provider has reasonable cause or evidence to suspect a patient may intentionally or unintentionally physically injure himself/herself or others, is unable to care for his/her own physical needs, or is in need of mental health treatment against his/her will.
- This does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years and the patient is under the supervision of family or another healthcare provider, unless the family or healthcare provider has activated EMS for a specific behavioral emergency.
- Attempt to persuade the patient that there is a need for evaluation and compel him/her to be transported to the hospital.
- If persuasion is unsuccessful, contact Medical Control and relay the history of the event. Clearly indicate your suspicions and/or evidence and have the base station physician discuss the patient's needs with the parties involved in the situation.
- The EMS crew will then follow the direction of the base station physician in determining the disposition of the patient or termination of patient contact. Another agency's or party's opinion should not influence the EMS provider's assistance to a mental health need.
- Under no circumstances does transport of the patient, whether voluntarily or against his/her will, commit the patient to a hospital admission. It simply enables the EMS providers to transport a person suspected to be in need of mental health treatment.
- If a patient is combative or may harm self or others, call law enforcement for assistance and follow the **Procedure 9018 – Patient Restraint**.

# Treatment of Minors and Mentally Incompetent

Revised: 10/18

**Policy:**

- Determine the authority for providing medical care to patients who are minors or medically incompetent.

**Definitions:**

- Medically Incompetent – a medically incompetent person is one who is not competent to give informed consent because of age, immaturity, mental impairment or medical condition. Medical incompetence renders one incompetent to consent to or to refuse medical care. However, a patient will not be deemed medically incompetent simply because he or she refuses treatment.
- Minor – a minor is a person who is under the age of 18 years. Generally, a minor is presumed to be medically incompetent. However, a minor may be medically competent where he or she possesses sufficient maturity to understand and appreciate the nature of the condition, the proposed treatment plan, and the alternatives thereto and the risks inherent therein.
- Emancipated Minor – an emancipated minor is a minor who is deemed an adult, for informed consent purposes, because of pregnancy, parenthood, marriage, judicial determination, or for certain types of treatment. The rules respecting informed consent applicable to adults are applicable to emancipated minors. An emancipated minor can consent to his/her own treatment as well as to the treatment of his/her children.

**Procedure:**

- When consent is necessary: Consent is obtained for invasive treatment and/or procedures. In emergency situations, consent will be implied if express consent cannot be obtained.
- Emergency Situations – In emergency situations, treatment should commence while attempts are made to obtain consent. Whenever there is any doubt as to the patient's medical competence and consent is refused, treatment should commence. In emergency situations, consent of the un-emancipated minor's parents or legal guardian need not be obtained if, in the sole opinion of the EMS provider or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the minor's health.

- Non-Emergency Situations – In a non-emergency situation, a competent adult or emancipated minor may consent or refuse to consent to the performance of any and all diagnostic or therapeutic procedures. This consent or refusal is valid regardless of the consequences of the decision.
- Patients who are medically incompetent may not give a valid consent. The EMS provider should attempt to ascertain whether the patient has a representative such as a guardian, agent under the Health Care Powers of Attorney Act, or surrogate under the Health Care Surrogate Act. If such a person is found, consent should be obtained.
- If there is no authorized representative or if the authorized representative refuses to consent to treatment, Medical Control should be contacted.
- An un-emancipated minor is generally not considered capable of providing consent. Consent of either one of the parents or the authorized representative of the minor is sufficient to render care.
- Persons authorized to give consent:
    - Medically Competent Patients – a medically competent patient may consent or refuse to consent to treatment. The consent or refusal is valid regardless of the consequences.
    - Patients who are medically incompetent may not give a valid consent. The hospital should ascertain whether a representative such as a guardian, agent under the Health Care Powers of Attorney Act, or surrogate under the Health Care Surrogate Act has been appointed. If there is one, consent should be obtained from the authorized representative.
    - Emancipated Minors – Minors who are married, pregnant or are a parent and who are not otherwise medically incompetent, by reason of medical or mental condition, may give valid consent or refusal to consent to treatment.
- Mature minors who are not legally emancipated:
    - A minor who possesses sufficient maturity to understand and appreciate his/her medical condition, the nature of the proposed treatment, the alternatives to treatment and the risks inherent in the treatment may be medically competent for consent purposes. This should be discussed with medical control.
    - Always attempt to reach parents to obtain consent. If parents cannot be reached, each situation should be evaluated on an individual basis.
- Children of minors: Consent from a minor parent is valid for treatment of the minor's child.

- Minors with Divorced or Separated Parents: Consent for treatment of minors when the parents are divorced either parent may consent to the performance upon his/her child of a medical or surgical procedure, unless otherwise authorized in a custody agreement or in a divorce decree. It is not the responsibility of the EMS Provider to determine who is the custodial parent, nor is it the hospital's duty to enforce a custody agreement or divorce decree. If a non-custodial parent brings the child in for treatment, you should proceed with treatment as requested by the parent. The issue as to which parent pays for the minor's health insurance is not significant.
- If there are any questions regarding consent, Contact Medical Control and consider treatment and transport to the hospital under implied consent.

# Relinquished Newborn

Revised: 10/18

**Definitions:**

- Neonate: means a child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished to a hospital, police station, fire station, emergency medical facility, and who is not an abused or neglected child.
- Relinquish: means to bring a neonate, who a licensed physician reasonably believes is 30 days old or less to a hospital, police station, fire station, emergency medical facility, and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant.
- Emergency Medical Professional: includes licensed physicians, and any EMT, EMT-I, Paramedic, TNS, and PHRN as defined in the EMS Systems Act.

**Procedure:**

- The relinquishing person is presumed to be the infant's biological parent.
- Assess the infant. Look particularly for any signs of abuse or neglect.
- Ask the relinquishing parent for the infant's name and date of birth.
- If the child is presumed to be more than 30 days old, or has been abused or neglected, EMS providers should proceed as if the child is abused or neglected. Follow **5205 – Suspected Child Maltreatment** and file a report with DCFS. While this is all that is required under the Act, refusing to take an infant presumed to be older than 30 days or one who is abused or neglected from a parent who wishes to relinquish him or her could possibly result in harm to the infant. It is in the best interest of the child to accept them and proceed as below.
- Initiate emergency treatment that is necessary per protocol under implied consent and contact the nearest hospital.
- Ensure that the infant is kept warm and transport to the nearest System hospital with the infant secured appropriately in an infant car seat or pediatric restraining device.
- Complete a patient care report on the infant. List the infant's name as "Baby Girl/Boy Doe" if it is unknown.
- The System will honor the intent of the Act to allow for the anonymity of the relinquishing parent. However, nothing in the Act precludes a relinquishing person from providing his or her identify. If the infant is presumed to be 30 days of age or younger and there is no evidence of abuse or neglect:

- Identify the infant as relinquished in the comments section of the patient care report but omit any descriptive information regarding the relinquishing individual;
- The parent has the right to remain anonymous and to leave the fire station at any time and not be pursued or followed. If abuse or neglect is later suspected, the hospital will report it. The parent will not be prosecuted for relinquishment unless the infant was abused or neglected
- Normal patient confidentiality will surround this process.

**Procedure: Communication with the Parent**

- EMS personnel must offer the relinquishing parent the packet of information specified in the Act (see below), and if possible, verbally inform the parent that:
  - His or her acceptance of the information is completely voluntary;
  - Completion of the Illinois Adoption Registration form and Medical Information Exchange form is voluntary;
  - A Denial of Information Exchange form may be completed which would allow the relinquishing parent to remain anonymous to the infant and other parties involved in the infant's subsequent adoption;
  - The parent may provide medical information only and remain anonymous; and
  - By relinquishing the infant anonymously, he or she will have to petition the court in order to prevent the termination of parental rights and regain custody of the child. This information will be printed and included in the packet.
  - If the parent returns within 72 hours to reclaim the infant, they should be told the name and location of the hospital to which the infant was transported.
- Information to give to relinquishing parent (325 ILCS 2/35) Hospitals, fire stations, police stations, and emergency medical facilities must offer a packet of information to the relinquishing parent that contains the following:
  - Illinois Adoption Registry – Explanation
  - Illinois Adoption Registry Application
  - Illinois Adoption Registry Application Section C (2 pages)
  - Birth Parent Registration Identification
  - Medical Information Exchange authorization form
  - Denial of Information Exchange
  - Illinois Adoption Registry Medical Questionnaire (2 pages)
  - Illinois Adoption Registry website address and toll free phone number

  - Written notice of the following:
    - No sooner than 60 days following the date of the initial relinquishment, the child-placing agency or IDPH will commence proceedings for the termination of parental rights and placement of the infant for adoption.
    - Failure of the parent of the infant to contact the Department of Public Health and petition for the return of custody of the infant before termination of parental rights bars any future action asserting legal rights with respect to the infant.
  - A resource list of providers of counseling services, including grief counseling, pregnancy counseling, and counseling regarding adoption and other available options for placement of the infant.
- The parent may be unwilling to wait for discussion. Document on the infant's patient care report that the required information was offered to the parent and whether or not it was received. Note: These packets should be available in every fire station.
- Inform the parent that the fee for filing the application is waived if the medical questionnaire is completed.

IMMUNITY (Section 27): A hospital, fire station, or emergency medical facility, and any personnel of a hospital, fire station, or emergency medical facility, are immune from criminal or civil liability for acting in good faith in accordance with the Act. Nothing in the Act limits liability for negligence for care and medical treatment.

EVALUATION (Section 65)

- IDPH shall collect and analyze information regarding the relinquishment of newborn infants and placement of children under the Act. Fire stations, emergency medical facilities, and medical professionals accepting and providing services to a newborn infant under the Act shall report to the Department data necessary for the Department to evaluate and determine the effect of this Act in the prevention of injury or death of newborn infants. Child-placing agencies shall report to the Department data necessary to evaluate and determine the effectiveness of these agencies in providing child protective and child welfare services to newborn infants relinquished under the Act.
- The information collected from Fire stations shall include, but need not be limited to: the number of newborn infants relinquished and the services provided to relinquished newborns.
- IDPH has not yet specified the format and manner in which the required data is to be submitted.

RESOURCES

- The complete text of the Abandoned Newborn Infant Protection Act is available online.
- To obtain the application forms for the Illinois Adoption Registry and Medical Information Exchange:
    - Call the Department of Public Health at 217-557-5169
    - Print them from the Illinois Adoption Registry website.

# Mandated Reporting

Revised: 10/18

**Procedure:**

- Illinois law establishes requirements that any person licensed, certified or otherwise authorized to provide healthcare shall offer immediate and adequate information regarding services available to abuse and neglect victims. EMS personnel should not rely on another mandated reporter to file a report on the victim's behalf.
- For elder abuse: mandatory reporting requirements only apply when the reporter believes that the adult is not capable of reporting the abuse, neglect, or financial exploitation themselves.
- When reporting abuse, the caller should have the following information
    - Alleged Victim(s)
        - Name(s) of victim(s)
        - Birthdate(s) or approximate age of victim(s)
        - Address
    - Alleged Perpetrator(s)
        - Name(s)
        - Birthdate(s) or age(s) or some approximation so role of DCFS can be determined
        - Relationship to victim(s)
        - Address
    - Harms to Victim(s)
        - Physical Abuse
        - Sexual Abuse
        - Risk of Harm
        - Neglect
        - Death
    - Description of Incident(s)
        - As much detail as you have about the actual incident
        - Indication of intention
        - Description of the time and place of the incident
        - Information, if any, about possible witnesses to the abuse.
        - Evidence of abuse
- Child Abuse Hotline 1-800-252-2873
- Elder Abuse Hotline 1-866-800-1409