2023

System Policy Manual

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Contents

911 Calls Initiated from Hospitals

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

a. When a 911 call is received at the Emergency Dispatching Center it is not up to the Dispatcher to determine if the call is a true emergency or not. The Dispatcher must page the call out to the appropriate agency just as they would for any other emergency 911 call. When the call is paged, the responding agency should be made aware of the location of the patient.

b. When a responding agency receives an emergency dispatch to a hospital, they need to notify the hospital that they are responding to through the MERCI radio to the Emergency Department. This information shall be relayed to the Charge RN or Emergency Department M.D. while the agency is en-route to the call.

c. The Emergency Department Charge RN or M.D. will then forward the information to the appropriate department of the hospital so that they can assess the validity of the call before the EMS personnel arrive. An Emergency Department RN or MD shall meet the responding ambulance at the door when they arrive to direct them to the appropriate area.

d. When the responding agency arrives in the Emergency Department, they will speak with the charge RN or MD to find out the location of the call and proceed to that area. The EMTs will make direct contact with the patient that initiated the call.

e. The EMTs along with the patient will determine the outcome of the call. If the patient does not need EMS at that time, then a refusal form will be signed by the patient. If the patient insists on being transported to another facility, then the hospital staff will fill out the appropriate paperwork with the patient for discharge from that facility.

Abuse of Controlled Substances by System Personnel

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

a. Any pre-hospital care provider as a member of the McLean County Area EMS System who voluntarily requests assistance with a personal substance abuse problem shall be referred directly to the EMS Medical Director for an evaluation and referral for treatment when necessary.

b. Any pre-hospital care provider as a member of the McLean County Area EMS System who is suspect to have a personal substance abuse problem and who is suspect of being under the influence of alcohol and/or drugs, while in the provision of emergency care shall be referred to the EMS Medical Director for an evaluation and referral for treatment when necessary.

c. With the exception of EMS Students, the McLean County Area EMS System **DOES NOT** require EMS System members to submit to blood and/or urine testing for alcohol and/or drug use.

d. If the EMS Medical Director has determined that the individual, within reasonable medical certainty, is under the influence of alcohol and/or drugs while in provision of emergency care, and whose performance is below acceptable standards, shall be subject to disciplinary action.

- **i.** The first occurrence shall result in a referral of the pre-hospital care provider to the appropriate assistance program and subject to disciplinary action. **The pre-hospital care provider will not be responsible for any associated costs.**
- **ii.** The second occurrence, within one year, shall result in disciplinary action as determined by the EMS Medical Director and ***may result in suspension of the EMT license and/or System participation.***
- **iii.** If a System member under the influence of alcohol and/or drugs while engaged in provision of emergency care does not cooperate or refuses physician evaluation and/or treatment, ***the EMSMD shall subject that member to potential suspension of their EMT license and System participation.***

e. 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 was not 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 of illegal drug activities shall be referred to the appropriate law enforcement agency.

Aeromedical Resource Guidelines

Effective Date: 5/2010
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy:

Aeromedical resources should be used in the following situations.

1. When emergency personnel determine that the time needed to transport the patient by ground to an appropriate facility poses a threat to the patient's recovery.

2. When weather, road or traffic conditions would seriously delay the patient's access to ALS care.

3. When critical care equipment and personnel are not available but deemed necessary to care for the patient during transport.

4. When a critically injured patient is entrapped, and an extended extrication time is expected.

5. When a critically injured patient is in a location not easily accessed by ground vehicles.

Dispatch Standby Criteria

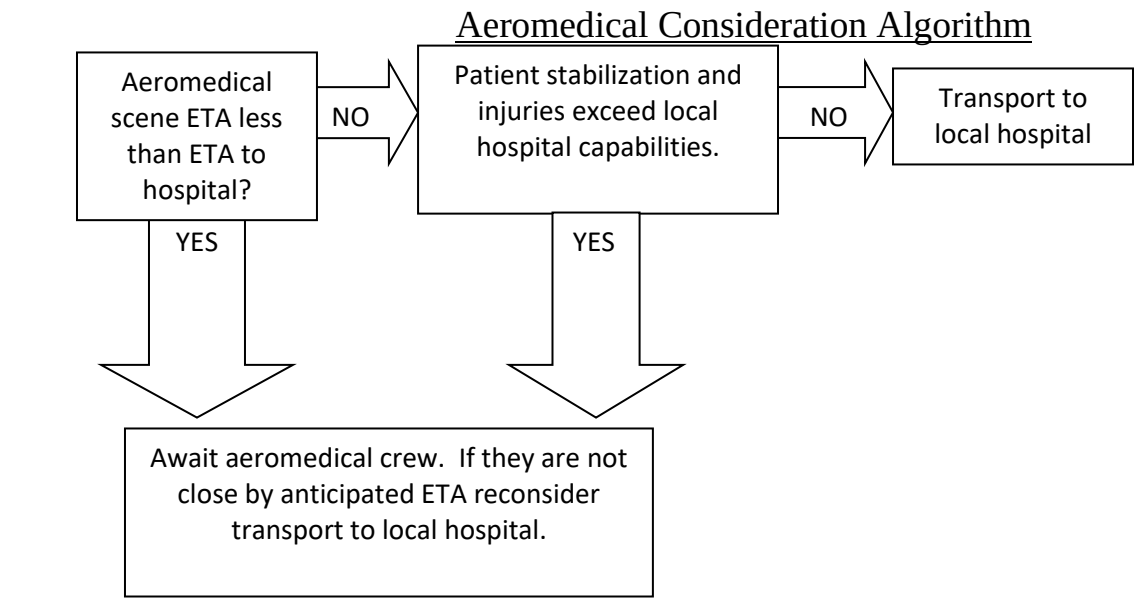
1. Unless the ground transport time in less than 20 minutes, aeromedical resources should be placed on standby at the time of dispatch for the following MOI:
    - Ejection from the vehicle at highway speed
    - Pedestrians were struck by a vehicle at highway speed.
    - Motorcycle crash (rider/bike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

General Guidelines and Considerations

1. In general, when ground transport of a seriously injured or ill patient will exceed 20 minutes, aeromedical resources should be considered.
2. All requests for aeromedical resources shall be made through the agency's dispatch center. Personnel making the request will provide all necessary information that is available.
3. If aeromedical resources are dispatched, an ALS ground unit shall be dispatched at the same time (if not already on scene or enroute).
4. Medical control must be kept informed of any situation in which aeromedical resources are used.
5. Aeromedical transport is contraindicated for patients in cardiac arrest.

Landing Zone Safety Precautions

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



Agency Inspection

Effective Date: 5/2010
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

a. In accordance with the Administrative Code derived from the State of Illinois EMS legislation, inspections may be conducted at any time at any EMS Agency by I.D.P.H. officials, the EMS Medical Director and/or the EMS System Manager/Coordinator.

b. At the time of these inspections, the respective EMS System Manager/Coordinator shall file a report on the results of the inspection with the EMS Medical Director (EMSMD). If remedial action is necessary, the EMS System Coordinator and/or EMSMD shall decide what shall be required to bring the vehicle or agency into compliance.

c. Each transport agency will be notified by the EMS of the date and time of annual inspection.

d. Any system modification for replacement vehicles will require an IDPH inspection.

e. It is the responsibility of the agency to pay any fees to IDPH upon completion of inspection. Payment can be made at the following website: ILDOH EMS Master (illinois.gov). While vehicle licenses are issued for a 4-year period, they still require yearly inspections and fees

f. All non-transport agencies will perform yearly self-inspection every February. The EMS office may inspect non-transport vehicles at their discretion.

g. Each EMS Agency (FR, BLS, ILS, ALS) is required to complete routine inspection to ensure compliance.

Alternate Communication Applications

Effective Date: 9/2020
Review Date: 8/2023
Approvals: EMSSC, EMSMD

Background to Policy:

There has been a recent development of alternative communication tools and applications for EMS providers to utilize in lieu of using traditional methods like the MERCI radio or cellular communication.

Policy Statement:

The purpose of this policy is to create a clear understanding for the utilization of alternate communication applications and tools. This is an interim policy. Further use of these applications must be approved by the EMS System and the hospital(s) that are utilizing these applications.

Policy:

1. The utilization of these applications is optional to agencies and providers. The use of MERCI radio and cellular communication are still acceptable methods of communicating with the hospital.
2. The current applications should ***NOT*** be used in any of the following situations:
    a. STEMI Alert
    b. Stroke Alert
    c. Trauma Alert
    d. Sepsis Alert
    e. Medical Control Orders
    f. Documenting Refusals
    g. Cease efforts or death declarations.
    h. Or any case where the patient's condition is considered unstable or critical including but limited to:
        i. Patients' vitals are unstable.
        ii. Cardiac Arrest
        iii. Patient is intubated.
        iv. Patient is combative.
3. Providers experiencing any issues arising from the use of alternate applications must complete an incident report and turn it into the EMS within 24 hours of the event.

EKGs should still be sent through traditional methods. Use of alternative applications should only be used if there is a failure to transmit EKGs.

Alternate Response Authorization

Effective Date: 12/2023
Review Date: 8/2023
Approvals: EMSSC, EMSMD

Background to Policy:

The Illinois Department of Public Health allows providers to petition for a waiver if unreasonable hardship results from compliance requirements of the EMS Act or its Rules and Regulations or System Program Plan.

Policy Statement:

To provide a process that allows for an ambulance to go enroute if a second EMS licensed personnel is enroute or on scene.

Policy:

1) A Vehicle Service Provider **that exclusively uses volunteers or paid-on-call personnel or a combination** to provide patient care who are not required to be stationed with the vehicle may apply to the Department for alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed by at least one licensed EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician.

2) A Vehicle Service Provider operating under alternate response authorization **shall ensure that a second licensed EMS Personnel is on scene or in route to the emergency response location**.

3) Unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h), the Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with:

   A) fewer than two EMTs, Paramedics or PHRNs, PHPAs, PHAPNs;

   B) a physician; or

   C) a combination, at least one of whom shall be licensed at or above the level of the license for the vehicle.

4) Alternate response authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization presents an immediate threat to the health

or safety of the public. After summary suspension, the licensee shall have the opportunity for an expedited hearing (see Section 515.180).

j) Alternate Response Authorization – Secondary Response Vehicles

1) A Vehicle Service Provider that uses **volunteers or paid-on-call personnel or a combination** to provide patient care and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one System authorized licensed EMT, A-EMT, EMT-I, PHRN, PHPA, PHAPN or physician.

2) A Vehicle Service Provider operating under the alternate response authorization shall ensure that a second System authorized licensed EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician is on the scene or in route to the emergency response location, unless the Vehicle Service Provider is approved for alternate rural staffing authorization, in which case the second individual may be an EMR or First Responder.

3) Unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h), the Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported without at least one EMT who is licensed at or above the level of ambulance, plus at least one of the following: EMT, Paramedic, PHRN, PHPA, PHAPN or physician.

4) Alternate response authorization for secondary response vehicles may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization for secondary response vehicles may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization for secondary vehicles presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing (see Section 515.180).

Alternate Staffing for Rural Ambulance Providers

Effective Date: 12/2023
Review Date: 8/2023
Approvals: EMSSC, EMSMD

Background to Policy:

To provide a process that allows for alternative staffing **by rural ambulance providers with populations of less than 10,000.**

Policy Statement:

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

Policy:

1) The EMS Personnel licensed at or above the level at which the ambulance is licensed shall be the primary patient care provider in route to the health care facility.

2) The Vehicle Service Provider shall obtain the prior written approval for alternate rural staffing from the EMS MD. The EMS MD shall submit to the Department a request for an amendment to the existing EMS System plan that clearly demonstrates the need for alternate rural staffing in accordance with subsection (h)(4) and that the alternate rural staffing will not reduce the quality of medical care established by the Act and this Part.

3) A Vehicle Service Provider requesting alternate rural staffing authorization shall clearly demonstrate all of the following:

   A) That it has undertaken extensive efforts to recruit and educate licensed EMTs, A-EMTs, EMT-Is, Paramedics, or PHRNs, PHPAs, PHAPNs.

   B) That, despite its exhaustive efforts, licensed EMTs, A-EMTs, EMT-Is, Paramedics or PHRNs, PHPAs, PHAPNs are not available; and

   C) That, without alternate rural staffing authorization, the rural or semi-rural population of 10,000 or fewer inhabitants served will be unable to meet staffing requirements as specified in subsection (g).

4) The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates **not to exceed 48 months**. The EMS MD shall re-evaluate subsequent requests for authorization for compliance with

subsections (h)(4)(A) through (C). Subsequent requests for authorization shall be submitted to the Department for approval in accordance with this Section.

5) Alternate rural staffing authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate rural staffing authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate rural staffing authorization presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing.

6) Vehicle Service Providers that cannot meet the alternate rural staffing authorization requirements of this Section may apply through the EMS MD to the Department for a staffing waiver pursuant to Section 515.150.

Alternate Staffing for Private Ambulance Providers

Effective Date: 12/2023
Review Date:
Approvals: EMSSC, EMSMD

Background to Policy:

To provide a process that allows for alternative staffing by private ambulance providers for interfacility transfers.

Policy Statement:

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

Policy:

1) An ambulance provider requesting alternative staffing for BLS ambulances for interfacility transfers will provide the following to IDPH:
   - A) Assurance that an EMT will always remain with the patient and an EMR will act as driver.
   - B) Certificate of completion of a defensive driver course for the EMR and validation that the EMT has one year of pre-hospital experience.
   - C) A system plan modification form stating this type of transport will only be for identified interfacility transports or medical appointments excluding dialysis.
   - D) Dispatch protocols for properly screening and assessing patients appropriate for transport utilizing the alternative staffing models.
   - E) A quality assurance plan which must include monthly review of dispatch screening and outcome.

2) **The System modification form and alternative staffing waiver** plan shall be submitted to the EMSMD for approval and forwarded to the REMSC for review and approval. The provider shall not implement the alternative staffing plan until approval by the EMSMD and the Department.

Ambulance Licensing and Operational Requirements

Effective Date: 12/2023
Review Date: 8/2023
Approvals: EMSSC, EMSMD

Background to Policy:

To ensure that all EMS vehicle licensing and operational requirements are met.

Policy Statement:

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

Policy:

a) Vehicle Design

1) Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as National Fire Protection Association, Ground Vehicle Standards for Ambulances, the Federal Specifications for the Star of Life Ambulance, or the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances.

2) *A licensed vehicle* shall be exempt *from subsequent vehicle design standards or specifications required by the Department* in this Part, *as long as* the *vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until* the *vehicle's title of ownership is transferred*. (Section 3.85(b)(8) of the Act)

b) Equipment Requirements – Basic Life Support Vehicles Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

1) Stretchers, Cots, and/or Litters

A) Primary Patient Cot

B) Secondary Patient Stretcher

2) Oxygen, Portable
Shall be secured.

3) Suction, Portable

A manually operated suction device is acceptable if approved by the Department.

4) Medical Equipment

A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask, and child size bag-valve-mask ventilation unit with child, infant and newborn size transparent masks

B) Lower-extremity traction splint, adult and pediatric sizes

C) Blood pressure cuff, one each, adult, child and infant sizes and gauge

D) Stethoscopes, two per vehicle

E) Long spine board with three sets of torso straps, 72" x 16" minimum

F) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional

G) Airway, oropharyngeal – adult, child, and infant, sizes 0-5

H) Airway, nasopharyngeal with lubrication, sizes 14-34F

I) Two adult and two pediatric sized non-rebreather oxygen masks per vehicle

J) Two infant partial re-breather, or equivalent oxygen masks per vehicle

K) Three nasal cannulas, adult and child size, per vehicle

L) Bandage shears, one per vehicle

M) Extremity splints, adult, two long and short per vehicle

N) Extremity splints, pediatric, two long and short per vehicle

O) Rigid cervical collars – one pediatric, small, medium, and large sizes or adjustable size collars, or equivalent per vehicle. Shall be made of rigid material to minimize flexion, extension, and lateral rotation of the head and cervical spine when spine injury is suspected.

P) Medical grade patient restraints, arm and leg, sets

Q) Pulse oximeter with pediatric and adult sensors

R) AED or defibrillator that includes pediatric capability

5) Medical Supplies

A) Trauma dressing – six per vehicle

B) Sterile gauze pads – 20 per vehicle, 4 inches by 4 inches

C) Bandages, soft roller, self-adhering type, 10 per vehicle, 4 inches by 5 yards

D) Vaseline gauze – two per vehicle, 3 inches by 8 inches

E) Adhesive tape rolls – two per vehicle

F) Triangular bandages or slings – five per vehicle

G) Burn sheets – two per vehicle, clean, individually wrapped

H) Sterile solution (normal saline) – four per vehicle, 500 cc or two per vehicle, 1,000 cc plastic bottles or bags

I) Material or device intended to maintain body temperature

J) Obstetrical kit, sterile – minimum one, pre-packaged with instruments and bulb syringe

K) Cold packs, three per vehicle

L) Hot packs, three per vehicle, optional

M) Emesis basin – one per vehicle

N) Drinking water – one quart, in non-breakable container; sterile water may be substituted

O) Ambulance emergency run reports – 10 per vehicle, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515.Appendix E or electronic documentation with paper backup

P) Sheets – two per vehicle, for ambulance cot

Q) Blankets – two per vehicle, for ambulance cot

R) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care

S) Urinal

T) Bedpan

U) Remains bag, optional

V) Nonporous disposable gloves

W) Impermeable red biohazard-labeled isolation bag

X) Face protection through any combination of masks and eye protection and face shields

Y) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall have a thumb suction control port

Z) Pediatric specific restraint systems or age/size appropriate car safety seats

AA) Current equipment/drug dosage sizing tape or pediatric equipment/drug age/weight chart

BB) Flashlight, two per vehicle, for patient assessment

CC) Current Illinois Department of Transportation Safety Inspection sticker in accordance with Section 13-101 of the Illinois Vehicle Code

DD) Illinois Poison Center telephone number

EE) Department of Public Health Central Complaint Registry telephone number posted where visible to the patient

FF) Medical Grade Oxygen

GG) Ten disaster triage tags

HH) State-approved Mass Casualty Incident (MCI) triage algorithms (START/JumpSTART)

c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS MD in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These vehicles shall have current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

d) Equipment Requirements – Rescue and/or Extrication
The following equipment shall be carried on the ambulance, unless the ambulance is routinely accompanied by a rescue vehicle:

1) Wrecking bar, 24"

2) Goggles for eye safety

3) Flashlight – one per vehicle, portable, battery operated

4) Fire Extinguisher – two per vehicle, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment

e) Equipment Requirements – Communications Capability
Each ambulance shall have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400.

f) Equipment Requirements – Epinephrine
An EMT, EMT-I, A-EMT or Paramedic who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) *with him or her* in the ambulance or drug box *as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System* within the context of the EMS System plan. (Section 3.55(a-7) of the Act)

g) Personnel Requirements

1) Each Basic Life Support ambulance shall be staffed by a minimum of one System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses unless there is an approved staffing waiver.

2) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one System authorized A-EMT, EMT-I, Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses unless there is an approved staffing waiver.

3) Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one System authorized Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses unless there is an approved staffing waiver.

h) Operational requirements

1) An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the Act and this Part.

2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required in this subsection (k), each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is always in operation. An ALS vehicle can be used to provide coverage at either an ALS, ILS or BLS level, and the coverage shall meet the requirements of this Section.

A) At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

i) A current roster shall also be submitted that lists the System authorized EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs, PHPAs, PHAPNs or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date and telephone number, and shall state whether the person is scheduled to be on site or on call.

ii) An actual or proposed four-week staffing schedule shall also be submitted that covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

B) Licensees shall obtain the EMS MD's approval of their vehicles' hours of operation prior to applying to the Department. An EMS MD may require specific hours of operation for individual vehicles to ensure appropriate coverage within the System.

C) A Vehicle Service Provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day. (See Section 515.800(j).)

3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Appendix E.

4) A Vehicle Service Provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.

5) A Vehicle Service Provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h).)

6) A Vehicle Service Provider shall not operate its ambulance at a level exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless the vehicle is operated pursuant to an EMS System-approved in-field service level upgrade or ambulance service upgrades – rural population.

7) The Department will inspect ambulances each year. If the Vehicle Service Provider has no violations of this Section that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it,

the Department will inspect the Vehicle Service Provider's ambulances in alternate years, and the Vehicle Service Provider may, with the Department's prior approval, self-inspect its ambulances in the other years. The Vehicle Service Provider shall use the Department's inspection form for self-inspection. Nothing contained in this subsection (k)(7) shall prevent the Department from conducting unannounced inspections.

n) A licensee may use a replacement vehicle for up to 10 days without a Department inspection, provided that the EMS System and the Department are notified of the use of the vehicle by the second working day.

o) *Patients, individuals who accompany a patient, and* EMS Personnel *may not smoke while inside an ambulance or SEMSV. The Department of Public Health* shall *impose a civil penalty on an individual who violates this subsection* (m) *in the amount of $100.* (Section 3.155(h) of the Act)

p) Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

Agency Inspection

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

A. In accordance with the Administrative Code derived from the State of Illinois EMS legislation, inspections may be conducted at any time at any EMS Agency by I.D.P.H. officials, the EMS Medical Director and/or the EMS System Manager/Coordinator.

B. At the time of these inspections, the respective EMS System Manager/Coordinator shall file a report on the results of the inspection with the EMS Medical Director (EMSMD). If remedial action is necessary, the EMS System Coordinator and/or EMSMD shall decide what shall be required to bring the vehicle or agency into compliance.

C. Each transport agency will be notified by the EMS office of the date and time of annual inspection.

D. All non-transport agencies will perform yearly self-inspection every February. The EMS office may inspect non-transport vehicles at their discretion.

C. Each EMS Agency (FR, BLS, ILS, ALS) is required to complete routine inspection to ensure compliance.

Ambulance Report Requirements

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure appropriate documentation of all patient encounters by pre-hospital personnel who are affiliates of the McLean County Area EMS system.

Policy Statement:

Documentation of all patient encounters is essential for record keeping and essential to the continuum of care.

Policy:

A. All agencies must complete a report for all patient encounters.

B. The report shall be completed using system approved software or forms.
   a. ESO, Code Red, Firehouse, Image Trend, EM Scan, Medi-view.

C. All reports shall be uploaded to the state database monthly, no later than the 15th of the following month in accordance with IDPH regulation.

D. All transport agencies must report data to the state database in the NEMSIS version in effect at the time.

E. Reports are to be completed and distributed as soon as possible after the call. If a sufficient reason exists to delay completion of the report immediately after the call, the report must be completed and distributed to the receiving facility within 2 hours of the patient arriving at the receiving facility.

F. If the report cannot be left upon hospital departure, EMS must complete and leave a short form which includes the following elements.

1) Patient Name
2) Patient Age
3) Vital Signs
4) Chief Complaint
5) Current Medication list
6) List of Allergies
7) Documentation of all treatment rendered by pre-hospital provider.
8) Date/time of arrival
9) Signature of prehospital provider confirming that all required information is present.

G. EMS may either utilize the short form (template on website) **OR** is expected to review the information recorded on the ECRN report sheet, provide updates if needed and sign form. The intent is to ensure that accurate and comprehensive information is provided for transition of

care.

H. Agencies and or personnel that fail to meet the requirements of items C and/or D above will be reported to the Medical Director who will act as is deemed appropriate to ensure reportsare completed and transmitted in a timely manner.

I. Agencies must be sure to have all patient demographics, reason for call, narrative, times of call.

J. All EKG's paper notes, refusal forms should be uploaded to the electronic report if the system is not automatically doing so.

Assistance by Non-System Personnel

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

Only a LICENSED EMS provider or EMS student under the direct supervision of a preceptor, who are approved members of the McLean County Area EMS System, and are authorized to perform direct patient care, may perform in the out-of-hospital setting. Pending approval of medical control, after the EMS personnel on-scene determine it is necessary, a trained healthcare provider may be allowed to assist as needed.

Policy:

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

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

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

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

Authority of the Alternate EMS Medical Director

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

The McLean County Area EMS System recognizes the EMS Medical Director will be periodically unavailable (i.e., Out of town work, Vacations, Illness, etc.…) to exercise his/her responsibilities as the EMS Medical Director. The Alternate EMS Medical Director will function as the EMS Medical Director during the primary EMS Medical Director's absence.

Policy:

A. When the EMS Medical Director has determined he/she will be unavailable to fulfill their responsibilities, he/she shall contact the appointed Alternate to ensure of their availability during specific dates and times.

B. The EMS Medical Director shall obtain from the Alternate, his/her contact numbers (i.e., home and work telephone numbers, pager number, cellular telephone number) and his/her work schedule with their basic personal itinerary for purposes of immediate contact, if necessary, by the EMS System Coordinator and/or by the Medical Control Physician.

C. The EMS Medical Director with as much notice as possible, shall notify the EMS System Coordinator, Emergency Department Staff, and all potential Medical Control Physicians with the above information listed in (B), along with the effective dates and times the Alternate EMS Medical Director has the designated full authority as EMS Medical Director.

D. When the EMS Medical Director is unavailable to fulfill the duties and responsibilities as the EMSMD, the Alternate EMS Medical Director has the delegated full authority to serve as the EMS Medical Director with identical duties and responsibilities as the EMSMD.

E. If the EMS Medical Director or Alternate EMS Medical Director are not accessible, the duties and responsibilities as the EMSMD will be delegated to the on-duty Medical Control Physician with guidance from the EMS System Coordinator.

BLS IM Injection Program

Effective Date: 10/2004
Review Date8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

A. Notification
   a. Any BLS agency that wishes to become an IM approved agency will notify the EMS System Coordinator of their intention.
   b. An agency must choose one method or the other. If an agency becomes IM approved,the are able to administer both glucagon and epinephrine IM.

B. Training
   a. After the notification, the EMS System will provide a minimum 2-hour training session.Topics to be covered in this session include indications, contraindications, potential complications, and practice of the psycho motor skills.
   b. It will be the responsibility of the agency training officer to ensure that new employees are trained on IM injections when completing the skills checklist.

C. Prescription
   a. After the required training has been completed, the system will issue an updated prescription for the needed supplies.

D. Equipment
   a. Only equipment that has been placed on the EMS System BLS equipment checklist will be permitted to be carried. Needle and syringe sizes will be prescribed by the system.
   b. All BLS system vehicles will be required to carry 1 vial containing 1 mg of 1:1000 Epinephrine. Only vials are acceptable. Glass ampules, which must be broken open, are not acceptable for the BLS level. Please note that Epinephrine vials are not routinely stocked at either hospital pharmacy. You will need to purchase from a third-party vendor such as Boundtree or EMP
   c. All BLS system vehicles that are IM equipped may choose to carry 1 box (1mg) of Glucagon as opposed to the required 2.
   d. All BLS agencies are still required to carry a pediatric epi pen auto injector. In addition, glucagon for the pediatric patient will be given intranasal in accordance with the pediatric protocol manual.

Bypass Status – Diversion to a Hospital, Trauma Center, or Regional Trauma Center Other Than the Nearest Hospital

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To clarify for Medical Control and pre-hospital care providers the bypass or the diversion of a patient to a hospital other than the nearest hospital, trauma center, or regional trauma center.

Policy Statement:

Patients of EMS agencies affiliated with the McLean County Area EMS System shall not be transported to a hospital other than the nearest hospital, Regional Trauma Center or Trauma Center unless the EMS Medical Director or a qualified designee (Medical Control Physician) has certified that the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from the transport to the more distant facility, **or the transport is in accordance with the EMS System's Policy, for "Patient Hospital Preference" or "Patient Right of Refusal".**

Policy:

A. **NO BYPASS OR DIVERSION OF AN EMERGENCY PATIENT(S) TO A HOSPITAL OTHER THAN THE NEAREST HOSPITAL UNDER ANY CIRCUMSTANCES WITHOUT MEDICAL CONTROL PHYSICIAN AUTHORIZATION IS PERMITTED. IT IS THE RESPONSIBILITY AND THE MANDATE BY ILLINOIS STATE LAW THAT THE MEDICAL CONTROL PHYSICIAN IS THE ONLY PERSON WHO MAY AUTHORIZE THE BYPASS OR DIVERSION OF A PATIENT(S).**

B. Patients of EMS agencies affiliated with the McLean County Area EMS System shall not be transported to a hospital other than the nearest hospital, Regional Trauma Center or Trauma Center unless the EMS Medical Director or a qualified designee (Medical Control Physician) has certified that, the Medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more district facility outweigh the increased risks to the patient from the transport to the more distant facility, or the transport is in accordance with the EMS Systems Policy and Procedure for "Patient Hospital Preference" or "Patient Right of Refusal".

C. The Medical Control Physician may determine a trauma patient may benefit from the transport directly to Carle BroMenn Medical Center Regional Medical Center or OSF St. Joseph Medical Center, both level II Trauma Centers; likewise, the Medical Control Physician may authorize transport directly to a level I Trauma Center or specialty care center (e.g., burn center), rather than transport to the nearest hospital that is not a trauma center. This determination may only be made by the Medical Control Physician and in compliance with thetime requirements as mandated in the "Field Triage of the Trauma Patient" policy.

D. If either of the Resource Hospitals, both level II Trauma Centers, has determined the need to initiate Trauma Center Bypass, the respective Medical Control, after proper notification, shall have all ambulances with trauma patients diverted to other hospital emergency departments. Both hospitals will comply with the "Region 2 Trauma Center Bypass" policy.

E. **REGARDLESS OF A FACILITY BEING ON BYPASS STATUS OR NOT, A PATIENT IN A LIFE-THREATENING CONDITION SHALL BE TRANSPORTED TO THE CLOSEST FACILITY.**

F. A hospital can declare a resource limitation under certain circumstances, (i.e., internal disaster, unavailability of critical or monitored beds). Seek Medical Control direction.

G. **BYPASS STATUS MAY NOT BE HONORED** if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes. Seek Medical Control direction.

Cardiac Monitor and AED on Emergency Vehicles

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

All automated external defibrillators must be programmed to function only in the "semi-automatic." mode. This means that the EMS provider must hit a button for the device to discharge.

B. All automated external defibrillators must meet or exceed the following features and specifications:

1. Energy level modes to comply with the AHA national standards.
2. Voice prompts for semi-automatic mode
3. ECG Monitor screen with at least 3 second visual.
4. Code summary documentation print-out
5. Two (2) rechargeable sealed lead acid batteries
6. Utilizes defibrillation pads.

C. All First Responder and licensed Basic Life Support alternate response EMS vehicles are to be equipped with an A.E.D. Although, if the vehicle is licensed for defibrillation, the A.E.D. must comply with the specification as listed in "B: item 1, item 4 and item 6" of this policy with all other features listed in "B" optional.

D. A licensed BLS ***transport*** EMS vehicle is required to be equipped with a device(s) capable of 12-lead and defibrillation.

E. A licensed ILS vehicle must have the ability to do the above and synchronize cardiovert.

F. A licensed ALS vehicle must have the ability of all the above and to pace.

Cardiac Resuscitation vs. Cease Efforts and Coroner Notifications

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

Resuscitation vs. Recognition of Death

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

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

B. Guidelines for determining resuscitation efforts or ceasing efforts:

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

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

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

D. Signs of death are notably evident:

- Confirm no Blood Pressure, respirations, or EKG activity.
- Contact Medical Control

- Receive direction to notify Coroner.

E. Upon EMS arrival, CPR is in progress:

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

F. Special circumstance where prolonged resuscitation efforts are indicated:

- Hypothermia
- Pediatric patients
- Treatable contributing factors

Code of Conduct

Effective Date: 08/2021
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

• Respect all patients regardless of socio-economic status, financial status, or background. Dignity includes greeting, conversing, respectful mannerisms, and protecting physical privacy.

• Respect every person's right to privacy. Sensitive information regarding a patient's condition or history should only be provided to medical personnel with an immediate need-to-know. Sensitive information regarding our profession may only be provided to those with a right to know.

• Provide the patient with the best possible care by continuously improving understanding of the profession and maintaining continuing education and required certifications. Protect the patient from incompetent care by knowing the standard of care and being able to identify those who do not.

• Protect the health and well-being of the patient, yourself, your co-workers, and the community by constantly following safety guidelines, principles, and practices.

• Act within your training, know your limitations, and accept responsibility for both satisfactory and unsatisfactory actions.

• Demonstrate devotion by maintaining confidentiality, assisting in improving morale and not publicly criticizing.

• Demonstrate professionalism by maintaining high moral, ethical and grooming standards. Do not participate in behavior that would discredit you, your co-workers, and the profession.

• A fundamental responsibility of the EMS Provider 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 based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status.

• Uphold the law and perform the duties of citizenship; as a professional, I further understand that it is a never-ending responsibility to work with concerned citizens and other healthcare professionals in promoting a high standard of emergency medical care to all people.

EMS agencies are expected to advertise in a responsible manner and in accordance with rules, regulations, and statutes to assure the public is protected against misrepresentation.

- No agency (public or private) shall mislead, advertise, or identify their vehicle or agency as providing any EMS service unless the agency does, in fact, provide said service as defined in the EMS Act and has been approved by IDPH.
- Any person (or persons) who violated the EMS Act, or any rule promulgated pursuant there could be subject to legal action. It is the responsibility of all McLean County Area EMS System providers to report any such infractions of this section to the EMS Medical Director.
- Citizens in need of out-of-hospital medical services rely on the EMS System and the existence of state licensure/ certification or national certification to assure that those who respond to their calls for aid are worthy of this extraordinary trust. Considering the high degree of trust conferred upon EMS providers by virtue of licensure and certification, EMS providers should be held to a high standard. For these reasons, the EMS certifying/licensing agency has a duty to exclude individuals who pose a risk to public health and safety by virtue of conviction of certain crimes.
- System Certification of individuals convicted of felonies presents an unreasonable risk to public health and safety. Thus, applications for certification by individuals convicted of any felony crime are subject to review by IDPH and the System medical director.

Communicable Disease Policy

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

1.) To ensure the protection of Emergency Medical Service (EMS) personnel and patients, break the chain of infection of certain diseases, and provide guidance if a significant exposure occurs. Those communicable diseases are but not limited to: HIV, AIDS, Hepatitis, Pulmonary TB, Meningococcal Meningitis and Chicken Pox.

2.) Pre-hospital care providers have an ethical and moral responsibility to provide care to all patients to the best of their abilities. In this role, they place themselves in certain circumstances, at a higher-than-normal risk of being exposed to blood and body fluids that mightcontain infectious diseases. When administering care to patients, EMS providers will not alwaysbe aware or informed that these patients have a communicable disease. This policy also appliesto paramedic students involved with the Carle BroMenn Medical Center, OSF St. Joseph Medical Center, McLean County Area EMS System Paramedic Training Consortium.

Policy Statement:

The following best practices are for the use of protective equipment; the cleaning and disinfecting techniques that have been established in accordance with the Centers for Disease Control.

Policy:

a. Treating and Exposure

i. If you are exposed percutaneously:

1. Wipe off blood or fluid and apply alcohol.
2. After arriving at the hospital, and as soon as patient care allows, wash your hands and the wound.
3. If the wound is such that requires sutures, seek prompt medical attention.
4. If you have received a puncture wound, seek medical attention to evaluate your tetanus immunization status.

ii. If you are exposed mucocutaneously:

1. Flush your eye(s) or rinse your mouth with saline or water.
2. After arriving at the hospital, and as soon as patient care allows, wash your face.
3. Seek medical advice if further treatment or evaluation is necessary.

b. Protective Measures

iii. The best way to avoid exposures to body fluids is to use protective procedures on all responses. It is better to enter a situation with protective gear in place than to delay treatment while you put on protective clothing.

iv. All pre-hospital care personnel must wash their hands before and after contact with any patient. This should be done regardless of the use of gloves.

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

b. Protective Gear:

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

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

ii. **HEPA Mask**

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

iii. **Eye Protection**

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

iv. **Airway management**

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

c. Needles and Syringes

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

d. Cleansing of Ambulance and Equipment

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

e. Soiled Clothing

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

[158°F]) in the laundry cycle is used, chemicals suitable for low-temperature washing at properly used concentration should be used.

f. Masks

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

g. Protective Eye Wear

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

h. Gloves

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

i. Cardiopulmonary Resuscitation

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

j. Sharps

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

k. Hand washing

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

l. Cleaning Procedures

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

xv. Critical items that come in contact with mucous membranes but are not disposable, such as laryngoscope blades require high level disinfection with a Cidex or 70% Isopropyl alcohol solution for at least thirty (30) minutes.

xvi. Always wear gloves when cleaning and disinfecting pre-hospital equipment.

xvii. Interior of Transport Vehicles

1. For the interior of transport vehicles, routine and consistent cleaning procedures with detergent disinfectants and hot water will provide adequate decontamination. The use of bleach is not recommended since repeated applications corrode metal and may damage some equipment.

xviii. Care of Clothing

1. Routine laundering practices are adequate to decontaminate clothing that is soiled with blood or body fluids, utilizing hot water (106°F) and detergent.

m. Ineffective Procedures

xix. All disinfectants require a clean surface before they can work.

xx. The spraying of disinfectants is not recommended. Sprays are applied unevenly so that the amount sprayed may not disinfect the area adequately. Spray disinfectants can cause electrical equipment to malfunction.

n. Types of Disinfectants and Antiseptics:

xxi. Commercially available biohazard substance cleaning substances.

xxii. Bleach

1. Uses
   a. As a powerful anti-microbial agent, bleach is recommended for cleaning up fresh un-dried blood spills or surfaces that are difficult to clean. Good disinfectant for plastic materials.
2. Concentration
   a. 1:10 dilution (5000ppm) = 1 cup of bleach to 9 cups water (slightly more than ½ gallon).
3. Contact time
   a. Thirty (30) minutes.
4. Precautions
   a. Highly corrosive to metal even at low concentrations. Can hamper the function of electrical connections and electronic equipment. Can decolorize fabrics. Undiluted and 1:10 dilutions can cause eye, skin and respiratory irritations.

xxiii. Alcohol, 70% Isopropyl

1. Uses
   a. Can be used around electrical connections and electronic equipment because it leaves no ionic residue and does not corrode metal. A good skin antiseptic; the primary anti-microbial ingredient of most waterless hand washing products.
2. Contact time
   a. Five (5) to thirty (30) minutes for high-level disinfection.
3. Precautions
   a. Equipment must be immersed for disinfection; not recommended for disinfection of surfaces that cannot be

immersed since it evaporates quickly. Flammable; inactivated by the presence of blood and dirt; can stiffen and crack plastic. May dry and irritate the skin.

xxiv. Glutaraldehyde, 2%

1. Uses

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

2. Contact time

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

3. Precautions

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

xxv. Hydrogen Peroxide

1. Uses

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

2. Concentration

a. 3%

3. Contact time

a. Reacts immediately upon contact.

4. Precautions

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

xxvi. Iodophors

1. Uses

a. Excellent skin antiseptics

2. Concentration

a. Varies with product.

3. Contact time

a. Must dry in air for maximum effectiveness.

4. Precautions

a. Not recommended for disinfecting equipment. Corrode metal, dissolve rubber, crack plastic and stain metals. Can irritate fresh, open wounds or burns.

xxvii. Phenolic and Quaternary Ammonium Compounds

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

xxviii. Detergent Disinfectants

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

o. Significant Exposure

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

xxx. Classifications of EMS Providers

1. EMS Students
2. First Responders, EMT-B, EMT-I, EMT-P
3. Other ambulance service personnel

xxxi. Procedure for Exposure Incident

1. Any EMS Students or EMS Systems member with significant exposure in the clinical setting (i.e. Emergency Department, ALS Unit…) must report the incident to their educational supervisor and the EMS System office.
2. Any EMT or other ambulance service/rescue personnel with significant exposure shall report the incident immediately to their agency.

supervisor, Director, Chief or Command Officer. The Individual must comply with the guidelines of their agency's "Exposure Control Program".

3. Complete a detailed incident report including, but not limited to the following:
    a. Documentation of the route(s) of exposure, and the circumstance under which the exposure incident occurred.
    b. Identification and documentation of the source individual.
4. Seek treatment at the emergency department of the hospital clinical site or where the source individual was transported, if transported to an emergency department.
5. If the patient was not transported to an emergency department, treatment should be sought at a local emergency department. NOTE: ***An EMS employer may require an individual to seek medical attention at a medical facility contracted with the EMS Agency to provide such services that is not an emergency department.***
6. Complete follow-up care as directed.

Communications Etiquette

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To assure that appropriate and complete radio communication exists in the McLean County Area EMS System.

Policy Statement:

All McLean County Area EMS System agencies communicate with area hospitals daily. The Carle BroMenn Medical Center, OSF St. Joseph Medical Center, and System associate and participating hospitals' emergency departments have EMS communications equipment. EMS providers may receive orders from the resource hospital or associate resource hospital. All refusals and declarations of death must call the active resource hospital, with exception of agencies outside of McLean country who may call their closest associate resource hospital. Agencies transporting to hospitals outside of the EMS System who are not associated with MCAEMS, must contact the active resource hospital for all medical control orders. To reduce the circumstances that may lead to misinformation or misunderstandings when transmitting patient information and treatment orders, criteria have been developed which comply withregulations of the Federal Communications Commission.

Policy:

A. Only the precise airtime necessary to transfer essential patient care information should be utilized by all EMS providers and all Medical Control sites, whether on UHF radio, VHF radio, or cellular phone.

B. If it is necessary to transmit telemetry ECG recordings to Medical Control. Failures of EKG transmissions should be reported to the EMSoffice within 1 business day.

C. Medical Control is the designated authority to elicit efficient radio transmissions as circumstances arise.

D. Voice communications must always remain professional. Foul language must never be used as it is an illegal act. Do not use slang or other words that may not be commonly spoken in the region. In addition, providers and ECRN's should be aware of their tone of voice and remain professional.

E. Do not use 10 codes.

F. Any violation of this policy shall be reported to the EMS System immediately via an incident report and may result in disciplinary action.

Communications Recording Procedures

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

The following guidelines have been established to assist the ECRN, the Medical Control Physician, or receiving facility in the proper procedure of recording all in-bound, pre-hospital patient care information. The purpose for recording all calls is two-fold. First, is to seek Continuous Quality Improvement through retrospective evaluation of out-of-hospital care and second is to validate patient care in cases of litigation.

Policy:

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

Resources:

515.410 (b)

Conceal Carry Policy

Effective Date: 01/2014
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

All weaponry must be treated with due caution, for the protection of patients as well as EMS personnel. Firearms shall not be permitted in EMS facilities, with minimal exceptions. The safety of EMS personnel has priority in these situations.

Policy:

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

Applicable Scenarios

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

General Guidelines

A. Under no circumstances should an emergency responder or healthcare worker compromise their safety regarding these guidelines. When in doubt about a patient with a weapon or the weapon itself, emergency responders and healthcare personnel should contact local law enforcement. Law enforcement officers will make the decisions regarding disarming the patient and the weapon.

1. **Note:** *Do not ask the patient whether he/she has the right to carry a weapon. If the person has no legal right, they may become alarmed and cause EMS personnel harm.*
2. All weapons are to be removed from the patient. The only exception is a conscious and alert law enforcement officer. No EMS personnel shall provide medical care to an armed person.

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

11. Any public park, athletic area, or athletic facility under the control of a municipality or park district.
12. Any building, classroom, laboratory, medical clinic, hospital, artistic venue, athletic venue, entertainment venue, officially recognized university-related organization property, whether owned or leased, and any real property, including parking areas, sidewalks, and common areas under the control of a public, or private community college, college, or university.
13. Any building, real property, or parking area under the control of a gaming facility licensed under the Riverboat Gaming Act or the Illinois Horse Racing Act of 1975, including inter-track wagering location licensee.
14. Any stadium, arena, or the real property or parking area under the control of a stadium, arena, or any collegiate or professional sporting event.
15. Any building, real property, or parking area under the control of a public library.
16. Any building, real property, or parking area under the control of an airport.
17. Any building, real property, or parking area under the control of an amusement park.
18. Any building, real property, or parking area under the control of a zoo or museum.
19. Any street, driveway, parking area, property, building, or facility, owned, leased, controlled, or used by a nuclear energy, storage, weapons, or development site or facility regulated by the federal Nuclear Regulatory Commission. The licensee shall not under any circumstance store a firearm or ammunition in his or her vehicle or in a compartment or container within a vehicle located anywhere in or on the street, driveway, parking area, property, building, or facility descried in this paragraph.
20. Any area where firearms are prohibited under federal law.

I. EMS agencies are encouraged to designate themselves as a weapons-free facility. No-carry signage should be clearly posted in emergency squads and EMS facilities. Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles or in hospitals that have declared themselves as no-carry zones.

Conscious Patient Willing to Relinquish a Weapon

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

control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.

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

Conscious Patient Unwilling to Relinquish a Weapon

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

Patients with Altered Levels of Consciousness

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

8. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.
9. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form.*
10. Medical facility personnel shall give an empty replacement box to the emergency responders.

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

A. The decision to transport family members and/or friends with the patient solely rests with existing policies of individual emergency response agencies.

B. Agencies that permit transport of family/friends with the patient shall;
1. Ask the family member/friend to declare if they have a concealed weapon.
2. Explain that no unsecured weapons may be transported in the emergency vehicle.

C. If a family member/friend discloses a concealed weapon AND the patient's condition is such that the emergency medical personnel deem it in the best interest of the patient to transport the family member/friend with them:
1. The family member/friend should be instructed to leave the weapon in a secure place at the home. If the family member/friend refuses, emergency response personnel have the prerogative to decline transport of the family member/friend with the patient. No family member/friend should be transported with an unsecured weapon.

D. If the scene is not at the family member's/friend's residence, or circumstances prevent the weapon from being secured in the home:
1. Have the family member/friend place the weapon into the Lock Box.
2. Secure the Lock Box with a numbered security seal and place the Box in a locked exterior vehicle compartment for transport.
3. Complete and have the family member/friend sign the *Chain of Custody Form* (Attachment A).
4. If additional weapons are discovered, begin again at Step (1). If no additional weapons are discovered, load the patient into the vehicle and transport to an appropriate medical facility.
5. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
6. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.
7. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form.*
8. Medical facility personnel shall give an empty replacement box to the emergency responders.

Patients Transported via Emergency Responders to a Medical Facility

A. EMS should make every attempt to screen all patients for concealed weapons prior to transport to a medical facility.

B. Patients with concealed weapons that could not be secured at their residence may have had them placed in a Lock Box by emergency personnel. In the absence of an established community protocol whereby the local law enforcement agency of the emergency responders meets the transport vehicle at the medical facility to assume control of the weapon, medical facilities may need to assume control when the patient is delivered.

C. While en route, emergency response personnel shall notify the receiving facility that a weapon is being transported in a Lock Box with the patient.

D. Facility security personnel shall meet the transport vehicle at the doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with coded snap locks in place.

E. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form.*

F. Facility security personnel shall give an empty replacement box to the emergency responders.

Lock Box

A. A System-wide exchange program is established under these guidelines such that all emergency response agencies and healthcare facilities participating shall purchase similar safety boxes to secure deadly weapons. The recommended new box is manufactured by Flambeau. The box name is the "Flambeau Safe Shot Pistol Gun Case, 14-inch Polymer Black," product number 682841
(Attachment B).

B. Each participating agency shall procure their own boxes. Each agency shall draw/paint a gun template with indelible medium outside of the Lock Boxes to indicate the direction of the barrel of a stored firearm. A gun template is attached with these guidelines (Attachment C).

C. These Lock Boxes shall be secured with a numbered security seal to document a chain of evidence. Emergency response agencies and healthcare facilities shall procure their own locks. Each Lock Box shall have an outside label indicating "CAUTION: DEADLY WEAPON (Attachment D)."

D. Lock boxes containing weapons must be stored in a secure, locked storage compartment or cabinet by emergency response agencies and healthcare facilities. The Lock Boxes will be exchanged at the interface of emergency responders and healthcare facilities when patients are delivered who had a weapon that could not be left at their residence.

E. Emergency response personnel shall hand-over a Lock Box secured with coded snap locks to a healthcare facility security officer. In exchange the healthcare security officer will provide an empty box back to the emergency responder. The intent is to minimize the handling of potentially dangerous weapons by emergency response and healthcare facility staff. Additionally, at the discretion of the emergency response agency, a family member/friend may be transported with the patient. If the family member/ friend has a weapon and is transferred, the family member's/friend's weapon must also be secured and given to a healthcare facility's security staff by emergency response personnel. As above, the healthcare facility security officer and emergency responder shall exchange the Lock Box with the weapon for an empty Lock Box.

Activities Which Shall Result in Immediate Licensure Suspension

A. Attempting to engage a "safety" or undoing a "safety" on a handgun, stun gun or pepper spray.

B. Treating a gun as if it were not loaded.
C. Unloading a gun.
D. Failure to place a weapon in a Lock Box.
E. Showing off a weapon or flashing a weapon.
F. Making remarks about violence with a weapon
G. Bringing a weapon into a prohibited area while on duty.

ATTACHMENT "A"

McLean County Area EMS System

CONCEALED WEAPON CHAIN OF CUSTODY FORM

DOCUMENTATION OF WEAPON(S)

Firearm(s) Cutting Blade(s) Electroshock Weapon Other_____

How Many & type(s) of each indicated above_____

CONFINEMENT OF WEAPON(S)

Patient/ Other (Circle one) Signature of Release to Secure Weapon_____

Lock Box Snap Lock Number(s) _____

Placed by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

Witness_____ (Agency/Facility) _____ (Signature) on _____ (Date)

DELIVERY OF WEAPON(S) FROM EMS TO HOSPITAL

Patient/ Other (Circle one) Signature of Release to Secure Weapon_____

Lock Box Snap Lock Number(s) _____

Given by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

Received by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

DELIVERY OF WEAPON(S) FROM EMS/HOSPITAL TO LAW ENFORCEMENT

Patient/ Other (Circle one) Signature of Release to Secure Weapon_____

Lock Box Snap Lock Number(s) _____

Given by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

Received by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

RELEASE OF WEAPON(S) FROM HOSPITAL TO OWNER

Patient/ Other (Circle one) Signature of Release to Secure Weapon_____

Lock Box Snap Lock Number(s) _____

Given by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

Received by_____ (Agency/Facility) _____ (Signature) on _____ (Date)

Patient Name: DOB: Patient ID #:	Proof of Identification: Proof of CCW Permit:

January 2014

ATTACHMENT "B"

McLean County Area EMS System

Flambeau Safe Shot Pistol Gun Case 14" Polymer Black

Technical Information

Material : Hard Plastic

External Dimensions: 14" Long X 11" Wide X 3-1/4" High
Weight: 1.45 Pounds
Number of Firearms: 1 Handgun
Type of Lock: Sliding, Lockable Latches **FAA Approved:** No

Notes:

- Full Egg-Shell Foam Padding
- Cases are stackable
- Based on inside dimensions, this case will hold one handgun up to a 7" grip length and 12" overall length including barrel

January 2014

ATTACHMENT "C"

McLean County Area EMS System

January 2014

ATTACHMENT "D"

McLean County Area EMS System

January 2014

Consent for Treatment of Minors

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

DEFINITIONS:

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

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

C. If the minor's parent or legal guardian is present at the scene, consent or refusal of care must be obtained from the parent or legal guardian.

D. In the situation of a minor requiring emergency treatment but the parent or legal guardian does not consent due to religious beliefs, then the EMS provider should advise the parent or guardians of the risks involved and follow the Patient Right of Refusal policy.

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

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

1. **Emancipated, Pregnant or Married Minors may consent for their own treatment:** A minor between the age of 16 and 18 years old who presents a court order declaring themselves emancipated, or are pregnant or married minor of any age, may lawfully consent to the performance of any medical or surgical procedure.

2. **Minors who are parents may consent for their own treatment:** A minor who is a parent may lawfully consent to treatment of their minor child and themselves.

3. **Parental or guardian consent is not required for patients over the age of 12** seeking treatment for **mental health**, **sexually transmitted diseases, sexual abuse/assault, alcohol or drug abuse**.

4. **Emergency Care -** A minor may receive emergency care without the prior consent of a parent or guardian when obtaining such consent is not reasonably feasible without adversely affecting the minor's health.

G. Refusal of Transport after Emergency Treatment

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

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

Controlled Substances

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

The McLean County Area EMS Systems recognizes the importance of medications carried on Advanced level EMS vehicles in relation to patient care. It is also important to understand the risks involving the potential abuse and addiction of controlled substances.

Policy:

All controlled substances will be kept inside each ambulance within the drug box. The medication will be secured inside a pouch or container sealed with a numbered tamper-proof tag.

B. At the beginning of each shift, the on-coming highest level of licensed provider (either EMT-I or EMT-P/PHRN) will verify that the controlled substance tag is secure, and the tag number is to be verified with the log.

C. If the tag is not intact or the number is not verifiable, a complete inventory should be taken immediately, and an EMS Agency Supervisor shall be notified. An incident report shall be completed and forwarded to the EMS System office immediately.

D. Controlled substances shall be available for inspection by the Illinois Department of Public Health, EMS System Coordinator or authorized other individual by the EMS System.

E. Each usage of a controlled substance must be properly documented including the following information:

- Date of administration
- Time of administration
- Old tag number
- New tag number
- Patient name
- Drug and dose given
- Drug amount wasted
- Total amount of drug
- EMT-I or EMT-P signature
- Witness signature of waste, RN at receiving hospital (waste)

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

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

G. Any controlled substance that has not been administered must be properly disposed. The amount wasted must be noted on the log and witnessed by a nurse or physician at the receiving hospital. When the replacement medication is received from the pharmacy, the EMT-I or EMT-P will sign the narcotic log in the Hospital.

H. At the end of each month, the EMS agency must send a copy of their controlled substance logs (one for each unit carrying controlled substances) to the EMS office, by no later than the 5th day of new month. Failure to do so can result in suspension of use of narcotics or other disciplinary actions. The control log will be inspected and reviewed by the QA Coordinator to ensure appropriate use of narcotics and to look for any discrepancies in documentation.

Coroner Notifications

Effective Date: 09/2009
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

Recognition of Death

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

- **Notification Requirements and Procedures**
  Under 55 ILCS 5/3-320 of the Illinois Revised Statutes - Coroners, it is written that:

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

- Those deaths that are subjected to an investigation, are classified in the following categories:
  1. **ACCIDENTAL DEATHS**
     - Anesthetic Accident (death on the operating table or prior to recovery from anesthesia
     - Blows or other forms of mechanical violence.
     - Burns
     - Crushed beneath falling objects
     - Cutting or stabbing
     - Drowning
     - Electric shock
     - Explosion
     - Firearms
     - Fracture of bones. Such as cases to be reported even when fracture is not primarily responsible for death.
     - Falls
     - Carbon Monoxide poisoning
     - Hanging
     - Thermal Exposure

- Poisoning
- Strangulation
- Suffocation
- Vehicular Accidents

2. **HOMICIDAL DEATHS**
3. **SUICIDAL DEATHS**
4. **ABORTIONS** -Criminal or self-induced maternal or fetal deaths.
5. **SUDDEN DEATHS** - When in apparent good health or in any suspicious or unusual manner including sudden death on the street, at home, in a public place, ultimately is the subject of investigation.

- In notifying the coroner, or his designee, give the following information:
  - Your name
  - Your provider
  - Location
  - Phone number and/or radio frequency from which you may be contacted.
  - Brief explanation - i.e., possible suicide, car accident - two dead.
  - During transport of an emergent patient and the patient goes into cardio-pulmonary arrest, run a monitor strip while noting the time and location and then contact medical control (obtain the ED physician name) while following appropriate medical protocols. Record this information on the run sheet.
    EXCEPTION: During a non-emergent inter-facility transport (patient to a residence or long-term care facility) **and** the patient has a valid advanced directive **and** the patient goes into cardio-pulmonary arrest: continue transport to the final destination (if this is a private residence or long-term care facility) and wait for the coroner at that location. If at any time under this exception transport of the patient would mean either:

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

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

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

- When death is obvious at the scene:

    - **FIRST** call medical control for death declaration.
    - If you are the first to arrive on a scene where death is obvious, ensure that the police andcoroner are enroute to the scene.
    - If you are the first to arrive on a scene where death is obvious and police have yet to arrive, keep everyone away from the area including family and friends.
    - If police and/or coroner have yet to arrive and death is obvious at the scene which is inside a building, (i.e., house or apartment) leave the room and protect the scene from the outside.

Do Not Resuscitate

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To provide guidance to EMS personnel in situations where a valid DNR/POLST order is encountered. A valid DNR/POLSTorder should reflect the patient's personal views and wishes related to end of life decisions.

Policy Statement:

A Do Not Resuscitate Policy/ Portable Medical Orders are tools to be used in the pre-hospital setting to set forth guidelines for providing CPR/resuscitation or for withholding resuscitation efforts. The purpose of this policy is to specify requirements for valid DNR/POLST orders and to establish a procedure for field management of these situations. A DNR/POLST policy shall be implemented only after it has been reviewed and approved by the Department of Public Health, in accordance with the requirements of Section 515.380.

Policy:

Any EMR/FRD, EMT-B, EMT-I, EMT-P or Pre-hospital RN who is actively participating in a department approved EMS System may honor, follow, and respect a valid DNR/POLST order. Medical Control will becontacted in all cases involving DNR/POLST's.

B. DNR/POLST refers to the withholding of life sustaining treatment such as: Cardiopulmonary resuscitation (CPR); electrical therapy to include pacing, cardioversion, and defibrillation; tracheal intubation and manually or mechanically assisted ventilation, unless otherwise stated on the DNR/POLST order.

C. By itself, a DNR order does not mean that any other life prolonging therapy, hospitalization or use of the Emergency Medical System is to be withheld. On-line Medical Control must be consulted in cases involving DNR/POLST orders. DNR orders do not affect treatment of patients **not in full cardiac arrest (pulseless and breathless), however a POLST form may specify selective treatments patient agrees to.**

D. A DNR order may be invalidated if the immediate cause of a respiratory/cardiac arrest is related to trauma or mechanical airway obstruction.

E. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR is not in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist:

- Obvious signs of biological death are present.
- Decapitation
- Rigor mortis without profound hypothermia
- Dependent lividity
- Obvious mortal wounds with no signs of life
- Decomposition
- The patient has been declared dead by the patient's physician or a coroner.

- A valid DNR/POLST order is present, and the EMS provider has made reasonable effort to verifythe identity of the patient named in a valid DNR order (i.e., identification by another person, ID band, Photo ID or facility or homecare/hospice nursing staff)
- If the above signs of death are recognized, EMS personnel must contact Medical Control to confirm the decision not to attempt resuscitation (cease effort or do not resuscitate orders)
- prior to notifying the coroner.
- If System 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 further orders.
- If the EMS provider has concerns regarding the validity of the DNR orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition the provider should immediately institute BLS measures and contact Medical Control for further directions.

F. When EMS personnel arrive on scene and discover CPR is in progress, the Ems provider should:

- Assess pulse and breathing and analyze EKG activity.
- Determine if signs of death are present or a valid DNR exist.
- Continue resuscitation if signs of death are not obvious and a valid DNR is not available.
- Contact Medical Control for orders, including possible cease effort orders.

G. If the patient's primary care physician is at the scene or on the telephone and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity (if not known to the EMT) and notify Medical Control of the request of the on-scene physician. The physician on scene shall sign the ambulance report form if Medical Control approves their request(s).

I. **Effective July 1, 2001**, the only recognized DNR forms EMS providers are obligated to honor, follow and respect is the IDPH uniform **Do Not Resuscitate (DNR) Advance Directive** form, which is easily identified by its brightly colored paper and the Seal of the State of Illinois. (see attached)—OR—the Illinois Department of Public Health POLST (physician orders for life sustaining treatment) form (See Attached). Photocopies are acceptable in either form.

J. Any other advance directives or "living will" cannot be honored, followed, and respected by pre-hospital care providers. EMS personnel 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 Medical Control.

K. A Durable Power of Attorney for Health Care is an agent who has been delegated by the patient to make any health care 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 pre-hospital personnel and they direct those resuscitative efforts are not instituted:

- The EMT is required to ask the durable power of attorney for health care agent to provide positive identification (i.e., driver's license, picture ID, etc.), see the document and ask the agent to point out the language that confirms that the 'power' is in effect and that it covers the situation at hand (i.e., assure the scope of authority the durable power of attorney for health care has, and that the patient's medical or mental condition complies with the document designating the DPAH).
- A durable power of attorney for health care agent or a surrogate decision maker can

provide consent to DNR order, but the order itself must be written by a physician.

- An EMT cannot honor a verbal or written DNR request or order made directly by a durable power of attorney for health care agent or a surrogate decision maker or any other person, other than a physician. If such a situation is encountered, contact Medical Control for direction in interpreting the validity of the order or request.

L. 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 written consent to the order. Pre-hospital 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. All patients should have access to emergency medical services and may refuse treatment including CPR.

M. When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear (i.e., upset family situation, no agreement on DNR, etc.), EMS personnel should provide assessment, initiate resuscitative measures, and contact Medical Control for further directions.

N. If EMS personnel are transporting a patient with a valid DNR order to or from home and the patient arrests enroute, contact Medical Control for orders regarding the transport. Do not initiate resuscitative measures unless otherwise directed by Medical Control.

O. If EMS personnel are transporting a patient transfer with a valid DNR order during an inter-hospital and the patient arrest enroute, continue transport to the hospital and contact Medical Control for orders. Do not initiate resuscitative measures unless otherwise directed by Medical Control.

P. If System personnel are transporting a patient facility with a valid DNR order from a long-term care and the patient arrest enroute, continue transport to the hospital and contact Medical Control. Do not initiate resuscitative measures unless otherwise directed by Medical Control.

R. On occasion, EMS Personnel may encounter an out-of-town patient with a valid DNR order visiting in the EMS System area. If the DNR order appears to be valid (signed by the patient and physician and has a current date), contact Medical Control for orders.

S. The coroner will be notified of any patient or family wishes that there is to be tissue donation and the patient is not transported to the hospital.

T. The on-line 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. If the DNR order cannot be validated, EMS personnel should be ordered to initiate or continue resuscitative measures.

U. All EMS System personnel will receive a copy of the policy and education will be conducted initially, annually and on an 'as needed' basis.

V. All associate and participating hospitals, area physicians and Medical Society staff, extended care facilities, hospice and home health agencies, coroners, dispatchers, and private duty nursing agencies within the service area of the EMS System will also receive copies of the policy, as appropriate. The policy may be reviewed with these parties as requested or warranted by quality assurance activities.

W. Education shall include, at a minimum, the following information:

- An overview of the System DNR policy.
- Approved forms and/or the required components of a valid DNR order.

- Expectations healthcare staff in obvious death and DNR situations.
- Instructions on System access.

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

Y. Continuous monitoring and evaluation will be conducted on all charts involving DNR orders.

Z. All System personnel are to submit an incident report regarding difficulties experienced with DNR situations. These will be evaluated on an individual basis and summarized quarterly. Any quality issues identified will be reported to the EMS Medical Director, as well as any corrective action necessary.

Domestic Violence

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To provide for proper reporting of an incident through notification of appropriate persons and resources and offering immediate and adequate information regarding services available to victims of abuse or for any person suspected to be a victim of domestic abuse.

Policy Statement:

The following guidelines have been established to provide the First Responder, EMT and/or Pre-hospital RN direction in cases of domestic violence or suspected victim of domestic abuse. It is the lawful duty of the EMS provider to report suspected cases of child abuse and/or neglect. The EMS provider must also provide emergency medical care as appropriate and ensure the suspected victim or victim of abuse receives immediate and adequate information regarding services available to victims of abuse.

Policy:

DEFINITION- Domestic Violence

Although commonly thought of as hitting, shoving, kicking, stabbing and other serious physical attacks, domestic violence may also be sexual or psychological. It involves: The infliction or threat of infliction of any bodily injury or harmful physical contact or the destruction of property or threat thereof as a method of coercion, control, revenge or punishment upon a person with whom the actor is involved in an intimate relationship (i.e. between spouses, former spouses, past or present unmarried couples, between children, between children and parent(s), between children and a relative).

ILLINOIS STATE LAW:

ABUSE and NEGLECT REPORTING; DOMESTIC VIOLENCE REFERRALS

- All persons licensed, certified, or approved under the Illinois EMS Systems Act shall report suspected cases of child abuse or neglect in accordance with the requirements of the Abused and Neglected Child Reporting Act. (325 ILCS 5/4).
- All persons licensed, certified, or approved under the Illinois EMS System Act shall offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse, in accordance with Section 401 of the Illinois Domestic Violence Act of 1886.

A. Expressed or Implied consent shall be obtained to provide emergency medical care and transfer of the victim to the hospital facility of the victim's choice or to the nearest appropriate facility.

B. All cases of domestic violence shall be treated as victims of a crime and the assault and/or battery shall be reported to the appropriate law enforcement agency.

C. It is important for the EMS provider to convey an attitude of concern, respect, and confidentiality to the patient. Provide support and encouragement to the victim. Understand the victim's fears of future violence if they express concern and/or fear.

D. All victims or suspected victims of domestic abuse including child abuse or neglect shall be provided immediate and adequate information regarding services available.

All victims or suspected victims shall be offered emergency medical care as appropriate and transfer to a hospital facility for additional medical care including abuse referrals to an appropriateagency or service.

All victims or suspected victims who refuse or do not require emergency medical care shall be offered tothe following domestic violence services as appropriate:

Resources:

- **PATH**, a Bloomington/Normal help hotline, (309) 827-4005 Toll Free 800-570-7284
- **Countering Domestic Violence, or CDV**, a 24-hour hotline, (309) 827-7070
- **Neville House** in McLean County, a local shelter, (309) 827-7070
- **McLean County Center for Human Services, Inc. Crisis Team** During Business Hours: 309-827-5351 After Hours: 309-827-4005
- **Mid Central Community Action's Countering Domestic Violence Shelter ,** 309-827-7070
- **DOVE**, serves DeWitt and Macon Counties, (217) 935-2241
- **Chestnut Health Systems, SECURE Program,** 309-820-3500
- **Tri-County Women Strength**, serves Peoria, Tazewell and Woodford Counties, (309) 691-4111 or (309) 691-0551
- **AVERT**, for males accused of domestic violence, (309) 828-2860
- **McLean County Child Protection Network**, (309) 888-5656
- **Illinois Department of Children and Family Services, DCFS**, (800) 252-2873
- **National Domestic Violence Hotline,** 800-799-SAFE (7233) TDD Hotline 800-787-3224
- **Child Abuse (Any Setting),** 1-800-252-2873
- **Domestic Abuse (Any Setting),** 1-800-787-3224
- **Disabled Abuse (Any Setting),** 1-800-368-1463
- **Elder Abuse (In Nursing Home),** 1-800-252-4343 **(Other Settings),** 1-800-252-8966 **(After Hours)** 1-866-800-1409

Duty to Perform all Services Without Discrimination

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure all EMS providers within the McLean County Area EMS System shall perform all services without unlawful discrimination.

Policy Statement:

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

Policy:

A. All EMS providers of the McLean County Area EMS System have the duty to perform all services without any type of discrimination.
B. The McLean County Area EMS System respects the rights of each individual and EMS patient care providers shall provide care to all individuals respecting their fundamental human, civil, constitutional, and statutory rights.
C. All individuals requesting emergency medical services shall have reasonable access to care.
D. All individuals shall be provided emergency medical care without regard to race, age, religion, beliefs, sex, national origin, communicable disease carrier and/or the inability to pay for services.

EMAC-MAC-REMERT Deployment Notification

Effective Date: 12/2023
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

To establish availability of local EMS coverage and allow providers to participate in regional and national response to a disaster.

Policy Statement:

Agencies **MUST notify and get approval from the EMS Medical Director and IDPH before execution of the deployment can take place.**

Policy:

Prior to Deployment:

1. Notification must be made on a System Modification Form.

- Do NOT fill in the "Requested Level" box.
- In the Comment Box of the System Modification Form indicate:
  - What vehicle is deploying?
  - Where are you deploying?
  - Why are you deploying?
  - Names and licenses number of crew deploying.
  - Anticipated length of stay

2. Once the System Modification Form has been approved by IDPH, the vehicles may deploy.

Upon Return from Deployment:

1. Notification must be made on a System Modification Form.

- Do NOT fill in the "Requested Level" box.
- In the Comment Box of the System Modification Form indicate:
  - Do NOT fill in the "Requested Level" box.
  - What vehicle was deployed?
  - Where were you deployed?
  - Why were you deployed?
  - Name and licenses number of crew deployed.
  - Date you initially deployed.
  - Any unfavorable conditions to the vehicle

1. The EMS System or Regional EMS Coordinator may at any time request an inspection to be completed on the deployed vehicle by means of self-inspection, system inspection or IDPH inspection before the vehicle can return to service.

2. The vehicle may only return to service once the System Modification Form is approved, and it is determined if the vehicle(s) need to be inspected.

Emergency Vehicle Response Greater Than Six Minutes

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

All transport agency members of McLean County Area EMS System that provide ambulance response to 911 calls are required to have an enroute time < 6 minutes from time of dispatch.

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

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

A. Calls received by the McLean County Area EMS System dispatch centers in the primary coverage area:
- Consider mutual aid if ambulance or staffing is not immediately available.
- Notify caller of the estimated time of arrival of the responding unit.

B. Calls received by dispatch for the secondary and outlying areas:
- Consider mutual aid if ambulance or staffing is not immediately available.
- Notify caller of the estimated time of arrival of the responding transport unit.
- Contact and request response of the nearest EMS first responder agency in situations of an emergency.

C. If a transport agency is not able to respond with their ambulance to an emergency call, an incident report should be filed with the McLean County Area EMS System within 24 hours.

D. Agencies who fail to respond to a 911 call due to lack of personnel or apparatus issues must fill out an incident report within 24 hours.

a. The EMS System will review each case on an individual basis to determine if further action is required.

E. Agencies who miss a 2nd call within 90 days of the original will require the following:

a. A meeting between the EMS System and the agency to determine factors that lead to the missed call.
b. The agency will be required to complete an incident action plan within 15 days from the 2nd missed call to address and correct actions that lead to the failure.

F. Any additional missed calls in a 180-day period will be subject to report and sanctions according to IDPH.

Emergent/Temporary Transfer of Resource Hospital Designation

Effective Date: 05/2010
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

There are numerous responsibilities that relate to serving as the resource hospital in the McLean County Area EMS System. Occasionally there may present a need to temporarily transfer that designation to an Associate Hospital

Policy Statement:

To provide a mechanism to quickly and efficiently transfer Resource Hospital designation to the Alternate Resource Hospital on an emergent and temporary basis due to an incident or disaster affecting the designated Resource Hospital.

Policy:

A. Within the McLean County Area EMS System, the designation of Resource Hospital rotates annually between Carle Bromenn Medical Center and OSF St. Joseph Medical Center. This policy will refer to the hospital that is not the current Resource Hospital as the "Alternate Resource Hospital".

B. The McLean County Area EMS System realizes an emergency incident or disaster may impact the designated Resource Hospital significantly more than the Alternate Resource Hospital. Such an incident may affect the Resource Hospital's ability to fulfill the responsibilities as Resource Hospital. In the event the responsibilities of the designated Resource Hospital cannot be met, a temporary transfer of Resource Hospital designation may be made to the Alternate Resource Hospital.

C. If both hospitals are impacted to a similar extent, or if it is reasonably expected that both hospitals will be similarly impacted, this policy would not apply.

Procedure:

a. Determination of Need and Approval
   i. Should an incident impact the Resource Hospital's ability to fulfill Resource Hospital responsibilities, discussion regarding a transfer of Resource Hospital designation will occur between the Resource Hospital, Alternate Resource Hospital, and the McLean County Area EMS Office. This may be initiated by any of the three parties, whomever is first to realize the need for such. If possible, this willbe done via conference call.
   ii. A consensus should be obtained from the three parties regarding whether:
      1. The suggestion to transfer Resource Hospital designation is valid; and,
      2. The Alternate Resource Hospital is significantly better able to manage Resource Hospital responsibilities.
   iii. If agreement for transfer of Resource Hospital designation is determined, each hospital will follow its own internal procedure to receive administrative approval for the transfer.

b. Notifications and Response
   iv. Once approval is received from both hospitals, the McLean County Area EMS Office will notify IDPH of a temporary transfer of Resource Hospital designation to the Alternate Resource Hospital.
   v. The EMS Office will also inform system agencies of the temporary transfer.
   vi. The Alternate Resource Hospital, now functioning as the Resource Hospital, will notify the RHCC (Regional Hospital Coordination Center) and the other McLean County Area EMS System hospitals.
   vii. The Alternate Resource Hospital will then function as and perform as the Resource Hospital until it is determined that it is appropriate to move the designation back to the original Resource Hospital.
   viii. Hospitals shall document information regarding transfer or acceptance of Resource Hospital designation on required HICS forms**.**

c. Demobilization/Recovery
   ix. The Resource Hospital, Alternate Resource Hospital, and McLean County Area EMS Office will discuss the current situation on a regular basis (at least daily) regarding the original Resource Hospital's ability to recover and accept a transfer of Resource Hospital designation back from the Alternate Resource Hospital.
   x. When it is determined that Resource Hospital designation can be returned to the original Resource Hospital, the notification procedure listed above will be repeated to inform external agencies.
   xi. The Resource Hospital (rather than the Alternate Resource Hospital) should make the notification to the RHCC and the other system hospitals.
   xii. Hospitals shall document information regarding transfer or acceptance of Resource Hospital designationon required HICS forms.

Emotionally Disturbed Patients

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure patients with behavioral health emergencies receive appropriate emergency medical care, and mental health services.

Policy Statement:

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

Policy:

DEFINITIONS:

EXPRESSED CONSENT:	The consent given by adults who are of legal age and **mentally competent** to make a rational decision in regarding their medical well-being.
IMPLIED CONSENT:	Situation involving an unconscious patient where care is initiated under the premise that the patient would desire such care if they were conscious and able to make the decision. In the case of an adult individual where he/she is unable to understand Expressed Consent, who may have a legal guardian who is not present, emergency care and transportation is given on the basis of Implied Consent.

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

B. If persuasion is unsuccessful, and determination is made that patient is at risk of harm to self or others, NOTIFY THE APPROPRIATE LAW ENFORMENT AGENCY TO RESPOND.

C. Consult with police regarding their willingness to complete involuntary paperwork.

D. If the EMS provider determines the patient cannot understand EXPRESSED CONSENT for patient care and transportation to the hospital and emergency treatment is required to preserve life or prevent serious impairment to health, contact medical control. The Medical Control physician may order against the patient's will and based upon IMPLIED CONSENT the emergency care and transportation to the hospital using restraint policy and chemical restraint protocol.

E. IN NO WAY does this mean that the EMS crew are committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of mentalhealth treatment to a hospital against his/her will so that a physician may further evaluate said patient.

F. If patient requires restraints, EMS personnel shall use all the force reasonably required to restrain the patient. "Reasonable force" depends on the degree of resistance on part of the patient.

G. If a patient runs from EMS, this matter should be left to law enforcement personnel.

EMS Medication Replacement at Carle BroMenn and OSF St. Joseph

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

This policy is to ensure the safe restocking and documentation of use of medications within the McLean County Area EMS System.

Policy Statement:

The McLean County Area EMS System recognizes the importance of medications carried on emergency medical service (EMS) response vehicles in relation to patient care.

Policy:

A. **Replacement of Administered Medications**: Any EMS medication that has been administered to a patient must be documented on a BLS, ILS or ALS medication replacement form. This form must contain the following information:
   1. EMS agency name
   2. Date of medication administration
   3. EMS agency unit identification number
   4. Patient name
   5. Patient identification number (EMS report number)
   6. EMT name (printed)
   7. EMT license
   8. Total medications administered
   9. Total medications requested
   10. Emergency Department RN/MD signature (all controlled substance requests must have a physician signature)
   11. EMS agency representative signature
   12. Pharmacy representative signature

B. **Replacement of Expired Medications**: Any EMS medication that is being requested for replacement of expired product must be documented on a BLS, ILS or ALS medication replacement form. This form must contain the following information:

   1. EMS agency name
   2. Date of request
   3. EMS agency unit identification number
   4. EMT name (printed)
   5. EMT identification number
   6. Total medications requested

7. Emergency Department Nurse/Physician signature (all controlled substance requests must have a physician signature)
8. EMS agency representative signature
9. Pharmacy representative signature

C. Once the medication form has been completed the emergency department charge nurse will verify that a pharmacist is at the in-patient pharmacy.

D. Providers may replace medications within 14 days of expiration at the pharmacy. Medications that are in short supply may require a shortened exchange window and will be determined by the pharmacy. All medications being exchanged/replaced shall be brought to the pharmacy for proper disposal.

E. All ILS and ALS controlled substances must be secured inside a pouch or container sealed with a numbered tamper-proof tag inside each ambulance within the drug box.

F. At the beginning of each shift, the on-coming EMT will verify that the EMS vehicle medication inventory is correct. Volunteer EMS agencies should verify their EMS vehicle medication inventory is correct at least monthly.

G. The hospital pharmacies will invoice the EMS agencies at the average wholesale price for medications they have replaced over the previous month.

H. EMS medication inventory shall be available for inspection by the Illinois Department of Public Health, EMS System Coordinator or EMS System designee.

EMS Supply Exchange at Carle BroMenn Medical Center

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure the item per item replacement of disposable medical supplies for patients transported to Carle BroMenn Medical Center.

Policy Statement:

Ambulance patients are transported to the Carle BroMenn Emergency Trauma Center daily. The EMS agency may replace disposable medical supplies with like items from the Emergency Trauma Center on an item per item basis for patients transported to Carle BroMenn Medical Center.

Policy:

A. The EMS agency may replace disposable medical supplies with like items from the Emergency Trauma Center on an item per item basis for patients transported to Carle BroMenn Medical Center.
B. The EMS Agency member shall complete a "Patient Charge" form which indicates what items were exchanged.
C. When the form is completed, the EMS Agency member shall submit the form to the ED Staff. The ED Staff member shall assist the EMS provider in the procurement of the replacement items.
D. Backboards and other reusable equipment that must remain for a time in the Emergency/Trauma Center due to patient condition, may be retrieved by the EMS personnel later.
E. The Ambulance Agency may replace soiled linen with clean linen from the linen cart kept in the ambulance garage.
F. EMS Agencies are encouraged to carry a sufficient supply of equipment so that immediate restocking of non-disposable equipment is not necessary in most cases. Agencies are also encouraged to clearly label their equipment with the agency name so that the equipment may be retrieved later.
G. If there is not a sufficient supply of replacement equipment, agencies should wait until the equipment is released by the Emergency Department staff.
H. EMS Agencies are strongly discouraged from replacing their equipment with other ambulance services' equipment. Any individual doing so may be subject to disciplinary action by the EMS System.
I. EMS personnel should properly clean and disinfect non-disposable equipment after each pt. use.

EMS Supply Exchange at OSF St. Joseph Medical Center

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure the item per item replacement of disposable medical supplies for patients transported to OSF St. Joseph Medical Center.

Policy Statement:

Ambulance patients are transported to the OSF St. Joseph Medical Center Emergency Trauma Center daily. The EMS agency may replace disposable medical supplies with like items from the Emergency Trauma Center on an item per item basis for patients transported to OSF St. Joseph Medical Center.

Policy:

A. The EMS agency may replace disposable medical supplies with like items from the Emergency Trauma Center on an item per item basis for patients transported to OSF St. Joseph Medical Center.
B. After arrival at OSF St. Joseph. Medical supplies should be restocked from the supplies located at the emergency department.
C. Supplies should be restocked from the emergency trauma centers locked storage. An "EMS Supply Replacement" form should be completed by the EMS responsible for restocking the supplies.
D. Forms should include the date the supplies were used, the patients name, the name of the EMS Agency, the patient's hospital admission number (obtained from the emergency department unit secretary), and the signature of the EMT replacing the supplies. The EMT should also document the quantity of supplies used on the patient. If the supply is not listened on one of the forms, the EMT should write the name of the supply and the quantity on the appropriate form. **If an item has a sticker, the sticker can be given to the nurse or technician. Do not use both the sticker and the form for replacement.** Give the sticker to the appropriate ED personnel.
E. Completed forms should be given to the Emergency Department RN or technician. The EMT should accompany the ED staff members to the storage area for the replacement supplies. **Only those supplies used on patients transported to OSF St. Joseph Medical Center shall be replaced.**
F. EMS Agencies are encouraged to carry a sufficient supply of equipment so that immediate restocking of non-disposable equipment is not necessary in most cases. Agencies are also encouraged to clearly label their equipment with the agency name so that the equipment may be retrieved later.
G. If there is not a sufficient supply of replacement equipment, agencies should wait until the equipment is released by the Emergency Department staff.

H. EMS Agencies are strongly discouraged from replacing their equipment with other ambulance services' equipment. Any individual doing so may be subject to disciplinary action by the EMS System.
I. EMS personnel should properly clean and disinfect non-disposable equipment after each pt. use.

EMS System Improvement Opportunity Report Form

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To properly communicate and address any opportunity to improve the local emergency medical services and ensure that situations are resolved through education.

Policy Statement:

Pre-hospital care providers, emergency department physicians and nurses, and any other person directly involved in pre-hospital care in the Carle BroMenn Medical Center shall complete an "EMS System Improvement Opportunity Report Form" whenever an opportunity exists to improve the local emergency medical services or when a situation can be resolved through education. When completing the form, describe the reason why an opportunity exists, including a brief narrative summary of the current situation and any additional documentation that would help describe the situation.

Policy:

A. If an opportunity exists for improvement in the local emergency medical services or when a situation can be resolved through education, an "EMS Systems IOR Form" shall be submitted to the respective EMS System Coordinator.

B. The purpose of the "IOR Form" is to properly communicate and address any situation that may be corrected through education or presents itself as an opportunity to improve the delivery of emergency medical services.

C. Once an IOR Form has been received, it shall be reviewed by the EMS System Coordinator. Those reports serious in nature shall be reported immediately to the EMS Medical Directors and the EMS System Coordinators. Opportunities that do not need immediate attention may be dealt with by the QA Coordinator.

D. The Project Medical Director and the EMS System Coordinator constitute the Executive Board of the McLean County Area EMS System Quality Council. The Executive Board may choose to take the appropriate immediate action with the IOR Form or defer the report to the McLean County Area EMS System Quality Council.

E. All IOR forms serious in nature shall eventually be referred to the Quality Council. Refer to the EMS Quality Council policy.

F. The person originating the report shall be notified of the receipt of the IOR form.

EMS System Improvement Opportunity Report Form

EMS System Incident Report

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To properly communicate and address any violation of policy, procedure or protocol which may arise in the McLean County Area EMS System.

Policy Statement:

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

Policy:

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

1. EMS System Incident Report Form

EMS Quality Council

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure Continuous Quality Improvement in pre-hospital care in the McLean County Area EMS System.

Policy Statement:

Continuous Quality Improvement is the watchword within the health care industry today. In business terms, it means to continually adjust services to become more customer oriented. In EMS, our customers are our patients. To better serve the patients of the McLean County Area EMS System, the hospital organizations developed a plan to ensure Continuous Quality Improvement in pre-hospital care in the McLean County area.

Policy:

The McLean County Area EMS System Quality Council was established in February, 1995. The responsibilities of the Council are as follows:

- Overall management of the joint Quality Improvement Program for the McLean County Area EMS System.
- Establishing and maintaining standards of care.
- Establishment and implementation of EMS policy with well-defined expectations.
- Binding authority of all disciplinary action but requires agreement with recommended action by the EMS Medical Director.
- Establishing objective criteria for chart audits as well as focused audits.
- Evaluate chart audits, focused audits, and recommendations provided by peer QI Teams and implement appropriate PROSPECTIVE educational programs for quality improvement.
- Assist QI Teams in retrospective per debriefing.
- Evaluate data collection and chart review performed by the EMS System and implement appropriate PROSPECTIVE educational programs for QI.
- Evaluate data collection for trending and create educational objectives.
- Provide retrospective feedback to all EMS Provider members of the McLean County Area EMS System.
- EMSMD's and Coordinators serve as advisors to QI Teams.

B. The membership of the Council is that which is outlined in the most current quality assurance plan.

C. The Council formally functions in the following manner:

- Conducted according to "Robert Rules of Order."
- All members of the Council may vote with exception of QA Coordinator. The QA

Coordinator votes in case of ties only.
- Council bylaws are developed and implemented by the initial Council members.

D. Peer QI Teams are sub-committees of the EMS Quality Council. These teams meet on a monthly or as needed basis and have the following responsibilities to the Council:

- Report to the Council.
- Chairperson is a voting member of Quality Council.
- Assist and recommend to the Council objective criteria for specific chart audits and focused audits.
- Provide peer review of chart audits and focused audits, and report findings to Quality Council.
- Make other recommendations to the Council as deemed appropriate.
- Participate in Peer retrospective debriefing.

E. The membership of QI Teams is comprised of peers, consisting of the following:
- ALS QI Team - Four or more Paramedic members, Chairperson determined by Team, Ex-officio, non-voting member, Executive Committee Member.
- BLS/ILS QI Team - Two or more EMT-I members, Two or more EMT-B members, Chairperson determined by Team, Ex-officio, non-voting member, Executive Committee Member.
- Emergency Communications QI Team - Four or more members, at least one Tele-communicator METCOM, at least one Tele-communicator from Bloomington Dispatch. Chairperson determined by Team, Ex-officio, non- voting member, Executive Committee Member.

F. The QI Team functions in the following manner:
- Conducted according to “Robert Rules of Order.”
- All members of QI Teams are voting members.
- Chairperson of QI Teams serves as a voting member of the Quality Council.

Current Quality Assurance Plan

Encountering a Scene While Already Having a Patient

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

A. Should the EMS crew discover a secondary emergency requiring assistance during patient transport; the local 911 system will be activated. Priorities are to the onboard patient. If current transport includes two or more pre-hospital providers, one member may attend the scene while the other completes the original task.

B. If there is not a patient onboard the ambulance and an emergency situation is encountered, the crew may stop and render care. However, the local 911 system should be activated.

Equal Opportunity Statement

Effective Date: 10/2012
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure that McLean County EMS provides equal opportunities to create an inclusive and diversified workforce.

Policy Statement:

McLean County EMS is devoted to the fair treatment and participation opportunities of individuals regardless of their backgrounds.

Policy:

McLean County Area EMS System and their associated programs provides equal opportunity in system participation and does not discriminate based on race, color, religion, sex, national origin, age, marital status, sexual orientation, or disability.

Failure to Respond – Transport Ambulances

Effective Date: 08/2021
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

All licensed ambulances commit to responding on a 24-hour coverage (Ill. Admin Code title 77, § 515.810).

Policy Statement:

It is necessary for all licensed ambulances to respond when dispatched for an emergency call. The EMS System believes it necessary to ensure that all agencies can fulfill their duty as an ambulance service for their community. Regardless of the staffing model an agency uses (volunteer, paid on call, paid on site) agencies must respond when dispatched.

Policy:

A. This policy is applicable to transport ambulance units. This policy applies only to your front-line transporting unit(s). If an agencies system plan shows that the secondary unit is dispatched as the next due unit for a secondary call, these rules apply as well. This is not applicable to agencies whose units serve only as a backup unit and are not the next due unit on secondary calls.
    a. This **is** applicable for the following example: Agency A has 1 primary transport unit and a backup transport unit. If the primary unit is out on a call and a second call is dispatched, the backup unit is paged out to respond.
    b. This is **not** applicable for the following example: Agency B has 1 primary transport unit and a backup transport unit. If the primary unit is out on a call, and a second call is dispatched, mutual aid is automatically paged.
B. Agencies who fail to respond to a 911 call due to lack of personnel or apparatus issues must fill out an incident report within 24 hours.
    a. The EMS System will review each case on an individual basis to determine if further action is required.
C. Agencies who miss a 2nd call within 90 days of the original will require the following:
    a. A meeting between the EMS System and the agency to determine factors that lead to the missed call.
    b. The agency will be required to complete an incident action plan within 15 days from the 2nd missed to correcting actions that lead to the failure.
D. If a 3rd missed call occurs within 180 days from the original missed call date,
    a. Agencies will be put on system probation for at least 6 months.
    b. Agencies will be required complete a new incident action plan that propose new measures addressing agency issues within 15 days of the 3rd missed call.

E. Any additional missed call during the probation period will result in suspension from the EMS System. Once suspended from the system, agencies will be unable to respond to calls. IDPH will be notified of the system suspension.
F. Agencies may appeal system suspension to the Medical Director. The medical director may overturn the suspension at their discretion.
G. Failure to report missed calls within the appropriate allotted time may result in agencies being put on probation or suspended from the system.
H. Agencies will be removed from probation based on successfully implementing their action plans and demonstrating their ability to successfully respond to their calls for service.

Field Triage of the Trauma Patient

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

The goal of triage is prompt and appropriate treatment, at a facility with capabilities for optimal care of the individual's injuries.

Policy Statement:

Triage has been defined as the classification of patients according to medical need. Field triage requires EMS personnel to make an estimation of injury severity and match patient needs with available resources.

Policy:

A. The Trauma Field Triage Criteria as created by the committee on Trauma of the American College of Surgeons, 1993, and by the American College of Emergency Physicians, "Trauma Care System Guidelines" 1992, has been adapted for use in region 2. Any patient who meets the ACS guidelines for field triage, as defined, will be considered to have entered the Trauma System.

B. **TRANSPORT TIME LESS THAN 25 MINUTES:** Any trauma patient who meets the following criteria shall be transported to the closest Trauma Center.

C. **TRANSPORT TIME GREATER THAN 30 MINUTES:** Any trauma patient who meets the following criteria with a transport time greater than 30 minutes to a Trauma Center or to an affiliate trauma hospital, transport to the nearest hospital.

D. **TRANSPORT TIME GREATER THAN 45 MINUTES:** Any trauma patient who meets the following criteria with a transport time greater than 45 minutes to a Trauma Center or to an affiliate trauma hospital in a rural area where there is no comprehensive hospital available, transport to the nearest hospital.

E. Field Triage Medical/Legal Considerations.

- If a patient is unconscious and meets ACS Trauma Field Triage Criteria, the patient shall be taken to a Level I or II Trauma Center.
- If a patient has an altered level of consciousness and meets ACS Trauma Field Triage Criteria, the patient shall be taken to a Level I or II Trauma Center.
- If an adult patient is alert and oriented to person, place and time with stable vital signs, refer to the Patient Hospital Preference policy.
- In the case of a Minor or an Incompetent Adult patient, and a guardian or person with the Power of Attorney for Healthcare is present at the emergency scene, that person can provide the Informed Consent for the patient to be transported to the appropriate facility according to the ACS Trauma Field Triage Criteria. Also, refer to the Patient Hospital Preference policy.

- If there are any questions regarding the patient's status, treatment or destination, the EMS. provider must contact the Medical Control Physician.

- ACS strongly recommends that pre-hospital care providers inform the patient, the patient's legal guardian or Power of Attorney for Healthcare, or the patient's family member(s) of the appropriate Trauma Center care availability and capability. The patient's choice, the patient's legal guardian or Power of Attorney for Healthcare choice of receiving hospital shall be documented.

F. If the more distant hospital is full or is on Trauma Center bypass, the patient shall be transported to the nearest hospital.

G. **Carle BroMenn Medical Center** and **OSF St. Joseph Medical Center** are designated Level II Trauma Centers by the State of Illinois, Department of Public Health. If either facility has determined the need to initiate Trauma Center bypass, the respective Medical Control Physician, after proper notification, shall have all ambulances with trauma patients diverted to other hospital emergency departments. Both hospitals comply with the **REGION 2** Emergency Department Trauma Center Bypass Policy. Refer to the Trauma Center Bypass policy.

ILS/AEMT/ALS Intercept Policy

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure the highest level of care is being utilized when indicated and

available.

Policy Statement:

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

Policy:

When a patient's condition warrants a higher level of care and an advanced level is available, the more advanced agency shall be called immediately for assistance. It is the responsibility of the responding agency or on-line Medical Control to request response of the higher level of care when patient condition warrants. This shall be done when the condition has been recognized as listed below but not limited to:

- Trauma patients entrapped with required extrication.
- Patients with compromised or obstructed airways
- Impending cardiac and/or respiratory arrest
- Patients exhibiting signs of hypoxemia (respiratory distress, restlessness, cyanosis, altered LOC).
- Unstable cardiac rhythms
- Chest pain unresolved
- Patient exhibiting signs of impending or decompensating shock (B/P<100, diaphoresis, altered LOC, tachypnea)
- Unconscious patients
- Any case deemed by the responding agency or Medical Control as beneficial to patient outcome.
- Pediatric cases with any of the conditions listed above.

B. Availability of Advance Assistance

1. If the primary response area (**) is covered by any combination of BLS, ILS or ALS, the highest level of service shall be utilized for any patient whose condition warrants advanced level care as indicated in item A above.
2. When determining need for assistance from an advanced secondary or tertiary provider, consideration should be given to the following:
    - Transport time to hospital
    - Rendezvous site
    - Availability of resources
    - Interventions needed (i.e., defibrillation, airway, drugs)

- Transport of the patient should not be unreasonably delayed for transfer of care.
- Decisions for or against requesting advanced assistance should be based on the patient's best interest.
- Regardless of response jurisdiction, if two different agencies with differing levels of care are dispatched to and arrive on the scene of an emergency, the agency with the highest licensure level shall assume control of the patient(s).

3. When requesting an advanced secondary or tertiary provider, specify the exact resource and the route of travel.
4. Communicate with the responding higher level of care unit via radio to provide a brief patient condition report and confirm route of travel/rendezvous site.

C. Transfer of care

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

* "In-Field Service Level Upgrades" as referred to in this policy imply services above the level of care provided by the initial responding agency. This may include a higher-level ambulance or higher level alternate response vehicle. **The closest available 24- hour coverage higher-level agency shall alwaysbe requested.**

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

In Field Service Level Upgrade-*(Only applies to agencies serving <7500 people)*

Effective Date: 09/2015
Review Date:8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

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

Security

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

a. i.e., Providers at the primary licensure level need to be able access all equipment neededfor their level of licensure.

Equipment

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

Quality Improvement

A. Any instance in which a transport vehicle with an in-field service level is unable to provide that care and requires an intercept at the same level shall file with the EMS System within 48 hours.
    a. i.e., a BLS ambulance with ALS infield capabilities requests an ALS intercept.
B. The EMS office will compile this data and will forward information to IDPH on a regular basis. This information will be completed on a form as prescribed by IDPH. Data forwarded shall include, but not limited to the number of usages by agency, and any adverse outcomes associated with the in-field service level upgrade.
C. All agencies with an in-field service level upgrade vehicle by the last day of every month submit to the EMS office a completed Equipment/Medication inspection sheet.
D. As is the same with all other licensed vehicles, in field upgrade vehicles are subject to inspection by the EMS System or IDPH at any time.

Personnel

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

Special Considerations

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

(*) “In-Field Service Level Upgrades” as referred to in this policy implies services above the level of careprovided by the initial responding agency. This may include a higher-level ambulance or higher-level alternate response vehicle. **The closest available 24- hour coverage higher-level agency shall always be requested.**

Initial Education Courses

Effective Date: 09/2015
Review Date:8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

Initial education courses (EMR, EMT, AEMT, Paramedic, ECRN, PHRN/PHPA/APRN, and EMD) are required to be approved by the *EMS* System and the EMS System Medical Director

Policy Statement:

This policy outlines the means in which initial education can be obtained with the McLean County Area EMS System. These processes are in place to protect students, agencies, and patients by ensuring a high quality of education for EMS providers.

Policy:

1. Pursuant to IDPH Administrative Code AEMT Courses and Paramedic courses may only be conducted by an EMS System and/or a community college (with EMS System Approval)
2. All Paramedic courses which are conducted within the McLean County Area EMS System will be held at Heartland Community College.
3. All Paramedic courses which are conducted by the McLean County Area EMS System will be accredited programs, accredited by the committee on accreditation for the Emergency Medical Services Profession.
4. AEMT courses are not routinely offered or approved by the EMS System. Individuals or agencies with a need for such a course shall contact the system director for options and guidance.
5. EMT-Basic and EMR courses will only be conducted by the EMS System. Classes taught offsite with internal instructors is not permitted.
6. EMT-Basic classes will primarily be offered at Heartland Community College. If an agency has a unique and compelling need and wishes to host an EMS course taught by the EMS System please contact the system office.
7. EMR courses will be offered primarily off site at affiliate agencies stations. On occasion the EMS System may offer a EMR course at our office, or through alternate delivery methods (Online/Hybrid/Distance Learning)
8. ECRN and Preceptor courses will be offered via hybrid learning platform and registration is available on www.mcleancountyems.org website.
9. PHRN/PHPA/APRN courses may be offered through the MCAEMS office based on need and availability.
10. Students will not be reimbursed for ride time hours by any agency and will always be third man on ambulance if skills, patients, or leads are counted.

Interaction with Law Enforcement/Evidence

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

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

b. Treatment
   i. When you insert an airway or use resuscitation, inform the police. Resuscitative efforts can contribute to confusing elements for pathologists and law enforcement personnel if they are not informed. Some of these elements are:
      1. Marks on external aspects of the body fracture of ribs and/or sternum
      2. Spleen and liver lacerations
      3. Alteration of the airway
      4. Change in contents in the mouth.
   ii. During treatment or patient exam, if you find a cartridge or any other evidence, leave it and notify law enforcement authorities.
   iii. In drug overdose cases, if you take medication bottles, remember where

you obtained them. If you give them to medical personnel at the hospital, record who you gave them to and the time.

iv. Do not rinse or clean hands of the patient for it may disrupt certain evidence, i.e., gun powder, blood, dirt.

c. Clothing

i. Do not tear or cut through bullet holes, knife wounds, etc.
ii. If you must cut clothing or remove clothing, be careful, as the slightest movement can destroy evidence such as paint, hair, fiber and gun powder, etc.
iii. If you recover clothing, do not put everything in one bag; put each item in a separate PAPER BAG; NEVER USE PLASTIC OR CELLOPHANE.

d. Below is a partial list of items a law enforcement agency or crime lab might take as evidence from a crime scene:

i. Stains: blood and body fluids (saliva, semen, tears, perspiration, urine, human milk, pus)
ii. Fiber and textiles, clothing examination, glass.
iii. Gun powder particles, paints, narcotics.
iv. Tool mark comparison and identification with suspect tool.
v. Restoration of obliterated data, explosive residue.
vi. Soil examination, fingernail scrapings.
vii. Comparative microscopy: firearms, tool marks, fingernail striations.

e. When death is obvious at the scene

i. If you are the first to arrive on a scene where death is obvious, ensure that the police are in route to the scene.
ii. If you are the first to arrive on a scene where death is obvious and police have yet to arrive, keep everyone away from the area including family or friends.
iii. If police have yet to arrive and death is obvious at the scene which is inside a building, (i.e., house apartment) leave and protect the scene from the outside.

Interfacility/Interregional Transport Policy

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To provide consistent guidelines to McLean County Area EMS System agencies/providers and hospital personnel for interfacility/interregional transports.

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

Policy Statement:

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

Policy:

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

Levels of EMS providers:

Basic Life Support (BLS) services include basic airway management, cardiopulmonary resuscitation including the use of AED's, basic shock management and control of bleeding, and basic fracture management.
Minimum staffing: 2 EMT-Basic providers
Intermediate Life Support (ILS) services include all BLS services, IV cannulation/fluid therapy, advanced airway management and limited medication administration.
Minimum staffing: 1 EMT-Intermediate and 1 EMT-Basic

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

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

Fluids and Medication list:

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

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

Foley catheters
Gastric devices (NG tubes, G tubes, ostomy equipment)
Saline locks
Wound drains
Clamped vascular devices (Central lines, Groshong catheters, PIC lines)
CPAP
Gravity Chest Tubes

Equipment that may be transported and used by ILS/ALS providers only:

BiPAP
IV infusion pumps
Pain medication pumps-if trained
Portable ventilators-if trained
Chest tubes attached to suction
Nitroglycerin drips on pumps
Heparin drips on pumps – if trained
Morphine drips on pumps – if trained

Latex Policy

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

The Centers for Disease Control and Prevention (CDC) estimates that one in 10 people is sensitive to natural rubber latex. Among individuals with latex allergy, repeated exposure to latex results in sensitization and an increased risk of allergic reactions

Policy Statement:

The purpose of this policy is to identify patients with, suspected of, or at risk for latex allergy, and to
provide guidelines to ensure safe, consistent care of patients in the above category.

Policy:

1. Latex-free products will be readily available to all prehospital care providers.
2. Clinical findings depend upon the sensitivity of the patient, route of administration, and quantity of antigen.
3. Signs and symptoms of latex reactions can include localized tissue inflammation, redness, irritation, eczema, and in more severe cases urticaria, wheezing, bronchospasm, edema to the mouth, eyes, and face, and anaphylaxis.
1. Reaction can manifest itself from a contact dermatitis to an anaphylactic reaction. The distinction between the two types of reactions is not always clear.
2. Most severe reactions to latex have resulted from latex proteins contacting the mucous membranes of the mouth, vagina, urethra, or rectum.
3. If a latex reaction is suspected, notify the receiving hospital of suspected latex allergy during radio report and again during delivery of the patient to the Emergency Room.
4. Use only known latex-free items in caring for patients with latex sensitivity.
5. Avoid wearing latex gloves for extended periods of time. Wash your hands thoroughly after wearing latex gloves
6. Population at risk for latex allergy are:

    a. Individuals with congenital urologic disorders.
    b. Individuals with multiple congenital defects.
    c. Individuals who have undergone multiple surgical procedures early in life.
    d. Individuals with frequent occupational exposure to latex.

License Reciprocity Policy

Effective Date: 8/2023
Review Date:
Approvals: EMSSC, EMSMD

Background to Policy:

To allow licensed EMT, A-EMT, EMT-I, and Paramedics from out of state, or who hold a national registry license to apply for an Illinois state EMS license through reciprocity.

Policy Statement:

To operate on an EMS System transport or non-transport IDPH licensed Vehicle under provisional system status, an individual must have applied for licensure with the Department and meet all requirements under the Act. All Department-required application materials for submission must be provided to the EMS System for review prior to system provisional reciprocity approval.

Policy:

a) An EMT, A-EMT, EMT-I or Paramedic licensed or certified in another state, territory or jurisdiction of the United States who seeks licensure in Illinois may apply to the Department for licensure by reciprocity on a form prescribed by the Department available on the MCAEMS website www.mcleancountyems.org .

b) The reciprocity application shall contain the following information:

1) Verifiable proof of current state, territory or jurisdiction licensure or certification, or current registration with NREMT.

2) A letter of recommendation from the EMS MD of the EMS System in the state, territory, or jurisdiction from which the individual is licensed. The letter should include a statement that the applicant is currently in good standing and up to date with CE hours.

3) A current CPR for Healthcare Providers card that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

c) The Department will review requests for reciprocity to determine compliance with the applicable provisions of this Part. CE hours from the state of current licensure will be prorated based on the expiration date of the current license.

d) Individuals who meet the requirements for licensure by reciprocity will be State licensed consistent with the expiration date of their current license but not to exceed a period of four years.

e) Following licensure by reciprocity, the individual must comply with the requirements of this Part for re-licensure.

f) IDPH shall permit immediate reciprocity to all EMS personnel who hold an unencumbered National Registry of Emergency Medical Technicians certification for EMTs, AEMTs, or Paramedics, allowing such individuals to operate in an EMS System under a provisional system status until an Illinois license is issued:

1) The EMS System has the responsibility for validating the National Registry Certification of each individual.

2) An individual with a Class X, Class 1 or Class 2 felony conviction or out-of-state equivalent offense, as described in Section 515.190, is not eligible for provisional system status.

Licensure Renewal /Continuing Education Policy

Effective Date: 12/1/2023
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure all providers in MCAEMS remain current with licensure status.

Policy Statement:

All Providers are required by the EMS system and IDPH to take part in continuing education and to have the required number of CE hours for their license renewal.

Policy:

General Information

- It is the responsibility of the individual member to maintain accurate and true records of continuing education. Although agency training officers are encouraged to keep records, it does not trump the responsibility of the individual to keep their own continuing education records.
- See Illinois Administrative Code, Section 515.90 for other CE guidelines as outlined by IDPH.
- Online education will be recognized by the MCAEMS system if it is approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS), IDPH site code, or CAPCE approved.
- Must have a current BLS Provider CPR Card (American Heart Association) ONLY, no other type of card will be accepted).
- Providers must have identified MCAEMS as their primary system affiliation and be listed on the roster of a MCAEMS system affiliated agency. Individuals not meeting these requirements must apply for independent renewal directly to the state.
- If, at any time, EMT licensure is allowed to lapse, said provider will concurrently be removed as an active member of the MCAEMS system.
- A Pre-hospital Provider who exclusively serves as a volunteer for units of local government or a not-for-profit organization that serves a service area with a population base of less than 5,000 may apply to the Department for waiver of these fees on a form prescribed by the Department. (Section 3.50(d)(9) of the Act).
- This application must be sent to the EMS Office with the CE Record Forms

Required Items for Renewal

Level	Requirements
EMR-D	• 24 CEU hours • Current CPR card • Child support/felony conviction statement • IDPH Fee or waiver
EMT	• 60 CEU hours • Current CPR card • Child support/felony conviction statement • IDPH Fee or waiver
EMT-INTERMEDIATE/ADVANCED EMT	• 80 CEU hours • Current CPR card • Current ITLS/PHTLS • Current PALS/PEPP • Current ACLS • Child support/felony conviction statement • IDPH Fee or waiver
PARAMEDIC/PHRN/PHPA/APRN	• 100 CEU hours • Current CPR card • Current ITLS/PHTLS • Current PALS/PEPP • Current ACLS • Child support/felony conviction statement • IDPH Fee or waiver
ECRN	• 32 CEU hours (EMS appropriate as deemed by the Medical Director or designee) • Current CPR card • Current pediatric course • Current ACLS • Current trauma course • Current Illinois RN licensure • Child support/felony conviction statement • IDPH Fee

Renewal Fees- To be paid online or with check made out to IDPH dropped off at MCAEMS office

FEE TYPE	EMT-B	AEMT/ EMT-I	EMT-P
Examination Fee*	$20*	$30*	$40*
Initial Licensure Fee*	$45*	$45*	$60*
Renewal Fee*	$20*	$30*	$40*
Reinstatement Fee*	$45*	$45*	$60*
Reciprocity Fee*	$50*	$50*	$50*
Duplicate License Fee	$10	$10	$10

Suggested IL CE Hr distribution (optional – subject to local EMS MD approval)

Topic area	PM	AEMT	EMT	ECRN	PM NR	PM NR %
Airway, Respiratory	20	16	12	6	6/30	0.2
Cardiology	23	19	14	8	7/30	0.233
Medical	27	21	16	8	8/30	0.267
Trauma	17	13	10	6	5/30	0.167
Operations	13	11	8	4	4/30	0.133
Total Hrs IL	100/4 yrs	80 / 4y	60 / 4y	32 / 4y	NREMT 30/ 2 yrs	

EMR/EMR-D

Emergency Medical Responders must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. 24 hours of CE in a four-year period (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period.
4. Must attend at least one continuing education session annually, reviewing System-specific protocols, policies, and operating procedures.
5. Attendance at CE sessions for specific skills and topics deemed mandatory by the Medical Director.

EMT

EMTs must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. 60 hours of CE in a four-year period (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period.
4. Must attend at least one continuing education session annually, reviewing System-specific protocols, policies, and operating procedures.
5. Attendance at CE sessions for specific skills and topics deemed mandatory by the Medical Director.

EMT-INTERMEDIATE/ADVANCED EMT

EMT-INTERMEDIATE/ADVANCED EMTs must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. 80 hours of CE in a four-year period (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period.
4. Must attend at least one continuing education session annually, reviewing System-specific protocols, policies, and operating procedures.
5. Attendance at CE sessions for specific skills and topics deemed mandatory by the Medical Director.

PARAMEDIC

PARAMEDICs must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. 100 hours of CE in a four-year period (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period.
4. Must attend at least one continuing education session annually, reviewing System-specific protocols, policies.
5. Attendance at CE sessions for specific skills and topics deemed mandatory by the Medical Director.

PHRN/PHPA/APRN

PHRN/PHPA/APRN's must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. 100 hours of CE in a four-year period (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period.
4. Must attend at least one continuing education session annually, reviewing System-specific protocols, policies, and operating procedures.
5. Attendance at CE sessions for specific skills and topics deemed mandatory by the Medical Director.
6. Attendance at annual skills review stations (failure to attend ANY annual skills review will result in revocation of system privileges)

ECRN

ECRNs must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. Must accrue 32 hours of EMS appropriate CE hours (as determined by the Medical Director) in four years (see suggested topic breakdown above)
2. Current Healthcare Provider CPR card
3. Complete 1 hour of approved Alzheimer training in a licensure period
4. Current trauma course certification
5. Current pediatric course
6. Current AHA ACLS

EMD

Emergency Medical Dispatchers must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. A minimum of 12 hours annually of medical dispatch continuing education
2. Recommendation for recertification by the EMS Medical Director
3. Current Healthcare Provider CPR card

Lead Instructor

Lead Instructors must meet the following continuing education requirements of the EMS System to continue to function in the System:

1. A letter of support or electronic authorization from an EMS MD indicating that the EMS LI has satisfactorily coordinated programs for the EMS System at any time during the four-year period.

2. Documentation of at least 40 hours of continuing education, of which 20 hours shall be related to the development, delivery and evaluation of education programs; and

3. Documentation of attendance at a department-approved national EMS education standards update course, if applicable, in accordance with subsection (d).

Overall Renewal Process

Providers are encouraged to be pro-active in the renewal process. It is not the responsibility of the MCAEMS System to remind providers of upcoming renewal deadlines. Issues dealing with a lack of hours for renewal can be alleviated if the provider is aggressive in attending CE sessions throughout the period of licensure. Extensions of licensure expirations will not be approved for individuals who do not show a continual effort towards completing their CE requirements.
All requests for licensure renewal must be submitted, along with all required documentation, to the MCAEMS System Director no later than 60 days prior to expiration. All training records originating from agency records must be accompanied by a signature of the officer in charge of maintaining and verifying said records.
Only CE sessions attended during the current licensure period will be accepted. Any CEs accompanied by an IDPH site code will be accepted, assuming said record can be verified. Further, CEs with a code awarded by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS) will likewise be accepted. The Medical Director or his/her designee may approve other educational opportunities that do not have either of these site codes completely at his/her discretion.

Denial of Recommendation for re-licensure

If an EMT does not meet the requirements for relicensing in the EMS System, he/she will not be recommended for relicensing by the EMS Medical Director. Should this occur the EMS Medical Director will notify the EMT of the denial of recommendation in writing within fourteen (14) business days after the decision. Should the EMT not meet the requirements for re-licensure by the EMS Medical Director, the EMT may appeal for re-licensure directly to the Illinois Department of Public Health. The EMT must complete an Independent Renewal Request Form and submit this form along with a copy of the EMS Medical Director's notification of denial of re-licensure recommendation, documentation of continuing education hours, and a copy of the EMTs current CPR card to the Illinois Department of Public Health within ten (10) days after the receipt of the EMS Medical Director's notification.
The EMS Medical Director may refuse to renew the license of an EMT for one or more the following reasons:

1. The EMT has not met continuing education or re-licensure requirements as prescribed by the Department.
2. The EMT has failed to maintain proficiency in the level of skills which he/she is licensed.
3. The EMT, during the provision of medical serves, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

4. The EMT has failed to maintain or has violated standards of performance and conduct as prescribed by the Department in rules adopted pursuant to the EMS Act or the EMS System Program Plan.
5. The EMT is physically impaired to the extent that he/she cannot physically perform the skills and functions for which he/she is licensed, as verified by a physician, unless the person is on inactive status.
6. The EMT is mentally impaired to the extent that he/she cannot exercise the appropriate judgment, skill and safety for performing the functions for which he/she is licensed, as verified by a physician, unless the person is on inactive status.
7. The EMT has violated the EMS Act, any rule of the EMS Rules and Regulations or any MCAEMS System policy, protocol, or procedure guideline.

Final decision about relicensing rests with the Illinois Department of Public Health.

Extension Requests

If an EMT/PHRN/ECRN foresees that he/she will not be able to meet the requirements for re-licensure in the MCAEMS System, he/she may request an extension to his/her license expiration date. Should this occur, the EMT should request an Extension Request Form From the MCAEMS System. The form must be typewritten, and all copies submitted to the EMS System Director. The form must be received by the EMS System at least 60 days prior to the EMS's license expiration date (See Appendix E)

The EMS Medical Director or his/her designee will review the request and either recommend that an extension be granted or deny his/her recommendation that an extension be granted. Should the EMS Medical Director or designee recommend that the extension be granted, the EMS Medical Director or designee shall sign and submit the form to the Department. Should the EMS Medical Director or designee not recommend that the extension be granted, the EMS Medical Director or designee shall notify the applicant in writing of the reasons for denial.

EXTENSION REQUESTS ARE DISCOURAGED AND SHOULD ONLY BE USED, AND WILL ONLY BE APPROVED, IF EXTREME CIRCUMSTANCES PREVENT AN EMT FROM MEETING HIS/HER CONTINUING EDUCATION REQUIREMENTS.

Final decisions regarding extension requests rest with the Illinois Department of Public Health. The maximum extension allowed is 6 months, although a 6-month extension will not be automatically granted in most cases.

Resources:

MCAEMS System Plan
Illinois System Act 515.570, 515.580, 515.90

Licensure Reinstatement Policy

Effective Date: 01/2014
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

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

testing fees, and reinstatement fees due to IDPH. A current schedule of fees for reinstatement will be available upon request at the system office.

F. Once the applicant has successfully completed the paperwork, interview, and skills competency requirements of this policy, the applicant will be released to challenge the applicable state licensure exam. Applicants must successfully challenge the certification exam before licensure is reinstated.

G. All requirements must be completed prior to the applicant reaching the 36th month of lapsed licensure.

H. Nothing in this policy shall be construed as a guarantee of licensure reinstatement, and no guarantee of reinstatement is implied.

Line of Duty Death Notification

Effective Date: 06/2017
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

Line-of-duty deaths have continued to be a risk for public safety personnel.

Policy Statement:

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

Policy:

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

Mandatory Abuse Reporter Policy

Effective Date: 08/2021
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

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. **Healthcare providers must by law report any suspicious acts of suspected maltreatment of children and eligible adults.**

Policy Statement:

Healthcare providers are mandated reporters. Regardless of whether another mandated reporter agrees to file a report or if law enforcement is on-scene, it is the responsibility of each suspecting or witnessing healthcare provider to **report child, dependent adult, and elder abuse and/ or neglect**.

Policy:

DEFINITIONS

Abuse:
Evidence of physical or emotional harm or neglect, which may be defined as intimidation, cruel punishment, fiduciary (financial) abuse, abandonment, isolation, or treatment resulting in physical harm or pain or mental suffering or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

Child:
Any person under the age of 18 years.

Dependent adult:
Any person between the ages of 18 and 64 years who has physical or mental limitations which restrict their ability to carry out normal activities or to protect their rights including, but not limited, to persons who have physical or developmental disabilities or those whose physical or mental abilities have diminished due to age.

Elder:
Any person of the age 65 years or older.

Reasonable suspicion:
Information known to EMS personnel which, based on their training and experience, would lead another EMS provider in the same situation to suspect that the injury or condition of the patient was the result of a violent act or neglect.

1. 1) If the EMS provider has reasonable suspicion that individual has been abused or neglected is a patient and is suffering from a medical emergency, make reasonable efforts to transport the patient to a receiving hospital for evaluation. Provide the receiving hospital staff with the basis for the abuse/ neglect suspicions.

2. 2) Document observations and findings of suspected abuse or neglect, in addition to the other required information concerning the patient's medical complaint, in the electronic health record.

3. 3) Contact the appropriate reporting agency:

4. Refer to the protocol manual for further direction.

Elder Abuse Hotline: 1-800-252-4343.

Department of Children and Family Services (DCFS) by calling 1-800-252-2873.

Mandatory System Reports

Effective Date: 08/2021
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

EMS providers are required to submit mandatory reports on certain calls.

Policy Statement:

Mandatory reports are used for quality improvement purposes and to ensure that any high-risk procedures are being performed within system standards. These reports are not used for punitive matters, but rather to ensure all patients are receiving appropriate care.

Policy:

1. Reports can be made via the EMS office website or through paper forms that are either emailed or faxed to the office.
2. All reports must be submitted within 24 hours of the event.
3. The following events are required reports:
    a. Pre-Hospital Delivery
    b. Pre-Hospital Return of Spontaneous Circulation
    c. Pediatric Cardiac Arrest
    d. Utilization of Drug Assisted Intubation
    e. Utilization of Chemical Restraint Protocol (Ketamine)
    f. Refusal taken from a medical facility office.
    g. Failure to respond to a 911 call due to lack of personnel or apparatus issues

Mass Casualty Incident Policy

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure that EMS system participants are well-versed in the procedures for a mass casualty incident. This will help ensure that the system response will be as quick and effective as possible.

Policy:

In the case of a mass casualty incident, it is important to immediately establish a chain of command in which all operatives understand their responsibilities and the accompanying procedures.

A. General

A. Mass casualty incidents for the purpose of this policy shall be defined as:

1. An incident with 5 or more patients that are triaged Immediate (red) and or Delayed (yellow)
2. An incident with more than 10 patients regardless of triage category
3. An incident with 5 or more patients of any category that require special resources to treat or to gain access. Such as technical rescue, HazMat response, and or enhanced scene security.

B. The first arriving company at an incident meeting the above definition shall notify dispatch that a mass casualty has occurred and shall institute the provisions of this standard.

C. Responding personnel at each MCI shall utilize the National Incident Management System.

II. Command and Control

A. It shall be the responsibility of the first arriving company to establish command and manage the incident until relieved.

B. A staging area should be established and announced over the radio.

C. As more people arrive on scene one person should be assigned as the Operations Section Chief.

D. Once an Operation Section Chief is assigned a Medical Group Supervisor should be assigned

E. If no Operations Section is established the Incident Commander will assume the role of Section Chief.

F. If no Medical Group Supervisor is established the Operations Section Chief will assume the role of the Medical Group Supervisor

G. The Medical Group Supervisor shall establish a Triage Team, Treatment Team, and a Transport Team

H. Each team leader shall report directly to the Medical Group Supervisor

I. As the incident evolves the Incident Commander should assign the General Staff Functions

III. Responsibilities

A. Incident Command

1. Overall management of the incident.

2. Establish the appropriate Divisions/ Groups and summon sufficient resources.
3. Ensure that the EMS system coordinator and resource hospital are notified.

B. Triage

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

C. Treatment/Casualty Collection Point (CCP)

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

D. Staging

1. An area where personnel, ambulances, and fire apparatus report to prior to beingassigned. The level and number of staging areas will be determined by the size and magnitude of the incident.
Responsibilities include:

    a) Determine the level of staging.
    b) Maintain a record of the names of all personnel deployed at the incident and record the amount and type of equipment managed by staging.
    c) Maintain a reserve of at least one ambulance, and enough other resources as may be required.
    d) Request and deploy additional resources as needed.

E. Transport

1. A separate area adjacent to the treatment area where the packaged patient is assigned to an ambulance for transportation to a medical facility Responsibilities include:
    a) Ensure a communications link is established and maintained with the Resource Hospital
    b) Notify Resource Hospital of the types and numbers of casualties including any special hazards e.g., hazardous materials.
    c) Obtain the patient's hospital destination from Medical Control and write the destination on the patients triage tag.
    d) Assign and arrange patient transportation using the patient's triage. category and Resource Hospital assignment as indicated on the triage tags.
    e) Maintain a record of the patients transported and their respective destinations.
    f) Keep staging informed of estimated transport needs.

IV. Operational Phases

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

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

B. Phase 1- Initial agency response

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

C. Phase 2 - Establishment of command

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

D. Phase 3 - Scene report

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

E. Phase 4 - MCI declaration

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

F. Phase 5 - Secondary response

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

accounted for. Freelancing will hinder the effectiveness of the operation and put responders or other victims at risk.

G. Phase 6 - Continued incident management.

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

H. Phase 7 – Release / termination

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

I. Phase 8 Incident documentation / review

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

V. <u>Operational considerations</u>

A. Triage

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

B. Treatment

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

C. Transport

1. Patient destination shall be determined by medical control through consultation with the treatment sector.

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

D. Patient tracking

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

E. Responding transport units

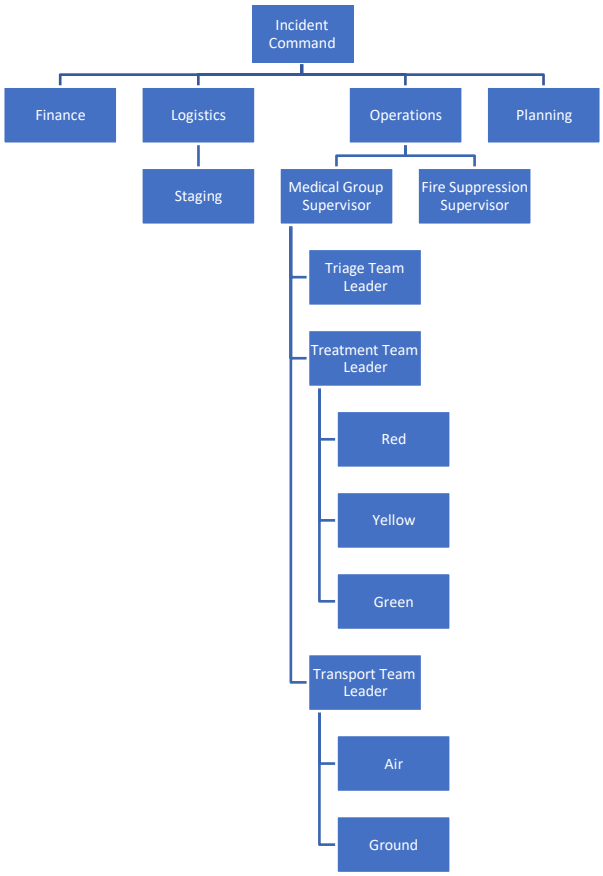
1. Responding units are to report to the staging area unless directed otherwise by incident command. Once at staging the personnel should sign in and remain with their unit.
2. Emergency warning lights should be turned off once in staging.
3. While transporting a patient a brief radio report should be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

VI. Agency requirements

A. All EMS agencies within the Mclean County area EMS system shall complete and use EMS run cards for MCI incidents.

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

VII. Sample Organization Chart



Medical Control – Operation Control Point

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

Resource and Associate Hospitals of the Mclean County Area EMS System are committed to providing on-line medical control at each of the emergency department operational control points, 24 hours per day. All voice orders shall be given by or under the direction of the EMS Medical Directors, or the EMS MD's designee, who shall be an ECRN or Emergency Department Physician.

Policy:

A. The operational control point telecommunications equipment allows both EMS Medical Directors or their designee to monitor all First Responder, EMT-Basic, EMT-Intermediate and EMT-Paramedic to- hospital transmissions, and all hospital to First Responder, EMT-B, EMT-I and EMT-P transmissions within the area serviced by McLean County Area EMS System.

B. The telecommunications equipment at all Resource and Associate Hospitals are to be staffed and maintained 24 hours every day, which includes the VHF radio control points and the required telephone equipment. All operational control points must tohave the ability to receive 12-lead ECG's.

C. All voice orders via VHF/UHF radios or on telephone equipment shall be given by or under the direction of the EMS Medical Directors or by the EMS MD's designee, who shall be an ECRN or an Emergency Department Physician. All voice communications must be recorded. These recordings must be stored for seven (7) years.

D. Upon receiving a radio or telephone call at the operational control point, the ECRN shall initiate contact and document all appropriate information. The EMS MD or the designated on-duty emergency department physician shall be notified of the incoming call, as soon as possible.

E. Once the EMS MD or the Medical Control Physician designee has arrived at the operational control point, the ECRN and Physician shall continue to utilize the field treatment protocols as a patient treatment guide during the EMS call. If the EMS MD or the Medical Control Physician is not readily available, the ECRN has the authority, delegated by the EMS Medical Directors, to CONTINUE EMERGENCY CARE IN ACCORDANCE WITH THE FIELD TREATMENT PROTOCOLS.

F. If the EMS MD or Medical Control Physician is not present at the operational control point at the time of a call which requires orders for procedures marked contact medical control, THE ECRN IS NOT AUTHORIZED TO INITIATE THAT ORDER. Those orders marked contact medical control REQUIRE MEDICAL CONTROL PHYSICIAN DIRECT VERBAL ORDERS TO PERFORM. However, this verbal order may be relayed through an ECRN.

G. In the absence of the EMS MD at the operational control point, the on-duty Medical Control physician has the responsibility to follow the field treatment protocols as approved by and under the authority of the EMS Medical Directors.

H. Communications from the operational control point must be available to the McLean County Area EMS System for review.

MERCI Radio Operations

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

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

Mutual Aid Services

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To verify all affiliate agencies of the McLean County Area EMS System, provide and receive mutual aid services as dispatched by their respective Telecommunications Center in accordance with established protocols.

Policy Statement:

All ambulance transport agencies affiliated with the McLean County Area EMS System are following the [Title 77: Illinois Adm. Code, Chapter I, Part 515, Section 515.810h] requirement of utilizing a back-up system providing or receiving mutual aid services. All non-transporting agencies including First Responder Services of the EMS Systems also have simultaneous dispatched mutual aid services provided by a transporting ambulance service. Tele-communicators utilize protocols that provide for automatic, simultaneous, or back-up mutual aid services depending upon specific needs or situations.

Policy:

A. All agencies within the McLean County Area EMS Systems are dispatched by Tele-communicators. Tele-communicators utilize protocols that provide for **automatic, simultaneous or back-up mutual aid services** depending upon specific needs or situations.

B. All non-transporting agencies including First Responder Services within the McLean County Area EMS Systems also have **simultaneous dispatched mutual aid services** provided by a transporting ambulance service.

C. In cases of an emergency arising within the response area of the McLean County Area EMS System affiliate agency where the situation is beyond its own resources of personnel and/or equipment to provide EMS services, or is unable to provide EMS services (i.e., manpower…) shall request mutual aid assistance through contacting their respective telecommunications Center.

D. The Telecommunications Center shall dispatch according to established protocol of the nearest appropriate EMS agency and resources.

E. All agencies within the McLean County Area EMS System must have a completed EMS “Box Card” on file to follow in an MCI incident.

Notification of Ambulance Personnel of Exposure to Communicable Disease

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To identify and notify those pre-hospital personnel who transport a patient with a communicable or infectious disease, so that those personnel may take necessary precautions prior to or seek recommended treatment following patient contact.

Policy Statement:

The hospital shall notify pre-hospital care providers if it is determined a patient transported by paramedics or ambulance personnel has a communicable or infectious disease.

Policy:

A. Pre-hospital providers shall complete a patient care report on each patient transported and submit a copy to the receiving facility.

B. Pre-hospital patient care reports shall include any significant exposure to patient body substances.

C. Providers who have been significantly exposed during patient care are to seek treatment at the emergency department that patient was transported to.

D. If patients transported by pre-hospital services are diagnosed as having a communicable or infectious disease, the involved pre-hospital personnel shall be notified by the Occupational Health department within seventy-two (72) hours after the confirmed diagnosis.

E. If EMS personnel that are transporting a patient are directly exposed to a patient's body substances, the pre-hospital personnel should indicate *"Significant Exposure"* on the run sheet.

F. All pre-hospital care providers, including those from outlying areas, shall complete an incident form with an explanation of *"Significant Exposure."*

G. Types of Exposure

- **i.** Parenteral (i.e., needle stick)
- **ii.** Mucous membrane (eyes, mouth, genital)
- **iii.** Significant skin exposure (i.e., open sores, cuts, cracks in skin) to blood, urine, saliva, bile, semen

H. When a hospital patient with a listed communicable disease is to be transported by pre-hospital personnel, the hospital staff sending the patient shall inform the pre-hospital personnel of any precautions to be taken to protect against exposure to disease. If the pre-hospital personnel fail to take precautions and a significant exposure occurs, the pre-

hospital personnel shall complete an incident report form and send it to the EMS System office.

I. Pre-hospital personnel shall maintain all information received as confidential medical records.

Patient Abandonment vs. Prudent Use of EMS Personnel

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To assure that pre-hospital abandonment of patients does not occur unless specifically defined conditions exist.

Policy Statement:

Patient abandonment occurs when there is termination by the physician (or his agency, i.e., the First Responder/EMT/Pre- hospital RN) of the doctor/patient (EMS/patient) relationship without consent of the patient and without allowing sufficient time and resources for the patient to find equivalent care. This is assuming, and unless proven otherwise, there exists a need for continuing medical care and the patient is accepting treatment.

Policy:

A. EMS personnel must not leave a patient if there is a need for continuing medical care that must be provided by a knowledgeable, skilled, licensed EMS provider unless one or more of the following conditions exist.

xii. The patient or legal guardian refuses pre-hospital care and transportation. In this instance, follow the procedure as outlined in the "Patient Right of Refusal" policy.

xiii. Pre-hospital personnel are physically unable to continue care of the patient due to exhaustion or injury.

xiv. When law enforcement, fire officials or the EMS crew determine the scene is not safe and immediate life or injury hazards exist.

xv. The patient has been determined to be dead and all policies and procedures related to death cases have been followed.

xvi. If medical control concurs with a DNR order.

xvii. Whenever specifically requested to leave the scene due to a specific overbearing need (i.e., disaster, triage prioritization).

xviii. Medical care and responsibility for the patient is assumed by comparably trained, certified and licensed personnel. Refer to "Physician/Nurse at Scene" policy and "Patient Hospital Preference" policy.

B. If EMS personnel determine that a continuing medical need does exist and the patient refuses care, the EMS crew shall refer to "Patient Right of Refusal" policy for the process to follow for refusal of care.

C. EMS personnel may leave the scene of an episodic illness or injury incident where initial care has been provided to the patient or securing a signed refusal, if the following conditions exist:

xix. Delay in transportation of another patient from the same incident would threaten life or limb.

xx. An individual or occurrence of a more serious nature elsewhere necessitates life-saving intervention which could be provided by the EMS crew and without consequence to the original patient.

xxi. Definitive arrangements for the transfer of care and transportation of the initial patient to other appropriate personnel must be made prior to the departure of the EMS crew; and, the alternate arrangements, should, in no way, jeopardize the well-being of the initial patient.

D. If the patient requests transportation to a hospital outside of the ambulance primary response area, and there exists no obvious need for stabilization at a nearer hospital, the EMS crew may plan for transfer of the patient's care to a more appropriate ambulance service. Alternate arrangements and release of the patientshould be carried out with the approval of Medical Control. Whenever possible, the EMScrew should remain with the patient until the arrival of the transporting ambulance. The"Patient Right of Refusal" policy and "Patient Hospital Preference" policy should also bereferenced in such cases. Consult your agency's policies regarding transport of patient'sout-of-district.

E. If the patient requests transportation to a hospital outside of the ambulance primary response area, and there exists obvious or potential need for stabilization at a nearer hospital, the EMS crew should immediately contact Medical Control and follow the directions of the Resource Hospital Physician. The "Patient Right of Refusal" policy and "Patient Hospital Preference" policy should also be referenced in such cases.

Patient Complaint Policy

Effective Date: 12/2023
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

To provide a process to receive, investigate, and report all EMS driven patient complaints to the system and the state.

Policy Statement:

Emergency Medical Service Providers and or agencies must complete the mandated patient complaint report anytime a patient complaint is filed. The EMS System will track, investigate, and provide appropriate mitigation for each complaint. The EMS System will be responsible for sending the Patient complaint log monthly to the IDPH REMSC as requested.

Policy:

A. EMS personnel or agency staff will file the mandated patient complaint report available on www.mcleancountyareaems.org website within 24 hours of received complaint (located under the quality assurance tab, mandatory reports.
B. EMS system will investigate each complaint and provide outcome, remediation, and corrective action as warranted.
C. EMS system will submit the following to the Department monthly:

    A) Number of EMS patient care complaints, including a brief synopsis of the issue.
    B) Outcome of the system investigation
    C) Names and licenses of the EMS personnel involved in sustained allegations.

Patient Confidentiality/Release of Information

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure appropriate confidentiality of personal and sensitive information regarding patient care and/or prognosis as well as ensure the legal authorization on release of patient information.

Policy Statement:

All McLean County Area EMS System personnel are exposed to or engaged in the collection, handling, documentation, or distribution of patient information. Therefore, all EMS System personnel are responsible for the protection of this information. The McLean County Area EMS System and affiliate EMS agencies have a statutory duty to protect the confidentiality of patient records. In all situations, including subpoenas, to obtain legal release of patient information, all requests for pre-hospital patient care information shall be directed to the EMS agency's affiliate Resource Hospital's Medical Records Department.

Policy:

The McLean County Area EMS System agencies and personnel and all others involved in EMS patient care have a statutory duty to protect the confidentiality of patient medical records in accordance with the Illinois EMS Systems Act [210 ILSC, 50/3.195], and the Illinois Medical Patients' Rights Act [410 ILSC 50/3 (d)]. Under 735 ILSC 5/8-802, which was amended in 1995 to broaden the definition of health care providers subject to Medical Records as privileged communications, includes entities which provide medical services. Clearly the services as an Emergency Medical Technician or Pre-hospital RN fulfill the role of one providing medical services.

B. In all situations, including subpoenas, to obtain legal release of patient information, all requests for pre-hospital patient care information shall be directed to the EMS agency's affiliate Resource Hospital's Medical Records Department. It is the responsibility of the Medical Records Department to verify a legal release of patient medical records, written or recorded. The duty of confidentiality would be breached by production of any written or recorded documentation **BY <u>ANYONE</u>** pursuant to:

- A subpoena directed to the Resource Hospital's Medical Records Department; or
- A signed authorization by the patient for "Release of Information/Medical Records; and
- Verification of legal release of patient information by the Medical Records Department.

C. Unnecessary sharing of confidential information will not be tolerated by the McLean County Area EMS System. EMS personnel must understand that breach of confidentiality is a serious infraction with personal legal implications and may result in corrective action, including System licensure suspension.

1. Written

- Confidentiality regarding written patient care documentation is governed by the "Need to Know" concept.
- Only McLean County Area EMS System personnel and Hospital Medical staff from third party payers should be directed to the Resource Hospital's Medical Records Department.
- Request for Release of all patient care information, including request from third party payers, should be directed to the Resource Hospital's Medical Records Department.
- Request by law enforcement, coroner, fire or other agencies for patient care reports must also be directed to the Medical Records Department.

2. Verbal

- System personnel are not to discuss specific patients in public areas. Loose or "elevator talk" regarding specific patient problems and/or care in inappropriate.
- Do not repeat to your friends and relatives, or the friends and relatives of patients, any information learned through the course of carrying out your duties. If you learn of the hospitalization of a friend or relative, you may not act on that information or pass it on unless it came from an outside source or the patient himself. If you happen upon information (or the chart) of a friend or relative in the course of performing your job, you are responsible for keeping that information confidential.

3. Radio

- Generally, no patient name will be mentioned in the process of pre-hospital radio transmissions utilizing MERCI regarding non-direct admit patients.
- Customary "Direct Admits" may need to have the initials of patient's names included in the radio transmissions. This is necessary for identification and is acceptable to transmit.
- Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.

D. Scene

- Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and en route.
- EMS personnel should limit bystanders at the scene of an emergency. Law enforcement may be called upon to assist in maintaining bystanders at a reasonable distance.
- EMS providers who encounter an individual filming a scene, should not directly confront the individual. Rather create a barrier around the patient using providers,vehicles, or blankets. The patient should be moved as quickly as what is safe to thewaiting ambulance.

Patient Hospital Preference

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To assure patient hospital preference is respected unless such preference would potentially jeopardize or would compromise patient outcome. Ensure compliance with State and Federal laws and regulations.

Policy Statement:

The patient has the right to choose the hospital he/she is transported to unless Medical Control determines otherwise. Any ambulance service provider with McLean County Area EMS System affiliation, which is owned and operated by any of the System's participating hospitals (i.e., Carle BroMenn Medical Center and OSF St. Joseph Medical Centers, Dr. John Warner Hospital) are subject to transport an emergency patient to the provider's own hospital by mandate of Federal Anti-dumping Statute (42 CFR 489.24) of the Emergency Medical Treatment and Active Labor Act (EMTALA)

Policy:

DEFINITIONS:

EMERGENCY- A MEDICAL CONDITION OF RECENT ONSET AND SEVERITY THAT WOULD LEAD A PRUDENT LAY PERSON, POSSESSING AS AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, TO BELIEVE THAT URGENT OR UNSHCEDULED MEDICAL CARE IS REQUIRED. (Illinois EMS Systems Act [210 ILCS 50] Section 3.5)

EMTALA - Emergency Medical Treatment and Active Labor Act (42 CFR 489) requires a hospital that operates an ambulance service to ensure an emergency patient is transported to the ambulance provider's own hospital. To transfer the patient anywhere else would be an EMTALA transfer. The hospital with ownership of that ambulance service must comply with all requirements of an EMTALA transfer if the patient is not transported to said hospital.

TRANSFER - The movement of an emergency patient from the pre-hospital scene to a medical facility at the direction of the agency's Medical Control Physician.

INFORMED CONSENT - A patient who is of legal age and is a mentally competent adult signifying that he/she knows, understands, and agrees to patient care rendered and is aware of:

1. The nature of the illness or injury
2. The recommended treat and associated risks
3. The alternative treatment and risks involved.
4. The danger of refusing treatment

In the pre-hospital setting, EMS providers are not obligated to obtain consent to the

same degree as within a health care facility. The patient must only verbally agree or at least not object to the general nature of the treatment.

STABILIZED - In respect to a patient with an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer, (as defined in this part), of an individual to a medical facility other that the nearest appropriate facility.

A. Patient choice and medical urgency should be the guiding principles to EMS personnel as to where each ambulance case is delivered. However, it is inherent that each patient has the right to make an informed decision, provide Informed Consent, as to which hospital they are transported to within the service area of the ambulance agency as defined by the EMS System Plan.

B **NO EMERGENCY PATIENT** of any EMS agency affiliated with the McLean County Area EMS System shall be transported to a medical facility which is not within the service area of said EMS agency without first being STABILIZED and approved by the Medical Control Physician.

C. **ALL EMS AGENCIES OWNED BY A HOSPITAL PARTICIPATING IN THE MCLEAN COUNTY AREA EMS SYSTEM ARE REQUIRED TO COMPLY WITH EMTALA AS DEFINED IN THIS PART.**

- If transport to the EMS agency's own hospital bypasses the closest hospital or trauma center; the receiving hospital has no EMTALA transfer issue, but the hospital directing the transport (which may be a different hospital) must still comply with the EMS System Bypass/Diversion policy.

- If a patient is transported to the closest hospital or trauma center but that is not the hospital that operates the ambulance service:
  - The hospital giving medical direction has no EMS System bypass/diversion issue, but the EMS agency's own hospital must still handle it as a EMTALA transfer issue.

D. Should the patient refuse to be transported to the nearest appropriate facility, the patient should be advised of the risk, if any, associated with not being transported to the nearest appropriate hospital. Once risk factors have been explained, the patient's decision should be honored unless superseded by the Medical **Control Physician** (in compliance with this part), by the **Trauma Policy/ or Bypass/Diversion Policy**.

E. All **TRAUMA** patients shall be subject to the Field Triage of the Trauma Patient policy, as well as the Illinois Department of Public Health Rules and Regulations, Section 515. Appendix C, "Minimum Trauma Field Triage Criteria".

F. Patient hospital preference should be documented on the EMS Report Form.

Patient Restraints

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

The use of patient restraints should be held to a minimum and only used as a last resort to transport a patient who exhibits physical resistance to transport or violence towards EMS personnel. The purpose of restraints is not to arrest, but to protect the patient and others from their irrationality.

Policy Statement:

To ensure appropriate use of patient restraints in the pre-hospital setting.

Policy:

A. The use of restraints is determined by the physical resistance to transport or violence towards EMS personnel by a patient who meets the criteria for implied consent and intentionally or unintentionally physically injures themselves or others.

B. Whenever possible, Medical Control is contacted for guidance and concurrence in determining the need for restraints. Unless patients possess an immediate threat to themselves or other persons, Medical Control should be contacted prior to the restraint.

C. Attempt voluntary application of restraints.

D. Notify the local law enforcement to respond.

E. If voluntary restraint is not possible, assemble adequate personnel. Ideally, this should include one person for each of the patient's limbs.

F. For Involuntary Restraint, do not spend much time bargaining with the patient. If the patient does not respond in a brief time to the request for voluntary restraint, then move quickly to apply involuntary restraint. Indecisiveness may agitate the patient even further.

G. EMS Personnel shall use all the force reasonably required to restrain the patient for the safety of all involved individuals. "Reasonable force" depends on the degree of resistance on part of the patient. The force of restraint must equal the degree of combativeness. Legal claims of excessive force may be made for restraint beyond what is necessary.

H. Once the patient is on the stretcher, begin application of restraints. The patient should be gently grasped and placed on their back. In addition to four extremity restraints, the cot's five straps (over–the-shoulder, chest, hips and legs) should be applied.

I. The gender of the pre-hospital personnel present when restraints are being applied should be considered in relation to the patient's problem (i.e., it is better to have same gender EMS crewmember present when a patient is out of control and needs restraint).

J. After application of restraints, the patient must at no time be left alone. Someone must be assigned to talk with the patient about the patient's feelings and explain the purpose of the restraints.

K. Restraints must periodically be checked for proper application (i.e., adequate circulation to limbs, with documentation in the Patient Care Report that these periodic checks were conducted at least every five minutes).

L. A patient under arrest by a law enforcement agency must first be restrained with hand-cuffs. The restraint and/or EMS-personnel hospital transport of a patient who is under arrest but has not been restrained initially with handcuffs by law enforcement ARE NOT TO BE RESTRAINED AND/OR TRANSPORTED BY EMS PERSONNEL until handcuffs have been applied. The application of handcuffs must not interfere with patient care. If a patient has handcuffs applied, then law enforcement must accompany patient in the back of the ambulance.

The restraint and/or EMS-personnel hospital transport of a patient who is under arrest but has not been restrained initially with hand-cuffs by law enforcement ARE NOT TO BE RESTRAINED.

M. Documentation Requirements

1. Indication for using restraints (i.e., presence of self-destructive behavior, danger to others, meets criteria for implied consent, under arrest by law enforcement).
2. Prior attempts at less restrictive alternatives (i.e., verbal communication).
3. Periodic checks for proper application.

N. Avoiding Injury

4. Keep at a safe distance whenever possible.
5. Expect the unexpected.
6. Never turn your back to the patient.
7. Watch out for the patient's head; the patient can and will bite.
8. Remove any sharp objects from the patient's immediate environment.
9. Never restrain a patient face down.
10. Never restrain the legs to the arms.
11. Assess for digital circulation every five minutes after restraint application.

Patient Right of Refusal

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure that a patient's right to refusal can be properly accepted by the medical responders.

Policy Statement:

Competent patients have the right to accept or refuse any or all prehospital care and transportation provided the decision to accept or refuse treatment or transportation is made on an informed basis and these patients have the mental capacity to make and understand the implications of such a decision.

Policy:

Definitions:

Patient – A person for whom EMS was activated, that has suffered some form of mechanism and/or verbalizes a complaint, and the EMS provider establishes verbal and/or physical contact.

Minor – Any person under 18 years of age.

Emergency – A medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and unscheduled medical care is required.

Implied consent – A situation involving an unconscious or incompetent patient where care is initiated under the premise that the patient would desire such care if they were able to make the decision. In the case of a minor, if a parent or legal guardian is not present, care and transportation is provided on the basis of "Implied Consent".

Against Medical Advice (AMA) – The refusal of treatment or transport by a patient against the advice of medical personnel on scene and Medical Control.

Competency – The ability of a person to understand the nature of their illness/injury with no significant mental impairment by illness, injury, or mind-altering substances and understand the consequences of refusing medical care. Competency of a patient will be assessed by:

1. Orientation to person, place, and time.
2. The ability to hear and understand.
3. Lack of significant illness that would affect sound judgment, i.e., hypo perfusion, hypoxia,hypoglycemia, or other organic illness.
4. Lack of significant injury that would affect sound judgment, i.e., head injury, hypoxia, hypo-perfusion.
5. Impairment of decisional capacity due to mind-altering substances, i.e., alcohol, drugs, medications, or other substances

Decisional Capacity Evaluation Elements Table

Element	Details
Understanding	The patient can comprehend the medical information being discussed, including the risks and benefits of refusing the recommended option.
Appreciation	The individual not only comprehends the details but appreciates how these factors may affect them personally.
Reasoning	There should be some evidence of a reasoning process behind the patient's decision.
Ability to communicate a choice	Is the patient's decision remaining consistent over time.

Pre-hospital personnel allowed to obtain refusals;

1. EMT-P
2. PHRN
3. EMT-I
4. EMT-B
5. First Responder (Low risk patients only)

High risk patients include, but not limited to:

1. Head injury (based on mechanism or signs and symptoms
2. Any trauma with significant mechanism (i.e., MVC rollover)
3. Chest pain
4. SOB/dyspnea
5. Syncope
6. Seizure (new onset)
7. Headache (new onset)
8. TIA/resolving stroke symptoms.
9. Pediatric complaints
10. Impairment of decisional capacity due to alcohol and/or drugs
11. Altered level of consciousness or impaired judgment

Low risk patients:

1. Slow speed MVC without injury
2. Isolated injuries not associated with significant mechanism.
3. Low mechanism of injury
4. Ground level fall
5.

Who May Refuse Care

1. The patient
   a. If a patient is legally, mentally, and situationally competent, the patient has the right to refuse care. Obtain refusal signature.
2. Parent
   a. A custodial parent (i.e., a parent with a legal right to custody of a minor child) may refuse on behalf of a minor child. Obtain refusal signature from parent.
   b. A parent of a patient who is 18 years of age or older may not refuse care for their child (unless the parent is also happens to be a legal guardian - see below).
   c. A minor (i.e., under 18 years of age) may refuse care for their child. Obtain refusal signature from minor parent.

3. Guardian
   a. A legal guardian is one who is appointed by a court to act as "guardian of person" of an individual who has been found by a court to be incapacitated.
   b. Legal guardian may also be appointed in lieu of parents for a minor.
   c. If a person indicates they are a legal guardian to the patient, attempt to obtain documentation of this fact (court order, etc.) and attach to trip sheet. If no such documentation is available, you may obtain a refusal signature from the guardian if you do so in good faith and do not have any evidence or knowledge that theperson is misrepresenting as the legal guardian of the patient.
4. Health Care Agent (Attorney in Fact)
   a. A person appointed by the patient in a durable power of attorney document may refuse care on behalf of the patient if the power of attorney contains such authorization.
   b. Attempt to obtain a copy of the durable power of attorney document to attach to the trip sheet. If no such documentation is available, you may obtain refusal signature from the health care agent ("attorney in fact") as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting themselves as the health care agent or "attorney in fact" of the patient.

Procedure

All patients will be offered treatment and transportation to a hospital after an accurate patient assessment has been conducted to include the patient's complaint, history and objective findings, andpatient's ability to make sound decisions.

B. Determine mental competency of the patient and the reason for refusing care. (Complete the Informed Decision-Making Form) Providers should assess three major areas prior to permitting a patient to refuse care and/or transportation:

a. Legal Competence
   a. Assure that patient is at least 18 years of age.
   b. Or, if a minor, patient may refuse care if they have a court order of emancipation, is married, is a parent, is pregnant, or is a sworn member of the armed services.
   c. Patients subject to court decree of incapacity are not legally competent to refuse care.

b. Mental Competence
   a. Start with the presumption that all patients are mentally competent unless your assessment clearly indicates otherwise.
   b. Ensure that patient is oriented to person, place, time, and purpose.
   c. Establish that patient is not a danger to themselves or others.
   d. Ensure that patient can understand the risks of refusing care or transportation and any proposed alternatives.
   e. Check to be sure that patient is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, etc.

c. Medical or Situational Competence
   a. Ensure that patient is suffering no acute medical conditions that might impair their ability to make an informed decision to refuse care or transportation.
   b. If possible, rule out conditions such as hypovolemia, hypoxia, head trauma, unequal pupils, metabolic emergencies (e.g., diabetic shock), hyperthermia, hypothermia, etc.
   c. Attempt to determine if patient lost consciousness for any period.

d. If any conditions in (a)-(c) impair patient's decision-making ability, patient *may* not be competent to refuse care. This would be considered a "High Risk Refusal", and Medical Control should be contacted. Your documentation should clearly establish that the patient understood the risks, benefits, and advice given to them.

C. Explain to the patient the risk associated with their decision to refuse treatment and transportation.

D. Inform the patient they may contact EMS if they change their mind.

E. Advise the patient to seek medical care, i.e., go to a hospital, doctor's office, clinic, etc.

F. High risk patients:

1. Establish voice contact via MERCI radio or cellular telemetry with Medical Control and relay the patient's complaint, history, complete assessment, and vital signs. Clearly state that the patient refuses treatment and transport.

   The hospital will respond with the following statement to be heard by the patient:

   > You have not been evaluated by an emergency department physician; therefore, the EMS system does not recommend refusals of treatment andtransport. Since you are refusing treatment and transport despite being informed of the associated risks, it is recommended you be evaluated by your primary physician or the nearest emergency department as soon as possible.

2. After consultation with Medical Control, document refusal, complete the Release of Medical Responsibility Form (example pp.46-47) and have the patient sign the form. If a minor,this form must be signed by a legal guardian. MINORS CANNOT REFUSE CARE AND TRANSPORTATION TO THE HOSPITAL!
3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.

G. Low risk patients

1. First responders will establish contact with Medical Control and follow the recommendations of the Physician or ECRN.
2. EMT-B, I, and P pre-hospital personnel will complete the Release of Medical Responsibility form and reasonably assure the patient understands the refusal.
3. A witness to the patient's release of services must also sign the release form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, their name, address and telephone number should be obtained and written on the back of the report.
4. A crew member may sign as a witness, but only when no other appropriate bystanders, police, or family are available to witness the refusal.

H. 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 refusal to sign on the bottom section of the report, and have the entire crew witness the statement. Have an additional witness sign preferably a police officer. Include unit and badge number. Establish voice contact via MERCI or cellular telemetry with Medical Control and state that the patient refuses treatment/transport and refuses to sign the release. Request the tape number and mark the chart to be reviewed.

I. Refusal of transport to the nearest appropriate medical facility

1. If a patient refuses transport to the closest appropriate medical facility and the refusal would create a life threatening or "high risk" situation, follow the policy for "Patient Right of Refusal" and treat it as a "High Risk" refusal. After contact with Medical Control, obtain the patient's

refusal signature and transport to the requested medical facility.

2. If a patient refuses transport to the closest appropriate medical facility and the refusal would **not** create a life threatening or "high risk" situation, follow the policy for "Patient Right of Refusal" and treat it as a "Low Risk" refusal. Obtain the patient's refusal signature and transport to the requested medical facility.

J. Bypass or Diversion of a Hospital

1. If a hospital diverts an incoming ambulance or in any way refuses to accept an emergency patient, transport the patient to the nearest appropriate medical facility. Complete and Incident Report and forward to the EMS Office.

K. Refusal of Transport after Emergency Treatment

1. Some patients will refuse care after emergency treatment, i.e., hypoglycemia in diabetic patients.
2. If the patient meets the criteria for competency and the patient has received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "High Risk" refusal. After contact with Medical Control, obtain the patient's refusal signature.
3. If the patient meets the criteria for competency, has not received any medication or had a sign or symptom considered "High Risk", follow the policy for "Patient Right of Refusal" and treat it as a "Low Risk" refusal. Obtain the patient's refusal signature.

NOTE:

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

2. **Calls for assistance for transfer, where no mechanism of injury exists, the EMS provider does not need to obtain a written refusal (e.g., transfer from chair to bed, transfer from car to home). An EMS report still needs to be completed by the EMS provider for the emergency response.**

Patient Transport Policy

Effective Date: 2/23/2021
Review Date: 8/2023
Approvals: EMS MD, EMSSC

Background to Policy:

It is imperative that EMS personnel transport patients in a safe and appropriate manner.

Policy Statement:

During the transport of a patient in an ambulance, it is necessary that the patient be secured with proper safety restraints (i.e., seatbelts) throughout transport. The patient also must be secured in a manner that allows providers to fully assess the patient and provide full, appropriate, and effective care. Patients transported in unsafe or non-system approved ways could pose a danger for the patient and to the crew.

Policy:

1. All patients shall be transported appropriately secured to the stretcher with safety belts and shoulder restraints applied. Children of the appropriate age and weight must be secured in a state and federally **approved** child safety seat.
    a. During the transport of multiple patients, any patient not secured to the cot, must be secured with a 3-point harness. If patient is on a backboard, the board must be secured appropriately to the bench seat (if approved by the ambulance manufacture). At no time shall the number of patients in an ambulance exceed the number of safety restraints (including a safety restrain device for each EMS personnel in the patient compartment).

2. All transport patient care reports must explicitly state the manner the patient was transported. For example, “patient was transported on the stretcher with all safety belts applied” or similar phrase shall be documented in the narrative section. If the ePCR program has a defined space for patient transport manner, you may document in this area as an alternate to the narrative. In either event, the documentation must specifically state the manner of transport. Failure to comply may result in disciplinary actions.

Physician/ Nurse/Advanced Provider on Scene Policy

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

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

Policy:

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

e. If an on-scene physician has identified himself/herself, is not the patient's private physician, and obstructs efforts of the First Responder/EMT/Pre-hospital RN to aid a patient for whom they are called, or who insists on rendering patient care inappropriate to System standards for the circumstance and resists all of your efforts to function appropriately to the point where continued intervention will result in obstruction to rendering good and reasonable patient care, the First Responder/EMT/Pre-hospital RN should:
    i. Communicate the situation to Medical Control via radio or cellular communication.
    ii. One EMS team member should divert the interfering on-scene physician while the other EMS members attend to the patient and attempt to request law enforcement.

f. Upon request by any physician to give orders or directions at the scene of an accident or illness, the EMS crew will:
    iii. Inform the physician that they are in direct radio contact with the resource hospital physician.
    iv. Inform the physician that they can take orders only from the Resource Hospital physician.
    v. Inform the physician of the procedure for taking over medical control.

g. If the physician at the scene insists on assuming Medical Control, the EMS crew will:
    vi. Inform the resource hospital physician of the request.
    vii. Allow the physician at the scene to speak with the resource hospital physician as necessary.
    viii. Follow the directions of the resource hospital physician.

h. Should, at any time, the physician at the scene gives contraindicated or inappropriate directions or orders which could adversely affect patient care, or refuse to accompany the EMS crew to the hospital, the crew members will:
    ix. Immediately re-contact the Resource Hospital physician and inform him/her of the situation.
    x. Follow direction and orders of the Resource Hospital physician.

i. If the on-scene physician is given Medical Control by the Resource Hospital and has produced a valid State of Illinois physician and surgeon's license:
    xi. The on-scene physician must accompany the patient to the hospital; and
    xii. Sign the patient record.

Point-of-Care Covid Testing Policy

Effective Date: 12/2020
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy

With the outbreak of COVID and increased risk of EMS providers contracting COVID, it is imperative that agencies have the ability to perform COVID testing on site for their own personnel.

Policy Statement

The purpose of this policy is to create guidelines and ensure that agencies using Point of Care (POC) COVID testing follow state and federal requirements.

Policy

A. All agencies must ensure they follow local, state, and federal guidelines and policies for use of this policy.
B. Agencies must work with local health departments to ensure that testing is valid, and results are being reported appropriately.
C. Only licensed EMT, A-EMT, EMT- I, EMT-P/PHRN/PHPA/PHAPRN are allowed to administer the test.
D. The only approved test is the BinaxNOW Antigen Test.
E. This test is only for peoples ages 18 and above.
F. All agencies licensed at EMT and above may use this for their personnel as long as they meet all system, LHD and IDPH requirements.
G. Agencies must complete appropriate training requirements set forth by either the EMS system, the local health department, or the Illinois Department of Public Health (IDPH).
H. Results must be reported to the IDPH reporting system within 24 hours of a positive test.
    a. Agencies must keep a record of personnel being tested including:
        i. Name
        ii. Age
        iii. Dates
        iv. Times
        v. Location
        vi. Positive/Negative Results
        vii. Test administered by
        viii. Adverse reactions
I. Providers administering the test must complete all mandatory training and continuing education as required by the local health department, IDPH or the manufacture's recommendation.
    a. List of providers who completed training must be submitted to the EMS prior to administration of the test.
    b. Testing will follow manufactures training materials.
        i. Including video modules
        ii. Completion of skills/written test developed by manufacture.

iii. Continuing education must be done in accordance with manufacturers recommendations or to meet state or federal requirements.

J. It is the agency's responsibility to track all test administered, equipment and supplies. Agencies will be required to maintain equipment and supplies in a manner that is safe and within the manufacturer's recommendations.
K. Proper PPE must be worn during the administration of these test including but not limited to:
    a. Gowns
    b. Gloves
    c. Eye protection or face shield
    d. N95 or higher protection mask
    e. This standard is required for symptomatic and asymptomatic patients.
        i. If a person who is being tested is symptomatic and does not require medical care, that person should be directed back to their homes immediately.
        ii. Any location that symptomatic person was in contact with should be decontaminated with cleaning product that meets CDC criteria for COVID.
        iii. It is recommended that persons who are symptomatic follow up with their primary care physician.
        iv. Persons requiring immediate medical treatment should have the 911 system activated.
L. Testing will only be completed in indoor settings in large enough space for safer airflow (i.e apparatus bay, large training room)
M. All supplies must be disposed of in the proper bio-hazard receptacles per the manufacture requirements.
N. This must not be used on routine 911 calls. This is for internal personnel use only.
O. Consent must be formally recorded, and records kept by the administration of the agency.
P. Adverse issues must be documented. The following should be done for adverse reactions.
    a. Follow basic first aid treatment for persons experiencing adverse reactions such as nose bleeds.
    b. Activate the 911 system for person's experiencing any life-threatening conditions.
Q. The medical director or their designee has ultimate authority to halt testing if any or all these requirements are not followed.
R. EMS may request copies of documentation at various times to ensure compliance with policy.

Point-of-Care Ultrasound

Effective Date: 1/21/2020
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

The use of evolving technologies must be reviewed to determine the feasibility and practicality for use by EMS providers in the pre-hospital setting.

Policy Statement:

Point of Care Ultrasound (POCUS) is a tool that can have benefits for pre-hospital providers when used in the appropriate setting. The use of this application must be carefully implemented and used to better care for the patients we serve. POCUS will be used as a diagnostic tool and not a treatment tool. This policy will review the requirements, training and quality assurance needed to utilize this tool.

Policy:

A. Equipment

a. All devices must be approved by the EMS system prior to use.
b. All equipment must be maintained per manufactures recommendations.
    i. This includes:
        1. Ensuring equipment is properly calibrated.
        2. Ensuring equipment is properly stored and secured.
        3. Ensuring equipment and disposables are not expired, not damaged and in working condition.

B. Education

a. To utilize POCUS EMS providers must meet the following criteria:
    i. Must be an EMT-Paramedic or PHRN
    ii. Must complete initial education program approved by the EMS system.
        1. Initial Education Includes:
            a. Basic operation of device
            b. Troubleshooting device errors
            c. Understanding situations to utilize POCUS.
            d. Understanding of Ultrasound
            e. Basic Scanning and scanning within EMS protocol.
            f. Documentation and quality assurance
b. Providers who are approved to utilize POCUS must train quarterly. Training must include review of the education previously listed.
c. Providers must competency out yearly to continue use of POCUS.

C. Pre-Hospital Usage

a. The usage of POCUS should never delay patient care or transport of a patient.
b. POCUS can only be utilized by approved providers. The use of POCUS is considered a non-required equipment on an ALS unit. This means that if a trained provider is not available,

the unit can still be in service and available to respond. The POCUS equipment shall not be used by a non-trained, non-approved provider.

c. POCUS applications may be used for the following situations:
    i. *The Termination of Resuscitation* – provider can confirm the absences of cardiac activity for cease efforts.
    ii. *Pulse Checks* – the provider can scan the femoral or carotid artery to determine the presence of blood flow.
    iii. *To Differentiate Between Rhythms* – providers can use to differentiate between fine ventricular fibrillation and true asystole.
    iv. *Preforming a Rapid Ultrasound for Shock and Hypotension Exam (RUSH Exam)* – This exam can be used for differential diagnosis and looking for reversible causes of cardiac arrest.
    v. *Preforming a Focused Assessment with Sonography in Trauma Exam (FAST Exam)* – This exam can be utilized to determine the presences of bleeding and injury within the abdominal cavity.

D. Documentation and Quality Assurance

a. When POCUS is used, screen captures of assessment must be uploaded to EMS reporting system.
b. The use of POCUS shall be reviewed by the EMS QA Coordinator. The review will include:
    i. Proper usage of POCUS
    ii. Review for any potential scene delays due to the use of POCUS.
    iii. Proper documentation and reporting of data in ePCR.
    iv. Review any negative outcomes or challenges that occurred during the operation of POCUS.

Point-of-Care Glucometer Maintenance and Record Keeping

Effective Date: 03/2014
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

This policy is to ensure the accuracy and reliability of blood glucose point-of-care measurements performed by system-affiliated providers.

Policy Statement:

Since many EMS treatments rely on blood glucose measurements, it is imperative for point-of-care testing devices to be accurate and dependable. To ensure accurate and reliable blood glucose measurements, certain maintenance, training, and records must be maintained by agencies performing these tests.

Policy:

A. Equipment
   a. Lancets shall be auto-disabling, single-use finger stick devices.
   b. At no time shall glucometers be utilized in a matter not in compliance with manufacturer and/or system guidance.
   c. Glucometer strips shall not be utilized on patients for which the manufacturer states an inaccurate reading will result.

B. Training
   a. Initial
      i. All candidates for system entry shall be trained by their respective sponsoring agency.
      ii. Verification of this training and competency shall be documented on the system entry form under the "skills" section. This training and verification shall be completed on all makes/models of glucometers in service at the sponsoring agency ("general" training shall not be accepted).
      iii. Candidates shall not be approved for system entry until this training and competency documentation is submitted to and approved by the System.
   b. Ongoing
      i. Agencies shall verify *each* provider is competent in performing blood glucose level measurements with all makes/models of glucometer(s) in service at the agency at least once every 12 months.
      ii. This training shall be documented on the system's *Annual Glucometer Training Log* or other such comparable form that captures the same information. The agency's chief officer or designated representative must verify with signature the validity of the document and training.
      iii. This training log shall be submitted to the system during the period of annual vehicle inspections.

iv. If an agency places a new make/model glucometer into service, all personnel shall be immediately re-verified on the new glucometer as otherwise outlined under this subpart.

c. Procedure
   i. The System shall provide a general procedure for blood glucose level testing, to be found in the *System Procedure Manual*. This procedure is not intended to be all-encompassing, but rather to incorporate universal guidelines generally applicable to all point-of-care blood glucose level measurements.
   ii. The agency shall develop an agency-level blood glucose level testing procedure specific for all makes/models of glucometer(s) in use at the agency. This procedure shall be readily available to all agency, System, and regulatory authorities.

d. Maintenance and Quality Controls
   i. Glucometers, test strips, test solution, and other related equipment must be stored at all times in accordance with manufacturer specifications.
   ii. Agencies shall perform all required and recommended manufacturer maintenance and quality control guidelines for all glucometer(s) in use, including but not limited to routine calibration checks.
   iii. These tasks shall be performed on a timetable established by the glucometer manufacturer, but not less than every month.
   iv. A calibration test shall be performed on the glucometer anytime it suffers a significant drop, a harsh environmental exposure, or anytime mandated/suggested by the manufacturer.
   v. This maintenance and quality control activities shall be documented on the system's *Glucometer Maintenance and Quality Control Record* or other such comparable form that captures the same information. The record(s) shall be available upon request of the System or regulatory authorities. A separate log shall be created for each glucometer device in service.

Police K-9 Transport Policy

Effective Date: 01/2018
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

In 2017 the state of Illinois amended the EMS System act with passage of Public Act 100-0108. That legislation authorizes the following: "*An EMR, EMT, EMT-I, A-EMT, or Paramedic may transport a police dog injured in the line of duty to a veterinary clinic or similar facility if there are no person requiring medical attention, or transport at that time. For the purposes of this subsection, "police dog" means a dog owned or used by a law enforcement department or agency in the course of the department or agency's work, including a search and rescue dog, service dog, accelerant detection canine, or other dog that is in use by a county, municipal, or State law enforcement agency*."

Policy Statement:

It is the intention of the McLean County Area EMS System, and its affiliate agencies to be cooperative partners within the public safety community. The EMS System authorizes, but does not require agency affiliates to transport police K-9's.

Policy:

1. EMS agencies have the individual discretion and autonomy to decide whether they will transport police dogs. If an agency chooses to provide this service, they must do so in compliance with this policy.
2. All human patients must be transported or dispositioned in accordance with the systems Patient Right of Refusal Policy and/or Patient Abandonment vs Prudent use of EMS Resources Policy.
    a. The severity of injuries or lack thereof to either a human patient or the K-9 is irrelevant. The human patient will always have priority.
3. Under no circumstance shall an injured K-9 be transported with a human patient. The only acceptable exception to this would be the transport of an injured law enforcement officer and an injured police K-9.
    a. In this instance, the law enforcement officer will be transported to a hospital first. The K-9 can then be transported to a veterinary clinic or similar facility.
4. Under no circumstance shall an injured K-9 be transported to a hospital, as defined by its standard definition and connotation for emergency care.
5. Items which EMS agencies are required to have prescription to purchase such as medications, IV fluids, IV catheters, needles, ET tubes, etc. are prescribed by the EMS System Medical Director. The intended use for these prescription supplies and medications is for use on human patients.
    a. As a result, ILS/ALS services may not perform advanced level procedures on K-9's.
    b. EMR/BLS/ILS/ALS providers are prohibited from administering medication to K-9's other than Oxygen or Naloxone.

6. If a Doctor of Veterinarian Medicine is on the scene, then he/she may utilize supplies and medications that are available on the ambulance, with the exception of controlled substances.

7. The EMS System is not empowered or authorized by the EMS System Act, the Medical Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, or any state administrative rule to create protocols or in any way regulate the practice of veterinary medicine. Related there is no authority for an EMS System to create protocols for the provision of pre-hospital care to animals of any kind.
8. As a result of sections 5 and 6 above, the EMS provider should confine their interventions to transport, BLS bleeding control, and/or basic first aid. It is acceptable to administer oxygen therapy utilizing a pet oxygen mask system.
    a. As Naloxone administration has been included in the basic first aid curriculums for the public, EMS providers at any level may administer Naloxone if necessary to a police K-9. If administered the dosage recommended is 2 mg for an average sized police dog.
9. As there is no patient provider relationship established the EMS System does not make a recommendation regarding the permissibility of the use of lights and sirens in transporting injured police K-9.
10. Due to the protective instincts of these animals, it is recommended that the animal be transported with a handler who is familiar with the commands with which the dog was trained.
11. Due to the protective instincts of these animals, it is strongly recommended that the animal be transported with a muzzle if practical, to protect EMS providers from the possibility of being bitten.
    a. Should an EMS provider be bit, that provider shall follow the significant exposure procedure for their agency in additions to following the procedures outlined in the system communicable disease policy.
    b. In addition to the standard communicable disease policy, verification of the K-9's rabies vaccination status.
12. Agencies which have a working relationship with a law enforcement agency that regularly employs the use of K-9's are encouraged to have a conversation beforehand to identify a plan of action for these situations that is consistent not only with this policy, but also the policies and procedures of the involved law enforcement agency.

Power of Attorney for Healthcare

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To provide direction to the EMS provider who may encounter a person (other than the patient) expressing treatment, refusal of treatment, and transport wishes in cases where the patient cannot express those wishes.

Policy Statement:

A Power of Attorney for Healthcare acts as an agent for a person who is unable to express decisions regarding healthcare. Within the following guidelines, EMS personnel may honor the wishes of the Power of Attorney for Healthcare.

Policy:

EMS personnel may honor the requests of a person purporting to be the patient's Power of Attorney for healthcare when:

A. The patient is unable to express his/her own wishes regarding treatment, transport, or refusal of treatment/transport.

B. EMS personnel are presented with a written Power of Attorney for Healthcare document. The document should list the name and signature of the Power of Attorney for Healthcare, the patient's name and signature, the date the document was signed, and any restriction to the authority of the Power of Attorney for Healthcare.

C. EMS personnel must inform the Medical Control Physician of the presence of the Power of Attorney for Healthcare, the nature of the Power of Attorney for Healthcare document, the patient's condition (i.e., the inability to express his/her wishes), and the direction of the Power of Attorney for Healthcare. The Medical Control Physician must give direction as to whether to concur with the requests of the Power of Attorney for Healthcare.

D. EMS personnel may not honor the request of the Power of Attorney for Healthcare to discontinue resuscitative efforts on a patient in cardiac arrest unless a completed DNR form is presented. The Medical Control Physician must be contacted for direction.

Preceptor Policy

Effective Date: 10/2004
Review Date: 12/2024
Approvals: EMSSC, EMS MD

Background to Policy:

To identify the responsibilities and qualifications for individuals functioning as EMS preceptors within the McLean County Area EMS System, including participation in the Carle BroMenn Medical Center,OSF St. Joseph Medical Center, McLean County Area EMS System Paramedic Program Consortium.

Policy Statement:

The field internship component of any initial EMS education program is one of the most important components. It is necessary to ensure that students are given the opportunity to learn and interact with qualified and competent preceptors.

Policy:

A. Responsibilities

a. Responsible and accountable for decisions made in the field regarding patient care provided by the student.
b. Responsible for orientating, teaching, and supervising students during their field experiences
c. Complete the necessary documentation and evaluations regarding the student's field performance at the end of each shift.
d. Communicate with the MCAEMS System Education Coordinator/Paramedic Program Director monthly to provide a comprehensive evaluation and recommendation, either positive or negative, pertaining to each assigned student.
e. Commit to participate in a minimum of 8 hours' educational time per year in one or more of the following ways
    i. Perform lectures to EMS students
    ii. Teach class skill stations
    iii. Proctor EMS skills testing
    iv. Teach continuing education lectures.
    v. Proctor continuing education skills testing

B. Qualifications

a. To be considered for the position of System Preceptor, the individual must remainactive in the McLean County Area EMS System and must meet the following criteria:
    i. Maintain a valid license at or above the level being precepted.
    ii. The preceptor shall have practiced at their level of licensure level within the state of Illinois for at least 6 months.
    iii. To serve as a primary contact preceptor, the candidate must have practiced within the EMS System for 3 months.
    iv. The preceptor candidate must not be on probation or suspension with the EMS agency they are serving as a preceptor within

v. Successfully complete the Mclean County Area EMS System preceptor workshop
vi. Approval of the MCAEMS Medical Director and the applicant's agency chief officer
vii. Maintain all MCAEMS System requirements for the specific level of licensure.
viii. Attend all updates as needed and presented by the MCAEMS System.

Preparedness to a System-Wide Crisis

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

As a result, dispatch, EMS, and emergency department personnel must be cognizant of evolving trends or the influx of patients with similar signs and symptoms. Recognition of an impending or active system- wide crisis will better prepare participating hospitals and local ambulance providers to handle any type of situation.

Policy Statement:

Natural and technological crises may place an intense demand for EMS and emergency department resources on one or more of the EMS agencies and hospitals in the system. The potential exists for these crises to occur or evolve without adequate warning or notification. Such crises may include a heat emergency, communicable disease or influenza epidemic or terrorist act involving a nuclear, chemical, or biological agent, which could overload an emergency department's resources.

Policy:

A. **Recognition**

- EMD Personnel may be made aware of a system wide crisis by increased EMS requests for similar complaints or symptoms or a large number of patients in a single location whether medical complaint or trauma.
- Telemetry personnel may be made aware of a system-wide crisis by communication from the local ambulance provider (i.e., mass casualty incident) or by noting an increased number of emergency departments requesting ambulance diversion. The telemetry personnel should report these occurrences to the attending emergency doctor or charge nurse.
- When participating, hospitals see a rapid or developing increase of patients with similar symptoms, the attending emergency doctor or the charge nurse should contact their Resource Hospital and apprise them of the situation.
- When ambulance providers or their personnel notice that they have an increase of runs with patients complaining of similar signs and symptoms, they should report this information to their Resource Hospital.

B. **Notification of Personnel**

- The Resource Hospital shall document any calls they receive from their participating hospitals or ambulance providers and identify that they are seeing numerous types of patients complaining of similar types of symptoms. The Resource Hospital should note the time the call is received and seek a detailed account of the situation.
- If the Resource Hospital receives calls or has reason to suspect a potential system-wide crisis, the ECRN will page the EMS Coordinator or EMS Medical Director to inform them of the situation. The EMS Coordinator or EMS Medical Director will

contact the local ambulance provider(s) to see if they are seeing an increase in patients with similar types of symptoms.

- The EMS Coordinator or EMS Medical Director may also contact the Illinois Poison Control
  Center to see if they are receiving additional calls for similar type symptoms.
- If there appears to be a trend, pre-hospital, or hospital, of increased frequency of similar symptoms, the EMS Coordinator or EMS Medical Director shall page the Emergency Officer for the Illinois Department of Public Health at 1-800-782-7860. In addition, if there is a local health department medical director, that person may also be contacted. Associate, participating and adjoining EMS system hospitals and agencies may be contacted as necessary.
- The Emergency Officer for the Illinois Department of Public Health will contact the Director of Public Health, or his designee, and the Duty Officer with the Illinois Emergency Management Agency. Based on the type and magnitude of the crisis, the Director of Public Health, or his designee, may activate the RHCC, according to the State Medical Disaster Plan.

C. **Plan of Action**

- Once notified by the Illinois Department of Public Health that there may be a potential for increased utilization of resources, the EMS Coordinator will contact the participating hospitals and local ambulance providers within the System to inform them of the crisis. The EMS Coordinator will request that each participating hospital take steps to avoid ambulance diversion and alert them to the possible need of having to mobilize additional staff and resources or activate their internal disaster plans. The EMS Coordinator may request assistance from the RHCC and/or IDPH. The participating hospitals will also be informed that requests for BLS diversion will not be accepted during the crisis.
- The EMS Coordinator or most senior EMS person staffing telemetry will monitor transport times, while the local dispatch center that receives 911 calls will monitor ambulance responses. If transport times begin to exceed 10-15 minutes and ambulance response times become excessive as a result of hospitals being on diversion, IDPH Division of EMS will be contacted and will assist in contacting the Emergency Department Charge Nurses and Senior Administrators of the participating hospitals on diversion to advise them to activate their internal disaster plans so that they can rapidly come off diversion. They will be given a specified time frame in which to accomplish this.
- The monitoring of transport and ambulance response times requires frequent communication and close coordination between EMS personnel at the Resource Hospitals, dispatch and the local fire departments.
- During an impending or actual system-wide crisis, the local municipality may request mutual aid, through pre-existing agreements, from the surrounding areas.
- All information shall be recorded on the “System-Wide Crisis Form,” developed by the Illinois Department of Public Health which will be available upon request.

D. **All Clear**

1. The Director of Public Health, or his designee, will contact the Resource Hospital when the response to the crisis appears to be over.

Record Retention Policy

Effective Date: 12/2023
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

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

Policy Statement:

The System has developed and established the following policy and procedure regarding retention of records including PCRs, ALS Telemetry Calls and Logs, MERCI calls and other System documentation as stated below.

Policy:

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

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

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

1. A patient care run report shall be completed by each Illinois-licenses transport vehicle service provider for every inter-hospital transport and pre-hospital emergency call, regardless of the ultimate outcome or disposition of the call.
a. One patient care report shall be provided (paper or electronic) to the receiving hospital emergency department or health care facility before leaving this facility.

b. Each EMS System shall designate or approve the patient care report to be used by all its vehicle providers. The report shall contain the minimum requirements listed in Appendix E of the EMS Rules and Regulations.

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

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

1. All radio and cell phone reports from EMS providers to the receiving hospital are recorded on a radio log at the receiving hospital.

2. All calls are recorded at the receiving hospital.

3. All radio logs and recordings are kept by Resource, Associate and Participating Hospitals for a period of not less than seven years.

Region II School Bus Policy

Effective Date: 10/2004
Review Date: 06/2015
Approvals: EMSSC, EMS MD

Background to Policy:

Incidents involving school buses pose unique challenges to the EMS provider in assuring proper release of uninjured children. Once Medical Control confirms that the minor children are not injured, the custody and responsibility for these children will remain with the responding EMS provider until the children are transferred to parents, legal guardians, school officials or the hospital. If no procedure exists to have children transferred to a parent, legal guardian or school official, then these children will need to be transported to the Hospital.

Policy Statement:

On arrival at the scene, EMS personnel shall determine the category of the incident and request appropriate resources. EMS must also accomplish a complete assessment of the scene to include at least:

- mechanism of injury
- number of patients
- damage to the vehicle
- triage as outlined in the System Plan

Policy:

Once this has been accomplished, then the patients may be assigned to one of the following categories:

CATEGORY A: Significant mechanism of injury (i.e. rollover, high speed impact, intrusion into the bus etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have significant injuries or significant injury is present in one or more children. *All children in this categ01y must be transferred to an appropriate hospital unless a refusal form is signed by a parent or legal guardian.*

CATEGORY B: Suspicious mechanism of injury (i.e. speed of impact, some intrusion into the bus, etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have minor injuries or minor injury in one or more children exists with no obvious mechanism of injury that could reasonably be expected to cause significant injuries. *EMS personnel must complete the EMS School Bus Release form and secure a signature of an appropriate school official.*

CATEGORY C: No obvious mechanism of injury-school bus occupancy indicates no injuries may be present and that the release of uninjured children may be the only EMS need. No injuries are found to be present in any of the children. *EMS personnel must complete the EMS School Bus Release form and secure a signature of an appropriate school official.*

CATEGORY D: If the pediatric patient(s) have special healthcare needs and/or communication difficulties, then all of these patients must be transported to the hospital for evaluation unless approval for release is received from Medical Control or a parent/legal guardian has signed the approved refusal form.

1. After determining the category of the incident, EMS personnel shall determine the extent of EMS involvement and contact Medical Control.

2. Adults, victims 18 years and older, and occupants of other vehicles will be treated or released in accordance with routine System operating procedures.

3. If Medical Control has approved usage of this policy/plan, then each provider will implement their procedure for contacting parents, legal guardians or appropriate school officials to receive custody of uninjured children.

4. The approved regional/System School Bus Release form for school bus incidents must be utilized for all children who will not be transported.

5. Each child transported must have a completed individual run report left at the ED on completion of the call.

6. A run report indicating the nature of the incident, etc. should be completed according to System policy and should include all information regarding the incident including the number of patients released. A copy of the report with the release form or with refusal forms signed by the parents or school officials should be kept on file per System policy.

7. A parent, legal guardian or appropriate school official must be given a copy of the refusal/release form.

8. Any parent or legal guardian who arrives on scene to remove and assume responsibility for their child will be requested to sign an individual refusal form.

9. EMS providers shall use reasonable means to contact parents and/or school officials. This could include use of telephone, cell phone or direct contact by Jaw enforcement. If contacted by phone, EMS providers shall take reasonable means to confirm the identity and authority of the parent, legal guardian or school official.

10. Once the identity and authority of the parent, legal guardian or school official has been established, the EMS provider may release the child to that individual or alternate transport source. School officials will follow their established program for informing parents or legal guardians regarding the incident.

11. *The health and safety of the child is the primary concern.* It is the responsibility of the EMS provider to assure that the child is returned to the parent or placed on the school's alternate transport vehicle. If the EMS provider on scene determines whether a child should receive a physician evaluation or be offered medical care, the

child *will be transported to the hospital unless* a parent or legal guardian is on scene and consents to refusal.

12. Each prehospital provider agency in the affected System who may likely respond to a school bus incident must contact the school superintendents in their district to obtain the name and title of the "appropriate school official" who may take responsibility for the child on the bus involved in the incident.

13. Copies of documentation must be forwarded to the EMS office for review within 24 hours of the incident or per System policy.

14. A separate refusal or run report will be documented for the driver of the bus. He/she should not be included in the multiple school-bus refusal form.

Relinquished Newborn Policy

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To establish a consistent method of action associated with the receipt of newborn infants who, under the Abandoned Newborn Infant Protection Act, 325 Ill. Comp. Stat. § 2/1 *et seq.*, may be legally relinquished to the care and custody of a hospital, manned fire station or other emergency medical facility.

Policy Statement:

As directed by the Illinois Abandoned newborn Infant Protection Act, 325 Ill. Comp. Stat. § 2/1 *et seq.*, the personnel within McLean County Area EMS System, must accept and provide all necessary care to a newborn infant, who is relinquished at any staffed fire or EMS station that has been designated as a safe - surrender site.

Policy:

This policy addresses infants who are 30 days old or less and are relinquished under the terms of the Abandoned Newborn Infant Protection Act. Abandonment of an infant not covered by this policy would be subject to the Child Abuse Policy.

1. All department stations shall clearly display the appropriate signage identifying the station as a drop-off location (325 ILCS 2/22). In addition, fire station lobbies should display public outreach brochures obtained from the state or the local child welfare agency.

2. All department stations should have a person designated to manage materials and information packets regarding the Abandoned Newborn Infant Protection Act.

3. Qualified personnel should accept a relinquished infant, even if the infant appears older than 30 days old. If the infant appears to be older than 30 days, the receiving personnel should immediately notify law enforcement and the Department of Children and Family Services (DCFS), as provided in the Child. Abuse Policy.

4. If it appears that the infant has been the victim of child abuse or neglect, law enforcement personnel should be requested as provided in the Child Abuse Policy (325 ILCS 2/25).

5. Notify the Dispatch Center so that an ambulance and paramedic unit may be dispatched to transport the relinquished infant to the nearest hospital (325 ILCS 2/20).

6. Receiving personnel shall verbally inform the person that if the person chooses to remain anonymous, he/she must petition the appropriate court to prevent termination of parental rights and/or regain custody of the child (325 ILCS 2/30).

7. Receiving personnel shall make a good faith effort to provide the relinquishing person with an information packet containing the required brochures and other resources related to the Abandoned Newborn Infant Protection Act (325 ILCS2/35).

8. The relinquishing person should be encouraged to accompany the infant to the hospital to give the medical history directly to the hospital staff and should be reassured that the same protection from prosecution and the ability to relinquish the infant is available at the hospital.

9. If the relinquishing person does not wish to accompany the infant to the hospital, he/she should be encouraged to complete the medical questionnaire and should be given assistance, if needed.

10. If the relinquishing person is unwilling to complete the questionnaire and unwilling to accompany the infant to the hospital, personnel should make a good faith effort to provide the relinquishing person with any forms or written materials to be filled out later and returned by mail.

11. If an individual returns to claim a relinquished infant:

- The relinquishing person must be informed of the name and location of the hospital to which the infant was transported and should also be referred to DCFS (325ILCS 2/20).
- The identity of the relinquishing person must still be kept confidential.
- Department members should not make any judgments about time frames or the individual's ability to care for the infant. The local DCFS will determine whether the infant is released to the individual.

Reporting of Suspected Crimes and Crime Scenes

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To establish procedures to follow at the scene of a suspected crime to ensure proper patient care while preserving the scene.

Policy Statement:

Often the First Responder, EMT, or Pre-hospital RN may arrive at the scene of a violent crime before the police arrive. This requires an understanding by the EMS Crew of law enforcement in preserving, collecting, and using evidence. Anything at the scene may provide clues and evidence for the police.

Policy:

A. It is the duty of EMS personnel to notify the local law enforcement agency when it is suspected that the patient receiving treatment by EMS personnel:
   i. Has any injury resulting from the discharge of a firearm.
   ii. Has any injury sustained in the commission of or as a victim of a criminal offense.
   iii. Is a victim of suspected child abuse or neglect.
   iv. Is a victim of suspected elderly abuse or neglect?

B. Upon arrival at the suspected crime scene, note the following:
   v. Immediately notify the police or request the dispatch center to do so.
   vi. If the victim is obviously dead, then he or she should remain undisturbed. Even the position of the body can provide valuable clues.
   vii. Do not touch, move, or relocate any item at the scene unless absolutely necessary to provide treatment to an injured victim. You should mark the location of any item that must be moved so the police can determine its original position. (Refer to "Interaction of Law Enforcement/Evidence" policy).
   viii. Do not allow onlookers or other unauthorized personnel on the premises of the crime.
   ix. Observe and note anything unusual, especially if the evidence may not be present when the police arrive. This may include smoke and odors.
   x. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt treatment. Remember, your role is to provide emergency care, not law enforcement or detective work.
   xi. Keep detailed records of the incident including your observations of the victim and the scene of the crime. In many felony cases, EMS personnel are called to testify since they were first on the scene, and lack of records about the case can be professionally embarrassing.
   xii. Once the police arrive you should leave or at least not hinder their work, however, you should give them any information you believe would be useful.

Resource Hospital Medical Control Overrides

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure a mechanism whereby the Resource Hospital will override an associate hospital's orders in an appropriate and ethical fashion.

Policy Statement:

If an Associate Hospital is assigned Medical Control responsibilities, the Resource Hospital reserves the right to override the delegated medical control to ensure appropriate patient care.

Policy:

Definition:

An override call occurs when Resource Hospital personnel intercede the medical direction of a pre- hospital call directed by an Associate Hospital. The override may be requested by the EMT-B, EMT- I, EMT-P, ECRN, Pre-hospital RN and initiated by the on-duty Medical Control Emergency Department Physician at the Resource Hospital.

Indications for Override

i. When the original medical control of the call by Associate Hospital personnel could result in unreasonable or medically inaccurate treatment causing potential harm to the patient.
ii. Undue delay in initiating transport of a critically ill patient. (Greater than 20 minutes)
iii. When there is no response from the Associate Hospital to the EMT or Pre-hospital RN after three attempts to contact.
iv. When Associate Hospital personnel have provided medical orders that fall outside the approved MCAEMS System protocols.
    A. Intervention
v. Associate Hospitals are located in communities at a distance greater than 30 miles. The Associate Hospitals only serve as medical control for BLS, ILS, and ALS transport providers. The Associate Hospitals utilize the VHF radio, UHF, or cellular to communicate with EMS agencies.
vi. If the pre-hospital care provider encounters an indication for a Resource Hospital override, the EMT/Pre-hospital RN shall notify the Associate Hospital with the request for override and terminate communications with the Associate Hospital.
vii. The pre-hospital care provider shall then contact the Resource Hospital and notify the Medical Control Emergency Department Physician of their determination for override and relay the patient's pertinent medical history and condition for appropriate medical control guidance.
viii. After medical control guidance has been completed, the Resource Hospital Medical Control physician shall notify the Associate Hospital physician that an override was initiated and completed. All pertinent information shall be conveyed to the Associate Hospital regarding an up-date on the patient's medical status and the pre-hospital treatment rendered. The

Associate Hospital shall be given an estimated time of arrival of the patient to their facility.

ix. The Resource Hospital Medical Control Physician and the EMS provider shall both submit, in their own perspective, a written summary of the intervention, including the reason(s) for the requested, granted/denied resource hospital override. The summary shall be written on an "Incident Report Form" and submitted to the McLean County Area EMS System.

x. A summary of the intervention shall also be written by the Associate Hospital Medical Control physician and submitted to the McLean County Area EMS System.

xi. Only those physicians listed below may grant or deny a request for Resource Hospital Medical Control Override.

12. EMS Medical Directors
13. On-duty Emergency Department physicians at Carle BroMenn Medical Center and OSF St. Joseph Medical Center.

Rural Population Staffing Credentialling Waiver

Effective Date: 12/2023
Review Date:
Approvals: EMSSC, EMS MD

Background to Policy:

The ongoing shortage of volunteer EMS providers in rural areas has put a burden on the EMS System. This provision will allow for McLean County Area EMS System to submit an Alternative staffing waiver request to IDPH which would allow registered nurses, physician assistants, and advanced practice nurses to volunteer and function under the same scope as an EMT-Basic in their community for a period of one year.

Policy Statement:

An EMS agency in the system who wishes to utilize a Registered Nurse, Physician Assistant, or Advanced Practice Nurse as a volunteer may submit a written request to the Medical Director to function as an EMT-Basic scope of practice if the following conditions have been met.

Policy:

1) Completion of a McLean County Area System Entry Packet (available on website or at office)

2) A copy of a valid registered nurse, physician assistant, or advanced practice nurse license.

3) Proof of 20 hours of initial prehospital education (to include at a minimum*: airway management, ambulance operation, ambulance equipment, extrication, telecommunication, prehospital cardiac, and trauma care)* to be made available on MCAEMS Educational Platform.

4) Completion of 8 *hours of observation riding time* at an approved agency.

5) Letter of recommendation from agency administration.

6) Upon submission of required application, pre-hospital continuing education hours, and letter of recommendation from agency administrator, volunteer status will be granted for one year.

Service Animal Policy

Effective Date: 11/2011
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

The purpose of this policy is to provide direction for the interaction and safe disposition of service animals when their handler is transported by EMS.

Policy Statement:

EMS providers often encounter patients with chronic conditions that necessitate the use of a service animal. This policy outlines guidelines for interaction and safe disposition of service animals when their handler is transported by EMS.

Policy:

1. The Americans with Disabilities Act defines a service animal as:
   Service animal means any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Other species of animals, whether wild or domestic, trained or untrained, are not service animals for the purposes of this definition. The work or tasks performed by a service animal must be directly related to the handler´s disability. Examples of work or tasks include, but are not limited to, assisting individuals who are blind or have low vision with navigation and other tasks, alerting individuals who are deaf or hard of hearing to the presence of people or sounds, providing non-violent protection or rescue work, pulling a wheelchair, assisting an individual during a seizure, alerting individuals to the presence of allergens, retrieving items such as medicine or the telephone, providing physical support and assistance with balance and stability to individuals with mobility disabilities, and helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors. The crime deterrent effects of an animal´s presence and the provision of emotional support, well-being, comfort, or companionship do not constitute work or tasks for the purposes of this definition.

2. In addition to dogs, miniature horses may also serve as a service animal under 2011 guidance from the US Department of Justice. Based on the size of the miniature horse, EMS may or may not be able to transport the animal due to size limitations.
3. Providers should not speak to or touch a service animal unless given permission by the handler
4. If the handler is incapacitated and cannot manage the service animal, local law enforcement and animal control should be contacted for assistance.
5. If the handler is transported
    a. Every reasonable effort shall be made to ensure the service animal goes to the hospital.
        i. The first and ideal option would be to have a friend or family member transport the animal to the hospital. Law enforcement may be willing to assist and transport the animal. Consider the use of other agency vehicles e.g., ambulance assist non-transport EMS or command vehicles. The service animal may be

transported in the ambulance in the cab area as a first choice and in the patient area as a last resort. Consultation with the handler is strongly encouraged.

b. Notify the receiving hospital that a service animal will be arriving with the patient.

6. Refusal to transport the service animal can only be made when the presence of the animal jeopardizes patient and/or crew safety and/or when the presence of the animal significantly impedes or negatively affects patient care. This threat and negative impact must be real and not perceived (such as “sometimes dogs bite” or based upon past experience “another service dog acted up”).
    a. Refusal to transport a service animal and the reason must be documented in the patient care report along with the disposition actions taken to ensure the service animals safety.
    b. If the crew or handler refuses the transport of the service animal, the providers shall make every reasonable effort to ensure the animal remains safe, is properly secured, and cared for.

Sexual Harassment/Discrimination

Effective Date: 10/2012
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure that individuals are treated fairly and with respect, and that any harassment instances will be handled accordingly.

Policy Statement:

The McLean County Area EMS System values diversity in the workforce and education communities. Accordingly, discrimination based on race, sex, national origin, religion, age, disability, marital status, parental status, veteran's status, sexual orientation, genetic information, or any other characteristics as defined by state and federal law is explicitly prohibited.

Policy:

Sexual harassment, a form of sex discrimination, is defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical conduct of a sexual nature when:

A. Submission to such conduct is made whether explicitly or implicitly a term or condition of an individual's employment or enrollment.
B. Submission to or rejection of such conduct by an individual is used as the basis for employment or enrollment decision affecting such individual; or
C. Such conduct has the purpose or effect of substantially interfering with an individual's work performance or enrollment, creating an intimidating, hostile, or offensive work or academic environment.

Sexual harassment is strictly prohibited. Occurrences will be dealt with in accordance with the general guidelines listed in the student manual and associated system rules.

Spit Guard Policy

Effective Date: 09/2018
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

When responding to a variety of emergency medical calls, occasions arise when patients become combative. It is in the best interest of the provider(s) to take appropriate actions to protect the patient and the provider(s) from further injury or complications.

Policy Statement:

The purpose of this policy is to define the appropriate steps when utilizing a system approved spit-guard.

Policy:

A. When a 911 call is initiated, and concerns arise in regard to safety of the responders, standard precautions should be taken. This includes staging away from the scene until secured by law enforcement, utilizing law enforcement to search and/or secure the patient or restraining the patient per the *Patient Restraint* policy.

B. If a patient becomes aggressive and threatens or attempts to spit or spread their own personal secretions, providers may utilize a system approve spit guard. This device is not to be used as punishment for the patient, but rather protecting providers from unwanted spread of bodily fluid.

C. When utilizing system approved spit guard, the providers must assess vitals as soon as possible including skin color and condition, pulse oximetry, heart/pulse rate, respiratory rate, and blood pressure. Vitals must be recorded every 5 minutes with these patients. Assessment of respiratory effort should be documented in detail.

D. The spit guard should be removed immediately if there is a change in level of consciousness, increased respiratory effort is noted, sudden onset of respiratory distress is noted or any signs or symptoms of patient condition is deteriorating.

E. Providers must thoroughly document continuous assessment throughout transport of the patient.

F. Quality Assurance measures will be utilized to track and monitor these events to ensure that proper application, assessment, and documentation are recorded.

Additional Notes

a. To utilize this policy, agencies must demonstrate through training records that they have had didactic and psychomotor training in the proper application of this device and how to properly monitor and document usage of this policy. Failure to provide proper training could result in removal of equipment and/or suspension of a provider's license.

System Entry Policy

Effective Date: 11/2011
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

To ensure the protection of patients, Emergency Medical Service (EMS) providers have an ethical and moral responsibility to provide care to all patients to the best of their abilities. In this role, they must demonstrate continued competence.

The McLean County Area EMS System requires demonstrated knowledge on a written exam for all Basic/Intermediate/Paramedic level personnel entering the system. The McLean County Area EMS System requires demonstrated competence on a practical competency exam for all Intermediate/Paramedic level personnel entering the system.
All First Responders must demonstrate competency to their individual hiring agencies' EMS officer.

Policy Statement:

The following will provide guidelines for entry into the McLean County Area EMS System.
If an individual participates in another EMS System, they will be required to identify which system is primary and secondary. If MCAEMS is listed as secondary, all license renewals will be completed through the primary system.

Policy:

A. System Entry Written Exam

a. All Basic (BLS), Intermediate (ILS), Paramedic (ALS), Prehospital registered nurse (PHRN), Prehospital Physician Assistant (PHPA), and Prehospital Advanced Practice RN (APRN) applicants must pass a written exam prior to approval to function in the McLean County Area EMS System (MCAEMS). Exam questions may cover: MCAEMS protocols, policies, and procedures as well as the most current national standard curriculum. In order to pass the written exam, applicants must achieve a score of 80% or higher. The BLS written exam will consist of 50 multiple choice questions. The ILS and ALS written exam will consist of 100 questions. Applicants will have a maximum of three (3) attempts to successfully complete the system entry written exam without the Medical Director's approval. If the applicant fails the first attempt, a second attempt may be scheduled only after a remediation plan, written by the applicant and approved by the MCAEMS office, is successfully completed. The second attempt will be scheduled as dictated by the remediation plan, but not less than two (2) weeks after the initial attempt. If the applicant fails the second attempt a third attempt may be scheduled only after a remediation plan, written by the applicant and approved by the MCAEMS office, is successfully completed. The third attempt will be scheduled as dictated by the remediation plan, but not less than three (3) weeks after the

second attempt. After the third failure of the written exam, any subsequent attempts must be approved in writing by the MCAEMS Medical Director.

B. System Entry Practical Exam

a. First Responder (FR) and BLS applicants must successfully complete a procedure competency exam at their hiring agency. A Procedure Competency Form must be completed by their sponsoring agencies' Training Officer. FR and BLS providers will not be allowed to function in the system until this form is completed and submitted to the MCAEMS System Office.

b. Applicants at the ILS, ALS, PHRN, PHPA, and APRN level must successfully complete a practical competency exam before being approved to function in the system. Each practical exam will consist of two (2) or more scenarios that may be traumatic emergencies, medical emergencies or a combination of both, patients can be single or multiple and of any age ranging from neonate to geriatric.
Each scenario will be scored using the National Registry of EMT's assessment skill sheets. In order to pass the practical competency exam, an applicant must score 80% or higher and must not commit a critical failure item. Each scheduled practical exam session will be counted as a single attempt. Applicants will have a maximum of three (3) attempts to successfully complete the system entry practical exam. Any attempts beyond three will require the Medical Director's approval. If the applicant fails the first attempt, a second attempt may be scheduled only after a remediation plan, written by the applicant and approved by the MCAEMS office, is successfully completed. The second attempt will be scheduled as dictated by the remediation plan, but not less than two (2) days after the initial attempt. If the applicant fails the second attempt a third attempt may be scheduled only after a remediation plan, written by the applicant and approved by the MCAEMS office, is successfully completed. The third attempt will be scheduled as dictated by the remediation plan, but not less than two (2) weeks after the second attempt. After the third failure of the practical competency exam, any subsequent attempts must be approved in writing by the MCAEMS Medical Director. The applicant will be required to pay a $75.00 fee to the McLean County Area EMS System for each attempt after the third attempt. Each attempt will be treated as an independent attempt. At least one different evaluator shall be present at each attempt after the second attempt.

C. Remediation Plan

a. After a failure of the system entry practical or written exam applicants must complete a remediation plan to qualify for a retake. The remediation plan should identify the deficiencies that lead to the failure and articulate steps to be taken to correct the identified deficiencies. Remediation plans will be created by the applicant after consultation with the MCAEMS System Education Coordinator. On the second attempt the remediation plan must be approved by the MCAEMS System Education Coordinator. On the third and subsequent attempts the remediation plan must be approved by the MCAEMS System Education Coordinator and the MCAEMS System Coordinator.

System Participation Suspensions

Effective Date: 10/2004
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

1. To ensure the right of due process to all participants within the McLean County Area EMS System. To allow for internal resolution of problems within the McLean County Area EMS System primarily with the assurance of further consideration of the matter if anyone should contest the initial decision and subsequent action.

Policy Statement:

1. The McLean County Area EMS System is dedicated in providing quality pre-hospital patient care through EMS System personnel whose performance and conduct are satisfactory. The EMS Medical Directors may suspend any System participant, agency or individual, who does not conform to System policy and procedure or protocol.

Policy:

a. All EMS System personnel are expected to maintain a proper and professional manner in the delivery of patient care. Personnel whose conduct deviates from this will be given an opportunity to correct their conduct. The EMS System Coordinator will assist in this effort. A conference will be held with the individual; disciplinary action will be taken based on the outcome of the conference, and the nature, seriousness and circumstances surrounding the individual's misconduct.

b. In case of serious misconduct, the EMS Medical Director may bypass the verbal and/or written warning process and suspend the individual from the EMS System.

c. The normal progression of disciplinary action shall be as follows:

   i. **VERBAL WARNINGS** - EMS Medical Director or designee shall inform the individual of reported misconduct, discuss means of correction, and inform the individual of the consequences, if the misconduct is not corrected. Documentation of this conference will be placed in the individual's file.

   ii. **WRITTEN WARNING** - EMS Medical Director or designee shall inform the individual in writing about the misconduct. The individual shall be requested to sign the warning indicating it was received. A conference shall take place between the EMS Medical Director or designee, EMS System Coordinator, and the individual. At that time, the reported misconduct, means of correction and consequences of continued misconduct shall be explained and discussed. Documentation of the written warning and conference shall be placed in the individual's system file indefinitely.

   iii. **SUSPENSION** - System suspension shall follow the written warning in instances where the individual has failed to correct misconduct. Instances where suspension is the first disciplinary action taken are outlined within this policy.

d. The EMS Medical Director may suspend from participation within the EMS System or discipline any individual, individual provider or other participant within the EMS System considered not to be meeting the standards of the approved EMS System.

e. Upon notification to an individual that they have been suspended from participating in the system, the MCAEMS System Coordinator will notify the System Coordinator of any other system that that individual is known to be functioning in. Notification will be made via email and phone call immediately upon decision for suspension.

f. Those standards include:

- **i.** Failure to meet the education and training requirements prescribed by the Department or by the EMS Medical Director(s).
- **ii.** Any violation of the Illinois EMS Systems Act.
- **iii.** Failure to maintain proficiency in the provision of first responder, basic, intermediate or advanced life support services.
- **iv.** Failure to comply with any provision of the System's Program Plan approved by the Department
- **v.** Intoxication or personal misuse of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the delivery, performance, or activities in the care of patients requiring medical care.
- **vi.** Intentional falsification of any medical reports or orders, making misrepresentations involving patient care, or engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.;
- **vii.** Abandoning or neglecting a patient requiring emergency care.
- **viii.** Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, health care facility, institution, or other workplace location.
- **ix.** Performing or attempting emergency care, techniques or procedures without proper permission, certification, training, or supervision.
- **x.** Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay.
- **xi.** Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.
- **xii.** Violation of the System's standards of care.
- **xiii.** Physical or mental impairment to the extent that he/she cannot physically perform emergency care or cannot exercise appropriate judgment, skill, and safety for performing emergency care, unless the person is a First Responder, EMT-B, EMT-I, EMT-P or Pre-hospital RN on inactive status pursuant to Department regulation.
- **xiv.** Providers who are charged with felonies while still in the system.

g. The process for System Participation Suspension shall fully comply with the Illinois EMS Systems Act [210 ILSC 50] pursuant to Section 515.420 of the Administrative Code [77 Ill Adm. Code 515], those regulations are as follows:

- **i.** An EMS Medical Director may suspend from participation within the system any individual, individual provider or other participant considered not to be meeting the

requirements of the program plan of that approved EMS System. (Section 3.40(a) of the Act)

ii. Except as allowed in subsection (I) of this Section, the EMS Medical Director shall provide the individual, individual provider, or other participant with a written explanation of the reason for the suspension; the terms, length and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.

iii. Failure to request a hearing within 15 days shall constitute a waiver of the rights to a Local System Review Board hearing.

iv. The EMS System shall designate the Local System Review Board, consisting of at least three members, one of who is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. (Section 3.40(e) of the Act)

v. The hearing shall commence as soon as possible but at least within 21 days after receipt of a written request. The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the Local System Review Board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the Act and this Part. (Section3.40(e) of the Act)

vi. 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, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing.

vii. 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.

viii. 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, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.

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

x. If the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for review of

the Local Board's decision by the State EMS Disciplinary Review Board. (Section 3.40(b)(2) the Act

xi. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the Local Board's decision or the EMS Medical Director's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed. (Section 3.45(h) of the Act).

xii. An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information is his or her possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS Medical Director which states the length, terms and basis for the suspension. (Section 3.40(c) of the Act)

xiii. Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger or telefax, a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the EMT or provider.

xiv. Within 24 hours following the commencement of the suspension, the suspended EMT or provider may deliver to the Department, by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMT or provider feels relate to that response.

h. Within 24 hours following receipt of the EMS Medical Director's suspension order or the EMT or provider's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the EMT's or provider's opportunity for hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended EMT or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee. (Section 3.40(c) of the Act)

Updates to EMS System Manual

Effective Date: 06/2017
Review Date: 8/2023
Approvals: EMSSC, EMS MD

Background to Policy:

EMS is a fast-evolving practice of medicine. From time to time the McLean County Area EMS System makes updates to policies and standing medical orders.

Policy Statement:

This policy ensures that system affiliate agencies are informed in a timely fashion of changes to system materials including policies, procedures, and the standing medical orders

Policy:

1. All changes to any of the above-mentioned items must be approved by the EMS System Coordinator and the EMS System Medical Director.
2. Once approved the revision is forwarded to the Region 2 IDPH Regional Emergency Medical Services Coordinator.
3. Once the EMS System has received an approval letter from the Illinois Department of Public Health the EMS System will conduct education through assorted means to assure information has been disseminated. These methods can include in person education, online education, correspondence education, or any other manner determined to be acceptable by the EMS System Medical Director or his designee.
4. The McLean County Area EMS always displays the most current version of information on its website http://www.mcleancountyems.org
5. Individuals and agencies may also purchase from Starnet publishing printed manuals at their own expense.

Use of Rescue Task Force in Active Shooter Situations

Effective Date: 11/2016
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

Active shooter situations are at their most basic level, crime scenes that have injured people in need of treatment, rescue, and expedient evacuation. Each incident is primarily a law enforcement event but requires coordination between law enforcement and EMS. EMS should recognize that law enforcement will initially be sending officers into the impacted area to directly engage the threat and to secure a perimeter. EMS providers should utilize this initial period to begin planning for rapid triage, treatment, and extrication of the wounded.

Policy Statement:

Since the inception of EMS the paradigm for responding to incidents involving active shooters has been to stage in the cold zone away from danger until law enforcement has completely secured the entire facility. With the rise, both in number and profile of these incidents, EMS agencies and providers nationwide have been looking at new ways to respond to these incidents. The Hartford Consensus identifies the importance of initial actions to control hemorrhage as a core requirement in response to active shooter incidents. Experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage. Well documented clinical evidence supports this assertion.

Policy:

a. Not all agencies within the EMS System will have the resources and support needed to implement the rescue task force concept. EMS agencies are under no requirement to implement a rescue task force procedure. However, agencies who do so are required to do so in compliance with this policy.

b. All developed rescue task force programs shall be designed with the following core tenants of the Hartford Consensus in mind, easily remembered by the acronym **THREAT**

i. **T**hreat Suppression (By law enforcement)
ii. **H**emorrhage Control
iii. **R**apid **E**xtrication to Safety
iv. **A**ssessment by medical providers
v. **T**ransport to definitive care

c. Agencies wishing to develop a rescue task force for the response to active shooter situations must do so in conjunction with the law enforcement agency having jurisdiction. A memorandum of understanding must be submitted to the EMS office signed by the lead administrators of both the law enforcement and EMS agency. At a minimum it must outline roles and responsibilities of each agency will be, a statement that they are supportive of the program, and how law enforcement and EMS will communicate on an incident site.

d. Agencies wishing to develop a rescue task force must jointly conduct a full-scale exercise with law enforcement authorities prior to implementation of the rescue task force concept. Exercises that have occurred prior to this policies implementation date will count. Full scale exercises shall be conducted at minimum once every four years.

e. Agencies wishing to develop a rescue task force must have written policies and procedures in place outlining the purpose and scope of the program. Those policies shall be reviewed by the EMS System prior to implementation.

f. Pursuant to the system conceal and carry policy and to 430 ILCS 66/65 EMS providers will not enter an active shooter situation with a firearm. The only exception to this policy is if the EMS provider is also a sworn law enforcement officer.

g. EMS providers shall operate in a designated cold or warm zone. EMS providers shall not knowingly enter a hot zone

- **i. Cold Zone:** the area of an incident free from potential harm and maybe safely used as planning, staging, and treatment without threat.
- **ii. Warm Zone**: The area of an incident police have cleared, but not yet secured; there is still a minimal risk of harm.
- **iii. Hot Zone**: The area of an incident police have not yet cleared or secured, and there is still a high potential of harm

h. Any EMS provider or team of EMS providers entering a warm zone shall be escorted by a minimum of 2 law enforcement officers, with a preference of additional law enforcement personnel if available.

i. If an area that was previously designated as a warm zone becomes a hot zone, EMS providers shall be evacuated at first opportunity with their law enforcement escort but may be directed to a hard cover location at the discretion of said escort members. This would only be in the event of imminent threat resulting in immediate law enforcement engagement.

j. EMS providers shall not enter the scene with the first wave of officers as their primary objective is threat neutralization/isolation.

k. EMS providers should utilize any and all protective equipment as prescribed by their agency. Agencies should select protective equipment based on a risk analysis and likelihood of an active shooter event in their jurisdiction. The EMS system does not specify the type of protective equipment that agencies are required to provide outside ofthe required body substance isolation precautions prescribed by the system infection control plan, and Illinois Department of Public Health regulation.

l. EMS providers participating on a rescue task force should have regular training on hemorrhage control techniques, including the use of tourniquets, pressure dressings, and hemostatic agents (Quick-Clot). ILS/ALS providers should also have regular training on thoracic needle decompression.

m. The focus of emergency care provided in the warm zone shall focus on bleeding control and basic airway management. It is understood by all parties that medical care in the warm zone will not be as comprehensive as that provided in the cold zone. All medical

equipment that will be utilized by rescue task force members shall be approved by the EMS System. Medical care provided in the cold zone will be in accordance with the appropriate MCAEMS SMO/Protocol.

Vaccine Administration

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

Following the 2009 H1N1 Flu outbreak and the 2020 COVID-19 pandemic, the Illinois Department of Public Health has allowed EMT-P, EMT-I and AEMT to administer vaccines.

Policy Statement:

The purpose of this policy is to create a clear understanding for the requirements for providers to administer vaccinations, the process of administration and quality assurance associated with the vaccination program.

Policy:

1. Vaccines
    a. EMS providers will be able to administer the following vaccines:
        i. Influenza Vaccine
        ii. COVID-19 Vaccine
        iii. Or any other vaccines deemed emergent and are required to administer for mass vaccination. This will be determined in conjunction with the local health department (LHD) and the Illinois Department of Public Health
    b. Vaccinations will only be administered by EMT-P, PHRN, EMT-I, or AEMT who have been authorized by the EMS office.
2. Education
    a. To administer vaccines, each EMS provider must document training efficient enough to cover the following competencies:
        i. Proper administration of vaccine
        ii. Documentation of vaccine administration
        iii. Contraindications and potential side effects of the vaccine
        iv. Storage and disposal of vaccine materials
        v. Any additional information pertinent to the proper administration of the vaccine per manufacture requirements
    b. Each EMS agency will be responsible for documenting the training for each provider. Those training records must be turned into the EMS office prior to authorization to administer vaccinations.
    c. If mass vaccination continues for a prolonged period, more than 6 months, continuing education must be implemented to ensure providers are maintaining initial competencies. Agencies must record proper continuing education for all authorized EMS providers.
3. Communications
    a. Upon authorization by local health department, approved EMS providers will work with LHD to coordinate the administration of vaccinations in conjunction with their mass vaccination plans.

b. EMS providers will be notified of location where they will be administering the vaccinations. This will be coordinated with LHD.
c. If authorized by the EMS System Medical Director or the LHD, EMS agencies may provider vaccine administration to their own agencies if deemed necessary.
d. If authorized by the EMS System Medical Director, agencies may provide vaccination at a community clinic administered through their own agency.

4. Medication Control
    a. If agencies are storing vaccine materials, all medications must be stored in a manner that meets all requirements of the manufacture and/or LHD.
    b. All medications must be disposed in proper bio-waste containers.
    c. Agencies will be required to ensure proper quality control, security, and equipment necessary to properly maintain all medications.
5. Documentation
    a. Providers must document and record administrations following LHD requirements.
        i. Records must be maintained in accordance with LHD and IDPH requirements.
    b. Providers must report any negative or adverse reactions to proper reporting agencies in an appropriate timeframe.
6. Administration
    a. Administration of vaccines will be done in a manner that follows manufactures recommendations and requirements.
    b. All proper measures body substance isolation precautions must be taken.
    c. Vaccination sites (anatomical locations) must be properly cleaned prior to administration.
    d. All biohazard material must be disposed in proper receptacles.
7. Quality Assurance
    a. EMS agencies will be required to turn in proper training associated with the vaccine prior to authorization to administer vaccines.
    b. EMS agencies will record what providers are used to assist with mass vaccinations. Agencies will record the following for each provider:
        i. Name of EMS provider and level of care
        ii. Date of vaccine administration
        iii. Hours in which vaccinations were administer
        iv. Location of administration
    c. Copies of the record should be turned in on a weekly basis to the EMS office.
8. Misc.
    a. EMS agencies may voluntarily partake in this program.
    b. IDPH has prohibited EMS providers from administering vaccines to people under 6 years of age.
    c. If deemed necessary by the EMSMD, agencies will be allowed to administer vaccines within routine duties. If this is done, a separate protocol will be issued for further guidance.
    d. This policy is subject to change based the Illinois Department of Public Health guidance.

Vehicle Service Advertising

Effective Date: 10/2004
Review Date: 2/2020
Approvals: EMSSC, EMS MD

Background to Policy:

To assure the public is protected against misrepresentation by an EMS Agency Provider.

Policy Statement:

The Illinois Emergency Medical Services Systems Act [P.A. 89-177, (210 ILSC 50/3.85)] mandates any Vehicle Service Provider is prohibited from advertising, identifying its vehicles, or disseminating information in a false or misleading manner concerning the Provider's type and level of vehicles, location, primary service.

Policy:

A. No agency, public or private, shall advertise, identify their vehicle as, or disseminate information leading the public to believe that the agency provides a specific level of service unless that agency does in fact provide and is licensed by the Department of Public Health at that specific level of service, as defined in the EMS Systems Act.

B. Penalty. Any person who violates the EMS Systems Act or any rule promulgated pursuant thereto is guilty of a Class C misdemeanor.

C. A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in such advertisement the hours of operation for those vehicle, if individual vehicles are not available twenty-four (24) hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate twenty-four (24) hours a day.

D. If is the responsibility of all McLean County Area EMS System personnel to report such infractions of this section to their EMS Medical Director and/or EMS System Coordinator.

E. Agencies that have in-field upgrade capabilities are restricted to advertising the level of service that they can guarantee 24/7/365.