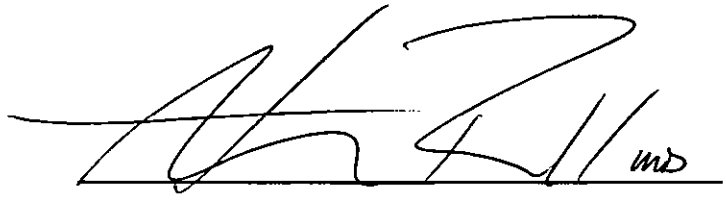
Anderson EMS System

System Policy Manual



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EMS Medical Director

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REGION IV POLICY MANUAL
ANDERSON HOSPITAL EMS POLICY MANUAL

TABLE OF CONTENTS

Section I – Introduction
Introduction
Professionalism
Patient Rights & Discrimination
Patient Confidentiality
Participant Descriptions & Responsibilities
Position Descriptions

Section II – Communications & Medical Oversight
Communications Policies
Medical Control
Medical Control Override
Direct Scene Observations

Section III – Personnel & Vehicles
Personnel Well-Being & CISD
Education, Certification, Licensing & Credentialing
System Credentialing For New Providers & Reciprocity Candidates
Application for Reciprocity
Relicensure Requirements
Relicensure Process
EMT Inactive Status - State of Illinois
EMT Inactive Status - EMS System
Reinstatement of License
Personnel Records
Field Training Officers
EMS Lead Instructors
EMS Field Representative
Personnel Education Requirements
Pre-Hospital RN Education & Licensure
Emergency Communications Registered Nurse Education & Licensure
Continuing Education Programs
Blanket Approval for CE Programs
Remediation & Suspension of Providers
Account of/Abuse of Controlled Substances by System Personnel
Suspension of an EMS Provider/Service
Ambulance Inspections

Ambulance Equipment and Drug Listing
Personnel Requirements for Ambulances
Ambulance Unit Labels
Alternate Response Vehicles – Ambulance Assistance Vehicles
Allowable Transport Medications - Transfers
Critical Care Transports

Section IV – EMS Response
Response
Mutual Aid
ALS Assist Guidelines for BLS/ILS Units (In-Field Service Upgrades)
Rural In-Field Service Upgrade Statute

Section V – On Scene
National Incident Management System
Scene Times
Interaction with Physician/Nurse on Scene

Section VI – Scene Safety
General
Fire, Technical Rescue, and HAZMAT Scenes
Infection Control
Exposure to Blood or Other Bodily Fluids
Emergency Personnel Notification of a Communicable/Infectious Disease

Section VII – Crime Scenes
Interaction with Law Enforcement
Crime Scene Interaction
Signs of Potential Abuse
Mandatory Reporting of Suspected Crimes

Section VIII – Patient Consent
Applicability of SOGs (Who is a patient?)
Patient Abandonment
Adult Consent
Minors
Refusal of Evaluation, Treatment, and/or Transportation
Patients Unable to Refuse Evaluation, Treatment, and/or Transportation
Parent/Guardian Refusal in the Presence of Potentially Life-Threatening Condition
Emotionally Disturbed Patients
Use of Restraints (Chemical and Physical)

Patients in Law Enforcement Custody

Section IX – Death On Scene
Withholding CPR
Do Not Resuscitate Orders
Death at the Prehospital Site/Coroner's Policy

Section X – Patient Transport and Destination
Destination Selection
Special Population: Pediatrics
Special Population: Trauma Patients
Special Population: STEMI
Special Population: Stroke
Use of Lights & Sirens
Non-Paramedic Transport of Patients
Anderson Hospital Direct Admissions

Section XI – Documentation & CQI
EMS System PCRs
System CQI Plan
Anderson System Run Review
EMS System Incident Report Form
Reporting of Clinical Errors

Section XIII – Miscellaneous
Policy for Mass-Gathering Events
Restock of Supplies/Medications
Restock of Controlled Medications
EMS Assistance Fund Grants
Conflict of Interest

Section XIV – Disaster Response
MCI Response
Region IV Multiple Victim Incident Policy
Uninjured Victim Incident Log
School Bus Incident
Preparedness to a State Wide Crisis

Section I: Introduction

It is the mission of the Anderson Hospital EMS System to deliver the highest level of pre-hospital care. Working together as one system, we will strive to minimize death and suffering of those we serve.

This Policy Manual shall be maintained at each ambulance service's base(s) of operation. All System personnel are responsible for being familiar with the contents of the Policy Manual. In the event that amendments are made to the Policy Manual, they will be distributed to each ambulance service's base(s) of operation. All System personnel are also responsible for familiarization with all Policy Manual amendments.

Communication of updates regarding System and Regional activities will be shared with EMS System personnel, services, and hospitals via:

1. Quarterly System Advisory Council Meetings
2. General Mail and Email
3. Quarterly Field Training Officer/QI Meetings
4. Quarterly EMS Run Reviews
6. Resource Hospital EMS vestibule bulletin board
7. EMT/PHRN/ECRN educational classes.

In addition, mandatory in-services will be scheduled for appropriate EMS personnel regarding the addition of changes in medications, equipment, or procedures.

The Anderson Hospital EMS System relies upon a system of regular patient care review and self-reporting with regard to any limitations on the provision of patient services. If any EMS personnel, providers or entities are incapable of providing services, they should promptly report the same in writing to the Illinois Department of Public Health, the EMS System Medical Director, and the EMS System Coordinator as soon as possible.

PROFESSIONALISM	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

It is a privilege for all of us to function within the Anderson Hospital EMS System. The level of trust that individuals we serve place in us during their time of need cannot be understated. Therefore, it is imperative that we conduct ourselves appropriately at all times and in all places, on or off duty.

Participants of the Anderson Hospital EMS System are in the unique position of representing Anderson Hospital, their communities and services, and themselves to the general public. As such, their conduct and appearance, along with their performance and attitude, directly reflect upon the quality and success of the hospital's and community's involvement in the provision of pre-hospital and emergency department care.

Providers will, at all times, conduct themselves in a professional manner. In so doing, they will avoid discussion of cases, arguments, disagreements, and other negative comments in the presence of patients and/or family members or other hospital personnel. Relationships with patients, hospital personnel and other providers will be on a professional level at all times while in the course of delivery of emergency medical care.

Uniforms shall be dictated by each agency. All shall be clean, neat, and professional in appearance.

System providers shall maintain personal grooming consistent with a clean, neat, and professional image, i.e. fingernails, hair, cologne, and jewelry.

PATIENT RIGHTS & DISCRIMINATION	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Patients shall be treated with the utmost respect, in a caring and professional manner at all times. Intent for the good of the patient shall be the precipice on which all of our actions and decisions are based.

2. No member of the Anderson Hospital EMS System will discriminate against any individual based on race, creed, sex, age, physical disability, disease process, national origin, religious beliefs, or economic status.

3. Each member of the Anderson Hospital EMS System will provide a process that informs patients of their rights, responsibilities and risks regarding available healthcare services.

4. Patient transport to other healthcare facilities is based entirely on the condition and needs of the patient and the ability and the availability of the organization to provide the services along with the approval of the patient. The patient's economic condition will not be a deciding factor in the decision for the transport.

PATIENT CONFIDENTIALITY	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. No names of patients or medical personnel may be mentioned on radio transmissions unless absolutely necessary.

2. Patient report forms should be kept in a secure area to maintain confidentiality.

3. Care must be given to protect the patient's confidentiality in all situations. Specifics of patients or events must not be discussed outside of normal operational necessity.

4. Camera Use
   a. Providers are only permitted to use cameras or other picture-taking or image generating devices authorized by his/her agency while rendering patient care. These devices are intended to be used for medical purposes only, such as to document the position of vehicles and patients at the scene of an accident or to document mechanism of injury for use by the receiving facility to assist in guiding treatment. No other picture-taking devices including PDA's, cameras, cell phones, or other personal computers shall be used by personnel while rendering patient care.
   b. All on-scene photography shall be for clinical and/or documentation purposes only and conducted only at the direction of agency personnel in charge at the scene or by medical command.
   c. Any photographs containing individually identifiable information are covered by the HIPAA Privacy Rule and must be protected in the same manner as patient care reports and other such documentation.
   d. Any on-scene images and any other images taken by a provider while rendering patient care shall be considered a portion of the patient's medical record and are not the property of the individual staff member. This includes any image inadvertently taken with a staff member's personally owned cell phone, camera, or other digital imaging device.
   e. No images taken by a provider may be used, printed, copied, scanned, emailed, posted, shared, or distributed in any manner. This prohibition includes posting photos on personal web or on other public safety agency web sites, or emailing images to friends, colleagues, or others in the EMS industry.
   f. When possible, copies of all images taken shall be printed and affixed to the system and agency's copies of run reports. All remaining images (electronic and print) shall be destroyed.

5. Failure to comply with this policy constitutes unprofessional/unethical behavior and may result in suspension, revocation and/or denial of licensure.

PARTICIPANT DESCRIPTIONS & RESPONSIBILITIES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. The **Resource Hospital** for the Anderson Hospital EMS System is Anderson Hospital. The Resource Hospital has the authority and the responsibility for the Anderson Hospital EMS System, as outlined in the IDPH-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, coordinates the clinical aspects, operations and educational programs. Responsibilities of the Resource Hospital include:
    a. Agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.
    b. Maintaining a Program Plan and Policy Manual in accordance with the provisions of the EMS Act and minimum standards and criteria established in rules adopted by IDPH pursuant to the EMS Act.
    c. Educate or coordinate the education of EMT personnel in accordance with the requirements of the EMS Act, rules adopted by IDPH pursuant to the EMS Act, and the EMS System Program Plan.
    d. Notify IDPH of EMT provider personnel who have successfully completed requirements for licensure testing and re-licensure by the Department.
    e. Educate or coordinate the education of Emergency Medical Dispatcher candidates, in accordance with the requirements of the EMS Act, rules adopted by IDPH pursuant to the EMS Act, and the EMS System Program Plan.
    f. Establish or approve protocols for prearrival medical instructions to callers by System Emergency Medical Dispatchers who provide such instructions.
    g. Educate or coordinate the education of Pre-Hospital RN and ECRN candidates, in accordance with the requirements of the EMS Act and the EMS System Program Plan.
    h. Approve First Responder, EMT-B, EMT-I, EMT-P, and Pre-Hospital RN and ECRN candidates to practice within the System, and reapprove personnel every 4 years in accordance with the requirements of IDPH and the System Program Plan.
    i. Establish operating guidelines for the use of Pre-Hospital RNs within the System.
    j. Establish policies for utilizing ECRNs and physicians licensed to practice medicine in all of its branches to monitor telecommunications from, and give voice orders to, EMS personnel, under the authority of the EMS Medical Director.
    k. Monitor emergency and non-emergency medical transports within the System, in accordance with rules adopted by IDPH pursuant to the EMS Act.
    l. Utilize levels of personnel required by IDPH to provide emergency care to the sick and injured at the scene of an emergency, during transport to a hospital or during inter-facility transport and within the hospital emergency department until the responsibility for the care of the patient is assumed by the medical personnel of a hospital emergency department or other facility within the hospital to which the patient is first delivered by System personnel.

m. Utilize levels of personnel required by IDPH to provide non-emergency medical services during transport to a health care facility and within the health care facility until the responsibility for the care of the patient is assumed by the medical personnel of the health care facility to which the patient is delivered by System personnel.
n. Establish and implement a program for System participant information and education, in accordance with rules adopted by IDPH pursuant to the EMS Act.
o. Establish and implement a program for public information and education, in accordance with rules adopted by IDPH pursuant to the EMS Act.

All other hospitals within the Anderson Hospital EMS System which have standby, basic or comprehensive level emergency departments must function in the Anderson Hospital EMS System as either an Associate Hospital or Participating Hospital and follow all System policies specified in the System Program Plan, including but not limited to the replacement of drugs and equipment used by providers who have delivered patients to their emergency departments.

All hospitals within the Anderson Hospital EMS System have a duty to self report to both the Resource Hospital, IDPH, and the other participating members of the System any significant changes in the appropriateness of their care. The Resource Hospital has no duty to verify the capabilities of a hospital properly licensed under the Act who holds themselves out as capable of receiving patients.

The activities of the Anderson Hospital EMS System are facilitated by a number of regional and state committees and positions:

1. **Anderson Hospital EMS System Advisory Committee**
   a. This committee meets on a quarterly basis to advise the Anderson Hospital EMS Medical Director. Bylaws are as follows:
   b. The meetings will be governed by Roberts Rules of Order.
   c. The committee will be chaired by the EMS Medical Director/EMS System Coordinator.
   d. Each EMS service and Anderson System Associate Hospital gets one vote.
   e. The meeting is open to everyone. However, each service shall appoint one person to vote each meeting. He/she need not be the same person at each meeting in order to accommodate all of our busy schedules.
   f. A matter shall be approved by a majority vote.
   g. In the event of a tie vote on an issue, the Chairperson shall vote on behalf of the Resource Hospital. Other than in such instance, the Resource Hospital shall not cast a vote.
   h. There is no quorum. Business will proceed regardless of attendance.
   i. As with any advisory council, some decisions must be made unilaterally without or against the opinion of the advisory council. However, the EMS Medical Director will make every effort to follow the recommendations and opinions of the advisory council.

j. Decisions made by the advisory council that are put into effect by the EMS Medical Director and EMS Coordinator shall be binding for the entire system.
k. These rules may be altered by a majority vote by the advisory council.
l. First responder organizations may vote on issues pertaining to first responders.

2. Region IV EMS Advisory Committee

a. Comprised, at a minimum, of the Region IV EMS Medical Director's, the Chair of the Regional Trauma Committee, a representative from an Associate Hospital, EMS System Coordinators from each Resource Hospital within Region IV, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within Region IV, one administrative representative of a vehicle service provider from each system within the region, one EMTB, one EMTP, one PHRN, and one RN currently practicing win an emergency department within Region IV. At least one of the administrative representatives of vehicle service providers shall represent a private vehicle service provider. The IDPH Region IV EMS Coordinator shall serve as a non-voting member.
b. This Committee shall address, at minimum:
   i. Provide advice to the Region IV EMS regarding activities listed above.
   ii. Every 2 years, the members of the Region's EMS Medical Directors Committee shall rotate serving as Committee Chair, and select the Associate Hospital, Participating Hospital and vehicle service providers which shall send representatives to the Advisory Committee, and the EMTs/Pre-Hospital RN and nurse who shall serve on the Advisory Committee.

3. The **Region IV EMS Coordinator** is a designee of the Chief, Division of EMS and Highway Safety of IDPH. He or she shall facilitate the activities of the above committees and ensure compliance with IDPH Rules and Regulations.

4. Regional IV Trauma Advisory Committee

a. Consists of the Trauma Center Medical Director for the Region IV Trauma Centers (SLU Hospital, Barnes Hospital, Children's Hospital, Cardinal Glennon Children's Hospital), the EMS Medical Directors, the EMS System Coordinators, one representative each from a public and private vehicle service provider within Region IV, an administrative representative from each Region IV Trauma Center, one EMT, one Emergency Physician, and one Trauma Nurse Specialist (TNS) currently practicing in a Region IV Trauma Center. The IDPH Region IV EMS Coordinator serves as a non-voting member of the Region IV Trauma Advisory Committee.
b. Every 2 years, the members of the Trauma Center Medical Directors Committee rotate serving as Committee Chair, and select the vehicle service providers, EMT, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee.
c. Advise the Trauma Center Medical Directors regarding:
   i. The identification of Regional Trauma Centers (Adult and Pediatric).
   ii. Protocols for inter-system and inter-region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional Considerations.

iii. Regional trauma standing medical orders.
iv. Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing or diversion to any hospital trauma center or Regional trauma center which are consistent with individual System Bypass of diversion protocols and protocols for patient choice or refusal.
v. The identification of which types of patients can be cared for by Level I and Level II Trauma Centers.
vi. Criteria for inter-hospital transfer of trauma patients, including pediatric patients.
vii. The treatment of trauma patients in each trauma center within Region IV.
viii. The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to IDPH.
ix. A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients.

5. **State EMS & Trauma Advisory Committees** serve similar functions on a state level. Specific information regarding these committees may be found within the EMS Act and IDPH's rules.

POSITION DESCRIPTIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. **EMS Medical Director**
   a. The EMS Medical Director will be a graduate of an approved medical school accredited by the liaison committee on medical education, be licensed to practice medicine in all of its branches, and will have completed an approved residency program. The EMS Medical Director will also be ACLS and ATLS certified.
   b. The EMS Medical Director will also have/obtain experience on an EMS pre-hospital unit, be knowledgeable of and possess the skills taught to paramedic students, and have/obtain experience instructing all levels of EMT students.
   c. The medical and legal responsibility for the operation of the EMS System rests with the EMS Medical Director. All personnel functioning in the system do so under his/her delegated authority. The EMS Medical Director, in addition to this responsibility, is also responsible for the following:
      i. Development of standing treatment protocols to be used in the EMS System and ensure that they are being properly followed.
      ii. Development of lists of drugs, equipment, and supplies to be utilized by system personnel and to be carried on the pre-hospital units.
      iii. Remain current all necessary System approvals.
      iv. Supervision of all personnel involved in the EMS System.
      v. Designation of a physician to serve as Alternate EMS medical director.
      vi. Serve as a member of the Anderson Hospital EMS System Advisory Committee, Region IV Trauma Advisory Committee, Region IV EMS Medical Director's Committee, and Region IV EMS Advisory Committee.
      vii. Review of CQI activities with the EMS System Coordinator.
      viii. Notify IDPH of all changes in personnel providing pre-hospital care.
      ix. Enforce the compliance of the System policies and procedures by the system participants.
      x. Licensure (initial and renewal) of System personnel.
   d. The EMS Medical Director is empowered to suspend or to modify the participation of any individual functioning in the EMS system.

2. **EMS Alternate Medical Director**
   a. The physician designated by the EMS Medical Director to perform the above duties in the absence of the EMS Medical Director.

3. **EMS System Coordinator/Educator**
   a. The EMS System Coordinator will be a registered nurse or EMT-P licensed in the state of Illinois. This individual will have a diverse background in critical care, be knowledgeable in the care of the critically ill or injured patient, will be ACLS & ITLS-certified, and have a background of experience in the field care of pre-hospital

patients. The individual should also have a history of extensive involvement in the instruction of critical care practices.

b. The EMS System Coordinator is responsible for the following:
   i. Ambulance and equipment checks of provider agencies on an initial, annual, and unannounced basis.
   ii. System data collection and statistical analysis.
   iii. System quality assurance collection.
   iv. Arrange system review board meetings.
   v. Provide continuing education for EMT-B/I/P, PHRN and ECRN's within the Anderson Hospital EMS System.
   vi. Process licensure forms to IDPH as approved by the EMS Medical Director.
   vii. Process applications for an upgrade of pre-hospital care from services.
   viii. Act as chairman of the EMS run review meetings.
   ix. Assist in problem solving for the system.
   x. Coordination of reciprocity procedures for EMT-B/I/P and PHRN's.
   xi. Communicates on an ongoing basis with the EMS Medical Director regarding EMS policies/procedures/operations.
   xii. Coordination of hospital/community activities.
   xiii. Assist in the coordination of hospital sponsored ACLS, ITLS, and PALS programs
   xiv. Act as a resource person to the staff nurses and pre-hospital care providers.
   xv. Report to the EMS Medical Director for or on any matter as deemed necessary.
   xvi. Keep records for all personnel in the EMS System and collecting pertinent program data and statistics.

c. The EMS Educator is responsible for the following:
   i. Keep a current record of students.
   ii. Interview prospective EMT-P students.
   iii. Supervision of student field internships.
   iv. Provide continuing education for EMT-B/I/P and ECRN.
   v. Coordinate and instruct EMT and EMT-P courses.
   vi. Coordinate and conduct classroom skill labs.
   vii. Coordinate and supervise clinical experience of students.
   viii. Educate field units and the ED on radio/telemetry communication.
   ix. Coordinate texts, syllabi, supplies, and handouts for class.
   x. Schedule classes and clinical experience for students.
   xi. Communicate on an ongoing basis with the EMS System Coordinator and EMS Medical Director regarding EMS policies/procedures/operations.
   xii. Assist in the instruction of hospital sponsored ACLS, ITLS, and PALS programs.

4. EMS Administrative Director

a. The EMS Administrative Director will be the administrative director designated by the Resource Hospital.
b. The EMS Administrative Director's responsibilities will be to collaborate with the EMS Medical Director, EMS System Coordinator, and ED Director on the following:
   i. Administrative problem-solving for the system.
   ii. Public relations as related to the pre-hospital care providers
   iii. Development and ongoing operations of the EMS system.

iv. Overseeing budgetary needs for educational supplies/equipment.
v. Overseeing budgetary needs for communication equipment of medical control.
vi. Serve as chair of the Anderson Hospital EMS System Advisory Committee.

Section II: Communications & Medical Oversight

COMMUNICATION POLICIES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. General Operations
   a. The Anderson Hospital EMS System communication system utilizes the following to interface with ambulances, hospitals, ESDA, and existing systems: VHF, Cellular, Star Com, landline…

2. All EMS telecommunication equipment within the Anderson Hospital EMS System must be configured to allow the EMS Medical Director or designee, to monitor all ambulance-to-hospital and hospital-to-ambulance communications within the system.

3. All telecommunication equipment must be maintained to minimize breakdowns. Both Resource and Associate Hospitals have maintenance agreements with a local vendor, which provides for routine as well as 24 hr. emergency repairs of radios. Resource/Associate Hospital telecommunications operating personnel are to contact a repair person immediately should a breakdown occur.

4. All hospitals in the Anderson Hospital EMS System have been advised to communicate hospital-to-hospital on VHF frequency 155.280, or EMSR4 channel on Star Com particularly in the event of telephone failure.

5. Ambulances have an option to utilize IREACH to communicate with fire/police agencies.

6. Resource Cellular Numbers:
   a. 288-3810
   b. 288-5870

7. Operation Control Point
   a. Communications will be answered promptly by an ECRN or Emergency Physician. The ECRN or Emergency Physician shall answer as follows:
      i. Identify Hospital's name.
      ii. Repeat the transmitting unit's call letters.
      iii. Give orders/directions promptly and courteously.
      iv. Keep communications to a minimum.
      v. Do not voice names of EMS personnel or patients.
      vi. Call ED physician to the operational control point per ECRN policy.
      vii. End recorded communication with date, time, and call letters.

1. In an effort to establish timely radio contact, when an ECRN or physician is not available, a nurse within the Emergency Department may answer at the operational control point but

all information must be provided to an ECRN or physician prior to termination of radio contact.

2. Pre-hospital Communications
   a. Communications will be transmitted to medical control as soon as feasible utilizing the following:
      i. Identify Hospital's name.
      ii. State unit identifier (call letters) and level of care.
      iii. Give BRIEF report to include only necessary information.
      iv. Be courteous and professional at all times.
      v. Echo all orders to the ECRN or MD.
      vi. Do not voice names of EMS personnel or patients.
      vii. Voice ETA and identify receiving facility.
      viii. Advise medical control of re-contact number if situation warrants.
      ix. End recorded communications with unit identifier.
   b. ALS communications should occur on the cellular phone patch when possible.
   c. BLS communications should occur on the VHF radio or cellular phone patch when possible.
   d. Outbound calls are desired when responding to calls.

3. All communications must be documented completely and accurately in the radio communications log book posted at the operational control point.

MEDICAL CONTROL	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. All personnel functioning in the System do so under the authority of the Illinois Department of Public Health and the EMS Medical Director.

2. In the absence of the EMS Medical Director, the physician staffing the ED at Anderson Hospital shall be considered the Anderson Hospital EMS Physician with all of the authority necessary to conduct the daily operations of the system.

3. All Anderson Hospital EMS System personnel must be familiar with the field operations, treatment, and operational protocols, and all equipment used in the performance of these tasks.

4. All personnel in the Anderson Hospital EMS System must meet the requirements of the System and be approved by the EMS Medical Director.

5. Only the EMS Medical Director and/or an approved designee, including physicians and ECRNs in the ED of the Resource Hospital or Associate Hospital may give patient treatment orders to field personnel.

6. The ECRN has the authority, delegated by the EMS Medical Director, without first notifying the EMS Medical Director or his designee (the ED physician), to initiate emergency care in accordance with the field treatment guidelines.

7. Once the EMS Medical Director or the medical control physician designee has arrived at the radio, the ECRN and physician shall continue to utilize the field treatment protocols as a patient treatment guide during the EMS call

8. Except for the placement of an IV or treatment with oxygen, only the EMS Medical Director or Medical Control Physician can initiate orders outside of the prehospital Operating Guidelines (OGs). Orders requiring a physician include, but are not limited to the following:
   a. When EMS requests physician direction.
   b. High-risk refusals (see Section 9).
   c. Situations related to medico-legal issues.
   d. Requests for medications/procedures outside of the provider's OGs or scope of practice.
   e. All pre-hospital termination of resuscitation.
   f. When the ECRN is unfamiliar with any system protocol or if an unusual event or occurrence presents outside the realm of the Anderson Hospital EMS System OGs/Treatment Protocols.

g. When the patient's condition is deteriorating and System OGs/Treatment Protocols have been exhausted.
h. When DNR/Advanced Directive Orders are requested.
i. When pronouncement of death is required.
j. Request for bypass to another facility.

9. In the event that physician authorization is required, the name of the physician shall be documented with the order in the log book. It is suggested that the EMS crew ask for and document the name of the ED physician providing the order.

10. OGs are to be considered the standing orders of the EMS Medical Director and are to be followed by field personnel whenever contact with the resource hospital is impossible, or where a delay in patient treatment would be of harm to the patient.

11. The Associate Hospital is authorized to provide orders only:
    a. For patients being transported to the Associate Hospital, or
    b. In the event of communication failure with the Resource Hospital.

MEDICAL CONTROL OVERRIDE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. To allow the EMT/PHRN to contact the Anderson Hospital EMS System Resource Hospital if, in the judgment of the provider, orders for patient treatment:
   a. Vary significantly from the provider's OGs.
   b. Could result in unreasonable or medically inaccurate treatment causing potential harm to the patient.
   c. Could result in undue delay in initiating transport of a critically ill patient (greater than 20 minutes).
   d. When there is no response from the Associate Hospital after three attempts to contact.

2. This pertains to:
   a. Orders for patient care given by the Associate Hospital during transport to the Associate Hospital.
   b. Orders for patient care given by any hospital for inter-facility transfers.

3. Procedure:
   a. Clarify the order.
   b. Advise the Physician/ECRN issuing the order that the order is not allowed or deviates significantly from approved OGs.
   c. Advise the Physician/ECRN that you will contact the Anderson Hospital EMS System Resource Hospital for guidance/orders.

4. After medical control guidance has been completed:
   a. For patients being transported to the Associate Hospital, the Resource Hospital Medical Control Physician shall notify the Associate Hospital Medical Control physician that an override was initiated and completed. All pertinent information shall be conveyed to the Associate Hospital medical control regarding an update on the patient's medical status and the pre-hospital treatment rendered. The Associate Hospital shall be given an Estimated Time of Arrival of the patient to their facility.
   b. For patients requiring inter-facility transfer, the Resource Hospital Medical Control Physician shall discuss the patient's management with the transferring physician and determine an appropriate course of action. Note that it is the responsibility of the transferring physician to determine a suitable destination facility and arrange accordingly, not that of the Medical Control physician.

5. Only those physicians listed below may grant or deny a request for Resource Hospital Medical Control Override:
   a. EMS Medical Director
   b. Associate EMS Medical Director.
   c. On-duty Emergency Department Physician Anderson Hospital.

6. Any override of medical orders shall be submitted in writing via the "Incident Report Form", and promptly presented to the Anderson Hospital EMS Medical Director.

7. In the unlikely event that further consultation is needed, the EMS Medical Director (or his Alternate when he is unavailable) may be contacted. Final authority rests with the EMS Medical Director on all matters.

DIRECT SCENE OBSERVATIONS

The EMS System Coordinator or EMS Medical Director, or his designee may respond directly to agencies' emergency scenes to monitor the quality of patient care.

Section III: Personnel

PERSONNEL WELL-BEING & CISD	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

EMS providers often work long hours caring for others in difficult environments. In doing so, we often fail to take appropriate care of ourselves. It is imperative, as healthcare providers in a stressful and physically demanding environment, to keep ourselves well nourished, well rested, and physically fit.

Taking care of ourselves includes maintaining seemingly small ideals such as proper lifting techniques, abstinence from smoking, and regular visits to a physician. However, maintaining good health doesn't simply involve our physical selves. We must be emotionally and mentally well. Exhaustion and the stress of what we see and do on a daily basis takes a great toll on our bodies, not to mention compromises the care that we deliver to our patients. A provider may, at any time, contact the EMS Office for assistance with these matters.

In addition, the use of Critical Incident Stress Debriefing cannot be overlooked. While seemingly simple in nature, CISD is very beneficial to providers. The EMS Office will arrange for CISD at any point when requested. Please make the EMS Office aware of any particularly stressful scenes. These include, but are certainly not limited to calls involving children, coworkers or close acquaintances, grotesque scenes, multiple fatalities, or when providers are subjected to a series of stressful calls within a short period of time. Also, providers may, at times, suffer undue stress to seemingly mundane calls, i.e. routine cardiac arrest. The stress from these incidents can be as debilitating as that encountered on a "once-in-a-career call". These providers may personally contact the EMS Office for assistance. Coworkers are also encouraged to contact the EMS Office for assistance if you notice a provider who seems to be going through a difficult time and may be in need of assistance.

EDUCATION, CERTIFICATION, LICENSING & CREDENTIALING	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

What's the difference? (Taken from the National EMS Scope of Practice.)

1. Education includes all of the cognitive, psychomotor, and affective learning that providers have undergone throughout their lives. This includes entry-level and continuing professional education, as well as other formal and informal learning. Clearly, many individuals have extensive education that, in some cases, exceeds their EMS skills or roles.

2. Certification is an external verification of the competencies that an individual has achieved and typically involves an examination process. While certification exams can be set to any level of proficiency, in health care they are typically designed to verify that an individual has achieved minimum competency to assure safe and effective patient care.

3. Licensure represents permission granted to an individual by the State to perform certain restricted activities. Scope of practice represents the legal limits of the licensed individual's performance. States have a variety of mechanisms to define the margins of what an individual is legally permitted to perform.

4. Credentialing is a local process by which an individual is permitted by a specific entity (medical director) to practice in a specific setting (EMS agency). Credentialing processes vary in sophistication and formality.

5. For every individual, these four domains are of slightly different relative sizes: However, one concept remains constant: an individual may only perform a skill or role for which that person is:
   a. educated (has been trained to do the skill or role), AND
   b. certified (has demonstrated competence in the skill or role), AND
   c. licensed (has legal authority issued by the State to perform the skill or role), AND
   d. credentialed (has been authorized by medical director to perform the skill or role).

ANDERSON HOSPITAL EMS SYSTEM CREDENTIALING FOR NEW PROVIDERS AND RECIPROCITY CANDIDATES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

All applicants for credentialing in Region IV Anderson Hospital EMS System shall complete an application. Providing false, inaccurate, or misleading information on the credentialing application shall be immediate grounds for termination and/or suspension from the EMS System.

Requirements for credentialing include:

1. All personnel (FR, EMT-B/I/P, PHRN) must complete the Application for Reciprocity Form and submit to the EMS System Coordinator.

2. All personnel must submit a copy of a current Illinois license at his/her respective level of provider.

3. All personnel must submit a copy of a current CPR for Healthcare Provider card.

4. EMT-P and PHRN candidates must submit a copy of a current ACLS, PALS/PEPP, and ITLS cards.* PHRN candidates may substitute TNS or TNCC certification.

5. All personnel must pass the written SOG exam with a minimum 80% score.
   A. No more than total of 2 attempts, after which the candidate must receive Medical Director approval prior to any further attempts.
   B. A minimum of 24 hours between attempts.
      i. Candidates that fail the reciprocity (SOG) exam twice will need Medical Director approval to take a third time.
      ii. Candidates that fail the reciprocity (SOG) exam a third time will not be allowed to retake the exam until 6 months from the date of the first exam attempt.

6. All personnel must function, on average, 24 hours per month within the EMS System.

7. For reciprocity candidates, a recommendation from the medical director or EMS system coordinator of the previous system must be included or forwarded to the EMS Office.
   A. To qualify for Anderson System Reciprocity as a Paramedic, the following must be met:
      i. If licensed obtained in less than 24 months, you must have attended as Accredited (CAAHEP) program that has a minimum of 1,100 hours. (*Can be waived with Medical Director approval*)
   B. Reciprocity candidates from outside of Region IV must also complete a minimum of five *acceptable* runs with a Field Training Officer.
   C. Acceptable runs are those which clearly demonstrate critical thinking and/or the application of EMT-P level skills. This will be determined jointly by the EMS System Coordinator and EMS Educator. Any concerns shall be referred to the EMS Medical Director.

D. Reciprocity candidates must receive a positive recommendation from the Field Training Officer.

8. For providers seeking reciprocity from outside of the State of Illinois, please download and complete the IDPH State Reciprocity Candidate Form.

Anderson Hospital EMS System
Application for Reciprocity

ANDERSON HOSPITAL EMS SYSTEM RECIPROCITY APPLICATION

THIS APPLICATION IS FOR RECIPROCITY INTO THE ANDERSON EMS SYSTEM AS AN:

_____ EMT-B _____ EMT-P _____ Field RN _____ ECRN

A. PERSONAL DATA	IN CASE OF EMERGENCY
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY / STATE / ZIP:	CITY / STATE / ZIP:
SS# (REQUIRED BY STATE):	RELATIONSHIP:
DOB:	HOME PHONE #:
TELEPHONE #:	OTHER TELEPHONE #:
E-MAIL ADDRESS:	WORK TELEPHONE #:

EMPLOYMENT EXPERIENCE

CURRENT EMPLOYMENT:	SUPERVISOR:
ADDRESS:	DATE OF EMPLOYMENT:
CITY / STATE / ZIP:	TELEPHONE #:
POSITION:	SYSTEM COORDINATOR:

PROFESSIONAL REGISTRATION

ILLINOIS LICENSE NUMBER	EXPIRATION DATE: MO/DAY/YEAR	NATIONAL INFORMATION
_____	_____	# _____ exp: _____

INITIAL TRAINING SITE:	CERTIFICATE / DEGREE:
TRAINING DATE START:	TRAINING DATE END:
STATE (NAT) EXAM DATE:	STATE (NAT) EXAM LOCATION:

ADDITIONAL CERTIFICATIONS

CERT TYPE:	TRAINING SITE	EXPIRATION DATE
CPR		
ACLS		
ITLS/PHTLS		
PALS		
PEPP		
OTHER		

PROFESSIONAL ORGANIZATION MEMBERSHIP

WHY DO YOU WISH TO APPLY FOR RECIPROCITY (DEPARTMENT WHO IS SPONSORING)

I hereby certify that the above information is true to the best of my knowledge and belief. I authorize and direct information to be released from the EMS System Coordinator &/or employer previously listed.

Date: Signature of Applicant: _____

RELICENSURE REQUIREMENTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. EMTBs must complete **60 hours** of continuing education every **four** years to include both adult and pediatric care. EMTIs must complete **80 hours** continuing education every **four** years to include both adult and pediatric care. EMTPs must complete **100 hours** continuing education every **four** years to include both adult and pediatric care.
    - A. Half of total hours must be acquired within the first 2 years
    - B. No more than 20% within the same subject
    - C. Current Health Care Provider CPR card (EMT-B/I/P/PHRN)
    - D. Current ACLS required for all EMT-P/PHRNs
    - E. Current Advanced ITLS/PHTLS required for all EMT-I/P/PHRNs
    - F. Current PALS or PEPP required for EMTP/PHRNs
    - G. GRACE PERIOD FOR ACLS, PALS/PEPP, ITLS, and CPR for Healthcare Providers.
        - i. Due to classes not being on the same exact day of every month, the system has a built in grace period lasting 30 days. If you above listed certification expires, you qualify for this grace period if you:
            1. Are enrolled in a certification class within the 30 days
            2. Notify the EMS Coordinator of the date and location of enrolled class.
        - ii. You MUST present a current card showing successful completion of the class within this 30 day grace period.
            1. Failure to present a current card will result in system suspension until such date the card is presented.
    - H. May acquire up to 20% total hours of approved Emergency Room clinical time within the four year licensure period (appropriate clinical attire required)
    - I. May acquire up to 20% total hours of continuing education units for clinical field supervision (system approved field supervisors only) within the four year licensure period (EMT-I/P/PHRN) per System approval
    - J. May acquire up to 20% total hours of continuing education units teaching classes within the four year licensure period
    - K. May acquire up to 20% total hours of continuing education units through acceptable computerized continuing education units within the four year license period.(Only IDPH approved sites)
    - L. Pass relicensure exam with 80% (EMT-B/I/P/PHRN) (See Relicensure Process)
    - M. Mandatory in-service obligations must be met
2. Continuing education units must have prior System, IDPH, or CECBEMS approval and be related to emergency medical services

3. Applicant must be on EMS call at least an average of 24 hours per month within the Anderson EMS system.
4. Must complete and sign IDPH renewal application form.
5. Must attend two Run Review Conferences annually/eight in a licensure period.
6. Airway Education
   A. All EMT-I/P, PHRN shall provide documentation of at least 1 intubation per year (in the pre-hospital setting, ED, or approved simulation). It is highly desirable for personnel to obtain many more intubations each year. Providers are further encouraged to practice regularly at their place of employment or at Anderson Hospital on mannequins. Providers may also request OR time to obtain continuing exposure, experience, and education.
   B. Any provider unable to obtain one endotracheal intubation annually will be required to attend clinical airway instruction as deemed by the medical director.
   C. Airway education will continue to be emphasized at all Anderson Hospital certification courses (PALS, ACLS, ITLS, PEPP).
7. Must have (8) hours continuing clinical education for initially licensed EMT-Paramedics annually scheduled at the Resource or Associate Hospital ER.
8. A minimum of half total CEUs are to be obtained by attendance of Anderson EMS System continuing education approved programs.
9. Run Supervisors may obtain one CEU per accepted supervised field run
10. Records of licensure/certification and all related material for EMS system personnel will be kept on file at the EMS office. It will be the responsibility of the EMS system personnel to insure that all records are up to date and in order.
11. In the event EMS system personnel do not meet EMS System requirements, the individual may seek licensure renewal through the Illinois Department of Public Health.

RELICENSURE PROCESS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. All system participants will schedule a meeting with the EMS System Coordinator not less than 60 days prior to expiration. The purpose of the meeting will be to submit all continuing education received over the past four year licensure period. It will be considered the responsibility of the system participant to maintain their status in the system and meet all system requirements. If system requirements are not met and the participant will require an extension, the IDPH prescribed forms will be submitted to the participant. All State fees associated with relicensing are to be completed by the applicant directly with IDPH.
2. After it is determined that the participant has met all the requirements of the system for relicensure they will be scheduled for a relicensure (SOG) exam. This exam should be taken within 45 days of expiration and pass with a score of no less than 80%.
    a. Candidates that fail the relicensure (SOG) exam twice will need Medical Director approval to take a third time.
    b. Candidates that fail the relicensure (SOG) exam a third time will not be allowed to retake the exam until 6 months from the date of the first exam attempt.
        i. These candidates will have their relicensure (state license) processed and sent to IDPH for approval.
        ii. These candidates will not be allowed to function in the Anderson EMS System at their license level.
            1. If this candidate is a paramedic, they can function in our system as an EMT.
3. EMS participant relicensure is approved by the EMS Medical Director.
4. The license of an EMT who has failed to file an application for renewal shall terminate on the day following the expiration date shown on the license.
5. At any time prior to the expiration of the current license, an EMT-I or EMT-P may revert to the EMT-B status for the remainder of the license period. The EMT-I or EMT-P must make this request in writing to the EMS Medical Director and EMS Coordinator. To relicense at the EMT-B level, the individual must meet the EMT-B requirements for relicensure and submit the original license to the Department.
6. An EMT-I or EMT-P who has reverted to EMT-B status may be subsequently relicensed as an EMT-I or EMT-P, upon the recommendation of an EMS Medical Director who has verified that the individuals knowledge and clinical skills are at an active EMT-I or EMT-P level, and that the individual has completed any retraining, education or testing deemed necessary by the EMS MD for resuming EMT-I or EMT-P activities.
7. Any EMT whose license has expired for a period of more than 60 days shall be required to reapply for licensure, complete the training program and pass the test, and pay the fees as required by the **Reinstatement Policy.**
8. An EMT whose license has expired, may, within 60 days after licensure expiration, pay a fine to the Illinois Department of Public Health. If all is in order and there is no disciplinary action pending against the EMT, the Illinois Department of Public Health will relicense the EMT.

EMT INACTIVE STATUS - STATE of ILLINOIS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Prior to the expiration of the current license, an EMT/PHRN may request to be placed on inactive status. The request will be made in writing to the EMS Medical Director. The EMS Medical Director will apply to the IDPH in writing and request that the EMT/PHRN be placed on inactive status. The request will contain the following information:
    a. Name of individual
    b. Date of licensure
    c. Licensure level
    d. IDPH identification number
    e. Circumstances requiring inactive status
    f. A statement that relicensure requirements have been met by the date of the application for inactive status
2. If the request for inactive status is granted by the IDPH, the EMS Medical Director will forward the EMT/PHRN license to the IDPH.
3. For the EMT/PHRN to return to active status, the EMS Medical Director must apply in writing to the IDPH that the EMT/PHRN is capable of functioning within the EMS system; that the EMT/PHRN knowledge and clinical skills are at the licensure level necessary to function; and that the EMT/PHRN has completed any refresher training deemed necessary by the EMS Medical Director and approved by the IDPH. If the inactive status was based on a temporary disability, the EMS Medical Director will verify that the disability has ceased.
4. During inactive status, the EMT/PHRN will not function as an EMT/PHRN at any level.

EMT INACTIVE STATUS – EMS SYSTEM	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 06/17**
Version: 1.0	**Council Approved:**

EMT's must be in an ACTIVE status, allowing them to perform duties within the Anderson EMS System. EMT's are placed into an INACTIVE status if one of the following occur:

- Failure to maintain 24 hours per month for a period of 2 months or more.
    - If you have not worked 24 hours for a period of 2 months or more, to become active, you must:
        - Run 1 ALS call with an FTO for each month you are inactive.
            - Example: EMT is off for 7 months due to surgery, prior to returning to Active Status, the EMT will need to run 7 ALS calls with an FTO.
        - Receive positive review from FTO that you are competent enough for return to Active Status.
- Maintain current required certifications (ACLS, PALS or PEPP, ITLS, and CPR)
    - A 30 day grace period can be granted if certification expires within 30 days prior to a class. The candidate must be enrolled in a class for the 30 day grace period to be granted.
    - Failure to pass a class during a grace period will result in you being placed into an INACTIVE status until a current certification is presented to the Medical Director.
- Any other conditions according to the EMS Act.

REINSTATEMENT OF LICENSE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

This policy defines the steps necessary for reinstating the license of Emergency Medical Services (EMS) personnel who have failed to comply with licensure renewal requirements or who voluntarily surrendered their license within the last 36 consecutive months.

A. EMS Personnel requiring reinstatement must meet the provisions in accordance with this policy.
   1. A letter to the Anderson Hospital EMS Medical Director asking to be reinstated within the System.
   2. Provide a copy of an approved CPR and if applicable, ITLS, ACLS, and PALS.
   3. Copies of continuing education as required for current licensure renewal period.
   4. Evidence of successful completion of System permitted skills and the NREMT practical skills appropriate for licensure level.
   5. All levels of personnel not having practiced clinically within the System for greater than 6 months must successfully complete a refresher course as appropriate for licensure level.
   6. Completion of the Region IV standard Operating Guidelines examination with a minimum score of 80% as applicable to licensure level.
   7. Completion and submission of an IDPH "Renewal/Child Support Form" and an "Electronic Transaction Form."
   8. A letter from the applicant to IDPH asking to test for reinstatement of their license at the level sought to be reinstated.
   9. A fee (Money Order or Cashier's Check ONLY) made payable to Illinois Department of Public Health will be assessed, for applicants seeking reinstatement of a previously expired license.

B. To allow submission of a request for reinstatement of a license to Illinois Department of Public Health all requirements of the Administrative Code Section 515.640 must be completed.
   1. The applicant must submit satisfactory proof of completion of continuing medical education requirements in accordance with the following:
      a) Continuing education in accordance with IDPH requirements of Sections 515.560, 515.570 and 515.580.
      b) EMT Training in accordance with Sections 515.500, 515.510 or 515.520

   2. The applicant shall submit a positive recommendation from an EMS Medical Director attesting to the applicant's clinical qualification for retesting. The EMS Medical Director shall verify that the applicant has demonstrated competency of all skills at the level of EMT licensure sought to be reinstated.

3. The applicant shall pass a Department approved test for the level of EMS licensure sought to be reinstated, in accordance with section 515.530 (Section 3.50 (d) (5) of the Act.

PERSONNEL RECORDS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. It is the sole responsibility of the individual First Responder, EMT, PHRN, and ECRN to:
   a. Maintain and update their continuing education records.
   b. Enter copies of all required certifications into Vairkko (or current certification tracking system)
   c. Keep current in all required certifications, registrations and/or licensure.
   d. Advise the EMS Department and IDPH, in writing, regarding changes in name, address and phone number.

2. All First Responder & EMT-B initial student records will be kept by the Lead Instructor or teaching agency for seven years. All EMT-I, EMT-P, PHRN, and ECRN initial student records will be kept by the Resource Hospital for seven years.

3. All EMT-B, EMT-I, EMT-P, PHRN and ECRN continuing education records submitted to the EMS Department will be kept for four years.

FIELD TRAINING OFFICERS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Field Training Officers have the duty to supervise and instruct students and reciprocity candidates in the pre-hospital setting.

2. They also may supervise other providers seeking further field education for CEUs.

3. FTOs may obtain up to 20% hours of continuing education every 4 years by supervising others.

4. Lead Training Supervisors shall be appointed by the EMS System Coordinator/EMS Medical Director.

5. Requirements:
   a. Maintain a valid license and all mandatory continuing education listed above.
   b. Remain in good standing with the Anderson Hospital EMS System.
   c. Exemplary field skills and documentation skills as verified by the EMS System Coordinator.
   d. Minimum of one year field experience at the advanced life support level.
   e. Experience in teaching/training/supervision of EMS personnel.
   f. Recommendation of the EMS System Coordinator.
   g. Pass an OG exam with a 85% or better.
   h. Demonstrate verbal teaching skills (with the EMS Educator or EMS System Coordinator monitoring).
   i. Attend a Field Training Officer class with EMS System Coordinator.
   j. Approval of EMS Medical Director.

6. Maintenance of FTO status:
   a. EMT-P/PHRN FTOs must continue to actively supervise students.
   b. Attend at least one quarterly Field Training Officer meeting yearly.
   c. Remain active and in good standing in the System.
   d. Score 85% or above on all OG exams.
   e. Maintain the highest standards of professionalism, knowledge, and skills.

LEAD INSTRUCTORS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Lead Instructors shall be responsible for coordinating all education, training and continuing education courses for EMT-B, EMT-I, EMT-P, Pre-hospital RN, ECRN, First Responder and EMDs.

2. A program may use more than one EMS Lead Instructor. A single EMS Lead Instructor may simultaneously coordinate more than one program or course.

3. To apply for the position of EMS Lead Instructor, the candidate shall submit:
   a. Documentation of experience and education in accordance with section (c) below;
   b. The fee required by IDPH.
   c. A letter from the EMS Medical Director recommending approval for the Lead Instructor candidate to conduct EMS courses.
   d. An EMS Lead Instructor application form prescribed by the Illinois Department of Public Health, which shall include, but not be limited to name, address, and resume.

4. Qualifications:
   a. A current license as an EMT-B, EMT-I, EMT-P, RN or physician.
   b. A minimum of four years of experience in pre-hospital emergency care.
   c. At least two years of documented teaching experience.
   d. Documented classroom teaching experience, i.e., ITLS, ACLS, CPR, Pediatric Advance Life Support (PALS).
   e. Documented successful completion of the NAEMSE EMS Instructor course or similar course approved by IDPH.

5. Upon the applicant's completion of the NAEMSE EMS Instructor course or similar course approved by IDPH and completion of the EMS Lead Instructor examination with a score of at least 80%, the Illinois Department of Public Health will approve the individual as an EMS Lead Instructor. The approval will be valid for four years.

6. Renewal:
   a. The EMS Lead Instructor shall submit to the Department of Public Health at least 60 days, but no more than 90 days, prior to the approval expiration:
   b. A letter of renewal of support from an EMS Medical Director indicating that the EMS Lead Instructor has satisfactorily coordinated programs for the EMS System at any time during the four year period.
   c. Documentation of at least 10 hours of continuing education annually, (Program used to fulfill other professional continuing education requirements, i.e., EMT, Nursing may also be used to meet this requirement.

7. Lead Instructor Reciprocity Requirements:
    a. Possess a current Illinois license as an EMT-B, EMT-I, EMT-P, RN, or physician.
    b. A minimum of four years of experience in pre-hospital emergency care.
    c. At least two years of documented teaching experience.
    d. Completion of a National Association of EMS Educators (NAEMSE) course or equivalent.
    e. Completion of an EMS educators course examination with a passing score of at least 80%.
    f. Letter of support from the EMS Medical Director.

8. Suspension/Revocation:
    a. The Department of Public Health shall, in accordance with Section 515.160 of the rules and regulations, suspend or revoke the approval of an EMS Lead Instructor, after an opportunity for a hearing, when findings show the EMS Lead Instructor has failed:
        i. To conduct a course in accordance with the curriculum prescribed by the EMS Act.
        ii. To comply with protocols prescribed by the EMS Act.

EMS FIELD REPRESENTATIVE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

The EMT Field Representative position is strictly volunteer. The individual in this position may be an EMT-Intermediate or Paramedic who has been voted into this position by his/her peers. This individual acts as a liaison between field personnel, the EMS Coordinator, and the EMS Medical Director. The length of term is two year.

The responsibilities of this individual include:

- Meet no less than quarterly with the EMS Medical Director or EMS System Coordinator to address field related problems and/or concerns.
- Contact supervisors of each service prior to quarterly Advisory Council meeting to determine any problems or obtain comments.
- Serve as a member of the System Review Board.
- Report to the EMS Medical Director on any matter as the EMS Medical Director deems necessary.

PERSONNEL EDUCATION REQUIREMENTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

PERSONNEL EDUCATION REQUIREMENTS

The curricula for all courses shall follow the National EMS Core Content, National EMS Scope of Practice Model, and National EMS Education Standards.

Requirements for First Responder and EMT-B Courses within the Anderson Hospital EMS System

1. Entrance Requirements:
   a. Register with sponsor agency or SWIC.
   b. Current CPR for Healthcare Provider certification.

2. Attendance Requirements
   a. No more than 8 hours of absence for First Responder students.
   b. No more than 10 hours of absence for EMT-B students.

3. FR-D Grade Breakdown:
   a. Test Average: 50%
   b. Final Practical: 25%
   c. Final Written: 25%

4. EMT-B Grade Breakdown:
   a. Assignments: 10%
   b. Quizzes: 10%
   c. Test Average: 25%
   d. Final Practical Exam: 30%
   e. Final Written Exam: 25%

5. The grading scale for this program is:

A = 94-100
B = 86-93
C = 77-85
D = 70-76
F = 69 or less

6. Completion Requirements:
   a. Must maintain an overall 80% average.
   b. Must pass the final exam with at least 80%.
   c. Must successfully pass all practical testing stations with at least 80%.

7. Practical Exams shall include, but not be limited to:
   a. Trauma and Medical Assessment
   b. CPR
   c. Airway Adjuncts
   d. Bandaging
   e. Splinting
   f. Immobilization
   g. AED

8. EMT-B Students must complete 10 hours of ED observation.

9. EMT-B Students must also successfully complete the state licensure exam and/or National Registry Exam.

Requirements for Hosting a First Responder or EMT-B Training Course (1.38a)

1. The "Training Program Application Form" (Site Code) must be received by IDPH *60 days in advance*. Complete and submit to the Anderson Hospital EMS System Coordinator for approval and signature. The EMS System Coordinator will then forward to IDPH. Allow ample time for System approval/mailing prior to the 60 day deadline. Attach the following:
   a. Completed "Class Schedule for EMT Basic Program"
   b. Course syllabus
   c. Simple resume or qualifications for teaching a certain module for NON-Lead Instructors

2. Submit to System EMS Coordinator an "Attendance Roster" *within 10 days after the first class.*

3. Forward the following to the EMS Coordinator within 10 days of course completion for review and advancement to IDPH for licensure:
   a. Course completion roster
      i. Didactic requirements
      ii. Clinical requirements
   b. Completed Child Support form
   c. Completed Transaction form.

4. Submit to EMS Coordinator an "Attendance Roster" including final grade *within 10 days after last class*. The passing grade is 80%.

5. Give each student who successfully completes and passes the course a "Certificate of Attendance" with the Department site code on it.

6. Students will have 90 days (*from their final class date*) to take either their initial National Written Exam or Illinois State Exam.

7. Maintain class and student records for seven years.

Note: The Lead Instructor assumes total responsibility for ensuring that the Course is taught professionally and in accordance with the National Standard Curriculum.

PRE-HOSPITAL RN EDUCATION AND LICENSURE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Entrance Requirements for PHRN:
   a. Current RN licensure in the State of Illinois
   b. Minimum of two years ED, ICU, or field experience within three years of initial application is strongly preferred.
   c. Letter of support from ALS agency providing field experience.

2. Requirements for Licensure:
   a. Completion of a system-approved PHRN or EMTB course.
   b. Demonstrate didactic and practical knowledge of emergency medicine and Anderson Hospital EMS System OGs.
   c. Pass final written exams with an 80%.
   d. Pass practical exam in accordance with established guidelines for EMT-P's.
   e. Current ITLS, ACLS, PALS/PEPP, and BLS certification.
   f. Field experience may commence upon successful completion of the System/State Practical Exam and will be commensurate with that of EMT-P students:
      i. The provisional PHRN will complete an *acceptable field internship* as determined by the EMS Educator/Coordinator and the EMS Medical Director. Individuals have one year to complete their field internship.
      ii. The provisional PHRN must obtain a positive recommendation from the Field Training Officer.

EMERGENCY COMMUNICATIONS REGISTERED NURSE (ECRN) EDUCATION & LICENSE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Entrance Requirements:
   a. Current RN Licensure in the State of Illinois
   b. Current certification of ACLS, PALS, BLS.
   c. Current trauma certification (TNS, TNCC, ITLS…) or will obtain within one year of ECRN training.

2. Requirements for Licensure:
   a. Fifty two hour didactic and practical course of instruction for the adult and pediatric population.
   b. The training course shall include:
      i. 2 Hours – Telecommunications/Disaster Operations
      ii. 4 Hours – EMS Operating Guidelines
      iii. 4 Hours – EMS System Policies
      iv. 10 Hours – PALS Provider Course
      v. 10 Hours – ACLS/CPR Provider Course
      vi. 12 Hours – Trauma Certification within one year of ECRN certification
      vii. 8 Hours – Field Experience
      viii. Successful completion of the ECRN training course, field and clinical experience, and written examination with a minimum score of 80%.

3. Requirements for ECRN re-licensure every four (4) years:
   a. All requirements must be completed and submitted 30 DAYS IN ADVANCE to the EMS System Coordinator.
   b. Licensed Registered Nurse in the State of Illinois.
   c. 32 Hours of continuing education.
   d. Pass a written examination with a minimum score of 80%. Exam format shall include, multiple choice and matching type questions. If relicensure requirements are met and mandatory education/update sessions are attended, written examination may be waived.
   e. ACLS/PALS/CPR certified
   f. ITLS/TNS/TNCC certified

4. A licensee who has not been recommended for re-licensure by the EMS Medical Director must independently submit to the Department an application for renewal. The EMS Medical Director or his designee shall provide the licensee with a copy of the appropriate form to be completed.

CONTINUING EDUCATION PROGRAMS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

a) Didactic continuing education classes, seminars or other types of programs shall be approved by the IDPH before being offered. An application for approval shall be submitted to the EMS Coordinator at least 60 days prior to the scheduled event.

b) All classes must have a Lead Instructor listed, even though content can be taught by approved personnel.

c) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for Paramedics. Upon approval, the Department will issue a site code to the class, seminar or program.

d) Applying department shall be responsible for submitting written proof of didactic continuing education attendance to the EMS System Coordinator, in the manner prescribed by the System Program Plan.

e) Applying department shall be responsible for maintaining copies of all documentation concerning continuing education programs or activities that he or she has completed.

BLANKET APPROVAL FOR CONTINUING EDUCATION PROGRAMS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

In order to facilitate EMT-Intermediate and Paramedic personnel in the Anderson EMS System in meeting the requirements for continuing education, a "Blanket-Approval policy is here defined. The intent of the policy is to provide credit for attendance of continuing education programs not specifically included in the formal Continuing Education program of the Anderson EMS System.

2. Programs affected by this policy include out-of-state conferences, case presentations, run review conferences, mock disasters, and other programs not included in the formal Continuing Education program for the system and for those programs whose construct does not lend itself to being included in the formal Continuing education program for the system.
3. Approval of said programs will be given on a case-by-case basis by the EMS Medical Director. This policy in no way circumvents or supersedes the standing continuing education requirements of the program.

Acceptance of Didactic Continuing Education Programs:

Anderson Hospital EMS System will accept any course that has received an approved Illinois Department of Public Health site code, CECBEMS, or is approved as a national conference.

REMEDIATION & SUSPENSION OF PROVIDERS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Providers within the Anderson Hospital EMS System 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.

2. In case of serious misconduct, in the sole judgment of the EMS Medical Director, the EMS Medical Director may immediately suspend an individual for an indefinite time from the EMS System. The appeal process for the same is set forth herein.

3. The normal progression of disciplinary action shall be as follows:
   a. Verbal Warning: The 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.
   b. Written Warning: The 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 may be placed in the individual's file indefinitely.
   c. Suspension: System suspension shall follow the written warning in instances where the individual has failed to correct a misconduct. Instances where suspension is the first disciplinary action taken are outlined in the following policy.

4. 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 not considered to be meeting the standards of the Anderson Hospital EMS System. Those standards include:
   a. Failure to meet the education and training requirement prescribed by IDPH or by the EMS Medical Director including failure to complete previously required remediation.
   b. Any violation of the Illinois EMS Act.
   c. Failure to maintain proficiency in the provision of basic, intermediate or advanced life support services
   d. Failure to comply with any provision of the system's program plan approved by IDPH.
   e. Engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public.

f. Intoxication or personal misuse of intoxicating liquors, narcotics, controlled substances or other drugs including stimulants in such manner as to adversely affect the delivery, performance, or activities in the care of patients requiring medical care.
g. Intentional falsification of any medical reports or orders, making misrepresentation involving patient care, or engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.
h. Abandoning or neglecting a patient requiring emergency care.
i. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, healthcare facility, institution or other work place location.
j. Performing or attempting emergency care, techniques, or procedures without proper permission, certification, training or supervision.
k. Discrimination in rendering emergency care because of race, sex, religion, national origin or ability to pay.
l. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.
m. Violation of the System's standards of care.
n. 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 an EMT-B/I/P or PHRN on inactive status pursuant to IDPH regulation.

5. Remediation may consist of, but is not limited to:
   a. Research paper.
   b. Being reassigned to a FTO for supervision.
   c. Clinical rotations (hospital, etc.).
   d. Mega-code scenarios.
   e. Skills verifications.
   f. Clinical interview with the EMS Medical Director.

6. Notification of suspension:
   a. The EMS Medical Director shall issue a written notice via US Mail (at the most recent address on file with the EMS Office) to the individual or provider of the suspension.
   b. The notice will include a statement describing the reason(s) for the suspension, the terms, length, and condition of the suspension, and the date the suspension will commence, unless a hearing is requested.

7. A request for a hearing, via certified mail, must be submitted within 15 days to the EMS Medical Director. Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.

8. The Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an Emergency Department Physician with knowledge of EMS, one of whom is an EMT, and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. No person or entity with prior direct knowledge of the incident may serve on the Local System Review Board of an event.

9. The hearing shall commence within 21 days after receipt of the written request.

10. 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. The decision of the Board shall be effective immediately upon publication.

11. 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.

12. The EMS Medical Director shall notify the Illinois Department of Public Health in writing, of the Local System Review Board's decision within five days after it is issued.

13. 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.

14. 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.

15. 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.

16. An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information in his or her possession indicates that the continuation in practice by an EMT or the provider would constitute an imminent danger to the public. The suspended First Responder, EMT-B/I/P/PHRN or other provider shall be issued an immediate verbal notification followed by a written suspension order to the First Responder, EMT-B/I/P/PHRN or other provider by the EMS Medical Director which states the length, terms and basis for the suspension.

17. Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger or fax, a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the First Responder, EMT-B/I/P/PHRN or provider.

18. Within 24 hours following the commencement of the suspension, the suspended First Responder, EMT-B/I/P/PHRN or provider may deliver to the Department by messenger or fax, a written response to the suspension order and copies of any written material which the First Responder, EMT-B/I/P/PHRN or provider feels relate to that response.

19. Within 24 hours following receipt of the EMS Medical Director's suspension order or the First Responder, EMT-B/I/P/PHRN 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 First Responder, EMT-B/I/P/PHRN or provider's opportunity for hearing or review in accordance with the EMS Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended First Responder, EMT-B/I/P/PHRN or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.

20. The Director, after providing notice and an opportunity for an administrative hearing to the applicant or licensee, shall deny, suspend or revoke a license or refuse to relicense any person as a First Responder, EMT-B/I/P/PHRN in any case in which he or she finds that there has been a substantial failure to comply with the provisions of the EMS Act. Such findings must show one or more of the following:
    a. The First Responder, EMT-B/I/P/PHRN, has not met continuing education or relicensure requirements.
    b. The First Responder, EMT-B/I/P/PHRN, has failed to maintain proficiency in the level of skills for which he or she is licensed.
    c. The First Responder, EMT-B/I/P/PHRN, during the provision of medical services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public (e.g., use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status)
    d. The First Responder, EMT-B/I/P/PHRN, has failed to maintain or has violated standards of performance and conduct as prescribed by IDPH or his/her System's Program Plan.
    e. The First Responder, EMT-B/I/P/PHRN, is physically impaired to the extent that he or she cannot physically perform the skills and functions for which he or she is licensed, as verified by a physician, unless the person in on inactive status.
    f. The First Responder, EMT-B/I/P/PHRN, is mentally impaired to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the functions for which he or she is licensed, as verified by a physician, unless the person is on an inactive status.
    g. The First Responder, EMT-B/I/P/PHRN, has violated the EMS Act.
    h. The First Responder, EMT-B/I/P/PHNR, has demonstrated medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.
    i. The First Responder, EMT-B/I/P/PHRNs, license has been revoked, denied or suspended by IDPH.

ACCOUNT OF/ABUSE OF CONTROLLED SUBSTANCES BY SYSTEM PERSONNEL	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Narcotics will be kept locked under **double lock** and key out of sight of the general public.
2. Narcotics will be dispensed at the Resource Hospital ONLY.
3. Narcotic tag check will be performed at the beginning of each shift by the on-coming and off-going Paramedics at the station. Signatures of the individuals counting must be noted on the yellow narcotic substance check list.
4. If a tag discrepancy is found, every attempt must be made to find the error. The department supervisor and EMS Coordinator must be notified. For an unresolved discrepancy, the EMS Medical Director and Pharmacist at the Resource Hospital will be notified and a problem documentation form completed.

5. Narcotic wastage:

   No narcotic wastage will occur in the field. All waste is to be packaged and returned as per the Narcotic Exchange policy.

SUSPENSION OF AN EMS PROVIDER/SERVICE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Grounds for suspension of an EMS Provider/Service include, but are not limited to:
   a. Evidence of continued disregard for documentation and data collection procedures. This includes consistent incomplete documentation of or failure to timely submit the required CQI data or run reports.
   b. Evidence of failure to maintain dependable operation status for vehicle and/or equipment as required by IDPH and Anderson Hospital EMS System Policies.
   c. Evidence of failure to maintain the stock or supply of equipment and material as required by IDPH and Anderson Hospital EMS System Policies.
   d. Failure to adhere to commitments made in the services' proposal and application for service.
   e. A reasonable belief by the EMS Medical Director that the continued participation by the Provider constitutes an unacceptable risk of imminent harm to the population served by the Provider.

2. All suspensions of an EMS Provider/Service shall be made in accordance with the above suspension policy and IDPH rules and regulations, with the interests of the population served by the provider/service at the forefront.

AMBULANCE INSPECTIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. All ambulances and alternate response vehicles in the Anderson Hospital EMS System will carry the equipment and supplies as listed above. Alternate response vehicles shall use the equipment list for BLS or ALS ambulances (as appropriate). An equipment waiver may be obtained following IDPH guidelines.

2. All ambulances and alternate response vehicles will be inspected annually. Random inspections may be conducted at any time and without advance notice thereof. All inspections will be by the EMS System Coordinator or designee.

3. Anderson Hospital EMS System providers will perform equipment and supply inspections on a daily basis.
   a. First responder organizations may inspect equipment on a less frequent basis as determined by the organization's call volume. However, inspections will occur weekly, at minimum. This includes inspection of all AEDs.

AMBULANCE EQUIPMENT AND DRUG LISTING	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

All ambulances are required by IDPH to have minimal equipment. That list can be found at the IDPH website:

http://dph.illinois.gov/sites/default/files/forms/ems-ambulance-inspection.pdf

In addition to the above requirements by IDPH, the EMS system requires the following:

1.	Approved ALS Medications	Quantity
1.1	Adenosine 6mg/ml (2ml)	3
1.2	Amiodarone 150mg	6
1.3	Aspirin 81mg chewable tablets	8
1.4	Atropine 1mg/10ml	4
1.5	Calcium Chloride 10% in 10ml	2
1.6	Decadron 10mg IV*	1*
1.7	*Diazepam (Valium) 10mg/2ml (total of 40mg)*[1]	
1.8	Diphenhydramine (Benadryl) 50mg	2
1.9	Epinephrine 1:1,000 1mg/ml	2
1.10	Epinephrine 1:10,000 1mg/10ml	8
1.11	Etomidate 10ml vial 2mg/ml	3
1.12	*Fentanyl 2ml vial 50mcg/ml*[1]	1
1.13	Furosemide (Lasix) 40mg & 100mg	1 each
1.14	Glucagon 1mg	2
1.15	Haloperidol 5 mg/ml	1
1.16	Labetalol 100 mg/20 ml	1
1.17	Lidocaine 2% 100mg/5ml	1
1.18	Magnesium Sulfate 1 gram/2ml	2
1.19	*Morphine Sulfate (MSO4) 4mg or 10mg/ml (total of 40mg)*[1]	
1.20	Naloxone (Narcan) 2mg/ml	5
1.21	Nitroglycerine spray	1 bottle
1.22	Nitroglycerine Tablets 0.4mg	1 bottle
1.23	Nitroglycerine paste 1-inch pre-packaged	1 dose
1.24	Sodium Bicarbonate 50mEq/50ml	2
1.25	Solu-Medrol 125mg/2ml*	1*
1.26	Thiamine 100mg/2ml	1
1.27	Toradol 30mg	2
1.28	*Versed 5mg or 10mg/2ml (total of 20mg)*[1]	
1.29	Zofran (Ondansetron) 4mg Tabs (total of 8mg)	2
1.30	Zofran (Ondansetron) 4mg/2ml	1

1.31	Albuterol (Proventil, Ventolin) Unit dose 2.5mg in 3ml	4
1.32	0.90% Sodium Chloride Solution 3ml	2
1.33	Oral Glucose 15grams	1
1.34	Normal Saline flush 10ml	4
1.35	Lactated Ringers 1000ml	4
1.36	Normal Saline 1000ml	4
1.37	Dopamine 400mg/250ml premix	1
1.38	D5W or NS 100ml	1
1.39	NS 250ml	1
1.40	Dextrose 10% 500ml	2

*****Either 1 – Decadron or 1 – **Solu-Medrol**, not both.

1 = to be sealed in narcotic lock box, in locked cabinet:

2. Transfer medications listed below

3. Medication Delivery Supplies		Quantity
3.1	Tubex Injectors	2
3.2	Nebulizer Kits	2
3.3	Aerosol Masks	2
3.4	Nasal Atomizers	2
3.5	5ml Syringe	2
3.6	10-12ml Syringe	2
3.7	20ml Syringe	2
3.8	30-35ml Syringe	2
3.9	19 gauge needle, 1 ½"	4
3.10	18 gauge filter needle, 1 ½"	4

4. Intravenous Supplies & Equipment		Quantity
4.1	IV Start Kits or supplies included in a start kit	4
4.2	14 gauge IV catheter	4
4.3	16 gauge IV catheter	4
4.4	18 gauge IV catheter	6
4.5	20 gauge IV catheter	6
4.6	22 gauge IV catheter	4
4.7	IV tubing, macrodrip (10, 15, or 20 gtt/ml)	4
4.8	IV tubing, microdrip (60 gtt/ml)	2
	Microdrip not required if IV pump or Dial-a-Flow in stock	
4.9	Saline Lock device	4
4.10	19 gauge needle (butterfly)	2
4.11	25 gauge needle (butterfly)	2
4.12	Red, Green, Purple, & Blue top blood tubes	2 each
4.13	Intraosseous Needles and/or mechanical device with needles	2

5.	Airway Supplies & Equipment	Quantity
5.1	Bag-Valve-Mask devices – ADULT	2
5.2	Bag-Valve-Mask devices – PEDIATRIC	1
5.3	Bag-Valve-Mask devices – NEONATAL	1
5.4	Tongue blades	5
5.5	Magill forceps	1
5.6	Laryngoscope handle & blade set (straight & curved, sizes 0-4)	1
5.7	Back-up batteries for laryngoscope (set)	1
5.8	Endotracheal tube – 2.5 mm	1
5.9	Endotracheal tube – 3.0 mm	1
5.10	Endotracheal tube – 4.0 mm	1
5.11	Endotracheal tube – 5.0 mm	1
5.12	Endotracheal tube – 6.0 mm	1
5.13	Endotracheal tube – 7.0 mm	2
5.14	Endotracheal tube – 8.0 mm	2
5.15	Endotracheal tube – 8.5 mm	2
5.16	Endotracheal tube – 9.0 mm	1
5.17	Stylets – for adult & pediatric sized tubes	2
5.18	LMA or King Airway – size 3	1
5.19	LMA or King Airway – size 4	1
5.20	LMA or King Airway – size 5	1
5.21	End tidal CO2 device – qualitative or quantitative – ADULT	2
5.22	End tidal CO2 device – qualitative or quantitative – PEDIATRIC	2
5.23	ET tube holder	1
5.24	Meconium Aspirator	1
5.25	Continuous Positive Airway Pressure (CPAP) device	1

6.	Assessment & Monitoring Supplies & Equipment	Quantity
6.1	Pulse Oximetry	1
6.2	Blood Glucose Monitor	1
6.3	Cardiac Monitor with 12-Lead & Defibrillation	1
6.4	Hands-Free Pacing/Defibrillation Pads – ADULT	2
6.5	Hands-Free Pacing/Defibrillation Pads – PEDIATRIC	2
6.6	Monitor Lead Electrodes (10 Leads)	1 set

7.	Additional Supplies & Equipment	Quantity
7.1	Pleural Decompression kit including Heimlich Valve	1
7.2	Disaster tags	20

PERSONNEL REQUIREMENTS FOR AMBULANCES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Each ambulance shall be staffed by a minimum of two EMTs, PHRNs, or physicians on all emergency calls.

2. Each Basic Life Support vehicle shall be staffed by a minimum of one EMT-Basic and one other EMT-B/I/P, PHRN, or physician.

3. Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one EMT-I, EMT-P, PHRN or physician and one other EMT-B/I/P, PHRN, or physician.

4. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one EMT-P, PHRN, or physician and one other EMT-B/I/P, PHRN, or physician.

5. Each ambulance provider that operates an emergency transport vehicle shall ensure, through written agreement with the Anderson Hospital EMS System, that the agency providing emergency care at the scene and en route to the hospital meets the requirements.

6. A provider shall routinely provide care at a level not exceeding the level for which the ambulance is licensed (basic life support, intermediate life support, advanced life support), unless such vehicle is operated pursuant to an EMS System-approved in-field service level upgrade. Exceptions to this rule:
   a. When a patient being transported by a BLS ambulance staffed with an EMT-P or PHRN and the patient appears to be in immediate jeopardy of life or limb, the EMT-P or PHRN may use the equipment at hand on the BLS ambulance to render limited ALS care within the EMT-P or PHRN's scope of practice.
   b. EMT-P personnel credentialed to provide a more advanced level of ALS care within the Anderson Hospital EMS System (CCEMT-P personnel approved for the critical care transport ambulances) may utilize the CCT protocols at any time, on any ALS unit.

AMBULANCE UNIT LABELS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

To assure that all ambulances in the Anderson Hospital EMS System can be readily identified as to their level of care, all ambulances within the Anderson Hospital EMS System will be labeled their respective level of state licensing.

1. All ambulances within the Anderson Hospital EMS System will display their licensed level of care on both sides of the ambulance (BLS Unit, ILS Unit, ALS Unit).

2. The letters designating the licensed level of care will be 4" (four inches) or larger.

3. Positioning of the lettering is at discretion of the individual service, however the lettering must be plainly visible from 50' (50 feet).

4. The color of the lettering is left to the discretion of the individual provider.

5. Ambulances used as reserve or back-up units their level of licensure. These units may also utilize signage that can be placed over this lettering when these units are utilized at different levels of licensure.

ALTERNATE RESPONSE VEHICLES – AMBULANCE ASSISTANCE VEHICLES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Section 515.825 Alternate Response Vehicle

a) Ambulance assistance vehicles
Ambulance assistance vehicles are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. These assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by this Section. These vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available. The agency shall identify these vehicles as a program plan amendment outlining the type and level of response that is planned. The vehicle shall not transport or be a primary response vehicle but a supplementary vehicle to support EMS services. The vehicle shall be dispatched only if needed. Ambulance assistance vehicles shall be classified as either:

1) Advanced ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-P and shall have all of the required equipment; or

2) Intermediate ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-I and shall have all of the required equipment; or

3) Basic ambulance assistance vehicles. These vehicles shall be staffed with a minimum of one EMT-B and shall have all of the required equipment; or

4) First Responder assistance vehicles. These vehicles shall be staffed with a minimum of one First Responder and shall have all of the required equipment.

b) Non-transport vehicles
Non-transport vehicles are dispatched prior to dispatch of a transporting ambulance. These vehicles include ambulances and fire engines that contain the staff and equipment required by this Section. The vehicle service provider shall identify these vehicles as a program plan amendment outlining the type and level of response that is planned. These vehicles shall be staffed 24 hours per day, every day of the year.

1) ALS/ILS non-transport vehicles. These vehicles shall have a minimum of either one EMT-P, or one EMT-I and one other EMT-B, and shall have all of the required equipment.

2) BLS non-transport vehicles. These vehicles shall have a minimum of two EMT-Bs and have all of the required equipment.

c) Equipment requirements
Each vehicle used as an alternate response vehicle shall meet the following equipment requirements, as determined by the Department by an inspection.

1) Full portable oxygen cylinder, with a capacity of not less than 350 liters

2) Dial flowmeter/regulator for 15 liters per minute

3) Delivery tubes

4) Adult, child and infant masks

5) Adult squeeze bag and valve, with adult and child masks

6) Child squeeze bag and valve, with child, infant and newborn size masks

7) Airways, oropharyngeal − adult, child and infant (sizes 00-5)

8) Airways, nasopharyngeal with lubrication (sizes 12-30F)

9) Manually operated suction device

10) Triangular bandages or slings

11) Roller bandages, self-adhering (4" by 5 yds)

12) Trauma dressings

13) Sterile gauze pads (4" by 4")

14) Vaseline gauze (3" by 8")

15) Bandage shears

16) Adhesive tape rolls

17) Blanket

18) Long backboard

19) Cervical collars − adult, child and infant

20) Extremity splints − adult/child, long/short

21) Adult/child/infant blood pressure cuffs and gauge

22) Stethoscope

23) Burn sheet, individually wrapped

24) Sterile saline or water solution (1,000ml), plastic bottles or bags

25) Obstetrical kit, sterile − minimum one, pre-packaged with instruments, bulb syringe and cord clamps

26) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one

27) Cold packs

28) EMS run reports

29) Nonporous disposable gloves

30) Eye/nose/mouth protection or face shields

31) Flashlight

32) Equipment to allow reliable communications with hospital

33) ILS/ALS System-approved equipment

A) Drug box

B) Airway equipment, including laryngoscope and assorted blades

C) Monitor/defibrillator, equipped with pediatric size defibrillation pads or paddles

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

e) Registration of non-transport agencies
Each non-transport provider shall complete and submit to the Department one of the following: the First Responder Provider Initial EMS System Application

(Form First 10/97), the Non-Transport Provider EMS System Application (Form NT 5/97), or the Non-Transport Provider Application (Form NT 6/99).

f) Inspection of non-transport EMS providers
The Regional EMS Coordinator will perform initial inspections. Thereafter, non-transport ambulance assist providers shall perform annual self-inspections, using forms provided by the Department, and shall submit the form to the Department upon completion of the inspection. The Regional EMS Coordinator will perform inspections randomly or as the result of a complaint.

g) Issuance and renewal of license
Upon payment of the appropriate fee, qualifying non-transport providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual non-transport vehicles. Providers shall inform the EMS System and the Department of any modifications to the application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

ALLOWABLE TRANSPORT MEDICATIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

In addition to medications/procedures included in the Operating Guidelines, the following medications and procedures are approved for ALS transfer. Additional Transfer Medications – Not To Be Titrated/Pump Required unless ordered by transferring physician – NOTE: These medications may be monitored by the EMTP/PHRN during a inter-facility transfer but are not stocked with the ALS ambulance medication inventory.

2.1 Alteplase (tPA)
2.2 Aminophylline/Theophylline
2.3 Amiodarone
2.4 Antibiotics
2.5 Benzodiazepines
2.6 Beta Blockers (atenolol, metoprolol, propranolol, esmolol, labetalol)
2.7 Blood/Blood Products
2.8 Digibind
2.9 Diltiazem (Cardizem)
2.10 GP llb/llla Inhibitors (ReoPro, Integrilin, Aggrastat)
2.11 H1 blockers (Benadryl, promethazine) and H2 blockers (Tagamet, Zantac, Pepcid, Axid)
2.12 Heparin
2.13 Ketamine
2.14 Lidocaine
2.15 Magnesium Sulfate
2.16 Mannitol
2.17 Multivitamin preparations for infusion
2.18 Narcotics, including Patient Controlled Analgesic (PCA) pumps
2.19 Nitroglycerin Infusion (Tridil)
2.20 Norepinephrine
2.21 Phenobarbital
2.22 Phenytoin/Fosphenytoin
2.23 Pralidoxime
2.24 Procainamide
2.25 Steroids (mineral and glucocorticoid)

Ambulance Critical Care Transports

CRITICAL CARE TRANSPORTS	
Anderson EMS System	**Approved: Region Medical Dir**
Author: Region IV	**MD Approved: 09/16**
Version: 1.0	**Council Approved:**

A. Definition of Critical Care Transport

Critical Care Transport means the pre-hospital or inter-hospital transportation of critically injured or ill patients by an Illinois licensed vehicle service provider, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the Illinois Paramedic. When medically indicated for a patient, as determined by a physician licensed to practice medicine in all of its branches, an advanced practice nurse or a physician's assistant, in compliance with Section 3.155 (b) and (c) of the Act. Critical care transport may be provided by **Tier II and Tier III** providers.

B. Advanced Care Transports are defined in Region 4 as three levels of care.

Tier I is considered expanded scope performed under the current approved system guideline .
Tier II is considered a Critical Care Transport.
Tier III is considered a Critical Care Transport.

C. Critical Care personnel licensure

1. Licensed Illinois Paramedic or Pre-Hospital Registered Nurse (PHRN);
2. Current in required certifications (Section E.)
3. Have completed Scope of Practice Education more comprehensive than the National Scope of Practice curriculum and more comprehensive than the expanded scope practice level of tier I.
4. Be approved to practice by Illinois Department of Public Health EMS Division in accordance with the EMS System/Regional plan.

D. Qualification Requirements for Tier II and Tier III

1. A minimum of 2 years experience on an Advanced Life Support (ALS) unit for Paramedics. PHRN's will meet the requirements of 515.730 (PHRN) with a minimum of 2 years on an Advanced Life Support unit or as a critical care RN (CCN/ICU) or Emergency Department RN.
2. PHRN without critical care or emergency department experience must have 2 years experience on an ALS unit as PHRN/Paramedic.

E. Certifications required for all Tiers of transport:

1. Healthcare CPR
2. ACLS
3. ITLS (PHTLS accepted until renewal date)
4. PALS (PEPP accepted until renewal date)

F. Initial Requirements for Critical Care Transport Functions: Tier II and Tier III

1. Licensed Illinois Paramedic or PHRN with minimum required experience as described in Part D above.
2. Approved by EMS Medical Director and Illinois Department of Public Health in accordance with the EMS Region 4 Plan.
3. Completion of an approved Critical Care Emergency Transport Program (minimum of an 80 hour course) to function at a **Tier II/III** level.
4. Demonstrated competencies of expanded scope of practice didactically and skills as required by the Tier level of care.
5. Successful completion of the Regional designated Critical Care test with a score of 84% or greater.

G. Criteria to Maintain Critical Care Status

1. Paramedic or PHRN in good standing within a Region 4 EMS System. Additional requirements as designated by the EMS System.
2. Successful completion of **Tier II or III** annual competencies as Tier applicable.
3. Maintain licensure requirements for a paramedic/PHRN current in the Region/System.
4. 12 hours of annual (48 hours during 4 year licensure period) competencies of **Critical Care** knowledge, equipment and procedures or Critical Care based continuing education (EMS, Nursing or CME) shall be completed.
6. The EMS vehicle service provider shall maintain documentation of **Tier II and III** education for each critical care paramedic or PHRN taught, equipment and procedures of annual competencies;
7. Provide documentation to the EMS Resource Hospital for relicensure purposes. Additional training as required by the Region/System.
8. All didactic and clinical competencies will require an 84% to receive a passing Score for ongoing Critical Care function.

H. Vehicle Standards

1. Any vehicle used for providing critical care transport shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure.

(A) "Ambulance" means any publicly or privately owned on-road vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or

operated for the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such individuals.

2. Meet and maintain requirements for all vehicles as mandated by Illinois Department of Public Health and the EMS System for licensure/relicensure ambulance inspections.

3. Critical Care medical equipment and ambulance equipment as required by Illinois Department of Public Health and the affiliated EMS System.

4. All critical care transport ambulances shall be equipped with an onboard AC supply capable of operating and maintaining the AC current as a required medical device used in providing care during all patient transports.

I. Treatment and Transport Protocols that address the following:

1. EMS System Medical Director or Designee will be available at all Region 4 Resource and Associate Hospitals Medical Control 24 hours daily (see page 17 section II Communications and Oversight in Regional Policies.)

2. Communication points for contacting Medical Control (pg. 17 section II Communications and oversight in Regional Policies). and a written Expanded Scope of Practice Standard Operating Guideline and the CCEMT-P Standard Operating
Guidelines as is available in the Region 4 SOG's following ALS care recommendations.

J. Critical Care Transport Paramedics and Nurses

1. A copy of an approved Expanded Scope of Practice completion or a Critical Care Transport program completion documentation will be provided to the System EMS Office along with an Illinois State paramedic or PHRN license. Current CPR, ACLS, ITLS or PHTLS and PALS or PEPP card must accompany any system entry request.

2. Critical Care Transport Nurses (PHRN): must provide professional licensure as a State of Illinois Registered Nurse and a current State of Illinois PHRN licensure or EMT-P licensure to the System EMS Office.

3. The EMS vehicle service provider shall maintain documentation of competencies, provide documentation of competencies and provide

updated documentation to the EMS Resource hospital upon request.

K. Tier II/III Transports:

1. **Tier II/III** provides a level of care for patients who require care beyond the USDOT
Curriculum and expanded scope of practice ALS (paramedic) transport program, and who require formal advanced education for ALS paramedic staff as provided in Critical Care Emergency Medical Programs (e.g. University of Maryland Baltimore CCEMTP Program) receiving treatment with advanced equipment medications and advanced patient care to include

A. Use of a ventilator,
B. Medication-assisted intubations,
C. Infusion pumps with titrated medication(s),
D. Non titrated IV medications,
E. Maintenance of chest tubes ,
F. Aortic balloon pump management
G. Additional active interventions necessary in providing care to the patient

L. Minimum Staffing Tier II (2 person minimum crew - Ambulance). Tier II is determined as having no more than 2 items listed in section K.

1. Driver: System Paramedic
2. System approved Critical Care Paramedic/PHRN, who shall remain with the patient at all times.

M. Minimum Staffing Tier III (3 person minimum crew - Ambulance). Tier III is determined as having 3 or more items listed in section K.

1. One EMT-B/EMT-I/Paramedic primarily as the driver.
2. One Critical Care Paramedic/PHRN/RN/Respiratory Tech crew member to remain with the patient at all times,
3. One Critical Care Trained PHRN/RN crew member to remain with the patient at all times.

N. Education, Certification and Experience

1. Initial Advanced Formal Education
   A. 80 hours established higher collegiate Critical Care education or equivalent critical care education based on existing University program models (e.g. UMBC CCEMTP)
   B. Demonstrated competencies, as required by Illinois EMS System and/or affiliated Critical Care Service

2. Certifications – **Tier II and Tier III** personnel shall maintain the following renewable certifications and credentials in active status:

A. ECRN (RN Only) (Required on Tier III transports)
B. Healthcare CPR
C. ACLS
D. PEPP or PALS
E. ITLS or PHTLS

Note-PEPP or PHTLS is only accepted until first System renewal.

3. Experience-- Licensed Illinois Paramedic or PHRN with a minimum of 2 years of pre-hospital experience on an ALS ambulance.
   i. For **Tier III**, Critical Care RN/PHRN must have 2 years as a critical care RN (CCN/ICU) or Emergency Department RN with documented competencies.

O. Quality Assurance Program

1. The quality assurance program provides an evaluation of Paramedic and PHRN patient care and documentation thoroughness.
2. **Tier II and Tier III** transport providers shall have a written QA Plan approved by the EMS System Medical Director and the Department, in accordance with subsection: 515.860 (g)(7)(D). The provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation. After the 12 months of QI has been validated by the Medical Director, the following evaluations shall be ongoing:
   A. Review EMS record assuring documentation of vital signs and frequency demonstrating that abnormal vital signs were recognized and appropriately detected and managed.
   B. Review the patient transport record for accuracy e.g. procedures, instability recognition and knowledgeable equipment use.
   C. Evaluate the Patient Care Record (PCR) for documentation and demonstration of side effects, complications, hypotension, bradycardia or tachycardia, chest pain variability, arrhythmias, altered mental status or variable neuro exam. Was the patient care provided as SOG's require?
   D. Were there any unanticipated occurrences e.g. IV dislodged or infiltrated? Was a medication rate of infusion changed?
   E. Were all events appropriately managed and documented?
   F. Was medical Control notified for direction for unexpected patient occurrences?
3. Written documentation of adverse events should be reported to the EMS Office within 24 working hours.
4. A copy of any written transfer orders will be submitted to the EMS System with the PCR.
5. Educational needs shall be determined and implemented by the Critical Care Physician or EMS Educator as appropriate.

6. The Critical Care Transport service must provide documentation of monthly reviews of Critical Care transport documentation.

7. Quality Assurance Reports: The EMS System Office shall receive bi-annual (submitted by the second week in January and June) quality reports of all Critical Care Transports after the quarterly first year reports, if the System has not identified any deficiencies or adverse outcomes during the first 12 months.

A copy of the Patient Care Report will be submitted to the EMS Office within 24 hours of a call.

P. A Medical Director shall oversee the QA Program.

1. The Department will approve vehicle service providers for critical care transport when the provider demonstrates compliance with an approved EMS System's Critical Care Transport Program Plan for **Tier II/III** transports. Only Department approved agencies may advertise as Critical Care Transport (CCT) / Specialty Care Transport (SCT) providers.

1. The Department or Director will suspend a vehicle service provider's approval for Critical Care Transport if any part of the provider's QA plan is not followed or if a situation exists that poses a threat to the public health and safety. Suspensions will be in accordance with 515.860 of the Illinois EMS Act.

Section IV: EMS Response

RESPONSE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. EMDs will dispatch ambulances and first responders urgent (with lights and sirens) or non-urgent according to protocols approved by the EMS Medical Director.

2. EMS units dispatched with a non-urgent response, will not upgrade to an urgent response unless:
   a. Public safety personnel on scene request an urgent response.
   b. The communications center determines that the patient's condition has changed necessitating an urgent response.

3. An EMS unit may divert from a current non-urgent call to a higher priority urgent call ONLY IF:
   a. The EMS unit can reach the location of the higher priority before other responding units.
   b. The EMS unit happens upon what appears to be a higher priority call.
   c. An EMS unit may bypass what appears to be a lower priority situation and continue to the originally assigned call.
   d. The diverting EMS unit must notify the EMS dispatch center that they are diverting to the higher priority call.
   e. The diverting EMS unit ensures that the dispatch center dispatches an EMS unit to their original call.
   f. Once a call has been diverted, the next EMS unit dispatched must respond to the original call. A call should not ideally be diverted more than one (1) time.

MUTUAL AID	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. All providers within the Anderson Hospital EMS System will assure proper maintenance, development, revision, and adherence to mutual aid agreements between all transport and non-transport providers in the Anderson Hospital EMS System.

2. These mutual aid agreements shall be written agreements between provider agencies that ensure a continuum of care during peak-load periods and personnel shortages. Cooperation among all EMS agencies must supersede geographical, political, and historical boundaries.

3. All agencies will maintain current written mutual aid agreement with other transport providers to be followed when a call for service is received and the agency called is:
   a. Not available to respond to an emergency in a timely manner (on a call, personnel shortage).
   b. Is a non-transport provider.
   c. Unable to respond.
   d. Distance to call location is closer to another provider.

4. Development/Revision of mutual aid agreements will be based upon the immediate needs of the community the provider agency is serving. Such development/revisions will be conducted in a timely manner to assure and maintain proper response mechanisms.

5. Mutual aid agreements should reflect the optimum level of care and response that can be provided to the caller. Ideally the agreement should be with the provider agency/agencies that are in the primary (6 min response) and secondary (6 to 15 min response) coverage areas.

6. Mutual aid agreements should describe methods of providing EMS service which include single and dual vehicle response and the level(s) of the response/transport vehicles

7. All agencies will adhere to mutual aid agreements as they were agreed upon. Personnel involved in the implementation of these agreements (i.e. dispatchers) should be kept informed of changes in the agreements so that proper operations are followed.

8. When the need arises to use/implement a mutual aid agreement, the caller should be notified of such and told that there may be a delay in response time. The caller should then be given an estimated time of arrival when requested.

ALS ASSIST GUIDELINES FOR BLS/ILS UNITS (IN-FIELD SERVICE UPGRADES)	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Any BLS unit may request ALS assistance to render a higher level of patient care for any patient.

2. A request for ALS assistance shall be implemented en route to the call when a call is received for a potentially critically ill or injured patient. Most commonly, the request for ALS assistance will occur at the end of the scene size-up.

3. Suggested criteria for requesting ALS assistance include, but are not limited to:
   a. Patients with compromised or obstructed airways.
   b. Respiratory distress or arrest.
   c. Cardiac arrest.
   d. Symptoms of acute coronary syndrome: chest pain, SOB, etc.
   e. Altered level of consciousness.
   f. Diabetic emergency.
   g. Seizure or postictal state.
   h. Pregnancy with imminent delivery.
   i. Poisoning/overdose.
   j. Major Trauma including, but not limited to:
      i. Multiple injuries or isolated severe injuries or pain.
      ii. Trauma patients with entrapment.
      iii. Major burns or those with potential respiratory involvement.
   k. Medical or trauma patients exhibiting signs of shock (altered mental status, hypotension, diaphoresis, and tachypnea).
   l. Any case deemed by the responding agency or Medical Control as beneficial to patient outcome.

4. If there is uncertainty regarding the need for ALS assistance, request ALS! Err on the side of the patient.

5. Consideration should be given to the following:
   a. Transport time to hospital.
   b. Rendezvous site.
   c. Availability of resources.
   d. Interventions needed (defibrillation, airway, drugs).

6. If, at any time, the BLS unit has the ability to arrive at the hospital within five minutes, ALS assist can be canceled unless the patient has a compromised airway. (This includes unresponsive patients, patients in respiratory or cardiac arrest, or in whom impending respiratory or cardiac arrest is suspected.)

7. All other cases require request for ALS intercept. The BLS unit shall call for ALS assist as soon as it is evident that ALS care is needed. The BLS unit will NOT delay transportation to the ED to await ALS assist. Rendezvous en route is appropriate in these circumstances.

8. BLS ambulance personnel at the scene of an emergency shall allow ALS ambulance personnel at the scene access to the patient for the purpose of assessing whether ALS care is warranted.

9. ALS personnel will have control of the scene.

10. If the ALS personnel determine that the patient requires advanced life support care, the BLS personnel shall transfer the care of that patient to the ALS personnel. Higher level personnel shall assume in-field responsibility for the patient during the remainder of a pre-hospital transport.

11. EMT-P/PHRN personnel may, on an ALS assist, temporarily transfer the ALS equipment to the BLS vehicle. A vehicle upgraded as per protocol will be recognized by IDPH as approved for the higher level of service during the remainder of the patient transport.

12. Medical Control should be contacted for clarification should patient care issues or concerns arise.

13. The BLS unit will complete a run record to include all assessments and treatments carried out while the patient was in their care. The BLS unit should conclude their report indicating they relinquished care to the appropriate ALS unit.

14. The ALS unit will complete a run record to include all assessments and treatments carried out while the patient was in their care.

15. The highest standards of patient care and professionalism at the scene will be maintained at all times. The care and safety of the patient is the highest priority. Should any conflict arise, submit an Incident Report to the EMS Coordinator.

RURAL IN-FIELD SERVICE UPGRADE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: 210 ILCS 50/3.87 / JCAR 515.833	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. An ambulance operated by a rural ambulance service provider or a specialized emergency medical services vehicle or alternate response vehicle operated by a rural vehicle service provider (population below 7500) may be upgraded as long as the EMS System Medical Director and the Illinois Department of Public Health have approved the proposal, to the highest level of EMT license (advanced life support/paramedic, intermediate life support, advanced EMT, intermediate life support, or basic life support) or Pre-Hospital RN held by any person staffing that ambulance, specialized emergency medical services vehicle, or alternate response vehicle. The ambulance service provider's proposal or rural services vehicle provider's proposal for an upgrade must include all of the following:

    a. The manner in which the provider will secure and store advanced life support equipment, supplies and medications.

    b. The type of quality assurance the provider will perform.

    c. An assurance that the provider will advertise only the level of care that can be provided 24 hours a day.

    d. A statement that the provider will have that vehicle inspected by the Illinois Department of Public Health annually.

2. If a rural ambulance service provider or rural vehicle service provider is approved to provide an in-field service level upgrade based on the licensed personnel on the vehicle, all the advanced life support medical supplies, durable medical equipment, and medications must be environmentally controlled, secured, and locked with access by only the personnel who have been authorized by the EMS System Medical Director to utilize those supplies.

3. The EMS System shall routinely perform quality assurance on in-field service level upgrades to ensure compliance with the EMS System plan.

4. The EMS System Medical Director may define what constitutes an in-field service level upgrade. An in-field service level upgrade may include, but need not be limited to, an upgrade to a licensed ambulance, alternate response vehicle or specialized emergency medical services vehicle.

Section V: On Scene

NATIONAL INCIDENT MANAGEMENT SYSTEM	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. In accordance with Homeland Security Presidential Directive #5, all Anderson Hospital EMS System providers are required to obtain ICS-100 and FEMA IS-700 certification. Note that this is a minimum requirement. Providers are encouraged to obtain further ICS and FEMA training.

2. Supervisors and officers – those individuals who would reasonably be anticipated to assume larger leadership roles during a disaster – should obtain ICS-100, ICS-200, ICS-300, ICS-400, FEMA IS-700, and FEMA IS-800.

3. All activities within the Anderson Hospital EMS System shall follow the principles of the National Incident Management System.

SCENE TIMES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. The recommended on scene time is 20 minutes or less on all medical emergency patients.

2. The recommended on scene time is 10 minutes or less on all STEMI patients and acute CVA patients.

3. The recommended on scene time is 10 minutes or less for all major trauma patients.

4. It is understood that isolated exceptions can and do occur in the pre-hospital environment. Document on the Patient Report Form when and why an on scene time exceeds the recommended maximum.

5. IV and medication administration are initiated in accordance with the patient's condition and needs.

INTERACTION WITH PHYSICIAN/NURSE ON SCENE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Only personnel credentialed within the Anderson Hospital EMS System and provisional personnel such as students or reciprocity candidates are allowed to perform advanced medical care in the pre-hospital setting.

2. Any nurse or medical personnel at the scene not credentialed within the Anderson Hospital EMS System may assist with Basic Life Support procedures only. The only exceptions are personnel delegated by a transferring physician to accompany a critically ill or injured patient in order to maximize the patient's care en route to the receiving facility.

3. If identity of the healthcare provider is not obvious, pre-hospital providers are encouraged to ask for identification and/or proof of licensure.

4. Physician On Scene
   a. EMS personnel will inform the attending physician of the need to accompany the patient in the ambulance to the hospital.
   b. If the attending physician is either unwilling or unable to accompany the patient to the hospital, follow routine procedures en route to the hospital.
   c. As soon as the patient's clinical condition permits, EMS personnel should notify Medical Control that a physician is on scene and desires to retain medical control.
   d. After notifying Medical Control of the physician's desire to retain control of the patient, encourage the physician to communicate directly with the emergency physician at medical control.
   e. If a physician gives orders, while on scene or en route, for procedures or treatments that the EMT/PHRN feels are unreasonable, medically inaccurate, and/or not within the scope of practice of the provider, refuse to follow such orders and establish communication immediately with on-line medical control to clarify further treatment.
   f. Document all orders/treatment given by the attending physician. The on-scene physician must sign the ambulance report form.

5. When voice communications with on-line medical control is not available, the EMS crew is instructed to follow the System OGs.

Section VI: Scene Safety

GENERAL

The importance of scene safety cannot be underestimated. Many hazards await us in the pre-hospital environment. Regardless of whether the threat is infectious, environmental, or criminal in nature, EMS providers must protect themselves.

Safety is the responsibility of each provider. Participants of the Anderson Hospital EMS System shall utilize basic safety measures:

1. Make certain a scene is secure. Evaluate a scene each and every time you approach. Maintain a balance between the need for immediate patient access and provider and patient safety.

2. Providers should use their best judgment to either stage at a distance from the patient, or retreat from the scene if immediate danger exists.

3. Wear seatbelts at all times, unless inhibiting patient care.

4. Drive appropriate for conditions. Use appropriate caution when driving, particularly when utilizing emergency lights and siren.

5. Wear ANSI reflective vests when necessary to do so.

FIRE, TECHNICAL RESCUE, AND HAZMAT SCENES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. EMS may be requested to respond to a fire, technical rescue, or HAZMAT scene to care for victims of the incident, treat the ill or injured responder, or provide responder rehabilitation during extended incidents.

2. Ideally, on extended or large incidents, an ambulance will be dedicated solely for the care of responding personnel and/or incident rehabilitation.

3. Do not impair the ability of apparatus to depart or access the scene or fire hydrants.

4. The principles of ICS will be adhered to at all times.

5. Responders may not enter the "hot zone" without permission of the Incident Commander.

6. Where specialized care for patients or responders is potentially needed in the "hot zone" of a technical rescue incident, EMS personnel with training in technical rescue should be utilized.

7. Requisite PPE will be worn while in and around the hot zone, including but not limited to helmets, eye protection, safety gloves, and turnout gear.

8. Consider the need for additional personnel and supplies and request early.

9. A large number of fire service injuries and deaths occur during post-incident activities including salvage and overhaul. Continue to be conspicuous and provide incident support through all phases of response unless released by the Incident Commander.

10. If a patient was extracted from a HAZMAT scene, ensure that the patient is decontaminated prior to placing a patient in the ambulance.

11. If this is not possible (PATIENT WAS PLACED IN THE AMBULANCE AND TRANSPORT INITIATED PRIOR TO REALIZING A HAZMAT EXPOSURE OCCURRED), call the receiving facility as early as possible to notify of the need for decontamination at the hospital.

INFECTION CONTROL	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. BODY SUBSTANCE ISOLATION (BSI), which incorporates Universal Precautions as recommended by the Center for Disease Control, has been adopted by the Anderson Hospital EMS System.

2. Each ambulance owner/administrator will provide BSI protective apparel as established by BSI and OSHA guidelines.

3. Because the potential for infectiousness of any patient's blood and body fluids cannot be known, *all patients should be handled as though they are potentially infectious.*

4. Disposable gloves must be worn with all patient contact to prevent exposure to blood, body fluids, mucous membranes, or non-intact skin. Wearing two pairs of gloves is recommended during situations where large amounts of blood may be present.

5. Most illnesses that are spread via air are transmitted through droplets. Droplet precautions consisting of a surgical mask with eye shield/coverage is sufficient to protect against most viruses and meningitis.
   a. Providers should wear a surgical mask when treating patients with:
      i. A temperature of 100.4 or greater with cough, dyspnea, hypoxia (flu-like symptoms).
      ii. Hemoptysis.
      iii. Unidentifiable rash or large amounts of bruised/necrotic skin tissue.
      iv. Stiff neck.
   b. Providers should also institute droplet precautions for patients with severe immune deficiency such as patients on chemotherapy or suffering from leukemia or patients with severe burns.
6. While unlikely, EMS personnel should also be aware of clues to suggest a bioterrorism event:
   a. An unusual increase or clustering of patients presenting with unexplained illness and any of the following:
      i. Sepsis
      ii. Pneumonia
      iii. Flaccid muscle paralysis
      iv. GI illness
      v. Bleeding disorders
      vi. Severe flu-like illness
      vii. Rash
      viii. Encephalitis/meningitis
   b. An unusual or impossible pathogen for our region in a patient without a travel history to an endemic area (e.g., a case of plague in a patient that does not live in, or has not traveled to the southwest region of the U.S.).

c. An unusual temporal and/or geographical clustering of illness (e.g., persons who attended the same public event or gathering).

7. Airborne precautions consisting of N95 masks should be worn when patients are suspected of suffering from Tuberculosis (combination of night sweats, fatigue, weight loss, and hemoptysis).

8. For patients on droplet or airborne isolation precautions:
   a. Only a minimum number of EMS providers should take care of the patient.
   b. Instruct the patient to wash his/her hands with waterless soap/alcohol gel.
   c. Place a surgical mask on the patient, if possible. Do not place an N-95 mask on any patient, and do not withhold oxygen if needed.

9. Wash hands immediately with bactericidal soap or alcohol gel after all patient contact. Remove gloves immediately after patient contact.

10. Use gloves, mask, gown and face protection during intubation and all procedures during which splashes/contamination are likely to occur.

11. Dispose all contaminated medical supplies in appropriate biohazard container. All red biohazard bags should be removed from each EMS unit upon arrival at the receiving facility. The hazardous material should be disposed of in accordance with the receiving facility's policy.

12. Needles and Syringes
   a. NO NEEDLE SHOULD EVER BE RECAPPED, BENT OR BROKEN BY HAND.
   b. Needles and syringes should be disposed of in rigid impervious containers

13. Decontamination Procedures
   a. Clean up all blood spills with 10 parts water to 1 part household bleach solution or commercial cleaning agent.
   b. Non-disposable equipment, i.e. laryngoscope blades, must be soaked in 10:1 water/bleach solution or commercial cleaning agent for 30 minutes. After soaking, wash with disinfectant detergent, rinse well, and dry.
   c. Linens soiled with blood and body fluids should be double-bagged and marked "Blood/Body Fluid Precautions". Those companies using a professional laundry service should notify recipients at the time of pick-up. Those companies who do their own laundry should use a professional solution or the same 10:1 water/bleach mixture.
   d. Air the ambulance after each run. Scrub and disinfect the ambulance interior once a day, or more often as necessary.

EXPOSURE TO BLOOD OR OTHER BODILY FLUIDS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Percutaneous exposure ("Needle Stick"):
   a. Immediately wipe off blood or fluid and apply alcohol or alcohol gel.
   b. After arriving at the hospital, and as soon as patient care allows, wash your hands and the wound.
   c. If the wound is such that it requires sutures, seek prompt medical attention.
   d. If you have received a puncture wound, seek medical attention to evaluate your tetanus immunization status.

2. Mucocutaneous exposure:
   a. Eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials.
   b. Flush your eyes or rinse your mouth with saline or water.
   c. After arriving at the hospital, and as soon as patient care allows, wash your face.

3. Any pre-hospital care provider exposed to blood or other bodily fluid should report the incident immediately to his/her supervisor and the Resource Hospital EMS Department.

4. The pre-hospital care provider may request to have HIV testing on the patient utilizing the following procedures:
   a. Documentation of the exposures (needle stick, etc.) must be on the patient report form.
   b. The HIV test request form must be completed <u>immediately</u> upon arrival to an Illinois Hospital by the EMT.
   c. If the patient is being transferred/transported to Missouri, the laws governing HIV testing and protection of allied health workers vary. If this occurs, contact the ER Director/Manager.
   d. All testing will be done at the expense of the employer or the requesting individual.

5. Verbal notification should be followed by a written report utilizing the Incident Report Form submitted to the EMS Department within two days.

NOTIFICATION OF A COMMUNICABLE/INFECTIOUS DISEASE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Upon confirmation of a reportable communicable/infectious disease, according to IDPH, the Infection Control Department will issue a letter of notification to the provider agency.

2. The EMS Office will review the patient's chart to verify that the patient was transported by ambulance and to identify crewmembers and any first responders who assisted.

3. If the patient is being discharged per ambulance, the nursing personnel caring for the patient will provide the ambulance personnel with additional information needed to protect against exposure to any communicable/infectious disease.

4. All patient-specific health information is to be treated in a confidential manner.

Section VII: Crime Scenes

INTERACTION WITH LAW ENFORCEMENT/EVIDENCE

If a law enforcement agency is present at a scene prior to EMS, the senior EMS crew member should contact the officer in charge to confirm scene safety.
If EMS discovers, after arrival on scene, that they have responded to a suspected crime scene, immediately notify law enforcement. Retreat from the scene as necessary to ensure safety of personnel.

CRIME SCENE INTERACTION	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

At a potential crime scene, providing medical care is *the highest priority*. 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. Providers should strive to disturb the crime scene as little as possible.

Also remember that most auto accidents are also crime scenes, and the debris is evidence. As with other crime scenes, providing medical care is the utmost priority. Try not to disturb the accident debris.

1. Observe any individuals or vehicles in the area.

2. Discourage onlookers or other unauthorized personnel on the premises of the crime.

3. Observe and note anything unusual, especially if the evidence may not be present when the police arrive. This may include smoke and odors.

4. When you leave, remember where you parked your vehicle for later crime scene reconstruction

5. Avoid touching, moving, or relocating any item at the scene unless absolutely necessary to provide treatment to an injured victim. If it is necessary to move any evidence or the victim in any way, note the location and position of the evidence or victim. Advise law enforcement of the actions you have taken.

6. Do not examine any potential evidence.

7. Do not cut through ropes, bindings, etc.; however, if it is necessary, never cut through or untie knots. Any ligature used in a suicide attempt should be left as intact as possible and should be cut rather than untied. All cuts made should be in an area well away from knots.

8. Do not tear or cut clothing through bullet holes, knife wounds, etc.

9. If you must cut or remove clothing, be careful, as the slightest movement can destroy evidence such as paint, hair, fibers, gun powder, etc.

10. If you recover clothing, do not put everything in one bag; put each item in a separate PAPER BAG.

11. During treatment or patient exam, if you find a cartridge or any other evidence, leave it and notify law enforcement authorities.

12. Weapons should not be handled by a provider unless necessary to ensure a safe patient care environment. If weapons must be handled, the provider must wear gloves, clearly document the items original/new location, and inform on-scene law enforcement.

13. In drug overdose cases, containers of any substance which may have been ingested in a suicide attempt should be left in the position found unless they need to be taken to the hospital. 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. Use gloved hands and limit handling to a minimum in order to preserve any fingerprints that may be present.

14. Do not rinse or clean the hands of the patient, for it may disrupt certain evidence such as gun powder, blood, and dirt. Victims of assault should be strongly discouraged against "cleaning up" prior to arrival of law enforcement or transport.

15. When you enter a potential crime scene and you determine no medical care is necessary, DO NOT disturb the scene. Exit the scene the same way you arrived.

16. When confirmation of death is required, only one properly credentialed provider should make entry to the area.

17. Once resuscitation efforts have ceased and a pronouncement has been obtained, providers should immediately vacate the area.

18. If the patient has been placed on a sheet, notify the receiving facility that the sheet and all personal effects may be considered evidence.

19. Clothing, jewelry, or other objects removed from the patient should be left on-scene. Clearly document any items left, and inform on-scene law enforcement of the items' original and current locations.

20. If the victim is obviously dead, then he or she should remain undisturbed. Even the position of the body can provide valuable clues.

21. Any scene involving a patient that is pulseless and apneic is to be considered a crime scene and treated accordingly.

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

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

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

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

26. Keep detailed records of the incident including your observations of the victim and the scene of the crime.

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

SIGNS OF POTENTIAL ABUSE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Potential clues in the history:
   a. Significant delay in seeking medical attention.
   b. Major discrepancies in the history.
   c. History of multiple ED visits for various injuries.
   d. A story that is vague and contradictory.
   e. An accusation that the patient injured himself or herself intentionally.

2. Potential clues in the physical exam:
   a. Excessive passivity, compliant or fearful behavior.
   b. Excessive aggression, hyperactivity, or violent tendencies.
   c. Apathetic or emotionally withdraw. Does not want to be near spouse, parents, or caregiver.
   d. Excessive crying, fussy behavior, or other behavioral disorders.
   e. Suspicious injuries.
   f. Injuries inconsistent with the reported mechanism of injury.
   g. Defensive injuries (e.g. to forearms).
   h. Injuries during pregnancy.
   i. Injuries in different stages of healing may indicate repeated episodes of violence.
   j. Fractures in pre-ambulatory children or non-ambulatory adults.
   k. Widely scattered injuries.
   l. Multiple bruises, burns, and abrasions especially around the trunk and buttocks.
   m. Injuries in various stages of healing
   n. Burns by cigarettes or scalds.
   o. Injuries about the mouth.

3. Potential signs and symptoms of neglect:
   a. Inappropriate level of clothing for weather.
   b. Inadequate hygiene.
   c. Absence of attentive caregiver(s).
   d. Physical signs of malnutrition.
   e. Long standing skin infections

4. General management:
   a. Treat all injuries per appropriate protocol. Medical treatment is the EMS provider's first priority.
   b. Provide emotional support to the victim.
   c. See policy on Crime Scene Interaction (above).
   d. See policy on Mandatory Reporting of Suspected Crimes (below).
   e. Make sure that the victim is transported to the hospital by the ambulance or another dependable source. Do not leave the task of transport to the alleged abuser.
   f. Do not accuse or challenge the suspected abuser.

MANDATORY REPORTING OF SUSPECTED CRIMES	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. This is a legal requirement to report, not an accusation.

2. All providers within the Anderson Hospital EMS System shall report the following to local law enforcement:
   a. Assaults, wounds from serious beatings, gunshot, knife, or other dangerous weapons.
   b. A patient with any injury sustained in the commission of or as a victim of a criminal offense.
   c. All violent or accident deaths including all suicides, homicides, and suspicious deaths.
   d. All moving vehicle accidents.
   e. Suspected child abuse or neglect.
   f. Suspected elder abuse or neglect.

3. There is no mandatory reporting requirement for victims of domestic violence in the State of Illinois. However, EMS providers are required to report to law enforcement when treating a victim of a crime, as stated above. This includes assault and battery.

4. Make the physician or charge nurse at the receiving facility aware, in private, of your concerns and intent to report. Do not make any reference to your suspicions of abuse on the radio.

5. EMS providers are *also* required to report potential cases of child abuse/neglect to the Illinois Department of Children & Family Services.
   a. HOTLINE : 1-800-25-ABUSE

6. EMS providers are *also* required to report potential cases of elder abuse/neglect to the Illinois Department of Aging.
   a. ELDER ABUSE/NEGLECT HOTLINE: 1-866-800-1409
   b. For cases of suspected abuse/neglect of a long term care facility resident, NURSING HOME ABUSE/NEGLECT HOTLINE: 1-800-252-4343.

7. Documentation
   a. Carefully document all observations and any statements made by the patient, family members, or care-givers on the run report. Remember, the run report is a legal document and may be used in a court of law.
   b. When the appropriate authorities are notified, record the following on the run record:
      i. Time.
      ii. Department.
      iii. Name, and if possible, badge number of the officer contacted.

8. All persons licensed under the Illinois EMS Act shall offer to a person suspected to be a victim of abuse, immediate and adequate information regarding services available to victims of abuse.

a. Illinois Domestic Violence Help Line: 877-863-6338
b. Illinois Coalition Against Domestic Violence: www.ilcadv.org

Section VIII: Patient Consent

APPLICABILITY OF OG'S/WHO IS A PATIENT?

1. Anyone that fits the definition of a patient must be properly evaluated and/or appropriate treatment options taken (including an informed refusal if the competent patient absolutely does not wish medical care or transport despite our suggestions that they do).

2. Anyone that does not fit the definition of a patient does not require an evaluation or completion of a patient care record. If there is ever any doubt, an individual should be deemed a patient and appropriate evaluation should take place.

3. The definition of a patient is any human being that:
   a. Has a complaint suggestive of potential illness or injury.
   b. Requests evaluation for potential illness or injury.
   c. Has obvious evidence of illness or injury.
   d. Has experienced an acute event that could reasonably lead to illness or injury.
   e. Is in a circumstance or situation that could reasonably lead to illness or injury.

4. These criteria are intended to be considered in the widest sense. If there are any questions or doubts, the individual should be considered a patient. EMS personnel should contact Medical Control if they have any questions as to whether someone should be considered a patient.

PATIENT ABANDONMENT	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Once a pre-hospital care provider has responded to an emergency, he/she must not leave a patient that requires continuing medical care until another competent, equally trained healthcare professional takes responsibility for that patient's care, or the patient refuses care.

ADULT CONSENT	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. The US Supreme Court has recognized that a "person has a constitutionally protected liberty interest in refusing unwanted medical treatment" even if refusal could result in death. Although courts protect a patient's rights to refuse care, "preservation of life, prevention of suicide, maintenance of the ethical integrity of the medical profession, and protection of innocent third parties" may also be considered when evaluating a patient's wish to refuse treatment. Each case must be examined individually.

2. In providing medical care, the universal goal is to act in the best interest of the patient. This goal is based on the principle of autonomy, which allows patients to decide what is best for them. A patient's best interest may be served by providing medical treatment, or it may be served simply by honoring a patient's refusal of care. Although complicated issues can arise when providers and patient disagree, the best policy is to provide adequate information to the patient, allow time for ample discussion, and document the medical record.

3. Consent must be obtained from every legally competent adult with present mental capacity (18 years of age and older), OR consent must be obtained from the guardian or person responsible for the patient.

4. Informed Consent
    a. It is the moral responsibility on the part of the EMS provider based on the recognition of individual autonomy, dignity, and present mental capacity to obtain informed consent. The patient must be aware of and understand the risk(s) of any care provided, procedures performed, medications administered, and the consequences of refusing treatment and/or transportation. He/she must also be aware of options available to them if they choose not to accept our evaluation and/or treatment.

5. Implied Consent
    a. In a potentially life-threatening emergency situation, consent for treatment is not required if the individual is:
        i. Unable to communicate because of an injury, accident, illness, or unconsciousness, and suffering from what reasonably appears to be a life-threatening injury or illness, OR
        ii. Suffering from impaired present mental capacity.
    b. The law presumes that if the individual with a real or potential life-threatening injury or illness were conscious and able to communicate, he/she would consent to emergency treatment.

6. Substituted Consent

a. Substituted consent is obtained in a situation in which another person consents for the patient, as in minors, incapacitated patients, incarcerated patients, and those determined by the courts to be legally incompetent.
b. Substituted consent is provided by:
    i. Court appointed guardians.
    ii. Power of Attorney for Healthcare when the patient lacks present mental capacity. (See below.)
    iii. Parents of minors. (See below.)

In order to provide consent for or refuse treatment, a patient must have:

1. Mental competency. Mental competency is a *legal* term. EMS providers shall presume an adult patient has mental competency unless he/she has been declared mentally incompetent by a court of law.
    a. If a patient has been declared legally incompetent, he/she will have a court-appointed guardian. This court-appointed guardian will have the same decision-making capability as a parent would for a minor child. The guardian has the right to consent to, or refuse evaluation, treatment, and/or transportation for the patient.
    b. He/she may NOT refuse life-saving therapy of the patient based on religious or other grounds.

2. Present mental capacity. Present mental capacity refers to one's present mental ability to understand and appreciate the nature and consequences of his/her condition and to make rational treatment decisions. He/she must:
    a. Be 18 or older.
    b. Be alert and fully oriented, able to communicate, and demonstrate appropriate cognitive skills for the circumstances of the situation. He/she must have the ability to engage in conversation about their condition, demonstrate understanding of the situation, and the risks associated with refusing.
    c. Show no indication of alcohol or drug use to the extent that it impairs his/her ability to make sound decisions.
    d. Show no current evidence of bizarre/psychotic thoughts and/or behavior, or display behavior that is inconsistent with the circumstances of the situation.
    e. Show no physical finding or evidence of illness or injury that may impair their ability to understand and evaluate their current situation, i.e. a patient with a head injury and abnormal GCS, a patient with significant hypoxia, hypotension, hypoglycemia, hypothermia/hyperthermia, etc.
    f. Show no current evidence of suicidal ideations, suicide attempts, or any indication that they may be a danger to themselves or others.

3. Patients with impaired mental capacity may be treated under implied consent.

MINORS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. A minor is one who has not yet reached the age of consent and refusal for purposes of medical treatment. Minors can neither consent to, nor refuse, medical treatment. Exceptions to this are:
   a. Emancipated minors whom *a court of law has granted the ability to make legally binding decisions*. Note that only a specific court order can render a minor emancipated. Prior pregnancy does NOT imply that a minor is emancipated.
   b. Any minor parent may consent to treatment for his/her child. A pregnant minor may consent to the evaluation and/or treatment related to the pregnancy
   c. A minor, 12 years of age or older, requesting treatment for sexual assault or abuse, a sexually transmittable disease, alcohol or drug abuse or limited out-patient mental health counseling, may give consent for treatment.
   d. A minor may consent to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law to be reported to a physician by IDPH.
   e. A minor on active duty with the armed services.
   f. A minor 16 or older and resides separate and apart from his/her parents/guardian and manages his/her own financial affairs.

2. In all cases, the minor must have present mental capacity as dictated above.

3. The following persons may consent to or refuse the evaluation, treatment, and/or transportation for a minor:
   a. Parent.
   b. Grandparent.
   c. Adult (18 or older) brother or sister, aunt or uncle.
   d. Educational institution in which the child is enrolled that has received written authorization to consent/refuse from a person having the right to consent/refuse.
   e. Adult who has actual care, control, and possession of the child and/or has written authorization to consent/refuse from a person having the right to consent/refuse, i.e. daycare, camps, etc.
   f. Adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court.
   g. A peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.

4. In all cases, the person must have present mental capacity as dictated above.

5. Implied consent of a minor
   a. Consent is not necessary for emergency treatment to sustain life of a minor who is suffering from what appears to be a life-threatening injury or illness.
   b. A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds.

REFUSAL OF EVALUATION, TREATMENT, AND/OR TRANSPORATION	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Providers should attempt to obtain a history and physical, in as much detail as is permitted by the patient.

Who may refuse care:

1. The patient
   a. Must be legally competent.
   b. Must have present mental capacity.
   c. Note that no friend or relative, such as an adult, of a patient 18 years of age or older may refuse evaluation, treatment, and/or transportation of an adult lacking present mental capacity unless he/she is the Healthcare Power of Attorney or court-appointed legal guardian of the patient. No one may refuse potentially life-saving care for a patient. An exception to this may be those at end of life. Contact medical control for clarification.

2. For minor patients:
   a. Those individuals listed above with the ability to consent for treatment of a minor.
   b. Must be legally competent and have present mental capacity.
   c. A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds.

3. A court-appointed Legal Guardian:
   a. If a person indicates that they are a legal guardian to the patient, attempt to obtain documentation (court order, etc.) and attach to trip sheet. If no such documentation is available, you may obtain refusal signature from the guardian as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as a legal guardian.
   b. A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds.

4. Health Care Agent (Durable Power of Attorney for Healthcare)
   a. A Health Care Agent is person appointed by the patient in a Durable Power of Attorney for Healthcare to consent or refuse care on behalf of the patient if the Power of Attorney contains such authorization.
   b. EMS Personnel may honor the requests of a person purporting to be the patients Power of Attorney for Healthcare when:
      i. The patient is unable to express his/her own wishes regarding treatment/transportation or refusal of treatment/transportation.
      ii. 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.

iii. EMS personnel must inform the medical control physician of the presence of the Power of Attorney for Healthcare, the nature of the document, the patient's condition, and the direction of the Power of Attorney for Healthcare.

iv. EMS personnel may not honor the request of the Power of Attorney for Healthcare to discontinue resuscitative efforts on a patient in cardiac arrest. The medical control physician must be contacted for direction. See Section X.

c. Attempt to obtain a copy of the Durable Power of Attorney for Healthcare document to attach to the trip sheet. If no such documentation is available, you may obtain refusal signature from the Health Care Agent as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the Health Care Agent.

Refusal Procedure

1. Attempt to obtain a history and physical, in as much detail as is permitted by the patient.

2. Complete the patient refusal form *in its entirety*. Document competency assessments, results of the history and physical exam, clinical symptoms on which need for transport was based, information provided to fully inform the patient and/or other authorized individual of the consequences of their refusal of treatment/transport, patients understanding, medical control instructions, alternatives offered, and crew signatures.

3. Contact medical control:
   a. If disagreement exists between care providers and the patient as to need for evaluation, treatment, and transportation, particularly for patients in need of ALS care.
   b. For high risk patients which include, but are not limited to patients with:
      i. Head Injury.
      ii. Any trauma with significant mechanism of injury.
      iii. Chest pain.
      iv. Dyspnea.
      v. Syncope.
      vi. Seizures.
      vii. Headache (new onset).
      viii. TIA/resolving stroke symptoms.
      ix. Pediatric complaints.
      x. Presence of alcohol and/or drugs.
   c. WHEN IN DOUBT, CONTACT MEDICAL CONTROL!

4. Review the form with the patient or signer.

5. Provide a detailed explanation of the risks and dangers to patient or signer.
   a. EMS providers should advise all patients that he/she has not been evaluated by an emergency department physician; therefore the EMS system does not recommend refusals of treatment and transport. Since he/she is refusing treatment and transport despite being informed of the associated risks, it is recommended he/she be evaluated

by his/her primary physician or the nearest ED as soon as possible. The patient should understand that their refusal may result in complications up to and including death.

6. Inform the patient to call 911, his/her primary care physician, or go to the nearest ED if symptoms persist or get worse or any danger signs appear.

7. Obtain signatures, and have the signer date the form. If the patient refuses to sign, document this on the refusal form.

8. Obtain a witness signature. This should preferably be someone who witnessed your explanation of risks and benefits, heard you advise the patient to receive medical evaluation and treatment, and who watched the patient sign. If no witness is available, a crew member may sign as a last resort. All should be 18 or older, have mental competency and present mental capacity. Document witnesses' address and telephone number.

9. If the patient refuses transport to the closest appropriate medical facility and the refusal would create a life threatening or "high risk" situation, treat as a high risk refusal. Contact medical control, and have the patient sign a refusal form.

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

PATIENTS UNABLE TO REFUSE EVALUATION, TREATMENT, OR TRANSPORTATION	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. If a patient is mentally incompetent or lacks present mental capacity, he/she may be evaluated, treated, or transported accordingly to the principle of implied consent.

2. In circumstances where an acute illness or injury impairs a patient's ability to make an informed decision (lacks present mental capacity) and the patient is in need of medical treatment or evaluation to prevent further significant illness or injury, the patient shall be transported to an ED for further evaluation.

3. Determine that a potentially harmful condition exists. If the condition is immediately life-threatening, the patient should be treated and transported as soon as safely possible.

4. Take all reasonable steps to secure treatment or transportation for a patient who is mentally incompetent or lacks present mental capacity to refuse care, but do not put yourself or your crew in jeopardy.

5. Take all reasonable steps to ensure that the patient is evaluated, treated, and transported to the Emergency Department in a calm and cooperative manner.

6. When appropriate, consult family and friends, the patient's primary care physician, or medical control to speak with the patient in an effort to convince him/her to comply.

7. Whenever possible, contact medical control prior to transporting a patient against his/her will.

PARENT/GUARDIAN REFUSAL IN THE PRESENCE OF POTENTIALLY LIFE-THREATENING MEDICAL CONDITIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Take all reasonable steps to convince the parent or guardian to consent to evaluation, transportation, or treatment. This includes contacting the patient's primary care physician or medical control to speak with the patient's parent or guardian.

2. If the parent or guardian continues to refuse evaluation, treatment, or transportation, contact local law enforcement for assistance. Local law enforcement may place the patient in protective custody and request evaluation, treatment, and transportation.

3. CONTACT MEDICAL CONTROL FOR DIRECTION AS SOON AS POSSIBLE!

4. Do not delay treatment of patients suffering from *immediately* life-threatening conditions.

EMOTIONALLY DISTURBED PATIENTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. Psychiatric, or behavioral emergencies, are those in which the patient's presenting problem is a disorder of mood, thought, or behavior that is dangerous or disturbing to themselves or others.

2. Note that current evidence of, or history of, mental illness does not, in itself, constitute lack of present mental capacity. EMS personnel or family must reasonably suspect that an emotionally disturbed patient at the time the determination is being made or within a reasonable time thereafter, would intentionally or unintentionally physically injure himself/herself or other persons, or is unable to care for his own physical needs.

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

4. Never leave the patient alone.

5. Never turn your back on the patient.

6. Never allow your exits to be blocked.

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

8. Always assess for other medical or traumatic conditions.

9. Always assess for mental status. Psychiatric illnesses typically do not impair a patient's level of orientation.

10. Rule out other common medical problems such as hypoglycemia, hypoxia, hypovolemia, etc.

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

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

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

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

a. If the medical control physician determines the patient cannot understand informed consent for patient care and transportation to the hospital for emergency treatment of a *non-psychiatric condition* is required to preserve life or prevent serious impairment to health, the physician shall order, against patient will and based upon implied consent, the emergency care and transportation to the hospital.
b. In no way does this mean that the EMS crew is committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of treatment to a hospital against his/her will so that a physician may further evaluate the patient.
c. Notify the appropriate law enforcement agency if the patient is combative or may harm self or others.

15. If the patient is not suffering from a non-psychiatric condition but may present a danger to him/herself due to a psychiatric condition, EMS providers shall contact mental health professionals.
    a. Mental health professionals have the authority to petition for involuntary admission and immediate hospitalization. Upon receipt of a petition, law enforcement shall take the patient into custody and transport him/her to a mental health facility.
    b. A police officer is the only individual given the authority to restrain and transport a person against their will. Neither a physician nor the patient's family may authorize such transport. Physicians may authorize involuntary commitment, but their authority does not extend to the forcible transport of a patient against their will.
    c. Should the local law enforcement or mental health professional not support the decision to transport the person against their will, the patient's condition, information conveyed to and from the patient, the assisting agencies involved, and the patient's refusal of service should be documented on the run record, patient's signature obtained, and, if possible, witnessed by an impartial observer (preferably, police, mental health professional, family, etc.). The names of mental health professionals and law enforcement officers involved shall be documented in the run report.

USE OF RESTRAINTS (CHEMICAL AND PHYSICAL)	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

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

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

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

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

5. Attempt voluntary application of restraints. Use of patient restraints should be held to a minimum and only as a last resort to protect the patient and others from his/her irrationality.

6. If voluntary restraint is not possible, assemble adequate personnel. One person for each of the patient's limbs is necessary.

7. Attempts to physically restrain a patient should be made with law enforcement assistance.

8. After application of restraints, the patient must at no time be left alone.

9. Maintain a calm, professional, reassuring demeanor.

10. Attempt to modify the patient's environment to minimize stimulation. (Avoid bright lights, loud sounds, etc.)

11. Protect the patient's privacy when in public areas.

12. Patients should be monitored continuously while restrained.

13. If chemical restraint is deemed necessary, refer to the appropriate OG and contact medical control.

14. If a patient is restrained by law enforcement with handcuffs or other law enforcement restraint implements, the patient will be accompanied in the ambulance by law

enforcement to the hospital to assist with further restraint of the patient or to release the restraints if patient care is impaired by the devices.

15. Documentation requirements:
    a. Indication for restraints.
    b. Prior attempts at less restrictive alternatives, i.e. verbal communication, removal from stressful environment, etc.
    c. Method of restraint.
    d. Periodic checks for proper application.

PATIENTS IN LAW ENFORCEMENT CUSTODY	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. When a patient in law enforcement custody requests evaluation, treatment and/or transportation, the responding provider shall conduct an evaluation and institute treatment and transportation to the ED in accordance with OGs.

2. Providers should maintain a nonjudgmental attitude when transporting patients in the custody of law enforcement.

3. If the patient requests treatment and transportation, but a law enforcement officer refuses to allow treatment and transportation, obtain the law enforcement officer's name and badge number. Document this on the refusal form, and have the officer sign the refusal. Inform the officer of the risks of refusing, benefits of evaluation and treatment, and alternatives as one would a patient refusing medical care.

4. A person in police custody has the right to sign a refusal of treatment unless the police mandate treatment for this person. The patient will then be transported to the hospital *in police custody* for further evaluation.

5. EMS providers acting within the Anderson Hospital EMS System may not draw blood for law enforcement purposes. While venipuncture is well within the scope of practice of EMT-I/P/PHRN, the pre-hospital provider may only render patient care in accordance with the written OGs.

6. A prisoner cannot be determined as being fit for confinement by EMS personnel.

Section IX: Death On Scene

WITHHOLDING CPR	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. EMS providers shall withhold CPR on apneic and pulseless patients with:
   a. Evidence of significant pulselessness.
      i. Asystole
      ii. Dependent lividity.
      iii. Rigor mortis.
      iv. Decomposition.
   b. Penetrating or blunt trauma with injuries obviously incompatible with life.
      i. Decapitation.
      ii. Incineration.
      iii. Obvious destruction of brain or intra-thoracic organs.
   c. All other blunt trauma patients found apneic and pulseless without organized ECG activity.
   d. All other penetrating trauma patients found apneic and pulseless without organized ECG activity or papillary reflexes.
   e. Patients submersed greater than 30 minutes in warm water or greater than 90 minutes in cold water. (An exception is a person trapped with a potential air source such as diver.)
   f. A patient with a completed State of Illinois DNR Form.

2. These patients do not require contact with medical control.

3. When in doubt, initiate resuscitative efforts. All other patients require contact with medical control.

4. Contact the appropriate coroner.

DO NOT RESUSCITATE/POLST ORDERS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

DO NOT RESUSCITATE ORDERS

1. The patient must have the State of Illinois Uniform Do-Not-Resuscitate (DMR)/Practitioner Orders For Life-Sustaining Treatment (POLST) Form which has the Seal of the State of Illinois in the upper left corner. This form also has a border around stating IDPH/DNR/POLST.

2. By itself, a DNR/POLST order does not affect treatment of patients NOT IN FULL CARDIAC ARREST. Anderson Hospital EMS System providers should institute treatment according to the OGs unless specifically instructed not to on the DNR/POLST form. If medical treatment warranted and a Medical Intervention is checked, follow instructions per the order. Transport both the patient and the DNR/POLST form to the hospital.

3. Providers should make a reasonable effort to verify the identity of the patient named in a valid DNR/POLST order.

4. If the EMS provider has concerns regarding the validity of the DNR/POLST orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition, the provider should immediately institute CPR or BLS treatment as indicated by the patient's condition and contact medical control for further direction.

5. If the primary care physician of a patient without a valid DNR/POLST order is at the scene or on the telephone and requesting specific resuscitation or DNR/POLST procedures, EMS personnel should verify the physician's identity and notify medical control of the request. Institute CPR or BLS treatment as indicated by the patient's condition until further direction can be obtained from medical control.

6. Note that a parent, guardian, or Power of Attorney for Healthcare can provide consent to a DNR/POLST order, but the order itself must be written by a physician.
   a. Pre-hospital providers can NOT honor a verbal or written DNR/POLST request or order made directly by a surrogate decision maker or any other person, other than the patient's primary care physician. If such a situation is encountered, institute CPR or BLS treatment as indicated by the patient's condition and contact medical control for direction.

7. DNR/POLST should NOT be honored when:
   a. A patient or person who executed the order destroys the form.

b. A patient or person who executed the order orders someone in their presence to destroy the form.
c. A patient tells a provider or primary care physician that it is his/her intent to revoke the order.
d. The primary care physician has voided the DNR/POLST.
e. The patient is known to be pregnant.

8. If a DNR/POLST Form is rescinded, 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.

9. A copy of the DNR/POLST Form should be retained and attached as supporting documentation to the pre-hospital care report form when possible.

10. Any other advance directives such as a "Living Will" cannot be honored, followed, or respected by pre-hospital care providers. EMS personnel must contact medical control for direction regarding any other type of advanced directive. Full resuscitation should not be withheld during the process of contacting or discussing the situation with medical control.

MEDICAL INTERVENTIONS

1. Follow directions on valid POLST order.

Coroner Stephen P. Nonn Madison County Coroner's Office

157 North Main Street, Suite 354 Edwardsville, Illinois 62025

HOSPITAL & HEALTH CARE INSTITUTIONS CORONER DEATH NOTIFICATION GUIDANCE

Upon the pronouncement of a patient death, the Madison County Coroner's Office must be notified promptly. The reporting party should be prepared to provide essential biographical data concerning the decedent, as well as the medical history and, when known, the essential facts of the events that appear to have caused the death. **The 24 hour telephone number is: 618 692-7478**.

a. In the event of a presumed **NATURAL** death, where a preexisting medical/ terminal condition is present, the decedent's personal physician should be contacted, to ascertain if he or she will sign the death certificate, prior to calling the Coroner's Office. In any event, the Coroner must be notified of the death within a reasonable time frame, (approximately 30 minutes).

b. Any death due to violence, trauma, external event (i.e. drug overdose, heat or cold exposure, allergic reaction, etc.), or the death of a patient with no medical history and/or attending physician, is a Coroner's case and must be reported to the Coroner's Office promptly.

c. All pediatric deaths must be reported to the Coroner's Office **immediately**.

During your initial telephone report, the Coroner or Coroner's Investigator will determine if the body may be released to a mortuary and if the attending physician may sign the death certificate — OR — if the body will be subject of further Coroner's investigation requiring Coroner personnel to respond to the hospital.

Pending release of the body by the Coroner, caution must be taken not to destroy, lose or eliminate any evidence that may be contained on or within the body.

a. In general, the body of the decedent shall not be disturbed or altered any more than it was during the resuscitation and treatment

b. All existing medical devices (E.T. tubes, IV lines, etc.) shall remain in place

All therapeutic (Hospital/EMS) venipuncture sites are to be circled in ink.

c. Clothing and personal effects (jewelry, pocket contents, etc.) shall not be altered or removed from the body. Any clothing and/or personal effects removed during the medical care should be inventoried, bagged (clothing and
personal effects - separately) and made available to the Coroner.

Do Not Release Personal Effects/Clothing To Anyone Unless Authorized To Do So By The Coroner.

d. In order to preserve "trace" evidence, (i.e. paint chips, hair & fibers, etc.), the body of the decedent must not be bathed or wiped down until inspected
or authorized by the Coroner.

4. The decedent's family or next of kin should be asked to remain at the Hospital pending the notification and/or arrival of the Coroner personnel.

a. No request for an autopsy should be made by Hospital personnel. **Authority for autopsy examination for deaths that fall under the Coroner's Act rests solely with the Coroner.** After release of the body by the Coroner's Office, the Hospital staff may pursue a "medical/private" autopsy of the body.

b. Organ donation requestors should be aware that the Coroner's Investigation may
preclude or modify the normal organ donation process.

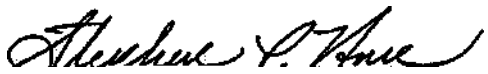
c. In the event that the decedent's family does leave the Hospital prior to the Coroner's arrival, it is necessary that a contact person from the family be identified, along with an address and/or telephone number where the family
member can be reached.

5. To expedite the reporting/documentation process, Nursing personnel may be
asked to FAX the ER/Admitting face sheet, and/or the E.M.S. run report, and/or
the HISTORY and PHYSICAL to the Coroner's Office.

The **FAX** line for the Madison County Coroner is: **(618) 692-6042.**

6. The requirements described in this guidance document are an adjunct to the "Index of Reportable Deaths" reporting requirements which you currently use and are in accordance with Illinois Compiled Statutes.

7. Anyone with questions regarding this guidance document or any matter not expressly covered herein are encouraged to contact the Madison County Coroner's Office at either of the numbers listed for further information.



Authority:_____

Stephen P. Nonn,
Coroner Madison
County, Illinois

03/22/201

Section X: Patient Transport and Destination

DESTINATION SELECTION	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

The following guidelines in Section X are intended to be just that, guidelines for destination selection. While each patient should ideally be transported to the most appropriate facility, it is understood that in the prehospital environment exceptions do exist. Prehospital providers should always contact Medical Control for any concerns.

Prehospital providers may choose at any time to divert to the closest facility when the patient is in *imminent* danger of death that cannot be adequately addressed by the prehospital provider. The provider should bear in mind his/her level of training, the nature of the patient's injury or illness, the possible need for a specialty center required for the patient's survival, if the patient's immediate needs can be adequately addressed at a closer facility, and the ETA to the specialty center vs. closest facility. Contact with Medical Control is encouraged, when time allows, assisting in making these difficult destination decisions.

DESTINATION SELECTION: SPECIAL POPULATION - PEDIATRICS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Anderson Hospital EMS is fortunate to have two pediatric hospitals & trauma centers in the St. Louis Metropolitan Area, Cardinal Glennon Children's Hospital and St. Louis Children's Hospital.

1. EMS providers must first identify which pediatric patients would benefit from treatment at a pediatric hospital/trauma center. Providers may always contact medical control for clarification.

2. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice. EMS providers may always contact medical control for assistance with transport decisions.

DESTINATION SELECTION: SPECIAL POPULATION - TRAUMA	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

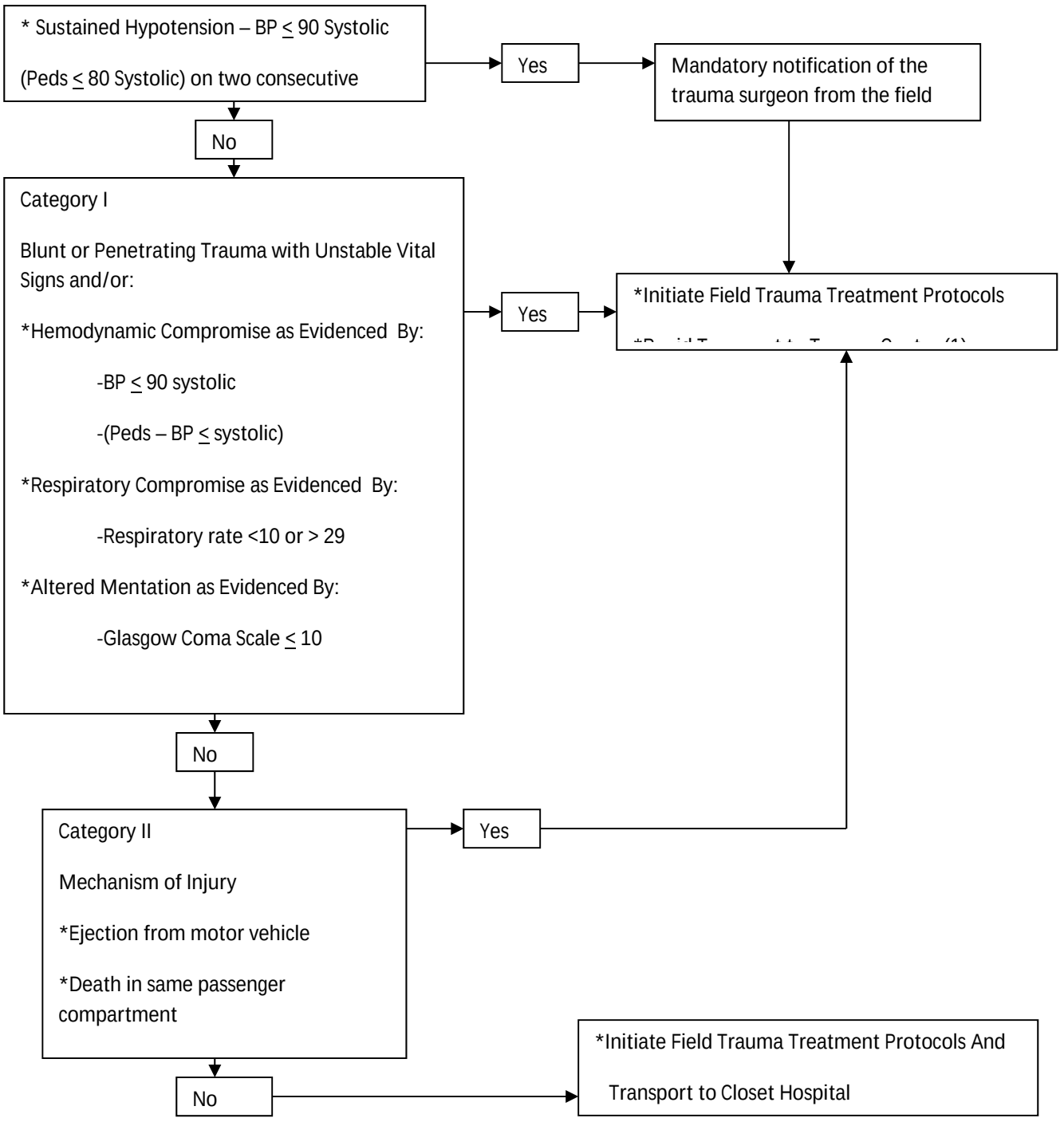
We are fortunate to have two American College of Surgeons (ACS) verified adult trauma centers, Barnes Jewish Hospital and St. Louis University Hospital, and two pediatric trauma centers, Cardinal Glennon Children's Hospital and St. Louis Children's Hospital, in the St Louis Metropolitan Area.

EMS providers must first identify which patients would benefit from treatment at a trauma center. Refer to the field triage diagram below for assistance. Providers may always contact medical control for direction.

1. When an EMS provider encounters a patient that he/she believes would benefit from treatment at a trauma center:
   a. BLS units should ask for ALS intercept/assistance, per the ALS assist guidelines.
   b. If the trauma center is the closest facility, transport to that facility.
   c. If the patient meets the field triage criteria below, consider transport to the trauma center, if the anticipated ETA is < 25 minutes.
   d. If the anticipated ETA to a trauma center is greater than 25 minutes, transport to the closest facility OR arrange for helicopter EMS transport.

2. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice.

3. Bypass of any facility should ***NOT*** occur when:
   a. The patient is treated and transported by a BLS unit, without the availability of ALS assistance.
   b. The patient is suffering from an immediately life-threatening condition such as airway compromise or severe hemorrhage uncontrolled with pre-hospital care including tourniquet application.
   c. The patient is in cardiac or respiratory arrest.


* Sustained Hypotension – BP ≤ 90 Systolic
(Peds ≤ 80 Systolic) on two consecutive
Yes
Mandatory notification of the trauma surgeon from the field
No
Category I
Blunt or Penetrating Trauma with Unstable Vital Signs and/or:
*Hemodynamic Compromise as Evidenced By:
-BP ≤ 90 systolic
-(Peds – BP ≤ systolic)
*Respiratory Compromise as Evidenced By:
-Respiratory rate <10 or > 29
*Altered Mentation as Evidenced By:
-Glasgow Coma Scale ≤ 10
Yes
*Initiate Field Trauma Treatment Protocols
No
Category II
Mechanism of Injury
*Ejection from motor vehicle
*Death in same passenger compartment
Yes
No
*Initiate Field Trauma Treatment Protocols And
Transport to Closet Hospital

DESTINATION SELECTION: SPECIAL POPULATION - STEMI	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 06/17**
Version: 1.0	**Council Approved:**

EMS providers must first identify which patients would benefit from treatment at a PCI (Percutaneous Coronary Intervention) center. Providers may always contact medical control for direction.

4. When an EMS provider encounters a patient that he/she believes would benefit from prompt treatment at a facility that would :
   a. BLS units should ask for ALS intercept/assistance, per the ALS assist guidelines.
   b. If the PCI center is the closest facility, transport to that facility.
   c. If the patient displays ST Elevation MI, consider transport to a PCI center, if the anticipated ETA is < 15 minutes.
   d. If the anticipated ETA to a PCI center is greater than 15 minutes, transport to the closest facility OR arrange for helicopter EMS transport.

5. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice.

6. Bypass of any facility should ***NOT*** occur when:
   a. The patient is treated and transported by a BLS unit, without the availability of ALS assistance.
   b. The patient is suffering from an immediately life-threatening condition
   c. The patient is in cardiac or respiratory arrest.

DESTINATION SELECTION: SPECIAL POPULATION - STROKE	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 06/17**
Version: 1.0	**Council Approved:**

EMS providers must first identify which patients would benefit from treatment at an Acute Stroke Ready Hospital, Primary Stroke Center, or a Comprehensive Stroke Center. Providers may always contact medical control for direction.

7. When an EMS provider encounters a patient that he/she believes would benefit from treatment at an above listed facility:
   a. BLS units should ask for ALS intercept/assistance, per the ALS assist guidelines.
   b. If the Acute Stroke Ready Hospital or Primary Stroke Center is the closest facility, transport to that facility.
   c. If the patient meets a non TPA candidate criteria, consider transport to a Comprehensive Stroke Center, if the anticipated ETA is < 15 minutes.
   d. If the anticipated ETA to a Comprehensive Stroke Center is greater than 15 minutes, transport to the closest Acute Stroke Ready Hospital or Primary Stroke Center OR arrange for helicopter EMS transport.

8. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice.

9. Bypass of any facility should ***NOT*** occur when:
   a. The patient is treated and transported by a BLS unit, without the availability of ALS assistance.
   b. The patient is suffering from an immediately life-threatening condition
   c. The patient is in cardiac or respiratory arrest.

USE OF LIGHTS AND SIRENS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

In an effort to maximize the safety of System providers, patients, and the public at large, EMS providers within the Anderson Hospital EMS System should restrict use of lights and sirens during patient transportation to the hospital to situations where the patient is (or potentially might be) critically ill or injured or where delayed arrival at an emergency department by even a few minutes may lead to increased morbidity or mortality. This includes, but is not limited to, suspected acute Stroke, STEMI, or trauma patients meeting criteria for anatomical injuries or mechanism of action.

The use of lights and sirens must be evaluated on a case-by-case basis, and the responsibility for this determination resides solely with the highest level EMS provider caring for the patient or the transferring physician for inter-facility transfers.

NON-PARAMEDIC TRANSPORT OF PATIENTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

It is occasionally desirable for a lower level provider to treat and transport a low acuity patient after paramedic evaluation. When a single-paramedic unit responds to an emergency, select patients may be cared for by an EMT-B after evaluation by an EMT-P. In addition, to maximize the number of ALS ambulances available for emergency care, an EMT-P may transfer care of the patient to a BLS ambulance by the following procedure:

1. All personnel are encouraged to participate in patient care while on-scene, regardless of who "attends" with the patient while en route to the hospital. If non-paramedic transport is desired, the EMT-P on scene must conduct a detailed physical assessment and subjective interview with the patient to determine their chief complaint and level of distress.

2. The determination of who attends should be based upon the patient's chief complaint, findings of the history and physical exam, immediate treatment needs and any reasonably anticipated treatment needs while en route to the hospital.

3. If the paramedic determines that the patient is stable and all foreseeable patient care needs can be managed by the EMT-B, patient care can be transferred to the EMT-B for transport to a hospital.

4. Both the transporting technician and the EMT-P who transferred care must write a narrative documentation that covers all aspects of assessment, care, and disposition. This should be done on one patient care report.

5. Patients who can NOT be transferred to a lower level of certification include, but are not limited to, the following:
   a. Any patient who would benefit from ALS care.
   b. Any patient with abnormal vital signs.
   c. Any patient with an acutely altered level of consciousness, signs of CVA, or postictal state.
   d. Any patient suffering from chest pain or difficulty breathing.
   e. Any patient suffering from abdominal pain.
   f. Any patient meeting anatomical injury or mechanism of injury criteria for field triage to a trauma center.
   g. Any patient for whom transport would be delayed significantly by waiting for a BLS unit to arrive.
   h. Any patient for which ALL EMS providers on scene do not agree can be safely transported without a paramedic.

DIRECT ADMISSION PATIENTS TO ANDERSON HOSPITAL	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 06/17**
Version: 1.0	**Council Approved:**

POLICY STATEMENT:

All EMS transportation services should enter through the Anderson Hospital Emergency Department entrance when transporting patients for direct admission services or outpatient services. Prior determination will be made with the EMS Providers if they should go directly to the units or if they need to be assisted by ER Registration Staff.

DEFINITIONS:

- **EMS Providers** are any emergency transportation services or agencies transporting patients for direct admission to a hospital unit or the rehabilitation unit or for an outpatient service, including surgery.
- **Emergency Entrance** is the Emergency Department/Ambulance Entrance to the hospital and the only entrance that should be used by all EMS Providers when delivering patients to Anderson Hospital.
- **Hospital Destination** is the receiving unit or hospital location that will be providing the service as ordered by a physician for inpatient services, rehabilitation services or outpatient services.

GUIDELINES/PROCEDURES:

- **DIRECT ADMITS**
  - EMS Providers should only access Anderson Hospital through the Emergency Department/Ambulance Entrance.
  - EMS Providers will be provided the floor/unit and room information from the sending facility or the Anderson Hospital House Supervisor or Care Coordination Staff for each patient being brought to the hospital for direct admission services or rehabilitation services.
  - EMS Providers should transport the patient directly to the floor/unit and advise the nurses station of the arrival prior to taking the patient to the designated room.
  - EMS Providers will provide the unit with any EMS Transmittal Documentation or other facility documentation regarding the patient before taking the patient to the designated room.

- Nursing staff will assist EMS Providers with placing the patient in the room.

- Nursing Staff will advise Admission Coordinator of patient has arrival so armband can be tubed to the floor prior to follow up with patient registration documentation.

- **TRANSPORTED OUTPATIENTS**
  - EMS Providers transporting patients for outpatient radiology services will be assessed by the ER Registrar upon arrival if they will be registered by the Radiology Registrar or in the Emergency Room by the ER Registrar.
    - Between the hours of 6:30a and 8:00p, Radiology registrar will complete the registration process for the service.
      - ER Registrar will assist the EMS Providers to the hallway where the Radiology registrar will assist with completing the registration process and placing the armband on the patient.
    - Between the hours of 8:00p and 6:30a the ER Registrar will register the transported Patient and then contact the Radiology Department to advise the patient is here for services.
  - EMS Providers will provide the appropriate registrar with the EMS transport information or the facility documentation regarding the patient.
  - ER Registrar will assist EMS Providers to the Radiology hallway pending assistance.

- **TRANSPORTED for CATH LAB / SURGERY**
  - The EMS Providers will provide the ER Registrar with any EMS transport documentation or transmitting facility documentation relating to the patient.
  - ER Registrar will complete the patient registration with the patient if possible or tube the armband and documentation to the appropriate department.
  - Registration documentation follow up will be performed with the patient as soon as possible by the Patient Access staff.

Section XI: Documentation and Continuous Quality Improvement

EMS SYSTEM PATIENT CARE REPORTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 06/17**
Version: 1.0	**Council Approved:**

1. Documentation shall be completed by each vehicle service provider for every emergency pre-hospital or inter-facility response, and every non-emergency medical transport by an IDPH-licensed vehicle.

2. All system units will utilize and complete in full, an Anderson Hospital EMS System approved patient care report.
   a. A patient care report will be left with the receiving hospital emergency department, trauma center or health care facility before leaving that facility OR
   b. utilizing a computerized reporting system that promotes "uploading" directly into Anderson Hospital's patient records for patients taken to Anderson Hospital.
      i. This process must be completed immediately upon completion of the call.
   c. Only the need to immediately respond to another call for emergency assistance may delay leaving a copy of the run report. If this occurs, the patient care report must be left with the receiving facility immediately upon completion of the pending run.

3. For quality assurance the EMS office will review patient care reports from EMS system providers.

4. System first responders must complete an Anderson Hospital EMS System approved patient care report on every patient.
   a. A patient care report is retained by the First Responder service.
   b. A patient care report is to be given to the EMT/PHRN upon their arrival for transport with the patient. This report will go in the medical record.

5. All System providers should notify the EMS Office of any AED utilization.

6. All system providers are required to send IDPH required data within IDPH required timeline.

ANDERSON HOSPITAL EMS SYSTEM CQI PLAN	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

CQI of the Anderson Hospital EMS System will typically consist of:

1. Review of the submitted data from each EMS service personnel.

2. Regular patient care report reviews.

3. Peer Review cases by Field Training Officers/EMS Advisory Council members/EMS office/ EMS Medical Director:
   a. Pediatric cardiac arrest.
   b. Adult cardiac arrest, including all pre-hospital termination of resuscitation.
   c. Major trauma.
   d. Miscellaneous.

4. Patient care trends, concerns, and excellence, will be addressed on a case by case basis.

Through continuous monitoring of EMS patient care reports, effective quality improvement will occur via direct personnel counseling, educational offerings, open discussion at EMS System Run Review and/or EMS Advisory Council meetings, root cause analysis,…etc.

ANDERSON EMS SYSTEM RUN REVIEW	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Anderson EMS System (EMS Medical Director) will conduct Run Review conferences on a quarterly basis. The format of such will be the presentation of significant field runs, information sharing, expert guest presenters, and emergency operations review.

The conferences are open to attendance by EMT-B's, EMT-Is, EMT-Ps, PHRNs, ECRNs, and Emergency Department and EMS Physicians. Continuing Education credit hours will be awarded on an hour-for-hour basis as approved by the IDPH per the EMS system site code. More than just the presentation and discussion of cases, the Run Review conference is intended to offer a forum for the open exchange and discussion of ideas, observations, and opinions of the above personnel and, therefore, provides a more formal avenue for rendering input into the operations of the Anderson EMS system by the personnel involved in these operations.

EMS SYSTEM INCIDENT REPORT FORM	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

The purpose of the following policy is to assure a proper sequence of action to resolve problems occurring in the system.

1. In an effort to resolve problems in an efficient and timely manner, those incidents which occur within the Anderson EMS System or between systems shall be documented on a form as provided by the Anderson EMS System.
    A. An E-Mail document can substitute this form
2. These problems shall include but not be limited to problems between services; with resource, associate, participating or other hospitals; patient care problems or radio communications.
3. The individual making the complaint or citing the problem shall document such and sign the appropriate form. This form shall be filed with the Anderson EMS System office and an investigation into the incident shall be made as per delegation of the EMS Medical Director.
4. Individuals involved in the incident/complaint shall be notified within 3 business days of the problem and again of the final outcome within 30 days after completion of the investigation (if necessary).

PROCESS

1. Notification:
    a. Sentinel incidents must be immediately reported. In case of emergency, notify the EMS System Coordinator or EMS Medical Director directly. Anderson Hospital ED may facilitate this contact after-hours.
    b. Non-sentinel incidents must be reported within one business day.
    c. An agency must identify and document as many near misses as possible and present the findings to the EMS System Coordinator.

2. The Anderson Hospital EMS System Incident Report Form shall be completed within 24-48 hours by pre-hospital care providers, ED physicians, nurses, or any other persons directly involved in the care of pre-hospital patients for:
    a. All sentinel events, non-sentinel events, and near misses.
    b. Any violation in policy, procedure, or protocol has occurred.
    c. Complaints regarding any activity covered by the EMS Act or any policy, protocol, or standing medical order of the EMS System.

3. When completing the form, describe the incident or specific violation including a brief narrative summary and any additional documentation that would help describe the incident.

4. The completed incident report, along with supporting documents, must be forwarded to the EMS Office.

5. Once an Incident Report has been received, it shall be reviewed by the EMS Coordinator. Those reported incidents which may or did have an adverse effect on patient outcome, crewmember(s), or the EMS System, shall be reported immediately to the EMS Medical Director. The EMS Medical Director and EMS System Coordinator shall determine the course of action to be taken regarding any incident report.

REPORTING OF CLINICAL ERRORS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

It is understood that errors will occasionally occur. The Anderson Hospital EMS System recognizes three types of errors:

1. Normal error (human error)
   a. Inadvertent action: slip, lapse, or mistake
   b. These are managed through changes in processes, procedures, training, design, and environment.
   c. The System provides SUPPORT to personnel to prevent similar errors in the future.

2. At-risk Behavior
   a. A choice: risk not recognized or believed justified.
   b. These are managed through removing incentives for at-risk behavior, creating incentives for healthy behaviors, educational remediation, and increasing situational awareness.
   c. The system COACHES personnel to perform the proper action.

3. Reckless Behavior
   a. Conscious disregard of unreasonable risk.
   b. These are managed through remedial actions and punitive actions.
   c. The System SANCTIONS personnel for these errors.

All errors must be promptly reported to the EMS Office. The greater purpose is to attempt to determine why the error occurred and address those things that we can change as a system to prevent further similar errors from occurring. In this manner, we can identify system trends at the earliest possible point in time and emphasize the avoidance/prevention of potentially adverse events.

All personnel involved in reviewing errors and evaluating care are committed to a performance improvement (non-punitive) approach to correcting circumstances that led to a medical error.

Section XIII: Miscellaneous

POLICY FOR MASS GATHERING EVENTS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

EMS providers are frequently called upon to provide medical care at mass gathering events. The following apply to mass gathering events staffed by personnel of the Anderson Hospital EMS System:

1. The EMS service staffing the event is responsible for notifying the EMS Office in advance of any events that may reasonably result in either a significant number of patients requiring transport to area EDs so as to cause a noticeable increased patient load OR if one may reasonably foresee the need to treat critically ill or injured patients.
   a. Management personnel of the requested EMS agency must take into account the nature of the event, crowd size, anticipated weather conditions, etc.
   b. This determination will be at the discretion of management personnel of the EMS service requested to attend.
   c. It is highly recommended to work with local resources and event planners to complete an Incident Action Plan prior to the event.

2. The EMS service staffing the event may, at any time, request assistance with planning or execution of the Incident Action Plan.

3. The concepts of NIMS/ICS will be utilized at all events.

RESTOCK OF SUPPLIES AND MEDICATIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

1. The Emergency Department at Anderson Hospital and Anderson Hospital EMS Associate and Participating Hospitals will provide exchange of supplies and medications approved by the Anderson EMS System and the Region 4 EMS Advisory Committee utilized on any patient brought to their facility by pre-hospital providers. Only supplies that were used on the patient will be restocked.

2. Restocking of medications utilized on patients received at Anderson Hospital will be accomplished by contacting an Emergency Department RN. The RN will then acquire the medication from the "Pyxis".

3. Anderson Hospital EMS System personnel may restock medications and immediately prior to expiration at Anderson Hospital or an Anderson Hospital EMS System Associate or Participating Hospital pharmacy. The medication must be presented to pharmacy personnel before exchange can take place.

4. On supplies that are not immediately exchangeable, the Emergency Department Staff will issue the ambulance service a receipt for the article until such time as it can be retrieved by the unit.

5. Pre-hospital providers in the Anderson EMS System will restock supplies for patients taken to other hospitals at the receiving facility. Anderson EMS System Providers reserve the right to bill for and restock their own supplies. All supplies will meet the following criteria:
   - these supplies will conform with supplies used in the Anderson EMS System/Region 4
   - these supplies must be approved by the EMS Medical Director for use in the System.

RESTOCK OF CONTROLLED MEDICATIONS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 07/16**
Version: 1.0	**Council Approved:**

Box Contents

• Morphine Sulfate	4mg/ml – 1ml	10
• Fentanyl	50mcg/ml – 2ml	2
• Diazapam	5mg/ml – 2ml	4
• Versed	1mg/ml – 2ml	10
• Control Substance Sheet		1
• Yellow tags		3
• Biohazard bag		2
• 3cc syringe		3
• Carpuject		1

Exchange Process

1. The Pharmacy at Anderson Hospital will provide exchange of controlled medications approved by the Anderson EMS System and the Region 4 EMS Advisory Committee. Any patient receiving the medication by a system provider will be restocked, no matter the receiving facility. Anderson Hospital pharmacy is the only location that Anderson System EMS services can restock controlled medications.
2. All controlled medications will be issued by pharmacy in a sealed, non-transparent container. The container inventory (par value) will be stocked and verified by pharmacy staff.
3. All containers not in-service will be stored at Anderson Hospital pharmacy.
4. An Anderson System EMS provider paramedic will accept a sealed box from pharmacy staff. The proper paperwork tracking release and accepting of these medications will be completed. The accepting paramedic will be a system paramedic in good standing with an active "Paul" number, (P). The paramedic receiving the controlled medications from pharmacy will be required to show acceptable picture identification.
5. The sealed controlled substance container will ONLY be stored on an ambulance behind two locked mechanisms, per state of Illinois statute. Sealed containers cannot be stored in a building or storage closets.
6. Tracking of the containers will occur via numbered seals. A container received from pharmacy will have a red colored seal. This seal is to remain intact until contents needed for patient use. At no time is anyone to break the seal for any other reason, including expiration date checks, inventory, and so on. The most recent upcoming expiration date for all meds contained will be printed on the exterior of the container.

7. After breaking the red seal and opening the container for patient use, the proper documentation (stored within the container) will need completed.
8. Any waste (*medication not used yet still in a vial*) will need to be returned to Anderson Hospital pharmacy, a plastic bag to place the vial and seal will be located in the container. All unused medication will be returned to our Pharmacy and wasted, witnessed by both a pharmacy staff member and a paramedic.
9. Each container will contain yellow numbered seals. After the proper use of medication and completion of enclosed documents, the box will be sealed using the enclosed yellow seal. The color differences will indicate to all involved parties that the container has been accessed by non-pharmacy personnel.
10. Any container sealed with a yellow seal will need returned to Anderson Hospital pharmacy as soon as possible.

EMS ASSISTANCE GRANT FUNDS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Any Illinois licensed and based EMS provider agency that provides EMS service within the State of Illinois may apply for funds through the Regional EMS Advisory Committee.

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- Application shall be made on forms prescribed and provided by the Department.
- Applicants shall provide evidence of financial planning, to include but not be limited to: equipment replacement plans, budgeting plans, and fundraising plans.
- Applicants shall submit a copy of their current provider license.
- To be eligible for any grant, the EMS provider agency shall be in compliance with pre-hospital reporting requirements.

The award of funds shall be based upon demonstrated need and one or more of the following:

- Establishment of a new EMS agency, program or service where needed to improve emergency medical services available in an area;
- Expansion or improvement of an existing EMS agency, program or service;
- Replacement of equipment that is unserviceable or procurement of new equipment; and
- Establishment, expansion or improvement of EMS education and training programs including the adult and pediatric population.

All purchases and training shall occur during the fiscal year in which the grant is awarded.

The grant cycle runs from July 1 through June 30 of each year.

Grant recipients shall complete and return documentation as prescribed by the Department (e.g., grant application, Reimbursement Certification Form or Internal Revenue Service W-9 Form).

Grantees receiving grant funds are required to permit the Department, the Auditor General, and the Attorney General to inspect and audit any books, records or papers related to the program, project, equipment or use for which the EMS Assistance Grant funds were provided.

All funds remaining at the end of the period of time in which grant funds are available for expenditure (June 30 of the fiscal year in which the grant was awarded) shall be returned to the State within 45 days.

All grants shall be subject to all requirements and limitations imposed by Illinois law, including, without limitation, the Illinois Grant Funds Recovery Act [30 ILCS 705].

Emergency Grant Awards

- The Regional EMS Advisory Committee may recommend that the Department issue emergency grant awards. Emergency grant awards shall not exceed 10 percent of the total funds available in a year.

- The award of funds shall be based on the demonstrated needs arising from a natural or man-made disaster.

Amount of Grant Award

- The amount of the grant award shall be based on the amount requested by the applicant, the recommendation of the Regional EMS Advisory Committee, the Department's review of the application, and the amount available in the Fund for distribution. The amount awarded shall not exceed the amount requested by the applicant.

- The applicant shall provide adequate information to substantiate the requested amount or any hardship claim.

Modification of a Grant Agreement

- Any change in the use of grant funds from that specified in the approved grant agreement will be permitted only by written modification of the grant agreement. The grantee may request modification of the grant agreement by submitting in writing to the Illinois Department of Public Health the reasons and circumstances necessitating the request.

The grant award shall be suspended and all disbursements of funds held in situations including, but not limited to:

- Failure to comply with this policy;

- Failure to follow the EMS System Plan and

- Violation of the terms of the grant agreement.

CONFLICT OF INTEREST	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Anderson Hospital agrees to notify the Department in writing of any association that the EMS Medical Director, EMS System Coordinator or the EMS Administrative Director may have with an ambulance service provider through employment, contract, and ownership, or if they should in any way be answerable to or directed by an ambulance service provider concerning any matter falling within the scope of the Emergency Medical Service System Act.

Section XIV: Mass Casualty Incident Response

The purpose of this policy is to assist Emergency Medical Services providers in developing a response plan to address management of a mass casualty incident (MCI) using the principles of the Incident Command System (ICS). A MCI is an incident that overwhelms the resources of the responding agencies.

I. General
   A. Mass Casualty Incidents may be defined by:
      1. The total number of patients at an incident
      2. The severity of the patients at an incident
      3. Requirement of special resources to treat or to gain access such as technical rescue, HazMat response, and or enhanced scene security.

II. Command and Control
   A. It will be the responsibility of the first arriving company to establish Incident Command and manage the incident until relieved.
   B. A staging area should be established and the location provided to all responding units.
   C. The Operations Section Chief manages the operations of the incident. The Operations Chief receives direction from the Incident Commander.
   D. The EMS Branch Director is responsible for the emergency medical operations during the incident. Depending on the size of the incident and available personnel, the EMS Branch Director may further delegate and assign duties to the Triage Group Supervisor, the Treatment Group Supervisor and the Transportation Group Supervisor. The EMS Branch Director receives direction from the Operations Section Chief.
   E. The Triage Group Supervisor is responsible for initiating and directing the Triage Group which is responsible for the rapid assessment and categorization of patients. The Triage Group Supervisor receives direction from the EMS Branch Director.
   F. The Treatment Group Supervisor is responsible for initiating and directing the Treatment Group which provides on-scene treatment of patients. The Treatment Group Supervisor receives direction from the EMS Branch Director.
   G. The Transportation Group Supervisor is responsible for ensuring that all patients are transported to the appropriate facility. The Transportation Group Supervisor receives direction from the EMS Branch Director.

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 and resource hospital are notified.
   B. Triage- The immediate area where rescue operations and initial patient evaluation is being performed.
      1. Identify and prioritize mitigation of scene hazards.

2. Identify and categorize patients on scene using the START triage system.
3. Manage the disposition of victims who are obviously deceased.

C. Treatment- An area located a safe convenient distance from the triage area where victims are taken for pre transport stabilization.
   1. Secondary and ongoing triage
   2. Pre-transport treatment and packaging.
   3. Determine the level and type of transportation required and communicate this information to the transport team leader.
   4. Supervise the delivery of patients to the transport area.

D. Staging- An area where personnel, ambulances and fire apparatus report to prior to being assigned.
   1. Determine the level of staging.
   2. Maintain a record of the names of all personnel deployed at the incident and record the amount and type of equipment managed by staging.
   3. Maintain a reserve of at least one ambulance, and a sufficient number of other resources as may be required.
   4. Request and deploy additional resources as needed.

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

IV. <u>Operational Phases</u>

A. Phase 1- Initial agency response
   1. Upon receipt of a call for service by the agency's dispatch center, the primary jurisdiction should 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.

B. Phase 2 - Establishment of command
   1. Incident command should 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.

C. 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

D. 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 are notified. The agency's dispatch center will dispatch resources as requested by the incident commander following the agencies EMS run cards.

E. 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 should report to the designated staging area or assignment. Personnel should 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.

F. Phase 6 - Continued incident management
    1. The incident commander should 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.

G. Phase 7 - Release / termination
    1. The Incident Commander should release units as soon as possible, in the interest of maintaining optimal coverage for all assigned jurisdictions. No units should return to service without accounting for their personnel and being release by the Incident Commander. Once all patients have reached their final disposition the IC should notify the Resource Hospital. Upon completion of the operation the IC should notify all participating agencies including the Resource Hospital that the operation is complete and command is terminated.

H. 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 will 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. Operational Considerations

A. Triage
   1. Initial triage of adult patients will use the START triage system.
   2. Initial triage of patients less than 8 years of age will use the Jump START triage system.
   3. Triage personnel will place SMART triage tags on all patients whenever available.

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

C. Transport
   1. Patient destination should 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 as needed.
   5. Aeromedical transport should be consistent with the aeromedical policy.

D. Patient Tracking
   1. 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. The transporting 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 may be given to the receiving facility. Report should only include triage category, life threats, and 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 of patients for which they cared.

MULTIPLE VICTIM INCIDENT	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

This policy governs the handling of multiple injury incidents. It is meant to be implemented by EMS personnel in conjunction with System/Regional policies in the event of a large-scale incident. The goal of this policy is to provide a mechanism to obtain refusals on individuals experiencing no injuries or very minor injuries.

Each ambulance service provider within the System/Region is required to design and implement a procedure for discharging uninjured adults. A statement must be included within the service policy stating that the highest level of care available will be dispatched to the scene for patient evaluation.

Procedure:

A. Determine individual competency.

COMPETENT ADULT

A patient shall be considered to be competent if the patient is:

- An adult 18 years or older or an emancipated minor and:
- Conscious and of sound mind. The person must be able to understand the nature and severity of his/her illness or condition, the potential consequences of treatment or the withholding of treatment, and the alternatives to the proposed treatment and:
- The possible consequences or alternatives to the proposed treatment and;
- Possesses the ability to make informed and deliberate choices concerning his/her course of treatment.

INCOMPETENT ADULT:

A patient shall be considered to be incompetent if the patient is:

- Under the age of eighteen, unless the patient is emancipated or:
- Unable to understand the nature and severity of the injury involved or:
- Is unable to understand the possible consequences of and alternatives to the proposed treatment or:
- Is unable to make informed and deliberate choices concerning the course of treatment or:
- Declared to be incompetent by court order.

MINORS

Illinois law generally provides that only the parent or guardian of a person under the age of eighteen may consent to medical treatment for that minor. However, the law provided several exceptions to this general rule:

- Medical Emergency.
  Emergency medical treatment may be provided to a minor without parental consent when, in sole opinion of the physician, or hospital, obtaining such consent is not reasonably feasible under the circumstances without adversely affecting the condition of the minors health.
- Minors Who Are Parents
  A minor who is a parent may consent to his or her own health care even though he or she is under the age of eighteen.
  Any parent, including a parent who is a minor may consent to health care on behalf of his or her child. This provision applies to parents who are divorced or separated.
- Emancipated. Pregnant or Married Minors.
  A minor is considered emancipated who is pregnant or who is married and may lawfully consent to the performance of any medical or surgical procedure even though such minor is under age eighteen. Emancipated minors are minors between the ages of sixteen and eighteen who have a court order which stated the individual is legally emancipated.

C. Determine if implementation of this policy is appropriate. *Implement this policy only if the victim is competent* Follow multiple victim and disaster preparedness policies for all competent adults.
D. Contact medical control, advise of the existence of multiple injury incident and determine if a scene discharge of uninjured competent adults by the emergency department physician in charge of the call, is appropriate.
E. Victims by exam or complaint are treated and transported as deemed necessary and appropriate by EMS personnel. Medical Control physician or at the request of the individual
F. Medical Control, after consulting with scene personnel, will discharge the uninjured adults to the care of the ambulance provider who then will assume responsibility for release and assurance of transportation from the scene.
G. Each uninjured adult's name must be added to the Multiple Injury Log and completed as indicated.

UNINJURED PATIENT REFUSAL LOG*

All individuals involved in the incident should sign in the indicated spaced adjacent to their name when uninjured. Signature will indicate agreement that no injury has been suffered and no transportation is required to the hospital.

Provider Name _____ Unit License Number _____ Date _____ Time _____
Type Incident _____ Location _____
Total Number of Persons _____Number Transported _____ Number Not Transported _____

(Please Print)

NAME	AGE	M/F	ADDRESS	PHONE	SIGNATURE

SCHOOL BUS INCIDENT	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Each ambulance service provider within the System/Region is required to design and implement a procedure for discharging uninjured children/students to their parents/legal guardians or to local school officials. A statement must be included within the service policy stating that the highest level of care available will be dispatched to the scene *for* patient evaluation. Discharge procedures will facilitate transferring care of uninjured children/students to the parent/legal guardians or school officials consistent with System and Regional policies. It is recommended that these procedures be developed in coordination with school officials and provider's legal counsel.

PROCEDURE

A. Determine the category of the collision/incident

- CATEGORY I bus collision/incident - significant injuries present in one or more children/students or there is a documented mechanism of injury that could reasonably be expected to cause significant injuries.
- CATEGORY II bus collision/incident - minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students also present.
- CATEGORY III bus collision/incident - no injuries present in any children/students and no significant mechanism of injury present.

B. Determine if implementation of this policy is appropriate. Implement this policy only if the collision/incident is a Category II or III bus collision/incident. Follow multiple victim and disaster preparedness policies for all Category I bus collisions/incidents, and transport all children/students to the hospital. Children/students with disabilities, special needs or communication difficulties will be transported to the hospital for evaluation, when involved in a Category I or Category II collision/incident. For those involved in a Category III, where there is no injury and no significant mechanism of injury present, list children/students on the "School Bus Incident Log."

C. Contact medical control, advise of the existence of a Category II or III bus collision/incident and determine if a scene discharge of uninjured children/students by the emergency department physician in charge of the call is appropriate.

D. Injured children/students by exam and/or complaint are treated and transported as deemed necessary and appropriate by EMS personnel or at the request of the child/student.

E. Implement provider procedures for contacting school officials or parents/legal guardians to receive custody of the uninjured children/students consistent with System/Regional policies. Procedures may include option of ambulance service provider escorting bus, if operable, back to school or origin or other appropriate destination.

F. Medical Control, after consulting with scene personnel, will discharge the uninjured children/students to care of the ambulance service provider, who then will release the children/students, consistent with appropriate System/Regional policies and procedures, to parent/legal guardians or school officials.

G. Each uninjured child/student name must be added to the "School Bus Incident Log" and the "Notice of Emergency Medical Services Response to a Minor" form. A copy of the evaluation form must be given to the parent/legal guardian or school official.

REGION IV SCHOOL BUS INCIDENT LOG OF UNINJURED PATIENTS*

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

==========

Date & Time _____ Location _____ School Name _____

Bus Number _____ Total # of Persons _____ # Transported _____ # Not Transported _____

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NAME	AGE	M/F	ADDRESS	PHONE	INITIALS

*Region-Wide Policy

PREPAREDNESS TO A SYSTEM-WIDE CRISIS	
Anderson EMS System	**Approved: Dr. Andrew Russell**
Author: System	**MD Approved: 09/15**
Version: 1.0	**Council Approved:**

Natural and technological crises may place an intense demand for EMS and emergency department resources on one or more of the EMS Systems in Illinois. 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 Anderson Hospital emergency department resources.

As a result, 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 prepare participating hospitals and local ambulance providers to handle any type of situation.

The following outlines demonstrate how and when recognition or notification may occur:

1. Recognition
   a. ED personnel answering radio calls may be made aware of a system-wide crisis by communication from the local ambulance provider, or by noting an increasing number of emergency departments requesting ambulance diversion. The ED personnel should report these occurrences to the attending emergency doctor or charge nurse.
   b. When a participating hospital sees rapid or developing increases of patients with similar symptoms, the attending emergency doctor or the charge nurse should contact their Resource Hospital and apprise them of the situation.
   c. 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.
   d. Public Health personnel may notice an influx of patients with similar symptoms to area emergency departments.

2. Notification of Personnel
   a. The Resource Hospital shall document any calls they receive from their participating hospitals or ambulance providers, identifying that they are seeing numerous patients complaining of similar types of symptoms. The Resource Hospital should note the time the call is received and seek a detailed account of the situation.
   b. If the Resource Hospital receives calls from two participating hospitals, or has reason to suspect a potential system-wide crisis, staff 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 providers to see if they are noticing an increase in patients with similar types of symptoms.
   c. The EMS Coordinator or EMS Medical Director may also contact the Illinois Poison Control Center (1-800-222-1222) to determine if they are receiving additional calls, for similar type symptoms.

3. Plan of Action
   a. 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 to mobilize additional staff and resource or to activate their internal disaster plans.
   b. 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.
   c. During an impending or actual system-wide crisis, the local municipality may request mutual aid, through pre-existing agreements, from the surrounding areas.
   d. All information shall be recorded on the “System-Wide Crisis Form”.

4. All Clear
   a. The Director of Public Health, or his designee, will contact the Resource Hospital when the response to the crisis appears to be over.