Appendix D (Trinity EMS System Forms)

EMS Incident Report

Improvement Opportunity Report (IOR) Form

Service Excellence Form
EMS INCIDENT REPORT

Date of Incident: ______________________ Date Report Filed: ______________________

REASON FOR REPORT: (Check all that apply)

Violation of:    _____ Policy    _____ Procedure    _____ Protocol    _____ Unusual Incident
Related to: _____ Medical Control    _____ Dispatch    _____ Patient    _____ Safety
    _____ FRD    _____ BLS    _____ ILS    _____ ALS

Situation: Describe the specific incident.
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Background: Pertinent information related to the situation.
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Assessment: Why do you think this happened?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Recommendation: What can be done to improve the situation?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Submitted by: __________________________________________________________________

EMS System Coordinator/EMS Quality Coordinator:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

EMS Medical Director:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Action Taken:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

EMS Medical Director                                          Date

EMS System Coordinator                                      Date

CONFIDENTIAL DOCUMENT
DATE: ____________________________

TIME: ____________________________

**SITUATION:** Briefly explain the current situation:

___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

**BACKGROUND:** Pertinent information related to the situation:

___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

**ASSESSMENT:** Why did this happen?

___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

**RECOMMENDATION:** What can be done to improve the situation?

___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

Submitted by:

___________________________________________________________

Attach 2nd sheet if necessary
2/2015
SERVICE EXCELLENCE FORM

Date: ___________________

Name of Individual or Unit deserving recognition: __________________

Situation: Tell us how this individual or unit provided service above your expectations in the Trinity EMS System.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Submitted by: ____________________________________________

Please send to the EMS System Coordinator
## EMS System Policies:

### Section # 01: General

- Description of Pre-Hospital Advisory Board 01-01
- General System Requirements / Recommendations 01-02
- Remediation 01-03
- System Participation Suspension 01-04
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- Special Events Requirements 01-10
DESCRIPTION OF PREHOSPITAL ADVISORY BOARD POLICY # 1 - 01

PURPOSE:
To provide a forum for prehospital care providers to learn of new legislation, equipment, skills, and to address the concerns of prehospital care providers

OBJECTIVES:
1. Promote and provide an optimum level of prehospital care to our communities
2. Promote camaraderie, teamwork, and understanding among all prehospital providers
3. Improve communications and exchange of information between the prehospital provider agencies and local hospitals
4. Maximize prehospital care through standardization of equipment, procedures and protocols between prehospital providers and local hospitals
5. Evaluate the delivery of emergency services in our region and effectively deal with any questions or problems encountered
6. Provide ongoing education and educational offerings to prehospital providers
7. Plan for the future of EMS care delivered in our system

MEETINGS:
The Prehospital Advisory Board meets the first Wednesday of designated months. All prehospital providers are welcome to attend. Membership is afforded to all Trinity EMS System services.

For additional information about the Prehospital Advisory Board, contact:

Trinity Office of EMS
2701 17th St
Rock Island, IL 61201
(309)779-7756
Fax (309)779-7746
PURPOSE:
To identify for all Trinity EMS System personnel general system requirements not identified in other policies. To delineate for Trinity Medical Center EMS Provider Agencies recommendations (non-mandatory) policies the agency may wish to develop.

POLICY:

1. All ALS/Trinity Medical Center EMS System personnel will determine a patient is either ALS or BLS by the highest level of care provider on scene. If the patient is determined ALS, then a monitor will be used in addition to any other treatments necessary. ALS personnel may not choose ILS as a category of treatment.

2. All patients who require intermediate/advanced treatments should have them started **regardless of distance to destination**. If protocols indicate treatment or Medical Control issues orders, then begin treatment as indicated. If transport time is extremely short, contact Medical Control for treatment decisions. Do not arbitrarily determine transport time is too short to begin ILS/ALS treatment without checking with Medical Control. However, **do not delay transport** to perform interventions or procedures if medically feasible.

3. All patients requiring ALS intervention should be ALS if it can be done in a timely manner and does not delay transport or arrival to destination. For example, an ambulance expecting an ALS tier should not stop if their expected wait time is in excess of their time to destination.

4. The Trinity EMS Office maintains an open door policy and encourages discussion of protocols, policies, emerging issues and system concerns.
PURPOSE:
To identify for Trinity EMS System personnel when supervision, remediation, or re-education (minor infractions) is required such as, but not limited to: documentation problems, non-professional conduct, patient care issues, language offenses, clinical techniques, continuing education questions. These infractions are such that they can be cleared up with re-education/remediation process. In these situations the EMS system personnel may ask for due process.

POLICY:

1. EMT’s should always follow their agencies chain of command, but the EMS Department is available to discuss specific case issues.

2. The EMS Medical Director may at any time call a provider to the office for discussion regarding poor standard of performance, documentation, and/or patient care. After notification of the personnel, the provider’s agency will be notified. Documentation of these discussions will be maintained in the EMT’s file at the resource hospital and not at the provider agency. The information/documentation files will be signed by the EMS personnel when presented. Information will be protected under the Medical Studies Act.

3. The EMS Medical Director will decide when the offense is criteria for removal from being scheduled on the agency ambulance. He will notify the EMT at the time of a scheduled discussion and note the length of time off ambulance, remediation and inform the EMT of all recourses. The EMS Medical Director will notify the Agency Director of the EMT’s removal from work and expected time of return (See System Participation Suspension Policy).

4. Upon completion of remediation, the provider’s agency will be notified of reinstatement and return to service. Written confirmation will be provided to the agency of completion of remediation and return to active service, and documentation will be kept in the provider’s personnel file in the Trinity Office of EMS.
PURPOSE:
To identify the grounds and process by which a Trinity Medical Center System participant may be suspended or have revocation of licensure. The EMS Medical Director may recommend for suspension a license or refuse to license any FR, EMT-B, EMT-I, or EMT-P where he/she has been found in failure to comply with the EMS System Act and/or the policies and standards of TMC/EMS system. The severity of the infraction shall determine the degree of action taken by the EMS Medical Director.

POLICY:

A. SYSTEM PARTICIPATION SUSPENSIONS:
Suspensions may be based on one or more of the following:

1. Failure to meet the initial and continuing education requirements
2. Violation of the Act, Rules, and Regulation
3. Failure to maintain proficiency in the provision of basic, intermediate, or advanced life support services
4. Failure to comply with the provisions of the System's Program Plan approved by the department
5. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substance, or other drugs or stimulants in such a manner as to adversely affect the delivery, performance or activities in the care of patients requiring medical care (For the purposes of this subsection, adversely affected means anything which could harm the patient or treatment that is administered improperly)
6. Intentional falsification of any medical reports or order, or making misrepresentations involving patient care
7. Abandoning or neglecting a patient requiring emergency care
8. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility, institution or other work place location
9. Performing or attempting emergency care, techniques, or procedures without proper permission, licensure, education, or supervision
10. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay
11. Behavior or conduct inappropriate or unbecoming of a member of the Trinity EMS System including social media and the internet
12. EMTALA or HIPAA violations
11. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care
12. Violation of the system’s standards of care
13. Physical impairment of an EMT to the extent that he/she cannot exercise the appropriate judgment, skill, and safety for performing the emergency care and life support functions for which he/she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part; or
14. Mental impairment of an EMT to the extent that he/she cannot exercise the appropriate judgment, skill, and safety for performing the emergency care and life support functions for which he/she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part

B. SYSTEM PARTICIPATION IMMEDIATE SUSPENSIONS:
This policy defines under what grounds a system participant may be immediately suspended. The EMS Medical Director may immediately suspend from participation within the system any individual or individual provider if he/she finds that the information in their possession indicates that the continuation in practice by an individual or individual provider would constitute an imminent danger to the public. The suspended individual or individual provider shall be issued an immediate verbal notification followed by a written suspension order to the individual or individual providers by the EMS Medical Director which states the length, terms, and basis for the suspension.

1. Within 24 hours the EMS Medical Director shall deliver to the Department (IDPH) a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director’s decision to suspend the individual or individual provider.
2. Within 24 hours the suspended individual or individual provider may deliver to the Department (IDPH) a written response to the suspension order and copies of any written materials which the individual or individual provider feels related to that response.
3. Within 24 hours of receipt of the suspension order or the response, whichever is later, the Department (IDPH) shall determine if the immediate suspension should be stayed or continued pending the individual or individual provider’s opportunity for hearing or review.
C. SYSTEM SUSPENSIONS:

1. The EMS Medical Director may suspend a provider from participation in the system for not meeting system requirements
2. The EMS Medical Director shall provide the individual with a written explanation of the suspension including terms, length, and date of commencement, and that a hearing can be held with the State Disciplinary Review Board
3. The individual must request, in writing, the hearing within 15 days or the right is waived
4. The individual still has the right to review by the State EMS Disciplinary Review Board
5. All documents and transcripts of the hearing/proceedings shall be retained in the custody of Trinity EMS System
6. Upon reinstatement, the individual and the providers service will be notified and documentation of the incident will be kept in the Trinity EMS System personnel records
TRINITY EMS SYSTEM RECORD OF DISCIPLINARY ACTION FORM

Name_____________________________________     Date___________________________

Job Classification_____________________     Agency________________________________

You are hereby officially counseled for the following incident(s) which occurred on_________

ISSUE/COUNSELING/ACTION:

ACTION TAKEN/DATE:

Verbal Counseling__________/__________

Written Warning__________/__________

Suspension__________/__________

Probation__________/__________

Was due process offered and explained?  Yes_____No_____Not Applicable_____

Has previous disciplinary action been given for this offense?  Yes_____No_________

A copy of this notice is being placed in your personnel file. You are warned that further
incidents of poor conduct or performance may lead to your termination from the Trinity EMS
System.

This is a quality improvement/corrective action plan intended for the use of EMS system
quality improvement and is protected by the Medical Studies Act.

Reviewed by:________________________________________________________________

EMS System Coordinator Date

Reviewed by:________________________________________________________________

EMS Medical Director Date

I have reviewed and understand the above:____________________________________

Signature Date

TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2013
PHARMACY-BASED OPTION FOR MEDICATIONS POLICY # 1 - 05

PURPOSE:
To establish a medication program for Trinity EMS System that meets or exceeds the requirements of Iowa/Illinois Code, Drugs in Emergency Medical Service Programs

POLICY:
The interaction of the physician medical director, pharmacist, service leadership and EMS providers is critical for the success of the medication program. All staff must understand their role, responsibilities and duties as part of the team. Every team member shall receive an initial orientation to this policy and be provided with an opportunity for input and updates when amended. The pharmacist in charge and service director shall develop, implement and adhere to these written pharmacy procedures for the operation and management with respect to prescription drugs.

1. The service shall maintain documentation of periodic reviews of these policies and procedures by the pharmacist in charge or designee, medical director and service director.
2. The service shall maintain documentation of staff training to the service pharmacy agreement and policies and procedures when initiated and amended.
3. All records regarding prescription drugs shall be maintained and be available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.
4. Identification, Access and Administration:
   a. The service shall ensure that access if limited to appropriate staff and proper documentation is maintained.
   b. The service shall maintain records that log access to prescription drugs and records regarding procurement, storage and administration of the drugs.
   c. The log shall be maintained in a readily-retrievable manner and be made available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.
   d. The log shall include the staff printed name and signature, printed and signed initials, level of certification and other unique identification used in the service records.
   e. Access to prescription drugs shall be limited to certified EMS providers that are listed on the pharmacy signature log and system registry roster.
   f. Drugs, excluding Schedule II controlled substances, may be administered beyond the limits of the patient care protocols provided that online or verbal medical direction has been obtained prior to administration.
5. **Procurement, Storage, Inspection, and Inventory Control**
   a. The pharmacist in charge or designee shall order, receive and distribute prescription drugs.
   b. Records of ordering and receipt of drugs shall be maintained by the pharmacy.
   c. The service shall maintain, at the primary site, an accurate list of all prescription drugs.
   d. The service shall maintain records of monthly inspections of all drugs at the primary site and all satellites.
   e. The inspection shall include removal of outdated drugs one month prior to expiration or removal of adulterated drugs that are quarantined for disposal.
   f. Yearly inventory will be done no later than January 31st but not before January 1st. All yearly inventory sheets will be turned into the EMS Coordinator.
   g. Staff may handle drugs within their current scope of practice as defined by the Bureau of EMS.
   h. Storage at the primary site and all satellites will be in a designated, secure, clean and free of debris climate-controlled area.
   j. Environmental temperatures shall be recorded on a daily basis, as a minimum.
   k. Refrigerated drugs will have daily recorded temperatures at a minimum.
   l. Drugs exposed to extreme temperatures (>104 degrees and <13 degrees Fahrenheit) shall not be administered to patients and removed from usable stock and quarantined for proper disposal.
   m. The pharmacist in charge shall notify the service regarding recalls and ensure removal and replacement.
   n. Expired, recalled and damaged drugs (except controlled substances) shall be removed from usable stock and returned to the pharmacy.

6. **Replenishment**
   a. Service staff may request replenishment of drugs maintained at the primary program site or satellites provided that the pharmacy has been supplied with administration records justifying the order.
   b. The pharmacist shall approve every drug taken from the pharmacy’s dispensing stock. The pharmacist shall document and maintain verification of approval.
7. Protocols, Administration of Drugs Beyond the Limits of Protocols, Patient Care Reports
   a. The medical director shall approve patient care protocols for all drugs carried by the service.
   b. The service will ensure the pharmacist in charge receives the patient care protocols when state or local updates are approved by the medical director.
   c. The pharmacist in charge and service director shall ensure that the drugs and controlled substances carried by the service match the drug list in the approved patient care protocols.
   d. Drugs, excluding Schedule II controlled substances, may be administered beyond the limits of the patient care protocols provided that online or verbal medical direction has been obtained prior to administration.
   e. Verbal orders for drugs not covered in the patient care protocols shall be repeated back to the physician or designee for verification.
   f. Drugs administered outside the parameters of the approved patient care protocols shall be documented in the patient care report including the name of the authorizing prescriber and any person that may have relayed the order.
   g. Patient care reports that include drugs administered outside the parameters of the approved patient care protocols are subject to an immediate written audit of the patient care report per the service Continuous Quality Improvement Policy.

8. Controlled Substances Administration, Destruction & Disposal, Inventories and Record Maintenance, Suspicion of Loss or Theft
   a. The service shall deliver an order signed by the prescriber to the pharmacy within seven days of the date the administration was authorized, for all Schedule II controlled substances.
   b. Every inventory and other required records shall be maintained by the pharmacy and the service and shall be readily retrievable and available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.
   c. A perpetual inventory (electronic or manual) of Schedule II controlled substances shall be maintained at the primary program site:
      i. The electronic inventory shall provide for a hard-copy print out for any specified period of time and shall include the current inventory quantities for each drug at the time the record is printed.
      ii. Electronic entries may not be changed once recorded. Adjustments or corrections shall require a separate entry that includes the identity of the person making the correction and the reason for the correction.
iii. The perpetual inventory shall identify all receipts and disbursements of Schedule II controlled substances by name or National Drug Code.

iv. The perpetual inventory shall include patient administration, wastage, return to the pharmacy and disposal.

v. The record of receipt shall identify the source of the drug, the strength and dosage form, the quantity, the date, and name or the unique identification of the individual verifying receipt of the drug.

vi. The record of disbursement shall identify where and to whom the drug is disbursed or administered, the strength and dosage form, the quantity, the date, and the name or the unique identification of the individual verifying receipt of the drug.

vii. The pharmacist in charge or designee shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance monthly.

vii. Any discrepancy shall be reported to the EMS Coordinator.

d. The service shall document an annual accurate inventory of Schedule II controlled substances at the primary site and any satellites that carry controlled substances.

e. All controlled substance records for the primary program site and any satellites shall be maintained at the primary site. The records will clearly identify which records are for the primary site and each of the satellite(s).

f. The pharmacy and primary program site shall maintain records of destruction or disposal of controlled substances.

i. Outdated, adulterated or unwanted supply shall be quarantined until the controlled substance can be returned to the pharmacy. EMS personnel shall not destroy controlled substances, except during wastage.

ii. For destruction and disposal of controlled substances the pharmacist shall use the services of a DEA-registered and licensed disposal firm or other means approved by the board.

iii. EMS personnel, the medical director or pharmacist may destroy or dispose of the unused portion of a controlled substance resulting from administration to a patient.

1. Wastage shall be conducted in the presence an EMS provider authorized to administer the drug or a licensed healthcare professional.

2. Written or electronic records of controlled substance wastage shall be maintained by the service and pharmacy.
3. The records shall include legibly printed names and the signatures or other unique identification of the witness and of the individual wasting the controlled substance and:
   a. The controlled substance wasted;
   b. The date of destruction or disposition;
   c. The quantity or estimated quantity of the wasted controlled substance;
   d. Patient identification;

   g. Upon suspicion of loss or theft of any controlled substance, the service shall notify, in writing (email preferred), The EMS System Office and the pharmacist in charge within 48 hours of the discovery of the theft or loss.

   h. The pharmacist in charge shall notify, in writing, the DEA and the Board of Pharmacy of any theft or significant loss of any controlled substance within two weeks of the discovery of the theft or loss.

   i. The incident report shall be maintained at the pharmacy and at the EMS System office.

9. **Misuse or Diversion**
   
   A. This is a criminal offense, which may result in loss of employment, immediate suspension from the system and/or revocation of license

   B. The agency Director, Chief or designee is responsible to review the count records frequently

   C. If a pattern evolves of continued breakage or documentation by one EMT the Director or Chief should follow up with interview and/or drug screen (Policy of the agency)

   D. Report any infractions to the EMS System office(See system participation suspension policy)

   E. If system personnel are proven to abuse drugs or alcohol while on duty they will be subject to system disciplinary action(see system suspension policy)

   F. Immediate system suspension will occur if the system personnel use on duty and/or distribute controlled substances for other than their intended use. This may also involve termination of their current employment

A complete copy of the Pharmacy-based Option Policy can be obtained from the Trinity EMS System Office upon request.
PURPOSE:

This policy is to define for Trinity EMS System Personnel the type of communication methods and acceptable equipment to be used.

A. **FR, BLS, ILS, ALS**
   1. All services, whether transport or non-transport, will communicate to Medical Control via Merci (VHF) radio, Med channel 6, or a recorded cellular line on tones assigned by IDPH.
   2. In any instance where communication is not possible on Merci, cellular communication should be used. If this is not possible, call from a landline before leaving the site.

C. Use unit identifier number in all communication. This unit number will be used for re-contact and should use common terms, i.e., “Moline Ambulance 11”

D. See standard operating guidelines and policy for radio report contents and care initiated prior to contact of medical control.

COMMUNICATIONS TO FACILITIES:

A. Should there be a phone communication failure at Trinity, use MERCI radio (recorded line).

B. Reports of patient transfer to another facility may be repeated and/or given by the ECRN at TMC by phone and/or radio to the receiving facility.

C. The UHF channels dedicated to our area are 1-4-6-8, 8 being an all calls and can be used in certain circumstances to transfer a report.

D. Communication orders may be received only from Trinity RI Campus, ECRN’s/MD’s. Hammond Henry Hospital is approved as an associate hospital at the ILS level and may give orders to BLS, ILS in the TMC system. Hammond Henry Hospital provides system approved ECRN’s and is monitored by TMC.
PURPOSE:
This policy is to identify minimum accepted staffing patterns for all system vehicles and process to follow if you are unable to meet this criteria on a constant basis.

POLICY:

FR
1. All First Response vehicles are to be staffed 24 hours a day, 365 days a year with First Responders trained at that level
2. Other Appropriate personnel trained to a minimum of CPR

BLS
1. All BLS transport vehicles are to be staffed 24 hours a day, 365 days a year with one of the following: (Drivers may be used anytime, but not in place of EMT staff)
   A. Two (2) EMT-B’s, licensed appropriately per state law
   B. One (1) EMT-B and system field PHRN or ILS,ALS personnel working at the BLS level licensed appropriately per state law

ILS
1. All ILS transport vehicles are to be staffed 24 hours a day, 365 days a year with one of the following: (Drivers may be used anytime but not in place of licensed EMT staff)
   A. Two (2) EMT-I’s licensed appropriately per state law
   B. One (1) EMT-B or system field PHRN, one (1) EMT-I or ALS personnel working at the ILS level, licensed appropriately per state law

ALS
1. All ALS vehicles transport are to be staffed 24 hours a day, 365 days a year with one of the following crews: (Drivers may be used but not in place of licensed EMT staff)
   A. Two (2) EMT-P’s
   B. One (1) EMT-P, one (1) EMT-I, EMT-B or system PHRN
VEHICLE STAFFING REQUIREMENTS
POLICY # 1 - 07

RESCUE NON-TRANSPORT/AMBULANCE ASSIST VEHICLES
1. FR must staff/arrive with appropriate FR personnel at the level of the service offered
2. BLS responders must arrive with appropriate BLS personnel appropriately licensed per state law and at the level of the service offered
3. ILS responders must staff/arrive with ILS personnel appropriately licensed per state law and at the level of the service offered
4. ALS responders must arrive with ALS personnel appropriately licensed per state law
5. All levels BLS, ILS, and ALS non-transport first responding provider agencies must carry system equipment and state required equipment for the level of the vehicle license (See EMS Act for state required equipment and system required supplies policy) and follow system policies, procedures, and standing operating guidelines

STAFFING WAIVERS
1. Staffing waivers may be approved by the EMS Medical Director system services. Waivers are completed and sent to the Illinois Department of Public Health for final approval. The department will approve the waiver if it determines there is no reduction in the quality of care established by the act and/or if full compliance with the regulation in the act at issue would constitute a hardship for the applicant
2. Anytime that a service can not meet it's staffing obligation due to extenuating circumstances, please contact the EMS System office at once to review the problem and, if applicable, request a staffing waiver
3. All staffing waivers must be approved by the EMS Medical Director and sent to the Department of Public Health

LICENSE
1. All staff will be licensed by IDPH and approved to work in the EMS system
2. The EMS Medical Director in Illinois is responsible for all levels of EMT licensure in that he/she will approve CE and other requirements listed by IDPH and present the provider for licensure and relicensure
PURPOSE:
To delineate for agencies in the Trinity Medical Center EMS System tiered response, time response, and caller information. To provide information for entering the Trinity EMS System

VEHICLE RESPONSE:
1. Any agency may respond with one vehicle to a call. That vehicle will be of the level and type that is indicated in the provider application. Staffing shall be as listed for that level of response/vehicle and according to Trinity Medical Center EMS Vehicle Staffing Requirements Policy
2. Any agency may respond with a second vehicle to the scene such as: Fire Engine, Rescue Vehicle. The second vehicle may or may not be utilized as EMS Responders, but as extra personnel for manpower. If these responders are trained as EMS Providers they may assist medically if they are in the System and recognized by the Medical Director
3. If a call to a scene has dual responding ambulances, the highest level provider will determine the need of the patient
4. All First Responding vehicles in the System will be listed in the provider application and licensed as required. Each subsequent vehicle will be listed as transport/non-transport and may be designated as FR, BLS, ILS, or ALS if system equipment, staffing requirements are met

TIERED RESPONSE:
1. Any agency may participate in a tiered response to patient care providing that response is listed in the system plan and documented in the agency commitment.
2. Any Agency may utilize:
   A. Ambulance assist vehicle
   B. Transport vehicle of another agency
   C. First responding vehicle
   D. Non-transport vehicle
3. Designation with mutual aid or by contract for the transport vehicle must be made and attached to the commitment to the system
4. Staffing must be maintained as listed in the vehicle staffing policy
TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2013

VEHICLE RESPONSE REQUIREMENTS
POLICY # 1 - 08

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TIME RESPONSE:
1. All system ambulances, assist/non-transport vehicles and rescue vehicles listed in the system plan/commitment must adhere to the response time listed in EMS Act section 515.810
2. A commitment to optimum response times up to 6 minutes for the primary coverage areas, 6-15 minutes in the secondary coverage areas, and 15-20 minutes in the outlying coverage areas

SYSTEM APPLICATION:
1. Each provider entering Trinity Medical Center EMS System must provide application as determined by the Illinois Department of Public Health and all attachments requested in the application. All vehicles using EMS providers at any level must be included in the application
2. All provider agencies will have Mutual Aid Agreements established and submitted in the provider application
   A. Fire, Municipal within its own agency, i.e. Paramedic Engine Company level as it is. Agency needs a transport agency agreement.
   B. Fire, Municipal with First Response and requires another agency to transport does need a transport agreement signed with that agency
3. Any First Responding, non-transport agency will provide a transport agreement with the agency utilized to transport
4. Renewal of applications will be with renewal of the EMS System Plan as requested by IDPH
PURPOSE:
To identify for the Trinity Medical Center Emergency Communication Registered Nurse personnel and the Emergency Room Physicians their responsibilities in regard to the communications of medical orders to prehospital care providers. To delineate a course of action should the Resource Hospital Medical Control need to override medical orders from any other hospital to Trinity Medical Center System personnel.

1. An Emergency Communications Registered Nurse in the Trinity Medical Center EMS System, who has received the entire course of ECRN instruction and passed the required system examination is approved to communicate via radio to personnel in the field.
2. The ECRN must follow the Standing Operating Guidelines of the EMS Medical Director and/or relay orders from the designated Emergency Room Physician. If the Medical Control Physician is not in direct communication with the ECRN, the ECRN must begin orders in strict adherence to SOG’s.
3. The designated Emergency Room Physician should be notified and called to the console as soon as possible.
4. The Emergency Room Physician may deviate from the SOG’s for certain patient situations, but may not advise the field personnel to administer any treatments/medications which have not been previously approved through the EMS Medical Director.
5. Suggestions for change of Policy/Procedure may be made to the System EMS Medical Director.
6. Overriding other Medical Control Communication may occur if the ECRN/Medical Control Physician determines that those orders could be harmful or dangerous to either the field personnel/patient.
7. Document fully any override situations or unusual occurrences and send to EMS MD/EMS System office.
8. Medical Control Physicians may also override decisions of transports to facility based on the interpreted condition of the patient (See Closest Hospital/Transport Decision Policy).
PURPOSE:
A Special Events Form is to be completed as an amendment to an existing EMS System plan by an ambulance provider who will be providing coverage at the specific event. This form with attachments, if appropriate, should be submitted to the EMS Department ideally 45 days prior to the event. The form will be filed in the EMS Department and will be sent to the Illinois Department of Public Health if requested.

A copy of the Special Events Form and the items required by the EMS System for each level of care can be found on the IDPH Department of EMS website or requested from the EMS office, titled Emergency Medical Service (EMS) Systems Special Events Request Application.

1. First Responder Assist Vehicles inclusive of:
   A. Bicycle
   B. Boat
   C. Paramedic Engines

2. Transport/Non-Transport Vehicle Assist

3. Intermediate Life Support Transport Vehicles

4. Advanced Life Support Transport Vehicles
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PURPOSE:
To identify for all system personnel the term abandonment and those aspects which may constitute abandonment

POLICY:
● Abandonment is the unilateral severance of the EMT-patient relationship without reasonable notice, when further medical treatment is required. Abandonment occurs when the EMT-patient relationship, once created, is terminated intentionally and unjustifiably by the EMT. Very often abandonment takes the form of negligence or an act of omission.
● Abandonment can ensure after the patient-EMT relationship is formed, i.e. when an ambulance is dispatched and arrives at the scene of an emergency and the EMT begins treatment or begins contact with the patient, the relationship is formed, then leaving care of the patient to anyone of a lesser level than the responding service EMT’s constitutes abandonment.

There are only three (3) ways the patient-EMT relationship can be terminated without abandonment:
1. The patient does not require further medical care
2. The patient terminates the relationship
3. The patient is transferred to another qualified medical professional of equal or greater licensure. You cannot turn the patient over to lesser licensed personnel.

Recommendations to eliminate abandonment questions are:
A. Once you start treatment, or accept the duty to provide service, then remain with the patient until he/she is safely transferred to the care of another provider of equal or greater licensure.
B. Do not leave a patient who decided he/she may not require emergency care unless you obtain a refusal (See System Refusal Policy)
C. Never leave a patient in an Emergency Department until you have provided the staff with all the required reports and information and the staff has assumed care of the patient. Document the name of the doctor and/or nurse you turned the patient over to by having them sign your run/bedside report form.
D. Do not leave the patient or discontinue treatment because of police interference. If you receive a direct order from police to desist and the patient is removed from you under direct police custody, you no longer have the option to treat, but you must document fully the statements of police and police ID’s, as well as immediately notify Medical Control.
E. In a triage situation, it is advisable to summon an adequate number of personnel to assure that all patients are treated and transported in a timely fashion.
PURPOSE:
To identify for system personnel at all levels their responsibility to patient care and unlawful discrimination

POLICY:
The patient is to be considered primary at anytime you are called to serve.
1. Once you are dispatched you are to offer any care/treatment to your patient at the level of your licensure (that of the vehicle you serve on)
2. You are responsible to know the laws of your state and the regional/system policies and Standard Operating Guidelines of your system
3. You must provide for the well-being of the patient while rendering the necessary interventions relevant to your licensure level
4. You must be cognizant of the patient’s ability to understand and comprehend your applications of treatment and his/her rights to refuse any part or all treatments. You must fully explain any risks involved with refusal of treatment and/or refusal of transport with this refusal. It is your responsibility to have the appropriate refusal signed and to document the explanation of risks in the narrative report
5. Provide privacy/confidentiality and allow patients to maintain dignity
6. Allow access to relatives and caregivers on request if appropriate
7. Make all emotional and physical needs of the patient a priority
8. Maintain honest/open discussions of events and procedures to the patient and their families
9. Explain the process of procedures
10. Recognize and respect all rights of property, patient, and families
11. Recognize the emotional needs of the infant and pediatric patient as well as the adult and elderly
12. Physical contact should be limited to treatments or therapeutic interventions
13. Maintain professional attitude at all times
14. Use appropriate language and do not try to overwhelm a patient with technical language
15. Allow interpreters and/or those who “sign” to accompany the patient

Discrimination:
1. No service/agency or EMT can refuse an emergent patient service based on race, sex, age, religion, mental competency/capacity, or ability to pay
2. When an ambulance is called, it is a call for help and appropriate response, care must be given
3. Any refusal to care for patient, even those who are in need, will result in system discipline and/or licensure suspension
PURPOSE:
To identify for the Trinity Medical Center EMS System personnel the procedures to preserve a chain of evidence. To identify necessary reporting of crime and circumstances in which reporting is mandated. It is recommended that EMS management work closely with the police to avoid any interaction problems. Police/EMS joint education may be helpful. Trinity Medical Center EMS personnel must keep in mind that the patient is your primary responsibility.

POLICY:

Dying Declaration: is a statement or declaration from the dying patient is meant to be communicated to others you must: (this statement may indicate who the perpetrator of the crime is)
1. Record the message in as much detail as possible. Have the written record signed by two witnesses who may have heard the declaration
2. Communicate the message to the immediate police
3. A declaration may also be regarding property, particularly regarding valuables or burial instructions. Also turn the documentation over to authority Police/Hospital and family if indicated

Suspicious Death: You must work with police and not disturb evidence. Police should never ask you not to examine the patient or transport if necessary. Ask police if you can move patient to a “non-crime area” to begin treatment. (If this will not endanger the patient). Patient exam and treatment is your responsibility and must be done and documented
1. Move nothing at a crime scene unless it is necessary to immediately treat a patient
2. If you must move something document its original location and give to police
3. Any bottles etc. that may be taken with you in transport must stay in a chain of custody. You are responsible for that chain until turned over the MD/police document who receives the property

Arrest: Police may wish to place restraints on the patient. Discuss the EMS policy for restraints with the officer prior to transport. Contact medical control if any questions arise which you may feel can compromise patient care. Document all information that pertains
Reportable crimes are as follows but not limited to:

**Child/Elder Abuse**
- Provide care/comfort to the child/adult
- Report all evidence you find or see
- Should you be called to an abused child/adult, and a parent/guardian arrives and refuses care, immediately call police and standby to render aid after police arrive
- Document any and all evidence of abuse

**Domestic Violence**
- Provide comfort and care to the victim
- Report all evidence noted
- Do not place yourself in a position of danger. Call police immediately
- Document all evidence

**Rape**
- Comfort, treat injuries, appropriate assessment, call Rape Crisis if requested.
- Do not force unwanted questions about the rape.
- Do not examine or treat the genital area unless hemorrhage is present. Save all clothing.
- Do not allow the patient to wash, urinate or defecate until at the hospital
- Document all information/evidences and notify the police.

**Alcohol/Drug Abuse/Controlled Substances**
- Document fully all evidence of use
- Bring any evidence of use with you if possible
- Document behavioral effects

**Suicide**
- Document all evidence including statements that could point to suicide or attempted suicide
- Bring appropriate bottles, poisons, or notes with you if the patient is transported

**Animal Bites**
- Care for the patient. Document information and report to authorities, identify animal (if possible) for police

**Other Reportable Crimes**
- Gunshot/knife wounds, other assaults, injuries, MVA’s, etc.
- When in doubt, call police/Medical Control

**MAKE NO STATEMENTS TO THE MEDIA**
PURPOSE:
Child abuse is the physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child’s welfare. The recognition of abuse and the proper reporting is a critical step to improving the safety of children and preventing child abuse.

POLICY:
Assessment of a child abuse case based upon the following principles:

- **Protect** the life of the child from harm, as well as that of the EMS team from liability
- **Suspect** that the child may be a victim of abuse, especially if the injury/illness is not consistent with the reported history
- **Respect** the privacy of the child and family
- **Collect** as much evidence as possible, especially information

PROCEDURE:
1. With all children, assess for and document psychological characteristics of abuse, including excessively passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders
2. With all children, assess for and document physical signs of abuse, including and especially any injuries that are inconsistent with the reported mechanism of injury
3. With all children, assess for and document signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition
4. Immediately report any suspicious findings to both the receiving hospital (if transported) and to the Department of Children and Family Services (DCFS). While law enforcement may also be notified, the law requires the EMS provider to report the suspicion of abuse to DCFS. EMS should not accuse or challenge the suspected abuser. This is a legal requirement to report, not an accusation. In the event of a child fatality, law enforcement must also be notified.
PURPOSE:
Illinois provides a mechanism for unwanted infants to be taken under temporary custody by a law enforcement officer, social services worker, healthcare provider, or EMS personnel if an infant is presented by the parent within 30 days of birth. Emergency Medical Services will accept and protect infants who are presented to EMS in this manner, until custody of the child can be released to the Department of Social Services.

POLICY:
To Provide:
✓ Protection to infants that are placed into the custody of EMS under this law
✓ Protection to EMS systems and personnel when confronted with this issue

PROCEDURE:
1. Initiate the Pediatric Assessment Procedure
2. Initiate Newly Born Protocol as appropriate
3. Initiate other treatment protocols as appropriate
4. Keep infant warm
5. Call local Department of Children and Family Services or the county equivalent as soon as infant is stabilized
6. Transport infant to medical facility as per local protocol
7. Assure infant is secured in appropriate child restraint device for transport
8. Document protocols, procedures, and agency notifications in the PCR
POLICY:
Domestic violence is physical, sexual, or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality health care, and preventing further abuse.

Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of a caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and wellbeing of senior citizens.

PURPOSE:
Assessment of an abuse case based upon the following principles:

✓ Protect the patient from harm, as well as protecting the EMS team from harm and liability
✓ Suspect that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the report history
✓ Respect the privacy of the patient and family
✓ Collect as much information and evidence as possible and preserve physical evidence

PROCEDURE:
1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessive passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, also contact the Department of Children and Family Services (DCFS) or equivalent in the county.
5. EMS personnel should attempt in private to provide the patient with the phone number of the local domestic violence program, or the National Domestic Violence Hotline, 1-800-799-SAFE.
PURPOSE:
To identify for the System personnel information to deal with the emotionally disturbed

POLICY:
The emotionally disturbed patient is defined as:
One who would intentionally or unintentionally physically injure himself or others. One who is unable to care for himself and guard himself from physical injury and who cannot provide for his own physical needs. The emotionally disturbed patient may be in need of treatment and is not able to comprehend the risks in refusing or needing treatment.

The emotionally disturbed does not include a person whose mental processes have:
A. Been weakened or impaired by advanced years
B. Effects from an overdose of drugs or the ingestion of mind-altering hallucinogens or psychosis causing controlled substances
C. Alcoholic beverages that bring the patient to the point of intoxication
D. Anxiety, depression, suicidal tendency, or metabolic disease
E. Emotional distress caused from accidents or other life crisis

Approach to the Emotionally Disturbed:
A. Provide a calm atmosphere, reassurance, and well defined explanations. Have someone with the patient at all times
B. Document any criteria which confirms your opinion of decisional capacity of the patient evidence by:
   ● Patient’s general behavior
   ● Inappropriate conversation/responses
   ● Evidence of drug or alcohol abuse or use
   ● Confirming statements of family/bystanders
C. When the patient consents to treatment, you may treat as usual and transport. If the patient is quiet and does not consent but does not actively resist, decide in favor of treatment, particularly when the patient appears extremely psychotic
D. Some emotional disorders show behavior that may be harmful to you, themselves or others. Under these circumstances you may treat and transport the patient without consent. This is done under the legal theories of:
   Emergency Doctrine- if the patient had the mental capacity to, they would consent
   Police Powers- this is the power to protect citizens from people who can cause themselves bodily harm
E. If it is necessary to restrain the patient follow the Region II Restraint Policy
PURPOSE:
To identify for Region II EMS personnel when restraints are necessary and the application procedure for restraining the violent patient. A restraint is identified as a manual or physical mechanical device that restricts the patient’s freedom or movement or normal access to his/her body and cannot be easily removed.

POLICY:
Patients will only be restrained if clinically justified. The use of restraints is only utilized if the patient is violent and may cause bodily harm to themselves or to others. Restraints are a last result in caring for the emotionally disturbed patient.

CLINICAL JUSTIFICATION:
- Aggression
- Behaviors out of control/combative
- Appears the patient will cause injury to themselves or others
- Impulsive striking out/throwing objects
- Self abuse
- Assaultive behavior/threats with weapons
- Mental confusion/incompetence with aggression

PROCEDURE:
1. To restrain the patient, use minimum of 4 people. Have 1-2 of those as the same sex as the patient, if possible.
2. As soon as possible contact medical control for guidance.
3. May use police protective custody if available. Notify as soon as possible.
4. Protect and preserve privacy and dignity of the patient.
5. Explain procedure to the family and patient if possible/ One person (team leader) should communicate with the patient.
6. Do not spend time in bargaining with patient. Once the decision is made, move to restrain. For example: a patient under the influence of drugs such as Bath Salts will not listen.
7. Remove any equipment from your person, which can be used as a weapon against you.
8. Assess the patient and area for any other types of potential weapons.
9. Approach the patient keeping the team leader near the head to continue communications.
10. Have a restrainer at 3 limbs and the team leader at the head.
11. Move patient to back board/stretcher
12. Have patient supine and place soft disposable restraints on 3-4 limbs and fasten to backboard. Do not restrain prone. Monitor airway frequently throughout transport
13. The restraint is fastened to the backboard and the backboard strapped to the stretcher. This allows ease in moving the patient if necessary to their side (May be necessary to prevent aspiration)
14. Continue verbal contact with the patient
15. Transport as soon as possible to nearest receiving hospital
16. Stay with the patient at all times after restraining
17. Document circulation checks every 15 minutes of restrained limbs, physical assessment, justifying factors for restraints, time of application of restraints, notification time of police and medical control. Document if police are on scene and accompany you to the receiving facility

SAFETY:
- Safety of yourself and the patient should be the most important factor at all times
- Stay with the patient
- Be prepared for the unexpected
- Continue to monitor for weapons the patient may have access to
- Police to accompany you in transport if possible
- Do not use metal restraints or requiring keys
- Do not remove restraints until released by medical personnel at the nearest receiving hospital
PURPOSE:
To delineate for the Trinity Medical Center EMS System personnel the steps to take in releasing a minor who refuses treatment in the field and/or continuing to treat without specific consent. To identify for the Trinity Medical Center EMS System personnel definition of emancipated minor, minor and guardianship. Adults have legal authority to make health care decisions, MINORS DO NOT HAVE AUTHORITY

Minor: a minor is defined as one who is under the age of 18 years

Emancipated Minor: In the state of Illinois is defined as one who is under the age of 18, married and/or self supporting or living independently or in the military service

Guardianship: When one is granted legal appointment by a court to manage another person's affairs, i.e. parents or court appointed guardians

Competent Adult: A person 18 years or older with no mental confusion or impairment who can understand risks of non-treatment and treatments needed

Minor Consent of Minors: Minors over the age of 12 may consent for treatment of:
- Sexually Transmitted Disease (STD)
- Treatment of ETOH use and alcoholism
- Treatment of drug use

Treatment of Minors:
A. The EMT may at any time treat a minor without parental or guardian consent where life-threat exists or he deems that the minor requires immediate care to prevent serious injury

B. Parents or guardians should be notified as quickly as possible (May be done by the Police)

C. When a condition is non-life threatening a parent or guardian should be contacted to obtain permission to treat. If this is not possible in the field, notify the police and transport the child for treatment to the appropriate facility

D. Complete documentation is required for treatment with or without parental or guardian consent, explaining the need to treat

E. An emancipated minor should have a legal document recognizing emancipation. If they do not, document carefully the identification of their own emancipation and treat under informed consent

F. If a child appears to need treatment to prevent further injury, contact Medical Control by radio, report the circumstances and receive permission. Always treat a child rather than not treat

Permission Acceptance:
You may accept permission for treatment from either parent, older sibling, grandparents, aunts or uncles, or police officer (in that order) when parents are not immediately available
PURPOSE:
To identify for system personnel the procedure for refusal and the criteria to utilize when allowing a refusal to be written

POLICY:
A. An approved system refusal form must be used on all refusals. The EMT is responsible to do an adequate assessment to make sound refusal decisions. Medical control should be contacted as soon as possible with the refusal decision if the patient appears to be high risk. High risk can be identified but not limited to, the following:
   ● Head injury
   ● Presence of alcohol/drugs
   ● Loss of consciousness
   ● Impaired judgment
   ● Minors
   Low risk does not require medical control contact such as:
   ● Slow speed accidents without injury
   ● Competent patient with minimal complaint
B. The approved form should be signed by the patient who refuses medical help and/or transportation and does not appear to be a threat to himself or others
C. Risks of not receiving medical care must be carefully explained to the patient. In the case of minors the parent/guardian must sign the refusal form and receive the full explanation of risks for refusal of medical care (see Minor Patient/Guardian Consent Policy)
D. In the care of the patient (with decisional capacity) making the decision to transport to a farther care facility and/or inappropriate hospital the risks must be fully explained. Explain the benefits of transport to the closest or most appropriate facility. For example, chest pain to cardiac lab facility, suspected strokes to a stroke ready hospital, or traumas to an appropriate level trauma hospital. Utilize the refusal form to denote this decision. Please inform medical control of this decision and ask for assistance
E. If a patient or guardian refuses a part of the treatment this must be fully documented in the run record and on the refusal form. Call medical control to discuss alternatives or further orders
F. Contact medical control as soon as possible on any patient who appears to be unstable and wishes to refuse. The patient may have to be stabilized at the closest hospital and then transferred on to the facility of their choice
G. Document carefully in any areas of these situations
H. Have a witness sign the refusal form with you. If an officer is on the scene, he may sign as the witness. Note the name and badge number on form

Note: Family members cannot refuse treatment and transportation of a patient to a hospital unless they have durable power of attorney for healthcare
PURPOSE:
The EMS Patient Disposition/Refusal Information form has been designed to be used by EMS personnel to legally document a variety of situations. This duplicate form consists of a single page. The front of the page is used to describe the situation and the back lists a variety of specific patient instructions by complaint. The form should be used to document any refusal of care by a patient (complete refusal or refusal of specific aspects of care) and to document the patient/guardian’s understanding of medical instructions. Common scenarios of refusal are:

1. COMPLETE REFUSAL OF EMS CARE OR TRANSPORT: The first box “Patient Refusal” should be marked. In the first section, the appropriate blocks for “EMS Recommendation” should also be marked. This section should be explained to the patient or guardian, who should understand that their refusal may result in complications up to and including death. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation and the information provided. If the situation warrants, the EMT should explain the risks of the refusal using the patient instructions section and the back of the form for assistance. If the instructions section is used, the appropriate blocks should also be checked.

2. REFUSAL OF A SPECIFIC PROCEDURE (IV THERAPY, C-COLLAR): The first box “Patient Refusal” should be marked. In the first section, the specific refused procedure should be marked. The first section should be explained to the patient or guardian, who should understand the potential consequences of their refusal. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation.

3. The box “Patient Instructions” and the appropriate blocks in that section should be marked. This section and the specific instructions (on the back) should be carefully explained to the patient and/or guardian, who understands them. The patient or guardian should be asked to sign the form, indicating that he/she understands the instructions and the seriousness of the situation.

In all situations, the top part of the form should be completed, and as much of the signature portion as necessary. It is preferable to have witnesses, particularly if the patient or guardian refuses to sign. The original form should be kept on file, while a duplicate copy provided to the parent or guardian.
PURPOSE:
This policy is for all System personnel as a guideline for identifying and reporting a death to the coroner’s office, and to note common types of reportable deaths.

POLICY:
● In all cases in which you do not resuscitate, the coroner’s office should be notified. You or the police officer on scene are responsible for that notification. The responding EMS personnel are required to stay with the body until the coroner or their designee arrives.
● You may, however, return to service if a police officer or coroner representative relieves you of your responsibility.
● You are not required by law to transport the body and be taken out of service. If you or your service do assist in this process, please see that your territory/service area is covered for emergency care.
● Please notify Medical Control about non-transport of the deceased person if there are any questions about procedures.

Reportable deaths include:
A. Traumatic violent death (suicide, homicide, accidental) to include but not limited to:
   Alcohol/Drug Causes, Burn, Crushing, Drowning, Elderly Abuse, Electrocution, Fall, Gunshots, Poison, Radiation Injury, Sex Crime Related, Stabbing, Starvation, Strangulation, Sudden Unexplained Death, Suffocation, Suspected Child Molestation/Abuse, Suspicious Circumstances, Vehicular Accidents, Weather Related

B. Jailed Victims
C. Deaths following procedures (i.e. at clinic or MD’s office)
D. Nursing Home/Extended Care Deaths
E. Birth/Death of Newborn delivered outside of Hospital

Exposure:
A. If any ambulance/police personnel are exposed to blood or body fluid, please notify the Coroner or Deputy at once so that a sufficient amount of blood can be held for testing. You are responsible to see that this occurs.
B. Follow Infection Control Policy for the agency.
PURPOSE:
To identify for EMS personnel patients which it is acceptable to withhold medical care

POLICY:
CPR and ALS treatment are to be withheld only if the patient is obviously deceased per the criteria below or a valid Do Not Resuscitate form (see separate policy) is present:

INDICATIONS:
One or more of the following is present:
- Rigor mortis and/or profound dependent lividity
- Decapitation
- Incineration
- Decomposition
- Mummification
- Frozen State
- If arrest is traumatic in origin, go to Traumatic Arrest Protocol

Do not resuscitate any patient who meets the above criteria. If resuscitation efforts are in progress, consider discontinuing the resuscitation efforts (Paramedic Only) per the Discontinuation of Prehospital Resuscitation Policy

The pronouncement may be done only by the Trinity Medical Control Physician in the following situations:
1. When, in the medical judgment of the physician, the patient has died and the initiation of medical treatment by paramedics is not appropriate

If at anytime the ALS personnel are not certain which policy applies (DNR or Criteria for Death or Discontinuation of Prehospital Resuscitation) begin treatment and contact Medical Control for orders/assistance

Notify law enforcement/coroner of the patient’s death according to the Deceased Persons Protocol

NOTE: If you are unsure whether the patient meets the above criteria, resuscitate
PURPOSE:
The purpose of this policy is to allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate ALS therapy by Paramedics only, when, in the medical judgment of the medical control physician, the patient has died and continued treatment of the patient would be ineffective and, therefore, inappropriate.

POLICY:
Unsuccessful cardiopulmonary resuscitation (CPR) and other advanced life support (ALS) interventions may be discontinued prior to transport or arrival at the hospital when this procedure is followed:

1. Discontinuation of CPR and ALS intervention may be implemented with contact to Medical Control if ALL the following criteria have been met:
   - Patient must be 18 years of age or older
   - Adequate CPR has been administered
   - An advanced Airway has been placed such as endotracheal intubation, Blind Insertion Airway Device (BIAD), or cricothyrotomy
   - IV or IO access has been achieved
   - Rhythm appropriate medications and defibrillation have been administered according to ACLS guidelines
   - Persistent VF, asystole or agonal rhythm is present
   - A minimum of 25 minutes of resuscitation
   - All EMS paramedic personnel involved in the patient’s care agree that discontinuation of the resuscitation is appropriate

2. If all of the above criteria are not met and discontinuation of pre-hospital resuscitation is desired, contact Medical Control

3. Document all patient care and interaction with the patient’s family, personal physician, medical examiner, law enforcement, and medical control in the patient care report (PCR)
POLICY: 
Any patient presenting to any component of the EMS system with a completed Do Not Resuscitate (DNR) form shall have the form honored. Treatment will be limited as documented on the DNR form.

PURPOSE:
✓ To honor the terminal wishes of the patient
✓ To prevent the initiation of unwanted resuscitation

1. When confronted with a patient or situation involving the DNR form, the following form content must be verified before honoring the form request.
   ● The form must be an original DNR form
   ● The effective date and expiration date must be completed and current
   ● The DNR form must be signed by a physician

2. A valid DNR form may be overridden by the request of:
   ● The patient
   ● The guardian of the patient
   ● An on-scene physician
   If the patient or anyone associated with the patient requests that a DNR form not be honored, EMS personnel should contact Medical Control to obtain assistance and direction

3. A living will or other legal document that identifies the patient’s desire to withhold CPR or other medical care may be honored with the approval of Medical Control. This should be done when possible in consultation with the patient’s family and personal physician
   Note: In any case not covered by this policy and/or there is not a signed DNR order then resuscitation procedures must be followed

4. In all cases in which you do not resuscitate, the coroner’s office must be notified. Either you or the police officer are responsible for this notification
   ● You are responsible to stay with the body until the coroner or deputy coroner arrives
   ● You may return to service if a police officer or coroner representative relieves you of your responsibility
   ● ALL pre-hospital deaths MUST be reported to the coroner and follow the Deceased Person Protocol
PURPOSE:
To identify for System Personnel procedural steps to take in those prehospital emergency situations where physicians volunteer to help.

POLICY:
**Patient’s local attending physician at the scene**
A. Work with the physician to provide any and all necessary emergency care to the patient. Establish contact with Medical Control and advise them of physician on-scene after informing the physician on-scene you are mandated by Illinois law to take orders only from Medical Control.
B. Ask the physician to accompany you to the hospital and assume responsibility for care of the patient. If there is a discrepancy or conflict in the care of the patient, you may request them to speak with Medical Control.
C. If agreement cannot be reached as to the care of the patient, the Trinity Medical Control has the ultimate responsibility for the patient. Begin transport and re-contact Medical Control.

**Physician/nurses on-scene and offer services**
A. The above procedure should prevail and if the physician is unknown to you and please ask them for their name and identification and verify with Medical Control any orders given provided the orders encompass skills and/or medications approved by both the EMS System Medical Director.

Note: Remember you are licensed to receive orders from a state approved EMS system or a TMC EMSS ECRN. The ER Physicians of Trinity Medical Center are the only physicians directed by our EMS Medical Director to give orders to Paramedics in the field, and their orders will always take precedence, either by the ECRN or the online MD.
PURPOSE:
To identify for all levels of EMS Provider in the Trinity EMS System appropriate destinations for transportation of the sick and injured. State law requires transport to the nearest hospital unless there is documented criteria for a different decision. The nearest hospital should be that facility which would be defined closest by travel time. These decisions still allow the patient, or power of attorney/healthcare to choose the facility they prefer, unless the risk outweighs the benefit of this transfer.

POLICY:
All sick or injured persons requesting transport who do not express a preference for a hospital will be transported without delay to the closest appropriate local hospital unless circumstances meet one of the following:

1. The patient is competent or a competent parent for a minor or POA agent and refuses transport to the nearest hospital then:
   A. Contact medical control
   B. Communicate the circumstances of patient condition, travel time and reasons the patient gives (i.e. the patient records/physicians are at the further facility)
   C. Medical control will weigh the risks and benefits to the transfer and certify the decision
   D. Then medical control physicians may determine the risks outweigh the benefits for a further transport
   E. If the transport decision is confirmed this will be documented on the radio log sheet and the run record
   F. If the transport is denied and the patient still insists on the further facility, they may be transported but against medical advice and must have a refusal signed
   G. The patient must have all risks and benefits explained to them regarding the bypass to a further facility
   H. Have the medical control ECRN contact the more distant hospital in advance to assure acceptance of the patient request for the more distant transfer. The ECRN will then document this information on the radio log sheet
   I. Should the responding ambulance service be a municipal agency which cannot transport to the further hospital then they must stay with the patient and initiate all ALS/BLS appropriate treatment until another private transport service can assume care
J. Continued monitoring and treatment of the patient condition must occur while waiting for the transport service. Contact with medical control should continue as needed. Any changes of patient condition treatments must be documented on the radio log sheet by the ECRN and the run record by the EMT.

2. The patient must be informed of the obvious risks of transportation of a greater distance. Document your discussion with the patient.
   A. Have a refusal form signed if patient refuses to go to the nearest most appropriate hospital (see Systems Refusal Policy).

3. It is mandatory for transport decisions other than the closest hospital that there is consultation with medical control and a well documented written report.

4. If the patient is judged incompetent or unable to make an educated decision they must be transported to the nearest hospital. Document all findings such as actions, behavior, statement, and or physical assessment, which indicated the patient, is unable to make a competent decision.

5. If the patient requires specialized services, which are available only at the more distant hospital, document the need for hospital destination. Patients whose condition is covered by a formal destination protocol (ROSC/Post-Resuscitation, STEMI, Stroke, Trauma, etc.) shall be transported in accordance with those specialty algorithms. All other patients should be transported per the policy.


7. Hospital resource limitations : refer to the bypass policy.

8. Trauma Transport: All trauma patients are to follow the Trauma Field Criteria Destination Protocol.

   The plan indicates:
   A. Those patients with appropriate criteria should be transported to the nearest level I or II Trauma Center unless that transport time is greater than 30 minutes.
   B. If transport time is greater than 30 minutes, the closest hospital prevails. Notify Medical Control that you will need assistance in making the decision. Give indications of patient’s condition and ETA to the nearest hospital. If prolonged transport, consider air medical transport.

   **When in doubt, transport to Trauma Center**

   Note: For all refusals to the nearer hospital, use the Disposition/Refusal form. If a patient also refuses to sign the refusal of service form, clearly document the patients refusal on the run record and refusal.
PURPOSE:
To provide an explanation and a written procedure in the event that the question of bypass arises. Bypass can be to another hospital other than which transport was originally intended or to a larger more comprehensive facility. To provide an explanation and procedure if an area hospital places itself on bypass for limited bed availability. The patient has the right to select a hospital of their choice (see Closest Hospital/ Transport Decisions Policy)

POLICY:
A. To bypass nearest hospital in favor of another, please confirm with Medical Control, decision should be determined by Medical Control based on the risks and benefits to the patient for the condition reported at the time, as well as, the level of Emergency Room at the hospital which is bypassed

B. When a hospital places itself on bypass due to limited bed availability or internal disaster the EMT must contact Medical Control to determine the best transport decision for the patient.
   ● Give Medical Control all patient information and transport time to assist in making a transport decision
   ● All Critical unstable patients must be taken to the nearest facility and disposition to a farther facility made after stabilization
   ● Use Mutual Aid/Outreach to assist if necessary in more distant transfers
   ● Do not sit on-scene with potentially unstable patients to wait for Mutual Aid

C. Hospitals may go on bypass due to lack of monitored beds, but the Emergency Room may well be able to take the patient. Please clarify this with Medical Control if you suspect such a condition exists
PURPOSE:
To define for the Intermediate and Paramedic personnel the conditions and requirements of interfacility transfer of patients. To identify that an interfacility transfer is a patient who has been diagnosed and treated under a licensed hospital facility and physician and to be transferred to another licensed hospital facility and physician. The ILS and/or ALS agency who transports may do so if there is adequate coverage in their 911 response areas (can be mutual aid).

POLICY:
The Intermediate within the Trinity Medical Center System may perform interfacility transfers in an approved ILS vehicle with approved ILS crew following this criteria

1. Run sheet documentation with inclusion of patient exam, condition, history and medications (medication information and that of history can be obtained from the transferring facility)
2. May transfer patients with the following:
   A. Heparin/Saline Lock
   B. IV fluids to include and IV/IO Pumps and Infusions
3. Maintenance IV established
4. The patient’s hospital record will accompany the patient

The Paramedic within the System may perform the interfacility transport an approved ALS vehicle with an approved ALS crew following:

1. Run Sheet Documentation with inclusion of patient exam, condition, history, and medications, patient, and hospital record
2. Documentation of Medications or IV drips which may be in use during transfer
3. Drips must be maintained at rate ordered by the attending physician

Notify Medical Control of the ensuing transfer and the general condition of the patient.

1. It is the responsibility of the transferring service to obtain any specific orders form the patient’s personal physician before beginning transport. A complete report should be given to the transporting crew by the facility caring for the patient
2. Patient condition should be monitored frequently through transport. Document your findings and if any changes, call Medical Control immediately and refer to the proper protocol for treatment
INTERCEPT-ILS/ALS ON SCENE
POLICY # 2 - 19

PURPOSE
To identify for Trinity EMS System personnel activation and communication for ILS/ALS intercept

POLICY:
To outline procedures of TMC EMSS ILS/ALS Ambulance Intercept Policy and ALS/ILS on scene

A. The first responding ambulance arriving on scene shall perform rapid patient assessment and determine the need for ILS/ALS intercept. Need for ILS/ALS intercept shall be determined by, but not limited to the following:
   ● Any patient care issue in which the EMT feels the need to call ILS/ALS
   ● Cardiac and Respiratory Arrest
   ● Chest pain (medical or trauma)
   ● Shortness of breath
   ● Unconscious patient
   ● Seizure
   ● Overdose/Ingestion
   ● Shock
   ● Childbirth
   ● Multi-casualty incidents
   ● Haz-Mat responses
   ● Trauma with potential for significant injury

B. Radio Reports are to be transmitted without delay so Medical Control also has the option to send ILS/ALS Intercept if they deem it necessary. Any request for ILS/ALS intercept by Medical Control is to be considered a direct order

C. Medical Control is the only party to cancel any ILS/ALS intercept request

D. Contact the intercepting ILS/ALS vehicle at once to predetermine an appropriate intercept point
Transport
A. No more than four (4) ambulance personnel should be in patient care area of the ambulance at any time

B. If there are two (2), each patient must have an appropriate level of provider with them (i.e. ALS/Paramedic, ILS/Intermediate, BLS/Basic)

ILS/ALS on Scene
A. If the ILS/ALS System personnel are on scene of a BLS call, they may assist BLS personnel with assessment of patients to determine if a higher level of care is needed. If ILS/ALS is needed, follow intercept policy

B. If ILS/ALS system personnel assumes responsibility, BLS must remain with the higher level of crew and assist in the care of the patient

C. Off-duty non-system personnel are not allowed to participate in the patient care

D. ILS/ALS system personnel are on scene and have no equipment and/or ambulance, they may still assist in the assessment of need of the higher level of care, but of course may not treat the patient beyond the BLS level. When the ILS/ALS intercept vehicle/personnel arrive, the ILS/ALS system personnel on scene may only participate in care if the intercepting agency has provisions for this, i.e. liability policies

E. These assessments must not delay transport or care of the patient

ILS/ALS intercepts are meant to improve care and be beneficial for the treatment of the patient, but should not unnecessarily delay transport to definitive care at the destination hospital

Note: If you feel the ILS/ALS assessments/transfer of care would jeopardize the condition of the patient, it is mandatory that you call Medical Control and they will make the decisions
PURPOSE:
To identify for Trinity EMS System personnel guidelines which may assist in identification of patients who may benefit from aeromedical transport

POLICY:
A helicopter may be utilized when ALL of the following criteria are present:
1. Patient meets criteria for trauma center evaluation
2. The patient is entrapped and extrication is expected to last greater than 20 minutes
3. The ground transport time is greater than 15 minutes
4. The patient is not in traumatic cardiac arrest

A helicopter may be utilized when any of the following is present:
1. A situation approved by the EMS Medical Director/medical control physician OR
2. Mass Casualty Incident (MCI) OR
3. The patient meets burn center criteria OR
4. The patient meets STEMI criteria and ground transport is greater than 15 minutes OR
5. The patient meets Stroke thrombolytic criteria and ground transport time is greater than 30 minutes

POLICY:
1. The need for a helicopter should be determined by both the service controlling the scene and the service taking care of the patient. The on-scene First Responder may request the helicopter in order to expedite transport
2. The on-scene service will request the helicopter from dispatch
3. A safe landing zone will be established
4. If the helicopter does not arrive prior to the extrication of the patient, the patient should be placed in the ambulance and transport started to the nearest appropriate hospital
5. Under no circumstances should transport of a patient be delayed to use a helicopter
CONCEALED CARRY/ WEAPONS
POLICY #2 - 21

PURPOSE:
To identify for System Personnel procedural steps to take in instances where a patient or family member lawfully carry a concealed weapon. The intent is to respect the citizens rights while ensuring the safety of EMS, healthcare providers, and the public.

POLICY:
A weapon can be defined as a firearm, a device capable of producing death or great bodily harm, or an electronic weapon.
A. EMS should always anticipate that a person may have a concealed weapon. Always ask a patient if they have any weapons on their person.
B. All ambulances and EMS agencies should designate themselves weapons-free facilities or “No-carry zones”. It should be clearly posted.
C. It is not the job of EMS to determine if a patient is in violation of the law.
D. Optimally, weapons should be secured in the patient’s residence and not transported. If transported, they should be secured in a firearms safety box inside a lockable cabinet or compartment.
E. Always contact law enforcement to assist. Never put yourself at risk.
F. A conscious pt willing to relinquish a weapon away from home should turn the weapon over to law enforcement on-scene. If law enforcement is not available and the condition of the pt warrants immediate transport, the weapon should be place in a designated locked location and transported to the destination with report to medical control of a weapon. The weapon should be turned over to facility security or law enforcement on arrival. Document in the PCR the chain of custody in detail.
G. A conscious pt unwilling to relinquish a weapon should have law enforcement called to intervene until “scene safety” is assured. A person carrying a concealed weapon in a “No-carry zone” is violating the law.
H. Patients with altered levels of consciousness demand extreme caution when found with a concealed weapon. Law enforcement should be called to disarm the patient. If the condition of the patient demands immediate transport, EMS personnel may attempt to safely and cautiously remove the weapon if able. Secure the weapon in a designated locked location and transport with notification to medical control of a weapon. The weapon should be turned over to facility security or law enforcement on arrival. Document in the PCR the chain of custody in detail.
I. Absolutely no family members or friends are to be transported with an unsecured weapon.

ALWAYS ASSUME EVERY WEAPON IS LOADED. ALWAYS HANDLE WITH CAUTION. NEVER ATTEMPT TO UNLOAD A WEAPON.
EMS System Policies:

Section # 03: Personnel / System Requirements

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PURPOSE:
To identify for prehospital personnel (FR, EMT-B, EMT-I, EMT-P, PHRN) the requirements to be completed before they may function independently of a preceptor in the Trinity EMS System.

POLICY:
System Entrance Process (FR-D, BLS, ILS, ALS, PHRN)
Application and entrance packet:
Complete Application to the system and return with the applicable attachments:
- Copy of current Illinois license
- Copy of current Iowa license if applicable
- Copy of National Registry Certification if applicable (not required in Illinois)
- Copy of letter of good standing from previous system
- Letter of course completion from educational program
- Copy of current CPR card (Health Care Provider)
- Copy of valid drivers license
- Copy of any certifications (ACLS, BTLS, PHTLS, PALS, NRP, TNS)

Application and entrance packet must be returned completed to the EMS System Office at: 2701 17th Street, Rock Island, IL 61201

FR-D:
A. Attend System Protocol and Policy review at Agency
B. Review and return demonstration of Skills Competency
C. Return the letter of competency completion to the system (included in entrance packet). Once the system requirements are completed, the system will issue a letter of independence to the agency.

EMT-B:
A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Return the letter of competency completion to the system (included in the entrance packet)
D. A period of preceptorship with agency will be completed per agency’s guidelines or bylaws. The Training Officer or an approved Trinity Preceptor will fill out a Field Evaluation tool, provided in packet, showing field competency
E. Complete and pass a system BLS protocol and policy exam (at Trinity EMS System office)
F. Once the system requirements are complete, the system will issue a letter of independence to the agency.
EMT-I:
A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Complete and pass a system protocol and policy exam (at Trinity EMS office)
D. A period of preceptorship with agency will be completed per agency’s guidelines or bylaws. The training officer or an approved Trinity Preceptor will complete a Field Evaluation Tool, provided in packet, showing field competency
E. Return the letter of competency completion to the system (included in the entrance packet)
F. Once the system requirements are complete the system will issue a letter of independence to the agency

EMT-P/PHRN:
A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Complete and pass a system ALS Protocol and Policy exam (at Trinity EMS Office)
D. A period of preceptorship with agency will be completed per agency’s guidelines or bylaws. The Training Officer or an approved Trinity Preceptor will fill out a Field Evaluation Tool, provided in packet, showing field competency
E. Return the letter of competency completion to the system (Included in the entrance packet)
F. Once the system requirements and files are completed, the system will send a letter of independence to the EMS agency

2. If after completion of all entrance requirements the agency does not feel the applicant can work independently of a preceptor, the agency must notify the system in writing noting deficiencies. Once this is reviewed the system will arrange education (if applicable). Education may consist of:
   ● Auditing classes
   ● Video review
   ● Testing
   ● Skills validation
   ● Clinical rotation
   ● Surgical rotation for intubation
   ● Field precepting at a system recommended agency
3. If the Applicant cannot complete all requirements for their respective level they will not be recommended to enter the system

4. The Applicant can retake all skills validations and system exams up to 3 times. If not successful in 3 retakes the EMS Medical Director will decide what further process the applicant must take or deny entrance to the System

5. The EMS System reserves the right to selectively do random testing on any personnel to assess knowledge and practical skills ability

**Transfer from out of state:**

A. EMT’s transferring from out of state who wish to function in Illinois as an EMT (of any level) may apply to the Illinois Department of Public Health EMS and Highway Safety Division for Licensure reciprocity

B. Once the license is awarded, the EMT may apply to the Trinity EMS System for entrance to the system
PURPOSE: To clarify for the EMS System personnel licensure, reciprocity, and renewal criteria

POLICY:
1. Original Licensure:

FR-D
● See First Responder Policy

EMT-B
● Must pass the Illinois EMT-B exam or the National Registry EMT-B exam
● Function in a state approved BLS system verified by that System’s EMS Medical Director
● Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled

EMT-I
● Must pass the Illinois EMT-I exam
● Function in a state approved ILS system verified by the EMS Medical Director
● Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled

EMT-P
● Must pass the Illinois EMT-P exam or the National Registry EMT-P exam
● Function in a state approved ALS system verified by the EMS Medical Director
● Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled
Note: Illinois State Licenses will be in effect for four years. The term “functioning in Trinity EMS System” may be in a vehicle, free standing clinic, ER and/or other health facility, industrial medical department, or education through the system.

2. Licensure Renewals:
All levels, EMT-B, EMT-I, EMT-P, Pre-hospital RN, ECRN, and TNS are required by the EMS Act 515.540, 730, 740, 750 to notify the Department of Public Health within 30 days of any address or name change. Notification may be by person, mail, email, phone or fax

After application through IDPH for renewal, a copy of CE must be sent to the Trinity EMS System office from the training officer of the agency prior to expiration of the current license

3. Reciprocity:
For those individuals who wish to function in Illinois and hold licensure in another state. Provide the following to the EMS System office and we will send this to the state with a letter of recommendation

A. Copy of the current state license
B. Copy of the Training Program which states that it meets or exceeds the National Standard Curriculum
C. Letter of Recommendation from the EMS Medical Director of the System in which you will function
D. CE hours pro-rated to the length of the current license
E. Current CPR card

A license will be issued by IDPH if all information is available, but only for the time left on your current state license and will not exceed 4 years

Following licensure by reciprocity the individual will comply with Illinois regulations for license renewal
PURPOSE:
To delineate for the prehospital personnel of the Trinity EMS System what constitutes inactive status and the requirements

POLICY:

I. INACTIVE STATUS

A. The EMT-B, EMT-I, EMT-P may apply in writing to the EMS Medical Director to be put on inactive status. The application made must be prior to expiration of the current license and contain:
   ● Name, date of licensure, level, EMT-ID number
   ● Circumstances which require inactive status
   ● Length of time of inactive status needed
   ● Documentation that relicensure requirements have been met to the date of application for inactive status

B. The EMS Medical Director, EMS System office will then review the information and if all requirements are met will submit to IDPH a request for inactive status form. The licensee will surrender his/her license with application

C. The EMS applicant will be notified by the EMS System office of acceptance or denial of the application following return notification of Illinois Department of Public Health. If the inactive status is granted, the EMT’s license shall be forwarded to IDPH

D. For the EMT to return to active status, the EMS Medical Director will make an application to IDPH. Included in that application is documentation that the EMT has been examined and is capable to return to active status. Testing will include but may be not limited to:
   ● System entrance requirements in full
   ● Continuing education, current
   ● Refresher as necessary

E. While the EMT is on inactive status he is not allowed to work in any prehospital capacity or level in any system

F. The inactive EMT is not under the policies of the system other than the inactive policies while on approved inactive status
   ● The request to reduce must be made in writing to IDPH and the EMT-I/P license must be surrendered to IDPH
• If, after a period of time as an active EMT-B, the I/P wished to be relicensed as an I/P, he/she may apply in writing to the EMS Medical Director and the EMS Medical Director will verify knowledge and skills of the appropriate level and resubmit to IDPH for the requested I or P license. Licensure will only be at the level the EMT has been previously educated and licensed.

II. Voluntary Reduction in Level:

A. EMT-Reduction to First Responder:
   • Any level of EMT may reduce to the level of First Responder prior to the expiration of their current license. They may revert to First Responder status for the remainder of the license period. The EMT must make this request in writing to the Department of Public Health. To re-register, the individual must follow First Responder registration requirements. The EMT who reduces to FR level cannot revert from FR to an EMT level.

B. EMT-Intermediate or Paramedic to EMT Basic or Intermediate:
   • An EMT-I/P may at any time, prior to current expiration date, revert to an EMT-B status and is then required to meet EMT-B relicensure criteria.
   • The request to reduce must be made in writing to IDPH and the EMT-P/I license must be surrendered to IDPH.
   • If, after a period of time as an active EMT-B, the I/P wishes to be relicensed as an I/P, he/she may apply in writing to the EMS Medical Director and the EMS Medical Director will verify knowledge and skills of the appropriate level and resubmit to IDPH for the requested I or P license. Licensure will only be at the level the EMT has been previously educated and licensed.
PURPOSE:
The purpose of this policy is to define for Trinity EMS System personnel the circumstances under which Emergency and Non-Emergency Medical Services can be performed in accordance with their level of licensure and their EMS System

POLICY:
A. Each EMT(all levels) is required to be associated with an approved EMS System. In this case the EMT can work in the following areas but will work in conjunction with the equipment, protocols and policies of the system which has medical oversight for that area of practice. If you are in the Trinity EMS System you must have a direct reporting relationship with Trinity EMS System or we accept no responsibility for your licensure(i.e., The public event, function must be approved through special events form by IDPH and the system). Other areas of work include:
   - Prehospital emergency setting, i.e. ambulance, First Responder service
   - Non-emergency transport, i.e. ambulance, wheelchair van
   - Locations which are not Health Care Facilities but which utilize EMT’s to render prehospital emergency care, i.e. industry, athletic events, public functions, public places
   - Industry prehospital (first response) requires the industry to enter the appropriate EMS System, and you must follow the dictates of that system

B. Any EMT may practice in an ER or other health care setting as follows:
   - For Continuing Education
   - As personnel hired by the Health Care Agency*
   - Industrial Health Care*
   - Clinics*

*Requires appropriate job description and orientation by the hiring agency. Individuals may at any time seek other credentials to enhance their ability to work in the healthcare setting under the jurisdiction of that employer, but they may not specifically utilize their EMS license as they enter criteria to work in these healthcare settings

C. Student EMT’s must follow the student policies of the system and work directly under an approved preceptor for the system
D. Anyone can work in 2 different systems but must follow the protocols, policies, and procedures of the system which has medical oversight
E. The EMT should list which system is his/her primary system
PURPOSE:
An Emergency Medical dispatch program is based on curriculum established by the U.S. Department of Transportation-National Highway Traffic and Safety Administration, The Illinois State Police and the Illinois Department of Public Health.

POLICY:

A. This course is designed to educate Emergency telecommunicators who receive calls for Emergency Medical Assistance from the public to provide pre-arrival instructions to callers in order to aid persons needing assistance prior to the ambulance arrival.

B. Any Emergency Medical Dispatch Center and Emergency Medical Dispatcher may enter the Trinity EMS System by application with documentation of an approved dispatch course.

C. State Registration
   ● Submission to IDPH a request for application with name, address, system affiliation and employer.
   ● Documentation of an approved medical dispatcher course meeting or exceeding the National DOT dispatcher curriculum.
   ● Documentation of continuing education meeting IDPH standards.

D. Medical prearrival instructions will be provided in accordance with the protocols established by the EMS System.

E. A state of Illinois lead instructor may teach an Emergency Medical Dispatch program following the appropriate IDPH approval process and approved by the system.
PURPOSE:
“First Responder” means a person who has successfully completed a course of instruction in Emergency First Responder Defibrillator which meets or exceeds the National DOT curriculum in the First Response. A First Responder or FRD agency should enter the EMS System to provide approved care.

POLICY:
A. A person must register as a First Responder Defibrillator with the Department of Public Health to:
   ● Enter the EMS System- see system entrance requirements
   ● The System will register the First Responder Defibrillator with name, address and service agency on a form provided by the Illinois Department of Public Health
   ● Provide the System with documentation of successful completion of a First Responder course, which meets or exceeds the National Standard curriculum
   ● Verification that required equipment is available

B. FR-D agency should submit an appropriate system application (available in the EMS System Office) and be trained in the Protocols and Policies of the System.
PURPOSE:
To delineate for all Emergency Department, Trauma Center nursing personnel the requirements and reciprocity for Emergency Communication Registered Nurse Certification in the Trinity Emergency Medical Services System. To define the ECRN rules and regulations of the EMS Act of Illinois. Section 515.740 mandates that an ECRN must notify within 30 days of name or address change.

POLICY:
A. An ECRN must be a licensed registered nurse under the Illinois Nursing Act of 1987 and complete a course of instruction required by the EMS Act of Illinois under the design and direction of Trinity EMS Medical Director.
B. Those persons with the following current certifications may possibly be exempt from the Trauma and Cardiac portions of the ECRN course:
   - A course in Trauma either TNS or TNCC
   - Advanced Cardiac Life Support Provider or Instructor
C. Everyone, regardless of their current certifications, must attend the Protocol/Policy Section and Communication Sections and take the final exam.
D. The ECRN course shall consist of didactic, practical, and clinical components including:
   - Medico-legal roles and responsibilities
   - Communications, telemetry, and nurse at the console
   - Cardiac and Rhythm review
   - Trauma Assessment/Treatment review/Pediatric Trauma
   - Protocol/Policy
   - Final exam
E. Complete 8 hours of field experience and 4 hours of EM dispatch authorized by the EMS MD.

Licensure:
A. The ECRN will complete an application for licensure and the EMS MD will license them for a four (4) year period after documentation of successful course completion.
B. Renewals will be through the EMS MC/System with documented 32 hours of continuing education in a four (4) year period.
Reciprocity
Those nurses trained in another Illinois Resource System will be granted reciprocity on the basis of four (4) year license period and with the following:
- Copy of current licensure
- Trinity System entrance exam completion
- Attendance of TMC SMO/Policy lecture, communication lecture
- Trinity System ECRN final exam completion

Inactive Status
A. Prior to expiration of current certification the ECRN may request to be placed on inactive status
B. Make the request to the EMS Medical Director in writing and include:
   - Name and date
   - Date of approval
   - Circumstances of inactive status
   - Statement of meeting current CE requirements
C. The EMS MD will allow return to active status:
   - By examination of mental/physical capability to return
   - Knowledge and skills of the system
   - Acknowledging the disability has ceased if applicable
D. During inactive status the individual must not function as an ECRN at any level

State Notification
Will be done by the EMS MD for approvals, re-approvals, or inactive status within 10 days of the status change
PURPOSE:
To define the requirements for completion of Prehospital nurse program and
continuing education requirements for rectification as set forth in the Trinity Medical
Center Emergency Medical Services System and by the Illinois Department of Public
Health through rules of the EMS Act. To delineate reciprocity into Trinity Medical
Center EMS System of a prehospital RN from another system. The PHRN is required
by EMS Act Section 515.730 to notify the IDPH within 30 days of any address or name
change

POLICY:
A. Must be a Registered Nurse licensed in Illinois under the “Illinois Nursing Act” of
1987 and an ECRN in the TMC EMS System
B. Will have a system developed prehospital RN course which contains
telecommunications, prehospital cardiac and trauma, pediatrics and other
specific courses delineated by the EMS MD (See prehospital RN course
syllabus)
C. Must be currently ACLS/PALS certified as a provider, ACLS/PALS instructor
preferred, but not mandatory
D. Complete a field internship of 10 ALS runs requiring monitor, drugs, IV’s, and if
possible, at least one with field intubation (May be Trauma/Medical mix)
(Candidate may return to OR for intubation if necessary)
F. When all classroom educational requirements are completed successfully, the
student must pass a system prehospital registered nurse exam
G. The prehospital nurse candidate must also complete a final practical exam
covering:
  ● Intubation, in-line, orotracheal, nasal
  ● Intraosseous access
  ● Chest Decompression
  ● Jugular vein access, transtracheal jet insufflation, cricothyrotomy
  ● Traction splint and other immobilization techniques
I. Once these requirements are completed, the prehospital RN will submit an application and the EMS Medical Director of Trinity Medical Center EMS program will sign and issue Illinois Department of Public Health prehospital RN card and send notification of certification to the State Office of EMS and Highway Safety Illinois Department of Public Health

J. The prehospital RN will be certified for a period of four (4) years

K. Continuing education requirements for the field RN renewal are:
   - Meet minimum guidelines for CE for renewal
   - CE hours can be obtained as listed in system CE policy
   - Maintain CPR, ACLS, PALS and Trauma Certifications

L. It is the responsibility of the prehospital RN to obtain the continuing education requirements and once obtained, and is in the prehospital RN personnel EMS file, the RN will be renewed

M. Reciprocity will be given to PHRN trained in another system on the basis of:
   - Presentation of the course outline and practicum from the preceding system which is an approved in Illinois
   - Completion of the Trinity ECRN course, or those portions indicated by the System EMS MD, and validation of skills of Trinity Medical Center EMS system not performed in previous system with written and practical exam

N. Re-licensure policy for PHRN shall follow the same requirements as EMT-P policy
PURPOSE:
To delineate the qualifications of a Trinity EMS System Field Preceptor

POLICY:
Preceptor Qualifications
A. The preceptor may be a Registered Nurse in the State of Illinois with current licensure and a current Prehospital RN license. ACLS and BTLS provider certifications are preferred but not mandatory. The nurse preceptor must review all policies and educational programs of the system, with the EMS department educators.

B. The preceptor may be a Physician currently licensed in Illinois and familiar with the Protocols and other operating policies of Trinity EMS System.

C. The preceptor may be the EMS Medical Director or Alternate EMS Medical Director of Trinity Emergency Medical Services System.

D. The preceptor may be an Emergency Medical Technician-Paramedic currently licensed in Illinois for a period not less than one year. This paramedic must be actively working on an ALS vehicle.
   - The paramedic should apply to the EMS Medical Director to be a preceptor and notify his agency of that desire.
   - The paramedic shall be approved by the EMS Medical Director and working in the Trinity EMS System.
   - The paramedic shall review, through an education program provided by the Trinity Emergency Medical Services Department, all educational policies and precepting policies, forms for students, as well as observe at least one run review, meet with EMS System office educators to identify current, correct procedures.

E. Once all above requirements are completed the paramedic may then function as a system preceptor.
PURPOSE:
To define for EMS Lead Instructors, within the Trinity EMS system, a method of obtaining a Lead Instructor Licensure/Renewal

POLICY:

LICENSURE:
The candidate who wishes to take a lead instructor course will submit to IDPH, through the appropriate training institution, the following
  a. Completed application
  b. Recommendation letter from the EMS System Medical Director
  c. A Lead Instructor application (IDPH) which includes, but is not limited to, name, address, and resume
  d. A copy of a current EMT-B/I/P,RN/MD license
  e. A minimum of four (4) years experience in prehospital Emergency Care
  f. Documentation of at least two (2) years of teaching experience with documentation of classroom experience (i.e., BTLS,PHTLS,CPR,PALS)
  g. Documented successful completion of the Illinois EMS Instructor Education Course
  h. License will then be sent and valid for four (4) years

EDUCATION:
TMC EMS Medical Director approves the candidate to take an IDPH approved course anywhere in the State

RENEWAL:
License renewal shall be as listed for a four (4) year period
  ● Approval letter from EMS Medical Director that the instructor has successfully coordinated programs for the EMS System
  ● Meet minimum CE guidelines for license renewal
TMS EMS System approves the following as continuing education:
- Seminars on education, continuing education, and teaching techniques
- Continuing education within the system
- Coordination of a full education course
- Coordination of certification courses (i.e., PALS, BTLS, ACLS, BCLS)
- Preceptor education courses within Trinity Education
- Trinity Education Department courses which are pertinent to the curricula of EMT-B, I, P, PHRN, and ECRN
- Degree work in an accredited college/university pertinent to healthcare/education
- Appropriate nursing education

Non-Renewal
May be determined by IDPH following a hearing based on:
- Not conducting a course in accordance with curriculum prescribed in the Act
- Not complying with protocols in Section 3.65 (b)(7) of the Act

EMS MD may ask the lead instructor to stop functioning within TMC EMS for the above or for non-compliance with policies and protocols of TMC EMS educational program.
**EMS System Policies:**

*Section # 04: Exposure / Documentation*

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PURPOSE:
To define a mechanism for reporting of problems not identified elsewhere in the System Manual

POLICY:
A. Reporting and documentation of problems may include:
   ● Communication issues
   ● Non-territory transfer
   ● Family conflict
   ● Non-system MD/Nurse
   ● Order conflicts (medications, treatments not accepted in System)
   ● Out-of-system treatment requests
   ● Equipment failure (see Medical Devices Policy)
   ● Personnel injury
   ● Exposure (follow the Infection Control Policy of your agency)
   ● Refusal to sign refusals or for pertinent areas of treatment

B. Make a separate, full written explanation of the incident and attach a copy of run report and send to EMS System office within 24 hours of the event. Utilize the EMS Incident Report form located in Appendix D. Include immediate steps of remediation in your written explanation

C. Report ALL communication problems immediately so it can be resolved as soon as possible

D. If supplies are not functioning properly or equipment fails, pull it from the service, contact your agency EMS Coordinator and agency manager. Exchanges or replacement need to be made and explanations given to the oncoming crew
PURPOSE:
The purpose of this policy is to aid in the collection of data, which serves as legal documentation of prehospital assessment and care. This policy also includes forms approved by the Trinity EMS System and under what circumstances the forms are to be utilized.

POLICY:
A. A Trinity EMS Run Sheet/Ambulance Report must be completed on all EMS runs regardless of the nature or outcome of the call. The run sheet is a legal medical record and is discoverable through subpoena. Ambulance reports will also be completed on refusal.

B. EMS personnel are responsible for making certain that all information noted is factual to the best of their ability and that all data has been correctly entered on the form, whether electronic or paper, so it represents a thorough and accurate record of the run before copies are distributed.

FORM COMPLETION GUIDELINES:
General Information:
1. Date of Run-Month, day and year of the run. Be accurate when a run extends from one day to the next. Note date on which run began.
2. Vehicle Number/License Plate Number- Numbers of all vehicles responding to this call, i.e. 1J22 or T4 and all plate numbers. This is a state requirement to assure that all ambulances providing care are approved and registered by IDPH. Medicare will not pay for services of an unapproved provider.
3. Agency Name- i.e. RIFD
4. Incident Number- Provider issued number.
5. Supplemental Report- Document the completion of additional forms/supplemental reports, i.e., child abuse, petition form, etc. This assists in identifying all written documents for one call.
6. Treatment Prior to Arrival or by Others- Treatment rendered before the arrival of EMS personnel. It is useful in cardiac arrest situations to document patient down time. It is important to document care provided by persons other than EMS personnel.
7. Ambulance Requested By- Originator of the call, i.e., police, citizen, co-worker, family member, friend, unknown, etc.
**Time Information:**
Use 24-hour clock times as given by department or dispatcher

1. **Dispatch** - Time dispatchers alert EMS personnel of the call
2. **Enroute** - Time the ambulance/squad leaves quarters or begins to respond, if already in motion
3. **Location** - Time of arrival at the scene
4. **Patient Contact** - Time of actual ability to touch or assess
5. **To Hospital** - Time departed scene. May also be interpreted as time departed to destination if an interfacility transport
6. **At Hospital** - Time arrived at receiving facility
7. **In Service** - Time available to handle another call
8. **Quarters** - Time back at the station/garage
9. **Total Time** - Total time elapsed from dispatch to in-service

**Road Conditions:**
Note road and traffic conditions which may have affected your response to the scene.

1. **Light** - No impedance by traffic
2. **Moderate** - Some traffic but caused minimal delay
3. **Heavy** - Roads filled with vehicles-caused response delay
4. **Dry**
5. **Wet**
6. **Icy**

**Call Location:**
Address of call, not the name of the company or institution

**Nature of Call:**
When categorizing a call, take into account the patient’s CHIEF COMPLAINT and your ultimate impression/diagnosis

1. **Cardiac** - An problem traceable to a cardiac condition/disturbance; i.e., chest pain, pulmonary edema, CHF, Cardiac Arrest, Dysrhythmia, Cardiogenic Shock
2. **Medical** - Infections, allergic reactions, hypertension, isolated pain, acute and chronic pulmonary diseases; diabetes, stroke, seizures, GI/GU problems, heat/cold emergencies, poisoning, and gynecologic problems, etc.
3. **Vehicle Accident** - Automobile/bus, motorcycle/bicycle crashes or pedestrians who are struck by a moving vehicle
4. **Trauma** - All other trauma. Note the specific mechanism of the injury
5. **Burn** - Thermal, chemical, electrical, and/or radiation exposure
6. **Psychiatric** - Mental illness or behavior disorders, suicidal ideations
7. **Chemical Abuse** - Drug and/or alcohol abuse and/or overdose
8. **OB** - Pre-partum complications, labor, delivery and/or post-partum complications up to one month after delivery
9. **Inter-Hospital** - Transport from one medical facility to another
   **Intra-Hospital** - Between campuses
10. **Code Blue** - Cardiopulmonary arrest victims

**Hospital Contacted:**
Hospital contacted for medical orders

**Communications:**
Document the type and quality of communication with the hospital
1. **UHF** - Voice Quality of transmission over telemetry radio
2. **EKG** - Transmission of 12 lead EKG’s
3. **MERCI** - Quality of VHF transmission
4. **Phone** - Landline phone
5. **Cellular phone** - Cellular phone contact
6. **Good** - Able to clearly hear majority of transmission with little static or interference
7. **Poor** - Transmission broken - unable to hear much of communication but could finish run
8. **Unable** - Either the hospital did not answer after reasonable attempts to contact them or the quality of communication was so poor that another method of communicating became necessary. Insert comments if poor or unable is marked

**Outcome of Run:**
Check all the boxes that apply to this patient
1. **ALS** - Patients requiring ALS services per System guidelines
2. **ILS** - Patients requiring ILS services per System guidelines
3. **BLS** - Patients requiring BLS services per System guidelines
4. **Assess/Treat** - Patient was assessed and given ALS or BLS treatment
5. **Transport** - Patient was transported
6. **No Contact** - No patient contact was made. No person found at the address to which you responded
7. **No Assessment**- Arrived at a scene where a mechanism of injury did occur or a situation exists that could potentially result in illness (noxious gas leak). Person present but refuses all EMS services. Person denies illness or injury and none are apparent to responders. No patient assessment is completed. No care is rendered. Example: MVA where you are called by police and none of the passengers wish medical attention. If one person involved: complete the run sheet with any information available to you about the scene and/or person. Must include mental status exam to document decisional capacity. Obtain refusal in accordance with the System Refusals Policy.

8. **Refused Care**- Patient is assessed but refuses any treatment. Requires full disclosure of risk and a release signed in accordance with System Refusals Policy.

9. **Refused Transport**- Patient may have been assessed and treated but refuses to be transported. Requires full disclosure of risk and a release signed in accordance with System Refusals Policy.

10. **Release Signed**- Indicated that the Release of Liability Form has been signed and witnessed after the patient has been given full disclosure of risks and has been advised to seek further medical care in accordance with System Refusal.

11. **Police on Scene**- Note an officer’s department, name, if present on scene.

12. **Patient Taken To**- Patient destination. Write hospital name. If a patient with decisional capacity requests a more distant hospital, a system refusal form may be completed to bypass a closer appropriate treating hospital.

**Patient Demographics:**

Completely document on all patients. The only exception should be no patient contacts and no patient assessments.

1. **Name**- If the identity of the patient is unknown, indicate John or Jane Doe. Note personal information that assists in identifying the patient.

2. **Home Address**- If known.

3. **Phone**- If known.

4. **Date of Birth**- Estimate age if not known.

5. **Sex**- Gender, male or female.

6. **Weight**- Enter weights on all pediatric patients and those receiving meds with weight dependent doses, i.e., lidocaine, dopamine.

7. **Medications patient now taking**- List all known medications. If unknown or none, place an “X” in the appropriate box. May document, patient’s list attached if numerous.

8. **Allergies**- List known allergies. Check box if patient denies any allergies. If patient is uncertain, check unknown.
**TRINITY EMS SYSTEM STANDARDS POLICY**

**TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2014**

**DOCUMENTATION/ CHART FORM**

**POLICY # 4 - 02**

**POLICY # 4 - 02**

**FIRST RESPONDER**

**EMT-BASIC**

**EMT-INTERMEDIATE**

**PARAMEDIC**

**MEDICAL CONTROL**

**FRD**

**B**

**I**

**P**

**M**

**LEGEND**

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**History:**

1. **Chief complaint, presenting problem, history of present, illness, cause of injury** - Record the patient’s chief complaint in his/her own words. If the patient is a minor, enter the parent or guardian’s statement. Note when and how this current condition occurred; what prompted this call; and why or how is it different from the past. Include precipitating factors, quality, recurrent, severity, onset and duration of the complaint. The section should be sufficient to refresh the clinical situation after it has faded from memory.

2. **Past Medical History** - Check applicable boxes provided. Note any other pertinent illness/surgeries in the space provided. Check box if valid DNR/Advance Directive present on scene.

**Assessment:**

1. The times noted for the first assessment will be interpreted as being the time of patient contact.

2. **Pupils** - Document on all calls involving an altered mental status, head injury, stroke, seizure, or symptoms indicating possible neurologic causes or involvement. Note the size and reactivity of each pupil and whether pupils are equal or unequal.

3. **Level of consciousness** - Document on all patients
   - A&Ox3- Alert and oriented to person, place, and time
   - Verbal- Responds to verbal stimuli- record GCS
   - Pain- Responds to painful stimuli- record GCS
   - Unresponsive- Unresponsive to any stimulus- record GCS
   - Combative- Patient agitated/fighting. Must be noted if restraints applied.

4. **Glasgow Coma Score** - Document on all calls where the patient has a mechanism of trauma that could result in a head injury and all patients with an altered mental status. Record the patient’s BEST response.

5. **Respiratory Effort** - Document on all patients.

6. **Lung Sounds** - Document on all patients c/o respiratory and/or cardiovascular distress, chest trauma, a history of lung disease and/or chest pain.

7. **Skin** - Document color, moisture, temperature on all patients.

8. **Pain** - Patients should be asked to rate pain on a scale of 0 to 10, 0=no pain and 10=worst pain imaginable. Document initial pain rating and subsequent pain reassessment scores.

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Vitals/RX:
Document at least two sets on all patients unless they are refusing assessment and care, are too combative or an exemption applies and is noted in the comments section.

1. **Vital signs** shall be reassessed and documented every 15 minutes or more frequently, as indicated by the patient’s condition.

2. **EKG Strips** - Interpret and note all EKG rhythms obtained on ALS calls. Document all rhythm changes. When recording rhythm strips, run at least 20 seconds. Attach a 6-second strip (30 large boxes) and leave copies.

3. **Defibrillation** - Time and wattage used for each defibrillation/cardioversion.


Exam:
Note all significant positive and negative findings for each of the body systems. Each system should have a notation as either showing pathology or being within normal limits (WNL). It is not necessary to repeat findings that have been noted in other areas of the record.

Treatment:
Capillary glucose readings should be noted on all patients with an altered mental status. Note the site, type of fluid, gauge of the catheter, flow rates, and amount administered in the field for all IV's. Note the liters per minute and delivery device for all oxygen administration. Indicate if ventilations were assisted and the number of breaths per minute.

Comments:
Document any other observations or care that was given, any pertinent findings or responses to treatment not covered in other areas of the sheet. Example: irrigated both eyes with NS. Document any unusual occurrences that happen to the patient before arrival of EMS personnel, during pre-hospital care or during transport. May also use to continue the narrative from the Chief Complaint/HPI/Mechanism of injury section.

Paramedic Impression: Correlate the findings of the chief complaint, PMH, History, Present illness and Patient assessment to determine a presumptive diagnosis upon which all pre-hospital treatment shall be based. Whenever possible, record all impressions in professional medical terminology. This area is not to be used for (subjective) comments. Be as specific/objective as possible.
Crew:
ALS runs must be signed by a minimum of two crew members, one of which is EMT-P level or pre-hospital RN, directly providing care. The names and system identifier numbers of all responding EMS personnel providing care must be noted. BLS/ILS runs must be signed by a minimum of two EMT-B’s or EMT-I’s with their system identifier numbers listed. Providers are responsible for assigning responsibility for completing the report.

Addendums/Corrections:
1. After completing an ambulance report, it is occasionally discovered that important information was omitted, an amendment is necessary, or information needs to be added to clarify the report or more thoroughly document the incident. Every effort must be made to avoid any discrepancy between the provider’s copy of the report and the hospital’s medical record copy. If an error is noted before distribution of the copies; draw a single line through the entry and date initial notation. Enter the correct information. Never obliterate an entry by scratching it out with heavy line, marker, or white out.

Distribution of EMS Rescue and Ambulance Report Form:
Transport to a system hospital:
**Original copy**- Original form used as the official run report for legal and agency records. This copy must be filed out completely, have the EKG strips attached, and shall be retained by the provider agency.
**Second copy**- Forward to Emergency Department personnel caring for the patient. This copy should be added to the patient’s permanent medical record kept in the medical records division of that hospital. EKG strips to be attached if obtained.

Preliminary Report Form (ambulance short form):
The **Preliminary report form** (short form) is designed to be an intricate part of Trinity Medical Center’s EMS reporting system. It is utilized by transporting and non-transporting agencies. This form produces initial information pertaining to the patient’s chief complaint, treatment, medical history, and response to care. The use of the preliminary report aids the emergency department staff with vital information pertaining to patient care and permits pre-hospital care services to return to their districts in a timely manner. Every effort should be to leave the completed run sheet (paper or electronic) at the ER with the patient.
1. The Preliminary Report form (short form) will be accepted by the staff at the Emergency Department if the following conditions are satisfied:
   - Approval from the Emergency Department RN or MD
   - Full verbal report will be given to the receiving RN upon arrival to the Emergency Department
   - The signature of the receiving RN must be on the form

2. The approved system Preliminary Report Form (short form) will be in duplicate and copy #1 is given to the Emergency Department RN or staff. Copy #2 is retained by the transporting service and attached to the computer generated run report. Remember the preliminary report form is a legal document and must be maintained as such.

3. The Preliminary Report form (short form) is not intended to be used in the following circumstances.
   - When the patient’s condition is critical, whether due to trauma or a medical cause
   - Cases that may have legal concerns need to have the full report left at the Emergency Department before the EMT leaves the facility

4. When the Preliminary Report Form (short form) is used, the paper or computer generated ambulance report must be received in the hospital within 24 hours after leaving the Emergency Department.

**Radio Report Form:**
The Radio Report form is designed to be an intricate part of Trinity Medical Center’s EMS reporting system. It is utilized by the Emergency Communications Registered Nurse when taking report on patients. This form produces initial information pertaining to the patient’s chief complaint, treatment, medical history, and response to care. The use of the preliminary report aids the Emergency Department staff with vital information pertaining to patient care and permits pre-hospital care services to return to service in a timely manner.

1. The Radio Report form will be used by the staff at the Emergency Department in the following situations.
   - The patient information per UHF or VHF/Cellular Transmissions
   - A second full verbal report will be given to the receiving RN at the bedside
   - The signature of the receiving RN or ER Physician must be on the form
2. The approved system Radio Report form is kept as part of the Trauma Center chart. The Radio Report form is a legal document

**Electronic Submission:**
The only approved pre-hospital computer programs for TMC, EMSS are:
1. Trinity PCR: copies may be obtained from the EMS System office
   - If a system provider chooses to utilize another software they must submit system required data in a form that will link to our database. This required information must be submitted monthly
2. Runs shall be submitted every month to TMC EMS to download into TMC database. TMC EMS will upload the appropriate State data to the Illinois Department of Public Health
3. Suggestions for change and other considerations are to be reported to TMC EMS and the vendor will be contacted
4. If there is a problem with the computer software, please utilize a regular run sheet until the problem is resolved by your agency director. Then re-enter the appropriate information in to the main agency computer to transfer to the EMS System office. The paper run sheet will be left at the receiving hospital
PURPOSE:
Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

POLICY:
To insure evaluation of every patient’s cardiovascular status and documentation of a complete set of vital signs:

1. An initial complete set of vital signs includes:
   - Heart rate
   - Systolic AND diastolic blood pressure
   - Respiratory rate
   - Pain/severity (when appropriate to patient complaint)
   - GCS for Injured Patients
2. When no ALS treatment is provided, palpated blood pressures are acceptable for REPEAT vital signs.
3. Based on patient condition and complaint, vital signs may also include:
   - Pulse Oximetry
   - Temperature
   - End Tidal CO₂ (if Invasive Airway Procedure)
4. If the patient refuses this evaluation, an assessment of decisional capacity and a Patient Disposition Form must also be completed.
5. When any components of vital signs were obtained using a cardiac monitor, the data should be included in the patient care report.
6. Document situations that preclude the evaluation of a complete set of vital signs.
7. Record the time vital signs were obtained.
8. Any abnormal vital sign should be repeated and monitored closely.
PURPOSE:
To define for the Trinity EMS System personnel reporting mechanisms for all medical devices carried on ambulance’s rescue vehicles. When a device does not function properly and/or in its malfunction may injure a patient. To comply with the Safe Medical Devices Act

POLICY:
Occurrence/Documentation
A. If a device fails and/or injures anyone in its failure the device must be preserved in the condition at the time of failure
B. Document date and time, if possible
C. Document a description of the failure and the injury/harm caused by its failure
   ● Note that equipment was removed from service at this time
   ● Note description of any injury and MD/Physicians who examined the patient/injured party, patient diagnosis, age
   ● Note the manufacturer of the equipment and last maintenance/inspection date. Note why routine maintenance is not applicable or is applicable
   ● Note if procedure to patient could not be completed due to failure
   ● Add complete location of incident information
   ● Include brand name, model number, lot number, serial number, any analysis post failure

Reporting/Record
A. Send documentation of any incident to Trinity EMS Department within 24 hours
B. EMS System office will relay information to Risk Manager of TMC for further reporting guidance
C. If applicable, you will assist in compiling: FDA Form #3500A to send to Secretary of Health and Human Services and to the manufacturer
D. All records will be maintained at the agency and a copy filed with the EMS System office on any reportable device failure

Medical Devices
A. Include: Any instrument, apparatus or other article that is used to prevent, diagnose or treat a disease or to affect the structure of the human body
If the device fails, but there is no harm to patient and/or change in treatment, the report may not have to be made to the FDA. But manufacturers will need to be notified and Risk Management and/or other legal counsel can assist in making these judgments
EMS System Policies:

Section # 05: Continuing Education

Continuing Education

Train the Trainer
CONTINUING EDUCATION
POLICY # 5 - 01

PURPOSE:
To delineate for Trinity EMS personnel requirements for Continuing Education (CE)

POLICY:

I. Number and Type of Hours Required Per Year:
   A. The Illinois Department of Public Health, Division of EMS, publishes rules and regulations stipulating requirements for CE for each level of service. Re-licensure will occur in accordance with the re-licensure policy when all of the following are complete. It is recommend that CE be completed each year of licensure. No more than 25% of the CE may be in the same subject. Trinity EMS System requires at least 50% of CE be in formal education hours
      - First Responder-D 24
      - EMT-B 60
      - EMT-I 80
      - EMT-P/PHRN 100
      - ECRN 32
      - Dispatcher 48
      - CCP 20
   
   B. All CE records are logged and maintained at the service that the provider works for and made available to the System Resource Hospital. Each pre-hospital provider/pre-hospital RN is responsible for keeping their own records and maintaining a copy of time accrued. All CE records either obtained elsewhere or with the appropriate CE number and signature must be filed in the appropriate service file. The responsibility for completing state required CE hours in a timely manner rests fully with the individual. Eligibility for system recommended re-licensure rests in great measure on the completion of these hours
   
   C. All license levels are required to request license renewal from the Resource Hospital. The Resource Hospital will then review CE for appropriateness and endorse the provider to IDPH for license renewal
D. All license renewals are due to the State office 30 days prior to expiration, therefore submit the request to the system resource hospital no later than 45 days prior to expiration. **There will be no requests for extensions from the resource hospital unless for illness or extreme circumstances.** The individual license holder is responsible to submit online the IDPH renewal in accordance with the renewal process. Upon completion the licensee will receive a confirmation page which should be submitted to the system office. The license renewal will be held by the state until CE is submitted to the system. Should the license expire during the time the department is awaiting CE submission to the system, the licensee cannot work following this expiration and will need to submit the appropriate late fee. IDPH will also not honor renewal attempts after the licensee renewal date.

II. Approval of Hours:

A. The EMS Medical Director (EMS MD) of the system in which the EMT/Pre-hospital RN functions shall determine whether a particular didactic CE program is acceptable for credit within that system. Approval for all hours rests with the system.

III. Options for Accruing DIDACTIC HOURS in the TMC EMS System:

A. At least half of the total didactic hours per year must be obtained within the system approved CE, unless prior authorization has been granted. This includes in-station CE, viewing videotapes, and attending classes conducted by a system provider or hospital. **All pre-planned continuing education classes need a State site code assigned before credit can be awarded.** The system EMS Coordinator/EMS MD must pre-approve agency CE before submission to IDPH for State site code. Use appropriate IDPH form for submission. CE is the responsibility of the service and the individual EMT. While the resource hospital may provide some CE, it will not determine monthly in-services and apply for them. Application for CE site codes/approvals must be obtained through the Regional EMS Coordinator (IDPH) after endorsement by Trinity EMS MD. Applications for approvals **must** be submitted **60 days** prior to the start date of the program. Trinity EMS System requires monthly CE requests to be submitted in October of each year for the subsequent year. All other CE requests must follow the 60 day request and be submitted to the Trinity EMS System office for approval prior to submission to the State.
At least 3 objectives for each level are needed for each CE subject requested. Objectives are to be written on a form obtained from Trinity EMS and delineated into Basic, Intermediate, Paramedic or First Responder status

B. Verification of attendance at offerings not sponsored by the resource hospital or system agency with approval must be submitted by the sponsoring agency with accompanying site code to the TMC/EMS System office for documentation. All Illinois education with site code is acceptable, as is Iowa advanced training centers

C. Video Taped Presentations- hour for hour to a maximum of 4 didactic hours/year will be granted for viewing approved videotapes. The tapes may be viewed at any system hospital or in the provider’s quarters with verification of viewing submitted by the provider EMS Coordinator or EMS Coordinator/Educator to the resource hospital

D. CPR- Must be recognized by American Heart Association (AHA) or Red Cross
- 2 hour of didactic credit will be awarded for the renewal of CPR Healthcare provider recognition every year. Copies of current CPR cards must be provided to the EMS System office each year or every other year as required by the service
- 4 hours of didactic credit will be awarded once every two years for successful completion of a CPR instructor or re-recognition course for any level. The individual must submit a copy of the current CPR instructor card to receive credit
- 4 hours of didactic credit can be awarded/year for teaching CPR. Submit copies of the class roster(s) sent to the AHA Community Training Center(CTC)

E. Teaching- hour for hour credit, up to a maximum of 10 hrs/year, will be granted to individuals who participate in teaching EMT-B course, EMT-I/P course, auto extrication, hazardous materials, CISM,TNS, ACLS, PHTLS, BTLS, or first responder courses. The course director must verify the date, topic taught and the number of teaching hours. These hours may be credited as didactic or clinical time, depending on the subject matter, and approved by the EMS Medical Director/Systems Coordinator(i.e. clinical with skills, or lecture)
F. ACLS, ATLS, PALS/APLS, PHTLS, BTLS- Hour for hour up to 16 hours of didactic (8hrs) of clinical (8hrs) will be awarded for initial completion of one of the above courses. To receive credit, the Basic/Intermediate/Paramedic/Pre-Hospital RN shall submit a photocopy of the card received after successful completion of the course

G. Renewal- an individual can receive 4 hours total of didactic credit per course. To receive credit, submit a photocopy of the new card

H. Hazardous Materials- A one time award of 16 hours time may be awarded for completion of the State site coded 40 hour HazMat operations level course. To receive credit, submit a photocopy of the State certificate or a letter from the department. Four hours of didactic time may be awarded every 2 years for Agency HazMat training with approved Site code number. Documentation of attendance is necessary to receive credit. CE credit will not be awarded in the same year as initial certification. Credit will also be given up to 16 hours for CE based on biological response

I. Drive, Trench, Rope Rescue and Confined Space Rescue- Two hours didactic time/year for initial or refresher training in these areas

J. EMT-P National Registry Exam and Refresher Training- A one time award of 8 hours didactic will be awarded for successful completion of the National Registry Paramedic Exam. To receive a credit, the Paramedic shall submit a photocopy of the card received. National Paramedic Refresher Training, with approval site code, will award hour for hour credit

K. Preceptors- Approved paramedic preceptors may be granted up to 10 hours didactic and 8 clinical hours of time/year for executing their duties appropriately. Eligibility will be confirmed by the Agency/EMS Coordinator/Physician with whom they communicate
IV. Out-Of System Hours:

A. A maximum of 50% of the total didactic hours per year may be obtained by attending classes sponsored outside of the System provided the content follows the US DOT Curriculum and the faculty is knowledgeable in pre-hospital concepts and treatment protocols. 50% must be obtained in TMC EMS System approved courses. Approval must be requested in advance from the Resource Hospital by submitting the program brochure outlining the dates, times, topics, and faculty. Verification of class attendance must be submitted to the Resource Hospital. Any Illinois EMS Region II System is acceptable for continuing education and is considered in system. Any education with an Illinois or Iowa approved site code is acceptable.

B. College Courses: Select college courses may be considered for didactic credit toward yearly continuing education. Upon successful completion of a course, the Basic/Intermediate/Paramedic/Pre-Hospital RN must submit the following to receive credit:
   - Copy of class outline/syllabus
   - Number of credit hours achieved
   - Name and credentials of instructor
   - Name of educational institution
   - Verification of successful course completion

The EMS MD or his designee will review the course for applicability to pre-hospital practice and determine eligibility for CE credit.

V. Additional Time Options:

A. Mass Casualty Drills- Drill and Preparatory classes/workshops (hour for hour) can be obtained by participating in a System-recognized drill. To receive credit, submit a letter from the drill director or the drill sign-in sheet documenting type or participation, number of hours (8 hours maximum)

B. Prom Night- Two hours per year of didactic credit for participation in prom night activity in system
PURPOSE:
This is to define quarterly education information dissemination to all trainers at each EMS service of TMC System. The policy will also define the roles and responsibilities of the trainer.

POLICY:
A. Definition:
- A trainer is the person who is responsible in the TMC EMS System Provider Service for education and monitoring of continuing education of the individual personnel of that service.

This includes:
- EMS Coordinators, Training Officers

Levels Include:
- FR-D, EMT-B, EMT-I, EMT-P, Pre-Hospital RN

B. Method:
- Trainers will be given updated system/education/information as necessary. They are then responsible to disseminate this information and/or educate the individual personnel of their corresponding service.
- Education will include, but not be limited to:
  - Cardiac Topics
  - Stroke Education
  - Pediatrics
  - Trauma Education
  - Protocol and Policy Guidelines
  - Monthly Service Education

C. Sessions:
- Will be taught by TMC staff, faculty or EMS Medical Director
PURPOSE:
The Trinity EMS department holds the responsibility for monitoring the run reviews of the services and evaluating the quality of patient care by the prehospital care providers. The responsibility is then delegated to the EMS Coordinator/QI representative of the service and the EMS Department. It is the responsibility of the caregiver to participate in data collection and action planning.

POLICY:
Providing care to patients in the prehospital setting involves much more than just rendering medical treatment. The following is to be reviewed in an ongoing manner by all services:

1. The EMS Coordinator/Medical Director may audit any patient encounter for review and quality control/improvement.
2. The EMS Coordinator/Director of the agency will be notified for any runs selected by the EMS System office to be reviewed and that Coordinator/Director will notify:
   - All crew members
   - Deputy chiefs, chiefs, or other officers will be notified after crew members and at the agency preference.
3. Agency EMS Coordinator/Director will relay to the crew concerns, if any, from EMSS/Medical Director involved in runs selected by EMSS office.
4. When a patient care encounter is selected for review because of request, concern, or patient care issues, the agency EMS Coordinator/Director will review the facts of the run privately with the appropriate crew members and relay the information to EMSS office. The EMSS retains the right to continue investigation if so necessary and make recommendations.
5. All run reviews should be attended by the involved crew members, agency officers, Trinity EMS coordinator and/or Medical Director.
6. All run reviews will be documented on a formatted run review sheet.
7. All run review information will be kept confidential in the EMS system office.
8. Due process will be offered, explained and documented.
9. This is a quality improvement and is protected by the Medical Studies Act.
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PURPOSE:
To delineate for Trinity EMS system personnel responses to mass casualty incidents which the number of patients or severity of injuries may overwhelm the providers

POLICY:
A. Mass Casualty:
At times EMT’s may find themselves in a situation where the number of injured patients exceeds the available personnel to care for them and resources available. In these situations the patients must be triaged according to the severity of their injuries in order to do the most good for the greatest number of patients. In such multiple casualty situations, several normal conventions may need to be set aside in order to meet the objective

B. MCI for FR-D/BLS/ILS/ALS-
1. Prioritize patients according to a recognized system
2. In mass casualty situations, the S.T.A.R.T. method of triage is recommended
3. Identify patient priority through the use of color coded triage tags
4. Rapidly assess (60 seconds or less) each patient, stopping only to open an airway or to control profuse bleeding. As you move through the scene, affix a triage tag to each patient according to their priority
5. Treat and transport those patients who are viable and have life-threatening injuries first, according to the resources available
6. Treat and transport those patients who have impending or potential life threats next
7. Walking wounded, those patients without life-threatening injuries, should be transported last. In some major incidents, these patients may even be transported by means other than ambulance
8. Non-viable patients, those in cardiac arrest or with obvious mortal wounds, should not be treated or transported unless adequate resources/personnel are available

The unique situation of a lightening strike causing a mass causality event presents the exception to the above rule. In this situation, when the victims have been struck by lightening, the cardiac arrest victims are treated and transported. Victims not in cardiac arrest rarely deteriorate and can wait while those in arrest are given top priority.
**PURPOSE:**
To aid Trinity EMS system personnel in the rapid triage of MCI patients

**POLICY:**
Any disaster plan or program designed to handle a large volume of patients in a short period can only work if the triage process is rapid and efficient. The following method of prioritization should be used for triage, treatment and transport to maximize the percentage of victims surviving a disaster

**Priority I- Immediate/Critical (RED)- Immediate Care:**
Highest priority: victims requiring immediate care and transportation. These victims must be treated first at the scene and transported as soon as possible. Victims may have one or more of the following problems whose chances of survival depend on immediate emergency care:
- Airway and breathing difficulties
- Hemorrhage
- Open chest or abdominal wounds
- Severe head injuries or head injuries with decreasing level of consciousness
- Major or complicated burns
- Tension pneumothorax
- Pericardial tamponade
- Impending shock and complicating severe medical problems
- Diabetes with complications
- Poisonings
- Pregnancy

**Priority II- Urgent (YELLOW)- Urgent Care:**
Intermediate priority: victims whose treatment and transportation can be delayed temporarily. Victims may have one or more of the following problems that need medical attention prior to transportation, but do not need immediate care to survive
- Blunt abdominal or thoracic trauma
- Major extremity or soft tissue injury
- Dislocations
- Major burns and electrical burns
Priority III- Delayed (Green)- Delayed Care:
Delayed or low priority (walking wounded); victims whose treatment can be delayed. Victims may have one or more of the following problems that require only simple emergency care or who appear to be uninjured and need only observation
- Fractures
- Sprains
- Lacerations
- Soft tissue injuries and other lesser injuries

Priority IV- Deceased (Black)- No Care Required:
Lowest priority; victims who are dead or are near death. Victims are already deceased or have such devastating injuries that they have little chance for survival

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**S.T.A.R.T. Triage System**
(Simple Triage and Rapid Transport)

Step 1: CLEAR THE SCENE OF ANY WALKING WOUNDED
- These patients are considered to be in the DELAYED category

Step 2: ASSESS VENTILATIONS IN REMAINING PATIENTS
- No respiratory effort: Dead/Non-Salvageable
- Respirations above 30: Critical/Immediate
- Respirations below 30: Delayed

Step 3: ASSESS PERFUSION
- No radial pulse: Critical/Immediate
- Pulse present: Delayed

Step 4: ASSESS NEUROLOGICAL STATUS
- Unconscious: Critical/Immediate
- Altered Level of consciousness: Critical/Immediate
- Altered mental processes: Critical/Immediate
- Normal mental processes: Delayed
PURPOSE:
To manage school bus accidents with appropriate resources; to ensure the children involved are dispositioned accurately and injured children identified rapidly

POLICY:
1. Initiate appropriate personal protective equipment
2. Assess and establish scene safety
3. Establish triage area and triage victims
4. Determine the Accident Category:
   A. Significant injuries present in one OR more children or there is a documented mechanism of injury that can be reasonably expected to cause significant injuries.
   B. Minor injuries present in one or more children AND NO documented mechanism of injury that can be reasonably expected to cause significant injuries. Uninjured children are also present
   C. No injuries present in any children AND NO mechanism of injury that can be reasonably expected to cause injury
   D. Pediatric patients with special healthcare needs or communication issues
5. Determine responses to Accident Category and utilize the School Bus Accident Special Response Protocol and School Bus Incident Release Form
6. Discharge any uninjured children to the custody of a school official(s) of their designee(s). Complete the School Bus Incident Release Form approved by the system. Ensure signatures are in place before release of children
7. School officials or their designee(s) will then disposition the uninjured children according to their own policies and procedures
8. If school officials or their designee(s) have any objections to the release, transport all children to the appropriate facility by ambulance or bus if appropriate with appropriate number of EMS personnel on board
POISON CONTROL
POLICY # 7 - 04

PURPOSE:
The state poison center may be utilized by the 911 centers and the responding EMS services to obtain assistance with the prehospital triage and treatment of patients who have a potential or actual poisoning. The purpose of this policy is to:

- Improve the care of patients with poisonings, envenomations, and environmental/biochemical terrorism exposures in the prehospital setting
- Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene
- Integrate the State Poison Center into the prehospital response for hazardous materials and biochemical terrorism responses

POLICY:
1. The 911 call center will identify and if EMD capable, complete key questions for the Overdose/Poisoning Animal Bites/Attacks, or Carbon Monoxide/Inhalation/HazMat emergency medical dispatch complaints and dispatch the appropriate EMS services and/or directly contact the State Poison Center for consultation
2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the State Poison Center at 800-222-1222. If possible, dispatch personnel should remain on the line during conference evaluation
3. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner. If dispatch personnel are not on-line, the Specialist will re-contact the 911 center and communicate these recommendations
4. If the patient is determined to need EMS transport, the Poison Center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options
5. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient
6. Minimal information that should be obtained from the patient for the State Poison Center includes:
   ● Name and age of Patient
   ● Substance(s) involved
   ● Time of Exposure
   ● Any treatment given
   ● Signs and symptoms
7. Minimal information which should be provided to the State Poison Center for mass poisonings, including biochemical terrorism and HazMat, includes:
   ● Substance(s) involved
   ● Time of Exposure
   ● Any treatment given
   ● Signs and symptoms