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Administrative
Edward EMS System Policies Index

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Training Equipment Loan Form
Edward Hospital EMS System

MISSION STATEMENT

The Edward Hospital Emergency Medical Services System is a team of highly-educated emergency specialists committed to providing quality emergency care to the communities we serve.
Purpose of the Manual:

The policies and procedures outlined in this manual, in general, serve to inform and guide emergency medical services personnel within the Edward Hospital EMS System. All participants in the system are expected to read and familiarize themselves with this information and are responsible for its content. This manual is to be used as a reference only and should not be construed as a contract between Edward Hospital, its staff and representatives, and any system participant. To retain flexibility necessary in the administration of emergency medical services policies and procedures, we reserve the right to change, revise, or eliminate any of the policies described. Suggestions from participants are welcome; these can be submitted by any participant directly to the EHEMSS office or through the suggestion box in the EH medic room. The only recognized deviations from the stated policies are those authorized by the EMS Medical Director and EMS System Coordinator. After receipt of this manual, system participants will sign the Acknowledgement of Receipt form and return it to the Edward Hospital EMS System Coordinator.

The Edward Hospital EMS System is based on a philosophy of quality patient care through the practice of evidence-based medicine. The primary function of the system is to provide professional emergency medical services to our community without unlawful discrimination. We feel the residents of our community deserve the highest degree of quality pre-hospital care and transportation service.

It is also the System’s belief that our participating system providers are the most vital asset to the overall achievement of the system. System providers refer to those IDPH approved and committed to the EHEMSS. System participants refers to all levels of personnel for whom the EMS Medical Director is responsible: all levels of EMTs; First Responder Ds; Emergency Medical Dispatchers; Lead Instructors; ECRNs; and emergency medical physicians providing on line medical direction. Working collaboratively in open forums to enhance patient care delivery in the system is our goal. We hope this manual will assist us all in this venture.

Any situation or question which arises within the Edward Hospital EMS System which is not specifically addressed by the policies herein shall be addressed in accordance with the “Emergency Medical System Act”, and the IDPH Rules and Regulations related to that Act.

Each policy and procedure contained within this manual, whether related to administration of the Edward Hospital EMS System, patient care, and/or protocol regarding medical situations, has been reviewed and approved by the EMS Medical Director and the EMS System Coordinator.

__________________________  __________________________
Daryl Wilson, MD             Doug Skotnicki
EMS Medical Director         EMS System Manager

Reviewed and revised
10/12; 01/14; 01/17, 9/19
TITLE Amendments, Revisions, and Review of the Policy Manual

PURPOSE To provide an orderly, expedient method for suggesting and issuing amendments to the Policy Manual. To maintain compliance with revisions in the EMS Act and its rules and regulations.

APPLICABILITY All EHEMSS participants

POLICY STATEMENT(S) All amendments, additions and revisions will be implemented on a specific date following approval by the appropriate parties and education of the system participants.

DEFINITION(S)

PROCEDURE
1) Suggestions for additions or revisions shall be submitted in written form to the EMS System Coordinator. Suggestions should be evidence-based.
2) All suggestions will be reviewed and presented to the System Provider Chiefs and EMS Coordinators.
3) A written reply to the submitter will be provided as well as follow-up regarding the final review of the policy for implementation.
4) Following System approval, the change will be submitted to the IDPH Regional EMS Coordinator for approval.
5) Amendments, deletions, or revisions to the manual will be published for insertion in the manual.
6) All changes will be communicated to the system participants through the continuing education process and may be deemed mandatory if needed.
7) The EMS Medical Director reserves the right to issue emergency policy/procedure changes as needed.
8) As determined by the EMS System, the Policy Manual can be recalled, updated, and redistributed to all system participants.
9) This manual will be reviewed completely and updated as needed at least every four (4) years.

CROSS REFERENCE(S) The CE Policy

New: 01/01
Revised: 03/09, 01/2017
Reviewed: 10/09, 04/10, 02/12, 09/19
# Edward Hospital EMS System

## Local Review Board

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## ECRN

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## Emergency Medical Dispatcher

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*Location posted – medic room @ Edward Hospital Emergency Department*
Role of EMS Medical Director

To define the scope, qualifications, and roles and responsibilities of the EMS Medical Director

The EHEMSS Medical Director

The Resource Hospital shall appoint an EMS Medical Director. For Edward Hospital EMS System, which is an ALS level system, the EMSMD shall be a physician licensed to practice medicine in all of its branches in Illinois, and be certified by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.

SCOPE:

1) The EMSMD shall:

   A. Have experience on an EMS vehicle at the highest level available within the system, or make provision to gain such experience within 90 days after assuming the position.
   B. Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system.
   C. Have or make provision to gain experience instructing students at a level similar to that of the levels of EMS personnel within the system.

2) The appointed EMS Medical Director shall submit to the Department proof of completion of a Department-Approved EMS Medical Director’s Course within six months after his or her date of appointment.

   A. The following courses are approved by the Department

      1) American College of Emergency Physicians
         Principles of EMS System – A Course for Medical Directors
      2) Base Station Course National Association of Emergency Medical Services Physicians

3) Responsibilities of the EMS Medical Director:

   A. Be responsible for the ongoing education of all System
personnel, including coordinating didactic and clinical experience;
B. Develop written standing orders (treatment protocols, standard operating procedures) to be used in the EMSMD's absence and certify that all involved personnel will be knowledgeable in emergency care and capable of providing treatment and using communications equipment once the program is operational;
C. Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;
D. Develop or approve one or more ambulance emergency run reports (run sheets) covering all types of ambulance runs performed by System ambulance providers;
E. Ensure that the Department has access to all records, equipment and vehicles under the authority of the EMSMD during any Department inspection, investigation or site survey;
F. Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;
G. Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;
H. Ensure that a copy of the application for renewal (a form supplied by the Department) is provided to every EMT-B, EMT-I or EMT-P within the System who has not been recommended for relicensure by the EMS Medical Director; and
I. Be responsible for compliance with the provisions of Sections 515.400 and 515.410 of this Part.
**TITLE**  
Role of EMS System Manager

**PURPOSE**  
To define the role, scope, and responsibilities of the EMS System Manager.

**APPLICABILITY**  
The EHEMSS EMS System Manager

**PROCEDURE**  
The Resource Hospital shall appoint a full-time EMS System Manager, who shall be responsible for coordinating the educational and functional aspects of the System. He or she shall be a Registered Professional Nurse or EMT-P licensed in the State of Illinois.

**SCOPE:**

1) The EMS System Manager shall:

   A. Be trained and knowledgeable in dysrhythmia identification and treatment.
   B. Have a diverse background in critical care.
   C. Within one year after being appointed, complete in-field observation and/or participation on at least 10 ambulance runs at the highest level of service provided by the System.
   D. Exercise authority as outlined in the IDPH Administrative Rules and Regulations Sec 515.320, and as directed by EMS Medical Director or EMS Administrative Director.

2) Responsibilities of the EMS System Manager:

   A. Supervision of clinical, didactic, and field experience training.
   B. Provides feedback to field personnel and ED staff on Pre-hospital care issues.
   C. Supervises data collection activities.
   D. Operates EMS program in compliance with State of Illinois Rules and Regulations 515.330 Section
   E. Oversees site visits to ambulance providers to insure compliance with the EMS Act.
   F. Oversees Quality Improvement Program for EMS.
   G. Initiates corrective action for problems identified in the EHEMSS.
   H. Oversees ECRN course and certification exam.
   I. Conducts EMS Council meetings.
J. Oversees licensure and relicensure of EHEMSS EMT’s.
K. Oversees Physician and ECRN education.
L. Member of EMS Region 8 Medical Director’s Committee
M. Member of EMS Region 8 Advisory Board

New: 09/2009
Reviewed: 04/10; 10/12; 01/17, 9/19
TITLE  Role of EMS Provider Coordinator

PURPOSE  To define the role and responsibilities of the EMS Provider Coordinator.

APPLICABILITY  The EHEMSS Provider Coordinator

PROCEDURE  SCOPE

1) The EMS Provider Coordinator shall:
   
   A. Have paramedic experience to the highest level of care at the department
   
   B. Have EMT-B experience if that is the highest level of care at the department

2) Responsibilities of the Department EMS Division:
   
   A. Serve as the communication link between the Resource Hospital, department Chiefs and EMS personnel regarding system changes and updates.
   
   B. Maintain current education and personnel records for all EMS personnel in the department.
   
   C. Forward required EMSS information to the Resource Hospital (all submissions will be made on a timely basis or as described in the appropriate policy):
      
      1. Monthly QA statistics
      2. Personnel changes: new hires, terminations, change of status, addresses, etc.
      3. Equipment changes
      4. Notice of pending lawsuits
      5. Changes in vehicle level of service or area of deployment
      6. In-house CE records
      7. Run report data
      8. Monthly Controlled Substance Inventory sheets
      9. Requests for Clarification
      10. Narcotic discrepancies
   
   D. Attend 80% of EMS Coordinators’ Meetings
   
   E. Assist with all CQI activities
F. Review all ambulance run reports

G. Communicate problems and concerns to the Resource Hospital EMS Office

H. Recommend personnel/runs to the EMS Office for commendation

I. Maintain adequate supplies of EHEMSS approved forms

J. Coordinate scheduling of paramedic student and ECRN field time

K. Work with preceptors to assure that required records are being submitted in a timely fashion and issues are being addressed.

L. Assist EMS office with educational activities:
   1. Lectures
   2. Clinical skills labs and testing
   3. System entry
   4. CE material preparation and reviews

New 09/09
Reviewed 04/10; 03/2015; 01/2017
Revised 10/2012; 8/2019
Section 2

Education, Relicensure and Status
TITLE  Emergency Communications Registered Nurse (ECRN) Initial Certification and Renewal

PURPOSE  Only IDPH licensed and EHEMSS approved ECRNs are authorized by the EHEMSS EMS MD to direct ALS/BLS functions over the telemetry/MERCI radio.

APPLICABILITY  All EHEMSS ECRNs

POLICY STATEMENT(S)

1. All EHEMSS ECRNs will attend and satisfactorily complete an ECRN course that is conducted in Region 8, unless they have functioned as an ECRN in another EMS Region (see ECRN Reciprocity policy). These courses rotate between the Resource Hospitals: Edward Hospital, Central DuPage Hospital, Good Samaritan Hospital and Loyola University Medical Center. Schedules and registration forms are available from the EMS office.

2. The nurse attending the course will need to meet all of the prerequisites and requirements for completion.

3. Selection of the nurses attending the course will be the responsibility of ED management.

4. Prior to attending the course, the nurse shall contact the EMS office to have the registration form completed, fee payment arranged, and any questions answered.

DEFINITION(S)

PROCEDURE

1. Prerequisites (per Region 8):

   A. 1 year of ED experience (preferred)
   B. ACLS or EKG interpretation equivalent
   C. Sponsorship by a Region 8 Resource or Associate Hospital

2. Course description:

   A. Forty (40) hours in length and consists of four (4) eight hour sessions of both clinical and didactic experience. Attendance at all of the sessions is required.

   B. The fifth day is spent at the host hospital taking the final exam for the first half of the day. The second half is spent at the sponsoring hospital with the EMS Coordinator reviewing specific policies and SOPs, the paperwork for preceptored calls, and to discuss ambulance ride time.

   C. The final exam score must be at least 80% and/or consistent with the course policy.
D. Following the course and exam, the ECRN must complete ten (10) ALS radio calls with a preceptor or the EMS Coordinator. Copies of the 10 radio calls must be submitted to the EMS office. Each ECRN must complete eight (8) hours of ride time on a system ambulance. Contact the EMS office for assistance in arranging this time. An ECRN Ride Time Verification form must be completed and submitted to the EMS office. All requirements must be completed and submitted to the EHEMSS EMS Coordinator within 90 days from the final exam date. 

Failure to do so could result in the need to repeat the ECRN course.

E. Following completion of all requirements, EHEMSS office will submit the nurse’s information to the host hospital of the course, who will then send a transaction card to IDPH. IDPH will issue an ECRN license which will be mailed directly to the nurse.

3. Re-Approval

A. An ECRN license lasts for a period of 4 years expiring at midnight on the expiration date stated on the license.

B. ECRN will track expiration and notify EHEMSS three (3) months prior to expiration. EHEMSS will also monitor expiration dates. Documentation of 32 hours of continuing education is required for re-approval.

C. EHEMSS continuing education programs deemed mandatory must be completed for re-approval.

D. IDPH will send the ECRN a Child Support statement that needs to be completed before the Department will issue a recognition/re-approval certificate. The ECRN will return the statement directly to the EMS Coordinator who will process the renewal.

Note: IDPH’s notification will be sent to the address that is in their licensure database. It will not be forwarded. Refer to the policy on ECRN address/status change.

CROSS REFERENCE (S)  IDPH Administrative Rules and Regulations 515.740

New 08/04
Revised 08/05
Reviewed 10/09, 04/10; 10/2012, 2/2012,
1/2017, 9/19
Revised 3/2014
TITLE  
ECRN Reciprocity

PURPOSE  
To define the process for nurses who are ECRN Certified in other EMS systems to become certified in EHEMSS.

APPLICABILITY  
EHEMSS ECRNs.

POLICY STATEMENT(S)  
Nurses who are certified in other EMS systems as ECRNs can function in that capacity at Edward Hospital after meeting the requirements. All must meet with the EHEMSS EMS Coordinator.

DEFINITION(S)  
Region 8 Resource Hospitals include Edward, Central DuPage, Advocate Good Samaritan and Loyola University Medical Center. Both Good Samaritan and Loyola have several Associate Hospitals in the west suburban area.

PROCEDURE  
1) ECRNs from Region 8 Hospitals:
   A. Nurses who are certified at hospitals in EMS Region 8 need only a letter of good standing, copies or verification of ECRN continuing education, and a copy of their ECRN approval/recognition certificate from IDPH.
   B. This documentation must be provided before the nurse meets with the EMS Medical Director and before beginning to answer the radio.
   C. Nurses who cannot obtain a letter of good standing from their previous EMS system will be dealt with on an individual basis.

2) ECRNs from hospitals outside of Region 8:
   A. Submit a copy of their ECRN approval from IDPH.
   B. Letter of good standing from current EMS system.
   C. Submit copies or verification of current ECRN continuing education.
   D. Satisfactorily complete the Region 8 ECRN final exam (minimum score of 80%).
   E. Submit copies of 10 preceptored ALS radio calls.
   F. Meet with the EMS Medical Director System to review EHEMSS system-specific SOPs and policies.
   G. ECRNs needing to do ride time in this EMS system will be at the discretion of the EMS Medical Director and Manager.
*Steps A-D must be completed prior to doing ride time or taking preceptored calls. All requirements must be completed within 60 calendar days of taking the ECRN final exam.

Upon completion of the above, EHEMSS office will issue a letter to the nurse stating that all of the requirements have been met and he/she can begin to answer the radio independently. Copies of the letter will be sent to the ED Manager and placed in the ECRN’s EMS system file.

CROSS REFERENCE(S)

New 08/04
Revised: 10/09, 04/10; 10/2012, 1/2017, 9/19
Revised 3/2014
ECRN Address, Name, and Status Changes

PURPOSE
To assure that EHEMSS is able to maintain a current and accurate database of all EMS system IDPH licensed ECRNs.

APPLICABILITY
Edward Hospital EMS System ECRNs

DEFINITION(S)
N/A

PROCEDURE
1) ECRN Address/Name Changes:
   A. The EMS office must be notified of address and name changes within 30 days of the change.
   B. Notification can be made to the EMS System Coordinator or CE/CQI Coordinator in writing (form is available on the EMS web site) or by email.
   C. Any pertinent information from IDPH or EHEMSS will be sent to the last name and/or address of record.
   D. Any consequences of the individual’s failure to provide accurate names or addresses will be the responsibility of the provider or ECRN.

2) Inactive Status:
   A. Request for Inactive Status can be made prior to the expiration of the current license.
   B. The request must be made in writing and addressed to the EHEMSS EMS MD. The original IDPH license must accompany the request and will be submitted to IDPH by the EMS office.
   C. The request must contain the following:
      1. Name of the ECRN
      2. Date of original license
      3. Description of the circumstances leading to the request
      4. Statement that continuing education requirements have been met by the date of the application. This will be defined as the percentage of the four year 32 hour CE requirement.
      5. A letter from the ED Manager must accompany the request.
   D. The EHEMSS EMS MD will review the request and notify the ECRN in writing when the request is forwarded to IDPH. Notification will be made within 10 working days of the receipt of the request by the
EMS office.
E. While inactive status continues, the nurse cannot function as an ECRN at any level. Letters of good standing requested during this time will reflect the inactive status.

3) Return to Active Status

A. The request to return to active status will be made in writing and addressed to the EHEMSS EMS MD.
B. If the request for inactive status was due to a temporary disability, a document stating that the ECRN is fit for duty must accompany the request. This can be a note from the private physician or EH Employee Health.
C. The EMS MD must confirm and document the following prior to forwarding the request to IDPH:
   1. The ECRN has been examined (physically and mentally) and is capable of functioning within the EMS system.
   2. The ECRN’s knowledge and clinical skills show competence in performing ECRN duties.
   3. The ECRN has completed any refresher training deemed necessary by the EMS system. Refresher needs will be determined on an individual basis and could include education, testing, ride time and/or interviews.
   4. The EHEMSS EMS MD will notify in writing the nurse and IDPH of the decision within 10 working days of the request for the change in status.

CROSS REFERENCE(S)    IDPH Administrative Rules and Regulations 515.740

New 01/05
Reviewed 10/09, 04/10; 10/2012, 1/2017, 9/19
EMT System Entry

PURPOSE
To define the process to evaluate cognitive and psychomotor skills of all EMTs prior to being given approval to provide patient care in the EHEMSS.

APPLICABILITY
Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S)
To ensure that any EMT entering the EHEMSS possesses a minimum cognitive and psychomotor skill level too safely and effectively provide patient care in the EHEMSS.

DEFINITION(S)
Primary System: Must be declared by provider. A Primary System monitors CE requirements and completes relicensure for providers.

Secondary System: A system an EMT is affiliated with, but it is not required to monitor CE requirements nor complete relicensure.

Reciprocity: EMTs from within Region VIII are exempt from the written exam and skills outlined in the Letter of Good Standing. System providers reserve the right to test any of their new hires regardless of region affiliation. All others must complete the entire process.

PROCEDURE
1. Any EMT outside Region VIII wishing to enter the EHEMSS must complete the EHEMSS Entry process in its entirety. Those within Region VIII that are granted reciprocity are exempt only from the written SOP exam and skills outlined in the Letter of Good Standing. Any paramedic student who has graduated from the Edward Hospital Paramedic Education Program and has been hired by an EHEMSS provider within 90 days of graduation is exempt from the written and skills evaluation. These graduates of the program will be required to complete the oral interview with the medical director.

2. All EMTs requesting to enter the system must be currently employed by or have an offer of employment pending from an EHEMSS provider upon successful completion of the EHEMSS Entry process.
3. All full-time EMTs requesting entry in the Edward Hospital EMS System must designate Edward as their primary EMS System. Part-time EMTs within the EHEMSS who wish to be secondary in the EHEMSS are required to complete all mandatory System testing. It is also the responsibility of the individual EMT, if secondary, to provide the EHEMSS with an updated Letter of Good Standing and current CE records from his/her primary system annually no later than June 30th.

4. All EMTs requesting to enter the system need to complete/submit the following information to the EHEMSS office.
   A. Letter of Good Standing from current EMS System(s) as applicable (those who are unable to obtain a letter of good standing from their previous EMS System will be dealt with on a case by case basis)
   B. Copies of all accrued continuing education
   C. Copy of current State of Illinois EMT license
   D. Copy of current CPR certification (health care provider)
   E. Copy of current driver’s license
   F. Necessary Psychomotor skill practical exam/sheets as outlined in Letter of Good Standing
   G. Entry Demographic Form
   H. Pyxis User Authorization Form
   I. Confidentiality Form
   J. Medical Director interview
      • The interview will include oral questions relating to patient scenarios and requires knowledge of the Region VIII SOPs, EHEMSS specific SOPs, skills, Policy and Procedures.

5. If outside Region VIII you will need to complete the following in addition to what is listed above.
   A. Written SOP exam-proctored by another department’s EMS Chief/Coordinator
      • A minimum score of 76 percent is considered passing on the written SOP/skills exam.
      1. Failure to achieve 76 percent on the written exam will result in a first failure and re-education to occur. The exam may be re-taken in not less than 72 hours.
2. Should failure occur for the third time on the written exam, repeating of the system entry process will be at the discretion of the EHEMSS office. Documentation from the Providers EMS Chief/Coordinator must be presented to the EHEMSS office that outlines the remedial education received.

B. Practical Psychomotor Skills—proctored by departments EMS division

- The psychomotor skills will be graded on a pass/fail basis
  1. Should an applicant fail a skill, they may be remediated immediately by the proctor and may challenge the skill again.
  2. A second failure will require remediation by the applicant’s department EMS Chief/Coordinator or designee. The applicant may challenge the skill again after 2 weeks from the second failure.
  3. Should failure occur for the third time on any psychomotor skill, repeating the system entry process will be at the discretion of the EHEMSS office.

6. Appointments for completing the MD interview will be scheduled with the EHEMSS office. Required material needs to be submitted to EHEMSS office not later than 3 days prior to the MD interview. Failure to do so will result in rescheduling of the interview.

7. All components must be successfully completed before the EMT can provide any patient care responsibilities within the EHEMSS.

New 08/94
Revised 01/01, 10/09, 04/12, 10/12, 11/15, 9/19
Reviewed 1/2017
TITLE: EMT License Renewal

PURPOSE: To provide the relicensure process for all paramedics and EMTs in the Edward Hospital EMS System.

APPLICABILITY: Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S): The Illinois Department of Public Health (IDPH) requires all providers of patient care be licensed, and the licenses must be renewed every four years. IDPH has assigned the task of verifying eligibility and relicensing of providers to their primary system. For those that are primary in this system, EHEMSS will notify IDPH when all requirements for relicensure have been met.

DEFINITION(S): Primary System: Must be declared by provider. A Primary System monitors CE requirements and completes re-licensure.

PROCEDURE:

1. Provider EMS Coordinator will communicate who is due for relicensure to EHEMSS three months prior to provider’s lapse date. EHEMSS will evaluate the provider’s file to insure that:
   a. The provider has completed all EHEMSS requirements
   b. The EMT has complied with IDPH Rules Section 515.590: EMT LICENSE RENEWALS
   c. The FR-D has complied with IDPH Rules Section 515.725: FR-D LICENSE RENEWALS

2. If all applicable requirements are complete, EHEMSS will submit a request to IDPH for relicensure on the provider’s behalf.

3. The file will be re-evaluated 15 calendar days prior to the lapse date if requirements have not been met.

4. Notification of deficiency will be made to the provider, Chief/CEO, and their EMS Provider Coordinator. Notifications will be on the following business day if this day falls on a weekend or holiday.

5. The provider will not be relicensed until the deficiencies are corrected.

6. An EMT whose license has expired may, within 60 days
after licensure expiration, submit all relicensure material and pay appropriate fees to the Illinois Department of Public Health by mail or online. If all material is in order and there is no disciplinary action pending against the EMT, IDPH will relicense the EMT.

7. Each Provider EMS Coordinator will maintain a current copy of the individual provider’s IDPH license.

8. The Edward EMS System is not responsible for any cost or fees related to license renewals.

CROSS REFERENCE (S) Illinois Department of Public Health Rules and Regulations 515.590, 515.640

New 07/94
Revised 01/01, 10/09
Reviewed 04/10
Revised 10/2012
Revised 3/2014, 1/2017
TITLE EMT Reinstatement

PURPOSE To provide the reinstatement process for providers in the Edward Hospital EMS System.

APPLICABILITY Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S) The Illinois Department of Public Health (IDPH) requires all providers of patient care be licensed, and the licenses must be renewed every four years. IDPH has provided a means for providers whose licenses have expired for less than 36 months to apply for reinstatement if certain criteria are satisfied, as outlined below.

PROCEDURE An EMT or paramedic whose license has been expired for less than 36 consecutive months may apply for reinstatement by the Department after completion of the following:

1. The applicant shall submit satisfactory proof of completion of continuing medical education and clinical requirements in accordance with Sections 515.560, 515.570, 515.580, 515.500, 515.510, and 515.520.

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

3. The applicant shall pass an Illinois Department of Public Health-approved test for the level of EMT license sought to be reinstated, in accordance with Section 515.530.

4. The applicant shall pay all applicable Illinois Department of Public Health fees per licensure level for reinstatement.

CROSS REFERENCE (S) Illinois Department of Public Health Rules and Regulations 515.640
TITLE  
EMT Licensure – Change of Status

PURPOSE  
To define the process by which an EMT may voluntarily change his or her licensure status.

APPLICABILITY  
All EHEMSS personnel.

POLICY STATEMENT(S)
1. Downgrade:
   
   A. At any time prior to the expiration of his or her current license, an EMT may downgrade their status to a lower level EMT as long as their CE hours are up to date. The EMT must submit in writing their intent to lower their EMT status, submit their current original state license, and a completed T-Card to their department EMS Coordinator who will forward this to EHEMSS for processing. EHEMSS office will complete the process and send to IDPH for completion.

New 09/09  
Revised 04/10; 10/2012, 1/2017
EMT Continuing Education

PURPOSE
To ensure that all Paramedics and EMTs are fully aware of their responsibilities regarding Continuing Education and to assure and demonstrate competency to the EMSMD.

APPLICABILITY
Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S)
All Edward Hospital Emergency Medical Service System (EHEMSS) Paramedics and Emergency Medical Technicians (EMT) are required; as allowed by the Illinois Department of Public Health (IDPH) to accrue a minimum of 100 hours continuing education during the 4-year licensure period in order to be relicensed by EHEMSS. EHEMSS utilizes most of IDPH’s recommendations for allowable continuing education and hours permitted*. EHEMSS will evaluate continuing education hour requests that have been submitted, track those that are acceptable, and submit the name of any EHEMSS paramedic or EMT to IDPH who has met the requirements for relicensure.

* See addendum for IDPH EMT Relicensure Recommendations

DEFINITION(S)
Cycle: January 1st to May 31st and August 1st to October 31st.
LOGS: Letter of Good Standing

PROCEDURE
1. EHEMSS offers 30.4 hours of continuing education per year:
   A. 8 monthly CE/Skills sessions worth 3.5 hours of credit (28 hrs. per year)
   B. 4 hours of CE for quarterly intubation skills (1 hr./quarter)
   C. Any other mandatory EHEMSS requirements.

2. Continuing education sessions will be developed utilizing the Region 8 Education Committee. Guidelines for modules will be developed utilizing Region 8 Policies. The Regional CE may be augmented with EHEMSS material but neither the providers nor the EHEMSS may remove information without system consent. Providers may not alter CE materials without EHEMSS approval.

3. EHEMSS paramedics and EMTs are required to successfully complete the 8 monthly Region 8 CE programs annually. In addition, the paramedics are required to complete the four (4) quarterly intubations annually.

4. A post test, content provided by the Region 8 Education Committee, consisting of 20 questions from the present month’s continuing education and 5 questions from the previous regularly scheduled monthly continuing education, will be administered immediately following the completion of the present month’s continuing education.
5. Post tests will be graded after completion of the exam. To receive credit for the monthly CE, a score of 76% or higher must be achieved.

   A. Post tests will be graded immediately after challenging the exam. If the score is failing, the original exam may be challenged again after remediation provided by a department designated instructor. The post test will be immediately scored. The word “retake” will be checked on the answer sheet. Credit will then be awarded for passing the post test. If the paramedic or EMT fails the repeat exam, see “Second Failure” below.

   B. If a paramedic or EMT fails the post test a second time or fails to retake within 15 days, he or she will meet with the EMSMD or designee.

6. Continuing education hours accrued outside the Edward Hospital EMS System will be accepted but:

   A. They must receive prior approval from the EMS System Coordinator
   B. documentation of attendance at outside activities is required for consideration for CE
   C. see attached IDPH recommendations for alternative CE programs

7. If a System paramedic or EMT fails to comply with required continuing education by December 1st, the Coordinator will initiate a letter to the respective provider Chief/CEO and EMS Coordinator. It will state Paramedic/EMT must be compliant by December 31st or be subject to suspension until he or she has successfully completed annual requirements.

8. It will be the responsibility of the paramedic or EMT to notify the EHEMSS Coordinator, through their respective Department, in writing, prior to December 1st as to the reason they will be unable to complete the required continuing education by December 31st. Included in this letter will be a specific plan for completion of the requirements, subject to approval by the Edward Hospital EMSMD and EMS Coordinator. Should requirements not be completed by the agreed upon date, the medic will be required to complete the System Entry process and may not perform in any EMS capacity within the EHEMSS until requirements have been completed successfully. IDPH and any primary/secondary system will be notified.

9. If the Paramedic’s or EMT’s primary System is in Region 8, but not EHEMSS, he or she will be responsible for completion of all
cycle skills and any CE deemed mandatory by the EHEMSS.

10. If the Paramedic’s or EMT’s primary System is not in Region 8, he or she is responsible for the CE requirements of EHEMSS.

11. Paramedics who are secondary in the EHEMSS will be required to produce a current Letter of Good Standing (LOGS) annually, during the month of June, no later than June 30. If a LOGS is not in the EHEMSS Office by June 30, the individual will not function in any EMS capacity in this System and may be required to complete the entire system entry process in order to be reinstated with their EMS privileges at the discretion of the Medical Director. All suspensions will include notification of IDPH and primary/secondary Systems. See “Suspensions”.

Quarterly Intubations

1. Each calendar quarter, all active EHEMSS paramedics will successfully perform 5 adult and 5 pediatric endotracheal intubations per System protocol. The intubations will be recorded by the end of the designated quarter. Those with extenuating circumstances may be granted an extension of one calendar month to complete the skills with a letter from the Department Coordinator to the EMS Manager prior to the extension.

2. Evaluators must hold a valid license at the paramedic level and be authorized to deliver emergency medical care in the EHEMSS. One hour of continuing education per quarter will be awarded for this skill performed during the quarter.

3. The EMSMD may, at his/her discretion, require any or all EHEMSS providers to attend/participate in a designated activity (SOP review, new equipment, procedure, etc.). The EMSMD will provide written notice. In addition, no activity decreed by the EMSMD can be cancelled or modified by anyone other than the EMSMD.

See Appendix A
TITLE

NON EHEMSS Requests for Clinical and Ambulance Ride Time

PURPOSE
To clarify the position of the EHEMSS regarding students/paramedics/EMT-Bs and ECRNs doing ride time in the System.

APPLICABILITY
EMS Personnel from outside the EHEMSS

POLICY STATEMENT(S)
Students from paramedic programs, paramedics, or ECRNs from other EMS systems will not be allowed to ride EHEMSS ambulances or work in the ED to obtain clinical experience. It is our intention to have System resources available for only our participants in our Edward programs, so as to not place undue burden on our providers.

EMT-B students from COD who do ride time or ED time for their clinical experience for class is acceptable.

DEFINITION(S)
N/A

PROCEDURE
Requests received for this type of experience should be referred to the EMS Medical Director and EMS Manager if necessary. Deviations from this policy will be allowed with only written approval from the EMS Medical Director.

New 01/05
Reviewed 10/09, 04/10, 10/2012, 1/2017
Section 3

Patient Care Issues
TITLE Abandonment vs. Prudent Use of EMS Personnel

PURPOSE To define circumstances when patient care can be justifiably ended.

APPLICABILITY All EHEMSS Participants

POLICY STATEMENT(S) First-responding EMS personnel must not leave a patient if a need for continuing medical care exists. The only exception shall be the presence and availability of individuals with equal training, education, and/or licensure or equipment who may assume responsibility for the patient.

DEFINITION(S) N/A

PROCEDURE

1. If an EMT determines that a continuing medical need does exist, and the patient is competent yet refusing care and/or transportation to the nearest hospital, the EMT shall contact medical control. The patient’s condition and refusal of care and/or transportation shall be communicated from the scene of patient contact. The patient shall be informed of the risks of not receiving recommended emergency care and/or transportation. If the patient continues to refuse intervention in spite of knowledge of the risks, their signature must be obtained on the Refusal of Services form. If the patient refuses to sign, this should be documented in the patient care report and on the telemetry radio log.

2. If a patient requests transportation to a hospital other than the nearest hospital, see System policy: Patient Transport/Selection of Receiving Facility.

3. If transferring responsibility for a patient to a private ambulance service, the initially responding service must stay with the patient until the arrival of the private ambulance unless unusual, compelling circumstances require that they leave. The patient’s safety must never be jeopardized. These circumstances must be documented on the patient care report and reported to the hospital PRIOR to leaving the scene.

CROSS REFERENCE(S) EHEMSS Policies:
Patient Transport/Selection of Receiving Hospital
Adult Right of Refusal/Involuntary Treatment or Transport
Minor Refusals
Multiple Patient Release (MPR)

New 06/94
Revised 01/01, 10/09
Reviewed 04/10; 10/2012, 01/2017
**TITLE**  
Adult Right of Refusal/Involuntary Treatment or Transport

**PURPOSE**  
To outline general guidelines to be followed when caring for patients who refuse transportation and/or treatment who may or may not be incompetent.

**APPLICABILITY**  
All EHEMSS participants

**POLICY STATEMENT(S)**  
The EMT has a duty to appropriately explain to the patient the need for care and transportation and, to the best of the EMT's knowledge, the specific consequences of failure to accept care and transport. Many people who initially refuse medical care/transport or treatment are in need of such care. To allow patients to refuse care in the face of obvious need is a failure of the EMT to perform at the expected level of competence. It is appropriate to have the refusing patient/guardian speak directly to the ED physician or ECRN.

A conscious adult who is determined by EMS personnel, in accordance with the procedures set forth below, to be:

- Not suicidal or potentially dangerous to himself/herself or others

Has the right to refuse medical treatment and/or transport even in an emergency. In the face of steadfast refusal, the Release of Care form should be used.

Refusal of treatment or transport of minors should be handled in accordance with the EHEMSS policy: Treatment Consent for Minors

**DEFINITION(S)**

- **Decisional Capacity**: the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment, including foregoing lifesustaining treatment, and the ability to reach and communicate an informed decision. A diagnosis of mental illness or mental retardation, in and of itself, does not mean that the patient lacks decisional capacity.

- **EMS Personnel**: defined as those persons recognized by the Edward Hospital EMS System who possess a valid EMT license from the State of Illinois. Such personnel have completed varying levels of training in emergency medical services.
- **Medical Control Physician**: an emergency department physician who ensures that care taken on behalf of ill or injured patients is medically appropriate. The ultimate responsibility and authority for medical actions taken by EMS personnel rests with the EMS Medical Director who delegates medical control responsibilities to the ED physician(s) on duty.

- **Self-Care**: a patient is able to provide self-care when:
  - The patient can provide care to himself/herself
  - The patient can guard himself/herself from physical injury
  - The patient can provide for his/her own physical needs

**PROCEDURE**

1) Identify yourself and attempt to gain the patient’s confidence in a non-threatening manner.

2) Consider and attempt to evaluate for possible causes of behavior problems and initiate treatment as required.

3) Assess decisional capacity and potential danger to self or others by observation, direct exam and reports from family, bystanders, and police or verified mental health agency personnel. Consider the following possibilities:

4) **Potential Danger**

<table>
<thead>
<tr>
<th>To Self</th>
<th>To Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>Homicide</td>
</tr>
<tr>
<td>Inability to care for self</td>
<td>Child/spouse/elderly abuse</td>
</tr>
</tbody>
</table>

5) All of the following refusals must be called in to Medical Control **before** the ambulance leaves the scene of the call:

A. In all cases of Minors, when the advice of the minor’s legal guardian is not available.

B. In all cases where ETOH, drug abuse, or lack of decisional capacity is suspected.

C. In all cases where an ALS treatment has been rendered, i.e. the diabetic patient who was administered IV dextrose and is now refusing transport.

D. In all cases where an ALS treatment would have been rendered if the patient had requested to be
transported, i.e. patients with chief complaints of chest pain, syncope, head injury, abdominal pain, etc.

E. In all cases when a patient’s age is (greater than) >55 on anticoagulants is involved in a fall or other mechanism of trauma.

F. In all accidents involving an injury where more than one person is involved, i.e. auto accident with three people, one complains of neck pain, two refusals.

G. Any patient refusing to sign the refusal form.

In the above cases, an ECRN in conjunction with a Medical Control Physician will determine if a patient’s behavior and/or the medical condition suggest that the patient has decisional capacity to refuse medical treatment or may be potentially dangerous to him/herself or others or unable to safely care for self.

1. In this case, an order from the Medical Control Physician must be received and documented in the run report. The name and number of the physician will be documented.

2. If the patient resists or poses a threat to personal safety, the vehicle crew, and/or bystanders, police shall be notified for assistance and reasonable force may be used to restrain the patient.

3. With an uncooperative patient, the requirement to initiate full care in the field may be waived in favor of assuring that the patient is transported to an appropriate facility.

6) **Ultimate decision is made by patient.** Once the ECRN in conjunction with the Medical Control Physician has determined that the patient has decisional capacity and not a danger to him/herself or others, and the patient continues to refuse care or transport after complete examination of the options and potential consequences, the wishes of the patient must be honored.

7) **Documentation of Refusal.** EMS personnel must either have the patient with decisional capacity sign a standard release form or, if the patient refuses to sign a release, the patient’s refusal should be documented on the standard report form by EMS personnel. The most
critical documentation is the basis for judging that the patient has decisional capacity; i.e. fully understanding the potential consequences. EMS personnel shall clearly document the following information on the EMS report:

A. Date, name, scene times, vital signs
B. Chief complaint and history of call
C. Physical exam or chief complaint
D. Level of consciousness and respiratory status
E. Presence of odor consistent with the consumption of alcohol, if applicable
F. Skin color, temperature, and condition
G. Patient signature
H. Patient has been informed of specific potential consequences (e.g., internal bleeding, loss of function, death) associated with refusal and understands and accepts the risks of refusal
I. If the patient continues to refuse intervention in spite of knowledge of the risks, their signature must be obtained on the Release of Services form. If the patient refuses to sign, document circumstances as appropriate in the written report and with Medical Control

8) Implied Consent to Treatment/Transport. The presence of implied consent in emergency situations applies only to situations in which patients are incapable of refusing consent, either because of their clinical condition (i.e., unconsciousness) or because of lack of decisional capacity.

CROSS REFERENCE(S)

EHEMSS Policies:
- Patient Transport/Selection of Receiving Hospital
- Adult Right of Refusal/Involuntary Treatment or Transport
- Minors: Treatment Consent for Minors
- Minors Refusals
- Reporting Child Abuse
- Reporting Elder Abuse
- Domestic Violence
- ECRN Physician Consultation

New 06/94
Revised 01/01, 10/09, 09/10; 2/2015, 4/2018
Reviewed 04/10; 10/2012, 1/2017

Daryl Wilson-PMD 4-4-2018
TITLE  
Domestic Violence Assistance

PURPOSE  
To define the obligation of EHEMSS participants to provide suspected victims of domestic violence with immediate information regarding available services.

APPLICABILITY  
All EHEMSS Participants and Providers.

POLICY STATEMENT(S)  
All licensed transport and non-transport vehicles will carry information to provide domestic violence victims information about services available for them.

DEFINITION(S)  
N/A

PROCEDURE  
1. At a minimum, county specific information will be provided. Additional information can be provided at the discretion of the provider.
2. All information provided will be approved by the EHEMSS Medical Director and on file in the EHEMSS office.
3. Documentation on the run report will specifically state what information was provided.
4. If the victim is under 18 years of age, the incident must be reported to the Illinois Department of Children and Family Services.
5. If victim is elderly (over the age of 60), the incident must be reported to the Illinois Department on Aging.

CROSS REFERENCE(S)  
750 ILCS 60/ 401, Chapter 40, paragraph 2314  
EHEMSS Policies: Reporting Child and Elder Abuse

New 01/05  
Reviewed 10/09, 04/10  
Revised 10/2012, 1/2017
TITLE          Abandoned Newborn

PURPOSE         To define the role of EHEMSS providers in compliance with the State of Illinois Abandoned Newborn process.

APPLICABILITY  EHEMSS Participants

POLICY STATEMENT(S) All EHEMSS providers will develop a policy in conjunction with their legal advisors. This policy will be consistent with (325 ILCS2/) Abandoned Newborn Infant Protection Act.

DEFINITION(S)  Newborn: a child whose age is reasonably believed to be 30 days or less.

PROCEDURE      1) A copy of the policy and procedure will be submitted to EHEMSS for inclusion in the provider’s commitment papers.
                2) EHEMSS reserves the right to review and suggest changes as needed.

CROSS REFERENCE(S) (325 ILCS 2/) Abandoned Newborn Infant Protection Act

New 10/09
Reviewed 04/10; 10/2012, 1/2017
Revised: 02/2015
TITLE

Do Not Resuscitate Guidelines

PURPOSE

Patient wishes concerning end of life procedures are to be respected. Valid POLST/DNR orders are to be honored, but care that would be consistent with comfort should be given. In cases where there are any questions or disputes, contact Medical Control and follow the orders given. If communication is not possible, begin treatment and transport as soon as possible.

APPLICABILITY

All EHEMSS participants and providers.

POLICY STATEMENT(S)

1. EMS Region 8 Standard Operating Procedures will be followed (Withholding or Withdrawing of Resuscitative Efforts). This SOP covers Power of Attorney for Healthcare, Living Will/Surrogates, POLST/DNR orders; Obviously Dead patients: “Triple Zero”; Hospice patients Not in Arrest; and Patients in persistent Asystole/PEA who do not respond to treatment.

2. Medical Control physicians can order resuscitative efforts to begin or continue and the order is to be honored.

3. If unable to establish communication with Medical Control, and any doubt exists, initiate and continue resuscitative efforts until the patient reaches the hospital.

4. If there is a potentially reversible process or injury (trauma or choking), the DNR order should not be automatically honored; IMC should be initiated.

DEFINITION(S)

A valid POLST/DNR order or its successor document as defined by IDPH must be written and may be on a form provided by IDPH (it may or may not be on colored paper) and contain All the following:

1. Name of the patient
2. Resuscitation Orders (section A of POLST form) or equivalent language in a previous DNR for (Doo Not Resuscitate; Withhold Treatment)
3. Three Signatures required
   - Evidence of consent-any of the following:
     a. Signature of patient or
     b. Signature of Legal Guardian or
     c. Signature of Durable Power of Attorney for Health Care Agent or
     d. Signature of Surrogate Decision maker under the Illinois Health Care Surrogate Act
• Signature of a Witness to Consent
• Signature of Attending Practitioner
  a. Physician or
  b. Licensed resident (2nd year or higher) or
  c. Advanced Practice Nurse or
  d. Physician Assistant
4. Effective date (date the practitioner signed the order)

*Note: the validity of all signatures is the responsibility of the physician issuing the order and not the EMT.*

DNR orders with effective dates prior to July 1, 2001 and containing the above five elements will be honored and considered valid. These orders might have stipulations that should be honored. NOTE: prior to this date, witness signatures were not required; the order is valid without those signatures.

Living Wills are not valid DNR orders.

Surrogates, Legal Guardians, or those who are Durable Power of Attorney for Health Care Agents cannot give orders to field personnel. Unless they are the signatory (not the witness), they cannot rescind the DNR order. Only the signatory can rescind/revoke a valid DNR.

**PROCEDURAL**

1. Determine the identification of the patient.

2. Determine the validity of the POLST/DNR order. POLST/DNR orders must be written.

3. Communicate with Medical Control and follow orders even if they are contrary to the POLST/DNR.

4. Verbal POLST/DNR orders from anyone (any agent, legal guardian, spouse, relatives, and significant others) or phone orders, even if from a physician, will not be honored without consulting with Medical Control.

5. Valid POLST/DNR orders that have been signed by any of the above can be rescinded by that agent as though the patient was revoking the order.

6. POLST/DNR orders can be rescinded by physically destroying the order or by the valid signatory or the physician who signed the order.
7. If care is withheld or withdrawn, refer to the Coroner Notification Policy.

8. Thoroughly document circumstances surrounding the use of the POLST/DNR order and attach a copy to the run sheet. If a copy is not available, record all information for validity from the POLST/DNR order in the comments section of the run sheet. Also document the name of the person presenting the POLST/DNR to the ambulance crew.

CROSS REFERENCE(S)  Region 8 Emergency Medical Services Standard Operating Procedures (Current)

New 06/94
Revised 01/01, 10/09; 10/2012, 01/2017
Reviewed 04/10
Invalid/Citizen Assists

To clarify the role of EHEMSS providers when called to provide assistance but not medical care (see definition).

EHEMSS Participants

While it is not the role of the EMS system to provide non-emergency care, it is recognized that people do contact providers for assistance from time to time.

Invalid: a disabled person needing assistance getting from bed to wheelchair or getting from a vehicle to the house. This assistance could have been provided by other personnel or agencies if they were capable and available.

Note: this does not include patients who have a positive mechanism for possible injury. These should be managed as a patient encounter.

1) Assess the scene to determine the nature of the incident.

2) If the situation is consistent with the definition of invalid as above, this is not an EMS system/provider patient relationship. There is no need for vital signs, assessment or interventions.

3) If a mechanism of injury or signs of illness are present, proceed to assess and treat the person per SOPs and/or refusal of care policies.

4) An EMS patient care report is not needed for these calls. However, the provider might have specific documentation requirements that should be followed.

5) On-line medical control is not necessary for invalid/citizen assists nor is it necessary to obtain a signed refusal of care form.

6) If a situation of neglect or abuse appears to exist, the situation should be reported.

7) In the event that the provider is being called repeatedly, EHEMSS staff can be contacted by the FD EMS Department for assistance in determining if other services are needed and/or available.

EHEMSS Policy: Reporting Elder Abuse and Neglect

EHEMSS Policy: Right of Refusal

New 10/09
Reviewed 04/10; 10/2012; 02-2015, 01/2017
TITLE

Patient Transport/Selection of Receiving Hospital

PURPOSE

To define criteria to select and transport patients to the appropriate hospital.

APPLICABILITY

All EHEMSS Participants

POLICY STATEMENT(S)

The goal of Edward Hospital EMS is to provide all patients with the best appropriate care. As one step to achieving this goal, all patients will be transported to the nearest, most appropriate hospital, per State law, unless specific criteria have been met.

DEFINITION(S)

Nearest hospital - the hospital which is closest to the scene of the emergency as determined by travel time.

Medical Control – Any Region 8 hospital; unless a system-specific protocol is being utilized, in which case Medical Control must be Edward Hospital or its associate AMITA Bolingbrook Hospital.

Stable Patients - patients that have vital signs within normal limits and do not have any of the following: respiratory distress, chest pain, hypotension, signs of shock, pulmonary edema, or inadequate perfusion.

PROCEDURE

All ambulance providers (municipal and private) will transport the patient to the nearest hospital unless one (1) of the following situations exist:

1. A legally and mentally competent patient, exhibiting decision making capacity, refuses to be transported to the nearest hospital.

   A. Stable patients requesting transport to a Region 8 hospital where transport time does not exceed 25 minutes may be transported without requesting permission. Phone, radio, or e-Bridge contact must be made with the desired destination once enroute.

   B. Unstable patients requesting a bypass to another Region VIII hospital, must have approval from that desired destination prior to initiating transport.

   C. If the patient-requested hospital is a non-Region 8 hospital, the EMT must contact the closest Region VIII hospital prior to transport. A physician must do a risk/benefit determination. If the authorization is made, the ECRN present shall note that on the telemetry radio log and contact the more distant hospital with report.
D. The EMT will document the patient’s refusal to go to the nearest hospital and obtain a refusal after the patient has been fully advised of the risks to their well-being as a result of the refusal. The EMT will also document within the narrative of the run sheet the ED physician’s authorization to transport to the more distant hospital.

E. If a fire department is unable to complete the transfer to the more distant hospital, the transport can be completed by a private ambulance service. The originating agency must stay with the patient and initiate appropriate ALS or BLS care until the requested transport arrives and assumes care for the patient.

F. If a patient is judged incompetent either legally or mentally to express consent or refusal, they must be transported to the nearest hospital. Their request for transport to a more distant hospital cannot be honored. Document the patient’s actions, statements, and/or physical finding leading to the conclusion that they are incompetent.

2. The patient requires specialized services not available at the nearest hospital; i.e., trauma, burn, spinal cord, stroke, hyperbaric oxygenation. In the case of trauma, regional triage policies will apply, otherwise, the following procedures shall be followed:

A. The EMT will contact the desired Region VIII specialty facility and communicate the patient’s need for specialized services.

B. A physician must do a risk/benefit determination. If authorization is made, the ECRN present shall note that on the telemetry radio log.

C. If the desired specialty center is outside of Region VIII, the EMT will contact the closest Region VIII hospital to request permission to transport. If approved, the ECRN shall contact the specialty facility with report.

D. The EMT will document within the narrative of the run sheet the ED physician’s authorization to transport to the specialty facility.

E. If a fire department is unable to complete the transfer to the specialty facility, specialty transportation shall be contacted. The originating agency must initiate appropriate ALS or BLS care and stay with the patient until the requested transport arrives and assumes care for the patient.
3. In a declared mass casualty situation, patients will be triaged to area-wide hospitals as their resources allow, in accordance with the region-wide disaster plan established. The closest Region VIII Resource Hospital will provide availability of surrounding hospitals through communications with the provider agency.

CROSS REFERENCE(S)   
EHEMSS Policy: Right of Refusal

New 06/94  
Revised 01/01, 10/09, 04/10, 10/2012, 2/2020
Minors: Treatment Consent for Minors

PURPOSE
To define the procedure for consent to treat minors whether or not they are attended by an adult who can give consent.

APPLICABILITY
EHEMSS Participants

POLICY STATEMENT(S)
EHEMSS pre-hospital personnel will make reasonable attempts to obtain legal consent to treat minors in need of emergency care. If obtaining consent would delay immediately needed medical care or the life of the minor is threatened, emergency treatment should begin without consent. Contact medical control as soon as possible.

DEFINITION(S)
1. Minor: any person under the age of legal competence: in Illinois under the age of 18 years.
2. A parent or legal guardian must consent to treatment of a minor, unless it is an emergency situation or the minor meets one of the conditions below.
3. Minors 17 years of age or younger can consent in the following situations:
   • Married, Pregnant or Parent: may consent for themselves or their child
   • Sexual Assault: minors of any age who are victims of sexual assault can consent for any disease or injury arising from the offense without parental consent
   • Alcohol, Drug-Related, Sexually Transmitted Disease: Minors 12 years of age or older may consent to diagnosis and/or treatment of STD, alcohol, or drug-related conditions without parental knowledge or consent
   • Emancipated Minor: an individual between 16 and 18 years of age who a court has determined is capable of managing their affairs and lives independent of parents or guardian.
   • Active member of military service.
4. Protective Custody: may be taken by police, DCFS, or physician if the custodian or resident presents an imminent danger to the minor’s life or health. NOTE: not to be used as the authority to take every minor for the purposes of obtaining consent.
PROCEDURE

Minor who IS or is NOT in need of “Emergency Care” who consents for treatment. Treatment and transport should progress per medical protocol or medical direction over normal and usual modes of communication.

1) Contact medical control as soon as possible for consultation and instructions. Treat and transport as advised.
2) Reasonable attempts to contact someone to consent to treatment of the minor should be fully documented.
3) In the event of guardianship or emancipation, request the official documents. Document your request and whether the document was produced.
4) In the event of protective custody, document the situation and the name of the individual taking protective custody.
5) In the event of abuse, follow the policy for reporting child abuse.

CROSS REFERENCE(S)

EHEMSS Policies: Involuntary Transport; Reporting Child Abuse

New 06/94
Revised 01/01, 10/09
Reviewed 04/10; 10/2012; 02/2015, 01/2017
TITLE

Minor Refusal

PURPOSE
To ensure the well-being of any minor in need of medical care when the advice of the minor’s legal guardian is not available. (Special consideration to the minor under age 14. See below.)

APPLICABILITY
All EHEMSS participants.

POLICY STATEMENT(S)
Minor: any person under the age of legal competence; in Illinois, under the age of 18 years.

DEFINITION(S)

PROCEDURE
Note: In reference to minors who are married, emancipated, (and present evidence of court determination), pregnant, or are parents, refer to Right of Refusal Policy for adults.

Legal Rationale: A minor does not have the legal competence to consent for treatment, nor does a minor possess the legal competence to refuse treatment.

General Rule: Any situation which by its nature infers an emergency situation exists or will exist in the immediate future, a minor person should be treated for such a condition without delay in the absence of a decision by a legal guardian.

Situation Examples: Although every situation will not meet the criteria set forth in the following examples, general categories seem to exist.

1) Minor in need of “Emergency Care” who refuses treatment. You must verify and document on the PCR that an injury/illness and the need for emergency care in fact exists; or if behavior of a patient suggests a lack of capacity to make a refusal in a valid manner, then document such behavior and continue to render care necessary for the situation, including transport.

2) Minor NOT in need of “Emergency Care” who refuses treatment or transport. Age 14 to 17—Explain to patient your responsibility and need for final determination to be made by a physician. If a patient still refuses, document explanations above on patient care report and allow patient to sign refusal form if he/she will cooperate.
If not cooperative, document this and have it witnessed by responsible witness. A reasonable attempt should be made to contact the legal guardian (document attempt) and

A. Minor released to a legal guardian or other guardian per medical control, or
B. Minor turned over to local police juvenile authority

Note: Certain injury, illness, ingested or injected substances can alter behavior and create a situation whereby the capacity to make a valid judgment by the patient no longer exists. It is better to treat and prevent any further harm to the patient who may not be able to judge his/her own condition.

3) Under age 14-- If appropriate guardian is not available, the minor should be transported to the emergency department. The right of the legal guardian /other appropriate guardian to refuse treatment must be cleared by medical control before obtaining the refusal. If clearance is given by medical control to obtain the refusal, the refusal must be obtained from the legal guardian or other guardian as per medical control. If clearance is not granted by medical control, further direction should come from medical control.

Note: Emergency Department physician must be consulted on all refusals of minors, and the Emergency Department physician’s name and/or number should be documented on all minor refusals. In any case where doubt or confusion may exist at the scene, further advice should come from medical control.

CROSS REFERENCE(S)

New 06/94
Revised 01/01, 10/09; 10/2012
Reviewed 04/10; 02/2015, 01/2017
TITLE

Multiple Patient Release (MPR)

PURPOSE
To provide a method of releasing multiple patients who are refusing assessment, treatment, and/or transportation at the scene of an MVI.

APPLICABILITY
EHEMSS Participants.

POLICY
STATEMENT(S)
The Multiple Patient Release form (MPR) may be used in incidents involving multiple persons, when the individuals are:

- Alert, oriented and competent
- Voluntarily refusing assessment, treatment, and/or transport
- Stating that they are NOT ill or injured
- Exhibits no apparent signs or symptoms of illness or injury

DEFINITION(S)

PROCEDURE
1. ALL involved individuals at the scene of an MVI are to be encouraged by emergency care providers to accept assessment, treatment, and transport, explaining that although they feel they are uninjured at present they may have serious injuries which are not apparent that could result in death/disability. An MPR should be used when more than one (1) patient is present. However, patients with extenuating circumstances also should have an EMSS Report completed (e.g., unable to contact a minor’s parent).

2. Medical Control should be contacted early in the incident if needed.

3. Attempt to examine all involved individuals according to EHEMSS guidelines. Every individual involved must be offered medical assistance and transport.

4. If multiple persons resist or refuse care and meet the criteria listed above:

   A. Ask the individuals to provide the necessary information and sign the form
   B. Complete one (1) EMS run sheet for the incident and document the fact that an MPR form was used. If possible, the total number of individuals should be documented here. Document Medical Control’s log number on the MPR and attach the MPR to the run sheet.
5. If any patient refuses to sign a refusal form or provide necessary information, documentation should clearly reflect the circumstances. The specific patient comments should be documented as stated.

6. A Release from Medical Responsibility form and run sheet will be completed for each patient who:

   A. Does not meet the above criteria
   B. Who is ill or injured in the judgment of pre-hospital personnel

7. If this is a school bus accident, an official school representative may sign the MPR form.

CROSS REFERENCE(S)  
School Bus Motor Vehicle Crashes

New 08/94  
Revised 01/01, 10/09; 10/12, 01/2017  
Reviewed 04/10
TITLE School Bus Motor Vehicle Crashes

PURPOSE To define the appropriate response to the following points about school bus accidents involving students:
- Mass casualty vs. Multiple Victims
- School agency authority over students
- Refusal of uninjured minor patients
- Dissemination of information to students, parents, and/or guardians

APPLICABILITY All EHEMSS Participants

POLICY STATEMENT(S) EHEMSS participants will manage incidents involving school buses in a manner to assure appropriate care; comply with the school agency’s authority; release of patients from the scene; and clarify tactical responses of the provider and receiving hospitals.

DEFINITION(S)

PROCEDURE
1. Upon arrival at the scene, obtain a passenger roster as soon as possible.

2. Once first-arriving units have established the crash has involved a bus transporting students, the Incident Commander will request Dispatch to immediately contact the appropriate school authority and request they send to the scene an authorized representative empowered to exercise authority and control over students.

3. EMS personnel shall provide appropriate medical treatment and hospital transportation for any student who exhibits signs of having sustained injury/illness or who makes a verbal complaint of the same. In instances of students that refuse medical treatment, EMS personnel will observe the existing policy regarding medical treatment and (refusal of treatment for minor patients.)

4. Students who demonstrate no signs of injury/illness or make no verbal complaint of such should be turned over to the custody of the authorized school agency representative on the scene. EHEMSS providers shall:
   A. Advise Medical Control of the condition of patients refusing treatment and are not being transported
   B. Document on an EMS Report Form or Multiple Patient Release (MPR), the names of all students not being
C. With the approval of Medical Control, request the appropriate school agency representative sign the Refusal of Treatment Form for all students not being transported

5. The Incident Commander will appoint a liaison to assist the school agency representative in accounting for all students by identifying the names of those transported, as well as those not transported, and reconciling those names with the passenger roster for the bus. School agency personnel will take responsibility for notifying the parents of all students involved in the incident whether transported or not transported.

6. If a school agency representative is unavailable, the following shall apply:

   A. EMS personnel will observe existing policies regarding the medical treatment and refusal of treatment for minor patients
   B. The Incident Commander will appoint an individual or individuals to maintain the accountability for any students not being transported and to make appropriate parental notification.

CROSS REFERENCE(S)  EHEMSS Policy: Minors – Treatment Consent for Minors

New 01/01
Revised 10/09; 10/12
Reviewed 04/10, 01/2017
TITLE Reporting of Elder Abuse or Neglect

PURPOSE Reporting of abuse or neglect of the elderly is intended to assure that they can live safely and as independently as possible. When cognitive impairment exists, legal steps can be taken to protect the elderly. EMS personnel are often in situations that do reflect abuse, neglect and/or unaddressed cognitive impairments of the elderly and might be the only people to begin to help them.

APPLICABILITY All EHEMSS Participants and Providers.

POLICY STATEMENT(S) All EHEMSS participants and providers will comply with required reports of abuse and neglect.

DEFINITION(S) Taken from PA 093-0300, Elder Abuse and Neglect Act (ILCS 320/et seq.)

**Elderly:** Person 60 years of age and older who, because of dysfunction is unable to seek assistance for himself or herself

**Abuse:** Causing physical, mental or sexual injury to an eligible adult, including exploitation of such adult’s financial resources.

**Neglect:** An individual’s failure to provide an eligible adult with, or willful withholding from an eligible adult, the necessities of life including but not limited to food, clothing, shelter or medical care.

**Mandated Reporter:** Licensed professionals. Effective January 1, 2004, a person who performs the duties of a paramedic or an emergency medical technician.

**Confidentiality:** The privileged quality of communication between any professional person required to report and his/her patient or client. It shall not apply to situations involving abused, neglected, or financially exploited eligible adults and shall not constitute grounds for failure to report as required by this Act.

**Immunity:** A person making a report under this Act in the belief that it is in the alleged victim’s best interest shall be immune from criminal or civil liability or professional disciplinary action. Violations of other requirements, such as HIPAA, that occur surrounding the report are not covered by this immunity.

**Penalty:** Some professionals such as physicians who willfully fail to report can be referred to the appropriate professional disciplinary
Any other mandated reporter required by this Act to report … who willfully fails to report the same is guilty of a Class A misdemeanor.” (Source: PA 90-628, eff. 01/01/1999) (New statutory language effective 01/01/2004)

**PROCEDURE**

Applicable Reporting Agencies:

- **State of Illinois Department on Aging, Senior Help Line:**
  1.800.252.8966
- **Elder Abuse Hotline 1.866.800.1409.**
- **DuPage County Department of Senior Services:**
  1.630.407.6500
- **Will County Guardian Angel Community Services:**
  Adult protective services-1.800.223.7398
- Consider notification of local law enforcement agencies

1. Make no assumption that other system members will file a report; i.e., physicians, nurses, etc.

2. In the event of a disagreement among mandated reporters, the person suspecting the alleged abuse will complete the reporting requirement.

3. Calls must be made during the same shift in which the run occurs.

4. The law requires reporting of suspicions, not just obvious abuse or neglect. It also requires reporting if there is any suspicion that these have occurred within the previous twelve (12) months.

5. Required information:
   A. Alleged victim’s name, address, telephone number, sex, age and general condition.
   B. Alleged abuser’s name, sex, age, relationship to the victim and condition.
   C. Circumstances which lead to the decision to report. Be as specific as possible.
   D. Is there immediate danger; best time to contact the person; whether the victim knows a report is being made; any potential danger to the worker who will investigate.
   E. Whether the reporter believes the victim could self-report.
   F. Reporter’s name, phone number and profession
   G. If the reporter is willing to be contacted again.
H. Any other relevant information

*Documentation:

1. All circumstances, observations and statements must be carefully documented in the PCR.
2. Judgmental statements should be avoided but facts should be accurately recorded.
3. Names of physicians, Illinois Department on Aging personnel, law enforcement personnel, coroners, etc. should be fully documented.
4. The date and time of the report filed should be documented.

CROSS REFERENCE(S)  
Elder Abuse and Neglect Act (ILCS 320//et seq.)

New 01/05  
Reviewed 10/09, 04/10,  
Revised 10/12, 01/2017
**TITLE** Reporting of Child Abuse or Neglect

**PURPOSE** To define specific documentation and reporting requirements of suspicions to appropriate persons and/or agencies to facilitate investigation as needed.

**APPLICABILITY** All EHEMSS Participants and Providers

**POLICY STATEMENT(S)** All EHEMSS participants and providers will comply with required reports of abuse and neglect. The Act does not require certainty; it requires that there be reasonable cause to believe the child is abused/neglected. Good faith reporting provides immunity from liability, civil or criminal, that might result from reporting.

**DEFINITION(S)**

- **Child**: Any person under the age of 18 unless legally emancipated by reason of pregnancy, marriage or entry into a branch of the United States Armed Services.

- **Abused Child**: A child whose parent, immediate family member, person responsible for the child’s welfare, any individual residing in the same house as the child, or a paramour of the child’s parent:

  1. Inflicts, causes, creates a substantial risk of, or allows to be inflicted upon such child, physical injury by other than accidental means which causes death, disfigurement, impairment of physical or emotional health, or any bodily function.
  2. Commits or allows to be committed any sex offense against said child as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include children under the age of 18 years.
  3. Commits or allows to be committed an act or acts of torture upon such child.

- **Neglected Child**: A child whose parent or responsible caregiver withholds or denies nourishment or medically-indicated treatment, including food or care denied solely on the basis of the present or anticipated mental or physical impairment as determined by a physician acting alone or in consultation with other physicians or otherwise does not provide the necessary support, education as required by law, or medical or other remedial care recognized under State law as necessary for the child’s well-being, or other care necessary for his/her well-being including adequate food, clothing, and shelter; or who is abandoned by his/her parents or responsible
caregiver. PA 86-274 and 275 amended the definition to include any newborn infant or minor whose urine or blood contains any amount of a controlled substance unless it was prescribed for medical treatment.

**Department**: Illinois Department of Children and Family Services (DCFS).

**Confidentiality**: Information provided to other parties should be limited to those parties providing direct care, involved in the investigation, or under subpoena. Privacy of the parties involved should be protected as much as possible.

**PROCEDURE**

**Reporting Agency**: DCFS State Central Register: 1-800-25-ABUSE (1-800-252-2873)

1. Telephone reports are to be made 24 hours per day to the abuse number; they should be made during the same shift in which the run occurs.

2. Make no assumption that other system members will file a report; i.e., physicians, nurses, etc.

3. In the event of a disagreement among mandated reporters, the person suspecting the alleged abuse will complete the reporting requirement.

4. Required information:
   A. Family composition including the name, age, sex, race, ethnicity, and address of the child named in the report and any other children in the environment.
   B. Name, age, sex, race, ethnicity, and address of the child’s parents, and the alleged perpetrator and his/her relationship to the child.
   C. The harm to the involved child/children and an estimation of the child’s present physical, medical, and environmental conditions. Any previous incidents should be included.
   D. The reporter’s name, occupation, and relationship to the child/children; actions taken by the reporter; where the reporter can be reached; other information the reporter believes will be helpful.
   E. Consider notification of local law enforcement agencies.
Death Caused by Abuse/Neglect
This must be reported to the appropriate coroner. This can be accomplished by reporting suspicions to law enforcement personnel and the receiving hospital physician. Document on the run sheet to whom suspicions were reported.

Protective Custody:
If the EMS suspects abuse/neglect and the caregiver is refusing treatment or transport, the EMT will seek the assistance of local law enforcement. If they are unwilling to place the child under protective custody, contact the designated system hospital and ask to speak to a physician.

Temporary protective custody can be taken without the consent of the legally responsible parent or guardian by the following parties: a physician treating the child, a designated employee of DCFS; an officer of a local law enforcement agency.

Three conditions must be met for protective custody:

1. The party believes the circumstances or conditions are such that continuing to allow the child to reside with or remain in the custody of the legally responsible person presents immediate danger to the child’s life or health.
2. The person responsible for the child’s welfare is unable to or has been asked and does not consent to the child’s removal from his/her custody.
3. There is not time to apply for a court order under the Juvenile Court Act for temporary custody of the child.

*Documentation:*
All circumstances, observations and statements must be carefully documented in the run report. Judgmental statements should be avoided, but facts should be accurately recorded. Names of physicians, DCFS personnel, law enforcement personnel, coroners, etc. should be fully documented. The date and time of the report filed should be documented.

NOTE: Knowingly making a false report is a Class 3 Felony. Willful failure to report constitutes a Class A misdemeanor which is punishable by up to one (1) year in jail and a fine of up to $1000.00.

**CROSS REFERENCE(S)**
*Abused and Neglected Child Reporting Act*
*Illinois Revised Statute, Chapter 23, paragraph 2053*
TITLE Restraints

PURPOSE To prevent emotionally disturbed and uncooperative patients from harming themselves or others through the use of restraints.

APPLICABILITY All EHEMSS participants and providers

POLICY STATEMENT(S) Hard or soft restraints may be used only as a measure to prevent physical harm to the patient or others. Under no circumstances will restraints be used to punish or discipline a patient. Patients should be treated with dignity and respect. Full restraints require the application of a restraint to each limb; each limb must be carefully monitored for circulation, sensation and movement. This assessment must be documented.

DEFINITION(S) Extremity check: assessment of circulation, sensation and motion in each restrained extremity at least every 15 minutes.

PROCEDURE 1) The first priority is to assure that the situation is safe for the EMT. At no time should an EMT assume an unreasonable risk. Additional personnel should be requested as needed.

2) Necessary force (minimum required) may be used to neutralize the force exerted by the patient. All attempts to avoid injury to the patient and crew members must be made.

3) Restraints should be positioned so that:
   A. there is no respiratory or circulatory impairment
   B. the airway is always accessible
   C. at no time should anything be forced into the patient’s mouth
   D. the patient is not transported in the prone position

4) The patient must be constantly observed by an EMT while restrained.

5) Handcuffs are to be applied and removed by police officers only. When it is necessary to transport a patient in handcuffs, the police officer who has the key must accompany the patient in the back of the
ambulance.

6) Sedation can be considered for combative, uncooperative patients. Refer to current EMS Region 8 Standard Operating Procedures.

7) Documentation must include the reason for initiation of restraints; vital signs following restraint; and extremity checks initially and every fifteen (15) minutes.

CROSS REFERENCE(S)  
EMS Region 8 Standard Operating Procedures (Current)

New 06/94  
Revised 01/01, 07/01  
Reviewed 10/09, 04/10, 10/12, 01/2017
TITLE Sudden Infant Death

PURPOSE To provide guidelines for appropriate handling and disposition of a sudden infant death patient and the family/caregivers. To assure compliance with police and coroner investigation of the situation.

APPLICABILITY All EHEMSS participants and providers.

POLICY STATEMENT(S) Sudden infant death incidents are emotionally charged incidents that will tax the rescuers’ skills as not only a rescuer, but also the emotional stability of the rescuer. It is the belief of EHEMSS that the family/significant other/caregiver should receive all due respect and emotional support in this situation.

DEFINITION(S) Sudden infant death: Sudden death of an infant during the first year of life from an illness of unknown etiology.

PROCEDURE 1) Carry out resuscitation using the following guidelines:

   A. Obtain as much information about the medical history and events as possible; avoid suggesting blame.
   B. If it appears that the infant has very recently died, i.e. no signs of long-term death, resuscitation should be initiated. If there are any questions, contact medical control.
   C. If there are signs of long-term death, the infant should be handled in the same manner as other long-term deaths. Notify the appropriate coroner and law enforcement agency.
   D. In all cases, the pre-hospital personnel should treat the infant and family/caregivers with respect and provide emotional support.
   E. Whether resuscitation is conducted or not, the situation should be handled as though it is a crime scene.

2) Assign one staff member to be with the family/caregivers to provide emotional support and assist with their immediate needs.

3) Documentation should include:

   A. Objective facts observed and statements made by
the family/caregivers.
B. ID of coroner contacted and direction they provide
C. ID of law enforcement personnel and direction they provide

4) Appropriate support will be made available for the rescuers as needed.

CROSS REFERENCE(S)  N/A

New 06/94
Revised 01/01, 10/09
Reviewed 04/10; 10/12, 01/2017
Hospital Limitation / Ambulance Bypass

To define actions to be taken in the event of hospital resource limitations that may include the need for ambulance bypass.

All EHEMSS Participants

No patient shall be transported by an ambulance or specialized emergency medical services vehicle to a facility other than the nearest hospital trauma center, or specialized care center unless the EMS Medical Director or his physician designee has determined and certified that, based upon the reasonable risks and benefits to the patient and that:

THE MEDICAL BENEFITS REASONABLY EXPECTED FROM THE PROVISION OF APPROPRIATE MEDICAL TREATMENT AT A MORE DISTANT HOSPITAL or trauma center OUTWEIGH THE INCREASED RISKS TO THE PATIENT FROM TRANSPORT TO THE MORE DISTANT HOSPITAL or trauma center, and

THE MORE DISTANT HOSPITAL or trauma center HAS AVAILABLE SPACE AND QUALIFIED PERSONNEL FOR THE TREATMENT OF THE PATIENT.

**Capitalization indicates statutory language.

Nearest Hospital: is the hospital that is closest to the scene of the emergency as determined by travel time.

Nearest Trauma Center: is either a Level I Trauma Center serving the trauma region in which the EMS system is located, or the Level II Trauma Center which is closest to the scene of the emergency as determined by travel time.

Specialized Care Center: is a center offering specialized services not available at all institutions which may require special certifications or accreditations from Joint Commission or other accrediting bodies; i.e., becoming a Primary Stroke Center.

*Note: in the event of the lack of availability of a specialty care unit, the emergency department of that institution shall be regarded as a functioning comprehensive emergency department without any specialty care back-up capabilities (e.g., burn unit, spinal cord unit, hyperbaric chamber, Level I Trauma Center).
**PROCEDURE**

1. **Risk/Benefit Certification**

   One of the mitigating circumstances, which may compel a physician to certify a transfer to a more distant hospital, is the declaration of a Limitation of Resources by the nearest hospital. The ECRN present for the ED physician’s authorization or denial of transport to the more distant hospital or trauma center shall document accordingly on the telemetry radio log including the ED physician’s name.

2. **Hospital Resource Limitation**

   Edward Hospital EMS System has agreed to provide emergency assessment and care to all patients presenting to their Emergency Department in accordance with all federal and state statutes and rules. However, it is recognized that hospital resources vary dependent upon patient care demands, equipment and staffing availability, and the status of the facility’s physical plant. Requests for bypass status must only be communicated after a prospective decision has been reached by medical, nursing, and administrative representatives with the authority to make such a request. An appropriately declared and reported limitation of resources will usually result in a patient being taken to a hospital other than the nearest hospital.

   Information about the limitation of resources is taken into consideration by the EMS Medical Director or his designee in making triage decisions. If it is determined that a resource limitation affects the ability of a system hospital to provide appropriate emergency care and/or stabilization for a particular patient, an emergency physician may choose to divert an ambulance transporting a patient with those needs to the next closest hospital based on an analysis of reasonable risks and benefits, and based upon the determination that the more distant hospital or trauma center has available space and qualified personnel for the treatment of the patient.

   A system hospital or trauma center is presumed to have available resources and qualified personnel in accordance with the provision of its system agreement, unless such facility has notified the EMS Medical Director or his designee that it has a shortage or limitation of space, equipment, or qualified personnel.
3. Resource Limitations Requiring Notification

The following resource limitation would impair the ability to provide emergency care and/or stabilization:

A. No appropriately staffed monitored beds based on the hospital individual plan governing staffing requirements.
B. No monitored or unmonitored beds and/or BLS capabilities (refers to the rare circumstances when Emergency Department resources are insufficient even for the routine evaluation and care of the BLS patients).
C. Hospital internal disaster (e.g., fire, flood, other physical plan incapacitation of the hospital).
D. Lack of sophisticated diagnostic capability that may be needed in caring for the patient (i.e., CT, angiograph or MRI).
E. Lack of staffed Operating Room or Intensive Care bed availability.

4. Despite resource limitations and being on bypass status, the Resource Hospital or nearest Trauma Center may continue to receive patients under the following circumstances:

A. If the reasonable risks to the patient resulting from a longer transport time are judged to be greater than the reasonable benefits of transporting to an Emergency Department with a declared resource limitation.
B. Other Emergency Departments within reasonable transport times have also declared a limitation of resources. In these cases, all must accept new patients.
C. The System may declare a disaster plan to be in effect.
D. In multiple-victim incidents

5. Procedure for Notification of Resource Limitation:

A. If Edward Hospital experiences a limitation of resources as specified in this policy, and wishes to request ambulance bypass, the senior hospital administrator or his/her designee will be contacted by the nurse or physician in charge of the Emergency Department at that time.
B. The decision to request ambulance bypass will ultimately be up to the senior hospital administrator or his/her designee.
C. It is the responsibility of Edward Hospital to notify system and non-system ambulance providers who normally serve that facility, of such limitation. Edward Hospital must enter
bypass information on the state HAN and update the information every 4 hours per IDPH requirements.

D. Notification must include the hospital name, official’s name and title, nature of bypass request, callback number, and estimated length of diversion. The system must return to normal operations as quickly as possible.

E. Pre-hospital providers are responsible for keeping their personnel informed regarding existing resource limitations within the system. Individual provider policies specifying their method of complying with this requirement shall be included in their letter of system participation.

F. Notification shall be promptly provided by Edward Hospital when the resource limitation is corrected. Edward Hospital shall re-notify those system members who had been made aware of the bypass situation and communicate the “open” status, as well as document the “open” status on the state HAN.

CROSS REFERENCE(S)  

*System-Wide Crisis*

*Section 515.315 Bypass Status Review*

New 06/94
Revised 01/01, 03/07, 10/09, 04/10; 10/12
Reviewed 01/17
TITLE  Notification of Coroner

PURPOSE  To define situations under which the provider will make coroner notification.

APPLICABILITY  All EHEMSS Participants and Providers.

DEFINITION(S)  N/A

PROCEDURE  1) Paramedics on scene may determine if a patient meets established criteria as defined in the standard operating procedure “Withholding or Withdrawing Resuscitation Efforts.”

2) Paramedics who serve only to recognize clinical death, may then notify the appropriate law enforcement agency and the coroner’s office of the death situation.

3) If there is any doubt as to the viability of the patient or applicability of the “Withholding or Withdrawing Resuscitation Efforts” standard operating procedure, the patient must be treated/transported per protocol. At no time may the coroner determine the type of care to be rendered to the patient.

DuPage County Coroner’s Office  630-407-2600
Will County Coroner’s Office       815-727-8455

CROSS REFERENCE(S)

New 06/94
Revised  01/01, 04/10
Reviewed  10/09; 10/12, 01/2017
TITLE  
**System-Wide Crisis Response**

PURPOSE  
To provide a proactive mechanism for recognition of and response to an impending or active system-wide crisis.

APPLICABILITY  
Edward Hospital & Health Services, EMS System Providers

POLICY STATEMENT(S)  
Recognition of evolving trends or the influx of patients with similar signs and symptoms will better prepare Edward Hospital, local EMS providers, and neighboring hospitals for an increased demand for EMS and Emergency Department resources.

DEFINITION(S)  

PROCEDURE  
The following procedures outline how and when notification/recognition may occur.

1. Recognition  
   A. ECRNs may be made aware of a system-wide crisis by communication from EMS providers (i.e., mass casualty incident) or by noting an increasing number of emergency departments requesting ambulance diversion. The ECRN should report these occurrences to the attending emergency physician and charge nurse.

   B. When participating hospitals see a rapid or developing increase of patients with similar symptoms, the attending emergency physician or the charge nurse should contact the EMS System Coordinator and apprise them of the situation. The EMS System Coordinator will determine the next course of action.

   C. When EMS providers notice they have an increase of patients complaining of similar signs and symptoms, they should report this information to the Edward Hospital emergency department, who will then contact the EMS System Coordinator.

2. Notification of Personnel  
   A. The resource hospital shall document any calls they receive from their EMS providers and identify that they are seeing numerous types of patients complaining of similar types of symptoms. The resource hospital should note the time the call is received and seek a detailed account of the situation.

   B. If the resource hospital receives calls from two (2) or more other area hospitals, or have reason to suspect a potential system-wide crisis, the ECRN will page the EMS System Coordinator or EMS Medical Director to inform them of the situation. The EMS System Coordinator or EMS Medical Director will contact the local EMS providers to see if they are
seeing an increase in patients with similar types of symptoms.

C. If there appears to be a trend, prehospital or hospital, of increased frequency of similar symptoms, the EMS System Coordinator or EMS Medical Director shall page the Emergency Officer for the Illinois Department of Public Health at 1-800-782-7860. In addition, the local health department medical director will also be contacted.

D. The EMS System Coordinator or EMS Medical Director may also contact the IL Poison Control Center to see if they are receiving additional calls for similar types of symptoms.

3. Plan of Action

A. Once notified by the Illinois Department of Public Health or POD Hospital (Loyola) that there may be a potential for increased utilization of resources, the EMS System Coordinator or his/her designee will contact the EHEMSS Provider Coordinators to inform them of the crisis.

B. The EMS System Coordinator will also notify the Edward Hospital Administrator on call and Disaster Management Manager should the need arise to institute the EOP (Emergency Operation Plan) at Edward.

C. All information shall be recorded on the “System-wide Crisis” form (see attached), developed by the Illinois Department of Public Health which will be available upon request.

D. The EMS System Coordinator, or his or her designee, will monitor area hospitals on bypass using the HAN and will inform the EMS Provider Coordinators of any changes.

4. All Clear

A. The EMS System Coordinator, or his or her designee, will monitor for the “All Clear” as directed by IDPH or the POD hospital (Loyola), and will notify the EMS Provider Coordinators of this.

CROSS REFERENCE(S)

New 10/09
Reviewed 04/10; 10/12, 01/2017
Establishment of Tactical Emergency Medical Support (TEMS)

To delineate the requirements and responsibilities of the various agencies and individuals responsible for providing medical support to law enforcement agencies involved in tactical situations.

All EHEMSS participants and providers.

Paramedics assigned to law enforcement tactical teams (SWAT, SRT, etc.) operate under dangerous conditions with unconventional hazards. The purpose of a tactical emergency medical support (TEMS) program is to provide preventative medicine with immediate access to medical care, despite hazardous conditions that might otherwise delay treatment. EHEMSS paramedics operating as members of a bona fide TEMS program are responsible for providing care under the current clinical standards, as defined in the Region VIII Standard Operating Procedures and EHEMSS C-TECC guidelines.

Agency Requirements

1) Provider agencies within EHEMSS wishing to establish a TEMS team under EHEMSS medical direction MUST have an affiliation with a local, county, state, or federal law enforcement entity through a memorandum of understanding or other written agreement.

2) A letter of support signed by the medical director and an IDPH system plan modification form is required for the individual provider agency planning on establishing a TEMS team.

3) If TEMS operators will be utilizing a police department rescue vehicle (I.E. Bearcat) or any other vehicle that is not currently registered with IDPH, a non-transport inspection application must be filed with IDPH. Use of that particular vehicle will require successful passing of inspection by IDPH prior to any mission call out.
   a. Teams wishing to place standard ALS gear on any vehicle must comply with current IDPH and EHEMSS procedures relating to the storage, safekeeping and annual inspection of ALS equipment.
4) Members from provider agency wishing to participate in a TEMS program must be:
   a. In good standing within the EHEMSS
   b. Licensed and credentialed at the level of EMT-Paramedic within EHEMSS

5) Within 1 year of assignment to team, provider members must attend with satisfactory completion:
   a. Minimum - 16 hour NAEMT certifying TCCC or TECC course
   b. Preferred - 32 hour recognized TEMS program (STORM, CONTOMS, NTOA, ACEP, ITLS Etc.)

6) Provider agency within the EHEMSS must establish policies addressing a minimum of the following:
   a. Department team standards
   b. Individual team member requirements/standards
   c. Call out procedures
   d. Types of Missions
   e. Medical threat assessment form
   f. Equipment
   g. Quality control

7) All equipment outside current standards and/or scope must be approved by IDPH and the system medical director prior to field utilization. EHEMSS may, but will not be responsible for purchasing, maintaining or replacing any specialty equipment related to a provider TEMS team. A current list of approved medical equipment is located in the appendix.

8) Provider agencies will be responsible for quality assurance and training in relation to TEMS operators. EHEMSS may, but will not be responsible for, providing continuing education hours for members on TEMS team or those that require maintenance of certifications (EMT-T, TP-C, etc.)

9) EHEMSS will be responsible for quality assurance in relation to care provided and patient care reports generated within the EHEMSS as they relate to TEMS operations.
10) EHEMSS will be responsible for review and revision of current policies and protocols relating to TEMS to ensure they are within the standard of the most current, relevant and recognized evidence based medicine, standards, and practices.

11) Current EHEMSS revised, IDPH approved, C-TECC guidelines are located in the appendix.

CROSS REFERENCE(S)

New 09/15
Revised: 02/17
Multiple Victim Incident / Mass Casualty Incident

**PURPOSE**

To provide guidelines to assist EMS providers and ECRNs when handling multiple victim incidents and mass casualty incidents. Resources are to be utilized effectively and efficiently so emergency responder and hospital resources are not completely taxed.

**APPLICABILITY**

All EHEMSS participants

**DEFINITION(S)**

A multiple victim incident involves more than one victim at a scene and can be handled by available resources. (example: car accident injures two people, both transported ALS)

A mass casualty incident involves more victims than can be handled by the resources that are available. (example: tornado injures 120 people; triaged as 28 red, 33 yellow, 50 green, 9 black)

**PROCEDURE**

**MVI**

1) Upon arrival to the scene, the first responding unit will assure the scene is safe.

2) After scene safety is established, Medical Command will assess the scene noting what type of incident it is while beginning the triage process. For an MVI, triage tags will not be used. While triaging, the number of victims will be obtained, and mechanism and severity of injuries will be assessed.

3) Incident Command will follow their own department policies regarding utilization of mutual aid. As responding units arrive they will assist with treating the injured, tending to the most critically injured first.

4) If transport is suspected, Medical Command will contact Medical Control early during the incident to report the following:

- The type of incident they are dealing with, how many victims there are, and what they have been triaged as: red, yellow, or green.
- Medical Command will ask how many patients the hospital can take, and if they are unable to handle all of the patients, the hospital will
contact other area hospitals to obtain their bed availability status.

- Medical Command will communicate with the ECRN what facilities are the next closest to the incident.
- Depending on the situation, Medical Command will either hold while Medical Control searches for availability of beds or Medical Command will recontact the hospital.

5) Medical Command will obtain bed availability. Medical Command will give a brief report of the injured victims including the following: mechanism of injury, approximate age of the patient, sex, triage color, conscious/stable, injuries, ETA.

6) Victims triaged as red will be transported first to the closest, most appropriate facility(ies). Each transporting unit will not call an individual report to the receiving hospital unless there is a substantial change in the patient’s condition that warrants an updated report to be given, or if medical control requests that you do so.

7) A patient care report will be completed on every patient that is transported.

**MCI**

1) Upon arrival to the scene, the first responding unit will assure the scene is safe.

2) After scene safety is established, Medical Command will assess the scene noting the type of incident. An assigned triage officer will begin the triage process. For an MCI, triage tags will be utilized. While triaging, the number of victims will be obtained and mechanism and severity of injuries will be assessed. Triage tags are to be placed on an upper extremity or another highly visible area on the patient.

3) Incident Command will follow own department policies regarding utilization of mutual aid. As responding units arrive they will assist with treating the injured, tending to the most critically injured first.
4) Medical Command will contact Medical Control early during the incident to report the following:

- The type of incident they are dealing with, approximately how many victims there are, and what they have been triaged as: red, yellow, or green.
- Medical Command will ask how many patients the hospital can take, and if they are unable to handle all of the patients, the hospital will contact other area hospitals to obtain their bed availability status.
- Medical Command will communicate with the ECRN what facilities are the next closest to the incident.
- It is highly advisable that medical command keep a constant line of communication open with medical control.

5) Medical Command will obtain bed availability. If time allows, Medical Command will give a brief report of the injured victims including the following: approximate age of the patient, sex, triage color, conscious/stable, injuries, ETA.

6) Victims triaged as red will be transported first to the closest, most appropriate facility(ies). Each transporting unit may call an individual report to the receiving hospital unless there is a substantial change in the patient’s condition that warrants an updated report to be given.

7) Patient information such as assessments and vital signs are to be written on the triage tag. The triage tag stays with the patient and becomes part of the medical record. A patient care report is not completed after transport during an MCI.

CROSS REFERENCE(S) Region 8 SOPs

New 10/09
Reviewed 04/10; 02/2015, 01/2017
Revised 09/10, 11/10; 10/12
Hydroxocobalamin (Cyanokit®) Field Administration

To establish guidelines for field storage and usage of hydroxocobalamin (Cyanokit®) in the treatment of the cyanide poisoning patient.

Edward Hospital Emergency Medical Services System Providers

This policy will provide a guide on the proper procurement, storage, patient selection, and administration of hydroxocobalamin (Cyanokit®). This policy will cover the use of hydroxocobalamin (Cyanokit®) in the treatment of the cyanide poisoning. If hydroxocobalamin(Cyanokit®) unavailable, refer to Region VIII standard operating procedures for cyanide poisoning.

Procurement – Each individual provider agency within the EHEMSS is responsible for the storage, and replacement of all hydroxocobalamin (Cyanokit®) kits. EHEMSS is responsible for providing, replacing, or storing hydroxocobalamin (Cyanokit®) kits for EHEMSS providers.

Storage – Each cyanokit will be stored and/or carried according to each individual provider department’s needs. This policy will not dictate where each hydroxocobalamin (Cyanokit®) kits will be stored. However, the hydroxocobalamin (Cyanokit®) kits should be stored according to the following guidelines:

1. Store at 25°C (77°F); excursions permitted to 15-30°C (59 to 86°F)
2. Hydroxocobalamin (Cyanokit®) may be exposed during short periods to the temperature variations of unusual transport (15 days ranging from 5-40°C (41-104°F)) and freezing/defrosting cycles (15 days submitted to temperatures ranging from -20 to 40°C (-4 to 104°F)).
3. Reconstituted Solution: Store up to 6 hours at a temperature not exceeding 40°C (104°F). Do not freeze. Discard any unused portion after 6 hours.

Patient Selection – The hydroxocobalamin (Cyanokit®) kit is to be utilized in the treatment of the suspected cyanide poisoning patient only. Cyanide poisoning itself may result from inhalation, ingestion, or dermal exposure. Victims of
cyanide poisoning will have some or all of the following: Exposure to fire or smoke in an enclosed environment; soot around the mouth, nose, or back of mouth; altered mental status (e.g. confusion, disorientation). Providers should look for additional signs and symptoms of cyanide poisoning as well prior to administering hydroxocobalamin (Cyanokit®). These symptoms include but are not limited to: Tachypnea/hyperpnea (early), bradypnea/apnea (late), seizures or coma, mydriasis (dilated pupils), hypertension (early) / hypotension (late), cardiovascular collapse, vomiting.

Administration – Each hydroxocobalamin (Cyanokit®) kit contains a 250mL vial with 5g of lyophilized hydroxocobalamin, a transfer spike, and infusion tubing.
1. Utilize the transfer spike to obtain 200mL of 0.9% sodium chloride solution into the hydroxocobalamin (Cyanokit®) vial itself.
2. Repeatedly invert or rock (Do Not Shake) the vial itself for a minimum of 60 seconds to properly mix solution. *If the reconstituted solution is not dark red or particulate matter is seen after the solution has been appropriately mixed, the solution should be discarded.
3. Insert the infusion tubing into vial
4. Administer through new IV site. *Do not use existing IV site for hydroxocobalamin (Cyanokit®) administration. Medication should be administered through its own dedicated IV line.
5. Infuse hydroxocobalamin (Cyanokit®) kit over a 15 minute period (15mL/min) for adult patients. Pediatric dose is 70mg/kg (Diluted ratio = 25mg/mL).
6. Contact medical control
7. Monitor patient

CROSS REFERENCE(S)

New 2/12
Revised 01/2017
TITLE INTER-FACILITY TRANSPORT

PURPOSE To outline general guidelines to be followed for agencies within the system providing emergent or non-emergent inter-facility transportation of patients.

APPLICABILITY All EHEMSS participants

POLICY STATEMENT(S) This policy is intended for any inter-facility emergent or non-emergent medical transport in which the physician from a sending facility requests EMS personnel based on the level of care required for safe physician to physician transfer.

DEFINITION(S) PROCEDURE An attending physician, clinic physician or Emergency Department physician will authorize or request the inter-facility transport.

- The transferring physician will determine the appropriate receiving facility.
- The transferring physician will receive confirmation of acceptance of the patient from the receiving facility and the receiving physician.
- It is the transferring physician’s responsibility to indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.
- EMS agencies providing inter-facility transports may only function to their level of licensure as defined by the DOT curriculum and Department regulations unless otherwise stated in this policy.
- For an inter-facility emergency or non-emergency medical transport of a patient who requires medical care beyond the scope of care which the EMS personnel are authorized to render pursuant to the Illinois EMS Act, a qualified physician, nurse, perfusionist, or respiratory therapist familiar with the scope of care needed must accompany the patient and the transferring hospital and physician shall assume medical responsibility for that portion of the medical care.
- Prior to the transfer, EMS providers shall obtain written orders from the transferring physician regarding any fluid therapy/medications and/or equipment being transferred with the patient.
Both ALS and BLS providers are required to act within their scope of practice defined by system policies, procedures, and regional standard operating procedures with the exception of the following:

- Patients with saline locks established prior to being transferred between facilities may be transported by basic life support ambulance personnel. The saline lock must be inspected prior to acceptance of the patient by BLS providers to ensure it is secure and without signs of infiltration. The BLS provider must ensure that any access to the saline lock port is disconnected by the RN prior to accepting the patient for transfer. AT NO TIME WILL THE BLS PROVIDER TRANSPORT A PATIENT WHO IS RECEIVING AN INFUSION OF ANY KIND. Should the saline lock become dislodged during transfer, the EMT-Basic will treat with direct pressure and sterile dressings.

**CROSS REFERENCE(S)**

*EHEMSS Policies:*

New 06/94
Revised 01/01, 10/09, 09/10; 05/12
Reviewed 04/10, 01/2017
Section 4

Patient Information, Documentation, and Communication
Communications Guidelines

PURPOSE
To define the equipment and use of out-of-hospital medical control practices.

APPLICABILITY
All EHEMSS providers and participants

POLICY STATEMENT(S)
Consistent with IDPH EMS Act Rules and Regulations, there shall be pre-hospital-to-hospital communication from the scene and/or in transit on calls involving the establishment of a provider-patient relationship.

Section 515.410 of the Rules and Regulations states:

(b) “EMS telecommunications equipment shall be configured to allow the EMS MD or designee to monitor all vehicle-to-hospital and hospital-to-vehicle transmissions within the system.”
(e) “Telecommunications equipment necessary to fulfill the requirements of this part shall be staffed and maintained 24 hours every day.”
(f) “EMS System personnel shall be capable of properly operating their respective communication equipment.”
(g) “All telecommunication equipment shall be maintained to minimize breakdowns. Procedures shall be established to provide immediate action to be taken by operating personnel to ensure rapid restoration in case breakdowns do occur.”

EHEMSS will use cellular phones as the primary means of communication; back up will be MERCI radio frequency 155.340 and/or 155.800.

EHEMSS ambulance providers transporting within Region 8 shall contact the receiving hospital directly as Medical Control. When the desired destination is not the closest, a request for bypass must be made prior to departing the scene. The request for bypass report must include the ETA to the closest facility and reason for requesting transport to the desired facility.

Per Region 8 SMO’s, calls designated as time sensitive shall be communicated to Medical Control at the initial point of contact, as soon as a clinical impression has been formed from assessment findings and be accompanied with patient identifiers – both name and date of birth when possible -
using **EMS System approved mobile device** that allows for use of e-bridge application.

EHEMSS ambulance providers requesting transport to any facility outside of Region 8 or when using a system specific SMO, Edward Hospital must be contacted as Medical Control and Edward Hospital will relay the report to the receiving facility.

Edward Hospital may receive communications from non-region 8 providers. Edward Hospital cannot provide medical direction to non-region 8 provider for ALS procedures. Non-region 8 providers must be directed to contact their medical control when the ECRN or MD believes any alteration in ALS care is needed.

**DEFINITION(S)**

N/A

**PROCEDURE**

1) Cellular Phone Calls to EHEMSS Base Station:

   A. Contact via cellular phone will be established with Edward Hospital in all cases where pre-hospital personnel anticipates, from the findings of the history and physical assessment, that a person requires Basic Life Support, Advanced Life Support; documentation of refusal of care or transport as per policy; or to confirm a Triple Zero.

   B. Conversations are recorded and are to be saved a minimum of 90 days subsequent to the call. This time may be extended at the Resource Hospital’s discretion.

   C. Cellular transmissions that are continuously dropped should be redirected to a MERCI frequency.

   D. Simultaneous calls can be handled with the two (2) phone lines that are monitored, answered, and recorded for the provision of medical oversight. All ALS transmissions are to include only necessary information to minimize the length of the call; however, both parties must communicate information needed for safe, continuous care of the patient.
2) VHF Radio/MERCI (Medical Emergency Radio Communication of Illinois):

   A. This is to be used for communication during Mass Casualty Incidents or when a disaster is declared by IDPH.
   B. Can be used as a backup when cellular transmission is continuously dropped.

3) Contingency Notification:

   A. A radio dispatcher should notify a receiving hospital of the imminent arrival of a patient only if all other modes of communication have failed.
   B. The receiving hospital should always receive advance notification of any patient being transported to their facility.

4) Documenting the Communication:

   A. All EMS calls will be documented by the ECRN/ED physician on a system-approved, log at the hospital providing medical oversight.

Field Re-Contact:
In the event the hospital needs to re-contact the field provider following termination of the initial report, hospital personnel may utilize MERCI or refer to the phone numbers below:

Bolingbrook Fire Department 630.226.8671
Darien-Woodridge Fire District 630.260.7512
Edward Ambulance Service 630-646-3000
Lisle-Woodridge Fire Protection District 630.260.7512
Monarch Landing 630-548-0400
Naperville Fire Department 630.420.6733
Romeoville Fire Department 815-886-2141
Warrenville Fire Protection District 630.260.7512

CROSS REFERENCE(S)  Illinois EMS Act Rules and Regulations, Title 77, Chapter 1, Part 515.410

New 06/95
Revised: 02/01, 10/09; 10/12, 02/2015, 09/2017, 03/15/2018, 10/2019
Reviewed 04/10, 2/2016
Confidentiality and Release of Patient Information

PURPOSE
Patients have the right to expect that all aspects of their care will be treated with the strictest interpretation of confidentiality.

APPLICABILITY
All EHEMSS providers and participants

POLICY STATEMENT(S)
Consistent with HIPAA guidelines, all protected health information will only be disclosed under circumstances as described in the Act.

All necessary information relevant to the patient’s care must be disclosed to those providing care; for business purposes; for quality assurance activities and when reporting is required under other statutes.

DEFINITION(S)
HIPAA: Health Insurance Portability and Accountability Act

PROCEDURE
1. All vehicle service providers will name a HIPAA Compliance Officer and notify the EHEMSS EMS MD of the name of that individual as a part of their commitment papers.

2. Patient records will be securely maintained and handled in a manner to assure that unauthorized individuals do not have access to the information.

3. Information about the evaluation and treatment of the patient can be revealed to other health care providers who are involved in the care of the patient.

4. Radio communication will provide information about the patient in a professional and discrete manner.

5. Patient records and information can be released under the following circumstances:

   A. Upon written request by any competent patient; parents or guardian of a minor; the administrator or executor of the estate of a deceased person; other legally appointed representative. The identity and authorization of the individual making the request must be verified by the provider.

   B. Upon written authorization from the patient or signatories above, information can be released to the patient’s attorney; spouse or other relatives specifically named; the patient’s insurance company.
C. A properly executed subpoena following review of the subpoena by the provider’s legal counsel.

D. Without the patient’s approval for purposes of compliance with reporting of certain injuries such as gunshot wounds, animal bites, communicable disease reporting, and reporting of abuse and circumstances in which EMS personnel are mandated reporters.

6. Media requests to review run reports are specifically exempted from the Freedom of Information Act.

7. Guidance about releasing information to police or other law enforcement agents should be obtained from the provider’s legal counsel or risk manager. This guidance should be written and able to be readily referenced when needed.

**CROSS REFERENCE(S)**

*Freedom of Information Act, Section 207 (b) (I)*
*Reporting of Child Abuse Policy*
*Reporting of Elder Abuse Policy*

New 06/94
Revised 1/01, 10/09
Reviewed 04/10; 10/12, 01/2017
ECRN Physician Consultation

PURPOSE
To clarify situations that ECRNs either can or must request an Emergency Department Physician become involved through consultation or taking primary responsibility for the call.

APPLICABILITY
All EHEMSS Pre-hospital Care Providers
All ECRNs and Emergency Department Physicians

DEFINITION(S)
N/A

PROCEDURE
1. The ECRN must request direct consultation with or transfer primary responsibility for radio/phone pre-hospital communications to an Emergency Department Physician under the following circumstances:

2. Situations that appear to require deviations from the SOPs

3. Patient care or scene management situation involving complex or sensitive medical/legal issues and/or interpretation of system policies. Examples may include but are not limited to:
   A. Competent patient who, against medical advice, is refusing care or transport
   B. Crime scene response involving conflict with law enforcement personnel
   C. Patients requesting transport to other than the nearest hospital; requires physician certification of risk/benefit
   D. Situations where the patient’s condition indicates withdrawal of resuscitative efforts in the field
   E. Presentation of a questionable DNR order
   F. Intervening physician on scene giving questionable instructions or providing care contrary to SOPs
   G. Any situation requiring ambulance diversion resulting from limitation of hospital resources when there is concern as to whether diversion is in the best interest of the patient
   H. Helicopter transport requests from the scene
   I. When the EMT requests consultation with the physician
   J. When unattended minors are refusing care/transport

4. The ECRN may request direct consultation with or transfer primary responsibility for the radio/phone pre-hospital communications to an Emergency Department Physician in any situation in which the ECRN feels the involvement would be
beneficial.

5. It is the responsibility of the EMS Medical Director or his designee to assure that there is immediate emergency physician response with on-line medical oversight whenever the ECRN requests consultation.

6. When the ECRN has requested physician consultation, the name and number of the physician providing the consultation must be documented on the Medical Oversight Log sheet.

**CROSS REFERENCE(S)**

- Title 77 Emergency Medical Services and Highway Safety Part 515.330 l) 5) D)
- EHEMSS policies:
  - Hospital Limitation and Bypass
  - Patient Transport/Selection of Receiving Hospital
  - Right of Refusal/Involuntary Transport and/or Treatment
  - Physician on Scene
  - Law Enforcement on Scene
  - Do Not Resuscitate Guidelines
  - Minor Refusals
  - Minors: Treatment Consent for Minors

New 06/94
Revised 01/01, 10/09
Reviewed 04/10; 10/12, 02/17
TITLE  
Falsification of Records

PURPOSE  
To clarify the EHEMS System’s expectation that all participants will be compliant with the EMS Act and that all information will be accurate.

APPLICABILITY  
All EHEMSS Participants

POLICY STATEMENT(S)  
No person shall knowingly enter any false information on any application form, run sheet, record, or other document required to be completed or submitted pursuant to this Act or any rule adopted pursuant to this Act, or knowingly submit any application form, run sheet, record or other document which contains false information.

DEFINITION(S)  
A patient record is defined as anything written or in electronic format.

PROCEDURE  
1. Only accurate and correct information, as known by the individual or provider, will be on any document listed above.

2. If inaccuracies are believed to have occurred, the EMS Medical Director, Manager or designee will discuss the situation with the provider EMS Coordinator.

3. False information can be, but is not limited to, the following:

   A. Any false information about a patient or run such as recording inaccurate vitals; procedures that are reported but not done; providing false information to medical control.
   B. Falsely reporting continuing education hours.
   C. Falsifying any application for license or renewal, system entry, or any EHEMSS course.

4. If after investigation, it is determined that the individual involved knowingly falsified a document, he/she will be subject to the disciplinary process of EHEMSS.

5. Any person who violates this is guilty of a Class C misdemeanor.

CROSS REFERENCE(S)  
210 ILCS 50 EMS Act; Sections 3.170 and 3.175
EHEMSS Policy: Provider/EMT Suspension

New 10/09
Reviewed 04/10
Revised 10/12, 02/17
TITLE  MERCI Radio Checks

PURPOSE  The MERCI radio is the back up communication system for EHEMSS participants. We must assure that the MERCI radio system is operational, and we need to continually reinforce the radio operation process to comply with IDPH Threat Level preparation requirements.

APPLICABILITY  All Edward Hospital EMS System participants.

POLICY  MERCI radios from transport and non-transport vehicles will be checked on a regular basis. Contact will be recorded by the Resource and Associate Hospital Emergency Departments. During these checks, the quality of the signal for both the provider and the hospital will be evaluated.

DEFINITION(S)  MERCI radio: the VHF radio system implemented by IDPH to provide communication from pre-hospital personnel to hospitals and from hospital to hospital.

IDPH Threat Level preparation requirements: Posted on the IDPH HHAN, these are activities expected of EMS systems at each Homeland Security Threat Level.

PROCEDURE  1. MERCI radio checks will be initiated from the assigned department/vehicles on at least a weekly basis.

2. Checks will be conducted no sooner than 0700 but will be as close to that time as possible.

3. The transmission will be evaluated for the ability to receive and the quality of the signal reception.

4. Items to be checked:
   A. Name of department/unit number
   B. Time of check
   C. Reception quality: Good or Poor
   D. Transmission quality: Good or Poor
   E. Comments: any corrective action taken

5. The EMS department will maintain a recording of these checks.

6. Any problems identified will be communicated to the EHEMSS office staff, Associate Hospital EMS Coordinator and the provider EMS Coordinator.
TITLE

Pre-Hospital Documentation

PURPOSE

To promote continuity of care, the EMT must provide thorough and accurate patient assessment and treatment information for use by receiving facilities, Edward Hospital EMS System, provider agency, and billing agencies.

APPLICABILITY

All EHEMSS providers

POLICY STATEMENT(S)

Consistent with the EMS and Trauma Center Code, a run report must be completed and left at the hospital for each patient transported. In addition, a run report will be completed for transfers and refusal.

DEFINITION(S)

Run report: As defined in Administrative Code Title 77 EMS and Trauma Center Code, Section 515.330 and Section 515.350, the run report will be developed or approved by the EMS Medical Director.

Approved abbreviations: See the Appendix for this document.

Unsafe abbreviations: See the Appendix for this list

PROCEDURE

1) All report forms will contain demographic information as available: patient’s full name, address, age, date of birth and gender.

2) All report forms will also contain all data elements required in the EMS and Trauma Center Code, Section 515.350 Appendix E: Minimum Prescribed Data Elements.

3) All report forms must be completed and signed by the EMT completing the report. The report must also list the names of all personnel involved in the care of the patient; all of those individuals have the right to review what is documented.

4) Other copies will be distributed as: one copy will be left for the patient’s medical record (faxed) and one will be left for the EMS system (electronically).

5) In circumstances where the patient is not transported to Edward Hospital, a copy of the run report must be forwarded to the Resource Hospital within one month or when requested.

6) Any verbal/radio/telephone orders received from
medical control must be documented on the run report. Note the time as well as which hospital provided medical control.

7) Drugs administered/wasted will be documented.

8) Run reports, when hand written, must be written legibly in black ink. Note: do not use gel pens.

9) Abbreviations must be compliant with the Approved and Unsafe Abbreviations included in the Appendix.

10) Under no circumstances will erasures or white-outs be made. Errors can be corrected by crossing through the error with one line and dating and initialing the error.

11) Vital signs will be documented in compliance with EMS Region 8 SOPs as a minimum.

12) Documentation of all treatment therapies and responses must be documented in detail.

13) Cardiac monitoring:

   A. All cardiac monitoring strips must be identified with at least the patient’s age and gender; paramedic’s interpretation of the rhythm; and the date and time of the recording. At the receiving hospital, the strip, original or a copy, must be mounted on the correct paper and accompany the patient care report.

   B. 12 lead strips sent from the field must have the name of the provider agency and the patient’s accurate age and gender and accompany the run report.

14) Run report documentation will be audited regularly by the EMS Medical Director and the EHEMSS staff.

CROSS REFERENCE(S)

Illinois Administrative Code Title 77, Emergency Medical Services and Trauma Center Code, Part 515.350 Appendix: Abbreviation List

New 01/01
Revised 10/09; 10/12; 02/2015
Reviewed 04/10, 01/2017
Section 5

Infection Control
Infection Control Guidelines

PURPOSE
To minimize opportunities for blood/body fluid contact and reduce the risk of infection transmission to EMS personnel, patients, and others.

APPLICABILITY
All EHEMSS Participants

POLICY STATEMENT(S)
The potential for exposure to infectious disease exists whenever patient care is initiated. Therefore, barrier precautions shall be observed whenever exposure to blood or body fluids is anticipated.

PROCEDURE
General guidelines to follow include:

1) Hands shall always be washed before and after contact with patients. Hands must be washed even when gloves have been worn. If hands come in contact with blood, body fluids, or human tissue, they must be washed with soap and water as soon as practical to do so.

2) Gloves shall be worn when contact with blood, body fluid, tissue, or contaminated surfaces are anticipated. Gloves soiled with blood, secretions, or excretions must be changed before initiating a clean procedure (such as an IV or wound care) on the same patient.

3) Gowns to protect clothing shall be worn when there is likelihood that soiling from blood or body fluids may occur.

4) Masks/protective goggles shall be worn when performing care such as IV insertion, wound care, suctioning, or endotracheal intubation. These tasks may cause splashes, spatters, or droplets of infection materials and pose a hazard of contamination to the eyes, nose, and mouth.

5) Disposable face masks are to be worn when caring for patients with suspected communicable respiratory diseases, and when possible, a mask should be applied to the patient as a further precaution unless contraindicated. In addition, if the provider rendering care has signs or symptoms of a respiratory illness, they are to wear a mask when caring for a patient. Special care is to be taken in donning an OSHA approved HEPA respirator for all suspected TB patients.
6) Ventilation devices will be used during all airway/ventilation procedures. Under no circumstances should mouth-to-mouth resuscitation be performed when such devices are available.

7) Sharp objects shall be handled with extreme care as to prevent accidental cuts or punctures. Used needles shall not be bent, broken or reinserted into their original sheath (recapping) or unnecessarily handled. Used needles will be discarded immediately after use into an impervious needle disposal container which will be readily available in all ambulances as well as the point of care when not in the ambulance. Filled boxes are to be left at the hospital emergency department for disposal. Never pass used needles from one person to another and do not stick needles into mattresses or other objects as a convenience.

8) Blood spills shall be promptly decontaminated with a designated disinfectant solution. Contaminated linen and linen from known or potentially infectious patients shall be removed from the ambulance and placed in properly labeled bags/containers at the receiving hospital. Ambulances shall be disinfected with a designated disinfectant solution after known or potentially infectious patients have been transported.

9) Disposable materials contaminated with blood or body fluids or other potentially infectious material shall be placed in red or other biohazard designated bags/containers for disposal.

10) Linens contaminated with potentially infectious materials will be double-bagged and placed with other soiled linen for processing.

11) All equipment and ambulance surfaces will be cleaned with soap and water followed by disinfecting with a CDC approved disinfectant as per the manufacturer’s recommendations.

12) Adherence to the infection control guidelines is the responsibility of each System participant. Departments and their designees shall monitor employee compliance and take corrective action as indicated.

New 06/94
Revised 01/01
Reviewed 10/09, 04/10; 10/12, 02/17
Section 6

Equipment, Medications, and Supplies
Drug and Supply Replacement: Soon-to-Expire, Outdated, or Damaged

**PURPOSE**
To assure that adequate supplies of safe drugs and solutions are available on each and every ambulance run.

**APPLICABILITY**
Edward Hospital EMS System Participants

**POLICY STATEMENT(S)**
EMS personnel will be responsible for daily checking of their supply of drugs, solutions and supplies to ensure the following:

- There are sufficient numbers of each in accordance with the most recent system Drug and Supply List
- That packaging is intact
- That they are well within their expiration date.

Replacement of these drugs/supplies will be done safely.

*Note:* No outdated supplies or drugs are to be replaced from the Pyxis; it is for replacing items used on patients.

All supplies that are not charged to the patient must be requested from Pharmacy using the EHEMSS Drug Exchange form.

**DEFINITION(S)**
Expiration dates are the month, day (or the end of the month if no day is indicated) and year printed on the package.

**PROCEDURE**
1. Drugs, solutions, or supplies that are damaged, tampered with, or have broken seals will be removed immediately from the EMS vehicle and brought to Edward Hospital or an Associate Hospital for exchange. Those that are due to expire may be replaced up until the day of expiration. *Due to critical drug shortages, it is recommended the drug is replaced just prior to expiration date to increase chance of its use. Attempt to give early notification to EMS department when multiple drugs are due to expire at the same time to facilitate easier replacement.*

2. Drugs/solutions and equipment that are outdated must be replaced through the Pharmacy or central supply.

3. A Drug Exchange form must be completed by the medic and taken to the Pharmacy. No supplies will be issued without it. See Appendix.

4. The Drug Exchange form assures that the correct drug/concentration/packaging will be replaced. If that is not possible,
the reason will be indicated. In all cases, the Pharmacy personnel handling the replacement and the EMS Provider will sign the form.

5. The Drug Exchange form will be left with the Pharmacy. Pharmacy will forward completed forms to the EHEMSS office.

6. Before placing the replacements in the vehicle, the medic must check for the correct type and size of equipment, proper drug concentration, and current dates.

7. When exchanging or replacing drugs at an associate hospital, follow their procedure.

CROSS REFERENCE (S)  Appendix: Pharmacy Drug Exchange Form

New 06/95
Revised  05/06, 01/01, 10/09, 10/12, 01/13, 02/17
Reviewed 04/10
TITLE  

Controlled Substance Management

PURPOSE  
To maintain quality control and current records of controlled substance administration.

APPLICABILITY  
Edward Hospital EMS System Participants

POLICY STATEMENT(S)  
- EHEMSS will handle controlled substances in a manner that complies with Edward Hospital Pharmacy and Drug Enforcement Agency requirements.
- EHEMSS will assure that controlled substances are always consistently and carefully accounted for through daily inventories of all drug boxes.
- When replacing administered controlled substances, the replacement will reflect the amount administered and the amount wasted on the Controlled Substance Inventory and Administration Record.
- The Controlled Substance Inventory and Administration Record will be completed with all the required information.

DEFINITION(S)  
Controlled substances (and items that will be treated as such for monitoring purposes) in the EHEMSS include those currently referenced by the Region 8 Medical Directors.

PROCEDURE  
1) All controlled substances shall be secured in the ambulance and daily inventories will be performed by the off-going and on-coming crew members as part of the vehicle/equipment check.

2) All controlled substances will be wasted with witness present, in the hospital setting with the provider and preferably a nurse at the receiving facility.

3) Vehicles not in service must be inventoried daily by the agency.

4) Completed inventory records are to be forwarded to the EMS Manager or designee no later than the 15th day of the following month.

5) Failure to follow appropriate documentation procedures on the part of the medic or nurse replacing the substance is a serious matter. Initial violations of the policy will result in notification of the participant through the agency’s EMS Coordinator or the ED
management. *Second violations* will necessitate a conference with the EMS MD or designee. *Subsequent violations* will result in disciplinary action in accordance with the Provider/EMT Suspension from EHEMSS Participation policy.

6) In the event that a controlled substance is missing or appears to have been tampered with, the following will occur:

A. The medic will immediately bring the situation to the attention of their Provider EMS Coordinator or designee.
B. The EMS Manager or designee will be contacted immediately to report the situation and facilitate proper replacement of the medication involved.
C. The EMS Medical Director and EMS Manager will be informed of the results of the agency investigation.

7) Controlled Substance Inventory Administration Records will be reviewed by the EMS CQI Coordinator and retained for two years.

8) Review of compliance with management of controlled substances will be part of the EHEMSS CQI plan.

**CROSS REFERENCE(S)**

*Appendix: EMS Drug Exchange Sheet*
*Appendix: Controlled Substance Inventory Administration Record*
*EHEMSS Policy: Provider/EMT Suspension from EHEMSS Participation*

New: 06/94
Revised 01/01, 11/04, 10/09, 04/10, 10/12, 11/15
Reviewed: 02/17
### Title
Body and Equipment Disposition After Withdrawal of Resuscitative Effort

### Purpose
To establish guidelines for management of invasive equipment and the body after withdrawal of resuscitation.

### Applicability
Edward Hospital EMS System Participants

### Policy Statement(s)
When resuscitative efforts are terminated in the field, invasive equipment and the body must be handled in accordance with the county coroner policies.

### Definition(s)
Invasive equipment includes items such as, but not limited to, endotracheal tubes and IV catheters, pleural decompression needles, and cricothyrotomy equipment.

### Procedure
1. Resuscitation in the field can be terminated if consistent with EMS Region 8 Standard Operating Procedures.

2. All invasive equipment must be left in place.

3. IV lines will be turned off and the BVM can be disconnected from the ET tube.

4. The Coroner of the county in which the pronouncement is made must be notified.

5. If the Coroner gives permission, the invasive equipment can be removed by pre-hospital personnel. This should be documented and include the name of the person giving such permission.

6. Following pronouncement, the body cannot be moved unless the Coroner gives permission. Document the name of the person giving such permission.

7. Equipment and drugs used are replaced in the usual method. See Pyxis policy.

New 02/98
Revised 01/01
Reviewed 10/09, 04/10; 10/12, 02/17
Approval of Additional Drugs, Equipment, or Protocols

Define the processes for introduction of drugs, equipment and/or procedures that are not a part of the current National Standard Curriculum (NSC). Assure compliance with Administrative Code Title 77, Subchapter f, Part 515 Emergency Medical Services and Trauma Center Code, Section 515.360

All EHEMSS Participants.

• All drugs and equipment intended for patient use must be approved by the EHEMSS EMS Medical Director and IDPH’s Division of EMS prior to being used in any capacity in the EMS system.

• Drugs and equipment for consideration must be introduced through the EHEMSS Coordinators Committee. Drugs and equipment must be safe for use in the pre-hospital setting, provide a significant benefit and be cost effective.

PROCEDURE

1. Anyone wishing to introduce new drugs, equipment or protocols must submit a request to have the Coordinators Committee consider it. This request should be made in writing to the EMS Medical Director.

2. If the Coordinator Committee and EMS Medical Director want to pursue the process a proposal to the Division of EMS & HS will be developed that documents the following:

   A. A description of the training program including the number of contact hours, any practical component and a description of individuals to be trained.

   B. A curriculum which includes at least the following (as applicable):
      - Indications and Usage
      - Complications
      - Adverse Reactions
      - Equipment Maintenance and Use

   C. Copy of new treatment protocol

   D. Tool for evaluation

   E. Time frame for evaluation

3. The Coordinator Committee will consider financial aspects of suggested change

   A. Cost to purchase
B. Charge to patient
C. Replacement process

4. Upon approval by IDPH, the EHEMSS will CQI the product, reporting back to the Coordinators Committee on a quarterly basis (January 1, April 1, July 1 and October 1) the following information:

A. Indications for use
B. Number of times used
C. Number and types of complications that have occurred
D. Outcome of the patient after each use
E. Description of follow-up actions taken by the system on each case where a complication has occurred

5. In the event of a death or complication that results in a deterioration of a patient’s condition involving the item under study, the EMT involved in the case will immediately, regardless of the time of day, contact the Department EMS Coordinator or designee who will contact the EHEMSS Manager. The EHEMSS office will notify IDPH within three (3) business days. A written follow up report will be submitted within ten (10) working days.

6. The EHEMSS Medical Director will not approve any EHEMSS participant to use the new drug, equipment or protocol unless the individual has completed the approved educational program, examination and demonstrated the required competency.

7. EHEMSS reserves the right to remove the drug, equipment or the use of any protocol from any participant not in full compliance with all of the requirements of the project as approved by IDPH.

8. IDPH can withdraw its approval at any time that EHEMSS is not in compliance with the requirements of Section 515.360.

9. IDPH can withdraw its approval at any time that the drug, equipment or protocol if any information submitted indicates that the safety in the pre-hospital setting is in question.

CROSS REFERENCE(S)

Illinois EMS Act rules and Regulations: Title 77, Chapter 1, Part 515.360

New 07/06
Reviewed 10/09, 04/10; 10/12
Revised: 02/17
TITLE

Equipment Lists for Ambulances, ALS Non-Transport, and Special Event Vehicles

PURPOSE

To define the Edward Hospital EMS System required equipment for vehicles providing ALS care.

APPLICABILITY

Edward Hospital EMS System Participants

POLICY STATEMENT(S)

Edward Hospital EMS System participants will carry sufficient equipment, drugs and supplies to carry out the standard operating procedures approved by EMS Region 8 and EHEMSS.

DEFINITION(S)

Equipment is defined by the equipment lists in the EMS/Trauma Center Rules and those items required by EHEMSS for the appropriate level of care: BLS, ALS, CCT, and Special Event Vehicles

PROCEDURE

1. All vehicles must meet the basic level of IDPH requirements for level of service.

2. ALS Supply and Equipment Lists will be developed by the EHEMSS Coordinator.

3. These lists will be used by the provider agencies to assure their vehicles are adequately supplied.

4. Ambulance inspections by the EHEMSS staff will be based on these lists as well as the official IDPH inspection paperwork for both ambulance and non-transport vehicles.

5. EHEMSS lists will be reviewed and revised through the Coordinator Committee with Medical Director approval as needed when items are added, removed, or regulatory changes occur, at least annually. All revised lists will be dated.

CROSS REFERENCE(S)

Illinois EMS Act Rules and Regulations: Title 77, Chapter 1, Part 515.330
EMS Region 8 Standard Operating Procedures (Current) Appendix: Equipment Lists

New 01/05
Revised 10/09; 10/12, 02/17
Reviewed 04/10
Non-Disposable Equipment Return

To assure the return of pre-hospital non-disposable equipment to the correct provider in good condition

Edward Hospital EMS System Participants

Edward Hospital ED will return non-disposable equipment left with patients to the correct provider in good condition.

Non-disposable equipment includes backboards, straps, air splints, etc.

1. When a piece of non-disposable equipment is left in the Emergency Department, a Non-Disposable Equipment Receipt should be generated by the paramedic leaving the equipment. These forms are located in the paramedic room.

2. The ED Charge Nurse must sign the form.

3. The EMS provider shall keep the original form and make a copy for the ED Charge Nurse who will forward it to the EHEMSS office.

4. Equipment will be cleaned and returned to the appropriate department locker in the designated locker in the ambulance bay.

5. The provider EMS Coordinator will be notified by the EHEMSS office via email when the equipment is ready to be picked up.

6. If the equipment is not picked up within three (3) days of notification, the hospital will no longer be responsible for the item.

7. If equipment is lost or damaged (e.g., straps cut), the hospital will review the matter for appropriate replacement or reimbursement for the item to the department.
Edward Hospital agrees to accept responsibility for the safekeeping of:

<table>
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<tr>
<th>QUANTITY</th>
<th>TYPE OF SUPPLIES OR EQUIPMENT</th>
<th>STATE OF REPAIR</th>
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If the equipment is lost or damaged, the hospital will review the matter for appropriate replacement or reimbursement for the item to the provider department / service.

Date left: ________________________________________      Time:  ___________________________
Name of patient: _________________________________      Run number: ________________________
Provider dept. / service: ___________________________      Vehicle Number: ______________________
Phone number of provider: __________________________      ED phone number: (630) 527- 3358
Signature of EMT: ____________________________________________
Signature of ED Charge Nurse: ____________________________________________

**RETURN:** All equipment must be picked up by the provider within 3 days of notification.

Person notified via email for pick up: ____________________________________________
Date notified: _______________________________ Time notified: _______________________________
Person making notification: ____________________________________________
Date returned to provider: ____________________________________________
Signature of receiving person: ____________________________________________

* Copy of form must be forwarded to the EMS Office by ED Charge Nurse
TITLE  
Latex Sensitive Pre-Hospital Patient

PURPOSE  
To minimize the risk of reaction in a patient with a known/suspected latex sensitivity/allergy

APPLICABILITY  
All Edward Hospital Emergency Medical Services System Participants

POLICY STATEMENT(S)  
Patients with known/suspected sensitivity to latex and those at high risk will be treated by utilizing environmental controls to prevent latex reactions.

Most medical supplies are now latex free; however, the EMT is responsible for confirming that before using supplies on a patient.

DEFINITION(S)  
N/A

PROCEDURE  
1. Initiating Latex Sensitive Precautions:
   A. Must be done for patients identified in the pre-hospital setting as having sensitivity to latex or latex-containing products.
   B. The EMT communicating with Medical Control must notify the hospital of the latex sensitivity.
   C. Latex sensitivity will be documented on the patient care report.

2. General Care:
   A. Ensure that NO LATEX comes in contact with the patient’s skin. (Kerlix or soft roll may be used between the patient’s skin and the latex-containing equipment, i.e. blood pressure cuff or tourniquet, if no other alternative is available.)
   B. Use only latex-free, powder-free gloves.
   C. Tympanic thermometers can be used.
   D. Oximeters may be used.

3. IV Medication Administration Issues
   A. Use latex-free tourniquets when available. If one is not available, then cover the exposed skin with a soft roll or Kerlix before applying the tourniquet.
   B. Latex-free IV catheters are to be used when starting IV fluids or saline locks.
   C. Use latex-free tape to secure any IV lines. Tegaderm dressings are latex-free.
D. Use latex-free tubing.

4. Medication Vials

A. When drawing up medications, it is not necessary to remove the rubber stopper from the vial.
B. Single- or multi-dose vials should only be punctured once and then discarded unless using the multi-dose vial adapter.
C. Stock plastic syringes are latex-free and may be used for injections and drawing medications; however, medications must be drawn up immediately before administration.

*When restocking supplies, it is the responsibility of the crew to ensure that all restocked supplies are latex-free.*

CROSS REFERENCE(S)  N/A

New 04/07
Revised 04/10
Reviewed 10/09; 10/12, 02/17
Out of Service Vehicles

PURPOSE
To assure notification of Illinois Department of Public Health and EHEMSS that replacement vehicles are being used.

APPLICABILITY
Edward Hospital Emergency Medical Services System Providers

POLICY STATEMENT(S)
EHEMSS needs to be notified any time a front line vehicle, transport or non-transport, is out of service in the following circumstance:

1. Routine maintenance greater than 24 hours.
2. Due to vehicle crash and/or out of service for greater than 10 days.
3. Any situation which alters the primary, secondary, or outlying response times that are depicted in the current commitment papers in the EMS System Plan.

PROCEDURE
1. If a front line vehicle will be out of service for any of the above reasons, the EHEMSS office will be notified via email or voicemail by the second working day.

2. If a replacement vehicle is in service for > 10 days, a system inspection is required and a System Modification form must be completed. EHEMSS will forward to IDPH.

3. When the front line vehicle is returned to service, the EHEMSS office will be notified by email or voicemail. If the vehicle was out of service for > 10 days, a system inspection is required.

CROSS REFERENCE(S)
Illinois Administrative Code Part 515.830

New 10/04
Revised 02/05, 04/10
Reviewed 10/09; 10/12, 02/17
TITLE
Pyxis Policy for Removing, Returning, and Wasting Medications and Supplies

PURPOSE
To establish guidelines for consistent use of PYXIS to access medications and maintain related records.

APPLICABILITY
Edward Hospital EMS Participants and Non-System Participants with Pyxis Access

POLICY STATEMENT(S)
Users of Pyxis must follow the guidelines established below when obtaining medications and supplies and performing related activities.

DEFINITION(S)
Pyxis® is an automated system to maintain medications and supplies as well as generate a charge for items to the patient.

PROCEDURE
To Remove a Medication

1. Log on to the Station and follow the directions located by the pyxis machine

To Return Medication or Equipment to Stock
(Only items removed from the station in error may be returned)

Follow directions attached to the pyxis machine.

To Waste a Medication

1. If the contents of a controlled substance dose is removed from its tamper-evident packaging or is drawn up and not administered, the remaining contents must be wasted at the Pyxis unit POD B and witnessed nurse or another EMT-P

2. To document a waste on the Station, the user should:
   A. Sign on and select patient name
   B. Select override meds
   C. Select medication
   D. Machine will ask if you want to administer the whole amount. If you have waste, press no. Indicate amount administered and waste amount is automatically calculated.
   E. Acquire the assistance of a nurse, or another paramedic, who will enter his/her ID and password to witness the waste
   F. Medication to be wasted should be destroyed by flushing in a sink or drain and witnessed by both persons.
3. It is not necessary to document the wasting of a non-controlled substance in writing at the Station.

CROSS REFERENCE(S)

New 01/05
Reviewed 10/09, 04/10; 10/12
Revised: 02/17
TITLE  Unannounced Inspections

PURPOSE  To determine compliance with the EHEMSS System Program Plan

APPLICABILITY  All EHEMSS participants and providers

POLICY STATEMENT(S)  The EHEMSS Medical Director or Manager will have access to all records, equipment and vehicles relating to participation in EHEMSS at any time.

DEFINITION(S)  PROCEDURE
1. The need to conduct an unannounced inspection will be determined by the EHEMSS Medical Director or Manager based on at least the following:
   
   A. Findings from a previous or scheduled inspection
   B. Findings from a Continuous Quality Improvement initiative
   C. Complaints received from the public or any system participant
   D. Concerns from IDPH
   E. At the discretion of EHEMSS administrative personnel

2. The unannounced inspection can be done at the provider’s department or in the ambulance bay. Unless there are extraordinary circumstances, any inspection conducted in the ambulance bay will be extremely focused and will not interfere with vehicle response.

3. Findings from unannounced inspections will be discussed with the provider EMS Coordinator as soon as possible to develop a corrective action plan if needed.

CROSS REFERENCE(S)  Illinois Administrative Code Title 77, Part 515 EMS and Trauma Center Code, Section 515.810, q)

New 10/09
Reviewed 04/10;
10/12 Revised: 02/17
TITLE Unstocked Reserve Vehicles

PURPOSE Define the notification process for activation and deactivation of unstocked reserve vehicles. Unstocked reserve vehicles can be put in service in order to maintain response times and patient care when primary vehicles are out of service. Use of these vehicles reduces the need to call on mutual aid allowing neighboring communities to maintain their levels of response.

APPLICABILITY All Edward Hospital EMS System Provider Agencies.

POLICY STATEMENT(S) Provider agencies can maintain unstocked reserve vehicles. Licensing of unstocked non-transports requires an approved waiver from IDPH. When activated or deactivated, the EHEMSS System must be notified. The provider agency policy will assure that all required (system and IDPH) equipment and supplies will be on the vehicle before it is put in service. EHEMSS reserves the right to inspect the vehicle after it is placed in service.

DEFINITION(S) If an ambulance is void of equipment, it will be licensed and meet all current State specifications with the exception of the patient care equipment and supplies. Non-transport vehicles will meet appropriate requirements.

PROCEDURE
1. The provider agency maintaining an unstocked reserve vehicle will have a written policy broadly stating when the vehicle will be activated.

2. The EHEMSS office will be notified via email or voicemail by the second working day of activation of the unstocked reserve vehicle.

3. EHEMSS reserves the right to inspect the vehicle after it is placed in service.

4. EHEMSS will monitor, track and trend the use of these vehicles as part of the Quality Control plan.

CROSS REFERENCE(S)
New 01/06
Revised 04/10; 10/12
Reviewed 10/09, 02/17
THE SAFE MEDICAL DEVICES ACT

PURPOSE

The Safe Medical Devices Act (U.S. Food and Drug Administration) requires that EMS providers report problems with medical devices. The EHEMS System should also make every effort to assure the safety of patients and providers. Failure to comply with these rules may expose providers to civil and criminal penalties.

APPLICABILITY

Edward Hospital EMS System Participants

POLICY

STATEMENT(S)

EMS providers in the Edward Hospital EMS System must submit a report on all adverse events involving significant problems with the use: medications, medical devices, and medical food products. Providers will submit reports to both the FDA and EHEMSS.

DEFINITION(S)

1. **Medical Product**: a medical product includes any drug, medical device/instrument used for the diagnosis, mitigation, treatment, or prevention of disease or injury.

2. **Adverse Event**: an event that relates to any experience associated with the use of a medical product that may have caused a detrimental effect on a patient’s or rescuer’s health. This includes incidents that occur due to user error. Resultant effects include:

   A. Death
   B. Life-threatening illness or injury
   C. Hospitalization – initial or prolonged
   D. Congenital anomaly
   E. Required medical or surgical intervention to prevent permanent impairment or damage.

3. **Product Problems**: concerns regarding the quality, performance, or safety of any medical product. These concerns include:

   A. Suspected contamination
   B. Questionable stability
   C. Defective components
   D. Poor packaging or labeling
   E. Device malfunction

PROCEDURE

1. Reporting Procedures – Adverse Events

   A. All adverse events and product problems must be reported to the EHEMSS Manager as soon as possible. A copy of the MedWatch form should also be forwarded to the EHEMSS office.

   1. Death due to product/device: provider must submit
a MedWatch form (FDA 3500A (10/05)) to both the manufacturer and the FDA within 10 days.

2. Serious injuries: report to either the manufacturer or FDA (MedWatch form 10/05)

B. MedWatch FDA form 3500 A (10/05) can be downloaded or completed online at http://www.fda.gov

C. In instances of product-related deaths or serious injuries, providers should:
   1. Immediately remove the product from service
   2. Take steps to preserve or document the condition of the product at the time of occurrence
   3. Notify the EHEMSS Manager
   4. The EMS Coordinator of the provider agency will conduct a thorough evaluation of the product and the incident and submit a copy of the report to the EHEMSS Manager.

2. Reporting Requirements - Product Problems

   A. Medical product problems which do not contribute to death or serious injury should be reported to the EHEMSS Manager by provider EMS Coordinators. It is important to monitor instances of product problems in order to determine if products should be recalled from service within the System

   B. This report should be made on the EHEMSS Communication Form.

   C. Providers can also make a voluntary report to the FDA using FDA form 3500A (10/05).

3. Record Keeping

   A. Providers and EHEMSS office must maintain medical device report (MDR) event files for recording information related to adverse events and product problems.

   B. Providers must retain documents in MDR event files for a minimum period of two (2) years.

   C. Reports, deliberations, and other information must be made available to FDA representatives for inspection and audit upon request.
Lending Educational Mannequins and Supplies

Purpose

Prehospital emergency medical personnel must be proficient in executing advanced skills including, but not limited to, endotracheal intubation, surgical airway maneuvers, intraosseous needle placement, and pleural decompression. These skills need to be practiced with appropriate equipment on realistic mannequins and models. The decision about which equipment/kits can be loaned will be at the discretion of the EMS administrative staff.

Applicability

All EHEMSS participants, providers and staff

Policy Statement(s)

EHEMSS will support training and practice of ALS skills by sharing mannequins and equipment to enable individuals to practice these skills.

Definition(s)

N/A

Procedure

EHEMSS providers and participants who wish to use these training aids in a setting other than the EMS Education Classroom at Edward Hospital need to do so with care and responsibility. The following steps are required:

1. Contact either the EHEMSS Manager with a request to borrow the equipment and its intended use

2. The EHEMSS Staff will check the availability of the item. In all cases, the needs of the Paramedic Education Program will have priority.

3. Only the equipment that is necessary to perform each specific skill will be loaned.

4. The requesting party must fill out a Training Equipment Loan form (Appendix) and pick up the equipment during normal EMS office business hours.

5. Equipment will be checked in and out by EHEMSS staff and a representative from the requesting agency.

6. Equipment may be on loan for no longer than two (2) calendar days, unless otherwise approved.

7. If equipment is lost or damaged, the requesting agency must
review the matter with the EHEMSS Manager to arrange for appropriate replacement or reimbursement to the EHEMSS.

CROSS REFERENCE(S)  N/A

New 07/07
Revised 10/09, 02/17
Reviewed 04/10; 10/12
Section 7

Quality
TITLE  Abuse of Controlled Substances, Other Drugs, and/or Alcohol by System Personnel

PURPOSE  To provide a safe environment for all members of the EMS system and the patients we serve, substance abuse is not tolerated. Substances such as controlled/prescription medications, certain over the counter drugs and alcohol when abused prior to or on duty can impair judgment and performance compromising safety.

APPLICABILITY  All EHEMSS personnel.

POLICY STATEMENT(S)  1. Each system member is responsible for reporting any suspected abuse whether on or off-duty of narcotics, stimulants, controlled substances, whether legal or illegal, to their superior and the EHEMSS Medical Director or Manager.

2. Reporting for duty while under the influence of alcoholic beverages, narcotics, stimulants, controlled substances or other drugs that impair judgment/performance will not be tolerated.

3. Use, sale, dispensing or possession of the defined substances while on duty on behalf of the EHEMSS is prohibited.

4. Unauthorized acquisition or possession of prescription pads from any hospital or physician is prohibited and will constitute a violation of this policy.

5. EHEMSS will follow the disciplinary process as outlined in its policy “EMT/Provider Suspension” and the IDPH Rules and Regulations for EMS and Trauma Center Code.

6. Provider agencies will be responsible for initiation of their disciplinary processes at their discretion.

DEFINITION(S)  Substances are defined as, but are not limited to, alcoholic beverages, narcotics, stimulants, controlled substances, legal, illegal, and over the counter drugs.

PROCEDURE  1. EHEMSS participants or providers will report known or suspected abuse of defined substances in writing to the Fire Chief/CEO and the EHEMSS Medical Director/Manager.

2. Providers are to report known abuses or infractions of this policy whether the infraction occurs on or off-duty to the EHEMSS Medical Director or Manager immediately.
3. If ED or EHEMSS staff believe that any EMT’s behavior suggests that judgment or performance is compromised for any reason or is in violation of this policy, the EHEMSS Medical Director/Manager are to be notified immediately.

4. The EHEMSS Medical Director/Manager reserves the right to immediately suspend from any further functions any EMT who is or appears to be in violation of this policy. The EMT’s employer will be notified immediately if the staff has the information to do so.

5. With the exception of information required by a Local System Review Board, all information will be handled in strictest confidentiality.

CROSS REFERENCE(S)

Illinois EMS Act Rules and Regulations: Title 77, Chapter 1, Part 515.330 l) 10) and 515.430

EHEMSS Policy “EMT/Provider Suspension”

New 06/94
Revised 01/01, 02/17
Reviewed 10/06, 10/09, 04/10, 10/12
**TITLE**

Medication and Procedure Errors

**PURPOSE**

To establish a review, follow-up, and re-education process for medication or procedural errors made by EHEMSS personnel.

**APPLICABILITY**

Edward Hospital EMS System Participants

**POLICY STATEMENT(S)**

It is understood that the practice of emergent medical care in the field is challenging. It is also understood that procedures completed in the field are done in less than ideal locations and circumstances. In the process of paramedic education and continuing education, these skills and medical knowledge are taught and reviewed. When potentially serious or life-threatening medication or procedural errors occur, there must be a process for review, re-education and, if necessary, corrective action.

**DEFINITION(S)**

**PROCEDURE**

1. When a patient is brought to the Emergency Department and identified to have a medication or procedural error, the Emergency Department health care worker will notify the EHEMSS Medical Director Manager within 24 hours.

2. The case will then be discussed with the respective department coordinators and finally, the medic or medics involved in the case.

3. A final recommendation shall be at the discretion of the EHEMSS Medical Director in consultation with the EHEMSS Manager.

**CROSS REFERENCE(S)**

*Safe Medical Devices Act*

New 06/94
Revised 01/01, 02/17
Reviewed 10/09, 04/10, 10/12
TITLE Provider/EMT Suspension from EHEMSS Participation

PURPOSE
- To define grounds for suspension from EHEMSS participation for a provider or EMT by the EHEMSS Medical Director.
- To define the process to request a Local System Review Board hearing and a State Disciplinary Review Board to challenge the EHEMSS Medical Director’s decision to suspend the provider or individual.
- To clarify that the Illinois Department of Public Health will make a final decision whether the suspension will remain in effect throughout the investigation and/or review board or if the suspension is stayed (put on hold) pending a review board hearing.

APPLICABILITY Edward Hospital EMS System Providers and Participants

POLICY STATEMENT(S) An EMS Medical Director may suspend from participation within the System any individual, individual provider or other participant considered not to be meeting the requirements of the Program Plan of that approved EMS System. (Section 3.40(a) of the Act)

DEFINITION(S) Immediate Suspension: Begins as soon as the EMS Medical Director verbally notifies the individual.

Local System Review Board: A standing Board consisting of at least three individuals, one of whom must be an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual. The membership of this Board is posted in the Edward Hospital EMS room in the ED where it is available 24 hours a day for viewing.

State Disciplinary Review Board: A standing Board of individuals appointed by the Governor to review requests of decisions by the Local System Review Board and/or EMS Medical Director.

Director or Director’s Designee: the Director of the Illinois Department of Public Health or his/her designee (Section 3.5 of the Act).

Department: Illinois Department of Public Health, Division of Emergency Medical Services and Highway Safety

Suspension may be based on one or more of the following:

1. Failure to meet continuing education and relicensure requirements as stated in the Policy Manual
2. Violation of the EMS Act, or IDPH Rules and Regulations
3. Failure to maintain proficiency in the provision of basic and/or advanced life support skills
4. Failure to comply with the provisions of the Edward Hospital EMS System Plan approved by the Department
5. EMT misuse of any drugs, intoxicating liquors, narcotics, controlled substance, or stimulants in such a manner that would adversely affect the patient
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, ability to pay, or illness/disease
11. Medical misconduct or incompetence or a pattern of continued or repeated medical misconduct or incompetence in the provision of care
12. Violation of the EHEMSS standards of care
13. Physical impairment of an EMT to the extent that he or she cannot exercise the appropriate judgment, skill, and safety for performing the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part.
14. This list is not all inclusive. Each situation will be reviewed and the final decision is at the discretion of the EMS Medical Director.

PROCEDURE

1. The EMS Medical Director will explain to the provider EMS Coordinator and EMT, who is being suspended, the process they may use if they wish to request a hearing board. The suspended individual/provider will be given all policies concerning the process.

2. The EMS Medical Director may immediately suspend an individual, individual provider, or other participant if he finds that the information in his possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS Medical Director which states the length, terms, and basis for the suspension. The EHEMSS office will also immediately notify the Provider EMS Coordinator of the agency where the suspended provider works.
A. The EHEMSS will notify IDPH of the suspension order.

B. Within 24 hours following the commencement of the suspension, the suspended EMT or provider may deliver to the Illinois Department of Public Health by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMT or provider feels relate to that response.

C. Within 24 hours following receipt of the EMS Medical Director’s suspension order, or the EMT or provider’s written response, whichever is later, the Director or Director’s designee shall determine whether the suspension order should be stayed pending the EMT’s or provider’s opportunity for hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The Director or Director’s designee shall issue this determination to the EMS Medical Director, who shall immediately notify the provider EMS Coordinator and suspended EMT. The suspension shall remain in effect during this period of review by the Director or the Director’s designee.

3. An individual or provider with an immediate suspension may bypass the local System Review Board and request a State EMS Disciplinary Review Board.

**Requesting a Local System Review Board:**
The process for suspensions which are not defined as “immediate” (Section 515.420). (The process for Immediate Suspension begins with #3 of this section.)

1. The provider or individual will receive the written suspension order, which will be sent by certified mail or hand delivered. The written order will include an explanation of the reason, terms, length, and condition of the suspension and the commencement date unless a hearing is requested.

2. The provider or individual may accept the terms of the suspension or challenge it by requesting a hearing.

3. To request a hearing, the provider or individual must notify the EMS Medical Director of the request within 15 days of receipt of written notice of the suspension by certified mail or personal delivery.

4. The EMS Medical Director will schedule a Review Board within 21 days of receiving the written request from the suspended individual(s).
5. The individual or provider will be notified by certified or personal delivery of the date, time, and place of the hearing.

6. Either the individual or provider or the EMS Medical Director may appeal the decision of the Local System Review Board.

7. Requests for a hearing before the State Disciplinary Review Board must be submitted to the Chief of the Department’s Division of EMS and Highway Safety within 10 days of receiving the local review board decision or the EMS Medical Director’s suspension order. A copy of the Board’s decision or suspension order must be included.

8. An individual or provider receiving an immediate suspension may bypass the Local Review Board and request a hearing from the State Review Board.

CROSS REFERENCE(S)  
Title 77: Public Health Part 515.430 Emergency Medical Services and Trauma Center Code
Health Facilities (210 ILCS 50/) Emergency Medical Service (EMS) Systems Act

New 06/94
Revised 01/01
Reviewed 10/09, 04/10, 10/12, 02/17
TITLE  
EHEMSS Communication Form

PURPOSE  
- To serve as a review tool to improve the quality of patient care and the functioning of the EMS system.
- To bring outstanding performance to the attention of the EHEMSS Medical Director, EHEMSS staff, and EMS Providers.
- To facilitate expedient resolution to issues raised within the System and provide feedback to all involved participants.
- To facilitate communication between EHEMSS participants.

APPLICABILITY  
Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S)  
Pre-hospital providers or hospital personnel shall initiate an EHEMSS Communication Form when any of the following occur: (Note: this is not considered a complete list of situations that may necessitate the need to complete this form).

1. When the actions of the EMT(s) or hospital personnel have been exceptional.

2. When unusual circumstances are verbalized or documented on the ambulance report form, telemetry radio log sheet, or medical oversight recordings.

3. There is an apparent discrepancy in EMT judgment and hospital ordered treatment, which may or may not constitute a deviation from Standing Operating Procedures.

4. EMT(s) does not carry out hospital orders.

5. There is interference at the scene, which hampered the EMT(s) in the performance of their duties.

6. There is a patient or provider injury sustained at the scene during the course of treatment or during transport relating to use of medical equipment including but not limited to incidents qualifying under the safe medical device act.

7. There is a question or problem relating to errors in medication administration.

8. There is a question or problem relating to the performance of any skill or care provided to a patient that did or did not result in harm to the patient.
9. Any other action or event that seems out of the ordinary and that the personnel involved feel should be reported.

DEFINITION(S)

PROCEDURE

1. Notification is made to the EHEMSS Medical Director or Manager that there is a situation that necessitates or potentially will necessitate the completion of an EHEMSS Communication form.

2. The EMS System participant(s) contact Edward Hospital EMS System office to log the EHEMSS Communication Form.

3. The following situations require immediate notification to the EHEMSS Medical Director and Manager for investigation/resolution:

   A. When care rendered by a pre-hospital provider may have resulted in or contributed to a poor patient outcome.
   B. Any incidents alleging the pre-hospital provider to be impaired by drugs or alcohol.
   C. Any EHEMSS Communication Form involving out of System providers and/or hospitals.

* All information obtained in a EHEMSS Communication Form shall be maintained as confidential by all involved participants and investigators.

** Be it further understood that all information contained herein shall be “Privileged and confidential under the Illinois Medical Studies Act”.

CROSS REFERENCE(S)

Appendix

New 01/01
Revised 10/09, 10/12, 02/17
Reviewed 04/10
TITLE Vehicle Staffing

PURPOSE To define minimum staffing patterns for each type of EHEMSS provider vehicle.

APPLICABILITY EHEMSS Providers

POLICY STATEMENT(S) All vehicles operating at any time in the EHEMSS will be staffed by appropriate numbers of EHEMSS approved personnel to provide safe patient care.

DEFINITION(S)

PROCEDURE

1) All 911 service providers front line transport ambulances providing advanced life support care will be staffed with a minimum of two (2) EHEMSS approved, IDPH licensed paramedics, unless otherwise approved by the EMS Manager and the EMS Medical Director.

2) New providers have one year to bring staffing levels to meet system requirements. During that time they may staff their front line ALS transport ambulances with one paramedic and one EMT-B.

3) Private providers within the EHEMSS must staff their ALS vehicles with at least one EMT-P and one EMT-B at a minimum, provided the paramedic has at least one year of paramedic experience. Critical care rigs must be staffed with one EMT-P and one critical care EMT-P at a minimum. The critical care paramedic must be certified as a critical care paramedic and have at least 4 years of paramedic experience. The paramedic on the critical care rig must have at least 2 years of paramedic experience. Individuals who are critical care certified, but lack the years of experience as a medic, may operate on the CCT ambulance as lead only at the discretion of the medical director.

4) At least one licensed paramedic must be in the patient compartment at all times for a patient receiving ALS care.
5) At least one licensed EMT-B or paramedic must be in the patient compartment at all times for a patient receiving BLS care.

6) All ALS engines and ALS non-transport vehicles will be staffed with at least one licensed paramedic.

7) Special event vehicles will be staffed with at least one paramedic unless otherwise approved by the EMS Manager and the EMS Medical Director.

8) Reserve ambulances will follow normal system staffing unless otherwise approved by the EMS Manager and the EMS Medical Director.

CROSS REFERENCE(S)

New 07/07
Revised 10/09, 04/10, 10/12, 05/15
Reviewed: 02/17
TITLE  
EMS Quality Improvement Program (QIP)

PURPOSE  
The purpose of the EMS Quality Improvement Program (QIP) is to ascertain the effectiveness and appropriateness of pre-hospital patient care that is delivered by pre-hospital personnel. The effectiveness of this pre-hospital care delivery system will be measured through systematic and continuous monitoring: identification of problems or opportunities to improve care, implementation of corrective actions, evaluation for attainment of sustained resolution and documented patient outcomes. Edward Hospital EMS System QI initiatives shall include participation in regional, system-wide, and provider specific initiatives.

APPLICABILITY  
Edward Hospital EMS System Providers and Participants

POLICY STATEMENT(S)  
This program will help to develop an effective tool to assess quality pre-hospital care through routine and systematic monitoring, problem identification, and resolution, and evaluation of care delivered in the pre-hospital setting.

This program will quantify and determine if patient care delivered in the pre-hospital setting is done at optimally achievable levels according to the EHEMS System’s standards of care and practice, as well as Illinois Department of Public Health (IDPH) Rules and Regulations.

The EHEMSS wants to assure that the professional competency of pre-hospital personnel, Emergency Care Physicians, and ECRN’s is routinely and reliably evaluated.

Our goal is to provide an effective system for the documentation and dissemination of quality improvement findings to the appropriate committees, EMS Medical Director, Project Director, EMS Coordinators, Fire Chiefs, and pre-hospital care providers.

DEFINITION(S)

PROCEDURE  
1) Authority

The EMS Medical Director has the authority and responsibility for demonstrating to consumers, regulatory bodies, accrediting bodies, and the administrative staff at the resource hospital that the quality and appropriateness of pre-hospital care
within the Edward Hospital EMS System is consistently acceptable.

2) Responsibility

The EMS Medical Director, Manager of EMS, Trauma Coordinator, Coordinator of EMS Education and Quality, and the EMS Provider Coordinators are responsible for supervising the Quality Improvement activities and the overall program operations. These include ensuring that:

A. All quality-related activities in the EMS System are coordinated and functioning properly and in accordance with the QIP needed improvement occurs and problems are resolved within an acceptable time frame.
B. The program is evaluated and updated as needed.
C. Mechanisms by which the Quality Improvement Data is used in the recertification process of paramedics and ECRN’s within the EHEMSS are developed and implemented.
D. Specific Responsibilities:

1. EMS Medical Director

- Oversees the delivery of pre-hospital care.
- Assures that field personnel have immediately available expert medical direction for emergency care.
- Assures continuing high-quality field care.
- Provides the means for monitoring the quality of field performance.
- Assures that the QIP is operational.
- Assures that the QIP meets Joint Commission of Accreditation of Healthcare Organization (JCAHO) Standards.
- Assures that the QIP is reviewed and revised on a yearly basis.

2. Manager of EMS

- Accepts the delegated authority from the EMS Medical Director to implement the QIP for the Edward Hospital EMS System.
• Communicates quality improvement results to the EMS Medical Director, EMS Provider Coordinators, Fire Chiefs, and System Emergency Care Physicians, ECRN’s, and pre-hospital providers.
• Evaluates Quality Improvement data and formulates follow-up plans.
• Reviews and revises the QIP yearly.

3. Coordinator of EMS Education and Quality

• Assists the Manager of EMS and the Trauma Coordinator with the implementation of quality improvement activities in the ED and pre-hospital setting within the scope of EMS.
• Assists in choosing areas for evaluation.
• Participates in the development and structuring of quality improvement monitors and data retrieval instructions.
• Collects quality improvement data as instructed by the EMS System.
• Assists the EMS System in choosing areas for evaluation.
• Assists the EMS System in the development and structuring of quality improvement monitors and data retrieval instructions.

4. Coordinator of Paramedic Education

• Provides overall planning, direction, coordination, supervision, and some instruction of the paramedic program
• Assures compliance with IDPH requirements for the course content
• Assure program meets NREMT licensure requirements
• Maintains and revises policies relevant to applications, selection of students, and the education program.
• Coordinates with various clinical departments for practical experience for students and with fire departments for field internships.
5. System Responsibilities

- To monitor time of ambulance response to requests for emergency medical treatment.
- To assure compliance to regional standard operating procedures as well as system-specific protocols/policies, by field personnel (EMT-Bs, EMT-Ps) and base station personnel (Emergency Care Physicians and ECRN’s).
- To evaluate and train EMT’s, nurses, and physicians involved with the EMS System to intervene appropriately in emergency situations via direct patient care as well as medical oversight.
- To authorize paramedics and ECRN’s to work in the Edward Hospital EMS System within the rules and regulations established by IDPH and local system guidelines.
- To assure the use of appropriate medical interventions for patients accessing the System for Emergency Medical Services.
- To implement EMS System policy and SOP changes when appropriate.
- To provide paramedic education in classroom and appropriate clinical settings at least once a year in compliance with IDPH Rules and Regulations.
- To provide paramedic continuing education through lectures, seminars, and clinical experience.
- To assure on-going monitoring of documentation of the pre-hospital and ECRN reports.
- To provide relicensure for EMT-B, EMT-P and ECRN levels, in compliance with IDPH Rules and Regulations.
- To assist system providers in developing internal quality improvement initiatives.
- Review and evaluation of unusual occurrence reports, complaints, initiation of EHEMSS communication forms, and/or malpractice claims.
- On an annual basis, focused studies may be
conducted using a System-acceptable format.

3) Providers

The Edward Hospital EMSS administers pre-hospital care by the following providers:

A. Naperville Fire Department  
B. Lisle-Woodridge Fire Protection District  
C. Bolingbrook Fire Department  
D. Warrenville Fire Protection District  
E. Edward Ambulance Service  
F. Romeoville Fire Department  
G. Monarch Landing

These providers offer 24-hour emergency ALS/BLS care. Each community also has an extensive Mutual Aid Agreement with its surrounding communities. Emergency care can be accessed through respective community 911 Systems.

4) Organization

The role of the EMS Quality Improvement Committee is to assist the EMS Medical Director and EMSS Coordinators with the implementation of the Quality Improvement Program. The EMS Quality Improvement Committee will meet to review quality improvement activities and report its findings.

EMS Quality Improvement Committee will consist of:

A. EMS Medical Director or his/her designee.  
B. Manager of EMS  
C. Trauma Coordinator  
D. Coordinator of EMS Education and Quality  
D. One (1) paramedic per provider from each system provider.  
E. One (1) ECRN  
F. EMS Provider Coordinators for each system provider.
5) Evaluation

Plans for linking pre-hospital emergency patient reports with hospital’s-related records (and transfer records) will permit tracking of case outcomes while preserving the privacy of the patient. If needed, cases will be reviewed by the EMSS Quality Improvement Committee. If as a result of their evaluation, a problem or opportunity for improvement is identified, appropriate action (s) will be taken.

6) Communication

The EMS QI Committee will work collaboratively with the ED and Trauma Committees. It is then the responsibility of the individual EMS Provider Coordinators to report back to the system pre-hospital providers the results of Quality Improvement activities.

7) Quality Improvement Confidentiality

The EMS staff and the Quality Improvement Committee are responsible for maintaining the confidentiality of all quality improvement information. Quality Improvement reports may be reviewed by:

A. The individual or department that submitted the inquiry.
B. The EMS Quality Improvement Committee
C. The EMS Staff
D. Governing bodies (i.e., hospital Quality Improvement Committees).

The Quality Improvement Program of Edward Hospital EMS System is part of Edward Hospital Quality Improvement process and is, therefore, protected from discovery under the Medical Studies Act.

8) Patient Care Standard for EMS

A. Each patient can expect individualized goal-directed emergency care in the pre-hospital care setting based on knowledge, assessment, and
evaluation.
B. Each patient can expect courteous and compassionate care that maintains dignity and assures confidentiality.
C. Each patient can expect a safe, clean environment.
D. Each patient can expect timely and competent pre-hospital care, administered in compliance with System policy and procedures and IDPH Rules and Regulations.

9) Standard of Practice

A. ECRN run sheet review
B. Paramedic process monitoring (assessment, treatment, and evaluation according to SOPs)
C. Follow-up on patient complaints
D. Follow-up on staff complaints
E. Complimentary letters to EMS personnel
F. Problem report review and follow-up
G. Ambulance inspections
H. Written EMS System policies and procedures and IDPH Rules and Regulations.

CROSS REFERENCE(S)

New 06/94
Revised 01/01, 10/12, 11/15
Reviewed 10/09, 04/10, 02/17
Section 8

Scene Issues
EDWARD EMERGENCY MEDICAL SERVICES SYSTEM

TITLE: CONCEALED WEAPONS

PURPOSE:
To provide the members of the Edward Hospital Emergency Medical Services System (EHEMSS) with a plan that manages encounters with concealed weapons while providing care for patients.

APPLICABILITY: All EHEMSS participants

POLICY STATEMENTS:
1. EHEMSS agencies are encouraged to designate themselves as a weapons-free zone or a “Prohibited area” (430ILCS 66/65). Illinois State Police No-carry signage should be clearly posted in emergency vehicles (attachment A). Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles that have declared themselves as prohibited areas.
2. It is recommended that emergency healthcare workers partner with their local law enforcement agencies in obtaining education regarding basic firearm safety.
3. Under no circumstances shall any EMS provider have a weapon on their person while delivering care to patients in the Edward EMS System.
4. When a weapon is encountered on a call, the patient care report shall include documentation that a weapon was located, what type of weapon it was i.e. handgun, where it was located, what the disposition was, and any actions or comments made to or by the patient.

PROCEDURE:
The following are procedures for handling patients with a concealed weapon(s) and to help create a safe environment for EHEMSS responders and patients.
Assume all weapons are loaded and never attempt to unload a firearm or engage its safety. Handling of a concealed weapon should be done by local law enforcement agencies when possible.

A. Conscious/Alert Patients
1. Patients that have the legal and mental capacity to consent/refuse treatment or transport should be asked if they are carrying a concealed weapon.
2. If patient has a weapon, and is physically able, ask them to lock up their own weapon at home, secure it in the trunk of their motor vehicle, transfer to a family member licensed to carry a weapon, or secure it in the lockbox and complete the Chain-of Custody Form (Attachment B).
3. If it is not possible to leave the weapon behind, have the local law enforcement agency respond, if not already on scene and take custody of weapon.
4. Patients and family shall be told that the EMS vehicles are prohibited areas for weapons as are the hospitals.
5. If it is not possible for local law enforcement agency to respond and take custody of the weapon, then the weapon will be secured in a lockbox. The lockbox will be sealed and a Chain-of Custody Form will be started. Inform receiving hospital during radio report that you have a secured weapon that will need to be handed over upon arrival to hospital and ask that security be present upon arrival. The lockbox will be secured during transport in the ambulance and then handed over to hospital security or Law Enforcement Agency upon arrival. EMS personnel will complete the Chain-of-Custody Form.

6. If the patient is unwilling to relinquish or secure their weapon, EMS personnel should continue treatment while explaining reasons why they wish to secure weapon and have local law enforcement agency respond, if not already on scene. Medical control should be contacted and inform them of situation.

7. If EMS personnel feel that the scene is unsafe/becomes unsafe, personnel should move to a safe location. Notify local law enforcement agency, and wait for the scene to be secured until returning to the scene.

B. Unconscious/Altered Mental Status Patients

1. Patients who present as unconscious or with altered mental status should be approached with extreme caution.

2. If the patient is unconscious and a weapon is discovered during an initial physical assessment, have law enforcement agency if on scene remove the weapon. If local law enforcement agency is not on scene and unable to respond, EMS personnel should use extreme caution when removing the weapon.

3. If the weapon is found in a holster, the weapon shall remain in the holster while it is secured in a lockbox. If you cannot remove the holster, cut away any restraining belts or cloths and secure the holstered weapon in a lockbox.

4. If it is not possible for police to respond and take custody of the weapon, then the weapon will be secured in a lockbox. The lockbox will be sealed and a Chain-of Custody form will be started. Inform receiving hospital during radio report that you have a secured weapon that will need to be handed over upon arrival to hospital, ask that security be present upon arrival. The lockbox will be secured during transport in the ambulance and then handed over to hospital security/law enforcement agency upon arrival. EMS personnel will complete the Chain-of-Custody form.

5. If EMS personnel feel that the scene is unsafe/becomes unsafe, personnel should move to a safe location. Notify local law enforcement agency, and wait for the scene to be secured until returning to the scene.

C. Passengers with a Concealed Weapon

1. If the EHEMSS provider agency allows passengers to ride along in the ambulance, such as family or friend of patient, then the potential passenger needs to be asked if they are carrying a concealed weapon. If the passenger is not willing to secure or relinquish their weapon, they will not be permitted to ride in the ambulance.
TITLE  Law Enforcement Interaction/Crime Scene Responsibilities

PURPOSE  To delineate the inter-related roles and responsibilities of Law Enforcement Officers and EMS Providers in the EHEMSS, when caring for the ill, injured, and/or deceased.

APPLICABILITY  Edward Hospital EMS Participants

PROCEDURE  1. EMS personnel responsibilities include, but are not limited to:

   A. Rapid evaluation of scene safety
   B. Request law enforcement presence at the scene in all cases where a crime, suicide, attempted suicide, accidental death or suspicious fatality has occurred
   C. Initiate assessment and treatment per SOP as soon as scene safety has been secured. Expeditious treatment and transport of a patient in critical condition should not be delayed pending police arrival unless the safety of EMS personnel would be placed in jeopardy.
   D. If access to the patient is denied, immediately notify Edward Hospital medical control.
   E. Preserve integrity of evidence on the patient and at the scene. EMS personnel should adhere to the advice and direction of law enforcement on the scene in all matters relevant to evidence collection unless doing so directly compromises patient care. Do nothing that would contaminate the patient or scene.
   F. EMS personnel shall do nothing that would breach law enforcement responsibility for arrestee security by demanding unreasonable security changes, such as the unnecessary removal of handcuffs or shackles.
   G. If EMS personnel suspect foul play, and the patient meets the criteria for Triple Zero, they should confirm pulselessness and asystole without moving the body or any of its parts. Law enforcement and coroner to be notified.
   H. EMS provider shall adhere to departmental HIPAA policies regarding release of medical information.

2. EMS personnel responsibilities regarding incarcerated patients:

   A. When requested, EMS personnel shall assess prisoners to determine whether medical intervention is indicated and convey their recommendation to the arresting law enforcement officer or other officer with custody
   B. EMS personnel will treat arrestees with respect and in a humane manner.
C. Patients who have been restrained using electro-muscular disruption (i.e. Taser ®) should be evaluated, if possible, for injuries.

3. Law Enforcement duties may include, but are not limited to:

A. Control the scene/bystanders, traffic, protection of people at the scene
B. Provide assistance to EMS personnel during patient restraint situations
C. Preserve evidence.
D. Maintain the morgue at declared disaster sites.
E. Serve as the ultimate legal authority at the scene.

4. Procedure to follow in cases of conflict between police and EMS personnel:

A. Although the State EMS Act states that the “authority for patient management in a medical emergency shall be vested in the EMS Medical Director or his designee” (Ill. Rev. Stat. ch 111.5, sub-section 5518), in circumstances where law enforcement/ambulance personnel come into conflict, legal counsel advises that the law enforcement officer has the ultimate authority at the scene.

B. If EMS personnel anticipate that a foreseeable harm or patient deterioration is likely to occur, and are ordered by a law enforcement officer not to proceed with appropriate care, they should make all reasonable attempts to verbally convey their concerns to the officer. Thoroughly document all communications with the officer to include name and badge number on the patient care report.

C. Medical control shall be contacted at the inception of the conflict, or as soon thereafter as possible to allow for direct communication between medical control and the law enforcement officer to facilitate problem resolution. Their conversation must be thoroughly documented on the telemetry radio log.

CROSS REFERENCE(S)

New 06/94
Revised 01/01, 10/09
Reviewed 04/10, 10/12, 02/17
TITLE Requesting Physician to the Scene

PURPOSE To define the process for requesting that a physician come to a scene and to clarify the responsibilities of the physician and pre-hospital staff.

APPLICABILITY All EHEMSS and EH ED Staff

POLICY STATEMENT(S) Circumstances requiring a physician at an incident scene are very limited. When needed, however, the Incident Commander or Officer can make such a request.

DEFINITION(S)

PROCEDURE 1. The individual making the request will identify himself/herself to the hospital. Preferably, this individual will be the Incident Commander or designee.

2. The reason/situation for the request should be explained to Medical Control.

3. The ECRN must call the ED physician to the radio for consultation.

4. The ED physician will determine if and what type of physician is needed and discuss the situation with that physician.

5. The ECRN will notify the provider of the name of the physician who will be responding and clarify whether transportation will be provided by the Naperville Fire Department, Police Department, Edward Hospital or an aeromedical service. If transportation to the scene via Naperville agencies, the ECRN will contact Naperville PSAP at 911.

6. Upon arrival at the scene, the physician will report to the Incident Commander or Officer.

7. The situation will be discussed with the Incident Commander/Officer and paramedic to formulate a plan of action.

8. The physician’s sole responsibilities are personal safety and patient treatment.

9. The EMS agency is in charge of the total scene.
TITLE

On Scene Physician/EMT-P Responsibility

PURPOSE

To define the process to be used when an on-scene physician wishes to assist in or take over patient care.

APPLICABILITY

Edward Hospital EMS Participants

POLICY STATEMENT(S)

Control of a medical emergency scene should be the responsibility of the individual who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport. When an Advanced Life Support vehicle, under medical direction from an EMS System physician, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction. EMS personnel are responsible for management of the patient, and act as the agents of medical direction unless the patient’s personal physician is present (ACEP, 1984)

DEFINITION(S)

PROCEDURE

IF a professed, duly-licensed, medical professional (physician, RN, EMT) wishes to assist in patient care on-scene, providers may allow such persons to perform specific required medical functions to aid the patient; i.e., start an IV, perform CPR, intubate, etc. under their direct supervision after appropriate verification of licensure. Providers shall communicate with Edward Hospital medical control and inform the on-duty physician or ECRN of the assistance of the on-scene medical professional.

1. **ON-SCENE PHYSICIAN** - not the patient’s personal physician, does not automatically supersede the authority of the EMS personnel. System protocol and standing orders provide the legal basis for pre-hospital function. The following guidelines apply.

   A. If the on-scene physician has displayed his or her medical license, is not the patient’s personal physician, and wishes to direct total patient care, he/she must agree in advance to assume legal responsibility for the patient and must accompany the patient to the hospital in the ambulance. This transfer of legal responsibility must be approved by Medical Control.

   B. The on-scene physician must sign the ambulance refusal report form to the effect that he/she will assume total patient responsibility.
C. Even under these circumstances, if such physician gives orders while on scene or enroute for procedures or treatments that the paramedic believes to be unreasonable, medically inaccurate, and/or not within the scope of practice of EMS personnel, they should refuse to follow such orders. Communicate with medical control and transfer responsibility for the patient’s care to the Edward Hospital emergency physician.

D. If an on-scene physician obstructs efforts of EMS personnel or insists on rendering patient care which EMS personnel believe is inappropriate for the circumstances or in violation of System standards to the point of obstructing good and reasonable patient care, pre-hospital personnel should:

1. Contact law enforcement to assure scene safety
2. Communicate the situation to Edward Hospital medical control
3. Document the behavior of the on-scene physician on the patient care report

2. PERSONAL PHYSICIANS: The following guidelines apply:

A. EMS personnel should comply with all medical orders issued by the personal physician as long as they are reasonable, medically accurate, and within their scope of practice.

B. If the personal physician gives orders that providers believe to be unreasonable, medically inaccurate, and/or not within their scope of practice, they should not comply with the order.

C. Move the patient to the ambulance. Maintain scene safety and do not argue with the personal physician.

E. Contact medical control and explain the situation.

F. Any treatment rendered per the personal physician or changes in the condition of the patient must be documented on the patient care report.

CROSS REFERENCE(S)

New 06/94
Revised 01/01, 10/09, 04/10
Reviewed 10/12, 02/17
Section 9

Rescue Task Force (RTF)
**EHEMSS Approved Supplemental RTF / TEMS Equipment**

**Note:** This equipment is to be carried by EHEMSS TEMS providers who successfully meet the requirements as set forth in the EHEMSS Policy “Establishment of Tactical Emergency Medical Support (TEMS)”. Items on this list may be approved on an individual basis with the consent of the medical director only. This list is subject to change.

**Commercial Tourniquets**
- CAT
- SOFT-T
- SWAT-T

**Commercial Chest Seals**
- HALO
- SAM
- Bolin
- Hyfin

**Bandages**
- Israeli Emergency Bandage
- Olaes Bandage
- TacMed Blast Bandage

**Hemostatic Gauze**
- Combat Gauze
- Chito Gauze
- Celox Gauze
EHEMSS Position Statement: Rescue Task Force Training

Rescue Task Force

Rescue Task Force (RTF)\(^1\) initial and ongoing training for all EMS providers should include Tactical Emergency Casualty Care (TECC) concepts and practical skills applications.

Tactical Emergency Casualty Care

The TECC guidelines are the civilian counterpart to the US military's Tactical Combat Casualty Care (TCCC) guidelines. The TECC guidelines take into account the specific needs of civilian EMS providers serving civilian populations. The TCCC guidelines were developed for military personnel who deploy in support of combat operations. These guidelines have proven extraordinarily successful, and provide the foundations for TECC.

The specifics of casualty care in the tactical setting will depend on the tactical situation, the injuries sustained by the casualty, the knowledge and skills of the first responder, and the medical equipment at hand. TECC focuses primarily on the intrinsic tactical variables of penetrating trauma compounded by prolonged evacuation times. The principle mandate of TECC is the critical execution of the right interventions at the right time.

Indirect Threat Care is rendered once the casualty is no longer under fire (i.e. warm zone). Medical equipment is limited to that carried into the field by RTF personnel typically including tourniquets, large trauma dressings, and basic adjunct airways.

\(^1\) See Establishment of Rescue Task Force (RTF) response Policy
Establishment of Rescue Task Force (RTF) response

The purpose of this procedure is to outline the Fire Department’s role in active shooter incidents or similar mass casualty type of incident. The primary focus is to provide medical treatment as soon as possible in a less-than-safe (Tactical) environment while reducing risk to responders.

All EHEMSS participants and providers.

Paramedics and EMTs assigned to a law enforcement security detail to provide patient care in the warm zone of tactical situations. The purpose of a rescue task force (RTF) response is to provide patients located in the warm zone with immediate access to medical care, despite hazardous conditions that might otherwise delay treatment. EHEMSS paramedics and EMTs operating as members of a bona fide RTF unit are responsible for providing care under the current clinical standards, as defined in the Region VIII Standard Operating Procedures and EHEMSS TECC guidelines.

Refer to “Tactical Incident Response Definitions / Hierarchy”

Agency Requirements

1) Provider agencies must train to the level of Rescue Task Force (RTF) with their local responding law enforcement agencies in accordance with the EHEMSS TECC guidelines.

2) Provider agencies must complete documented ongoing, annual training with their local responding law enforcement agencies.

3) All equipment outside current standards and/or scope must be approved by IDPH and the system medical director prior to field utilization. EHEMSS may, but will not be responsible for purchasing, maintaining or replacing any specialty equipment related to a provider RTF program. A current list of approved medical equipment is located in the appendix.

4) Provider agencies will be responsible for quality assurance and training in relation to a RTF program.
5) EHEMSS will be responsible for quality assurance in relation to care provided and patient care reports generated within the EHEMSS as they relate to RTF response.

6) EHEMSS will be responsible for review and revision of current policies and protocols relating to RTF programs to ensure they are within the standard of the most current, relevant and recognized evidence based medicine, standards, and practices.

7) Current EHEMSS revised, IDPH approved, C-TECC guidelines are located in the appendix.

RESPONSE GUIDELINES
See “RESPONSE GUIDELINES” located in the appendix

New 02/2017
Message from the U.S. Fire Administrator
September 2013

This paper was developed as a fire and Emergency Medical Services (EMS) resource that can be used to support planning and preparation for active shooter and mass casualty incidents (AS/MCIs). These complex and demanding incidents may be well beyond the traditional training and experience of the majority of firefighters and emergency medical technicians. The U.S. Fire Administration (USFA) offers this report as one source of many available for the public safety community, but it takes into consideration the diverse local service levels available across America. In developing this paper, USFA consulted with individuals and groups engaged in fire and prehospital EMS, law enforcement, and hospital medical and trauma care. We also consulted with public safety organizations and numerous federal agencies.

If you have questions regarding this document, please contact the USFA at www.usfa.fema.gov.

Sincerely,

[Signature]

Ernest Mitchell
U.S. Fire Administrator
U.S. Fire Administration
Executive Summary

Background

More than 250 people have been killed in the United States during what has been classified as active shooter and mass casualty incidents (AS/MCIs) since the Columbine High School shootings in 1999. AS/MCIs involve one or more suspects who participate in an ongoing, random or systematic shooting spree, demonstrating the intent to harm others with the objective of mass murder.

It has become evident that these events may take place in any community impacting fire and police departments, regardless of their size or capacity. Local jurisdictions must build sufficient public safety resources to handle AS/MCI scenarios. Local fire/Emergency Medical Services (EMS) and law enforcement (LE) must have common tactics, communications capabilities and terminology to have seamless, effective operations. They should also establish standard operating procedures (SOPs) for these very volatile and dangerous situations. The goal is to plan, prepare and respond in a manner that will save the maximum number of lives possible.

Maximizing Survival

Extraordinary efforts on the part of local fire/EMS agencies and direct pre-planned coordination with LE is required during response to these events in order to rapidly affect rescue, save lives, and enable operations with mitigated risk to personnel. It is essential that local policies be put in place before AS/MCIs happen to ensure coordinated and integrated planning, preparation, response, treatment and care.

The recognition of AS/MCIs as a reality in modern American life has led to the assembly of a number of public safety organizations representing various disciplines to share and develop strategies for combating the problem. One group, convened by the American College of Surgeons and the Federal Bureau of Investigation in Hartford, Connecticut, developed a concept document for the purpose of increasing survivability in mass casualty shootings. The paper, The Hartford Consensus, describes methods to minimize loss of life in these incidents.

The Hartford Consensus identifies the importance of initial actions to control hemorrhage as a core requirement in response to AS/MCIs. Experience has shown that the number one cause of preventable death in victims of penetrating trauma is hemorrhage. Well-documented clinical evidence supports the assertion.

The Hartford Consensus focuses on early hemorrhage control to improve survival. These very practical recommendations include the critical actions contained in the acronym THREAT:

T - Threat suppression
H - Hemorrhage control
RE - Rapid Extrication to safety
A - Assessment by medical providers
T - Transport to definitive care
The THREAT concepts are simple, basic and proven. The Hartford paper points out that life-threatening bleeding from extremity wounds are best controlled by use of tourniquets. Internal bleeding resulting from penetrating wounds to the chest and trunk are best addressed through expedited transportation to a hospital setting.

Coordinated/Integrated Planning and Response

To increase survivability of victims, fire and EMS agencies must incorporate THREAT principles as SOPs. At a minimum, SOPs should include:

- Jointly developing local protocols for responding to AS/MCIs. Fire/EMS and LE should plan and train together.
- Planning for and practicing rapid treatment and evacuation, including who, what, when, where and how it will be carried out.
- Using the National Incident Management System (NIMS) and the Incident Command System (ICS). Accordingly, fire/EMS and LE should establish a single Incident Command Post (ICP) and establish Unified Command (UC).
- Fire/EMS, LE and all public safety partners planning and training together.
- Including AS/MCIs in tabletop and field exercises to improve familiarity with joint protocols. Regularly exercise the plan.
- Using common communications terminology. In addition to NIMS and ICS terminology, fire department personnel must learn common LE terms and vice versa. Share definition of terms to be used in AS/MCIs and establish a common language.
- Incorporating tactical emergency casualty care (TECC) into planning and training. Training must include hemorrhage control techniques, including use of tourniquets, pressure dressings, and hemostatic agents. Training must also include assessment, triage and transport of victims with lethal internal hemorrhage and torso trauma to definitive trauma care.
- Providing appropriate protective gear to personnel exposed to risks.
- Considering fire hazards secondary to the initial blast if improvised explosive devices (IEDs) are used.
- Considering secondary devices at main and secondary scenes.
- Determining how transportation to and communications with area hospitals/trauma centers will be accomplished.

AS/MCIs are volatile and complex. Research and history have indicated that the active risk at most incidents is over before first responders arrive on scene, or shortly thereafter, but they may also require extended operations. Extensive planning, recurrent training, and preplanned coordination are all required for optimal results. Coordinated involvement by the whole community is essential. The public, fire/EMS, law enforcement, medical transportation, and medical treatment facilities must be engaged cooperatively in order to maximize survivability and minimize deaths due to AS/MCIs.
<table>
<thead>
<tr>
<th>X</th>
<th>#</th>
<th>Responsible Party</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preincident</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Local EMA/AHJ</td>
<td>Multiple victim incident EOP completed</td>
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<tr>
<td></td>
<td></td>
<td>Incident</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>LOG</td>
<td>CP established</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>LOG</td>
<td>CP secured</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>LOG</td>
<td>U/C and communications method established and communicated to all personnel and communications center</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>U/C</td>
<td>UC/LE establishes goals and overall strategy; <strong>Emphasize Rapid Triage, Treatment and Extrication</strong></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>U/C</td>
<td>ICS established; command and general staff positions established</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>OPS</td>
<td>Establish staging manager and staging areas</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>U/C PIO</td>
<td>PIO staffed, JIS considered</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>OPS</td>
<td>Fire, medical, and/or rescue branches or groups established in operations</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>EMS</td>
<td>Establish casualty collection points, evacuation routes and LZs</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>OPS</td>
<td>Size-up and determine resource requirement</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>UC and LOG</td>
<td>Request required resources</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>U/C</td>
<td>Notify hospitals to activate MCI plans</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>OPS</td>
<td>Develop operational plan</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>PLN</td>
<td>Start IAP process</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>OPS</td>
<td>Aviation division established by air assets planned or airspace control required</td>
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<tr>
<td>17</td>
<td></td>
<td>OPS</td>
<td>Safe, hard cover staging area established (multiples for discipline or geographically)</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>LOG/ALL</td>
<td>Personnel have readily identifiable ID</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>U/C</td>
<td>Duress code provided to all responders</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>U/C</td>
<td>Plan approved by AHJ</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>OPS</td>
<td>Accountability for victims and civilians involved — established</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>EMS</td>
<td>Medical branch or group establishes rapid triage, treatment (include hemorrhage control), and transportation portals and sites</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>EMS</td>
<td>Account for persons triaged, treated and/or transported (record and track locations)</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>PLN</td>
<td>Provide for rotation and maintenance of on-scene personnel</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>LOG</td>
<td>Provide refueling, battery charging, and replenishment of expendable materials</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>PLN</td>
<td>Demobilization plan in place</td>
</tr>
<tr>
<td>27</td>
<td></td>
<td>PLN</td>
<td>After action report process established</td>
</tr>
<tr>
<td>28</td>
<td></td>
<td>PLN</td>
<td>ICS evaluation report plan in place</td>
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<td></td>
<td>PLN</td>
<td>Debriefing personnel planned</td>
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<td>30</td>
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<td>LOG</td>
<td>Critical stress debrief action planned</td>
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<td>31</td>
<td></td>
<td>PLN</td>
<td>Personnel released</td>
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<td>Post-incident</td>
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<tr>
<td>32</td>
<td></td>
<td>PLN</td>
<td>After action report prepared</td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>PLN</td>
<td>After action report completed</td>
</tr>
<tr>
<td>34</td>
<td></td>
<td>U/C</td>
<td>After action report submitted to AHJ</td>
</tr>
<tr>
<td>35</td>
<td></td>
<td>PLN</td>
<td>Improvement plan established</td>
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<td>36</td>
<td></td>
<td>PLN</td>
<td>Plan updates processed</td>
</tr>
<tr>
<td>37</td>
<td></td>
<td>AHJ</td>
<td>Plan updates promulgated</td>
</tr>
<tr>
<td>38</td>
<td></td>
<td>AHJ</td>
<td>Training and exercises based on plan updates</td>
</tr>
</tbody>
</table>
Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents

**Background:** Active Shooter and Mass Casualty Incidents (AS/MCIs) require extraordinary efforts on the part of the local fire/rescue and EMS agencies. Although these attacks usually end within a few minutes from the time they begin, the incident and response actions may play out over an extended period of time. Also, they may include a “direct threat” or “hot zone” with an ongoing active shooter(s); multiple casualties requiring extensive triage, treatment and transportation efforts; and large numbers of response personnel, bystanders and spontaneous volunteers.

Research from prior AS/MCIs has shown that casualties sustaining only minor injuries in most cases will self-evacuate and may seek care from responding fire, EMS and LE assets on the periphery of the event. This creates a diversion and causes a delay in medical response to the area with people who are significantly wounded. Conversely, minor injured patients may directly self-transport to nearby local hospitals, thus arriving and creating emergency department crowding before the transportation of the more severely injured. If not prepared, this “reverse triage effect,” where the least injured enter the medical system first, can greatly impede response operations both on-scene and in the receiving hospitals. These incidents also require media engagement, demand organizing and managing large amounts of logistics, and require coordination among several disparate agencies, often from differing levels of government.

While the environment and circumstances will differ from incident to incident, there are an overarching series of actions that seem common to most, and awareness and planning will better position public safety agencies to effectively deploy when faced with an AS/MCI. The resultant monograph is intended to serve as a generic guideline in assisting fire/rescue and EMS agencies in preparing for and responding to AS/MCIs. While this document is intended to be comprehensive in scope, each agency will have to determine which parts of the information have value to their circumstances and those that will require additional development for local agency use. It is the intent of the USFA that this be a viable and dynamic document. As agencies engage in this work, we look forward to receiving comments, additional ideas, and suggestions for improvements in future editions.

**Active Shooter and Mass Casualty Incidents (AS/MCI):** This is a general term intended to cover active shooter incidents involving one or more subjects who participate in a random or systematic shooting spree, demonstrating their intent to continuously harm others. Since the purpose of this document is not focused on the LE operations, we will use AS/MCIs as the incident descriptor. AS/MCIs range from extensively planned terror-related events to unplanned, revenge-motivated or random events.
Successful command and control of AS/MCIs are based on multiple levels of planning and coordination including intra-agency among the fire/EMS response assets; interagency among all of the public safety and private sector responder agencies; externally with the facility personnel who provide expertise regarding facilities and technical matters; and regionally with the hospitals and receiving medical facilities. Using ICS provides a framework for managing the incident and should be utilized by the responders and incident infrastructure operators. Effective planning requires mutual goals, critical reviews, evaluation, revision and continued practice. Planning, coordination, communication and information sharing must be common if not daily practiced among all of the first responders to such an incident. Most often these agencies interact on routine calls on a daily basis providing for multiple, albeit less complex, interagency relationship building, communication and coordination. There must be a commitment to prepare and plan for such an incident before it occurs.

**General AS/MCI Operational Principles:** AS/MCIs are complex operations, and each requires the intricate coordination of people and other resources. They are extremely fast-evolving incidents. Each one is conducted real time under intense news and social media scrutiny and public interest. Several responding disciplines must work together to achieve the best possible outcome. Success in response to AS/MCIs requires prepared leadership, planning, communications, training and competent execution. Although overall operational priorities are unchanged from most routine incidents, for example, life safety, incident stabilization and property conservation, in AS/MCIs, the life safety and incident stabilization will be the nexus of the operation.

1. **ICS:** NIMS advocates the use of ICS. USFA has been a longtime supporter of the National Wildland Coordinating Group ICS. Public works, LE, military, education, and health agencies and associations have joined in supporting the use of ICS for all emergency incidents as well as special planned events. It is used by federal, state, tribal, territorial and local governments and is now embedded in most first responders’ operations. As such, this document supports ICS use. ICS should be the command and control system implemented for all AS/MCIs. The impact of well-deployed and practiced use of the ICS among providers who are likely to respond together cannot be overstated. The notion of a “unified” command must be well understood and practiced by all for successful command and control.

2. **UC:** AS/MCIs are, at their most basic level, crime scenes that have injured people in need of treatment, rescue and expedient evacuation. Each incident is a primary LE event but requires coordination between the LE on-scene lead and the fire/rescue/EMS on-scene lead. UC provides the proper vehicle for command and control of AS/MCIs; therefore, responders should establish UC and a UC Post (UCP) as soon as possible. Fire and EMS command elements should recognize that the LE on-scene lead will be actively sending LE officers into the impacted area to directly engage the threat, secure the
perimeter to ensure the perpetrator doesn’t evade, and to exclude inappropriate entry by additional perpetrators. Additionally, from almost the moment of arrival on-scene, the LE lead will be determining LE resource requirements, developing intelligence on the incidents, trying to identify the location and viability of the victim(s), and many other tasks. Thus, the fire and EMS commands should move to the LE Command Post (CP) and establish UC as planned.

Depending on local plans, there are several fire/rescue and EMS functions that can occur during the time frame that the LE lead will be making tactical decisions regarding operations prior to establishing threat zones for combined LE/EMS casualty rescue operations. These functions include establishment of fire/rescue and/or EMS branches or groups. Assist the LE on-scene lead by supporting the ICS functions that may not have been addressed yet. It is essential that UC protocols be pre-established, planned and practiced. Operational command and control of large-scale, multidiscipline/multijurisdictional responses requires practice and exercise to become effective. The selection of the Operations Section Chief (OSC) position is usually assigned to the agency having the highest priority for achieving the UCP incident action plan objectives. Hence the initial selection of a LE officer for the OSC position with assistance from fire/EMS, as the deputy OSC, in accordance with a UC system.

3. **Plan for Treatment of Casualties:** It is the perpetrator’s intended purpose to kill or injure people. Plan for casualties, when and where they will be treated, and how they will be evacuated from the point of wounding. THREAT principles (hemorrhage control, rapid extrication, assessment by medical, transport to definitive care), to improve survivability, should be an integral part of planning. Determine which agency or personnel will locate casualties, triage them, provide point of wounding medical stabilization, and/or remove them to a safe location. There should be preplanning discussions with medical directors, medical control and with the primary receiving medical centers regarding the principles of TECC. As the civilian equivalent of the military combat medical guidelines, the TECC guidelines account for the unique operational considerations and limitations of medical operations in high-risk conditions and prioritize and focus medical efforts to only what must be done to affect survival. Considerations should be made for all potential first responders, including LE patrol officers, to be trained to the basic tenets of TECC. Training, equipment and protocols around use of TECC for medical first responders should be explored, considered and implemented when feasible. The survival benefit of TECC is based on rapid application of point-of-wounding care, thus the equipment must be forward deployed for care to be immediately implemented. This requires that TECC equipment and supplies be carried with all other medical aid and equipment. In short, TECC equipment could become a valuable part of the standardized equipment for fire/EMS response assets.
Usually police resources in the initial moments of AS/MCIs are focused on locating, containing and eliminating the threat, thus the local fire/EMS resources should emphasize planning for rapid triage, treatment and extrication of the wounded. Tactical EMS support personnel are not a typical resource because they are usually very limited in number, not immediately available, and committed to their tactical team’s assignment. This will preclude them from casualty care activities until the tactical team’s objective is met. Considerations, planning and interagency training should occur around the concept of properly trained, armored medical personnel who are escorted into areas of mitigated risk, which are clear but not secure areas, to execute triage, medical stabilization at the point of wounding, and provide for evacuation or sheltering-in-place. Some jurisdictions accomplish this through the deployment of Rescue Task Forces (RTFs). Were this an ongoing ballistic or explosive threat, under the protection of LE officers these teams treat, stabilize and remove the injured rapidly while wearing ballistic protective equipment. An RTF team should include at least one advanced life support (ALS) provider. A few agencies are even exploring the use of LE for rapid patient removal. When possible, agencies should plan for warm zone, indirect threat-area medical operations to provide TECC-driven point-of-wounding care according to their resources and capabilities. Consider secondary devices at the main scene and secondary scenes in close proximity to the main scene. Such threats, if identified, would necessitate upgrading the area to one of direct threat requiring rapid evacuation of all medical personnel and surviving patients.

4. **News Media/Public Information Officer:** The community-specific Emergency Operations Plan (EOP) should have predetermined media connections, and the Public Information Officer (PIO) should be activated. Large extended events may necessitate the use of a joint information system. Media may appear quickly and may aggressively attempt to enter the CP, the exclusion zone, or other places to obtain direct surveillance and communications with survivors, family members and/or responders. They may also have aviation assets that may be co-opted for use in scene surveys but which should be controlled to ensure safety of the operation. If aviation units become problematic, the Incident Commander (IC) can request the Federal Aviation Administration to issue a restriction for the incident area air space.

Strong consideration should be given for the use of a Joint Information System (JIS) that consolidates all agency and incident information flow from the multitude of agencies involved. A JIS further establishes a well-controlled information-sharing plan. Utilization of the Joint Information Center (JIC) may be considered to house the JIS efforts. Experience at previous AS/MCIs demonstrates the advantages of locating the JIC at a different location than the CP. **DO NOT CO-LOCATE THE JIC AND THE ICP.** The PIO must have a plan for media announcements regarding a staging area for parents and relatives of victims. In school shootings, the scene is quickly inundated with parents and bystanders. Considerations should be given to assigning PIOs or liaison officers to support families of casualties in handling media requests.
5. **EOP:** It is unlikely that any community can anticipate specific AS/MCI scenarios they may experience, but it is possible to develop a generic plan that provides a model to apply in almost every situation that arises. Each community needs to have a detailed and comprehensive EOP. Federal Emergency Management Agency (FEMA) Publication CPG 101, available at [http://www.fema.gov/pdf/about/divisionsnpd/CPG_101_V2.pdf](http://www.fema.gov/pdf/about/divisionsnpd/CPG_101_V2.pdf), can be used to develop planning documents. The EOP may provide the framework for command and control at AS/MCIs in the general section, or more often, in an annex specific to AS/MCIs. In the absence of existing plans, the fire/rescue and EMS agency leadership should develop a plan for AS/MCI operations. The EOP must provide the framework for coordinating the activities of police, fire, rescue and other supporting agencies. Here are some things that should be considered in the development or revision of the AS/MCI annex to an EOP:

a. The EOP is a written document.

b. The EOP should reflect the multiagency, multidisciplinary nature of the incident.

c. The EOP establishes command, control and communications procedures.
   - Use of common communications terminology is imperative.
   - Personnel must understand common police terms to include:
     -- Cleared.
     -- Secured.
     -- Cover.
     -- Hot zone/warm zone/cold zone and related terms (red, green, etc.).
     -- Concealment.
     -- Rally points.
     -- Casualty collection points (CCPs).
     -- Other

d. In accordance with NIMS guidance, the EOP provides for the establishment of a single ICP.

e. The EOP plans for UC.

f. All emergency responders need to be apprised of LE plans and procedures, strategy, and tactics:
   - LE personnel may bypass injured victims to subdue the perpetrators.
   - LE protective gear will not protect them from all threats.
   - LE personnel may attempt to enter an AS/MCI area without waiting for additional units in order to contain or neutralize an active threat.
   - Most LE agencies will not wait for SWAT to engage active shooters.
   - LE may request fire/rescue/EMS equipment to breach or force structural elements or to access roofs or other areas, or other needs. LE may request fire/rescue/EMS personnel to assist with operating specialized equipment.
   - LE may request fire/rescue/EMS personnel to assist with victim triage, treatment and/or removal from the danger zone. LE should train to accompany personnel into areas of higher risk to perform these duties.
- LE should be aware of fire/rescue/EMS capacities, tactics and procedures.

g. The EOP establishes the preincident requirement for discipline and integrated training in use of the plan.

h. The EOP directs a coordinated public messaging process through the PIO and/or JIC.

i. The EOP should address aviation considerations including establishing helispots, landing zones, control of aircraft in the incident area, and excluding unauthorized aircraft. The EOP should include communications plans between aviation assets and incident operations and consider establishment of an Air Ops Branch.

j. The EOP must consider the use of additional community resources. Agreements for automatic and mutual aid should be formalized.

k. To the extent possible, in advance, designate staging areas, rally points, CCPs, and the CP. Consider designating primary, secondary and alternate positions in the event that one of your designated positions is in the “hot zone” and unusable. If possible, avoid obvious locations such as police or fire stations that may already be targets.

l. The EOP should consider specific target hazards and relocation and support areas in the preincident planning process. The incident may require facilities where outside persons will need to contact or interact with the “surviving victim population” (for example, schools, day care centers, hospitals, entertainment venues, hotels, and other public assembly areas) and identify and staff a family assistance center. The assistance center should be readily identifiable, large enough to hold and administratively process survivors as they are released to families, provide basic amenities, make referrals to post-incident counseling services, and have adequate traffic flow (buses may be used in large incidents) and parking. The family assistance plan includes custodial care, reunification, guardianship, accountability, mortuary service planning, and victim tracking.

m. The EOP should address the process for obtaining additional support and resources from external resources. Supporting agencies and resources should be integrated into the UC.

- Liaison officers and systems should be planned, empowered and understood by the UC and supporting agency.

- Management of planned and spontaneous volunteers must be addressed by UC and supporting agencies.

n. The EOP should be reviewed, endorsed and supported by the community policymakers, including medical and educational communities.

o. The EOP should be reviewed, exercised and updated regularly. After the AS/MCI, wherever located, consider the timeliness, completeness and efficacy of the EOP. EOPs are only effective when they are exercised, updated and regularly used. Where possible, jurisdictions should follow the Department of Homeland Security’s Homeland
Security Exercise and Evaluation Program. The improvement model used in this program will help the jurisdiction to enhance response readiness.

**Interagency On-scene Practices:** Many of the standard operating practices an agency uses in its day-to-day operations may be unchanged for AS/MCIs. Some will require reconsideration and perhaps modification. AS/MCIs usually involve a perpetrator trying to maximize casualties, so responders need to exercise due caution en route to the incident as well as after arrival. A single ICP is crucial. LE should always maintain a presence at the UCP to coordinate operations and ensure the safety of all personnel operating on the incident, even if the OSC assignment shifts from LE to fire/rescue/EMS.

- a. Use a deliberate and cautious approach to the scene.
- b. While the community-accepted practice has been staging assets at a safe distance (usually out of line-of-sight) until a perimeter is established and all threats are neutralized, considerations should be made for more aggressive EMS operations in areas of higher but mitigated risk to ensure casualties can be rapidly retrieved, triaged, treated and evacuated. Rapid triage and treatment are critical to survival.
- c. Consider turning off emergency lights and warning devices before arrival. Remember many frightened citizens may be fleeing the event and are likely to act in an unsafe manner, so use extreme caution. Clarify this procedure with LE authorities since there have been reports wherein the perpetrator ends the threat when they hear or see public safety personnel or units arrive on-scene.
- d. If exposed to gunfire, explosions or threats, withdraw to a safe area.
- e. Consider/Investigate the use of apparatus’ solid parts such as motor, pump, water tank and wheels as cover in the hot zone. Understand the difference between cover (protection from direct fire) and concealment (protection from observation).
- f. Remove victims from the danger zone in a manner consistent with predetermined agency training and standards of practice. LE officers may bypass casualties in order to eliminate the threat.
- g. Use internal CCPs for large area facilities with multiple casualties where evacuation distances are long. Point-of-wounding medical stabilization should occur prior to evacuation to the CCP, which should provide cover to the injured and responders and be secured by LE officers. Identify people at CCP for accountability and protection of staff.
- h. For larger geographic incidents or incidents with travel barriers, consider the use of multiple staging, triage and other supporting setup areas.
- i. Establish the single UC ICP in safe location. Secure the CP. Remember the CP may become a target.
- j. Events with mobile perpetrators or sequenced attacks may necessitate CP relocation and additional protection or security.
- k. Establish PIO and a JIS.
- l. Establish UC with LE as lead operational component.
m. Establish ICS structure necessary to manage the incident. Consider fire and EMS branches in operations.

n. The UC/LE lead determines the type of operation and direct strategy.

o. LE “on-scene” radio report should not be construed to imply that the scene is secure or safe. A scene is not considered secure until a detailed deliberate search of the entire area is concluded.

p. Stage fire/EMS resources, identify and prepare personnel for operations in areas of higher risk, if appropriate, and await instruction. The first unit/responder in staging capable of managing staging until the appointment/arrival of a designated staging officer should assume that responsibility.

q. The staging area should provide hard cover and concealment from perpetrators.

r. Minimize people exposed to unnecessary risk. Provide appropriate protective gear to personnel operating in indirect threat areas.

s. If bystanders become hostile, extricate yourself. Advise UC.

t. Have a “duress code” known to all responder personnel.

u. UC should have the communications center alert area hospitals. UC may ask for activation of their Multiple Casualty Incident Plan. Some casualties may “self-present,” and emergency rooms need to be aware of the situation.

v. Consider early ordering for additional triage, treatment and transportation resources. This should be detailed in a preplan established order by predetermined resource needs based on the extent, scope and anticipated duration of the event.

w. Use identification that is discernible from a distance. Police snipers at Columbine were unable to identify a fire officer and treated him as a suspect. Be aware that responders may be wearing uniforms and civilian attire, so exercise caution in identifying individuals.

x. Work as teams or in pairs as a minimum. If possible, assign an extra responder to serve as a team spotter. Their role is to observe, identify and avoid threats while the balance of the team executes their tactical assignment. This is similar to some of the safety precautions used in wildland/interface firefighting.

y. Have medics and personnel who might be in situations requiring indirect threat-area operations for point-of-wounding care train to the tenets of TECC for guidance on prioritization and familiarization with the management of ballistic and explosive wounds. Departments should train and equip fire/rescue/EMS personnel to work with LE within areas that are clear but not secure, representing an indirect threat risk, for immediate lifesaving interventions. The RTF concept is designed for this purpose.

z. Mental and physical health for responders remains a tactical consideration throughout the incident. It is possible that some of the responders know the aggressors and/or victims. The UC should determine how to utilize or relieve these responders.
aa. Assign extra communications personnel for the CP to monitor inbound intelligence from responders. These types of incidents provide a tremendous amount of radio traffic with real-time updates coming from fleeing civilians and responders. Due to the critical time factors involved in getting intelligence back to the entry team personnel, extra communications personnel should be allocated to receive, analyze, and rebroadcast (per the UC) the many data transmissions received.

**Operational Practices En Route and On-scene:** As a part of the initial assignment or for a senior officer en route to AS/MCIs, there are several additional considerations. These may include:

a. Obtaining the maximum information/intelligence en route. If closed circuit camera systems allow visual monitoring of the area or specific elements, they should be utilized.

b. On-scene, verifying what you can as a part of the size-up.

c. Determining threats to response personnel as well as additional civilians.

d. Obtaining as much information as possible from persons who have fled the event. This is usually done by LE personnel, but may also be done by fire/EMS, if in certain situations. Fire/EMS personnel must provide LE with any intelligence/information obtained during patient/casualty contact or treatment. Medical facilities should also be trained to provide any non-Health Insurance Portability and Accountability Act information to LE.

e. Considering IED possibility or other secondary devices. This speaks to the consideration of a second level of staging for the balance of responding resources until they are needed and can be advanced in safely.

f. If first on-scene, ensuring LE and other necessary resources are en route.

g. Expanding alarm as required, but using smallest response appropriate. Ideally, to the extent possible, this should be preplanned by the number of anticipated victims.

h. Identifying a safe staging area for inbound resources.

i. Establishing command (done by initial officer).

j. Establishing CP as soon as possible.

k. Using single CP to establish UC.

l. Using PIO/JIS function for release of information. Exercise caution regarding releases to avoid compromise of operations.

m. Accounting for victims on the scene, those who may be relocated to safer or reunion areas, and those transported to medical or other facilities. (Accounting by name, if practicable, or by gross numbers should be protected information). Most agencies will have explicit policies in that regard and have noted the tracking location of children to be essential.
n. Accounting for response personnel. Establish an accountability process for all incident responders to the incident. Use a check-in/-out procedure.
o. Communicating all movement on the incident, especially if the threat has not yet been contained, to the ICP and units in the operations section.
p. Calling for resources trained in AS/MCIs necessary to staff ICS to the appropriate level. This speaks to having an adequate number of ICS-trained and capable personnel to expand to the incident size. Reassess every 30 minutes or during periods of low activity.
q. Basing the assignment of staff on qualifications, available resources, and the need for extended operations periods.
r. Considering the possibility of spontaneous volunteers attempting to participate in the incident. Determine how/if they may be used, informed, controlled and dismissed. In AS/MCIs it is possible some volunteers will be armed. Consider this in planning.

Post-incident/Demobilization: While stand down is an appropriate time to decompress and refresh, it also is the best time to capture staff recollections of specific events that may not have been well documented. Obtain responder listings and tasks performed. This is also the time to account for equipment, pack supplies, complete records, and release staff to duty or home. A demobilization plan will include member information regarding post-incident briefings, stress management briefings, and family support information.
   a. Establish and manage a formal unit-release process.
   b. Collect incident management records and unit logs.
   c. Determine and announce an incident debriefing strategy (UC).
   d. Assign a debrief team to prepare a report of the incident.
   e. Determine and announce a stress debrief plan.
   f. The PIO position may stand down, returning that responsibility to the IC. Based on the size of the incident, there may be a need for ongoing support of this function.
   g. Set up an EOP AS/MCI plan review and evaluation team (UC).
   h. Prepare evaluations by position (UC).
   i. Close down the CP.
   j. Prepare and review the EOP AS/MCI report and evaluation (UC or command group, the community policymakers, and others as determined by policy). The report may be sensitive and involve ongoing investigation. It should be reviewed by appropriate legal authorities prior to release based on agency policy.
   k. Assure appropriate stress debriefing and management resources for all personnel.
Media/Information Resources

There is much more valuable information to be learned from past incidents and the best practices created by those who have experienced them. You are encouraged to go to the following locations for more information.

Note: We are providing the following information and links to third-party sites for your reference. USFA does not endorse any nongovernment publication, website, company or application.

- Vernon, August, June 2012, Fire Engineering.
- Video article, Fire Ground Commentary — Mass Shootings, October 18, FireRescueNews Chief Rob Wylie.
- Baldanza, Mauro V., 2005, Fire department response to “active shooter” incidents, Fire Engineering.
- FIRESCOPE’s Field OPS manual, MCI section.
- National IMS Consortium Model Procedures Guide, 2008 Book 1, Multi-Casualty section with appendix
- Website for the Committee for Tactical Emergency Casualty Care www.C-TECC.org.
- Joint Committee to Create a National Policy to Enhance Survivability From a Mass Casualty Shooting Event, Hartford Consensus, April 2, 2013.
- Joint Committee to Create a National Policy to Enhance Survivability From Mass Casualty Shooting Events, Hartford Consensus II, July 11, 2013.
- Urban Fire Forum/Metropolitan Fire Chiefs Association Active Shooter Position Paper.

If you have questions regarding this white paper, please contact the U.S. Fire Administration.

www.usfa.fema.gov

16825 South Seton Ave.
Emmitsburg, MD 21727
### Hemostatic Agents

#### INDICATIONS
Exsanguinating hemorrhage that cannot be controlled by direct pressure or by tourniquet.

#### CONTRAINDICATIONS
- Minor bleeding.
- Bleeding that can be controlled by direct pressure.
- Bleeding that can be controlled by application of a tourniquet.
- Open abdominal or chest wounds.

#### PROCEDURE

**Adult: Hemostatic Agents**

**Application Procedures:**

1. Expose injury by opening or cutting away clothing.
2. Remove excess blood from wound while preserving any clots that may have formed, if possible.
3. Locate the source of the most active bleeding.
4. Remove gauze from package and pack it tightly into the wound directly over the site of the most active bleeding. (More than one roll of gauze may be required to control the hemorrhage.)
5. Gauze may be re-packed or adjusted in the wound to ensure proper placement.
6. Apply direct pressure quickly with enough force to stop the bleeding.
7. Hold direct pressure for a **minimum** of 3 minutes.
8. Reassess for bleeding control.
9. Once applied, gauze is not to be removed (except by proper medical authority). If bleeding continues, reinforce wound with another roll of gauze and hold pressure.
10. Leave gauze in place and secure with a pressure dressing.
PURPOSE
The purpose of this procedure is to outline the Fire Department’s role in active shooter incidents or similar mass casualty type of incident. The primary focus is to provide medical treatment as soon as possible in a less-than-safe (Tactical) environment while reducing risk to responders.

APPLICABILITY
All EHEMSS participants and providers.

POLICY STATEMENT(S)
All EHEMSS personnel will be responsible for applying this procedure at active shooter, mass casualty incidents. The availability of Tactical Emergency Medical Support (TEMS) (SWAT Medics) is not realistic within the first 30 minutes of the incident. The on-duty EMS/Fire personnel must be familiar with the expectations of the Fire Department response.

RESPONSE GUIDELINES
A. Initial Response.
   a. When dispatch receives a report(s) of a shooting / mass casualty incident at a specific location, dispatch will relay as much information (as possible) to all responding units. “Preferred by CAD notes for secure reasons” (if available)
   b. Dispatch shall advise responding EMS / Fire personnel of safe routes into the incident location if provided by the Police Department.
      i. Command will determine the Box Alarm Type. Consider upgrading alarm automatically.
   c. First arriving personnel will:
      i. Cautiously proceed toward the reported location looking for signs of ambush, booby traps, or I.E.D.’s.
      ii. Identify safety route to staging location for Fire / EMS.
   d. Command will designate the Level I and II staging area.
      i. Fire and EMS will begin to stage at a designated location that provides cover and quick response (cold zone).
         1. A Medical Officer will be established and will report to EMS / Fire Ops.
            a. Rescue Task Force (RTF) will be considered. The RTF will initially report to EMS / Fire Ops. Once the Medical Officer is established, RTF will report to Medical Officer.
            b. Medical group.
               i. Medical Officer.
ii. Triage.
iii. Treatment (green, yellow, red).
iv. Transport.
v. Edward Hospital will be updated.
vi. Identity helicopter landing zone.

c. Initial Police Supervisor arriving on scene will:
i. Establish Incident Command.
ii. Establish an entry corridor / perimeter.
iii. Identify location of Mobile Command Post (to be moved to the cold zone ASAP). Identify Hot Zone, Warm Zone, and Cold Zone
iv. Determine a safe route into the incident / staging.
v. Initiate response priorities (hierarchy).
  1. Contact teams.
  2. TEMS Rescue Teams.
  3. Entry corridor / perimeter.
  4. Evacuation of the uninjured.
  5. Rescue Task Force Protection Element.

B. Initial Fire / EMS Actions.
a. FD will contact the PD Incident Commander for further information.
   i. Determine safe route in.
   ii. Situation status report from PD.
   iii. Assist with “Cold Zone” designation.
   iv. Assist with staging location.
   v. Determine medical need for RTF formation.
   vi. Verify PD / FD link-up location for RTF.

b. Police Department will be the lead agency and will work toward developing Unified Command with EMS / Fire.

c. If medical treatment is indicated, Command will have ambulance crews assemble a rescue element (with appropriate BPE and medical equipment) and report to the link – up location for RTF assembly

d. Prior to deploying a Rescue Task Force, threat zones must be identified.
   i. **Hot Zone** – Area where there is known hazard or life threat that is direct and immediate. Only Law Enforcement and TEMS shall enter
   ii. **Warm Zone** – Area of indirect threat – areas that have been cleared by PD or the threat has been isolated. These are areas of minimal or reduced risk. This area can be considered clear – but not secure. EMS / Fire will provide a Rescue Task Force(s) in this area, with ballistic PPE and law enforcement security, to treat victims.
   iii. **Cold Zone** – Areas where there is little or no threat. This area may have been secured by police or may be protected by geography. In
this area, EMS / Fire will stage to triage, treat, and transport victims (once removed from the Warm Zone). Police protection should still be considered in the Cold Zone, especially if the total number of shooters is not known.

e. Once the Warm Zone has been identified and secured, the Rescue Task Force will be advised of their response parameters and assigned a protection element as the link-up location.

f. Once EMS / Fire personnel have been assigned to the Rescue Task Force(s), mutual aid ambulances may be needed for transport.

g. Depending on the size and location of the incident, injured victims may need to be placed in the Casualty Collection Point (CCP) before transition to the Cold Zone. The CCP will be determined by the initial arriving police units, secured by PD, and relayed to the Rescue Task Force(s) through Incident Command.

C. Rescue Task Force Equipment (The equipment needed for Rescue Task Force members).
   a. Ballistic Vests.
   c. Treatment Bag / Drop Bag (for victim treatment). see attached equipment list
   d. Flashlight / Patient Tarp.
   e. Radio.

D. Deployment.
   a. Once Command and EMS / Fire Ops (or Unified Command) has agreed to Rescue Task Force Deployment, teams will deploy to the Warm Zone to begin victim care and movement.
   b. Each Rescue Task Force will deploy with at least two (2) PD Officers (security element) minimum two (2) EMS / Fire personnel, preferably three (3) (rescue element).
   c. The first Rescue Task Force or TEMS Rescue Team to enter should advise the Medical Officer (or EMS / Fire Ops if Medical Officer is not yet assembled) of the approximate victim count. All responding FD personnel will communicate via radio to FD Command.
   d. The first Rescue Task Force Team or TEMS Rescue Team will enter the area and treat as many patients as possible, then start the evacuation of injured. Additional Rescue Teams that enter the area should be primarily tasked with extrication of the victims treated by the initial RTF.
   e. When the Rescue Task Force or TEMS Rescue Team is operating in the Warm Zone, triage will be conducted (when appropriate). All patients
encountered by the Rescue Task Forces or TEMS Rescue Teams will be treated as they are accessed. Any patient that can ambulate without assistance will be directed to self-evacuate down the cleared corridor under police direction. Any patient who is dead will be visibly marked (by marker or triage tag) to allow for easy identification and to avoid repeated evaluations by additional rescue teams.

f. Rescue Task Forces or TEMS Rescue Teams can be deployed for the following reasons:
   i. Victim treatment.(per level of training)
   ii. Victim removal from the Hot Zone (TEMS only) or the Warm Zone to the Cold Zone, Warm Zone to CCP, or CCP to Cold Zone.
   iii. Movement of supplies from the Cold Zone to the Warm Zone or Cold Zone to CCP.
   iv. Any other duties deemed necessary to accomplish the mission.

g. RESCUE TASK FORCES AND TEMS RESCUE TEAMS WILL ALWAYS WORK WITH A LAW ENFORCEMENT SECURITY ELEMENT AND WILL WORK WITHIN THEIR SECURITY AT ALL TIMES.

E. Victim Removal / Transport to Cold Zone.
   a. Once victims have been rapidly assessed, treated, and evacuated from point of injury, RTF’s and / or TEMS rescue teams will move the victim to the casualty collection point (CCP) or to a waiting vehicle that will move the victim to the medical group (Cold Zone) for more definitive treatment / transport. Patients / victims will be transported in the following vehicles:
      i. Armored vehicle.
      ii. Squad car or other passenger vehicle (preferably van type).
      iii. Ambulance (least advisable – ambulances may be needed for hospital transport. If used, consider removal of pressurized oxygen vessels.)

   b. Vehicles used for Warm Zone transport should, if available, have an armed Police Officer for a protection element.

F. Emergency Actions / Duress.
   a. “Emergency” will be announced over the radio in the event of a life threatening event (shots fired, IED, gas release) is discovered in the immediate area of the RTF.

   b. The duress signal shall be immediately followed with a clear text radio communication describing the situation.
i. RTF Team Leader will take immediate action to protect the rescue element.
   1. Additional cover / concealment.
   2. Hasty evacuation.
ii. Personal Accountability Report (PAR) will be conducted with each RTF

New 02/2017
Appendix A

RTF 2 x 3:
2 Officer Protection Element, 3 preferred (2 minimum) firefighter Rescue Element

RTF 3 x 3:
3 Officer Protection Element, 3 preferred (2 minimum) firefighter Rescue Element

RTF 4 x 3
4 Officer Protection Element, 3 preferred (2 minimum) Firefighter Rescue Element
Example of incident elements needed for EMS/Fire participation in tactical incidents
TACTICAL EMERGENCY CASUALTY CARE GUIDELINES

DIRECT THREAT CARE (DTC)

Goals:
1. Accomplish the mission with minimal casualties
2. Prevent any casualty from sustaining additional injuries
3. Keep response team maximally engaged in neutralizing the existing threat (e.g. active shooter, unstable building, confined space HAZMAT, etc.)
4. Minimize public harm

Principles:
1. Minimal trauma interventions are warranted in this phase of care.
2. Consider hemorrhage control
   a. TQ application is the primary “medical” intervention to be considered in Direct Threat.
   b. Consider instructing casualty to apply direct pressure to the wound if no tourniquet available or application is not tactically feasible.
3. Consider quickly placing or directing casualty to be placed in position to protect airway.

Guidelines:
1. Direct the casualty to stay engaged in operation if appropriate.
2. Direct the casualty to move to a safer position and apply self aid if able.
3. Casualty Extraction
   a. If a casualty can move to safety, they should be instructed to do so.
   b. If a casualty is unresponsive, the scene commander or team leader should weigh the risks and benefits of a rescue attempt in terms of manpower and likelihood of success. Remote medical assessment techniques should be considered.
   c. If the casualty is responsive but cannot move, a tactically feasible rescue plan should be devised.
   d. Recognize that threats are dynamic and may be ongoing, requiring continuous threat assessments.
5. Stop life threatening external hemorrhage if tactically feasible:
   a. Direct casualty to apply effective tourniquet if able
   b. Apply the tourniquet over the clothing as proximal– high on the limb– as possible.
   c. Tighten until cessation of bleeding and move to safety. Consider moving to safety prior to application of the TQ if the situation warrants.
   d. Tourniquet should be readily available and accessible with either hand
   e. Consider instructing casualty to apply direct pressure to the wound if no tourniquet available or application is not tactically feasible
f. Consider quickly placing casualty, or directing the casualty to be placed, in position to protect airway if tactically feasible

**Skill Sets:**
1. Tourniquet application
   a. Consider PACE Methodology- Primary, Alternative, Contingency, Emergency
   b. Commercially available tourniquets
   c. Field expedient tourniquets
2. Casualty extraction
3. Rapid placement in recover position

**INDIRECT THREAT CARE (ITC)**

**Goals:**
1. Goals 1-4 as above with DTC care
2. Stabilize the casualty as required to permit safe evacuation to dedicated treatment sector or medical evacuation assets

**Principles:**
1. Complete the overall operational objectives.
2. As applicable, ensure safety of both first responders and casualties by rendering weapons safe and/or rendering any adjunct tactical gear safe for handling (flash bangs, gas canisters, etc).
4. Consider establishing a casualty collection point in the warm zone if multiple casualties are encountered
5. As applicable, establish communication with tactical and/or command element and request or verify initiation of casualty evacuation.

**Guidelines:**
1. Law Enforcement Casualties should have weapons made safe once the threat is neutralized or if mental status is altered.
2. **Bleeding:**
   a. Assess for unrecognized hemorrhage and control all sources of major bleeding:
      i. If not already done, use a tourniquet or an appropriate pressure dressing with deep wound packing to control life-threatening external hemorrhage that is anatomically amenable to such
treatment.
- Apply the tourniquet over the clothing as proximal– high on the limb– as possible, or if able to fully expose and evaluate the wound, apply directly to the skin 2-3 inches above wound.
- For any traumatic total or partial amputation, a tourniquet should be applied regardless of bleeding.

b. For compressible hemorrhage not amenable to tourniquet use, or as an adjunct to tourniquet removal (if evacuation time is anticipated to be longer than two hours), apply a hemostatic agent (if available) in accordance with the directions for its use and an appropriate pressure bandage. Before releasing any tourniquet on a casualty who has received IV fluid resuscitation for hemorrhagic shock, ensure a positive response to resuscitation efforts (i.e., a peripheral pulse normal in character and normal mentation).

c. Reassess all tourniquets that were applied during previous phases of care. Consider exposing the injury and determining if a tourniquet is needed. Tourniquets applied hastily during DTC phase that are determined to be both necessary and effective in controlling hemorrhage should remain in place if the casualty can be rapidly evacuated to definitive medical care. If ineffective in controlling hemorrhage or if there is any potential delay in evacuation to care, expose the wound fully, identify an appropriate location 2-3 inches above the injury, and apply a new tourniquet directly to the skin. Once properly applied, the prior tourniquet can be loosened. If a tourniquet is not needed, use other techniques to control bleeding and remove the tourniquet.

d. When time and the tactical situation permit, a distal pulse check should be accomplished on any limb where a tourniquet is applied. If a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet, side by side and proximal to the first, to eliminate the distal pulse.

e. Expose and clearly mark all tourniquet sites with the time of tourniquet application.

3. Airway Management:
   a. Unconscious casualty without airway obstruction:
      i. Chin lift or jaw thrust maneuver
      ii. Nasopharyngeal airway
      iii. Place casualty in the recovery position
   b. Casualty with airway obstruction or impending airway obstruction:
      i. Chin lift or jaw thrust maneuver
      ii. Nasopharyngeal airway
      iii. Allow casualty to assume position that best protects the airway, including sitting up
      iv. Place unconscious casualty in the recovery position
   c. If previous measures unsuccessful:
i. Oro/nasotracheal intubation per protocol
ii. Consider Supraglottic Devices per protocol.
iii. Surgical cricothyroidotomy per protocol

a. Consider applying oxygen if available

4. Breathing:
   a. All open and/or sucking chest wounds should be treated by immediately applying an occlusive material to cover the defect and securing it in place. Monitor the casualty for the potential development of a subsequent tension pneumothorax.
   b. In a casualty with progressive respiratory distress and known or suspected torso trauma, consider a tension pneumothorax and decompress the chest on the side of the injury with a 14-gauge, 3.25 inch needle/catheter unit inserted:
      i. In the second intercostal space at the midclavicular line. Ensure that the needle entry into the chest is lateral to the nipple line and is not directed towards the heart.
      ii. If properly trained and under approved local protocol, consider a lateral decompression, inserting the needle in the 4-5th intercostal space, anterior to the mid-axillary line on the injured side.

5. Intravenous (IV) access:
   a. Start an 18-gauge IV saline lock if indicated
   b. If resuscitation is required and IV access is not obtainable, use the intraosseous (IO) route (per agency protocol).

6. Fluid resuscitation: Assess for hemorrhagic shock; altered mental status (in the absence of head injury) and weak or absent peripheral pulses are the best field indicators of shock.
   a. If not in shock:
      i. No IV fluids necessary
      ii. PO fluids permissible if:
         a. Conscious, can swallow, and has no injury requiring potential surgical intervention
         b. If confirmed long delay in evacuation to care
   b. If in shock:
      i. Administer appropriate IV fluid bolus (500cc NS) and re-assess casualty. Repeat bolus once after 30 minutes if still in shock.
      ii. If a casualty with an altered mental status due to suspected TBI has a weak or absent peripheral pulse, resuscitate as necessary to maintain a desired systolic blood pressure of 90mmHg or a palpable radial pulse.
7. Prevention of hypothermia:
   a. Minimize casualty’s exposure to the elements. Keep protective gear on or with the casualty if feasible.
   b. Replace wet clothing with dry if possible. Place the casualty onto an insulated surface as soon as possible.
   c. Cover the casualty with commercial warming device, dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry.
   d. Warm fluids are preferred if IV fluids are required.

8. Penetrating Eye Trauma: If a penetrating eye injury is noted or suspected:
   a. Perform a rapid field test of visual acuity.
   b. Cover the eye with a rigid eye shield (NOT a pressure patch). If a commercial eye shield is not available, use casualty’s eye protection device or anything that will prevent external pressure from being applied to the injured eye.

9. Reassess casualty:
   a. Complete secondary survey checking for additional injuries. Inspect and dress known wounds that were previously deferred.
   b. Consider splinting known/suspected fracture to include applying pelvic binding techniques for suspected pelvic fractures.

10. Provide analgesia as necessary.
    a. Consider use of fentanyl per Region VIII protocols
       i. Consider adjunct administration of anti-emetic medicines
          Note: Have naloxone readily available whenever administering opiates
       ii. Monitor for adverse effects such as respiratory depression or hypotension.

11. Burns:
    a. Facial burns, especially those that occur in closed spaces, may be associated with inhalation injury. Aggressively monitor airway status and oxygen saturation in such patients and consider early definitive airway management for respiratory distress or oxygen desaturation.
    b. Smoke inhalation, particularly in a confined space, may be associated with significant carbon monoxide and cyanide toxicity. Patients with signs of significant smoke inhalation plus:
       i. Significant symptoms of carbon monoxide toxicity should be treated with high flow oxygen if available
       ii. Significant symptoms of cyanide toxicity should be considered candidates for cyanide antidote administration
    c. Estimate total body surface area (TBSA) burned to the nearest 10% using the appropriate locally approved burn calculation formula.
    d. Cover the burn area with dry, sterile dressings and initiate measures to prevent heat loss and hypothermia.
    e. If burns are greater than 20% of Total Body Surface Area, fluid
resuscitation should be initiated under medical control as soon as IV/IO access is established. If hemorrhagic shock is also present, resuscitation for hemorrhagic shock takes precedence over resuscitation for burn shock as per the guidelines.

f. All previously described casualty care interventions can be performed on or through burned skin in a burn casualty.

g. Analgesia in accordance with Region VIII guidelines may be administered.

h. Aggressively act to prevent hypothermia for burns greater than 20% TBSA.

14. **Monitoring:** Apply appropriate monitoring devices and/or diagnostic equipment if available. Obtain and record vital signs.

15. **Prepare casualty for movement:** Consider environmental factors for safe and expeditious evacuation. Secure casualty to a movement assist device when available. If vertical extraction required, ensure casualty secured within appropriate harness, equipment assembled, and anchor points identified.

16. **Communicate** with the casualty if possible. Encourage, reassure and explain care.

17. **Cardiopulmonary resuscitation (CPR)** within a tactical environment for victims of blast or penetrating trauma who have no pulse, no ventilations, and no other signs of life will not be successful and should not be attempted. However, consider bilateral needle decompression for victims of torso or polytrauma with no respirations or pulse to ensure tension pneumothorax is not the cause of cardiac arrest prior to discontinuation of care.

   a. In certain circumstance, such as electrocution, drowning, atraumatic arrest, or hypothermia, performing CPR may be of benefit and should be considered in the context of the tactical situation.

18. **Documentation of Care:** Document clinical assessments, treatments rendered, and changes in the casualty’s status in accordance with local protocol. Consider implementing a casualty care card that can be quickly and easily completed by non-medical first responders. Forward this information with the casualty to the next level of care.

**Skill set:**

1. **Hemorrhage Control:**
   a. Apply Tourniquet
   b. Apply Direct Pressure
   c. Apply Pressure Dressing
   d. Apply Wound Packing
   e. Apply Hemostatic Agent

2. **Airway:**
   a. Apply Manual Maneuvers (chin lift, jaw thrust, recovery position)
   b. Insert Nasal pharyngeal airway
   c. Insert Supraglottic Device
   d. Perform Tracheal Intubation
e. Perform Surgical Cricothyrotomy

3. **Breathing:**
   a. Application of effective occlusive chest seal
   b. Assist Ventilations with Bag Valve Mask
   c. Apply Oxygen
   d. Apply Occlusive Dressing
   e. Perform Needle Chest Decompression

4. **Circulation:**
   a. Gain Intravascular Access
   b. Gain Intraosseous Access
   c. Apply saline lock
   d. Administer IV/IO medications and IV/IO fluids

5. **Wound management:**
   a. Apply Eye Shield
   b. Apply Dressing for evisceration
   c. Apply Extremity Splint
   d. Apply Pelvic Binder
   e. Initiate Basic Burn Treatment
   f. Initiate Treatment for Traumatic Brain Injury

6. **Prepare Casualty for Evacuation:**
   a. Move Casualty (drags, carries, lifts)
   b. Apply Spinal Immobilization Devices
   c. Secure casualty to litter
   d. Initiate Hypothermia Prevention

7. **Other Skills:**
   a. Perform Hasty Decontamination
   b. Initiate Casualty Monitoring
   c. Establish Casualty Collection Point
   d. Perform Triage

**Note:** Care provided according to the ITC guidelines should be based upon the individual provider's level of training and scope of practice, available equipment, local medical protocols, and medical director approval.

**EVACUATION CARE (EVAC):**

**Goals:**
1. Maintain any life saving interventions conducted during DTC and ITC phases
2. Provide rapid and secure evacuation to an appropriate level of care
3. Avoid additional preventable causes of death

**Principles:**
1. Reassess the casualty or casualties
2. Utilize additional resources to maximize advanced care
3. Avoid hypothermia
4. Communication is critical, especially between treating medical providers and transporting EMS assets, and between scene providers and first receivers.

**Guidelines:**
1. Reassess all interventions applied in previous phases of care. If multiple wounded, perform primary triage for priority AND destination.
2. **Airway Management:**
   a. The principles of airway management in Evacuation Care are similar to that in ITC with the addition of increased utility of supraglottic devices and endotracheal intubation.
   b. Unconscious casualty without airway obstruction: Same as ITC
   c. Casualty with airway obstruction or impending airway obstruction:
      i. Initially, same as ITC Naso/oropharyngeal airway
      ii. If previous measures unsuccessful, it is prudent to consider supraglottic Devices, endotracheal intubation/Rapid Sequence Intubation or surgical cricothyroidotomy per local agency protocol.
   d. If intubated and attached to a mechanical ventilator, consider lung protective strategies and reassess for respiratory decline in patients with potential pneumothoraces.
   e. Consider the mechanism of injury and the need for spinal motion restriction. Maintain high clinical suspicion for casualties over age of 65yo with blunt mechanism.
3. **Breathing:**
   a. All open and/or sucking chest wounds should be treated by immediately applying an occlusive material to cover the defect and securing it in place. Monitor the casualty for the potential development of a subsequent tension pneumothorax. Tension pneumothoraces should be treated as described in ITC.
   b. Reassess casualties who have had chest seals applied or had needle decompression. If there are signs of continued or progressive respiratory distress:
      i. Consider repeating the needle decompression. If this results in improved clinical status, the decompression can be repeated multiple times.
      ii. If appropriate provider scope of practice and approved local protocol, consider placing a chest tube if no improvement of respiratory distress after decompression if long duration or air transport is anticipated.
   c. Administration of oxygen may be of benefit for all traumatically injured patients, especially for the following types of casualties:
      - Low oxygen saturation by pulse oximetry
- Injuries associated with impaired oxygenation
- Unconscious casualty
- Casualty with TBI (maintain oxygen saturation > 90%)
- Casualty in shock
- Casualty at altitude
- Casualties with pneumothoraces

4. **Bleeding:**

   b. Fully expose wounds to reassess for unrecognized hemorrhage and control all sources of major bleeding.

   c. If not already done, use a tourniquet or an appropriate pressure dressing with deep wound packing to control life-threatening external hemorrhage that is anatomically amenable to such treatment.
      
      i. Apply the tourniquet directly to the skin 2-3 inches above wound.
      
      ii. For any traumatic total or partial amputation, a tourniquet should be applied regardless of bleeding.

   d. Reassess all tourniquets that were applied during previous phases of care. Expose the injury and determine if a tourniquet is needed.
      
      i. Tourniquets applied in prior phases that are determined to be both necessary and effective in controlling hemorrhage should remain in place if the casualty can be rapidly evacuated to definitive medical care.
      
      ii. If ineffective in controlling hemorrhage or if there is any potential delay in evacuation to care, identify an appropriate location 2-3 inches above the injury, and apply a new tourniquet directly to the skin. Once properly applied, the prior tourniquet can be loosened.
      
      iii. If delay to definitive care longer than 2 hours is anticipated and wound for which tourniquet was applied is anatomically amenable, attempt a tourniquet downgrade as described in ITC.

   e. A distal pulse check should be performed on any limb where a tourniquet is applied. If a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet, side by side and proximal to the first, to eliminate the distal pulse.

   f. Expose and clearly mark all tourniquet sites with the time of tourniquet application. Use an indelible marker.

5. **Fluid resuscitation:** Reassess for hemorrhagic shock (altered mental status in the absence of brain injury, weak or absent peripheral pulses, and/or change in pulse character). If BP monitoring is available, maintain target systolic BP 80-90mmHg.

   a. Establish intravenous or intraosseous access if not performed in ITC phase

   b. If a casualty with an altered mental status due to suspected TBI has a weak or absent peripheral pulse, resuscitate as necessary to maintain a desired systolic blood pressure of 90mmHg or a palpable radial pulse.

   iv. If suspected TBI and casualty not in shock, raise the casualty’s head to 30
degrees.

6. **Prevention of hypothermia:**
   a. Minimize casualty's exposure to the elements. Move into a medic unit, vehicle, or warmed structure if possible. Keep protective gear on or with the casualty if feasible.
   b. Replace wet clothing with dry if possible. Place the casualty onto an insulated surface as soon as possible.
   c. Cover the casualty with commercial warming device, dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the casualty dry.
   d. Warm fluids are preferred if IV fluids are required.

7. **Monitoring**
   a. Institute electronic monitoring if available, including pulse oximetry, cardiac monitoring, etCO2 (if intubated), and blood pressure.
   b. Obtain and record vital signs.

8. **Reassess casualty:**
   a. Complete secondary survey checking for additional injuries. Inspect and dress known wounds that were previously deferred.
   b. Determine mode and destination for evacuation to definitive care.
   c. Splint known/suspected fractures and recheck pulses.
   d. Apply pelvic binding techniques for suspected pelvic fractures.

9. **Provide analgesia** as necessary.
   a. Consider use of fentanyl per Region VIII protocols
      i. Consider adjunct administration of Zofran.
         *Note: Have naloxone readily available whenever administering opiates*
      ii. Monitor for adverse effects such as respiratory depression or hypotension.

10. **Burns:**
    a. Burn care is consistent with the principles described in ITC.
    b. Smoke inhalation, particularly in a confined space, may be associated with significant carbon monoxide and cyanide toxicity. Patients with signs of significant smoke inhalation plus:
       i. Significant symptoms of carbon monoxide toxicity should be treated with high flow oxygen if available
       ii. Significant symptoms of cyanide toxicity should be considered candidates for cyanide antidote administration
    c. Be cautious of off-gassing from patient in the evacuation vehicle if there is suspected chemical exposure (e.g. cyanide) from the fire.
    d. Consider early airway management if there is a prolonged evacuation period and the patient has signs of significant airway thermal injury (e.g. singed facial hair, oral edema, carbonaceous material in the posterior pharynx and respiratory difficulty.)

11. **Prepare casualty for movement:** Consider environmental factors for safe and
expeditious evacuation. Secure casualty to a movement assist device when available. If vertical extraction required, ensure casualty secured within appropriate harness, equipment assembled, and anchor points identified.

12. *Communicate* with the casualty if possible and with the accepting facility. Encourage, reassure and explain care.

13. *Cardiopulmonary resuscitation (CPR)* may have a *larger role* during the evacuation phase especially for patients with electrocution, hypothermia, non traumatic arrest or near drowning. Consider bilateral needle decompression for victims of torso or polytrauma with no respirations or pulse to ensure tension pneumothroax is not the cause of cardiac arrest prior to discontinuation of care.

14. *Documentation of Care*: Continue or initiate documentation of clinical assessments, treatments rendered, and changes in the casualty’s status in accordance with local protocol. Forward this information with the casualty to the next level of care.

**Skills:**

1. Familiarization with advanced monitoring techniques
2. Familiarization with transfusion protocols
3. Ventilator and advanced airway management
PURPOSE
The purpose of this procedure is to outline the Fire Department’s role in active shooter incidents or similar mass casualty type of incident. The primary focus is to provide medical treatment as soon as possible in a less-than-safe (Tactical) environment while reducing risk to responders.

APPLICABILITY
All EHEMSS participants and providers.

POLICY STATEMENT(S)
All EHEMSS personnel will be responsible for applying this procedure at active shooter, mass casualty incidents. The availability of Tactical Emergency Medical Support (TEMS) (SWAT Medics) is not realistic within the first 30 minutes of the incident. The on-duty EMS/Fire personnel must be familiar with the expectations of the Fire Department response.

DEFINITIONS

Active Shooter – One or more subjects who participate in an ongoing, random or systematic attack to continuously harm others. The overriding objective appears to be that of mass murder, rather than other criminal conduct. For the purpose of this Directive, the term active shooter also includes anyone using any other deadly weapon (knife, bow & arrow, explosives, etc.) to systematically or randomly inflict death or great bodily harm.

Ballistic Protective Equipment (BPE) - A Level IIIA (minimum) ballistic vest and a Level III A ballistic helmet.

Casualty Collection Point (CCP) - A location designated for the holding, further assessment and treatment of casualties. The CCP is a secure area within the warm zone. An ideal CCP has cover and concealment.

Clear, but not secure (primary) - An area that is clear of the suspect only. Clear does not mean an area that is clear of victims. It is an area currently absent of a known threat. Law Enforcement has passed through; however, a deliberate search has not been conducted to guarantee life safety.

Cold Zone – A designated area that has been identified to contain a low degree of danger or hazards for 1st responders. Cold zones should be out of the line of sight of hot and warm zones. Secure area.

Concealment - Protection from observation. Minimal protection from direct fire and/or explosion.

Contact Team – Law enforcement strike team responsible for stopping the suspect. Shall locate and mark secondary devices. Shall call out approximate victim numbers/location.

Cover – Protection from direct fire and/or explosion.

Duress Signal – Duress signal of “Emergency” is the preface call to alert others of a duress situation. The duress signal will be immediately followed by common language to specifically identify the imminent danger.
**Entry Corridor** - Path from the Cold Zone to the Warm Zone. An established path to a location that has security measures in place. An entry corridor is generally utilized to move to an affected site or to leave a site and/or evacuate injured from the site.

**ERU** – Emergency Response Unit. “Also known as SWAT Team”.

**Forward Staging** – An aggressive staging position for RTF operations (once the rescue element and the protection element have been formed up).

**Hot Zone** – An area that contains an immediate threat to life safety. A Warm Zone could quickly become a Hot Zone and vice versa.

**IFAK** – Individual First Aid Kit. The IFAK is primarily used for treating the RTF personnel if needed. The IFAK may be used for patient care if needed as a last choice.

**Leapfrog** - To move ahead of each other in turn; to advance by keeping one RTF in action while moving the other RTF past it to a position farther in front. Also known as bounding, overwatch.

**Level I Staging** – A clear staging position for EMS/Fire operations; usually out of the line-of-sight of the threat.

**Level II Staging** - A secure staging position for EMS/Fire operations. Normally some distance from the event and large enough to accommodate a significant number of apparatus.

**Link-Up Location** – A location where the rescue element and the protection element meet up to form an RTF.

**Mass Casualty** - Any incident that may potentially overwhelm the initial emergency medical response.

**Protective Element** – Minimum of two law enforcement officers. One of which will be designated as the RTF Team Leader.

**Rescue Element** – A minimum of two, preferred three EMS/Fire personnel or TEMS personnel with BPE/IFAK. Takes direction from and provides information to the RTF Team Leader

**Rescue Task Force (RTF)** - Minimum two Paramedic/Firefighters, preferred three (rescue element) who team up with at least two Police Officers (protection element) to assess, treat, and evacuate victims in the warm zone. TECC concepts will be used in the warm zone.

**RTF Team Leader** - Law enforcement officer responsible for coordinating RTF movement. All movement in and around the warm zone must be communicated through the RTF Team Leader.

**Secure (secondary)** – A detailed and deliberate search of an entire area. This area is safe from the suspect and from secondary devices. Law enforcement will remain in a secure area to insure it remains protected.

**Security Measures** – Any means utilized to reduce the amount of dangers or hazards to first responders and victims in a specific area or location. This can include, but is not limited to, cover, concealment, ballistic shields, law
enforcement officers with lethal weapons, vehicles, armored vehicles, positioning, teams utilizing protection element, movement, etc.

**Tactical Incident** - Any malicious activity that threatens the safety of multiple bystanders. Tactical incidents require the response of police, fire, and emergency medical resources.

**Tactical Emergency Medical Support (TEMS)** - EMS who regularly train with a Police Department. TEMS Unit members are familiar with tactical. With an appropriate protection element, TEMS members are permitted to work in the Hot Zone.

**TECC** – Tactical Emergency Casualty Care. “Patient Care in the Warm Zone using limited Equipment”.

**TEMS RESCUE TEAM** - Minimum two TEMS trained Paramedic/Firefighters, preferred three (rescue element) who team up with at least two Police Officers (protection element) to assess, treat, and evacuate victims in all zones. TEMS RESCUE TEAMS will deploy after the contact team has deployed. TECC concepts will be used in the warm zone

**Treatment Bags/ Drop Bags** – Equipment and Supplies for treating victims, supply CCP with TECC equipment. Same equipment as IFAK and additional supplies.

**Triage/Treatment/Transport (TTT)** – Typical mass casualty level care. TTT is under the supervision of the Medical Officer. Activities for TTT are typically coordinated in the Cold Zone.
APPENDIX

Approved Abbreviations
Equipment List - ALS Ambulance
Equipment List - ALS Non-Transport
Equipment List - BLS Ambulance
Concealed Weapon Chain of Custody Form
Signage for Concealed Weapon
DNR form POLST FORM
Drug Exchange Sheet
Edward Ambulance System Drug Stock
EHEMSS Communication Form
IDPH Continuing Education Suggestions
IDPH Ambulance Inspection Form
MPR Forms and Individual Refusal Forms (Department Specific)
Non-disposable Equipment Receipt
Patient Care Report
Personal Information Change Form
Pyxis ID Form
Pyxis Confidentiality Statement
SEMSV ALS Equipment-Jump Bag
Training Equipment Loan Form
# Edward Hospital EMSS
Approved Medical Abbreviations

## Common Medical Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation/ Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD</td>
<td>abdominal/abdomen</td>
</tr>
<tr>
<td>ALS</td>
<td>advanced life support</td>
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<tr>
<td>AMA</td>
<td>against medical advice</td>
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<tr>
<td>AMI</td>
<td>acute myocardial infarction</td>
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<td>AP</td>
<td>anterior-posterior</td>
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<tr>
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<td>aspirin</td>
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<td>ASHD</td>
<td>atherosclerotic heart disease</td>
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<tr>
<td>Bid</td>
<td>twice a day</td>
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<tr>
<td>BLS</td>
<td>basic life support</td>
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<td>BM</td>
<td>bowel movement</td>
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<td>BP</td>
<td>blood pressure</td>
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<td>with</td>
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<td>cancer</td>
</tr>
<tr>
<td>CAD</td>
<td>coronary artery disease</td>
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<tr>
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<td>chief complaint</td>
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<td>coronary care unit</td>
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<td>carbon dioxide</td>
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<td>chronic obstructive pulmonary disease</td>
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<td>chest pain</td>
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<td>CPR</td>
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<td>cerebrospinal fluid</td>
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<td>cerebral vascular accident</td>
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<tr>
<td>D/C</td>
<td>discontinue</td>
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<tr>
<td>DOA</td>
<td>dead on arrival</td>
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<td>DOE</td>
<td>dyspnea of exertion</td>
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<td>DTs</td>
<td>delirium tremens</td>
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<td>diagnosis</td>
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<td>ECG/EKG</td>
<td>electrocardiogram</td>
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<td>emergency department</td>
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<tr>
<td>ETA</td>
<td>estimated time of arrival</td>
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<td>ethyl alcohol</td>
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<td>foreign body</td>
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<td>mercury</td>
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<td>hour</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>h/o</td>
<td>history of</td>
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<td>history</td>
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<td>intramuscular</td>
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<td>intrauterine device</td>
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<td>IV push</td>
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<tr>
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<td>IV piggyback</td>
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<tr>
<td>JVD</td>
<td>jugular vein distention</td>
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<td>Kg</td>
<td>kilogram</td>
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<td>keep vein open</td>
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<tr>
<td>L</td>
<td>liter</td>
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<tr>
<td>L</td>
<td>left</td>
</tr>
<tr>
<td>LLQ</td>
<td>lower left quadrant</td>
</tr>
<tr>
<td>LMP</td>
<td>last menstrual period</td>
</tr>
<tr>
<td>LOC</td>
<td>level of consciousness, loss of</td>
</tr>
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<td>lower left quadrant</td>
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<tr>
<td>Mcg, g</td>
<td>microgram</td>
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<td>MCL</td>
<td>modified chest lead</td>
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<td>mEq</td>
<td>milliequivalent</td>
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<td>nasogastric</td>
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<td>NKA</td>
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### Edward Hospital EMS System
#### Required Minimum Supply & Equipment List – ALS Ambulance

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<th>Inspected by (Provider staff):</th>
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<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Airway – Cricothyrotomy Kit x2</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Item</td>
</tr>
<tr>
<td>14g angiocath (1-1/4&quot;) – 2 each</td>
</tr>
<tr>
<td>#10 scalpel – 1 each</td>
</tr>
<tr>
<td>Curved hemostat – 1 each</td>
</tr>
<tr>
<td>Chloraprep &amp; Alcohol (for &lt; 2 months old)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Airway – Pleural Decompression Kit x1</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Item</td>
</tr>
<tr>
<td>14g tactical angiocath (3.25&quot;) – 2 each</td>
</tr>
<tr>
<td>16g angiocath (1-1/4&quot;) – 2 each</td>
</tr>
<tr>
<td>18g angiocath (1-1/4&quot;) – 2 each</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Airway – Intubation</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Item</td>
</tr>
<tr>
<td>2.5mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>3.0mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>3.5mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>4.0mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>4.5mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>5.0mm Uncuffed ETT – 2 each</td>
</tr>
<tr>
<td>5.5mm Uncuffed or Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>6.0mm Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>6.5mm Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>7.0mm Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>7.5mm Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>8.0mm Cuffed ETT – 2 each</td>
</tr>
<tr>
<td>End tidal CO2 detector – adult</td>
</tr>
<tr>
<td>End tidal CO2 detector - pediatric</td>
</tr>
<tr>
<td>I-Gel – 1 each (size 3, 4, and 5)</td>
</tr>
<tr>
<td>Posi-tube – 1 each</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**If available**

<table>
<thead>
<tr>
<th>Airway – Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Item</td>
</tr>
<tr>
<td>Hand held nebulizer – 2 each</td>
</tr>
<tr>
<td>Nasal clip – 1 each</td>
</tr>
<tr>
<td>CPAP circuit – 1 each</td>
</tr>
</tbody>
</table>

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<tr>
<th>Diagnostics and Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Item</td>
</tr>
<tr>
<td>VHF (MERCI) radio with hospital check</td>
</tr>
<tr>
<td>Cardiac monitor / defibrillator</td>
</tr>
<tr>
<td>Patient cables – 2 sets</td>
</tr>
<tr>
<td>12-lead cable – 1 set</td>
</tr>
<tr>
<td>Blood glucose monitor</td>
</tr>
<tr>
<td>Blood glucose test strips - &gt;10 strips</td>
</tr>
</tbody>
</table>
### Intravenous Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male adapter plug – 2 each</td>
<td>16g autoguard (1-1/4&quot;) – 4 each</td>
</tr>
<tr>
<td>Alcohol preps – 20 each</td>
<td>18g autoguard (1-1/4&quot;) – 4 each</td>
</tr>
<tr>
<td>Chloraprep – 4 each</td>
<td>20g autoguard (1-1/4&quot;) – 4 each</td>
</tr>
<tr>
<td>.9%NaCL 1000ml bags – 6 each</td>
<td>22g autoguard (1&quot;) – 4 each</td>
</tr>
<tr>
<td>Mini drip tubing (60gtts) – 4 each</td>
<td>24g autoguard (3/4&quot;) – 4 each</td>
</tr>
<tr>
<td>Regular drip tubing (15gtts) – 4 each</td>
<td>1 ml / TB syringe – 4 each</td>
</tr>
<tr>
<td>IV start kits – 6 each</td>
<td>3 ml syringe – 4 each</td>
</tr>
<tr>
<td>Medication needles (20 &amp; 22) – 4 each</td>
<td>5 ml/6 ml syringe – 4 each</td>
</tr>
<tr>
<td>Carpject holder – 1 each</td>
<td>10 ml/12 ml syringe – 4 each</td>
</tr>
<tr>
<td>J-loops – 4 each</td>
<td>20 ml/30 ml syringe – 4 each</td>
</tr>
<tr>
<td>Armboard, padded, long – 2 each</td>
<td>60 ml syringe – 1 each</td>
</tr>
<tr>
<td>Armboard, padded, short – 2 each</td>
<td>TB isolation masks – 1 per crew member</td>
</tr>
<tr>
<td>Nasal Atomizer – 2 each</td>
<td>Stroke blood draw kits – 2 each</td>
</tr>
</tbody>
</table>

### EZ IO Intraosseous Kit x1 (>3 kg)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>EZ IO adult needle kit x 1</td>
<td>10 ml syringe – 1 each</td>
</tr>
<tr>
<td>EZ IO pediatric needle kit x 1</td>
<td>Pressure Infuser – 1 each</td>
</tr>
<tr>
<td>EZ IO LD needle kit x1</td>
<td>Chloraprep x 2</td>
</tr>
<tr>
<td>EZ IO Driver</td>
<td></td>
</tr>
</tbody>
</table>

### Medications

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine 6mg preload – 1 each</td>
<td>Fentanyl 100 mcg – 2 each</td>
</tr>
<tr>
<td>Adenosine 12mg preload – 2 each</td>
<td>Glucagon, 1mg powder kit – 2 each</td>
</tr>
<tr>
<td>Albuterol 2.5mg 0.083 – 4 each</td>
<td>Glucose, oral – 1 tube</td>
</tr>
<tr>
<td>Amiodarone 150mg – 4 each</td>
<td>Ketamine, 500mg/10ml – 2 each</td>
</tr>
<tr>
<td>Aspirin, chewable, 81mg tablets – 8 each</td>
<td>Lidocaine, 100mg – 4 each</td>
</tr>
<tr>
<td>Atropine Sulfate, 1mg preload – 6 each</td>
<td>Narcan, 2mg preload – 6 each</td>
</tr>
<tr>
<td>Ammonia inhalants – 1 box</td>
<td>Nitroglycerin, 0.4mg spray – 2 each</td>
</tr>
<tr>
<td>Benadryl, 50mg preload – 2 each</td>
<td>Sodium Bicarbonate, 50mEq preload – 2 each</td>
</tr>
<tr>
<td>Benzocaine Multi dose Spray w/&gt;2 straws – 1 or 3 single unit doses</td>
<td>Tetracaine HCl, 0.5% unit dose – 2 each</td>
</tr>
<tr>
<td>Dextrose 10% 250mL bag-2 each</td>
<td>Versed, 10mg – 2 each</td>
</tr>
<tr>
<td>Dopamine premix, 400mg/250mL – 1 each</td>
<td>.9% NaCL pre filled syringes – 4 each</td>
</tr>
<tr>
<td>Epinephrine 1:10,000, 1mg preload – 6 each</td>
<td>Zofran 4mg ODT – 2 each</td>
</tr>
<tr>
<td>Epinephrine 1:1000 1mg/1ml vial – 2 each</td>
<td>Zofran 4mg IV – 2 each</td>
</tr>
</tbody>
</table>

*All vehicles shall comply with the Administrative Code, Title 77: Public Health; Part 515 Emergency Medical Services and Trauma Center Code; Section 515.830 “Ambulance Licensing Requirements.” Waivers relevant to section 515.830 are the responsibility of the provider agency EMSC.*

07-05-06
Revised 02 2011
Revised 02/2013
Revised 7/2014
Revised 7/2016
Updated 3/2017
Updated 4-3-19
Updated 7-11-19
Updated 7-25-
updated 8-23-19
## Edward Hospital EMS System
### Required Minimum Supply & Equipment List – ALS Non-Transport

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Local ID</th>
<th>VIN (last 4 digits)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Inspected by (EMS Staff):</th>
<th>Inspected by (Provider staff):</th>
</tr>
</thead>
</table>

### Airway – Cricothyrotomy Kit x1

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>14g angiocath (1-1/4”) – 2 each</td>
<td>Gauze sponges – 2 each</td>
</tr>
<tr>
<td>#10 scalpel – 1 each</td>
<td>6.0 ETT – 1 each</td>
</tr>
<tr>
<td>Curved hemostat – 1 each</td>
<td>3.0 ETT – 1 each</td>
</tr>
<tr>
<td>Betadine &amp; Alcohol (for &lt; 2 months old)</td>
<td>Chloraprep x 2 (for &gt; 2 months old)</td>
</tr>
</tbody>
</table>

### Airway – Pleural Decompression Kit x1

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>14g tactical angiocath (3.25”) – 2 each</td>
<td>Betadine &amp; Alcohol (for &lt; 2 months old)</td>
</tr>
<tr>
<td>16g angiocath (1-1/4&quot;) – 2 each</td>
<td>Chloraprep x 2 (for &gt; 2 months old)</td>
</tr>
<tr>
<td>18g angiocath (1-1/4&quot;) – 2 each</td>
<td>Syringe 10 ml – 1 each</td>
</tr>
</tbody>
</table>

### Airway – Intubation

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5mm Uncuffed ETT – 1 each</td>
<td>Laryngoscope handle w/spare batteries – adult</td>
</tr>
<tr>
<td>3.0mm Uncuffed ETT – 1 each</td>
<td>Laryngoscope handle w/spare batteries – ped</td>
</tr>
<tr>
<td>3.5mm Uncuffed ETT – 1 each</td>
<td>#0 straight blade</td>
</tr>
<tr>
<td>4.0mm Uncuffed ETT – 1 each</td>
<td>#1 straight blade</td>
</tr>
<tr>
<td>4.5mm Uncuffed ETT – 1 each</td>
<td>#2 straight blade</td>
</tr>
<tr>
<td>5.0mm Uncuffed ETT – 1 each</td>
<td>#3 straight blade</td>
</tr>
<tr>
<td>5.5mm Uncuffed ETT – 1 each</td>
<td>#2 curved blade</td>
</tr>
<tr>
<td>6.0mm Cuffed ETT – 1 each</td>
<td>#3 curved blade</td>
</tr>
<tr>
<td>6.5mm Cuffed ETT – 1 each</td>
<td>Spare bulbs if not using fiberoptics</td>
</tr>
<tr>
<td>7.0mm Cuffed ETT – 1 each</td>
<td>Magill forceps – adult</td>
</tr>
<tr>
<td>7.5mm Cuffed ETT – 1 each</td>
<td>Magill forceps – pediatric</td>
</tr>
<tr>
<td>8.0mm Cuffed ETT – 1 each</td>
<td>Tube tamer – adult</td>
</tr>
<tr>
<td>End tidal CO2 detector – adult</td>
<td>Tube tamer – pediatric</td>
</tr>
<tr>
<td>End tidal CO2 detector – pediatric</td>
<td>Stylet, adult – 1 each</td>
</tr>
<tr>
<td>I-Gel 1 each (size 3,4,5)</td>
<td>Stylet, pediatric – 1 each</td>
</tr>
<tr>
<td>Posi-tube – 1 each</td>
<td></td>
</tr>
</tbody>
</table>

### Airway – Miscellaneous

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand held nebulizer – 1 each</td>
<td>In-line nebulizer – 1 each</td>
</tr>
<tr>
<td>Nasal clip – 1 each</td>
<td>Broselow tape – 1 each</td>
</tr>
<tr>
<td>CPAP circuit 1-each</td>
<td>Soft T Tourniquet-1 each</td>
</tr>
</tbody>
</table>

### Diagnostics and Communication

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHF (MERCI) radio with hospital check</td>
<td>Electrodes, adult – 15 each</td>
</tr>
<tr>
<td>Thermometer</td>
<td>Defibrillation pads – 1 set (adult)</td>
</tr>
<tr>
<td>Cardiac monitor / defibrillator</td>
<td>Defibrillation pads – 1 set (pediatric)</td>
</tr>
<tr>
<td>Spare paper – 1 roll</td>
<td>Gel if not using pads</td>
</tr>
<tr>
<td>Patient cables – 1 set</td>
<td>Accucheck test strips &gt;10 strips</td>
</tr>
<tr>
<td>Accucheck glucose monitor – 1 each</td>
<td></td>
</tr>
</tbody>
</table>
### Intravenous Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male adapter plug – 2 each</td>
<td>16g autoguard (1-1/4&quot;) – 3 each</td>
</tr>
<tr>
<td>Vial adapter – 2 each</td>
<td>18g autoguard (1-1/4&quot;) – 3 each</td>
</tr>
<tr>
<td>Alcohol preps – 20 each</td>
<td>20g autoguard (1-1/4&quot;) – 3 each</td>
</tr>
<tr>
<td>Chloraprep – 4 each</td>
<td>22g autoguard (1&quot;) – 3 each</td>
</tr>
<tr>
<td>.9%NaCl 1000ml bags – 2 each</td>
<td>24g autoguard (3/4&quot;) – 3 each</td>
</tr>
<tr>
<td>Mini drip tubing (60gtts) – 1 each</td>
<td>1 ml / TB syringe – 3 each</td>
</tr>
<tr>
<td>Regular drip tubing (15gtts) – 2 each</td>
<td>3 ml syringe – 2 each</td>
</tr>
<tr>
<td>IV start kits – 4 each</td>
<td>5 ml/6 ml syringe – 2 each</td>
</tr>
<tr>
<td>Medication needles (20 &amp; 22) – 4 each</td>
<td>10 ml/12 ml syringe – 2 each</td>
</tr>
<tr>
<td>Carpuject holder – 1 each</td>
<td>20 ml/30 ml syringe – 2 each</td>
</tr>
<tr>
<td>J-loops – 4 each</td>
<td>60 ml syringe – 1 each</td>
</tr>
<tr>
<td>Nasal Atomizer – 2 each</td>
<td>TB isolation masks – 1 per crew member</td>
</tr>
<tr>
<td>Stroke Blood Draw Kit – 1 each</td>
<td></td>
</tr>
</tbody>
</table>

### EZ IO Intraosseous Kit x1 (>3 kg)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>EZ IO adult and bariatric needle x 1 each</td>
<td>EZ connect extension tubing x 2</td>
</tr>
<tr>
<td>EZ IO pediatric needle</td>
<td>10 ml syringe – 1 each</td>
</tr>
<tr>
<td>EZ IO Driver</td>
<td>Chloraprep x 2</td>
</tr>
<tr>
<td>EZ IO wrist band x 2</td>
<td></td>
</tr>
</tbody>
</table>

### Medications

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine 6mg preload – 1 each</td>
<td>Fentanyl 100 mcg – 2 each</td>
</tr>
<tr>
<td>Adenosine 12mg preload – 1 each</td>
<td>Glucagon, 1mg powder kit – 1 each</td>
</tr>
<tr>
<td>Albuterol 2.5mg 0.083 – 2 each</td>
<td>Glucose, oral – 1 tube</td>
</tr>
<tr>
<td>Amiodarone 150 mg – 4 each</td>
<td>Ketamine 500mg/10ml – 1 each</td>
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<tr>
<td>Aspirin, chewable, 81mg tablets – 8 each</td>
<td>Lidocaine, 100mg – 4 each</td>
</tr>
<tr>
<td>Atropine Sulfate, 1mg preload – 3 each</td>
<td>Narcan, 2mg preload – 6 each</td>
</tr>
<tr>
<td>Ammonia inhalants – 1 box</td>
<td>Nitroglycerine, 0.4mg spray – 1 each</td>
</tr>
<tr>
<td>Benadryl, 50mg preload – 2 each</td>
<td>Sodium Bicarbonate, 50mEq preload – 1 each</td>
</tr>
<tr>
<td>Benzocaine Multi-dose Spray w/2 straws – 1 or 2 single unit doses</td>
<td>Tetracaine HCl, 0.5% unit dose – 1 each</td>
</tr>
<tr>
<td>Dextrose 10% 250mL bag -1 each</td>
<td>Versed, 10mg – 2 each</td>
</tr>
<tr>
<td>Epinephrine 1:10,000, 1mg preload – 2 each</td>
<td>.9% NaCL pre filled syringes – 2 each</td>
</tr>
<tr>
<td>Epinephrine 1:1000, 1mg/1ml vial-2 each</td>
<td>Zofran 4 mg/2ml – 1 each</td>
</tr>
<tr>
<td></td>
<td>Zofran 4 mg ODT – 2 each</td>
</tr>
</tbody>
</table>

---

All vehicles shall comply with the Administrative Code, Title 77: Public Health; Part 515 Emergency Medical Services and Trauma Center Code; Section 515.825 “Alternate Response Vehicle.” Waivers relevant to section 515.825 are the responsibility of the provider agency EMSC.
## Edward Hospital EMS System
### Required Minimum Supply & Equipment List – BLS Ambulance

<table>
<thead>
<tr>
<th>Provider</th>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Local ID</th>
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<table>
<thead>
<tr>
<th>Inspected by (EMS Staff):</th>
<th>Inspected by (Provider staff):</th>
</tr>
</thead>
</table>

### Diagnostics and Communication

<table>
<thead>
<tr>
<th>√</th>
<th>Item</th>
<th>√</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cardiac monitor / defibrillator</td>
<td>Defibrillation pads – 1 set (adult) or gel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood glucose monitor</td>
<td>Defibrillation pads – 1 sets (pediatric) or gel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood glucose test strips - &gt;10 strips</td>
<td>Telemetry phone – 1 each</td>
<td></td>
</tr>
</tbody>
</table>

### Miscellaneous Supplies

<table>
<thead>
<tr>
<th>√</th>
<th>Item</th>
<th>√</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hand-held nebulizer – 1 each</td>
<td>TB isolation masks – 1 per crew member</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nasal Atomizer – 1 each</td>
<td>Tourniquet (SOFTT) - 1each</td>
<td></td>
</tr>
</tbody>
</table>

### Medications

<table>
<thead>
<tr>
<th>√</th>
<th>Item</th>
<th>√</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Albuterol 2.5mg 0.083 – 1 each</td>
<td>Glucose, oral – 1 tube</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aspirin, chewable, 81mg tablets – 4 each</td>
<td>Narcan, 2mg preload – 1 each</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1000 auto-injector (EpiPEN) Adult – 1 each</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1000 auto-injector (EpiPEN) Pediatric – 1 each</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Created 9/2016
Revised 02/17
# Concealed Weapon Chain of Custody Form

## Documentation of Weapon(s)

<table>
<thead>
<tr>
<th>Handgun(s)</th>
<th>Other</th>
<th>How Many &amp; Type(s) of Each Indicated Above</th>
</tr>
</thead>
</table>

## Confinement of Weapon(s)

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

**Lock Box Snap Lock Number(s)**

**Placed by**

- **Agency/Facility**
- **Signature**
- **Date**

**Witness**

- **Agency/Facility**
- **Signature**
- **Date**

### Delivery of Weapon(s) from EMS to Hospital

- **Patient / Other (Circle one) Signature of Release to Secure Weapon**
- **Lock Box Snap Lock Number(s)**

**Given by**

- **Agency/Facility**
- **Signature**
- **Date**

**Received by**

- **Agency/Facility**
- **Signature**
- **Date**

### Release of Weapon(s) from Hospital to Owner

- **Patient/Other (Circle one) Signature of Release to Secure Weapon**
- **Lock Box Snap Lock Number(s)**

**Given by**

- **Agency/Facility**
- **Signature**
- **Date**

**Received by**

- **Agency/Facility**
- **Signature**
- **Date**

## Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Proof of Identification:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>Proof of CCW Permit:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pursuant to 430 ILCS 66/65
A

CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

- Attempt Resuscitation/CPR
- Do Not Attempt Resuscitation/DNR

(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

B

MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

- Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated.
- Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit.
- Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Optional Additional Orders

C

MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

- Long-term medically administered nutrition, including feeding tubes. Additional Instructions (e.g., length of trial period)
- Trial period of medically administered nutrition, including feeding tubes.
- No medically administered means of nutrition, including feeding tubes.

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

- Patient
- Agent under health care power of attorney
- Parent of minor
- Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

<table>
<thead>
<tr>
<th>Signature (required)</th>
<th>Name (print)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>______________</td>
<td>__________</td>
</tr>
</tbody>
</table>

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

<table>
<thead>
<tr>
<th>Signature (required)</th>
<th>Name (print)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>______________</td>
<td>__________</td>
</tr>
</tbody>
</table>

Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient’s medical condition and preferences.

<table>
<thead>
<tr>
<th>Print Authorized Practitioner Name (required)</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>(          ) _________ -  ______________</td>
</tr>
</tbody>
</table>

Authorized Practitioner Signature (required)

<table>
<thead>
<tr>
<th>Date (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
</tr>
</tbody>
</table>

Form Revision Date - April 2016

(Prior form versions are also valid.)
**THIS SIDE FOR INFORMATIONAL PURPOSES ONLY**

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

### Advance Directive Information

I also have the following advance directives (OPTIONAL)

- [ ] Health Care Power of Attorney
- [ ] Living Will Declaration
- [ ] Mental Health Treatment Preference Declaration

<table>
<thead>
<tr>
<th>Contact Person Name</th>
<th>Contact Phone Number</th>
</tr>
</thead>
</table>

### Health Care Professional Information

<table>
<thead>
<tr>
<th>Preparer Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparer Title</td>
<td>Date Prepared</td>
</tr>
</tbody>
</table>

### Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

### Reviewing a POLST Form

This POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- or there is a substantial change in the patient’s health status, or
- or the patient’s treatment preferences change, or
- or the patient’s primary care professional changes.

### Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

### Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient’s guardian of person
2. Patient’s spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient’s guardian of the estate

For more information, visit the IDPH Statement of Illinois law at [http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives](http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives)

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Page 2
<table>
<thead>
<tr>
<th>Quantity:</th>
<th>Drug:</th>
<th>NDC:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adenosine 6mg/2ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adenosine 12mg/4ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albuterol 2.5mg/3ml 0.83% neb</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amiodarone 50mg/ml, 3ml vial*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aspirin 81mg chewable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atropine Sulfate 1mg/10ml syr</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ammonia inhalants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diphenhydramine 50mg/ml</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hurricane Spray</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dextrose 5%, 100ml BBraun PAB bag*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dextrose 25% 10ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dextrose 50% 50ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dopamine 400mg/250ml</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1,000 30mg vial – 1 each</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1,000 injection, 1ml</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:10,000 1mg/10ml Syringe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EAS only-Epinephrine 1:1000 auto injector (adult epi pen)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EAS only-Epinephrine 1:1000 auto injector (Peds epi pen)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Etomidate 40mg/20ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fentanyl 50mcg/ml, 2ml</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glucagon 1mg Kit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glucose gel, 37.5gm tube</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ketamine 500mg/10ml vial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lidocaine 100mg/5ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midazolam 10mg/2ml vial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Narcan 2mg/2ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nitroglycerin 0.4mg/spray, 4.9gm spray</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ondansetron 4mg ODT tab and 4mg/2ml vial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium Bicarb 1mEq/ml, 50ml Prefilled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tetracaine HCl 0.5% Opth, 2ml UD</td>
<td></td>
</tr>
</tbody>
</table>

*One vial of amiodarone, one bag of D5W 100ml (in the hard plastic, NOT a hospira bag) and one 0.2micron filter make up an “Amiodarone Kit. Pharmacy does not supply these kits pre-made, but we do supply all of the individual components.

**EMS Provider Name (printed): ____________________________

**EMS Provider Signature: ____________________________

**EMS Vehicle ID: ____________________________  (Circle one) Transport / Non-Transport

**EMS Departments: Bolingbrook, Darien/Woodridge, Edward Ambulance, Lisle/Woodridge, Naperville, Warrenville, Romeoville

***Providers from departments not listed above must fill out an Out of System Provider sheet for med restock***

**Pharmacy Tech Initials: _______  Pharmacist Initials ________  Date: ____________

Revised 10/02/15; 02/10/2017, 1/10/2018, 9/20/2018

G:\Pharmacy Doc\Forms\EMS Exchange Sheet
## Edward Ambulance Service Restock List

<table>
<thead>
<tr>
<th>Drug</th>
<th>NDC:</th>
<th>Qty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine 6mg/2ml Prefilled</td>
<td>00469-8234-12</td>
<td></td>
</tr>
<tr>
<td>Adenosine 12mg/4ml Prefilled</td>
<td>00469-8234-14</td>
<td></td>
</tr>
<tr>
<td>Albuterol 2.5mg/3ml 0.83% neb</td>
<td>00487-9501-01</td>
<td></td>
</tr>
<tr>
<td>Amiodarone 150mg/3ml vial</td>
<td>67457-0153-03</td>
<td></td>
</tr>
<tr>
<td>Amyl Nitrate amps</td>
<td>39822-9950-02</td>
<td></td>
</tr>
<tr>
<td>Aspirin 81mg chewable</td>
<td>63739-0434-01</td>
<td></td>
</tr>
<tr>
<td>Atropine Sulfate 1mg/10ml syr</td>
<td>00409-4911-34</td>
<td></td>
</tr>
<tr>
<td>Ammonia inhalants</td>
<td>39822-9900-01</td>
<td></td>
</tr>
<tr>
<td>Calcium Chloride 10% 1gm/10ml Syr</td>
<td>00409-4928-34</td>
<td></td>
</tr>
<tr>
<td>Calcium Gluconate 10%, 1gm/10ml vial</td>
<td>63323-0311-10</td>
<td></td>
</tr>
<tr>
<td>Dextrose 5%, 100ml IVPB (Bbraun PAB)</td>
<td>00264-1510-31</td>
<td></td>
</tr>
<tr>
<td>Dextrose 5%, 500ml IVPB</td>
<td>00264-7612-20</td>
<td></td>
</tr>
<tr>
<td>Dextrose 25% 10ml Prefilled</td>
<td>00548-3315-00</td>
<td></td>
</tr>
<tr>
<td>Dextrose 50% 50ml Prefilled</td>
<td>00409-4902-34</td>
<td></td>
</tr>
<tr>
<td>Diltiazem 5mg/ml 5ml vial</td>
<td>63323-0664-01</td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine 50mg/ml</td>
<td>63323-0664-01</td>
<td></td>
</tr>
<tr>
<td>Dobutamine 250mg/250ml Bag</td>
<td>00409-7809-24</td>
<td></td>
</tr>
<tr>
<td>Dopamine 400mg/250ml (1600mcg/ml)</td>
<td>00409-7809-24</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:1000 injection, 30ml vial</td>
<td>00517-1130-05</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:10,000 1mg/10ml Syr</td>
<td>00409-4921-34</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:1,000 1mg/ml, 1ml VIAL</td>
<td>42023-0122-25</td>
<td></td>
</tr>
<tr>
<td>Epinephrine RACEMIC Neb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epi Pen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etiomidate 40mg/20ml Prefilled</td>
<td>00409-8060-29</td>
<td></td>
</tr>
<tr>
<td>Glucagon 1mg Kit</td>
<td>55390-0004-01</td>
<td></td>
</tr>
<tr>
<td>Glucose gel, 37.5gm tube</td>
<td>00574-0070-30</td>
<td></td>
</tr>
<tr>
<td>Fentanyl 50mcg/ml, 2ml</td>
<td>00409-9631-04</td>
<td></td>
</tr>
<tr>
<td>Furosemide 40mg/4ml Prefilled</td>
<td>00409-9631-04</td>
<td></td>
</tr>
<tr>
<td>Ketamine 500mg/10ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labetalol 5mg/ml, 20ml vial</td>
<td>00409-2267-30</td>
<td></td>
</tr>
<tr>
<td>Lidocaine 100mg/5ml Prefilled</td>
<td>00409-4903-34</td>
<td></td>
</tr>
<tr>
<td>Magnesium Sulfate 5gm</td>
<td>00409-1754-10</td>
<td></td>
</tr>
<tr>
<td>Midazolam 10mg/2ml vial</td>
<td>55390-0138-02</td>
<td></td>
</tr>
<tr>
<td>Morphine Sulfate 10mg/ml vial</td>
<td>00409-1261-30</td>
<td></td>
</tr>
<tr>
<td>Narcan 2mg/2ml Prefilled</td>
<td>00548-3369-00</td>
<td></td>
</tr>
<tr>
<td>Nitroglycerin 0.4mg/spray, 4.9gm spray</td>
<td>59630-0300-65</td>
<td></td>
</tr>
<tr>
<td>Norepinephrine 1mg/ml, 4ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ondansetron 4mg/2ml vial</td>
<td>00409-4755-03</td>
<td></td>
</tr>
<tr>
<td>Sodium Bicarb 1mEq/ml, 50ml Prefilled</td>
<td>00409-6637-34</td>
<td></td>
</tr>
<tr>
<td>Succinylcholine 20mg/ml, 10ml vial</td>
<td>00406-6629-02</td>
<td></td>
</tr>
<tr>
<td>Tetracaine HCl 0.5% Opth, 2ml UD</td>
<td>00065-0741-12</td>
<td></td>
</tr>
</tbody>
</table>

Provider: ____________________________

Tech: ______________________________

RPh: ________________________________

Date: ______________________________

Epi Pen and Epi Pen Jr must be requested via Anne Yeglic two business days in advance
EHEMSS Communication Form

The information requested on this form is necessary to conduct a thorough investigation to clarify certain situations. This information is privileged and confidential.

Incident Information

Date Report Filed: Date of Occurrence: Time of Occurrence:

Location of Incident:

Type of Incident (check all that apply)

☐ Commendation ☐ Communication ☐ Assessment ☐ EMS Provider Related
☐ Medications ☐ Procedure ☐ Injury – Patient ☐ Patient Related
☐ Equipment Related ☐ Deviation from SOP ☐ Injury – EMT ☐ ED Staff Related

Agencies/Organizations Involved: EMS Report Number: ECRN Log Number:

Receiving Hospital: Report Initiated By:

System Personnel Involved (list all names):

Non-EMS System Personnel Involved:

Incident Description:

**EMS PERSONNEL – STOP! – DO NOT WRITE BELOW THIS LINE**

EMS System Review:

Disposition

☐ Commendation ☐ Unfounded ☐ Re-education ☐ Incident Closed
☐ Verbal Warning ☐ Written Warning ☐ Suspension ☐ Date: / / 

Signature of EMS System Coordinator: _______________________________ Date: ___/___/___

Signature of EMS Medical Director: ________________________________ Date: ___/___/___

All information contained herein shall be “Privileged and Confidential under the Illinois Medical Studies Act”
Emergency Medical Systems
Continuing Education Relicensure Recommendations

This Continuing Education (CE) list is NOT intended to be all-inclusive and should be considered as CE Recommendations ONLY. A wide variety of educational programs, seminars, online offerings, and workshops that are not listed below may also meet the intent of national standards for EMS continuing education.

**Standard Documentation** required to validate completion for all CE in Illinois: CE certificate, course card, or sign-in roster signed by instructor or authorizing person to include: name of participant; date; times; topic(s); number of CE hours awarded; and Illinois site code, CECBEMS, and/or medical or nursing accrediting body number. All CE hours awarded must be approved by the EMS Medical Director.

**Calculating hours for AEMT/EMT-I and EMT:** The hours listed in this document are for Paramedics (based on 100 hours in 4 years).

- **AEMT and EMT-I:** Multiply required hours for Paramedics by 0.8 (80 hours in 4 years).
- **EMT:** Multiply required hours for Paramedics by 0.6 (60 hours in 4 years).

NOTE: EMS personnel should verify the continuing education requirements within their EMS System(s). EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Documentation</th>
<th>Hours Recommended</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor</strong></td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr up to 16 hours for each course</td>
<td>May not exceed 20% of total hours for one subject area. Educators may not get credit for presenting the same topic/lecture multiple times. Up to 50% of total hours may be earned by teaching participants at a lower level of licensure. Should be considered on a case by case basis for any topics in EMS education standards.</td>
</tr>
<tr>
<td><strong>Advanced Trauma Life Support, Teaching EMS-related courses/ CE, Wilderness EMS Training, TEMS, MIH Community PM, Critical Care PM</strong></td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr for EMS content of course</td>
<td></td>
</tr>
<tr>
<td><strong>Refresher/renewal education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor</strong></td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr up to 8 hours</td>
<td></td>
</tr>
<tr>
<td>EMTs: PEPP (BLS) course</td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr up to 8 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric related CE</strong></td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr up to 16 hours max</td>
<td>Pediatric education now has much greater emphasis than in the 1998 DOT curriculum. Illinois recommends 16 hours in 4 yrs. Topics include: Pediatrics, Neonatology, Gynecology and Obstetrics.</td>
</tr>
<tr>
<td><strong>Initial courses:</strong> CPR Instructor, Emergency Vehicle Operators course, Emergency Medical Dispatch course</td>
<td>Standard documentation and course schedule</td>
<td>Hr/Hr up to 12 hours max</td>
<td></td>
</tr>
<tr>
<td><strong>Locally offered CE programs</strong></td>
<td>Standard documentation</td>
<td>Hr/Hr to max content hours</td>
<td>May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.</td>
</tr>
<tr>
<td>Audit of entry level EMT, AEMT, Paramedic courses</td>
<td>Standard documentation</td>
<td>Hr/Hr to max content hours</td>
<td>Unlimited hours if subject matter is at the appropriate level for the participant's license. May not exceed 20% of total required hours in one subject area, e.g., cardiac, trauma, rescue, etc.</td>
</tr>
<tr>
<td>Activity</td>
<td>Documentation</td>
<td>Hours Recommended</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Clinical preceptor or evaluator</strong></td>
<td>Signed letter from EMS Coordinator or lead instructor</td>
<td>Hr/Hr to max hours allowable</td>
<td>May not exceed 20% of total minimum required CE hours.</td>
</tr>
<tr>
<td><strong>Emergency Preparedness</strong></td>
<td>Written statement of participation from EMSC/EMS MD or exercise director.</td>
<td>Hr/Hr up to 12 hours (Paramedic/PHRN) 10 hours (EMT-I) 8 hours (EMT)</td>
<td>EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.</td>
</tr>
<tr>
<td><strong>College courses:</strong> Health-related courses that relate to the role of an EMS professional (A&amp;P, assessment, physiology, biology, chemistry, microbiology, pharmacology, psychology, sociology, nursing/PA courses, etc.)</td>
<td>Catalog description of course and evidence of successful completion through minimum grade of C (official transcripts or evidence from school)</td>
<td>Hr/Hr 1 college credit = 8 CEU</td>
<td>May not exceed 20% of total hours for one subject area. Should be considered on a case by case basis for any topics in EMS education standards.</td>
</tr>
<tr>
<td>Participation/observation in surgery, physical therapy, childbirth, autopsy, etc.</td>
<td>Written statement of participation from: clinical unit leader, preceptor or physician validating attendance</td>
<td>Hr/Hr up to max of 5 hours</td>
<td>Max 5 hours must be part of an approved educational experience or include defined educational objectives.</td>
</tr>
<tr>
<td><strong>Seminars/Conferences:</strong> EMS related education approved by CECBEMS or medical or nursing accrediting body</td>
<td>Copy of agenda/program plus certificate of attendance</td>
<td>Hr/Hr to max content hours</td>
<td>May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.</td>
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<tr>
<td><strong>Commercial CE:</strong> Electronic digital media (e.g. videotapes/CDs), journal articles with publication dates of 5 years or less prior to the date of CE completion. Approved by CECBEMS or medical or nursing accrediting body</td>
<td>Standard documentation</td>
<td>Hr/Hr to max content hours</td>
<td>May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.</td>
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<td><strong>Trauma Nurse Specialist or TNS Review Courses:</strong> May audit for CE with prior approval of TNS Course Coordinator to ensure space availability</td>
<td>Standard documentation</td>
<td>Hr/Hr to max content hours</td>
<td>May not exceed 20% of total minimum required hours in one subject area. Course covers multiple areas of A&amp;P, fluid &amp; electrolytes, acid base balance, shock pathophysiology and systems trauma appropriate for PMs and PHRNs for full credit.</td>
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<td><strong>ECRN Course (apart from Life Support courses):</strong> May audit for CE with prior approval of Course Lead Instructor to ensure space availability</td>
<td>Standard documentation</td>
<td>Hr/Hr to max content hours</td>
<td>May not exceed 20% of total minimum required hours in one subject area. Course may cover multiple across the spectrum of EMS appropriate for PMs and PHRNs for full credit</td>
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<td><strong>On-line options</strong> Webinars and on-line offerings with subject matter found in the EMS Education Standards [e.g. sponsored by a governmental agency (infectious diseases, emergency preparedness) legal experts (documentation HIPAA) organizations or commercial offerings].</td>
<td>Standard documentation</td>
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The below table outlines Illinois recommendations of Core Content breakdown during each relicensure period for Paramedics (hours for AEMT, EMT-I and EMT should be calculated accordingly).

**Note:** EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements as outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

<table>
<thead>
<tr>
<th>CORE CONTENT</th>
<th>ILLINOIS RECOMMENDED HOURS</th>
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<tbody>
<tr>
<td>Preparatory</td>
<td>8 hours in 4 years</td>
<td>Medical</td>
<td>20 hours in 4 years</td>
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<tr>
<td>Airway Management &amp; Ventilation</td>
<td>12 hours in 4 years</td>
<td>Special Considerations (Neonatology, Pediatrics, Gynecology, Obstetrics)</td>
<td>16 hours in 4 years</td>
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<tr>
<td>Patient Assessment</td>
<td>8 hours in 4 years</td>
<td>Geriatrics</td>
<td>4 hours in 4 years</td>
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<tr>
<td>Trauma</td>
<td>12 hours in 4 years</td>
<td>Operations</td>
<td>4 hours in 4 years</td>
</tr>
<tr>
<td>Cardiology</td>
<td>16 hours in 4 years</td>
<td>TOTAL</td>
<td>100 hours in 4 years</td>
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State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems
Ambulance Inspection Form

Provider __________________________________________________________ License No. ________________________
Garage Address _______________________________________________________________________________________
VIN _____________________________ Level of Care _______ Local ID ______________ EMS System No. __________
Inspection Type ___________________________ Inspected By ______________________________________
Inspection Date ___________________ Inspection Status __________________ Action ___________________________

Patient Transport Equipment

[1] Wheeled multi-level cot w/three sets of straps + over shoulder straps
[2] Three-Point fastener for cot
[3] Cot fits securely in fastener
[4] Secondary stretcher w/three sets of straps

Main On-board Oxygen Equipment

[5] Main (on-board) oxygen cylinder not empty
   -- volume (psi): ____________________
[6] Adult size non-rebreather oxygen mask (minimum one)
[7] Child size oxygen mask (minimum one)
[8] Infant size oxygen mask (minimum one)
[9] Adult size nasal cannulas (minimum three)
[10] Child size nasal cannulas (minimum three)

Portable Oxygen Equipment

   -- volume (psi): ____________________
[12] Dial flowmeter/regulator for 15 lpm
[15] Adult size non-rebreather oxygen mask (minimum one)
[16] Child size oxygen mask (minimum one)
[17] Infant size oxygen mask (minimum one)
[18] Adult size nasal cannulas (minimum one)
[19] Child size nasal cannulas (minimum one)

Suction and Airway Equipment

[20] Onboard suction capable of obtaining 300 mmHg suction within four seconds of clamping tube
   a) Vacuum level can be adjusted
   b) Collection bottle holds 1,000 ml
[21] Two packages suction tubing capable of reaching second patient being transported on squad bench
[22] Portable battery operated suction capable of obtaining 300 mmHg suction within four seconds of clamping tubing
   a) Capable of charging from vehicle 12-volt DC/115-volt AC OR
   b) Operated from internal rechargeable battery
   c) Operates for 20 continuous minutes (perform if battery sounds weak) OR
   d) Manually operated suction device (IDPH approved)
[23] Sterile, single-use suction catheters, two each size: 6, 8, 10, 12, 14, 16, 18 French with on-board suction control port
   one set with on-board suction; one set with portable suction
[24] Semi-rigid pharyngeal suction tips, with thumb suction control port (three)
[25] Airway, oropharyngeal, adult, child and infant sizes 00-5
[26] Airway, nasopharyngeal, sizes 12-34 French
[27] Lubricant for nasopharyngeal airways

Resuscitation Equipment

[28] Adult size squeeze bag-valve-mask ventilation unit with transparent adult mask (minimum one)
[29] Child size squeeze bag-valve-mask ventilation unit with child, infant and newborn transparent masks (minimum one)
[30] CPR mask with safety valve to prevent backflow of expired air and secretions (minimum one)
Resuscitation Equipment (continued)

[31] Automated External Defibrillator (AED) with adult and pediatric capability
  a) Adult AED pads
  b) Pediatric AED pads
  OR

[32] Cardiac monitor capable of defibrillation, with adult and pediatric capability
  a) Adult AED pads
  b) Pediatric AED pads

Extrication/Immobilization/Splinting Equipment

[33] Long spine board (72” x 16” minimum) with three sets of torso straps
[34] Short spine board (32” x 16” minimum) with two (9-foot) torso straps, one child strap and one head strap
  OR
[35] Vest type wrap around extrication device
[36] Infant size rigid cervical collar (minimum one)
[37] Child size rigid cervical collar (minimum one)
[38] Small adult size rigid cervical collar (minimum one)
[39] Medium adult size rigid cervical collar (minimum one)
[40] Large adult size rigid cervical collar (minimum one)
  OR
[41] Rigid cervical collar adjustable to adult sizes (minimum one)
[42] Rigid cervical collar adjustable to pediatric sizes (minimum one)
[43] Traction splint, adult
[44] Traction splint pediatric
[45] Extremity splints, adult (two long)
[46] Extremity splints, adult (two short)
[47] Extremity splints, pediatric (two long)
[48] Extremity splints, pediatric (two short)
[49] Restraints (two pair, arm and leg, for four-point restraint)
[50] Wrecking bar (24” minimum)
[51] Goggles

Assessment Equipment

[52] Pulse oximeter with adult and pediatric capability/probes
[53] Blood pressure cuff, large adult
[54] Blood pressure cuff, adult
[55] Blood pressure cuff, child
[56] Blood pressure cuff, infant
[57] Gauge(s) for blood pressure cuffs appropriately calibrated
[58] Stethoscopes (two)
[59] Flashlight, for patient assessment (minimum one)
[60] Adequate lighting to allow patient assessment
[61] Electric clock with sweep second hand

Medical Supplies

[62] Trauma dressings (12” x 30”), (six)
[63] Gauze pads 4” x 4”), sterile (20)
[64] Gauze, soft, self-adhering (4” x 5 yards), (10 rolls)
[65] Vaseline gauze (3” x 8”), (two)
[66] Adhesive tape (two rolls)
[67] Triangle bandages or slings (five)
[68] Bandage shears (minimum one)
[69] Burn sheets, clean, individually wrapped, (two)
[70] Cold packs (three)
[71] Obstetrical kit, sterile (minimum one, pre-packaged with instruments and bulb syringe)
[72] Thermal absorbent blanket and head cover OR aluminum foil OR appropriate heat reflective material (one per OB kit)
[73] Sterile solution (normal saline) in plastic bottles or bags, 2,000cc
[74] Drinking water, one quart (may substitute 1,000 cc sterile water)
[75] Epinephrine, adult
[76] Epinephrine, pediatric
[77] Pediatric equipment/drug dosage sizing tape, current
  OR
[78] Pediatric equipment/drug age/weight chart
[79] Pediatric trauma score reference
[80] Emesis basin or bag (minimum one)
[81] Bedpan (one)
[82] Urinal (one)
[83] Child and infant car seats or convertible car seat

Personal Protective Equipment (PPE)

[84] Impermeable biohazard-labeled isolation bag (minimum one)
[85] Nonporous disposable gloves
[86] Face masks (minimum one per crew member)
[87] Eye protection face shields or safety glasses/protective eyewear (minimum one per crew member)

Linens

[88] Pillows (minimum two)
[89] Sheets (minimum two)
[90] Blankets (minimum two)
[91] Pillowcases (minimum two)
Communication
[92] Ambulance emergency run reports with data required by IDPH (Minimum 10)

OR

[93] Electronic documentation with paper backup

[94] Illinois Poison Center Number

[95] IDPH Central Complaint Hotline number (must be posted where visible to patient)

[96] Ambulance-to-hospital radio tested and working

Safety/General Vehicle

[97] Patient area is clean

[98] Equipment in patient area is secured/crash-stable

[99] Flashlight (minimum one)

[100] Fire extinguishers (5 pound ABC, two with current service tag)

[101] Emergency warning lights operational

[102] Siren operational

[103] Flood lights operational

[104] Current Illinois Department of Transportation – issued safety inspection sticker on windshield

[105] No visually apparent issues which would compromise the safety of the patient, the ambulance personnel or the public

Inspector’s Comments:
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MULTIPLE PATIENT RELEASE FROM MEDICAL RESPONSIBILITY (MPR)

We acknowledge that we have received medical advice which we are refusing. **We understand that by refusing the advice offered, my (or the patient, in the case of my being the guardian or agent) condition could change or worsen and that we may suffer injuries which could cause disability or death.** Accordingly, we release the following persons and entities from any responsibility or liability for any injury that we might suffer after signing this form, including liability in favor of myself or any other person who may be entitled by law to compensation as a result of my injuries:

- The Bolingbrook Fire Department, and its employees;
- Edward Hospital Services, Edward Hospital Emergency Medical Services system, and their employees;
- Edward Hospital, which was consulted by the Emergency Medical Service (hereafter EMS) personnel for medical control, and its physicians, nurses and employees.

**X** I am not injured and I refuse services and transport.

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Created 5/2009 | WHITE – PROVIDER COPY | YELLOW – EMS SYSTEM OFFICE
EDWARD HOSPITAL EMS SYSTEM  
BOLINGBROOK FIRE DEPARTMENT

License #__________   Unit#_________ Date_____/_____/_____       Incident #___________________

RELEASE FROM MEDICAL RESPONSIBILITY

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- That I should have emergency first-aid treatment, or other medical treatment which I am refusing.

Patient Signature______________________________

- That having received emergency medical treatment, I am refusing further aid or transport to a medical facility.

Patient Signature______________________________

- That the communicating hospital has recommended transport to _________________________ Hospital and I refuse this, requesting transport to ___________________________ Hospital.

Patient Signature______________________________

- My personal preference is to be transported to _________________________ Hospital, but have been informed and understand that the responding EMS unit does not transport there. I refuse to be transported to any other hospital, and will wait for another ambulance service to transport me to the hospital of my choice.

Patient Signature______________________________

- Intervention refusal – I refuse to have the following intervention/s performed.________________________________

I have been advised of the reasons for which the treatment/intervention is offered and understand the risks of refusing this treatment/intervention

Patient Signature______________________________

- On-Scene Physician – I assume full medical and legal responsibility for the care and treatment of this patient during this encounter, and I agree to accompany the patient to the hospital. I agree to direct all treatment administered by the EMS personnel, and warrant that I am familiar with the training and capabilities of said personnel.

Signature______________________________  Print Name______________________________
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- That I should have emergency first-aid treatment, or other medical treatment which I am refusing.

**Patient Signature**

- That having received emergency medical treatment, I am refusing further aid or transport to a medical facility.

**Patient Signature**

- That the communicating hospital has recommended transport to __________________________ Hospital and I refuse this, requesting transport to __________________________ Hospital.

**Patient Signature**

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  I have been advised of the reasons for which the treatment/intervention is offered and understand the risks of refusing this treatment/intervention

**Patient Signature**

- On-Scene Physician – I assume full medical and legal responsibility for the care and treatment of this patient during this encounter, and I agree to accompany the patient to the hospital. I agree to direct all treatment administered by the EMS personnel, and warrant that I am familiar with the training and capabilities of said personnel.

**Signature**

**Print Name**

 Created 5/2009

WHITE – PROVIDER COPY

YELLOW – EMS SYSTEM OFFICE
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- The Romeoville Fire Department, and its employees;
- Edward Hospital Services, Edward Hospital Emergency Medical Services system, and their employees;
- Edward Hospital, which was consulted by the Emergency Medical Service (hereafter EMS) personnel for medical control, and its physicians, nurses and employees.

**X** I am not injured and I refuse services and transport.

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Created 5/2009

WHITE – PROVIDER COPY

YELLOW – EMS SYSTEM OFFICE
RELEASE FROM MEDICAL RESPONSIBILITY

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**Patient Information**

<table>
<thead>
<tr>
<th>Print Name</th>
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**Patient Signature**

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- Intervention refusal – I refuse to have the following intervention/s performed.

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**Patient Signature**

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Signature ___________________________  Print Name ___________________________
MULTIPLE PATIENT RELEASE FROM MEDICAL RESPONSIBILITY (MPR)

We acknowledge that we have received medical advice which we are refusing. **We understand that by refusing the advice offered, my (or the patient, in the case of my being the guardian or agent) condition could change or worsen and that we may suffer injuries which could cause disability or death.** Accordingly, we release the following persons and entities from any responsibility or liability for any injury that we might suffer after signing this form, including liability in favor of myself or any other person who may be entitled by law to compensation as a result of my injuries:

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**X** I am not injured and I refuse services and transport.

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EDWARD HOSPITAL EMS SYSTEM
WARRENVILLE FIRE PROTECTION DISTRICT

License #__________   Unit#_________ Date_____/_____/_____       Incident #___________________

RELEASE FROM MEDICAL RESPONSIBILITY

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Patient Information

| Print Name __________________________________________ | Date of Birth_________________
| Address_____________________________________________ | Age________________________
| City/State/Zip_________________________________________ | Phone #_____________________

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Signature________________________________                         Print Name __________________________________

Created 5/2009

WHITE – PROVIDER COPY
YELLOW – EMS SYSTEM OFFICE
EMERGENCY DEPARTMENT
NON-DISPOSABLE EQUIPMENT RECEIPT FORM

Edward Hospital agrees to accept responsibility for the safekeeping of:

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>TYPE OF SUPPLIES OR EQUIPMENT</th>
<th>STATE OF REPAIR</th>
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If the equipment is lost or damaged, the hospital will review the matter for appropriate replacement or reimbursement for the item to the provider department / service.

Date left: ____________________________ Time: ____________________________
Name of patient: ____________________________ Run number: ____________________________
Provider dept. / service: ____________________________ Vehicle Number: ____________________________
Phone number of provider: ____________________________ ED phone number: (630) 527-3358
Signature of EMT: ____________________________
Signature of ED Charge Nurse: ____________________________

RETURN: All equipment must be picked up by the provider within 3 days of notification.

Person notified via email for pick up: ____________________________
Date notified: ____________________________ Time notified: ____________________________
Person making notification: ____________________________
Date returned to provider: ____________________________
Signature of receiving person: ____________________________

* Copy of form must be forwarded to the EMS Office by ED Charge Nurse

Reviewed 02/17
**Patient Care Report**

- **Bolingbrook**
- **Lisle/Woodridge**
- **Naperville**
- **Warrenville**
- **EAS**
- **Romeoville**

**License #**
**Unit #**
**Date** / / 

**Name**
(Last) (First) (M)

**Address**

**City** St Zip

**Age** □ mo **DOB** / / **Wt** kg **Sex:** M F

**Chief Complaint:**

**Initial Impression:**

**Medications:** □ Denies

**Allergies:** □ Denies

**Medical History:** □ Denies □ Asthma □ Cancer □ Cardiac □ Renal □ CVA □ Diabetes □ Drug/ETOH □ HTN □ HTN □ Psych □ Respiratory □ Seizures □ TB

□ Other:

**LMP:** / / 

**Trauma Score:** ______

**Blood Sugar**

**SPO2 %**

<table>
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<tr>
<th>Time</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Resp</th>
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<th>Dose / Size</th>
<th>Location</th>
<th>Route</th>
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<th>Response</th>
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**Narrative:**

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<th>Resp</th>
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<th>Pupils</th>
<th>Lung Sounds</th>
<th>GCS</th>
<th>Total</th>
<th>Pain Score 0 - 10</th>
<th>Blood Sugar</th>
<th>SPO2 %</th>
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**Narrative (continued):**

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Signature (report writer):
Edward Hospital
Emergency Medical Services System

Personal Information Changes

**Date: ____________________ **Effective date of changes: ____________________

Information to change:

_____ Address _____ Phone  _____ Name  _____ Department

Old address:

<table>
<thead>
<tr>
<th>Address</th>
<th>Apt.</th>
<th>City</th>
<th>Zip Code</th>
<th>Phone</th>
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New address:

<table>
<thead>
<tr>
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<th>Apt.</th>
<th>City</th>
<th>Zip Code</th>
<th>Phone</th>
</tr>
</thead>
</table>

Previous Department: ____________________________________________________

New Department: ________________________________________________________

Previous name: _________________________________________________________

New name: _____________________________________________________________

**EHEMSS # ________________

**IDPH License # ________________

**Level: _____FR-D _____ EMT-B _____ EMT-P _____ ECRN

** Required information for requesting changes

______________________________  ________________________________
**Print Name  **Signature

Please address all changes to:

Manager of Emergency Medical Services
Edward Hospital
801 S. Washington Street
Naperville, IL 60540
Office: 630-527-3332

09/15/17
I understand that in combination with my User Code, my Pyxis password will be my electronic signature for all transactions to the Pyxis Medstation System. It will be used to track all of my transactions with a time and date stamp. These records will be maintained and archived in accordance with the policies of this hospital, and be available for inspection by the Drug Enforcement Agency (DEA) and the State Board of Pharmacy.

Employees will treat their computer passwords as confidential and understand that unauthorized disclosures of passwords will make them personally responsible for all the unauthorized disclosures of hospital or patient information obtained by others using the password. Employees will be subject to disciplinary action up to and including termination for violations of Information System Policies related to Pyxis.

Name of New User (PLEASE PRINT) & Department

Signature of New User

EMS User License#: _________________________

EMS User Authorized by: ____________________

Put an X in the appropriate box for title and privileges:

- [ ] EMT-P
- [ ] EMT-B

Pharmacy Use Only

Date Activated in Pyxis: ____________________  By: ____________________

Revised: 2-2017
**ALS EQUIPMENT CHECK**  
**SEMSV**  
**JUMP BAG**

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<tr>
<td>.9ns 10cc</td>
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<td></td>
<td>2-each 18g-24g</td>
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<td>J-loops</td>
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<td></td>
<td>15tts tubing</td>
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<td>Mini tubing</td>
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<td>IO Kit</td>
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**DRUGS**  

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<td>Kling</td>
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<td>Fluff Roll</td>
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## AIRWAY BAG

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## INTUBATION ROLL

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</table>
People wishing to use training equipment from the EMS department in a setting other than the EMS Education Classroom at Edward Hospital need to do so with care and responsibility.

Equipment may be on loan for no longer than two (2) calendar days, unless otherwise approved by the EMS Manager.

Please fill out the following loan form.

DATE: _______________________________________________________

TIME: _______________________________________________________

NAME OF PERSON REQUESTING EQUIPMENT: _______________________

HOSPITAL UNIT OR FIRE DEPARTMENT: ___________________________

EQUIPMENT TYPE: _____________________________________________

QUANTITY: ___________________________________________________

EQUIPMENT CHECKED OUT BY: _________________________________

DATE RETURNED: _____________________________________________

SIGNATURE OF RECEIVING PERSON: ____________________________

If equipment is lost or damaged, the requesting department must review the matter with the EMS Manager to arrange for appropriate replacement or reimbursement to the EHEMSS.

Reviewed 02/17