



**EDWARD HOSPITAL
EMERGENCY
MEDICAL SERVICES**

**POLICIES &
PROCEDURES**

EDWARD EMS SYSTEM



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Added: Image



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 (EMS/Trauma Program Manager). 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
EMS Medical Director

Shannon Morris RN BSN MHA
EMS System Coordinator

New 09/09
Reviewed 04/10

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	<ol style="list-style-type: none"> 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 two (2) years.

Edward Hospital EMS System

Local Review Board

Emergency MD
EMT-P

Ralph Hoover, MD
Chief Marty Nelson

Edward Hospital
Warrenville

EMT-B

Category	Name	Department
EMT-B	Krestan, Kieth	Lisle-Woodridge
EMT-B, Alt.	Fazio, Dave	Lisle-Woodridge
EMT-B	Kouba, Curtis	Warrenville
EMT-B	Olson, Matt	Bolingbrook
EMT-B, Alt.	Woitovich, Tony	Bolingbrook

EMT-P

EMT-P	Spinazola, Scott	Lisle-Woodridge
EMT-P, Alt.	Weaver, James	Lisle-Woodridge
EMT-P	Bramwell, Kevin	Bolingbrook
EMT-P, Alt.	Moser, Tara	Bolingbrook
EMT-P	Eggers, Barry	Naperville
EMT-P, Alt.	Howell, Scott	Naperville

First Responder-D

FR-D	Licht, Stephen	Naperville
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Lead Instructor

Lead Instructor	Niles, Paul	Bolingbrook
Lead Instructor, Alt.	Hughes, Edgar	Bolingbrook

ECRN

ECRN	Sharron Chivari RN	
ECRN, Alt.	Linda Alexander RN	

Emergency Medical Dispatcher

Diana Friedl – City of Naperville

*Location posted – medic room @ Edward Hospital and Plainfield Emergency Department

Revised 04/10

CROSS REFERENCE(S)

The CE Policy

New 01/01

Revised 03/09

Reviewed 10/09, 04/10

TITLE

Role of EMS Medical Director

PURPOSE

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

APPLICABILITY

The EHEMSS Medical Director

PROCEDURE

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

New 09/09
Reviewed 04/10

TITLE

Role of EMS System Coordinator

PURPOSE

To define the role, scope, and responsibilities of the EMS System Coordinator.

APPLICABILITY

The EHEMSS EMS System Coordinator

PROCEDURE

The Resource Hospital shall appoint a full-time EMS System Coordinator, 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 Coordinator 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 Coordinator:
 - A. Supervision of clinical, didactic, and field experience training.
 - B. Provides feedback to field personnel and ED staff on prehospital 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

New 09/09
Reviewed 04/10

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; or
 - B. Have EMT-B experience if that is the highest level of care at 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 rosters and scantron sheets
 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

TITLE**EMERGENCY COMMUNICATIONS REGISTERED NURSE: 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. EHEMSS will track expiration dates and notify the

CROSS REFERENCE (S)

IDPH Administrative Rules and Regulations 515.740

New 08/04

Revised 08/05

Reviewed 10/09, 04/10

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 Coordinator 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 Coordinator 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

Reviewed 08/04

TITLE

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

TITLE**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 to 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 EHEMS System Entry process in its entirety. Those 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 the last 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) At least three business days prior to beginning the EHEMSS Entry testing process, the following information must be submitted to the System office:

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)

Copies of all accrued continuing education

Copy of current State of Illinois EMT license

Copy of current CPR certification (health care provider)

Copy of current driver's license

- 5) Appointments for completing the System Entry testing process will be scheduled with the EHEMSS office. All

New 08/94

Revised 01/01, 10/09, 04/10

TITLE	EMT LICENSE RENEWAL
PURPOSE	To provide the relicensure process for providers by the Edward Hospital EMS System.
APPLICABILITY	Edward Hospital Emergency Medical Services System
POLICY STATEMENT(S)	The Illinois Department of Public Health (IDPH) requires that 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 relicensures.

PROCEDURE

1. Three months prior to provider's lapse date, the EHEMSS will communicate who is due for relicensure to the Fire Department/Company. 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. Certified 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 re-licensure material and a fee of \$50 in the form of a certified check or money order made payable to the Illinois Department of Public Health (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the EMT, IDPH will re-license the EMT.
7. Each department coordinator will maintain a copy of the individual provider's IDPH license.

CROSS REFERENCE (S)

Illinois Department of Public Health Rules
and Regulations 515.590

New 07/94
Revised 01/01, 10/09
Reviewed 04/10

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-P may downgrade to the status of EMT-Basic. The EMT-P must submit in writing their intent to drop their “P” status for reclassification to an EMT-Basic. CE hours must also be up to date. This information will be sent to IDPH on a transaction card for processing. Upon receipt of their new EMT-Basic license, the “B” will turn in their paramedic license to the EMS System and may not operate as a paramedic in the state of Illinois.
- B. The process for downgrading from EMT-Basic to a First Responder is the same as the process of downgrading from a Paramedic to an EMT-Basic.

2) Upgrade

- A. If an EMT-Basic wishes to reclassify as a paramedic, they may do so providing the following benchmarks are met: A recommendation from the EMS Medical Director must be obtained prior to starting the process. Verification of the individual’s knowledge and skills must be tested. This process will include but is not limited to the successful completion of a written exam, completion of a practical skills exam, an interview with the EMS Medical Director, and any other required training deemed necessary to evaluate the current competence and resumption of ALS level patient care responsibilities.
- B. Preparation for successful reinstatement of a previously licensed EMT-P is the sole responsibility of the individual seeking to revert back to the ALS level.
- C. Any denial for subsequent relicensure at an ALS level from the EMT-Basic level will be made in writing to both the individual and IDPH.
- D. The process for upgrading from a First Responder to an EMT-Basic is the same as the process of upgrading from an EMT-Basic to a Paramedic.

New 09/09
Revised 04/10

TITLE	EMT Continuing Education
PURPOSE	To ensure that all Paramedics 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)	<p>All Edward Hospital Emergency Medical Service System (EHEMSS) Emergency Medical Technicians (EMT) are required by the Illinois Department of Public Health (IDPH) to accrue a minimum of 120 hours continuing education during the 4-year licensure period in order to be relicensed. 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 EMT to IDPH who has met the requirements for relicensure.</p> <p style="text-align: right;">* See addendum for IDPH EMT Relicensure Recommendations</p>
DEFINITION(S)	<p>Cycle: January 1 to June 30 or July 1 to December 31 LOGS: Letter of Good Standing</p>

PROCEDURE

1. EHEMSS offers 30.4 hours of continuing education per year:
 - A. 8 monthly CE/Skills sessions worth 3.3 hours (26.4 hrs)
 - B. 4 hours of CE for quarterly intubation skills (1 hr/quarter)
2. Continuing education sessions will be developed utilizing the Region VIII Education Committee. Guidelines for modules will be developed utilizing Region VIII 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. Continuing education will be scheduled each month from January through April and July through October. This does not include other mandatory EHEMSS requirements. Each session will be scheduled for three (3.3) hours in length with credit awarded hour-for-hour of contact.
4. EHEMSS EMT-Ps are required to successfully complete at least 4 of the 8 (minimum 2 per cycle for each cycle) monthly Region VIII CE programs annually.
5. 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
 - D. In order to sit for a post test, the EMT must participate in the respective live lecture presented by a designated department instructor. All required lectures and post tests must be completed prior to the beginning of the next cycle.
6. A post test, content provided by the Region VIII Education Committee, consisting of 20 questions from the present month's continuing education and 5 questions from the previous regularly scheduled monthly continuing

New 06/94

Revised 01/01, 10/03, 03/05, 10/09

Reviewed 04/10

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

CROSS REFERENCE(S)

[IDPH Administrative Rules and Regulations 515.740](#)

New 01/05

Reviewed 10/09, 04/10

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. 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 Refusa/Involuntary Treatment or Transport
Minor Refusals
Multiple Patient Release (MPR)

New 06/94
Revised 01/01, 10/09
Reviewed 04/10

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)	<p>The EMT has a duty to appropriately explain to the patient the need for care and transportation and, to the best of the EMTs knowledge, the specific consequences of failure to accept care and transport. Many people who initially refuse medical care/transport or treatment are of such care. To allow such patients to refuse care in the face of obvious need is a failure to perform at the expected level of competence. It can be appropriate to have the refusing patient/guardian speak directly to the ED physician or ECRN.</p> <p>A conscious adult who is determined by EMS personnel, in accordance with the procedures set forth below, to be :</p> <ul style="list-style-type: none"> • Competent • Not suicidal or potentially dangerous to himself/herself or others (including the inability to provide self care); <p>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.</p> <p>Refusal of treatment or transport of minors should be handled in accordance with the EHEMSS policy: Treatment Consent for Minors</p>

DEFINITION(S)

- **Competency:** a patient is competent when the patient is determined to have decisional capacity. An “Incompetent” patient is one who lacks decisional capacity.
- **Decisional Capacity:** the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment, including foregoing life-sustaining treatment, and the ability to reach and communicate an informed decision in the matter as determined by the Medical Control Physician. 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 on duty.
- **Self Care:** a patient is unable to provide Self Care when the patient is unable to care for himself/herself so as to guard himself/herself from physical injury or to 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 competency 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:

Potential Danger

To Self To Others

Suicide Homicide

Inability for self-control or self care Child/spouse/elderly abuse

- 4) Report to Medical Control: All refusals must be called in to Medical Control **before** the ambulance leaves the scene of the call. A Medical Control Physician and/or ECRN will determine if patient's behavior and/or the medical condition suggest that the patient is incompetent to refuse medical treatment or may be potentially dangerous to him/herself or others or unable to safely care for self.
 - A. 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.
 - B. If the patient resists or poses a threat to the personal safety, the vehicle crew, and/or bystanders, police shall be notified for assistance and reasonable force may be used to restrain the patient
 - C. 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.
- 5) Ultimate decision is made by patient. Once a Medical Control Physician and/or ECRN has determined that the patient is competent 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 that patient must be honored no matter how unreasonable they may seem

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

Reviewed 04/10

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	<ol style="list-style-type: none"> 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 report to the Illinois Department on Aging.
CROSS REFERENCE(S)	<i>750 ILCS 60/ 401, Chapter 40, paragraph 2314 EHEMSS Policies: Reporting Child and Elder Abuse</i>

New 01/05
Reviewed 10/09, 04/10

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 who is reasonably believed to be 7 days or less old.

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

TITLE**DO NOT RESUSCITATE GUIDELINES****PURPOSE**

Patient wishes concerning end of life procedures are to be respected. Valid 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)

EMS Region 8 Standard Operating Procedures will be followed (Withholding or Withdrawing of Resuscitative Efforts). This SOP covers DNR orders; obviously dead “Triple Zero” patients; hospice patients; and persistent, unresponsive PEA/Asystole.

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

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

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 DNR order must be written and may be on a form provided by IDPH (it may or may not be on colored paper) and contain the following:

1. Name of the patient
2. Name and signature of the attending physician
3. Effective date (the order does not expire but can be modified or revoked by the maker)
4. The words "Do Not Resuscitate".
5. Two witness signatures.
6. Evidence of consent as evidenced by a signature from any of the following:
 - a. The patient
 - b. Legal Guardian
 - c. Durable Power of Attorney for Health Care Agent
 - d. Surrogate Decision-maker under the Illinois Health Care Surrogate Act.

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.

PROCEDURE

- 1) Determine the identification of the patient.
- 2) Determine the validity of the DNR order. DNR orders must be written.
- 3) Communicate with Medical Control and follow orders even if they are contrary to the DNR.
- 4) Verbal 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 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) 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 DNR order and attach a copy to the run sheet. If a copy is not available, record all information for validity from the DNR order in the comments section of the run sheet. Also document the name of the person presenting the 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
Reviewed 04/10

TITLE	Invalid/Citizen Assists
PURPOSE	To clarify the role of EHEMSS providers when called to provide assistance but not medical care (see definition).
APPLICABILITY	EHEMSS Participants
POLICY STATEMENT(S)	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.
DEFINITION(S)	<p>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.</p> <p>Note: this does not include patients who have a positive mechanism for possible injury. These should be managed as a patient encounter.</p>
PROCEDURE	<ol style="list-style-type: none"> 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.

CROSS REFERENCE(S)

EHEMSS Policy: Reporting Elder Abuse and Neglect
EHEMSS Policy: Right of Refusal

New 10/09

Reviewed 04/10

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)	The nearest hospital is defined as the hospital which is closest to the scene of the emergency as determined by travel time.

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 refuses to be transported to the nearest hospital.
 - A. The EMT will contact medical control and communicate the patient's request to go to a more distant hospital.
 - B. 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.
 - C. 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.
 - D. 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.
 - E. 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 findings 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 medical control and

CROSS REFERENCE(S)

EHEMSS Policy: Right of Refusal

New 06/94

Revised 01/01, 10/09, 04/10

TITLE

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 medial 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

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 MICU report 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

CROSS REFERENCE(S)

New 06/94

Revised 01/01, 10/09

Reviewed 04/10

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 serious 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 or mildly injured at present (i.e., minor extremity soft tissue or musculoskeletal injuries), 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 and **PRIOR to releasing patients from the scene.**
- 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. Contact Medical Control, explain the situation and follow the advice received. Document the physician's name in the space provided
 - B. Ask the individuals to provide the necessary information and sign the form
 - C. 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:

CROSS REFERENCE(S)

School Bus Motor Vehicle Crashes

New 08/94

Revised 01/01, 10/09

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 transported
 - 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 student involved in the incident whether transported or not

CROSS REFERENCE(S)

EHEMSS Policy: Minors – Treatment Consent for Minors

New 01/01

Revised 10/09

Reviewed 04/10

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 board. "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. Nights, Weekends and Holidays: 1.800.279.0400.**
- **DuPage County Department of Human Resources: 630.682.7000.**
- **Will County Senior Services Center: 1.815.740.4225**
- **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:**

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, Illinois Department on Aging personnel,

CROSS REFERENCE(S)

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

New 01/05

Reviewed 10/09, 04/10

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:

- a. 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.
- b. 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.
- c. Commits or allows to be committed an act or acts of torture upon such child.
- d. Inflicts excessive corporal punishment (IL Rev. Stat. Ch. 23, paragraph 2053. Effective: August 30, 1998)

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).

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.

CROSS REFERENCE(S)

Abused and Neglected Child Reporting Act
Illinois Revised Statute, Chapter 23, paragraph 2053
PA 86-274; PA 86-275

New 06/94
Revised 01/01
Reviewed 10/09, 04/10

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 restrains 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

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

TITLE	Hospital Limitation/Ambulance Bypass
PURPOSE	To define actions to be taken in the event of hospital resource limitations that may include the need for ambulance bypass.
APPLICABILITY	All EHEMSS Participants
POLICY STATEMENT(S)	<p>No patient shall be transported by an ambulance or specialized emergency medical services vehicle to a facility other than the nearest hospital or trauma 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:</p> <p style="padding-left: 40px;">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</p> <p style="padding-left: 40px;">THE MORE DISTANT HOSPITAL or trauma center HAS AVAILABLE SPACE AND QUALIFIED PERSONNEL FOR THE TREATMENT OF THE PATIENT.</p> <p>**Capitalization indicates statutory language.</p>
DEFINITION(S)	<p>Nearest Hospital: is the hospital that is closest to the scene of the emergency as determined by travel time.</p> <p>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.</p> <p>*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).</p>

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

CROSS REFERENCE(S)

System-Wide Crisis
Section 515.315 Bypass Status Review

New 06/94

Revised 01/01, 03/07, 10/09, 04/10

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

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

CROSS REFERENCE(S)

New 10/09
Reviewed 04/10

TITLE**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 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 tell the hospital 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 if available: 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

CROSS REFERENCE(S)

Region VIII SOPs

New 10/09

Reviewed 04/10

TITLE

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 everyday.”

(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 can call any other EMS Region 8 hospital directly if they are transporting the patient to that hospital. If EHEMSS system specific SOPs are being used or when using the bypass protocol, the provider must call Edward Hospital, and Edward Hospital will call the receiving hospital with report.

Non-Region 8 ambulance providers cannot call Edward Hospital for medical oversight of ALS procedures. They must call a hospital within their own EMS system.

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; 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

CROSS REFERENCE(S)

*Illinois EMS Act Rules and Regulations, Title 77, Chapter 1,
Part 515.410*

New 06/95

Revised 02/01, 10/09

Reviewed 04/10

TITLE	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)	<p>Consistent with HIPAA guidelines, all protected health information will only be disclosed under circumstances as described in the Act.</p> <p>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.</p>
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

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

TITLE

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:
 - A. Situations that appear to require deviations from the SOPs
 - B. 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:
 1. Competent patient who, against medical advice, is refusing care or transport
 2. Crime scene response involving conflict with law enforcement personnel
 3. Patients requesting transport to other than the nearest hospital; requires physician certification of risk/benefit
 4. Situations where the patient's condition indicates withdrawal of resuscitative efforts in the field
 5. Presentation of a questionable DNR order
 6. Intervening physician on scene giving questionable instructions or providing care contrary to SOPs
 7. 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
 8. Helicopter transport requests from the scene
 9. When the EMT requests consultation with the physician
 10. When unattended minors are refusing care/transport
- 2) 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.

CROSS REFERENCE(S)

*Title 77 Emergency Medical Services and Highway Safety Part
515.330 1) 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

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)

N/A

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

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 STATEMENT(S)

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

CROSS REFERENCE(S)

State of Illinois Homeland Security Threat Hospital Alert System

New 01/01
Revised 10/09
Reviewed 04/10

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 and one will be left for the EMS system.
- 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 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

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
Reviewed 04/10

TITLE

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

TITLE	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)	<p>EMS personnel will be responsible for daily checking of their supply of drugs, solutions and supplies to ensure the following:</p> <ul style="list-style-type: none">• 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. <p>Replacement of these drugs/supplies will be done safely.</p> <p><i>Note:</i> No outdated supplies or drugs are to be replaced from the Pyxis; it is for replacing items used on patients.</p> <p>All supplies that are not charged to the patient must be requested from Pharmacy using the EHEMSS Drug Exchange form.</p>
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. (Source: Aaron Gerber, Pharm. D., EH Pharmacy Operations Manager, September, 2004)

PROCEDURE

- 1) Drugs, solutions, or supplies that expire within 30 days, or 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.
- 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.

CROSS REFERENCE (S)

Appendix: Pharmacy Drug Exchange Form

New 06/95
Revised 05/06, 01/01, 10/09
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.
- The Controlled Substance Inventory and Administration Record will be completed with the required information.

DEFINITION(S)

Controlled substances (and items that will be treated as such for monitoring purposes) in the EHEMSS include the following medications:

- Morphine
- Midazolam (Versed)
- Amyl Nitrate
- Nitrous Oxide (optional equipment)

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) Vehicles not in service must be inventoried daily by the agency.
- 3) Completed inventory records are to be forwarded to the EMS Manager or designee no later than the 15th day of the following month.
- 4) 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.
- 5) 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.
- 6) Controlled Substance Inventory Administration Records will be reviewed by the EMS CQI Coordinator and retained for two years.
- 7) Review of compliance with management of controlled

CROSS REFERENCE(S)

Appendix: Pharmacy Drug Exchange Form

Appendix: Controlled Substance Inventory Administration Record

EHEMSS Policy: Provider/EMT Suspension from EHEMSS Participation

06/94

Revised 01/01, 11/04, 10/09, 04/10

TITLE	BODY/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	<ol style="list-style-type: none"> 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.

Revised 01/01
Reviewed 10/09, 04/10

TITLE**APPROVAL OF ADDITIONAL DRUGS, EQUIPMENT OR PROTOCOLS****PURPOSE**

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

APPLICABILITY

All EHEMSS Participants.

POLICY STATEMENT(S)

- 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 Equipment Committee.
- Drugs and equipment must be safe for use in the pre-hospital setting, provide a significant benefit and be cost effective.

DEFINITION(S)

PROCEDURE

- 1) Anyone wishing to introduce new drugs, equipment or protocols must submit a request to have the Equipment Committee consider it. This request should be made in writing to the EMS Medical Director.
- 2) If the Equipment 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 Equipment 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 EMS system will submit to them on at least 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

CROSS REFERENCE(S)

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

New 07/06

Reviewed 10/09, 04/10

TITLE	EQUIPMENT LIST FOR AMBULANCE AND 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, and Special Event Vehicles
PROCEDURE	<ol style="list-style-type: none"> 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 EH EMS System Coordinator. 3) These lists will be used by the provider agencies to assure their vehicles are adequately supplied. 4) Ambulance inspections by the EH EMS staff will be based on these lists as well as the official IDPH inspection paperwork for both ambulance and non-transport vehicles. 5) EH lists will be reviewed and revised through the Equipment Committee with Medical Director approval as needed when items are added, removed, or regulatory changes occur, and at least annually. All revised lists will be dated.
CROSS REFERENCE(S)	<p><i>Illinois EMS Act Rules and Regulations: Title 77, Chapter 1, Part 515.330</i></p> <p><i>EMS Region 8 Standard Operating Procedures (Current) Appendix: Equipment Lists</i></p>

New 01/05
Revised 10/09
Reviewed 04/10

TITLE**NON-DISPOSABLE EQUIPMENT RETURN****PURPOSE**

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

APPLICABILITY

Edward Hospital EMS System Participants

POLICY STATEMENT(S)

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

DEFINITION(S)

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

PROCEDURE

- 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 Edward EMS office.
- 4) Equipment will be cleaned and returned to the appropriate department locker in the designated area by the ED PCT.
- 5) The provider EMS Coordinator will be notified by the EMS 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.

Reviewed 04/10



EMERGENCY DEPARTMENT NON-DISPOSABLE EQUIPMENT RECEIPT

Edward Hospital agrees to accept responsibility for the safekeeping of:

QUANTITY	TYPE OF SUPPLIES OR EQUIPMENT	STATE OF REPAIR
_____	_____	_____
_____	_____	_____
_____	_____	_____

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)	<p>Patients with known/suspected sensitivity to latex and those at high risk will be treated by utilizing environmental controls to prevent latex reactions.</p> <p>Most medical supplies are now latex free; however, the EMT is responsible for confirming that before using supplies on a patient.</p>
DEFINITION(S)	N/A

PROCEDURE

1) Initiating Latex Sensitive Precautions:

- A. Must be done for patients identified in the prehospital 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

CROSS REFERENCE(S)

N/A

New 04/07

Revised 04/10

Reviewed 10/09

TITLE**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 EMS 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 EMS 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

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 select “Remove Med”. A list of current patients on the unit will appear.
- 2) Select the name of the patient for whom the medications were used. Press the first letter(s) of the last name to find a name quickly, or use the “Page Down” key
- 3) If the patient name is unknown or does not yet appear on the Station screen:
 - A. Select “Add Patient.”
 - B. At “Patient Name” prompt, type in: Last Name (enter), First Name (enter).
 - C. At “Patient ID” prompt, for refusals, enter “Refusal”. If resuscitation was withdrawn, enter “Withdrawal”. If these do not apply, leave this blank.
- 4) Select the needed medication or equipment from the list. Press the first letter(s) of the drug/equipment name to find it quickly or use the “Page Down” key.
- 5) If needed, press the “Brand” or “Generic” buttons to display meds alphabetically by generic or brand name.
- 6) Enter the quantity needed.
- 7) To select more medications or equipment (up to 10) for the same patient, select “Next Medication” and follow the above steps above for removal.

To Return Medication or Equipment to Stock

(Only items removed from the station in error may be returned)

- 1) From the Main Menu, select “Return”.

CROSS REFERENCE(S)

New 01/05

Reviewed 10/09, 04/10

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 designee 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 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

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 these vehicles requires an approved waiver from IDPH. When activated or deactivated, the EHEMS 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 KKK-A-1822 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 EMS 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
Reviewed 10/09

TITLE**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. In situations involving any medical product failure or malfunction, EMS providers will provide for the appropriate safety, health, and medical treatment of any injured patients or healthcare workers.
- B. All adverse events and product problems must be reported to the EHEMSS Medical Director or 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)
- C. MedWatch FDA form 3500 A (10/05) can be downloaded or completed on line at <http://www.fda.gov>
- D. 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 Medical Director or 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 administrative office.

2) Reporting Requirements-Product Problems

- A. Medical product problems which do not contribute to death or serious injury should be reported to the EHEMSS administrative office 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

CROSS REFERENCE(S)

New 06/94

Revised 08/96, 01/01, 10/09

Reviewed 04/10

TITLE**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 EMS CE/CQI Coordinator or the Paramedic Education Coordinator with a request to borrow the equipment and its intended use
- 2) The CE/CQI Coordinator or Paramedic Education Coordinator 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 an EHEMSS representative 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 EMS Manager to arrange for appropriate replacement or reimbursement to the EHEMSS.

CROSS REFERENCE(S)

N/A

New 07/07
Revised 10/09
Reviewed 04/10

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)	<ol style="list-style-type: none"> 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 EHEMS EMS Medical Director/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 EMS system 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 EMS 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 EMS Medical Director/ EMS 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 EMS Medical Director/EMS Manager are to be notified immediately.*
- 4) *The EMS Medical Director/EMS 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
Reviewed 10/06, 10/09, 04/10

TITLE**Medication and Procedure Errors****PURPOSE**

To establish a review, follow-up, and re-education process for medication or procedural errors made 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 or EHEMSS Manager of EMS/Trauma 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 of EMS/Trauma.

CROSS REFERENCE(S)

Safe Medical Devices Act

New 06/94
Revised 01/01
Reviewed 10/09, 04/10

TITLE**Provider/EMT Suspension from EHEMSS Participation****PURPOSE**

- To define grounds for suspension from EHEMSS participation for a provider or EMT by the EMS Medical Director.
- To define the process to request a Local System Review Board hearing and a State Disciplinary Review Board to challenge the EMS 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. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substance, or other drugs or stimulants in such a manner as to adversely affect means anything which could harm the patient or treatment that is administered improperly
6. Intentional falsification of any medical reports or order, or making misrepresentations involving patient care
7. Abandoning or neglecting a patient requiring emergency care

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 EHEMSS 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 provide 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 EMS office will also immediately notify the Provider EMS Coordinator of the agency where the suspended provider works.
 - A. The EMS System 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

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

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 EMS Medical Director, EMS System 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 EMS System participants.

APPLICABILITY

Edward Hospital Emergency Medical Services System

POLICY STATEMENT(S)

Prehospital 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 and/or Manager of EMS/Trauma 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 EMS Medical Director and EMS System Coordinator 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)

New 01/01
Revised 10/09
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 front line transport ambulances providing advanced life support care will ideally be staffed with a minimum of two (2) EHEMSS approved, IDPH licensed paramedics, unless otherwise approved by the EMS Medical Director
- 2) If ambulance crew configuration is other than 2 paramedics, i.e. one EMT-B and one EMT-P, there must be a total of two EMT-P's who respond to the scene of an ALS call. These paramedics may arrive on separate response vehicles. This configuration, as well as any deviation from it, must be approved by the EMS Medical Director in writing and is subject to audit by the EHEMSS Administration at any time.
- 3) New providers may staff their front line ALS ambulances with one paramedic and one EMT-B during the first year of service within EHEMSS.
- 4) All ALS engines and ALS non-transport vehicles will be staffed with at least one licensed paramedic.
- 5) Special event vehicles will be staffed with at least one paramedic unless otherwise approved by the EMS Medical Director.
- 6) At least one licensed paramedic must be in the patient compartment at all times for a patient receiving ALS care.
- 7) At least one licensed EMT-B or paramedic must be in the patient compartment at all times for a patient receiving BLS care.
- 8) Reserve ambulances can be staffed with one EMT-P and one EMT-B with the approval of the EHEMSS EMS MD.

CROSS REFERENCE(S)

New 07/07
Revised 10/09, 04/10

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 and Trauma Services, 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

CROSS REFERENCE(S)

New 06/94

Revised 01/01

Reviewed 10/09, 04/10

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

CROSS REFERENCE(S)

New 06/94

Revised 01/01, 10/09

Reviewed 04/10

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)	N/A
PROCEDURE	<ol style="list-style-type: none"> 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.

New 06/94
Revised 01/01, 10/09
Reviewed 04/10

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)	<p>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.</p> <p>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)</p>
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,

CROSS REFERENCE(S)

New 06/94

Revised 01/01, 10/09, 04/10



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 Medications Equipment Related	Communication Procedure Deviation from SOP	Assessment Injury – Patient ED Staff Related	EMS Provider Related Patient Related
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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”

APPENDIX

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Emergency Medical Systems and Highway Safety
500 E. Monroe Street, 8th Floor, Springfield, IL 62701

EMERGENCY MEDICAL SYSTEMS CONTINUING EDUCATION RELICENSURE **SUGGESTIONS**

EMERGENCY MEDICAL TECHNICIANS (EMTs) at all licensure levels are required to obtain **120 hours of continuing education (CE) within a four year licensure period**. It is also a requirement to maintain a current CPR card while actively licensed as an EMT. A wide variety of educational programs, seminars and workshops that are not listed below may meet the intent of the National Standard Curriculum. The list below is NOT an all inclusive list. This Continuing Education (CE) list should be considered as CE **SUGGESTIONS ONLY**.

ACTIVITY	DOCUMENTATION	HOURS	COMMENTS
INITIAL TRAINING PHTLS, ITLS, CPR, PALS, ACLS PEPP, COURSES, ETC.	COPY OF CERTIFICATE OR COURSE CARD SIGNED BY COURSE INSTRUCTOR	16	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS
INITIAL NAEMSE LEAD INSTRUCTOR COURSE	COPY OF SIGNED CERTIFICATE AND LETTER REVEALING A PASSING GRADE FOR COURSE	40	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS
INITIAL ACLS, CPR, ITLS, PALS INSTRUCTOR COURSES, ETC.	COPY OF CERTIFICATE OR COURSE CARD SIGNED BY COURSE INSTRUCTOR	16	16 CE HOURS MAXIMUM FOR INITIAL COURSE
RECERTIFICATION PHTLS, ITLS, CPR, PALS, ACLS COURSES, ETC.	COPY OF CERTIFICATE OR COURSE CARD SIGNED BY COURSE INSTRUCTOR	4 HOURS EVERY 2 YEARS	8 HOURS MAXIMUM PER 4-YEAR LICENSURE PERIOD OF RECERTIFICATION TIME PER SUBJECT
IDPH APPROVED CONTINUING EDUCATION PROGRAMS	CERTIFICATE TO INCLUDE NAME OF PARTICIPANT, DATE, TIME, NUMBER OF CE HOURS, INSTRUCTOR SIGNATURE	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS IN ONE SUBJECT AREA FOR EXAMPLE, NO MORE THAN 30 CE HOURS IN TRAUMA; NO MORE THAN 30 CE HOURS IN CARDIAC, ETC.
CLINICAL PRECEPTOR OR EVALUATOR	SIGNED LETTER FROM EMS COORDINATOR OR LEAD INSTRUCTOR	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS OF PRECEPTOR OR EVALUATOR CE HOURS

INSTRUCTION/TEACHING	COPY OF LETTER SIGNED BY EMSMD OR SIGNED APPLICATION AND SCHEDULE OR BROCHURE LISTING NAME OF INSTRUCTOR	2 TEACHING HOURS = 1 CREDIT HOUR	NO MORE THAN 25% OF HOURS TAUGHT IN ONE SUBJECT AREA NO MORE THAN 50% OF REQUIRED HOURS
DISASTER DRILL ACTIVITIES	LETTER FROM EMS COORDINATOR/ EMSMD	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS FOR DISASTER DRILL ACTIVITIES FOR EXAMPLE, TRIAGE, MOULAGE, DISASTER DRILLS, ETC.
FIRE FIGHTER II COURSE - EMS/MEDICAL PORTION	CERTIFICATE MEETING STANDARDS	HR/HR	21 CE HOURS MAXIMUM DURING 4 YEAR LICENSURE PERIOD
NURSING/ MEDICAL/ PHYSICIAN COURSES/ OTHER HEALTH RELATED COURSES AS DETERMINED BY REMSC	CATALOG DESCRIPTION OF COURSE, EVIDENCE OF COMPLETION OF COURSEWORK THROUGH GRADES OR TRANSCRIPTS	2 HOURS PER EACH COLLEGE CREDIT HOUR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS FOR NURSING, MEDICAL, PHYSICIAN COLLEGE COURSE WORK
PARTICIPATION/ OBSERVATION IN SURGERY, PHYSICAL THERAPY, CHILDBIRTH, AUTOPSY, ETC.	WRITTEN STATEMENT FROM CHARGE NURSE OR PHYSICIAN ASCERTAINING ATTENDANCE	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS FOR HEALTH RELATED COLLEGE COURSEWORK
EMS OUT OF STATE SEMINARS, CONFERENCES	COPY OF AGENDA AND PROGRAM INFORMATION PLUS A CERTIFICATE ASCERTAINING ATTENDANCE	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS FOR HEALTH RELATED COLLEGE COURSEWORK
VIDEO TAPE AND/OR MAGAZINE CE	LETTER FROM EMS COORDINATOR, COPY OF COMPLETION CERTIFICATE	HR/HR	MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS MUST BE EMS RELATED
NHTSA CHILD PASSENGER SAFETY TECHNICIAN PROGRAM	COPY OF COMPLETION CERTIFICATE	8 HOUR MAXIMUM	APPLICABLE FOR ALL EMT LEVELS

<p>TRAUMA NURSE SPECIALIST COURSE</p>	<p>COPY OF CERTIFICATE</p>	<p>HR/HR</p>	<p>MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS</p>
<p>TRAUMA NURSE SPECIALIST REVIEW COURSE</p>	<p>PROOF OF ATTENDANCE</p>	<p>HR/HR</p>	<p>MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS</p>
<p>APPROVED INTERNET SITES www.EMCert.com www.Eminet.com www.cms-ce.com www.medicEd.com also any site approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS)</p>	<p>COPY OF COMPLETION CERTIFICATE THAT STATES NAME OF COURSE AND NUMBER OF CE HOURS</p>	<p>AS STATED ON CERTIFICATE</p>	<p>MAY NOT HAVE MORE THAN 25% OF 120 HOURS OR 30 CE HOURS OF INTERNET EDUCATION IF PARTICIPATING IN A SYSTEM, SYSTEM APPROVAL IS REQUIRED.</p>



Illinois Department of Public Health UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM

Patient's name _____

Summarize medical condition:

When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
If this form is to be voided, write "VOID" in large letters on the other side of the form.
After voiding the form, a new form may be completed.

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed

Advance Directives

I also have the following advance directives: **Contact person** (name and phone number)

Health Care Power of Attorney _____
 Living Will _____
 Mental Health Treatment Preference Declaration _____

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆



EDWARD HOSPITAL EMS SYSTEM

BOLINGBROOK FIRE DEPARTMENT



License # _____ Unit# _____ Date ____/____/____ Incident# _____

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.

I am not injured and I refuse services and transport.

Print Name	Address	City/State/Zip
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #



EDWARD HOSPITAL EMS SYSTEM

BOLINGBROOK FIRE DEPARTMENT



License # _____ Unit# _____ Date ____/____/____ Incident # _____

RELEASE FROM MEDICAL RESPONSIBILITY

I acknowledge that I have received medical advice which I am refusing. **I 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 I may suffer injuries which could cause disability or death.** Accordingly, I release the following persons and entities from any responsibility or liability for any injury that I 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.

Patient Information	
Print Name _____	Date of Birth _____
Address _____	Age _____
City/State/Zip _____	Phone # _____

- 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 _____



EDWARD HOSPITAL EMS SYSTEM

LISLE WOODRIDGE FIRE DISTRICT



License # _____ Unit# _____ Date ____/____/____ Incident# _____

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 Lisle Woodridge Fire District, 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.

I am not injured and I refuse services and transport.

Print Name	Address	City/State/Zip
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
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____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #
____ of ____ Print		
Signature	DOB	Age Phone #



EDWARD HOSPITAL EMS SYSTEM

LISLE WOODRIDGE FIRE DISTRICT



License # _____ Unit# _____ Date ____/____/____ Incident # _____

RELEASE FROM MEDICAL RESPONSIBILITY

I acknowledge that I have received medical advice which I am refusing. **I 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 I may suffer injuries which could cause disability or death.** Accordingly, I release the following persons and entities from any responsibility or liability for any injury that I 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 Lisle Woodridge Fire District, 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.

Patient Information	
Print Name _____	Date of Birth _____
Address _____	Age _____
City/State/Zip _____	Phone # _____

- 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 _____



EDWARD HOSPITAL EMS SYSTEM

NAPERVILLE FIRE DEPARTMENT



License # _____ Unit# _____ Date ____/____/____ Incident# _____

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 Naperville 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.

I am not injured and I refuse services and transport.

Print Name	Address	City/State/Zip
___ of ___ Print		
Signature	DOB	Age Phone #
___ of ___ Print		
Signature	DOB	Age Phone #
___ of ___ Print		
Signature	DOB	Age Phone #
___ of ___ Print		
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Signature	DOB	Age Phone #
___ of ___ Print		
Signature	DOB	Age Phone #
___ of ___ Print		
Signature	DOB	Age Phone #



EDWARD HOSPITAL EMS SYSTEM

NAPERVILLE FIRE DEPARTMENT



License # _____ Unit# _____ Date ____/____/____ Incident # _____

RELEASE FROM MEDICAL RESPONSIBILITY

I acknowledge that I have received medical advice which I am refusing. **I 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 I may suffer injuries which could cause disability or death.** Accordingly, I release the following persons and entities from any responsibility or liability for any injury that I 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 Naperville 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.

Patient Information	
Print Name _____	Date of Birth _____
Address _____	Age _____
City/State/Zip _____	Phone # _____

- 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 _____



EDWARD HOSPITAL EMS SYSTEM

WARRENVILLE FIRE PROTECTION DISTRICT



License # _____ Unit# _____ Date ____/____/____ Incident # _____

RELEASE FROM MEDICAL RESPONSIBILITY

I acknowledge that I have received medical advice which I am refusing. **I 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 I may suffer injuries which could cause disability or death.** Accordingly, I release the following persons and entities from any responsibility or liability for any injury that I 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 Warrenville Fire Protection District, 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.

Patient Information	
Print Name _____	Date of Birth _____
Address _____	Age _____
City/State/Zip _____	Phone # _____

- 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 _____



EDWARD HOSPITAL EMS SYSTEM

WARRENVILLE FIRE PROTECTION DISTRICT



License # _____ Unit# _____ Date ____/____/____ Incident # _____

RELEASE FROM MEDICAL RESPONSIBILITY

I acknowledge that I have received medical advice which I am refusing. **I 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 I may suffer injuries which could cause disability or death.** Accordingly, I release the following persons and entities from any responsibility or liability for any injury that I 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 Warrenville Fire Protection District, 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.

Patient Information	
Print Name _____	Date of Birth _____
Address _____	Age _____
City/State/Zip _____	Phone # _____

- 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 _____

**Edward Hospital EMS System
Required Minimum Supply & Equipment List – ALS Ambulance**

Provider	Date
Local ID	VIN (last 4 digits)
Inspected by (EMS Staff):	Inspected by (Provider staff):

Airway – Cricothyrotomy Kit x2

√	Item	√	Item
	14g angiocath (1-1/4) – 2 each		Gauze sponges – 2 each
	#10 scalpel – 1 each		Shiley size 4 & 6 – 1 each
	Curved hemostat – 1 each		3.0 ETT – 1 each
	Betadine & Alcohol (for < 2 months old)		Chloraprep x 2 (for > 2 months old)

Airway – Pleural Decompression Kit x1

√	Item	√	Item
	14g angiocath (2-1/4") – 2 each		Betadine & Alcohol (for < 2 months old)
	16g angiocath (1-1/4") – 2 each		Chloraprep x 2 (for > 2 months old)
	18g angiocath (1-1/4") – 2 each		Syringe 10 ml – 1 each

Airway – Intubation

√	Item	√	Item
	2.5mm Uncuffed ETT – 2 each		Laryngoscope handle w/spare batteries– adult
	3.0mm Uncuffed ETT – 2 each		Laryngoscope handle w/spare batteries – peds
	3.5mm Uncuffed ETT – 2 each		#0 straight blade
	4.0mm Uncuffed ETT – 2 each		#1 straight blade
	4.5mm Uncuffed ETT – 2 each		#2 straight blade
	5.0mm Uncuffed ETT – 2 each		#3 straight blade
	5.5mm Uncuffed ETT – 2 each		#2 curved blade
	6.0mm Cuffed ETT – 2 each		#3 curved blade
	6.5mm Cuffed ETT – 2 each		Spare bulbs if not using fiberoptics
	7.0mm Cuffed ETT – 2 each		Magill forceps – adult
	7.5mm Cuffed ETT – 2 each		Magill forceps - pediatric
	8.0mm Cuffed ETT – 2 each		Tube tamer, adult – 2 each
	End tidal CO2 detector – adult		Tube tamer, pediatric – 2 each
	End tidal CO2 detector - pediatric		Stylet, adult – 1 each
	King Airway – 1 each (size 4 and 5 red/purple)		Stylet, pediatric – 1 each
	Posi-tube – 1 each		
	CPAP circuit – 1 each		

Airway – Miscellaneous

√	Item	√	Item
	Hand held nebulizer – 2 each		In-line nebulizer – 2 each
	Nasal clip – 1 each		Broselow tape – 1 each

Diagnostics and Communication

√	Item	√	Item
	VHF (MERC) radio with hospital check		Electrodes, adult – 15 each
	Cardiac monitor / defibrillator		Electrodes, pediatric – 9 each
	Telemetry patch cable w/coupler		Defibrillation pads – 2 sets (adult) or gel
	Spare paper – 1 rolls		Defibrillation pads – 2 sets (pediatric) or gel
	Patient cables – 2 sets		Telemetry phone – 1 each
	Accucheck glucose monitor		Accucheck test strips - >10 strips

Intravenous Supplies

√	Item	√	Item
	Male adapter plug – 4 each		16g autoguard (1-1/4") – 4 each
	Alcohol preps – 20 each		18g autoguard (1-1/4") – 4 each
	Chloraprep – 4 each		20g autoguard (1-1/4") – 4 each
	.9%NaCL 1000ml bags – 6 each		22g autoguard (1") – 4 each
	Mini drip tubing (60gtts) – 4 each		24g autoguard (3/4") – 4 each
	Regular drip tubing (15gtts) – 4 each		1 ml / TB syringe – 4 each
	IV start kits – 6 each		3 ml syringe – 4 each
	Medication needles (20 & 22) – 4 each		5 ml/6 ml syringe – 4 each
	Carpusject holder – 1 each		10 ml/12 ml syringe – 4 each
	J-loops – 4 each		20 ml/30 ml syringe – 4 each
	Armboard, padded, long – 2 each		60 ml syringe – 1 each
	Armboard, padded, short – 2 each		TB isolation masks – 1 per crew member
	Nasal Atomizer – 2 each		

Intraosseous Kit x1 (Pediatric patients <3 kg)

√	Item	√	Item
	Aspiration needle – 1 each		10 ml syringe – 1 each
	Betadine swabs – 2 each		
	Alcohol preps – 2 each		

EZ IO Intraosseous Kit x1 (≥3 kg)

√	Item	√	Item
	EZ IO adult needle and bariatric needle x 1		EZ IO connection tubing x 2
	EZ IO pediatric needle x 1		10 ml syringe – 1 each
	EZ IO Driver		Sterile gloves, size 7.5 & size 8 – 1 pair each
	EZ IO wrist band x 2		Chloraprep x 2

Medications

√	Item	√	Item
	Adenosine 6mg preload – 1 each		Etomidate, 40mg preload – 3 each
	Adenosine 12mg preload – 2 each		Glucagon, 1mg powder kit – 2 each
	Albuterol 2.5mg 0.083 – 3 each		Glucose, oral – 1 tube
	Amyl Nitrate (sealed) – 12 each		Lasix, 40mg (200mg total)
	Aspirin, chewable, 81mg tablets – 8 each		Lidocaine, 100mg – 6 each
	Atropine Sulfate, 1mg preload – 6 each		Morphine Sulfate, 10mg vial – 2 each
	Ammonia inhalants – 1 box		Narcan, 2mg preload – 5 each
	Benadryl, 50mg preload – 2 each		Nitroglycerin, 0.4mg spray – 2 each

Benzocaine Spray w/>2 straws – 1 bottle	Nitrous Oxide System - optional
Dextrose 50% 25gm/50ml – 3 each	Sodium Bicarbonate, 50mEq preload – 3 each
Dextrose 25% 10ml – 3 each	Tetracaine HCl, 0.5% unit dose – 2 each
Dopamine premix, 800mg/500ml – 1 each	Versed, 10mg – 2 each
Epinephrine 1:1,000, 30mg vial – 2 each	.9% NaCL pre filled syringes – 4 each
Epinephrine 1:10,000, 1mg preload – 2 each Epinephrine 1:1000 1mg/1ml vial – 2 each	Zofran 4mg ODT – 2 each

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: 9-26-07
Revised: 04-10

U:Phil\amb inspection\ALS Ambulance 10-1-08

**Edward Hospital EMS System
Required Minimum Supply & Equipment List – ALS Non-Transport**

Provider	Date
Local ID	VIN (last 4 digits)
Inspected by (EMS Staff):	Inspected by (Provider staff):

Airway – Cricothyrotomy Kit x1

√	Item	√	Item
	14g angiocath (1-1/4) – 2 each		Gauze sponges – 2 each
	#10 scalpel – 1 each		Shiley size 4 & 6 – 1 each
	Curved hemostat – 1 each		3.0 ETT – 1 each
	Betadine & Alcohol (for < 2 months old)		Chloraprep x 2 (for > 2 months old)

Airway – Pleural Decompression Kit x1

√	Item	√	Item
	14g angiocath (2-1/4") – 2 each		Betadine & Alcohol (for < 2 months old)
	16g angiocath (1-1/4") – 2 each		Chloraprep x 2 (for > 2 months old)
	18g angiocath (1-1/4") – 2 each		Syringe 10 ml – 1 each

Airway – Intubation

√	Item	√	Item
	2.5mm Uncuffed ETT – 1 each		Laryngoscope handle w/spare batteries– adult
	3.0mm Uncuffed ETT – 1 each		Laryngoscope handle w/spare batteries – peds
	3.5mm Uncuffed ETT – 1 each		#0 straight blade
	4.0mm Uncuffed ETT – 1 each		#1 straight blade
	4.5mm Uncuffed ETT – 1 each		#2 straight blade
	5.0mm Uncuffed ETT – 1 each		#3 straight blade
	5.5mm Uncuffed ETT – 1 each		#2 curved blade
	6.0mm Cuffed ETT – 1 each		#3 curved blade
	6.5mm Cuffed ETT – 1 each		Spare bulbs if not using fiberoptics
	7.0mm Cuffed ETT – 1 each		Magill forceps – adult
	7.5mm Cuffed ETT – 1 each		Magill forceps - pediatric
	8.0mm Cuffed ETT – 1 each		Tube tamer – adult
	End tidal CO2 detector – adult		Tube tamer – pediatric
	End tidal CO2 detector - pediatric		Stylet, adult – 1 each
	King Airway – 1 each (one red/one purple)		Stylet, pediatric – 1 each
	Posi-tube – 1 each		

Airway – Miscellaneous

√	Item	√	Item
	Hand held nebulizer – 1 each		In-line nebulizer – 1 each
	Meconium aspirator – 1 each		Broselow tape – 1 each
	Nasal clip – 1 each		

Diagnostics and Communication

√	Item	√	Item
---	-------------	---	-------------

VHF (MERC) radio with hospital check		Electrodes, adult – 15 each
Thermometer		Electrodes, pediatric – 9 each
Cardiac monitor / defibrillator		Defibrillation pads – 1 set (adult)
Spare paper – 1 roll		Defibrillation pads – 1 set (pediatric)
Patient cables – 1 set		Gel if not using pads
Accucheck glucose monitor – 1 each		Accucheck test strips - >10 strips

Intravenous Supplies

√	Item	√	Item
	Male adapter plug – 2 each		16g autoguard (1-1/4") – 3 each
	Vial adapter – 2 each		18g autoguard (1-1/4") – 3 each
	Alcohol preps – 20 each		20g autoguard (1-1/4") – 3 each
	ChloroPrep – 4 each		22g autoguard (1") – 3 each
	.9%NaCL 1000ml bags – 2 each		24g autoguard (3/4") – 3 each
	Mini drip tubing (60gtts) – 1 each		1 ml / TB syringe – 3 each
	Regular drip tubing (15gtts) – 2 each		3 ml syringe – 2 each
	IV start kits – 4 each		5 ml/6 ml syringe – 2 each
	Medication needles (20 & 22) – 4 each		10 ml/12 ml syringe – 2 each
	Carpject holder – 1 each		20 ml/30 ml syringe – 2 each
	J-loops – 4 each		60 ml syringe – 1 each
	Nasal Atomizer – 2 each		TB isolation masks – 1 per crew member

Intraosseous Kit x1 (Pediatric patients <3 kg)

√	Item	√	Item
	Aspiration needle – 1 each		10 ml syringe – 1 each
	Betadine swabs – 2 each		Sterile gloves, size 7.5 - 1 pair each
	Alcohol preps – 2 each		Sterile gloves, size 8 - 1 pair each

EZ IO Intraosseous Kit x1 (≥3 kg)

√	Item	√	Item
	EZ IO adult needle and bariatric needle x 1		EZ connect extension tubing x 2
	EZ IO pediatric needle		10 ml syringe – 1 each
	EZ IO Driver		Chloraprep x 2
	EZ IO wrist band x 2		

Medications

√	Item	√	Item
	Adenosine 6mg preload – 1 each		Epinephrine 1:10,000, 1mg preload – 2 each
	Adenosine 12mg preload – 1 each		Etomidate, 40mg preload – 3 each
	Albuterol 2.5mg 0.083 – 2 each		Glucagon, 1mg powder kit – 1 each
	Amyl Nitrate (sealed) – 12 each		Glucose, oral – 1 tube
	Aspirin, chewable, 81mg tablets – 8 each		Lasix, 40mg (100mg total) – 3 each
	Atropine Sulfate, 1mg preload – 3 each		Lidocaine, 100mg – 4 each
	Ammonia inhalants – 1 box		Morphine Sulfate, 10mg vial – 2 each

Benadryl, 50mg preload – 2 each	Narcan, 2mg preload – 3 each
Benzocaine Spray w/>2 straws – 1 bottle	Nitroglycerine, 0.4mg spray – 1 each
Dextrose 50% 25gm/50ml – 1 each	Sodium Bicarbonate, 50mEq preload – 1 each
Dextrose 25% 10ml – 1 each	Tetracaine HCl, 0.5% unit dose – 1 each
Epinephrine 1:1,000 1mg/1ml vial – 1 each	Versed, 10mg – 2 each
Epinephrine 1:1,000, 30mg vial – 2 each	.9% NaCL pre filled syringes – 2 each Zofran 4mg ODT – 2 each

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.

07-05-06
Revised: 7-1-09

**ALS EQUIPMENT CHECK
SEMSV**

JUMP BAG

ITEM	QTY	EXP	ITEM	QTY	EXP
Start Kits-2			IV pack-1		
.9ns 10cc-2			2-each 18g-24g		
J-loops-2			15tts tubing-1		
Vaseline Gauze-3			Mini tubing-1		
Burn Sheets-2			Start Kit-1		
Trauma Dressing-2			1000cc .9ns-1		
Multi-Cuff			IO Kit-1		
Stethoscope-1			IO needle-1		
Trauma Shears-1			Chloraprep-2		
Pen Light-1			Sterile gloves-2		
Triangular Bandage-2			Glucometer Kit-1		
Sling-2			Alcohol preps-10		
Sharps Shuttle-1			Lancets-10		
4x4s- 10			Strips-1 bottle		

DRUGS

SIDE COMPARTMENTS

ITEM	QTY	EXP	ITEM	QTY	EXP
Albuterol-1			Tape Rolls-3		
Ammonia Inhalants-1bx			Kling-8		
Atropine-2			Fluff Roll-2		
Benadryl-1					
Epi 1:10,000-2			Ice Packs-3		
Epi 1:1000-1 Ampule			Heat Packs-3		
Dextrose 50%-1			Band-aids-1box		
Oral Glucose-1					
TB/1cc syringe-2					

12cc syringe-2					
Male lure lock-2					
Filter Straw-1					
Vial Spike Adapter-2					
Med needles-2					

AIRWAY BAG

ITEM	QTY	EXP	ITEM	QTY	EXP
O2Tank/Pressure-_____			King Airway #4		
Tube Holder Adult-1			#5		
Peds			Adult NRB Mask-1		
ET Tubes 1 each			NC-1		
2.5			Oxygen Tubing-1		
3.0			Peds NRB Mask-1		
3.5			Nebulizer		
4.0			Infant Mask-1		
4.5			CPR Mask-1		
5.0			Cric Kit-1		
5.5			Shiley-4-1		
6.0			Shiley-6-1		
6.5			3.0 ET tube-1		
7.0			Chloraprep-2		
7.5			Angio 14g -2		
8.0			Angio 18g-2		
In-Line Neb-1			10 Blade -1		
Surgi-Lube-10			Curved Hemostat-1		
Adult Nebulizer-1			Sterile Gloves-2		

INTUBATION ROLL

ITEM	QTY	EXP
Oral Airways Adult-2		
Peds-2		
Infant-2		
End-Tidal CO2 Adult-1		
Peds-1		
Posi-Tube-1		
Stylets Adult/Peds-1ea		
Syringe-12cc -1		
Nasal Airway 12-32Fr 1- each		
Miller 0-3 (1 each)		
Mac 1-4 (1 each)		
Magill Forceps Adult-1		
Peds-1		
Bite Stick-1		

COMPARTMENTS

ITEM	QTY	EXP	ITEM	QTY	EXP
Airway Bag-1			Saline Bottles-2		
Jump Bag-1			C-Collar Bag-1		
BVM Peds-1			Collars Adult-2		
Adult-1			Peds-1		
Monitor			Baby-1		
Pacing Pads Adult-1			Head Beds-2		
Peds-1			Hare Traction-1		
D-fib Gel-1			OB Kit		
Electrodes Adult-15			PPE Kits-2		
Peds-9			Biohazard Bags-4		
			Sam Splints-2		
Spare Run forms-10			Hand-Held Suction-1		

EDWARD

EMERGENCY DEPARTMENT NON-DISPOSABLE EQUIPMENT RECEIPT FORM

Edward Hospital agrees to accept responsibility for the safekeeping of:

QUANTITY	TYPE OF SUPPLIES OR EQUIPMENT	STATE OF REPAIR
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

EDWARD

EMERGENCY MEDICAL SERVICES TRAINING EQUIPMENT LOAN FORM

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.

**Edward Hospital
Emergency Medical Services Drug Exchange**

Quantity:	Drug:	NDC:	Transport Par:	Non-Transport Par:
	Adenosine 6mg/2ml Prefilled		1	1
	Adenosine 12mg/4ml Prefilled		2	1
	Albuterol 2.5mg/3ml 0.83% neb		3	2
	Amyl Nitrate amps		1 box	1 box
	Aspirin 81mg chewable		8	8
	Atropine Sulfate 1mg/10ml syr		6	3
	Ammonia inhalants		1 box	1 box
	Diphenhydramine 50mg/ml		2	2
	Hurricane Spray		1	1
	Dextrose 25% 10ml Prefilled		3	1
	Dextrose 50% 50ml Prefilled		3	1
	Dopamine 800mg/500ml (1600mcg/ml)		1	1
	Epinephrine 1:1000 injection, 30ml vial		2	2
	Epinephrine 1:100,000 1mg/10ml Syr		2	2
	Etomidate 40mg/20ml Prefilled		3	3
	Glucagon 1mg Kit		1	1
	Glucose gel, 37.5gm tube		1	1
	Furosemide 40mg/4ml Prefilled		5	3
	Lidocaine 100mg/5ml Prefilled		6	4
	Midazolam 10mg/2ml vial		2	2
	Morphine Sulfate 10mg/ml vial		2	2
	Narcan 2mg/2ml Prefilled		5	3
	Nitroglycerin 0.4mg/spray, 4.9gm spray		2	1
	Ondansetron 4mg ODT tab			
	Sodium Bicarb 1mEq/ml, 50ml Prefilled		3	1
	Tetracaine HCl 0.5% Opth, 2ml UD		2	1

****Meds not listed on this sheet WILL NOT be provided without approval from Shannon Morris.****

Reason for request (check one) ___ Expired ___ Missing ___ Pyxis Out ___ Broken

Should any of the drugs listed above not be available in the prescribed packaging, please note the reason: _____

EMS Provider Name (printed): _____

EMS Provide Signature: _____

EMS Vehicle ID: _____ (Circle one) Transport Non-Transport

Quantity dispensed must be equal to or less than vehicle par. If requesting for more than one vehicle, please fill out a separate sheet for each vehicle.

EMS Dept: (circle one) Bolingbrook Lisle/Woodridge Naperville Warrenville

*****Providers from departments not listed above must fill out an Out of System Provider sheet for med restock.*****

Pharmacy Tech Initials: _____ **Pharmacist Initials** _____ **Date:** _____

**Edward Hospital
Emergency Medical Services Drug Exchange**

Forward completed sheets to Anne Yeglic, Pharmacy Buyer



HOSPITAL & HEALTH SERVICES

Edward Hospital and Health Services

Departments: Nursing, Respiratory Care, Pharmacy, and Central Distribution Services

PASSWORD VERIFICATION CONFIDENTIALITY STATEMENT / SIGNATURE ID

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.

Nursing, Respiratory Care, Pharmacy, and Central Distribution 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. EHSC employees will be subject to disciplinary action up to and including termination for violations of Information System Policies related to Pyxis.

Name of User (PLEASE PRINT) & Department

Signature of User

Meditech User ID:: _____

Authorization by: _____

Please put an X in the appropriate box:

- | | |
|--|--|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> NICU / LD RN |
| <input type="checkbox"/> Plainfield RN | <input type="checkbox"/> Oswego RN |
| <input type="checkbox"/> Central Supply | <input type="checkbox"/> Pharmacy Tech |
| <input type="checkbox"/> Clinical Educator | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> CST (Surg.Tech) | <input type="checkbox"/> Radiology Tech |
| <input type="checkbox"/> EMS | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> ER Tech / PCT | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Agency Staff | <input type="checkbox"/> Corporate Health RN |

If Agency Staff please specify:

Start date: _____ Finish date: _____

- Authorized Locations:**
- Ortho/Neuro
 - MSU
 - SSU
 - Med/Onc
 - L&D / C-Section
 - NICU
 - Mother – Baby
 - SSU – 2
 - Cardiac Tele 2 (CTU)
 - Cardiac Tele 3 (CTU)
 - Cardiac Tele 7 (CTU)
 - CCU
 - ICU / ICUOVF
 - Recovery
 - Surgery
 - SDS
 - EMS
 - CDU (Peds OP)
 - ED
 - PEDs ER
 - PEDs PICU / ICUOVF
 - Radiology
 - CVOR
 - Cath Lab / ECI Holding
 - Oswego
 - Plainfield
 - Endo
 - Cancer Center
 - ECI Diagnostics

Pyxis System Manager Use Only

Date Activated in Pyxis: _____

By: _____

Pyxis Password Procedure

- 1. Pharmacy will assign a Pyxis User ID (same as Meditech ID) and randomly generate an initial temporary password for all new users.**
- 2. The user must go to the Pharmacy to pick up their initial temporary password and all subsequent passwords (i.e.: forgotten password).**
- 3. All users must show proper identification (Edward Hospital badge) to obtain a Pyxis User ID and initial temporary password from Pharmacy.**
- 4. All users must have a Pyxis Tutorial Certificate of Completion attached to their Pyxis Authorization form signed by their Nurse Manager before a Pyxis User ID and initial temporary Password will be assigned.**
- 5. Pharmacy will maintain a log of all random passwords assigned (new and forgotten).**

EDWARD HOSPITAL EMS SYSTEM PERSONNEL CONFIDENTIALITY
STATEMENT

I, as an Authorized EMS Personnel of the Edward Hospital EMS System Provider set forth below, understand that my unique User ID and Pyxis Password will be my electronic signature for all transactions to the Pyxis Medstations to which I have access and will be permanently attached to those transactions with a time and date stamp. These records will be maintained and archived in accordance with the policies of Edward Hospital, and be available for inspection by the Drug Enforcement Agency (DEA) and the State Board of Pharmacy.

I have reviewed and understand Edward Hospital's policy titled "EMS Personnel Access to the Pyxis Medstation System". I will treat my Pyxis User ID and Password as confidential and understand that unauthorized disclosure of my Pyxis User ID and Password shall make me personally responsible for all the unauthorized accesses to, or disclosures of, hospital or patient information made by others using my Pyxis User ID and Password. I further understand that violations of Edward Hospital's policy related to EMS Personnel Access to the Pyxis Medstation System will subject me to the disciplinary process as described in the Edward Hospital EMS System policy titled "Provider/EMT Suspension".

Name of EMS Personnel (PLEASE PRINT)

EMS System Provider

Signature of EMS Personnel User

Witness

Date

Edward EMS System Policies Index

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- Mission Statement
- Purpose of Manual
- Amendment, Revision, and Review of the Policy Manual
- Local Review Board
- Role of EMS Medical Director
- Role of EMS System Coordinator
- Role of EMS Provider Coordinator

Section 2 Education, Relicensure and Status

- ECRN Initial Certification and Renewal
- ECRN Reciprocity
- ECRN Address, Name, and/or Status Change
- EMT System Entry
- EMT License Renewal
- EMT Licensure – Change of Status (license level)
- EMT Continuing Education
- Non-EHEMSS requests for clinical and ambulance ride time

Section 3 Patient Care Issues

- Abandonment
- Adult Right of Refusal/Involuntary Treatment or Transport
- Domestic Violence
- Abandoned Newborn
- Do Not Resuscitate Guidelines
- Invalid/Citizens Assist
- Patient Transport/Selection of Receiving Hospital
- Minors – Treatment Consent for Minors
- Minor Refusals
- Multiple Patient Release (MPR)
- School Bus MVC
- Reporting Elder Abuse
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- Notification of Coroner
- System Wide Crisis
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Section 4 Patient information, Documentation, and Communication

- Communications Policy
- Confidentiality and Release of Patient Information
- ECRN Physician Consultation
- Falsification of Records
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Section 5 Infection Control

- Infection Control Guidelines

Section 6 Equipment, Medications, and Supplies

- Drug Replacement – Soon to expire, outdated, or damaged
- Controlled Substance Management
- Body/Equipment Disposition after withdrawal of resuscitation
- Approval of additional drugs, equipment or protocols
- Equipment List for Ambulances, ALS Engines and SEVs
- Non-disposable Equipment Return
- Latex-Sensitive Patient
- Out of Service Vehicles
- Pyxis Policy
- Unannounced Inspections
- Unstocked Reserve Vehicles
- Safe Medical Devices Act
- Lending Training Equipment from EMS Department

Section 7 Quality

- Abuse of Controlled Substances
- Medication and Procedure Errors
- Provider/EMT Suspension
- EHEMSS Communication Form Policy
- Vehicle Staffing
- Quality Improvement Program

Section 8 Scene Issues

- Law Enforcement on Scene
- Requesting Physician to the Scene
- Physician on Scene

Appendix

- EHEMSS Communication Form
- IDPH CE Suggestions
- DNR form
- MPR forms and Individual Refusal forms (department-specific)
- Ambulance Equipment List
- ALS Engine Equipment List
- Special Events Vehicle Equipment List
- Non-disposable Equipment Return Form
- Training Equipment Loan Form
- Unstocked Reserve Activation/Deactivation Form
- Pharmacy Drug Exchange Form
- Pyxis ID form
- Pyxis Confidentiality Statement