REGION 11
CHICAGO EMS SYSTEM

POLICIES

REGION 11
CHICAGO EMS SYSTEM
EMS POLICIES

These Region 11 Chicago EMS System Protocols, Policies, and Procedures for EMTs and Paramedics are prehospital medical guidelines for patient assessment, treatment, and transportation within the system. They provide a framework for all patient encounters and Online Medical Control should be consulted in situations where there is not clear direction from the written documents.

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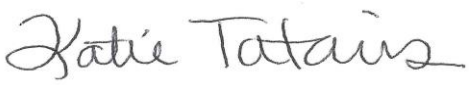

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REGION 11
CHICAGO EMS SYSTEM
POLICIES

GENERAL

Professional Ethical Standards and Behavioral Expectations
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REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Professional Ethical Standards and Behavioral Expectations
	Section: General
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PROFESSIONAL ETHICAL STANDARDS AND BEHAVIORAL EXPECTATIONS

I. Professional status as an Emergency Medical Services (EMS) Practitioner is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the EMS profession. EMS Practitioners in Region 11 have a duty to the following code of professional ethics:

A. To conserve life, alleviate suffering, promote health, do no harm, and encourage the quality and equal availability of emergency medical care.

B. To provide services based on human need, with compassion and respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status; to not judge the merits of the patient's request for service, nor allow the patient's socioeconomic status to influence demeanor or the care provided.

C. To not use professional knowledge and skills in any enterprise detrimental to the public well-being.

D. To respect and hold in confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.

E. To use social media in a responsible and professional manner that does not discredit, dishonor, or embarrass an EMS organization, co-workers, other health care practitioners, patients, individuals or the community at large.

F. To maintain professional competence, striving always for clinical excellence in the delivery of patient care.

G. To assume responsibility in upholding standards of professional practice and education.

H. To assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and to know and uphold the laws which affect the practice of EMS.

I. To be aware of and participate in matters of legislation and regulation affecting EMS.

J. To work cooperatively with EMS associates and other allied healthcare professionals in the best interest of our patients.

K. To refuse participation in unethical procedures and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Reference: National Association of Emergency Medical Technicians (NAEMT), Code of Ethics for EMS Practitioners, https://www.naemt.org/about-ems/code-of-ethics

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Participating Hospital Responsibilities
	Section: General
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PARTICIPATING HOSPITAL RESPONSIBILITIES

I. PURPOSE

To define a participating hospital and responsibilities under an EMS System.

II. DEFINITION

Participating Hospital: A licensed hospital that has signed a letter of agreement to participate in an EMS System and follow the EMS System Plan as defined below.

III. POLICY

A. Drug, Equipment and Supply (DES) Item Replacement

1. Each participating hospital is required to replace all drugs, supplies and exchange equipment as defined by the Region 11 EMS System Drug, Equipment and Supply List (DES).

2. Replacement of drugs and supplies to Region 11 EMS personnel should be facilitated by the receiving hospital and includes the following patient categories:

    a. Transported by EMS to an Emergency Department
    b. Transported by EMS to an inpatient bed
    c. Non-transports of termination of resuscitation patients that would have otherwise been transported to the hospital.

3. All replacement items should be immediately available to the EMT or paramedic as documented in the patient care report so as not to delay their return to service.

4. Failure to replace an item should be documented on a standardized form as provided by the employer agency.

5. EMS should retain this form and restock at their Resource Hospital and/or internally with their EMS agency.

6. In the event of transport of a patient with a suspected communicable disease, the following items must be made available to the EMT or paramedic for use:

    a. An EPA-registered disinfectant or surface disinfectant wipes
    b. Additional ambulance cleaning supplies as needed.

7. Controlled Substances

    a. Use of any controlled substance should be documented on a controlled substance accountability form and signed by the paramedic and a representative from the

receiving participating hospital. The hospital and EMS agency are responsible for maintenance of these forms as per internal policy and DEA requirements.

b. Each participating hospital must accept any waste or residual controlled substances from EMS personnel and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy.
c. Upon documentation of use, each participating hospital will then replace only the controlled substance from the EMS unit as listed according to the Region 11 EMS System Drug, Equipment and Supply List.
d. Resource and Associate Hospitals in Region 11 have the additional responsibility to replace "soon to expire" controlled substances according to the Controlled Substance Requirements Policy.

B. Communication With EMS

1. Each participating hospital should have a dedicated phone line for EMS pre-notification calls.

2. Every participating hospital must have a functioning MERCI radio.

3. A dedicated fax number or direct platform is required to receive EMS patient care reports.

4. A dedicated computer terminal is required to receive 12 lead ECG transmissions.

5. A dedicated computer terminal is required to access EMResource.

C. **Emergency Department Status and Hospital Capacity**

1. Each hospital should maintain adequate staff and capacity to allow for EMS patient transports to the Emergency Department or implement surge protocols when resources are limited.

2. Each hospital should have a protocol that addresses peak census, surge, and hospital diversion/ambulance bypass; current status should be updated in EMResource as detailed in the Hospital Diversion/Ambulance Bypass or Resource Limitation Policy.

3. According to federal EMTALA regulations, once a patient arrives at a hospital Emergency Department they become the responsibility of the hospital and its staff, and a transfer of patient care is considered to have occurred, regardless of whether or not a gurney or wheelchair is immediately available for the physical transfer.

4. Ambulances on hospital property cannot and will not be rerouted to another hospital for initial patient evaluation.

5. For patients arriving with cardiac rhythm monitoring by EMS, the hospital staff's triage assessment and internal protocols should dictate if continued rhythm monitoring is

necessary. Region 11 EMS Protocols require cardiac monitoring for a wide variety of conditions that may not be the same for 'in hospital' care (i.e. a 'monitored bed' might not be necessary in the Emergency Department).

6. It is mandatory for EMS crews to transfer care to hospital staff, generate a patient care report (PCR), clean their equipment, and restock their supplies in a MAXIMUM of 60 minutes so that they can return to service. Extended "wall times" or "ambulance offload delays" are not acceptable and create a potentially dangerous delay in responding to the next emergency.

7. Each participating hospital must have access to EMResource and report their bed availability according to the Illinois Department of Public Health (IDPH) requirements.

D. **Notification of a Significant Exposure to a Communicable Disease**

1. All hospitals are required to be compliant with the requirements outlined in the Illinois Hospital Licensing Act (210 ILCS 85/6.08).

2. Each participating hospital must have an internal policy addressing notification of communicable diseases to an EMS agency's Designated Infection Control Officer (DICO).

3. The guidelines for the notification for Emergency Response Employees (ERE) and *List of Potentially Life-Threatening Infectious Diseases to Which Emergency Response Employees May Be Exposed* can be found on the CDC webpage: https://www.cdc.gov/niosh/topics/ryanwhite/background.html

E. **EMS Case Review and Continuous Quality Improvement (CQI)**

1. Participating hospitals have the responsibility to notify the Resource Hospital EMS Coordinator of any concerns involving prehospital patient care, the Request for Clarification Form may be used for this purpose.

2. Participating hospitals must share patient medical information with the Resource Hospital for case review and/or quality improvement purposes.

Attachment I: List of Region 11 EMS System Participating Hospitals

Attachment 1

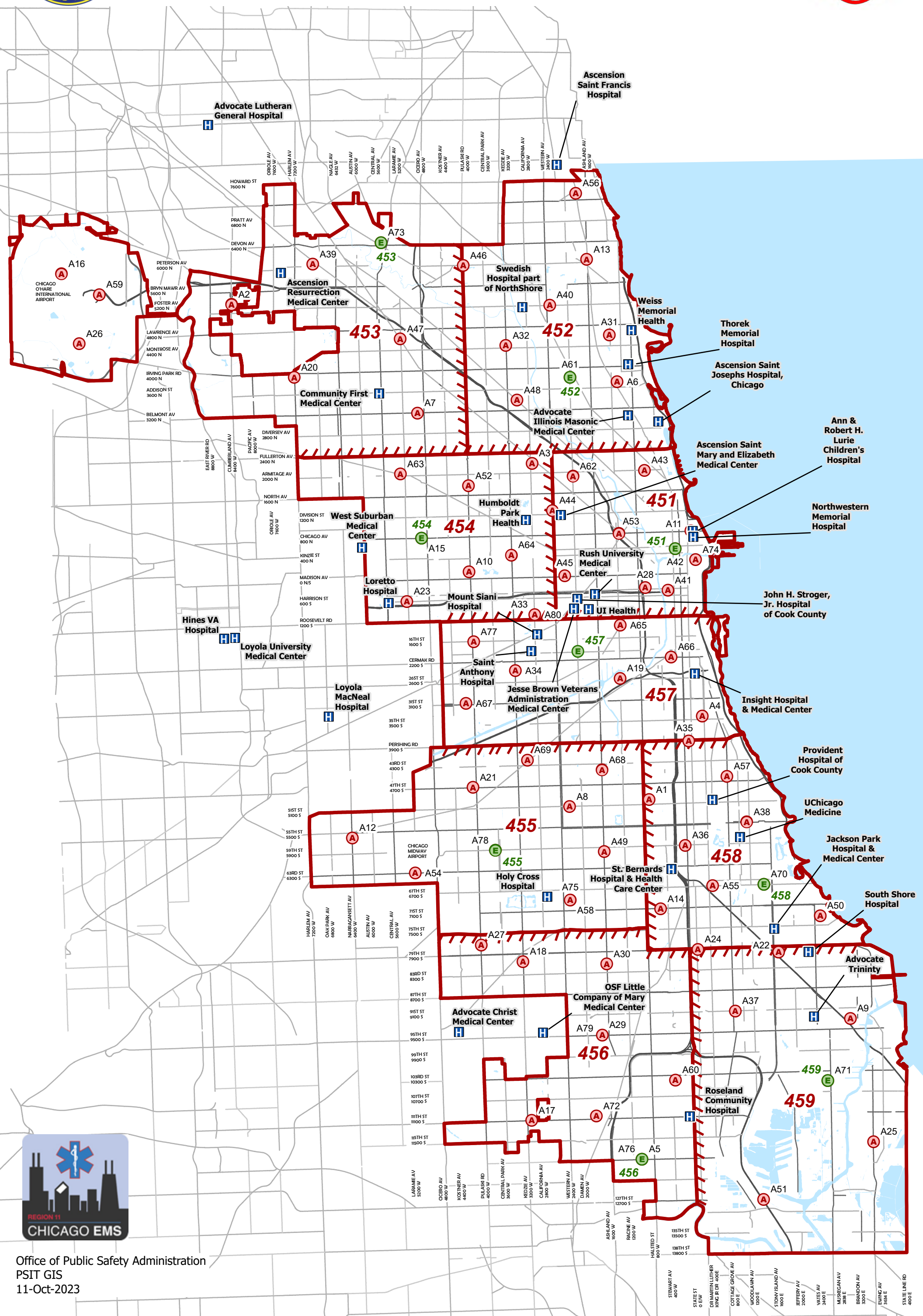
PARTICIPATING HOSPITALS

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Advocate Trinity Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago (Pediatrics ONLY)
Ascension Resurrection Medical Center
Ascension Saint Francis Hospital
Ascension Saint Joseph Hospital, Chicago
Ascension Saints Mary & Elizabeth Medical Center (St. Mary Campus ONLY)
Community First Medical Center
Edward Hines, Jr. Veterans Affairs Hospital
Endeavor Health Swedish Hospital
Holy Cross Hospital
Humboldt Park Health
Insight Hospital & Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Affairs Medical Center
John H. Stroger, Jr. Hospital of Cook County
Loretto Hospital
Loyola MacNeal Hospital
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Provident Hospital of Cook County
Roseland Community Hospital
Rush University Medical Center
Saint Anthony Hospital
South Shore Hospital
St. Bernard Hospital & Health Care Center
Thorek Memorial Hospital
UChicago Medicine
UI Health
Weiss Memorial Hospital
West Suburban Medical Center

Each hospital listed participates in the Chicago EMS System (Region 11) and is licensed by IDPH as providing Comprehensive Emergency Services.

Updated 12/12/23

Region 11 Participating Hospitals



REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Region 11 (Chicago) EMS Organizational Structure
	Section: General
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

REGION 11 (CHICAGO) EMS ORGANIZATIONAL STRUCTURE

I. PURPOSE

To define the organizational structure of the Region 11 (Chicago) EMS Systems.

II. DEFINITIONS

A. EMS System: An organization of hospitals, EMS agencies and licensed EMS personnel in a specific geographic area, which coordinates and provides prehospital and interhospital emergency care and non-emergency medical transports at a BLS and/or ALS level pursuant to an EMS System Plan.

B. Resource Hospital: The hospital with the authority and responsibility for an EMS System as outlined in the EMS System Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire EMS System, including clinical aspects, operations, and education. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Resource and Associate Hospital Policy and Participating Hospital Policy.

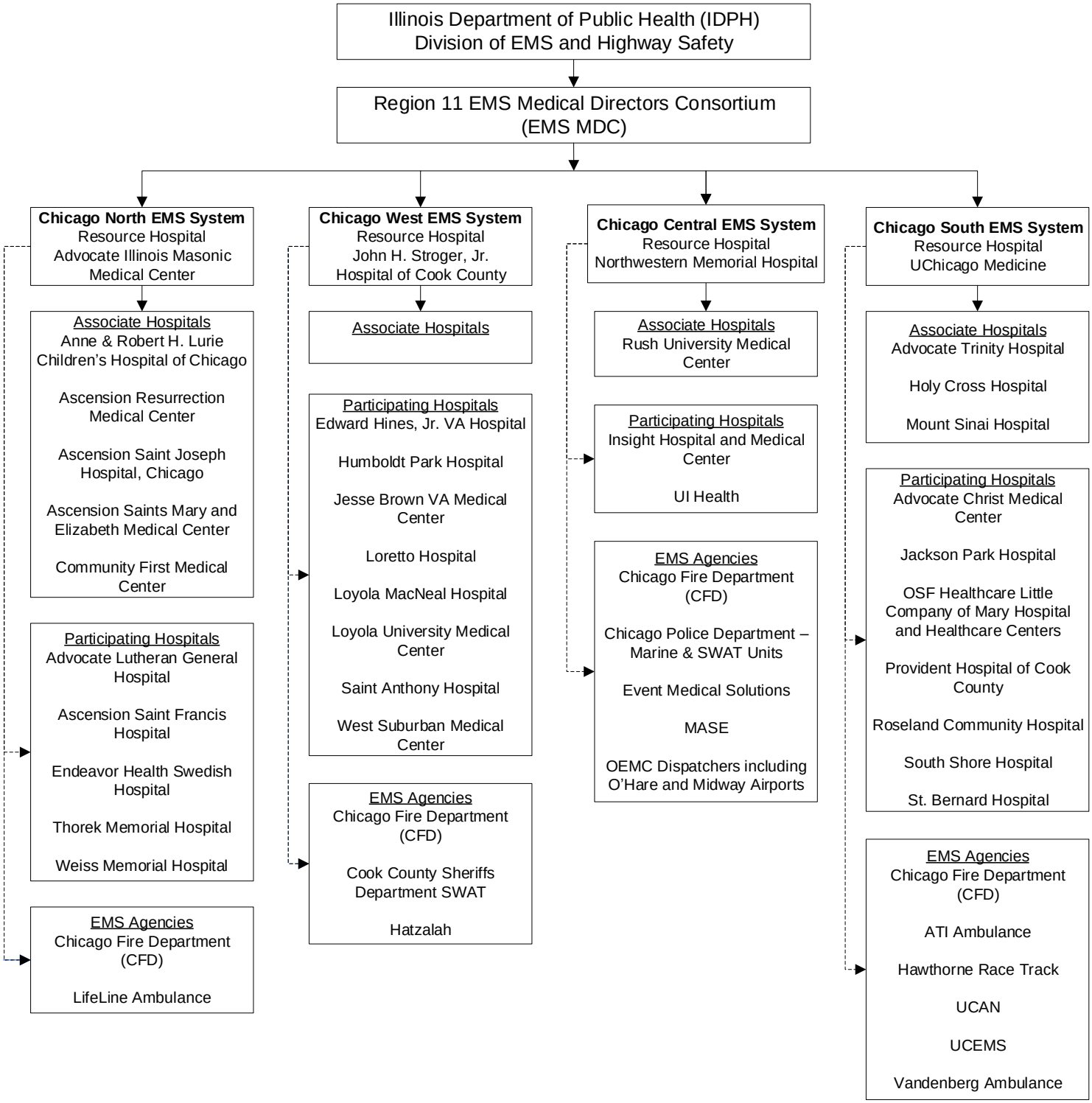
C. Associate Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs, nor the responsibility for the overall operation of the EMS System program. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Resource and Associate Hospital Policy and Participating Hospital Policy.

D. Participating Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Participating Hospital Policy.

E. EMS Agency: An entity licensed by IDPH to provide emergency or non-emergency medical services in compliance with the State of Illinois EMS Act and an operational plan approved by its EMS System(s).

See next page for an outline of the Region 11 (Chicago) EMS Organizational Structure.

Region 11 (Chicago) EMS
Organizational Structure



REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Resource and Associate Hospitals
	Section: General
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

RESOURCE AND ASSOCIATE HOSPITALS

I. PURPOSE

To define the responsibilities of the Resource and Associate Hospitals as part of an EMS System Plan under IDPH.

II. POLICY

A. Resource Hospital: The hospital with the authority and responsibility for an EMS System as outlined in the EMS System Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire EMS System, including clinical aspects, operations, and education.

1. EMS System Program Plan Defined Roles and Responsibilities:

   a. EMS System Medical Director: Physician appointed by the Resource Hospital who has the authority and responsibility for overseeing EMS continuing education, developing and authorizing EMS Protocols, Policies and Procedures and supervising all EMS personnel as described in the EMS System Program Plan.
   b. Alternate EMS System Medical Director: Responsible for the management of the EMS System Program Plan under the EMS System Medical Director.
   c. EMS System Coordinator: Responsible for data evaluation, quality management, complaint investigation, supervision of all didactic education, clinical and field experiences, and physician and nurse education as required under the EMS System Program Plan and under the authority of the EMS System Medical Director.

2. Region 11 Resource Hospitals and EMS Systems:

   a. Advocate Illinois Masonic Medical Center = Chicago North EMS System
   b. Northwestern Memorial Hospital = Chicago Central EMS System
   c. Stroger Hospital of Cook County = Chicago West EMS System
   d. University of Chicago Medicine = Chicago South EMS System

3. Region 11 EMS is defined as the City of Chicago city limits and is geographically comprised of four EMS Systems (Chicago EMS Systems). See attached Region 11 EMS System Geographical Boundaries Map.

B. Associate Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs, nor the responsibility for the overall operation of the EMS System program.

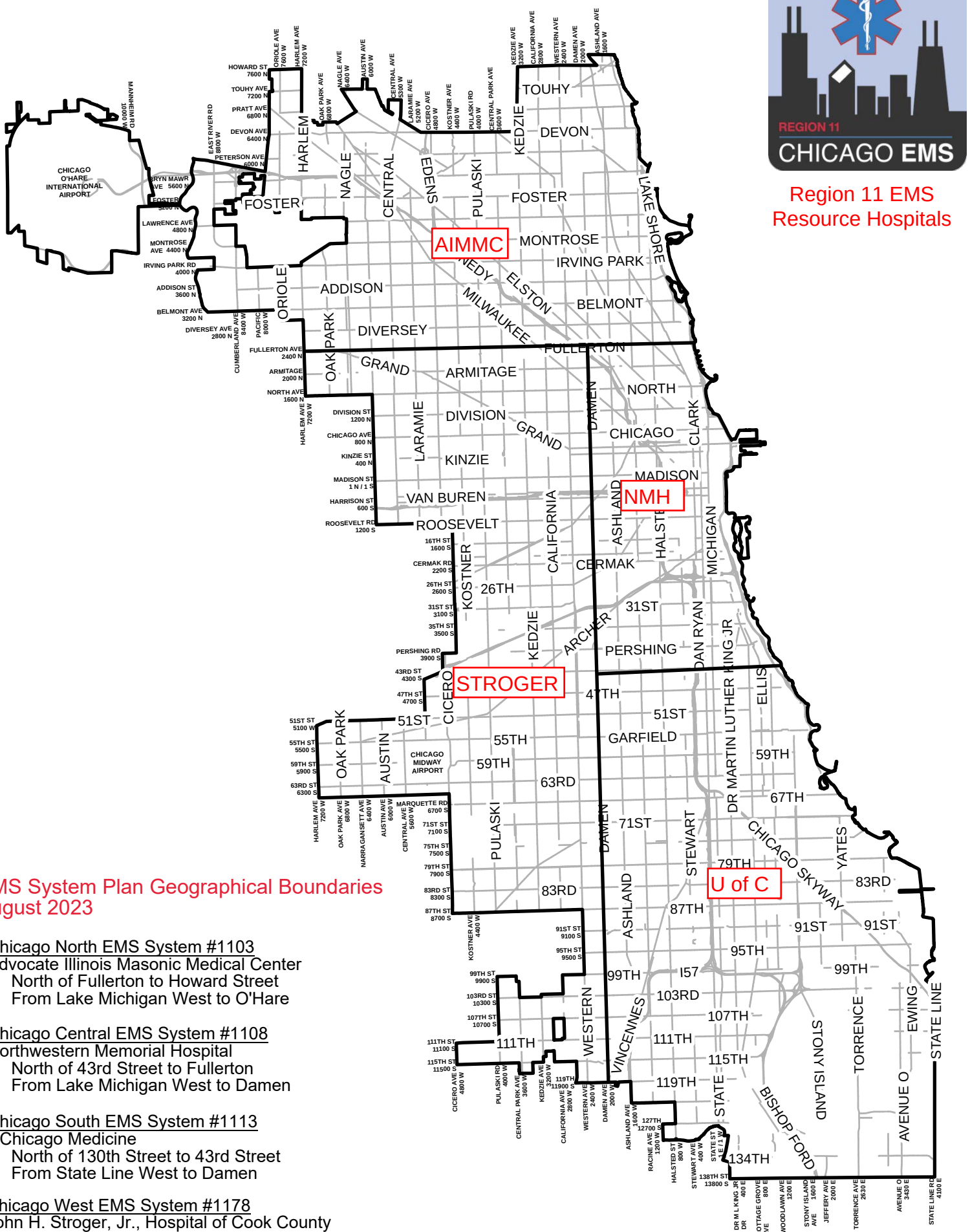
1. EMS System Program Plan Defined Roles and Responsibilities:

    a. Associate Hospital EMS Medical Director: Physician appointed by the Associate Hospital who is responsible for day-to-day operations of the Associate Hospital and supervision of ECPs, as it relates to the EMS System Program Plan and under the authority of the Resource Hospital.
    b. Associate Hospital EMS Coordinator: Responsible for following the EMS System Program Plan and supervision of ECRNs under the authority of the Resource Hospital.

2. Region 11 Associate Hospitals

    a. Chicago North EMS System - Advocate Illinois Masonic Medical Center
    Ann & Robert H. Lurie Children's Hospital of Chicago
    Ascension Resurrection Medical Center
    Ascension Saints Mary & Elizabeth Medical Center
    Ascension St. Joseph Hospital, Chicago
    Community First Medical Center
    b. Chicago Central EMS System - Northwestern Memorial Hospital
    Rush University Medical Center
    c. Chicago West EMS System - Stroger Hospital of Cook County
    d. Chicago South EMS System - University of Chicago Medicine
    Advocate Trinity Hospital
    Holy Cross Hospital
    Mount Sinai Hospital

C. In addition to the roles and responsibilities outlined above, Resource and Associate Hospitals must also follow the Participating Hospital Responsibilities Policy.


REGION 11
CHICAGO EMS
Region 11 EMS
Resource Hospitals
AIMMC
NMH
STROGER
U of C
CHICAGO O'HARE INTERNATIONAL AIRPORT
CHICAGO MIDWAY AIRPORT
HOWARD ST 7600 N
TOUHY AVE 7200 N
PRATT AVE 6800 N
DEVON AVE 6400 N
PETERSON AVE 6000 N
BRYN MAWR AVE 5600 N
FOSTER 5200 N
LAWRENCE AVE 4800 N
MONTROSE AVE 4400 N
IRVING PARK RD 4000 N
ADDISON ST 3600 N
BELMONT AVE 3200 N
DIVERSEY AVE 2800 N
FULLERTON AVE 2400 N
ARMITAGE 2000 N
NORTH AVE 1600 N
DIVISION ST 1200 N
CHICAGO AVE 800 N
KINZIE ST 400 N
MADISON ST 1 N / 1 S
HARRISON ST 600 S
ROOSEVELT RD 1200 S
16TH ST 1600 S
CERMAK RD 2200 S
26TH ST 2600 S
31ST ST 3100 S
35TH ST 3500 S
PERSHING RD 3900 S
43RD ST 4300 S
47TH ST 4700 S
51ST ST 5100 S
55TH ST 5500 S
59TH ST 5900 S
63RD ST 6300 S
MARQUETTE RD 6700 S
71ST ST 7100 S
75TH ST 7500 S
79TH ST 7900 S
83RD ST 8300 S
87TH ST 8700 S
91ST ST 9100 S
95TH ST 9500 S
99TH ST 9900 S
103RD ST 10300 S
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111TH ST 11100 S
115TH ST 11500 S
119TH ST 11900 S
127TH ST 12700 S
134TH ST 13400 S
138TH ST 13800 S
HARLEM AVE 7200 W
OAK PARK AVE 6800 W
NARRAGANSETT AVE 6400 W
AUSTIN AVE 6000 W
CENTRAL AVE 5600 W
CICERO AVE 4800 W
PULASKI RD 4000 W
CENTRAL PARK AVE 3600 W
KEDZIE AVE 3200 W
CALIFORNIA AVE 2800 W
WESTERN AVE 2400 W
DAMEN AVE 2000 W
ASHLAND AVE 1600 W
HALSTED ST 800 W
STEWART AVE 400 W
STATE ST E / 1 W
RACINE AVE 1200 W
KOSTNER AVE 4400 W
DR M L KING JR DR 400 E
COTTAGE GROVE AVE 800 E
WOODLAWN AVE 1200 E
STONY ISLAND AVE 1600 E
JEFFERY AVE 2000 E
TORRENCE AVE 2530 E
AVENUE O 3430 E
STATE LINE RD 4100 E
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NAGLE
CENTRAL
EDENS
PULASKI
KEDZIE
LAKE SHORE
ORIOLE
OAK PARK
LARAMIE
KOSTNER
CALIFORNIA
DAMEN
CLARK
HALSTED
MICHIGAN
CICERO
ARCHER
DAN RYAN
DR MARTIN LUTHER KING JR
ELLIS
AUSTIN
STEWART
CHICAGO SKYWAY
YATES
ASHLAND
WESTERN
VINCENNES
I57
STATE
BISHOP FORD
STONY ISLAND
TORRENCE
EWING
AVENUE O
STATE LINE
EMS System Plan Geographical Boundaries
August 2023
Chicago North EMS System #1103
Advocate Illinois Masonic Medical Center
North of Fullerton to Howard Street
From Lake Michigan West to O'Hare
Chicago Central EMS System #1108
Northwestern Memorial Hospital
North of 43rd Street to Fullerton
From Lake Michigan West to Damen
Chicago South EMS System #1113
UChicago Medicine
North of 130th Street to 43rd Street
From State Line West to Damen
Chicago West EMS System #1178
John H. Stroger, Jr., Hospital of Cook County
North of 119th Street to Fullerton
From Damen West to Harlem Avenue

REGION 11
CHICAGO EMS SYSTEM
POLICIES

COMMUNICATION

Field to Hospital Communication
EMS Report Format
Notification to the Resource Hospital

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Field To Hospital Communication
	Section: Communication
	Approved: EMS Medical Directors Consortium
	Effective: September 3, 2020

FIELD TO HOSPITAL COMMUNICATION

I. **Offline Medical Control:** These are the written Region 11 EMS Protocols and Policies that establish guidelines for prehospital patient care.

A. EMS providers will initiate care in accordance with these guidelines;

B. EMS providers should determine the appropriate hospital to contact for each patient encounter as defined below.

II. **Field to Hospital Communication:** For every patient encounter, EMS providers should provide a field to hospital communication report. Reports shall be categorized as:

A. "**Online Medical Control**" for medical, trauma, or refusal calls requiring Base Station contact and/or medical direction; or

B. "**Pre-notification**" for calls that do not require Base Station contact.

III. **Online Medical Control (OLMC)**: Base Station contact is required for: 1) Medical direction in Regionalized Systems of Care patients or complex patient care situations or 2) Situations not clearly defined by the Region 11 EMS Protocols and Policies as needed by the EMS provider.

A. Goal: To provide immediate medical direction to the EMS provider for situations where patient care or destination may be impacted.

B. Hospital staffing requirements: OLMC calls will only be answered by trained ECRNs or ECPs at Region 11 EMS Resource or Associate Hospitals.

C. Communication method: OLMC calls will be made through the MED Channels or cellular lines and all contact will be recorded.

D. Report format: The radio report should follow the Online Medical Control Report (OLMC) format (See EMS Report Format) and be presented in a clear and concise manner.

E. OLMC Assignments: Providers should directly contact the receiving hospital if it is a Region 11 EMS Base Station or contact their assigned Resource or Associate Hospital. If the contact is unsuccessful:

1. Attempt to contact the next closest Resource/Associate Hospital.

2. All attempts at contact must be documented in the patient care report.

3. Notification of a communication problem must be made to the Resource/Associate Hospital and the ambulance service provider's supervisor on duty after arriving at the receiving hospital.

F. **Situations requiring OLMC contact include, but are not limited to:**

1. Regionalized Systems of Care transports including patients with:
   a. Acute coronary syndrome and STEMI criteria
   b. Suspected acute stroke
   c. Trauma Field Triage Criteria (Steps 1-4)
   d. Ventricular Assist Device (VAD)
   e. Obstetric related complaint

2. Cardiac Arrest
   a. For patients in whom resuscitation is initiated, OLMC should be consulted before moving the patient. OLMC is required in making the decision to continue on-scene resuscitation, transport, or terminate resuscitation.
   b. Patients that meet criteria for withholding resuscitation (see Determination of Death / Withholding of Resuscitative Measures policy) do not require OLMC consultation (i.e. DOA).

3. Complex patient care situations and/or questions regarding the appropriate destination. For example:
   a. Any patient potentially requiring a Level 1 Trauma Center, but not clearly meeting Trauma Field Triage Criteria
   b. Patients with possible acute coronary syndrome or stroke symptoms that may not meet defined criteria for specialty center transport
   c. Patients potentially requiring diversion for critical airway stabilization

4. Refusals of care (as defined in the Consent/Refusal of Service policy)

5. Bypass: Transportation to a hospital on bypass

6. Multiple Patient Incidents: As per the Multiple Patient Incident (MPI) policy, in an EMS Plan Response the initial communication should be with the Resource Hospital and each transporting ambulance shall contact the appropriate hospital for a brief OLMC or pre-notification report.

7. Pediatric patients: Pediatric ALS transports should be called in to OLMC, all other pediatric transports require pre-notification.

8. Patient care situations not defined by protocols: Advanced life support (ALS) patients where EMS providers encounter a situation not clearly defined by the Region 11 EMS Protocols and Policies.

The base station is an available resource for any situation as requested by the EMS provider

IV. **Pre-Notification**: EMS should contact the receiving hospital directly for **ALL** transports not meeting criteria for Online Medical Control (OLMC).

A. Goal: To provide direct communication between EMS providers and the receiving hospital for straightforward BLS or ALS patient transports.

B. Hospital staffing requirements: All pre-notification calls shall be answered by receiving hospital personnel trained at minimum of Registered Nurse (RN).

C. Communication method: Pre-notification reports should be given through a hospital's dedicated telemetry line if the hospital is a Resource/Associate Hospital within Region 11 (or another Region). Contact may also be through a dedicated EMS telephone line if the participating hospital does not have a telemetry line.

D. Report format: The radio report should follow the 'Pre-Notification Report' format (see EMS Report Format) and be presented as a brief, clear report that provides pertinent information to the receiving hospital staff.

E. If there is a concern about patient treatment and/or transport, a non-Region 11 EMS Base Station receiving hospital may ask the EMS provider to call their assigned base station for online medical control direction.

F. No medical direction will be given by non-Region 11 EMS Base Station hospitals receiving pre-notification reports.

G. Any concern about patient care or transport destination should be reported to the Resource Hospital through a Request for Clarification (RFC) form.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Report Format
	Section: Communication
	Approved: EMS Medical Directors Consortium
	Effective: September 3, 2020

EMS REPORT FORMAT

I. Field to Hospital Communication

A. Online Medical Control (OLMC) Report - Use the I-SBAR mnemonic

1. **Identify**
   a. Agency
   b. Number
   c. Level of care (BLS, ALS, Critical Care)

2. **Situation**
   a. State primary reason for call (For example: "*We have a STEMI, Stroke, Trauma, Cardiac Arrest, or Refusal call for Online Medical Control*")

3. **Background**
   a. Age and sex
   b. History including:
      (1) Medical: brief history of present illness, including time of onset of symptoms for patients with suspected acute stroke
      (2) Trauma: description of the mechanism of injury
      (3) Pertinent past medical history
      (4) Medications applicable to circumstance
   c. Allergies, if applicable to circumstance

4. **Assessment**
   a. Vital signs including:
      (1) Level of consciousness and orientation
      (2) Blood pressure
      (3) Pulse and rhythm
      (4) Respiratory rate and degree of distress
      (5) Pulse oximeter
   b. Pertinent physical findings
      (1) Medical assessment including Cincinnati Stroke Scale (CSS) for patients with suspected acute stroke
      (2) Trauma assessment findings

5. **Rx(Treatment)/Response/Request**
   a. Treatment initiated
      (1) Procedures performed
      (2) Medications given
      (3) ETCO2 if advanced airway/cardiac arrest
      (4) Computer interpretation of 12-lead ECG
   b. Patient response to treatment and reassessment
   c. Request medical direction from ECRN/ECP as needed
   d. Destination and ETA

B. Pre-Notification Report

1. Identify agency and number
2. State “This is a pre-notification report.”
3. Age and sex
4. Chief complaint
5. Vital signs
6. “Routine protocols followed”
7. Additional details that may be needed for the receiving hospital to prepare for the patient
8. Destination and ETA

II. EMS Patient Handoff Report

A. On arrival to the Emergency Department, EMS should provide the receiving hospital nursing and physician staff a handoff report with pertinent prehospital information and then transition patient care.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Notification to the Resource Hospitals
	Section: Communications
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

NOTIFICATION TO THE RESOURCE HOSPITAL

I. DEFINITIONS

A. Emergency Management Assistance Compact (EMAC): A national interstate mutual aid agreement that enables states to share resources during times of disaster.

B. National Ambulance Contract (NAC): To provide licensed ambulance services and para-transit services in response to a disaster, an act of terrorism, or another public health emergency.

II. EMS RESPONSIBILITIES

A. There are special circumstances which require licensed EMS personnel and/or the EMS provider agency to provide notification to their respective Resource Hospital.

B. The following circumstances require written and verbal notification to the assigned Resource Hospital within the specified time frames:

1. Felony Conviction

    a. Under the EMS Act, all applicants for any license shall fully disclose any and all felony convictions in writing at the time of initial application or renewal.
    b. Under the EMS Act, all license holders shall report all new felony convictions to the Resource Hospital who will then notify IDPH within seven days after conviction.

2. Disaster Deployment

    a. The EMS provider agency must notify, and receive approval from, the EMS Medical Director and IDPH prior to any EMAC or NAC deployments.
    b. An EMS system modification form must be completed at the time of deployment and when returning from deployment.
    c. This form must be signed and approved by the Resource Hospital and IDPH.

3. Line of Duty Death

    a. The EMS provider agency must notify the Resource Hospital in the event of a line of duty death within 24 hours following the incident.
    b. The Resource Hospital will notify IDPH.

REGION 11
CHICAGO EMS SYSTEM
POLICIES

PATIENT CARE

Abandoned Newborn Infant Protection
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Reporting Abused and/or Neglected Patients
Restraints
Safe Transport of Children by EMS
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School Incidents
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Use of Latex Free Supplies

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Abandoned Newborn Infant Protection
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

ABANDONED NEWBORN INFANT PROTECTION

I. PURPOSE

A. To define EMS responsibilities under the *Abandoned Newborn Infant Protection Act*.

B. Abandoned Newborn Infant Protection Act: Illinois legislation that allows a parent to relinquish a newborn infant, whom a physician reasonably believes is 30 days old or less, to personnel of a hospital, police station (including campus police), fire station, or emergency medical facility which are considered "Safe Havens". The parent may remain anonymous and is immune from liability, as long as the infant is unharmed. It is recognized that establishing an adoption plan is preferable, to relinquishing a child using the procedures outlined in this Act, but to reduce the chance of injury to a newborn infant, this Act provides a safer alternative.

II. DEFINITIONS

A. Newborn Infant: A child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished and who is not an abused or neglected child.

B. Relinquish: To bring a newborn infant, who a licensed physician reasonably believes is 30 days old or less to a hospital, police station, fire station, emergency medical facility, and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant.

C. Emergency Medical Professional: Includes licensed physicians and any EMS personnel as defined in the EMS Systems Act.

D. Fire Station: A fire station within the State that is staffed with at least one full-time person.

E. Safe Haven: a hospital, police station (including campus police), fire station, or emergency medical facility with signage to visually help identify their location.

III. POLICY

A. EMS personnel in the Chicago EMS System will provide assessment, treatment, and transportation to the closest EDAP hospital for relinquished infants.

B. EMS personnel are required to provide the necessary information to the relinquishing parent as specified in this Act.

IV. INFANT CARE AND HOSPITAL CONTACT

A. The relinquishing person is presumed to be the infant's biological parent.

B. Assess the infant. Look particularly for any signs of abuse or neglect.

C. Ask the relinquishing parent for the infant's name and date of birth.

D. Ask the relinquishing parent if they have any medical issues that need to be addressed.

E. If the child is presumed to be more than 30 days old, or has been abused or neglected, EMS personnel should proceed as if the child is abused or neglected. Follow the Reporting Abused and/or Neglected Patients Policy and file a report with DCFS. While this is all that is required under the Act, refusing to take an infant presumed to be older than 30 days or one who is abused or neglected from a parent who wishes to relinquish him or her could possibly result in harm to the infant. It is in the best interest of the child to accept them and proceed as below.

F. Initiate emergency treatment that is necessary per Region 11 EMS Protocols under implied consent and keep the infant warm.

G. Transport to the closest, most appropriate Region 11 EDAP hospital with pre-notification.

H. Complete a patient care report on the infant. List the infant's name as "Baby Doe" if it is unknown.

V. COMMUNICATION WITH THE RELINQUISHING PARENT

A. EMS personnel must offer the relinquishing parent the information specified in the Act (see below), and if possible, **verbally inform the parent that**:

1. **His or her acceptance of the information is completely voluntary;**

2. Completion of the *Illinois Adoption Registration* form and *Medical Information Exchange* form is voluntary;

3. By relinquishing the infant anonymously, he or she will have to petition the court to prevent the termination of parental rights and regain custody of the child.

4. If the parent returns within 30 days to reclaim the infant, they should be told the name and location of the hospital to which the infant was transported.

B. **Information to give to relinquishing parent** - Hospitals, fire stations, police stations, and emergency medical facilities must offer a "Safe Haven Information Packet" or refer the parent to a website or another electronic resource that contains the following:

1. Safe Haven law information and optional self-mailer registration form.

2. Illinois Adoption Registry and Medical Information Exchange (IARMIE) form.

3. Post-partum health information for the mother.

4. Save Abandoned Babies Foundation which includes resources on counseling and adoption services.

C. Document on the infant's patient care report that the “Safe Haven Information Packet” or referral to a website or electronic resource was offered to the parent and whether it was received.

VI. **RESOURCES**

A. The forms required above are located at the Illinois Department of Children and Family Services (DCFS) website: https://www2.illinois.gov/dcfs

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Advanced Directives and POLST
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

ADVANCED DIRECTIVES AND POLST

I. HEALTH CARE AGENT/POWER OF ATTORNEY FOR HEALTH CARE (POAHC)

A. Illinois law allows persons to appoint an agent to make health care decisions for the patient in the event that the patient is unable to make his or her own medical decisions. The person chosen by the patient to make these decisions is called the "agent." An agent is appointed by the patient via a document called a "power of attorney for health care." The agent can ask you to withdraw or withhold medical care of the patient.

B. A health care agent has no authority if the patient himself or herself is alert and able to articulate consent to treatment or transport. If the patient is alert and consents to treatment, continue to treat the patient, even if thereafter the patient is unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.

C. In a situation where someone represents to you that they have power of attorney to make medical decisions for the patient, EMS personnel should do the following:

1. Begin treatment of the patient.

2. As soon as it is practical, ask the agent for the power of attorney form and examine the form to determine if the agent's name appears on the form as agent and ask the agent to verify that his/her signature appears on the form. Review the form to see what decision-making authority has been given to the agent.

3. Notify medical control as indicated of the confirmed presence of a health care agent and follow the instructions of the agent per the authority granted in the power of attorney form unless instructed otherwise by medical control.

4. If you have doubt as to the identity of the agent, the extent of the authority of the agent, or if communications with medical control cannot be established, continue treatment of the patient and document the situation.

II. LIVING WILLS AND PATIENT SURROGATES

Illinois law allows terminally ill patients to instruct their health care providers, either directly with a living will or indirectly through a patient surrogate, on their treatment in near death situations. However, the technical requirements of these laws make them difficult for field use. Therefore, Region 11 EMS personnel shall not follow the instructions contained in a living will or given by any person representing to be a surrogate for the patient unless instructed otherwise by medical control.

III. IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For the purpose of this policy, the POLST decision making process and form are defined as medical orders by a physician or practitioner for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. These orders provide guidance during life threatening emergencies and must be followed by all healthcare providers.

A. The IDPH Uniform POLST Form was revised in September 2022 and is detailed below. Prior versions of the DNR/POLST Form are still valid.

B. The sections of the POLST Form are defined as follows:

1. Section A of the POLST Form references "Orders for Patient in Cardiac Arrest." This section notes if the patient wishes to have resuscitation/CPR attempted or if they prefer medical providers "Do Not Attempt Resuscitation (DNAR)."

2. Section B of the POLST Form references "Orders for Patient Not in Cardiac Arrest." This section has three treatment options with the goal of maximizing comfort regardless of which treatment option is selected.

    a. **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments**. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
    b. **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
    c. **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. Use medication by any route as needed. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.**

3. Section C of the POLST Form references "Additional Orders or Instructions." These orders are in addition to those in the above sections and includes language that EMS protocols may limit emergency responder ability to act on orders in this section.

4. Section D of the POLST Form references "Orders for Medically Administered Nutrition".

5. Section E of the POLST Form references documentation of the discussion of the form and signatures of the patient or legal representative.

6. Section F of the POLST Form references the printed name, signature, and date of the patient's Qualified Health Care Practitioner.

C. Region 11 EMS personnel are permitted to follow a valid POLST Form regarding medical care in a life-threatening clinical event. This includes situations for patients in long-term care facilities, with hospice and home-care patients, and with patients who arrest during interhospital transfers or transportation to or from home.

D. A valid POLST Form will contain at least the following information:

1. Name of the patient.

2. "Orders for Patient in Cardiac Arrest" - Section A option selected.

3. Signature of patient or legal representative as defined on the form:

   a. Parent of minor
   b. Agent under Power of Attorney for Health Care (POAHC)
   c. Heath care surrogate decision maker

4. Name and signature of the patient's Qualified Health Care Practitioner.

5. Date.

E. If the POLST Form does not have the required items completed on the form, the form is not valid for prehospital use.

F. In situations with a POLST Form, EMS providers should do the following:

1. Verify the form contains the criteria for a valid POLST Form as listed above.

2. Make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid POLST Form.

3. Contact medical control as needed to discuss the situation and advise them of the presence of a POLST Form, along with the description of any specific treatments as defined in the POLST Form.

4. If the order is valid, follow the terms of the POLST Form. Document all information from the POLST Form on the patient care report.

5. If there is any doubt as to the validity of the POLST Form, treat the patient and contact medical control. Document the situation in the patient care report.

G. Voiding or revoking a POLST Form:

1. A patient with decision making capacity can void or revoke the POLST Form and/or request alternative treatment.

2. Changing, modifying, or revising a POLST Form requires completion of a new POLST form.

H. Digital copies (including on a cell phone or tablet) and photocopies, including faxes, on any color paper are legal and valid. POLST Forms with e-signature are legal and valid.

I. EMS and healthcare providers should honor any completed POLST Form that is formally authorized by a state or territory within the United States, as well as the National POLST Form (http://polst.org/national-form/).

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

- ☐ **YES CPR**: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)
- ☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

- ☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
- ☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
- ☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

- ☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
- ☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.
- ☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)*** | Date _____

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient:		
☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)***	Phone _____
Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* **X**	Date ***(required)*** _____

****THIS PAGE IS OPTIONAL – use for informational purposes****		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: ALS Upgrade of EMS Service
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

ALS UPGRADE OF EMS SERVICE

I. PURPOSE

To describe an in-field service level upgrade, using advanced level EMS vehicle service providers.

II. POLICY

BLS Vehicle Responding to a Patient Requiring ALS Care

A. If a BLS vehicle responds to a patient that meets criteria for ALS care as per the Initiation of Patient Care Policy, BLS personnel should contact Online Medical Control.

B. BLS personnel should estimate the patient transport time to the closest appropriate facility.

1. If the established patient transport time to the closest appropriate facility is within five minutes:

   a. The BLS vehicle shall transport the patient to the closest appropriate facility.
   b. The receiving facility shall be alerted to the unusual transport circumstances through the designated pre-notification phone line. If the receiving facility does not answer the phone call, the BLS vehicle should contact its dispatch.

2. If the estimated patient transport time to the closest appropriate facility is greater than five minutes:

   a. Consult with OLMC. OLMC will contact the private provider associated with the BLS vehicle and request availability of an ALS backup.
   b. If ALS response is not available in a timely manner by the provider of the BLS vehicle, OLMC will directly contact the Office of Emergency Management and Communications (OEMC) and request a CFD ambulance response.
   c. If the anticipated delay for ALS response is deemed detrimental to patient care, OLMC should recommend rapid transport by the BLS vehicle to the closest appropriate facility.

3. When a BLS ambulance transfers care to an ALS ambulance, the ALS ambulance will transport the patient.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Call Disposition
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: September 15, 2020

CALL DISPOSITION

I. In accordance with NEMSIS, each EMS dispatch for service should be categorized with the following call dispositions.

II. A **patient** is an individual requesting or potentially needing medical evaluation or treatment. The patient-provider relationship is established by phone, radio, or personal contact.

A. **Assist:**

1. **Assist, Agency:** This EMS unit only provided assistance (e.g. manpower, equipment) to another agency and did not provide treatment or primary patient contact at any time during the incident.

2. **Assist, Public:** This EMS unit only provided assistance (e.g. manpower, equipment) to a member of the public where no patient (as locally defined) was present (e.g. welfare check, home medical equipment assistance).

3. **Assist, Unit:** This EMS unit only provided additional assistance (e.g. manpower, equipment) to another EMS unit from the same agency and was not responsible for primary patient care at any time during the incident.

B. **Canceled:**

1. **Canceled (Prior to Arrival at Scene):** This EMS unit's response is terminated prior to this unit's arrival on scene by the communications center or other on-scene units.

2. **Canceled on Scene (No Patient Contact):** This unit arrived on scene but was canceled by other on-scene units prior to initiating any patient contact or rendering any other assistance.

3. **Canceled on Scene (No Patient Found):** This unit arrived on scene, but no patient existed on scene (e.g. patient left the scene prior to arrival, result of a good intent call and no patient existed). EMS providers should make every attempt to identify the person for whom dispatch initiated the EMS response. All circumstances surrounding the event and a description of efforts to locate the patient must be documented in the patient care report.

C. **Patient Dead at Scene (see Determination of Death/Withholding of Resuscitative Measures policy):**

1. **Patient Dead at Scene – No Resuscitation Attempted (With Transport):** Patient shows obvious signs of death or Do Not Resuscitate (DNR) order was presented, and no attempt was made to resuscitate the patient. However, the

body was transported off scene by the EMS unit with primary transport responsibilities due to scene issues as defined in the above local policy

2. **Patient Dead at Scene – No Resuscitation Attempted (Without Transport):** Patient shows obvious signs of death or Do Not Resuscitate (DNR) order was presented, no attempts were made to resuscitate the patient, and the body remains on scene in custody of law enforcement.

3. **Patient Dead at Scene – Resuscitation Attempted (With Transport):** Resuscitation efforts were attempted on the patient and terminated on scene either due to Do Not Resuscitate (DNR) order or further attempts were deemed futile after discussion with Online Medical Control. However, the body was transported off the scene by the EMS unit with primary transport responsibilities due to scene issues as defined in the above local policy.

4. **Patient Dead at Scene – Resuscitation Attempted (Without Transport):** Resuscitation efforts were attempted on the patient and terminated on scene either due to Do Not Resuscitate (DNR) order or further attempts were deemed futile after discussion with Online Medical Control, and the body remains on scene in custody of law enforcement.

D. **Patient Transport:**

1. **Patient Refused Evaluation/Care (With Transport):** Patient refused to give consent or withdrew consent for evaluation and/or treatment, but consented to transport to an appropriate definitive care facility.

2. **Patient Treated, Transported by this EMS Unit**: Patient was evaluated and/or treatment was provided by this EMS Unit, and this EMS unit initiated transport or transported to a definitive care facility.

E. **Patient Refusal (see Consent & Refusal of Service) policy:**

1. **Patient Refused Evaluation/Care (Without Transport):** Patient refused to give consent or withdrew consent for evaluation and/or treatment and refused to be transported to a definitive care facility by EMS personnel. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. This refusal requires consultation with Online Medical Control while still on scene with the patient.

2. **Patient Evaluated and Refused Transport:** Patient was evaluated and treatment provided; however, the patient refused further treatment and/or transportation to a definitive care facility by EMS personnel. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. This refusal requires consultation with Online Medical Control while still on scene with the patient.

F. **Patient Treated, Transported by Law Enforcement (Handled by Police):** Patient was evaluated and/or treatment was provided by this EMS unit; however, the police assumed custody for transport to either a definitive care facility or to a police/jail disposition. This situation may include behavioral emergencies, Driving Under the Influence (DUI), or criminal investigations. In these situations, it is expected that EMS perform a full patient assessment unless law enforcement (CPD) refuses access to the patient due to scene safety. EMS should advise CPD of any potential risks associated with the patient not receiving EMS care and/or transport. Online Medical Control is required for these situations.

G. **Patient Treated, Transferred Care to Another EMS Unit:** Patient was evaluated and/or treatment was provided by this EMS unit; however patient care was transferred to another EMS air or ground unit for final disposition while still on scene (e.g. special events or large incidents).

H. **Standby**

1. **Standby – No Services or Support Provided**: Response was for purposes of being available in case of a medical/traumatic emergency (e.g. sporting event, fire, police action) and there was no patient contact or support provided.

2. **Standby – Public Safety, Fire, or EMS Operational Support Provided**: Response was for purposes of being available in case of a medical/traumatic emergency (e.g. sporting event, fire, police action) and operational support was provided, but no patient existed (e.g. operating fire rehab sector, SWAT standby).

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Consent and Refusal of EMS Service
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

CONSENT AND REFUSAL OF EMS SERVICE

I. APPROACH TO CONSENT/REFUSAL OF SERVICE

A. In the event that EMS is activated and the patient refuses some or all of the recommended treatment or transport, the following procedure should be followed:

1. Identify yourself and attempt to gain the patient's confidence and initiate care in a non-threatening manner.

2. Determine the specific treatment or transport that the patient is refusing and reasons for this decision.

B. Perform an assessment of the patient:

1. Assess mental status of the patient.

2. Conduct, if possible, a complete history and physical including a full set of vital signs.

3. Advise the patient of his/her medical condition and explain why the care and/or transport are necessary.

4. Advise the patient of the possible consequences of delaying or refusing the proposed care.

C. Evaluate the patient for **decision-making capacity**. A patient with decision-making capacity has the legal right to consent to or refuse some or all of the recommended treatment and to consent to or refuse transport.

D. **Decision-Making Capacity**: The patient's ability to understand the nature and consequences of proposed health care. This includes understanding the nature of their injury or illness and/or risk of illness, the possible consequences of delaying or refusing care, and the ability to clearly communicate a decision regarding the proposed care.

1. Evaluation of decision-making capacity involves assessing for conditions that may influence the ability to make sound choices and is a status beyond being alert and oriented.

2. Assess for the following conditions that may influence decision-making capability:

a. Hypoxia
b. Hypotension
c. Hypoglycemia
d. Trauma (e.g. Head Injury)
e. Alcohol/Drug/Chemical Intoxication or Reaction
f. Stroke/CVA

g. Postictal States/Seizures
h. Electrolyte Abnormality
i. Infection
j. Dementia
k. Psychiatric/behavioral emergencies (e.g., suicidal, inability to care for self, homicidal)

II. **PATIENTS WITH DECISION-MAKING CAPACITY**

A. For situations in which a Paramedic/EMT assesses the patient and determines that they have decision-making capacity and are refusing medical assistance or transportation, they should next:

1. Follow below procedure for refusals.

2. Inform the patient of the risks of refusal and document your attempts to convey the importance of transport/treatment along with the patient's ability to comprehend.

3. Have the patient sign the written refusal of transport.

   a. There should be two witnesses to the refusal if possible. One witness should be the EMT/Paramedic assigned to the ambulance/ALS/BLS company and the other should be a family member or bystander (e.g., police officer, etc.).
   b. If a patient refuses to sign the refusal, the refusal to sign should be witnessed and signed by a family member or bystander if possible.

4. In the interest of assuring that the patient is transported to an appropriate medical facility rather than receive no care at all, deviations from the policies and procedures and standing medical orders may be necessary; consult with Online Medical Control while on the scene.

5. For refusal of treatment or any component of treatment, the refusal MUST BE thoroughly documented in the comments section.

B. Contact with Online Medical Control (OLMC)

1. <u>EMS providers should contact Online Medical Control prior to completing the refusal and departing the scene.</u> OLMC should be able to speak with the patient directly if requested.

2. In the event that EMS providers request OLMC consultation to determine decision-making capacity for a patient or, after consultation with OLMC, it is determined that the patient lacks decision-making capacity, EMS providers should follow the below guidelines (Section III. Patient Without Decision-Making Capacity).

III. PATIENT WITHOUT DECISION-MAKING CAPACITY

A. A patient whose behavior and/or medical condition suggests lack of decision-making capacity has the right to neither consent to nor refuse care and/or transport. Patients without decision-making capacity will not be allowed to make health care decisions.

B. Procedure:

1. Once a patient is judged to lack decision-making capacity, EMS personnel should attempt to carry out treatment and transport in the interest of the patient's welfare.

   a. At all times EMS personnel should avoid placing themselves in danger; this may mean a delay in the initiation of treatment until the safety of the EMS personnel is assured.
   b. Try to obtain cooperation through conventional means.

2. If the patient resists care and/or transport:

   a. Request police and/or fire department backup as needed.
   b. Contact OLMC as needed.
   c. Reasonable force may be used to restrain the patient if the patient is a risk to self or others (see Restraints Policy).
   d. The requirement to initiate assessment and patient care may be waived in favor of assuring that the patient is transported to the closest appropriate emergency department. Document clearly and thoroughly the reasons for deviation in care.

IV. MINOR PATIENT

A. In Illinois, any person under the age of 18 is a minor, but is legally recognized as an adult and may refuse care and/or transport if the person:

1. Has obtained a court order of emancipation

2. Is married

3. Is a parent

4. Is pregnant

5. Is a sworn member of the U.S. armed services

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

C. Parental or guardian consent is required for refusal of service for minors. If a parent or

guardian is not available to consent or refuse service, the following must be completed and documented:

1. Advise patient of his/her illness or injury and explain the need for further evaluation of the condition by a physician.

2. Contact OLMC and inform them of the situation while on the scene.

3. Administer appropriate care and if necessary request police assistance.

D. If a parent or guardian grants consent, but the minor refuses care:

1. Advise patient of his/her illness or injury and explain the need for further evaluation of the condition by a physician.

2. Contact OLMC and inform them of the situation while on the scene.

E. If a parent or guardian refuses to consent when medical care is indicated:

1. See Reporting Abused and/or Neglected Patients Policy.

2. Advise OLMC of the situation while on scene.

F. In any situation involving a minor patient, EMS personnel should attempt to solicit a responsible adult to accompany the minor from the scene.

V. MULTIPLE PATIENT REFUSALS

A. To ensure the efficient use of resources, a provider agency may utilize a Multiple Patient Release form that has been approved by the Region for incidents where there are three or more patients refusing services.

B. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. Any abnormal vitals, evidence of intoxication, concern about decision making-capacity or any complaint should be called into Online Medical Control and an individual PCR must be completed for that patient.

C. If no complaints or injuries exist and there is no significant mechanism of injury, they may sign a multiple patient release form and a PCR must be generated summarizing the event.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Controlled Substance Requirements
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

CONTROLLED SUBSTANCE REQUIREMENTS

I. DEFINITIONS

A. Controlled Substance: A drug whose manufacture, possession, or use is regulated by the government. Controlled substances for use by EMS in Region 11 include the following drugs:

1. Fentanyl

2. Midazolam

B. Drug Enforcement Agency (DEA): Federal organization in charge of enforcing the controlled substance laws in the United States.

II. REGULATIONS

A. Controlled Substance Act (CSA): Federal law that regulates substances with the potential for abuse or dependence.

B. Protecting Patient Access to Emergency Medications Act (PPAEMA): Amends the federal Controlled Substance Act to provide guidance around the administration of controlled substances by EMS agencies and EMS personnel.

III. RESPONSIBILITIES OF EMS AGENCIES

A. Drug Enforcement Administration (DEA) Registration

1. Each EMS agency and licensed EMS vehicle functions administratively under a Resource Hospital in an EMS System as defined in the system plan.

2. These EMS agencies are registered under the Resource Hospital and are supplied controlled substances under the hospital pharmacy.

B. Use of Standing Orders or Protocols

1. EMS personnel can administer a controlled substance as defined by EMS Protocols.

2. EMS personnel can also administer a controlled substance after a verbal order by the EMS Medical Director or after consultation with Online Medical Control.

C. Storage of Controlled Substances

1. Only controlled substances on the Region 11 Drug, Equipment, and Supply (DES) List shall be carried by EMS vehicles.
2. Controlled substances should be stored in a securely locked, substantially

constructed cabinet or safe that cannot be readily removed.

3. Controlled substances shall be stored with the ability to examine for tampering, expiration dates, and counts.

4. EMS agencies may store controlled substances in EMS vehicles used by the agency.

5. EMS vehicles that are out of service should have their controlled substances secured and accounted for per agency policy.

6. If controlled substances are removed from the cabinet or safe, they should remain under the paramedic's direct supervision at all times.

D. Access to Controlled Substances

1. Access to controlled substances should be limited to crew members authorized to utilize the medication during the course of patient care and those responsible for inventory.

2. All access to controlled substances should occur in the presence of two personnel.

E. Documentation

1. Every use of controlled substance shall be documented in the patient care record as well as on a Region 11 controlled substance accountability form.

2. Every access to controlled substances, whether for shift change count and examination or restocking, shall be documented with a beginning and ending count on an inventory form.

3. All documentation shall have two signatures.

4. All documents shall be securely stored for a period of two years.

F. Use of Controlled Substances

1. After each use of a controlled substance, the following should be documented on the patient care report:

   a. Medication used
   b. Amount used
   c. Amount wasted
   d. Patient name
   e. Patient address
   f. Date given
   g. Time given

h. Initials of Paramedic administering the controlled substance

2. Any amount of a controlled substance that is not administered to the patient and that is remaining in the vial should be brought to the hospital to be wasted. This process needs to be witnessed by at least two people (one paramedic and one hospital personnel) and recorded on the controlled substance accountability form.

3. After use, the entire stock of the controlled substance that was accessed should be counted by two personnel and the counts documented on the inventory form.

4. In the event that a controlled substance is administered by a non-transport EMS vehicle, the transporting EMS vehicle may exchange their stock of the same controlled substance vial with the non-transport EMS vehicle. The non-transport EMS vehicle should document the medication administration on the patient care report and both EMS vehicles should update their inventory records with the new lot number and expiration date.

G. Restocking EMS Vehicles at Hospitals

1. Following an emergency response, EMS agencies may restock their EMS vehicles with the controlled substance used from the receiving hospital.

2. For each use, a controlled substance accountability form should be completed by the paramedic and a hospital representative.

H. Accountability

1. At the start of every shift, all controlled substances must be examined for evidence of tampering, expiration dates, and counts.

   a. Counts shall be verified against the last count.
   b. Amount, concentration, and expiration date should be verified.
   c. Medication vials should be visually inspected for evidence of tampering.

2. Documentation of the daily inventory of controlled substances must have two signatures for accountability.

3. Any damage, loss, or expired medication should be reported immediately to the EMS vehicle's supervisor and assigned Resource Hospital EMS Coordinator in verbal and written format.

I. Maintenance of Controlled Substance Records

1. EMS agencies must maintain records for each controlled substance administered or disposed of in the course of providing emergency medical services.

2. This includes the medication name, concentration, amount administered, patient

name and incident number.

3. Records are required to be maintained for at least two years.

J. Expiring Controlled Substances

1. Each EMS vehicle is assigned to a Resource or Associate Hospital for exchange of soon to expire controlled substances.

2. Within seven calendar days of expiration, the EMS vehicle should report to their assigned hospital with the controlled substance and request an exchange.

3. Exchange will only occur at assigned hospitals and within the defined dates and hours on the Region 11 Expiring Controlled Substances Exchange Assignments list– see Appendix

K. EMS Agency Liability

1. EMS agencies are liable for ensuring the proper use, maintenance, reporting, and security of controlled substances used by the agency.

2. Each EMS agency should have an internal policy that defines and verifies controlled substance accountability.

3. EMS personnel should be trained in controlled substance accountability standards and policies.

IV. RESPONSIBILITIES OF ALL HOSPITALS

A. Each hospital will maintain an internal policy regarding replacement of controlled substances for EMS.

B. Each hospital will maintain a record of each controlled substance restocked for EMS after field administration as documented in the patient care report.

C. Each hospital will accept any residual controlled substances or waste from EMS personnel after patient care and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy.

D. After EMS submits the controlled substance accountability form, which documents the medication dose and concentration administered, the hospital will then replace the controlled substance according to the Region 11 Drug, Equipment and Supply (DES) List.

E. If the hospital does not have the exact amount and concentration as listed on the Region 11 DES list, the hospital should NOT restock the EMS vehicle and refer them to their Resource Hospital.

F. Any damage, loss, or expired doses requires immediate verbal and written notification of the Resource Hospital EMS Coordinator.

V. ADDITIONAL RESPONSIBILITIES OF RESOURCE HOSPITALS

A. If the receiving hospital is unable to restock an EMS vehicle, the Resource Hospital will be responsible for restocking the medication.

B. Cases of damage, loss, tampering, or expired medication shall be handled at the Resource Hospital.

1. The incident will be investigated per internal hospital policy by the Resource Hospital EMS Coordinator and the EMS Medical Director. Findings will be forwarded to IDPH.

2. A replacement will be issued to that vehicle by the Resource Hospital.

3. An investigation and report must be completed by the ambulance service provider with conclusions or outcomes forwarded to the Resource Hospital and IDPH.

Region 11 Expiring Controlled Substance Exchange Assignments

EMS vehicles may only exchange controlled substances within 7 calendar days of expiration date as assigned and detailed below.

Any missing doses, expired doses, or suspected tampering will be handled at the Resource Hospital per the Region 11 Controlled Substance Requirements Policy.

Chicago South EMS System #1113

University of Chicago Medicine
- CFD Ambulances: 1, 14, 24, 30, 35, 36, 38, 55, 57, 72, 78
- CFD Engines: 47, 50, 54, 60, 73, 84, 120, 122, 129
- CFD Mass Casualty Bus 8812
- ATI/Vandenburg Ambulance
- Hawthorne Racetrack Ambulance

Process for Exchange
CCD Building (main hospital) Pharmacy 2nd floor
Monday-Friday 10am-2pm

Advocate Trinity Hospital
- CFD Ambulances: 5, 9, 22, 25, 29, 37, 50, 51, 60, 70, 71, 76, 79
- CFD Engines: 46, 62, 72, 74, 82, 93, 97, 126
- CFD Truck: 40

Process for Exchange
See Pharmacy for exchange
Monday-Friday 6:00am – 9:00pm

Holy Cross Hospital
- CFD Ambulances: 8, 12, 17, 18, 21, 27, 49, 54, 58, 75
- CFD Engines: 64, 88, 115, 116, 123, 127
- CFD Trucks: 41, 45, 60,

Process for Exchange
Emergency Department
Monday-Friday 9:00am – 3:00pm

Mount Sinai Hospital
- CFD Ambulances: 23, 33, 34, 69, 77, 80
- CFD Engines: 38, 113
- CFD Truck: 32

Process for Exchange
Emergency Department
Monday-Friday 10:00am – 6:00pm

Chicago Central EMS System #1108

Northwestern Memorial Hospital
- CFD Ambulances: 11, 41, 42, 74
- CFD Engines: 1, 2 (Boat), 4, 13, 39, 98
- CFD FAS Boat 688, 689
- Event Medical Solutions
- MASE

Process for Exchange
9th floor Pharmacy Feinberg Building
Monday-Friday 8:00am – 4:30pm

Rush University Medical Center
- CFD Ambulances: 19, 45, 68
- CFD Engines: 23, 26, 49
- CFD Truck: 2

Process for Exchange
Emergency Department
Monday-Friday 9:00am – 3:00pm

Region 11 Expiring Controlled Substance Exchange Assignments

EMS vehicles may only exchange controlled substances within 7 calendar days of expiration date as assigned and detailed below.

Any missing doses, expired doses, or suspected tampering will be handled at the Resource Hospital per the Region 11 Controlled Substance Requirements Policy.

Chicago North EMS System #1103

Advocate Illinois Masonic Medical Center
- CFD Ambulances: 6, 32, 40, 61,
- CFD Engines: 71, 78, 124
- CFD Truck: 12
- Lifeline Ambulance

Process for Exchange
See Pharmacy for exchange
Monday-Friday 9am-5pm

St. Joseph Hospital
- CFD Ambulances: 13, 31, 56
- CFD Engines: 55, 59, 83, 102

Process for Exchange
Emergency Department
Monday-Friday 9:00am – 3:00pm

St. Mary & Elizabeth Medical Center
- CFD Ambulances: 3, 44, 52, 64
- CFD Engines: 30, 43, 57, 76
- CFD Truck: 36

Process for Exchange
Emergency Department
Monday-Friday 9:00am – 3:00pm

Community First Medical Center
- CFD Ambulances: 7, 20, 46, 47, 48, 63
- CFD Engines: 68, 91, 108, 125
- CFD Truck: 58

Process for Exchange
No Restrictions - 24/7 Emergency Department

Resurrection Medical Center
- CFD Ambulances: 2, 16, 26, 39, 59, 73
- CFD Engines: 9, 10, 11, 12, 79
- CFD Truck: 55
- CFD Tower Ladder: 63

Process for Exchange
No Restrictions - 24/7 Emergency Department
See ED Nurse/EMS Coordinator for exchange

Lurie Children's Hospital
- CFD Ambulances: 4,28, 43, 53, 62, 66
- CFD Engines: 8, 19, 29

Process for Exchange
Emergency Department
Monday-Friday 9:00am – 3:00pm

Chicago West EMS System #1178

Stroger Hospital of Cook County
- CFD Ambulances: 10, 15, 65, 67
- CFD Engines: 18, 34, 95, 99, 117
- CFD Truck: 29
- CFD SLD: Special Ops, Surge Ambulances 150-151-152-153-154-155-156-157-158-159
- Hatzalah

Process for Exchange
By Appointment Only, Call 312-864-1291
Monday-Friday, No Holidays

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Conveyance of Patients
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

CONVEYANCE OF PATIENTS

I. PURPOSE

To define safe conveyance of patients by licensed EMS personnel.

II. DEFINITIONS

A. Conveyance: Movement of a patient from the response location to the ambulance and from the ambulance into the hospital Emergency Department.

B. Transport: Movement of a patient in an ambulance with appropriate safety restraint based on the age or size of the patient and clinical condition.

III. CONVEYANCE

A. Methods

1. Stair chair
2. Stretcher
3. Backboard
4. Scoop stretcher
5. Basket stretcher
6. Patient tarp or OPCD (Oversized Patient Carrying Device)

B. Appropriate safety straps per manufacturer design should be used for all conveyance methods.

IV. AMBULANCE TRANSPORTATION

A. All patients transported by ambulance will be secured to the stretcher for safe conveyance during patient transport.

B. For multiple patient incidents or as needed with additional passengers, proper restraint is required including the bench seat with restraints as recommended by the manufacturer.

C. For patients in a stretcher, all safety harness belts (as below) should be secured on the patient prior to transport.

1. Chest, hip, and knee straps

2. Shoulder straps

D. Pediatric patients should be transported with size appropriate child restraint system as per the Safe Transport of Children by EMS Policy.

E. Patients should never be transported in a stair chair.

V. PATIENT CRITERIA THAT REQUIRE CONVEYANCE (NOT ABLE TO AMBULATE)

A. Require ALS (advanced life support) care per Initiation of Patient Care Policy.

B. Have a confirmed or potential significant acute condition.

C. Have any minor condition in which ambulation might result in clinical deterioration or further injury.

D. Have any of the following conditions, including (but not limited to):

1. Intoxication
2. Severe abdominal pain
3. Uncontrolled or controlled serious bleeding
4. Pregnancy related complaint
5. Extremely high or low body temperatures (hypothermia or high fever)

E. Are injured AND:

1. Require spinal motion restriction (SMR)
2. For whom ambulation will aggravate existing injury or risk new injury

F. Have unique circumstances that require conveyance

NOTE: These above patients shall not be allowed to walk to the ambulance, or at the hospital, even if found to be ambulatory at the scene.

IV. PROCEDURE

A. Approach the patient with the quick response bag, oxygen bag, AED or cardiac monitor/defibrillator and conveyance device per Initiation of Patient Care Policy.

B. Perform an initial assessment and necessary on scene treatment. Evaluate the patient for any of the conditions requiring conveyance as above and prepare for appropriate

conveyance of the patient to the ambulance.

C. If it becomes apparent enroute to, or upon arrival at the scene, that EMS personnel will need additional assistance to appropriately and safely convey the patient to the ambulance, the responding crew should immediately request additional assistance.

D. Convey patient by appropriate means to the ambulance assuring the patient is appropriately covered to respect dignity and personal privacy.

E. At the hospital, the patient should be conveyed by appropriate means into the Emergency Department. EMS personnel shall request assistance of hospital personnel if additional lifting and moving help is necessary.

F. Document any problems obtaining requested additional assistance in a timely manner or any other circumstances that prevent appropriate conveyance of patient.

G. If the patient refuses to accept appropriate means of conveyance at any point from the scene to hospital hand-off, after explaining the risks, document this on the patient care report.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Determination of Death / Withholding of Resuscitative Measures
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: April 1, 2020

DETERMINATION OF DEATH / WITHHOLDING OF RESUSCITATIVE MEASURES

I. INITIATION OF RESUSCITATION

All EMS personnel practicing within the Region 11 EMS System are required to immediately initiate cardiopulmonary resuscitation (CPR) on any patient who is apneic and pulseless, unless the patient meets criteria for withholding resuscitation (see below).

II. WITHHOLDING RESUSCITATION

A. Prior to withholding resuscitation, a thorough patient assessment must be performed to verify that the patient is:

1. Unresponsive
2. Apneic
3. Pulseless

B. Resuscitation should be withheld in the following circumstances:

1. Medical signs of long term death including:

a. Rigor Mortis: Stiffening of the body muscles due to chemical changes in muscle fibers, plus asystole on cardiac monitor in multiple leads.
b. Widespread Lividity: Skin discoloration in dependent body parts, plus asystole on cardiac monitor in multiple leads.
c. Decomposition or Putrefaction: The skin is bloated or ruptured, with or without soft tissue sloughed off, plus asystole on cardiac monitor in multiple leads.

2. **Traumatic injuries obviously incompatible with life including:**

a. Decapitation: The complete severing of the head from the patient's body.
b. Transection of the Torso: The body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.
c. Incineration: 90% of the body surface area with full thickness burns as exhibited by ash rather than clothing and complete absence of body hair with charred skin.

3. **Traumatic arrest plus asystole:** Blunt and penetrating trauma in an adult (age 16 years or greater) with a lethal mechanism of injury and asystole on cardiac monitor in multiple leads. The following conditions are excluded and should be resuscitated:

a. Drowning or strangulation
b. Lightning strike or electrocution
c. Situations involving hypothermia
d. Patients with visible pregnancy
e. The mechanism of injury does not correlate with the clinical condition suggesting a non-traumatic cardiac arrest.

4. If the patient has a valid DNR/POLST (see Advanced Directives policy).

C. IN CASES WHERE THE PATIENT'S STATUS IS UNCLEAR AND THE APPROPRIATENESS OF WITHHOLDING RESUSCITATION EFFORTS IS QUESTIONED, EMS PROVIDERS SHOULD INITIATE CPR IMMEDIATELY AND THEN CONTACT ONLINE MEDICAL CONTROL FOR FURTHER DIRECTION.

D. When resuscitation is withheld:

1. Notify Chicago Police Department (CPD) -- All notification of the Medical Examiner is done by the Chicago Police Department in accordance with Police General Order -- Processing Deceased Persons.

2. Preservation of crime scene elements may be appropriate (refer to Crime Scene Response policy).

3. EMS providers using the above criteria to determine death in the field should use the time when the assessment is complete or the cardiac monitor application as the time of death determination.

4. Online Medical Control is not required if the patient meets the above criteria to withhold resuscitation, but is a resource available as needed for clarification or direction.

5. In situations where determination of death is done by EMS providers in accordance with this policy, the name of the EMS Medical Director may be used for Medical Examiner documentation.

E. Documentation:

1. Scene environment

2. History from any family, bystanders, or other first responders on scene

3. Patient position and any movement of body

4. Patient assessment findings

5. Reasons for withholding resuscitation

6. Cardiac monitor verification with rhythm strip uploaded to the patient care report

F. Disposition of the patient when resuscitation is withheld:

1. Transfer custody of the body to CPD on scene.

2. In circumstances such as traumatic arrest with an unsafe scene, it may be necessary to remove the body from the scene. This may be appropriate or necessary given the nature of the scene. If so, transport the patient to the closest Emergency Department. The base station should notify the ED of the patient's arrival.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Guidelines for Infection Control
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	December 6, 2023

EMS GUIDELINES FOR INFECTION CONTROL

I. PURPOSE

To prevent or stop the spread of infection in the prehospital setting by using two levels of precautions: Standard Precautions and Transmission-Based Precautions.

II. DEFINITIONS

A. Standard Precautions: Basic level of infection control for all patient care that includes both safe practices and use of Personal Protective Equipment (PPE) to protect EMS personnel from infection and prevent the spread of infection from patient to patient.

B. Transmission-Based Precautions: A second tier level of basic infection control that are used in addition to Standard Precautions for patients with known or suspected infections.

III. POLICY:

A. EMS PERSONNEL GUIDELINES

1. EMS personnel should be vigilant for travel history and signs and symptoms of communicable disease (e.g., fever, cough, gastrointestinal [GI] symptoms, unusual rash). Standard precautions should always be used with the addition of appropriate transmission-based precautions whenever history or exam findings warrant.

2. **EMS personnel should implement strict standard and transmission-based precautions based on the patient's clinical information to avoid exposure to potentially infectious bodily fluids, droplets, and airborne particles (Table 1).**

3. EMS personnel should avoid direct contact with a patient who may have a communicable disease until they are wearing appropriate PPE.

4. Maintaining distance from the patient and increasing fresh air circulation can reduce respiratory transmission. Maintaining a distance of at least six feet is generally recommended unless specific PPE is worn.

5. Limit the number of EMS personnel in direct contact with a potentially infectious patient to the minimum required to perform tasks safely.

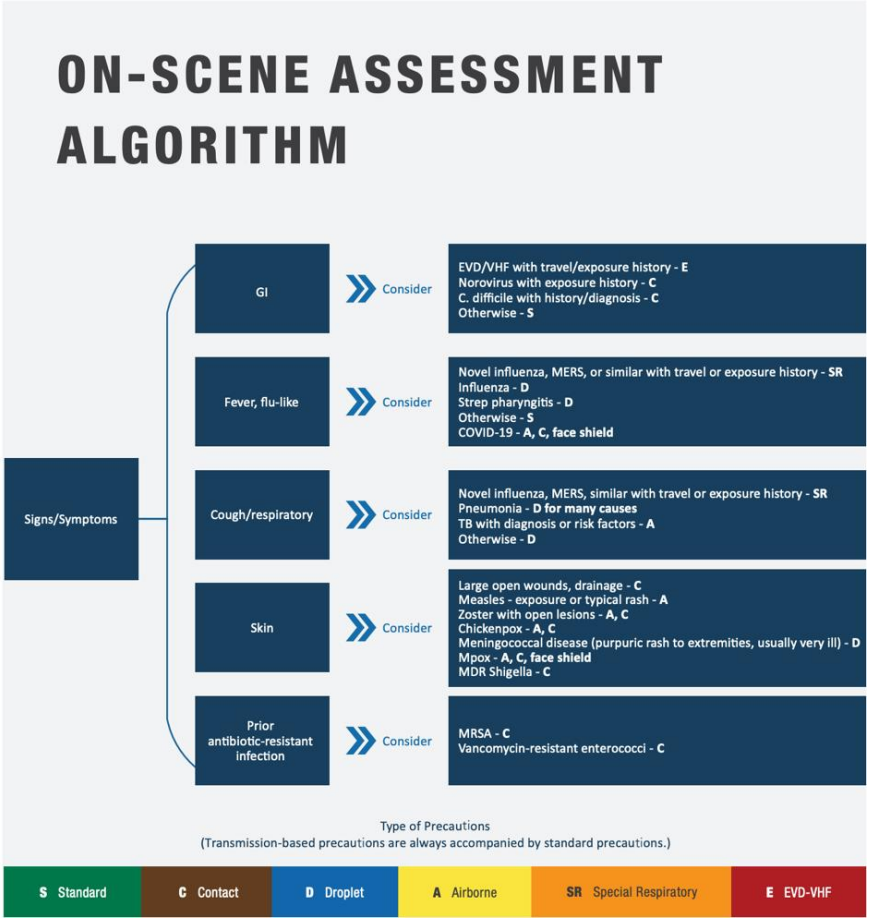
6. **Hand hygiene (e.g., handwashing with non-antimicrobial soap and water, alcohol-based hand rub [ABHR], or antiseptic handwash) is one of the best ways to remove pathogens, avoid getting sick, and prevent the spread of pathogens to others. Perform hand hygiene before and after all patient care activities.**

7. **Place a surgical mask on the patient (for source control) to contain infectious**

respiratory droplets if tolerated. Patients unable to tolerate a mask should cover their nose and mouth when coughing or sneezing, use tissues to contain respiratory secretions and properly dispose of them in the nearest waste receptacle after use, and perform hand hygiene after having contact with respiratory secretions and contaminated objects or materials.

8. Influenza and other diseases can transmit via the ocular surfaces as well as other mucous membranes. EMS personnel should use PPE to protect the mucous membranes of the eyes, nose, and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed.

Table 1: On-Scene Assessment Algorithm (EMS Infectious Disease Playbook 2023)



B. STANDARD PRECAUTIONS

1. <u>Goal of Precautions</u>: Apply standard practice to protect against contact with blood,

body fluids, non-intact skin (including rashes), and mucous membranes for all patient encounters. Examples include routine use of hand hygiene and gloves and adding eye protection and a mask when caring for patients with respiratory symptoms and during airway interventions, or gown for potential splash exposures.

2. Example Diseases: Acquired immune deficiency syndrome (AIDS)/human immunodeficiency virus (HIV), anthrax (cutaneous or pulmonary), botulism, cellulitis, dengue, minor wound infections including abscess, nonspecific upper respiratory infections.

3. Recommended Personal Protective Equipment (PPE)

    a. Gloves during patient contact for any potential exposure to infectious agents or bodily fluids.
    b. Goggles/face shield and surgical mask for any airway procedures (advanced airway insertion, suctioning) or patient with active cough from apparent infectious source and to protect mucous membranes from splash/ liquid exposure.
    c. Impermeable gown for any situation likely to generate splash/ liquid exposures.

4. Patient Care Considerations

    a. Provide a surgical mask for all patients with acute infectious respiratory symptoms who can tolerate it.
    b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.

5. Transport Considerations

    a. Standard transportation to appropriate health care facility.
    b. If the patient compartment is equipped with an exhaust fan, ensure that it is turned on.

6. Ambulance Decontamination

    a. Any visibly soiled surface must first be cleaned and decontaminated using an Environmental Protection Agency (EPA)-registered disinfectant according to directions on the label.
    b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
    c. Medical equipment (e.g., stethoscope, blood pressure cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient.

C. CONTACT PRECAUTIONS

1. Goal of Precautions: Provide impermeable barriers to infectious agents that are either highly pathogenic, drug resistant, contagious, or persistent and that can easily be contracted or spread to other environments via fomites and surface contact.

2. Example Diseases: Excessive wound drainage, MRSA, Vancomycin-resistant enterococci (VRE), C. difficile, norovirus, other suspected infectious diarrhea, head lice/body lice/scabies, respiratory syncytial virus (RSV).

3. Recommended PPE

   a. Disposable fluid-resistant gown.
   b. Disposable gloves.
   c. Ensure strict adherence to standard precautions based on situation (e.g., mask, goggles/face shield for splatter risk or airway interventions).

4. Patient Care Considerations

   a. Cover draining wounds with adequately absorbent dressings.
   b. Anticipate additional stool/vomitus to reduce contamination of EMS personnel and the ambulance (emesis bags, towels available, and/ or impermeable sheet placed on stretcher).

5. Transport Considerations

   a. Consider applying an impermeable barrier sheet to the patient to protect EMS personnel and environmental surfaces in the presence of excessive wound drainage, fecal incontinence, or other discharges.
   b. Advise receiving hospital of a patient on contact precautions who should preferably be transported to a private room.

6. Ambulance Decontamination

   a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
   b. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient. Other visibly contaminated equipment should similarly be cleaned and disinfected.
   c. Confirmed or suspected C. difficile infection decontamination should utilize hypochlorite solutions. EPA-registered disinfectants with sporicidal activity may be sufficient but limited data is available.

D. DROPLET PRECAUTIONS

1. Goal of Precautions: Protection of EMS personnel mucous membranes and respiratory system from exposure to potentially infectious droplets during direct patient care activities.

2. Example Diseases: Neisseria meningitidis, mumps, mycoplasma, streptococcal and many other causes of pneumonia, parvovirus, pertussis, pneumonic plague, rhinovirus, rubella, seasonal influenza, streptococcal pharyngitis.

3. Recommended PPE

    a. Disposable surgical mask (N95 respirator not required but optional).
    b. Disposable gloves.
    c. Eye protection – goggles or face shield.

4. Patient Care Considerations

    a. Provide a surgical mask for all patients with acute infectious respiratory symptoms who can tolerate it.
    b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
    c. EMS personnel not in appropriate PPE should maintain a distance of at least 6 feet from the patient and should wear gloves to guard against infectious agents on the surfaces of objects close to the patient.
    d. Minimize use of nebulizers to avoid aerosolization of respiratory droplets; consider metered dose inhalers instead.
    e. Minimize airway interventions that may cause coughing (e.g., suctioning) to degree possible.

5. Transport Considerations

    a. Consider having the patient compartment exhaust vent on high and isolating the driver compartment if performing aerosol generating procedures (airway suctioning, advanced airway insertion, aerosolized medication administration, non-invasive positive pressure ventilation). Increase ventilation by having air or heat on non-recirculating cycle and/or opening windows.
    b. Advise receiving hospital of respiratory symptoms and that a private (but not negative pressure) room is preferred.

6. Ambulance Decontamination

    a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
    b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
    c. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient.

E. AIRBORNE PRECAUTIONS

1. Goal of Precautions: Provide respiratory protection against inhalation of potentially infectious suspended droplet nuclei/aerosols (agents suspended in the air that are respirable and remain infectious over long distances).

2. Example Diseases: Measles, tuberculosis (suspected or confirmed pulmonary or laryngeal), varicella (chickenpox).

3. Recommended PPE:

   a. Disposable NIOSH-approved, fit-tested N95 respirator or PAPRs with full hood and HEPA filter for airborne precautions for employees who cannot safely fit test on N95 respirators due to facial hair, facial structure, and other factors.
   b. Disposable exam gloves.

4. Patient Care Considerations

   a. Ensure strict adherence with standard precautions.
   b. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   c. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
   d. The performance of procedures that can generate suspended droplet nuclei/aerosols (i.e., aerosol-generating procedures), such as advanced airway insertion, non-invasive ventilation, and open suctioning of the respiratory tract have been associated with higher risk of transmission of infectious agents to health care personnel, including tuberculosis. Protection of the eyes, in addition to respirator and gloves, is recommended while performing these procedures in accordance with standard precautions.

5. Transport Considerations

   a. Notify the receiving hospital of the need for an airborne infection isolation room (AIIR) for patient placement.
   b. Consider having the patient compartment exhaust vent on high and isolating the driver compartment from the patient compartment. Consider having the driver compartment ventilation fan set to high without recirculation.
   c. If driver compartment is not isolated from the patient compartment, vehicle operator should wear N95 respirator.
   d. Patients who have an advanced airway in place should be ventilated with a bag-valve device or ventilator equipped with a viral or HEPA filter in-line or on the exhalation port.

6. Ambulance Decontamination

a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
c. Medical equipment (stethoscope, BP cuff, etc.) making patient contact should be disposable or cleaned and disinfected before use on another patient.

F. SPECIAL RESPIRATORY PRECAUTIONS

1. Goal of Precautions:

   a. Provide protection of mucous membranes and respiratory protection against inhalation of potentially infectious suspended droplet nuclei/ aerosols (agents suspended in the air that are respirable and remain infectious over long distances).
   b. Create an impermeable barrier to reduce spread of highly pathogenic viruses on surfaces and via fomites during direct patient care activities (standard + contact + airborne + eye protection).

2. Example Diseases: MERS, novel influenza strains (e.g., H5N1), smallpox, Monkeypox, COVID-19.

3. Recommended PPE

   a. Disposable N95 or equivalent/higher level respirator (e.g., re-usable half face elastomeric respirator N95 or higher rating mask or PAPR with full hood and HEPA filter).
   b. Disposable face shield or disposable or cleanable goggles (if not using hooded PAPR).
   c. Disposable fluid-resistant gown that extends to at least mid-calf or disposable fluid-resistant coveralls.
   d. Disposable gloves with extended cuffs.
   e. Consider disposable boot/shoe covers.

4. Patient Care Considerations

   a. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
   c. Exercise caution when performing aerosol-generating procedures (advanced airway insertion, airway suctioning, administration of nebulized medication, non-invasive ventilation [continuous positive airway pressure (CPAP)], and/or cardiopulmonary resuscitation [CPR]). Only perform these procedures if medically necessary and cannot be postponed.

d. Ventilate patients who have an advanced airway in place with a bag-valve device or ventilator with a viral or HEPA filter in-line or on the exhalation port.

5. Transport Considerations

   a. Notify the receiving hospital of the need for an airborne infection isolation room (AIIR) for patient placement.
   b. The patient compartment exhaust vent should be on high and the driver compartment should be isolated from the patient compartment if possible. The driver compartment ventilation fan should be set to high without recirculation.
   c. The vehicle operator should wear an N95 respirator if the patient compartment and cab cannot be isolated.
   d. EMS agencies should have a plan for family members wishing to accompany the patient that minimizes additional crew exposures.

6. Ambulance Decontamination

   a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
   b. Disinfect all potentially contaminated surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
   c. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected using appropriate disinfectants before use on another patient.

G. EVD-VHF (EBOLA VIRUS DISEASE-VIRAL HEMORRHAGIC FEVER) PRECAUTIONS

1. Goal of Precautions: Provide maximal impermeable barrier and respiratory protection against highly pathogenic VHF viruses.

2. Example Diseases: EVD, MVD (Marburg Virus Disease), Lassa fever, Crimean-Congo fever.

3. Arriving EMS Actions and Considerations

   a. Inquire about travel and direct exposure history within the previous 21 days. *Has the patient had direct contact with a person who is confirmed or suspected to have EVD/VHF (including local cases, if applicable)?*
      i. If yes, does the patient have any fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, or unexplained hemorrhage (bleeding or bruising)?
   b. Positive EVD/VHF screen is travel or contact risk with symptoms of disease.

4. Guidance to Patients and EMS Personnel for EVD/VHF Positive Screen

a. EMS personnel should don appropriate PPE before direct contact with the patient.
b. If responding to an airport or other port of entry to the United States, notify the CDC Quarantine Station for the port of entry.
c. Notify EMS supervisor and Resource Hospital EMS Coordinator and Medical Director.
d. Consider alerting EVD/VHF specialized personnel and equipment/ ambulance if available as secondary EMS personnel and the patient is stable enough to await this resource.
e. If patient is transported, ensure follow-up with hospital regarding final diagnosis and report any exposures or issues to Chicago Department of Public Health.
f. Ensure that appropriate ALS/BLS care is provided. Most suspected cases will not have EVD/VHF.

5. PPE: Should be carefully donned and doffed with a checklist and trained observer.

a. Initial EMS personnel to suspect case WITHOUT active bleeding, vomiting, or diarrhea:
    i. Single-use (disposable) fluid-resistant gown that extends to at least mid-calf or single-use (disposable) fluid-resistant coveralls without integrated hood.
    ii. Single-use (disposable) full face shield.
    iii. Single-use (disposable) facemask
    iv. Single-use (disposable) gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.

b. Initial EMS personnel to suspect case WITH active bleeding, vomiting, or diarrhea:
    i. **Impermeable Garment**: Single-use (disposable) impermeable gown that extends to at least mid-calf or single-use (disposable) impermeable coveralls without integrated hood.
    ii. **Respiratory, Head, and Face Protection**:
        - **PAPR**: A hooded respirator with a full face shield, helmet, or headpiece OR
        - Single-use (disposable) N95 respirator or higher in combination with single-use (disposable) surgical hood extending to shoulders and single-use (disposable) full face shield.
    iii. Single-use (disposable) gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.
    iv. Single-use (disposable) boot covers that extend to at least mid-calf.
    v. Single-use (disposable) apron that covers the torso to the level of the mid-calf should be used over the gown or coveralls

c. Doffing is a high-risk step in VHF patient care. PPE should be doffed in a

designated PPE removal area. Meticulous care should be taken during this process to avoid self-contamination as this is a major contributor to EMS personnel disease. Place all PPE waste in a labeled leak-proof biohazard bag.

d. EMS and hospital personnel caring for patients with VHF must have received comprehensive training and demonstrated competency in performing VHF-related infection control practices and procedures.

6. Patient Care Considerations

   a. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   b. Be aware that the biggest risk to suspect EVD/VHF patients is withholding appropriate treatment as few will actually have the disease.
   c. Recognize that the more body fluids, the higher the transmission risk.
   d. Anticipate potential stool/vomitus and control contamination of EMS personnel and the ambulance (use emesis bags, towels, and/ or place impermeable sheet on stretcher).
   e. Minimize the number of EMS personnel who make patient contact.
   f. Use dedicated medical equipment (ideally disposable) for the provision of patient care whenever possible.
   g. Strongly consider having the patient wear a barrier garment, surgical mask, and gloves if tolerated.
   h. Exercise caution when performing aerosol-generating procedures (advanced airway insertion, airway suctioning, administration of nebulized medication, CPAP, CPR). Only perform these procedures if medically necessary and cannot be postponed. (Note that cardiac arrest early in the illness may be due to electrolyte imbalance and may be survivable. Late cardiac arrest from multi-organ failure likely carries a dismal prognosis.)
   i. Do not perform IV insertion or any other invasive procedures unless urgently required for patient care or stabilization. Handle any needles and sharps with extreme care and dispose in puncture-proof, sealed containers that are specific to the single patient. Do not dispose of used needles and sharps in containers that have sharps from other patients in them.
   j. Consider giving oral or nasal medicine to reduce nausea and/or pain per Region 11 Protocols rather than injectable.
   k. Use hands-free communications devices (e.g., tactical headsets) inside the PPE ensemble to facilitate communication and avoid contamination of radios.
   l. Complete documentation in a clean area or after transport.

7. Transport Considerations

   a. Advise the designated “Specialized Pathogen Treatment Center” as early as possible about a suspect case to allow them preparation time.
   b. If the patient is a highly suspect case and stable, consider specialized ambulance preparation and transport (as approved by Region 11 and IDPH) if time and acuity allow.

c. Interfacility transport of confirmed case should be performed by EMS personnel with properly prepared ambulances or patient containment devices.
d. For emergency transport, consider applying an impermeable barrier sheet or containment system to the patient to protect EMS personnel and environmental surfaces in the presence of incontinence, draining wounds, or other discharges.
e. The driver's compartment should remain clean. No family members or patient belongings are permitted in the driver's compartment.
f. Suspect EVD/VHF cases should be transported to a hospital capable of evaluation and initial management and placed into a dedicated isolation room. Placement should be coordinated in consultation with local/state public health authorities and the receiving facility.
g. Consider deferring ambulance decontamination for a brief period to determine if EVD/VHF can be quickly ruled out during initial hospital assessment.
h. Formal decontamination after transport of a suspect/confirmed case should occur in a designated area by trained personnel as described in the next section.

8. Ambulance Decontamination

a. Select an appropriate site for ambulance decontamination that protects the vehicle and the team from the weather, preferably a well-ventilated, climate controlled, large, enclosed garage/structure.
b. All waste, including PPE, drapes, and wipes, should be considered Category A infectious substances, and should be packaged appropriately for disposal.
c. Personnel must be in appropriate PPE during decontamination and disinfection. A third person should also be available as a trained observer and to assist as needed.
d. Grossly contaminated and visibly soiled surfaces must be decontaminated prior to disinfection.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Staffing
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS STAFFING

I. PURPOSE

To define Region 11 EMS staffing requirements in accordance with IDPH.

II. POLICY

A. Personnel Requirements

1. Each Basic Life Support (BLS) ambulance shall be staffed by a minimum of one system authorized EMT and one other system authorized EMT on all responses.

2. Each Advanced Life Support (ALS) ambulance shall be staffed by a minimum of one system authorized Paramedic and one other System authorized Paramedic on all responses.

B. Alternative Staffing for Private Ambulance Providers

1. Private, nonpublic, ambulance providers may request approval from IDPH to use an alternative staffing model that includes an EMR with a licensed EMT or Paramedic, as appropriate. The use of alternative staffing models are pursuant to the approval of the EMS System Program Plan developed and approved by the EMS Medical Director. Basic requirements for the use of alternative staffing models include:

    a. Alternative staffing models for a BLS transport using an EMR shall only be utilized for interfacility BLS transports, as specified by the EMS System Program Plan, as determined by the EMS Medical Director.
    b. The licensed EMR must complete a defensive driving course prior to participation in the alternative staffing model.
    c. Dispatch protocols for properly screening and assessing patients appropriate for EMR-staffed transports.
    d. Implementation of a quality assurance plan that shall include the monthly review of at least 5% of total interfacility transports utilizing an EMR.
    e. This quality assurance plan must include mechanisms to audit dispatch screening, reason for transport, patient diagnosis, level of care, and the outcomes of transports performed.
    f. Quality assurance reports must be submitted and reviewed by the EMS System monthly and made available to IDPH upon request.

2. The EMS System Medical Director shall develop a minimum set of requirements for individuals based on level of licensure that includes education, training, and credentialing for all team members identified to participate in an alternative staffing plan.

    a. The EMT, Paramedic, and Critical Care transport staff shall have the minimum experience in pre-hospital and inter-hospital emergency care, as determined by the

EMS Medical Director in accordance with the EMS System Program Plan, but at a minimum of 6 months of prehospital experience or at least 50 documented patient care interventions during transport as the primary care provider and approved by the Department.

b. The EMS personnel licensed at the highest level shall provide the initial assessment of the patient to determine the level of care required for transport to the receiving health care facility. This assessment shall be documented in the patient care report and with online medical control. The EMS personnel licensed at or above the level of care required by the specific patient as directed by the EMS Medical Director shall be the primary care provider en-route to the destination facility or patient's residence.

3. The system plan modification form and alternative staffing model program plan shall be submitted to the EMS Medical Director for approval and forwarded to IDPH for review and approval. The provider shall not implement the alternative staffing plan until approval by the EMS Medical Director and IDPH.

   a. Alternative staffing models may include expanded scopes of practice as determined by the EMS Medical Director and approved by IDPH. This may include the use of an EMR at the BLS or ALS level of care.
   b. If the EMS Medical Director proposes an expansion of the scope of practice for EMRs, such expansion shall not exceed the education standards prescribed by IDPH.

4. Alternative staffing plans are approved for a maximum of year and may be renewed annually if the following criteria are met:

   a. All system modification forms and supportive planning documentation are submitted, validated, and approved by the EMS Medical Director who shall submit to IDPH for final approval.
   b. All plans must demonstrate that EMS personnel will meet the training and education requirements as determined by IDPH for expanding the scope of practice for EMRs, testing to assure knowledge and skill validation, and a quality assurance plan for monitoring transports utilizing alternative staffing models that include EMRs.

5. Any other alternate response staffing requires approval by the EMS Medical Director under the EMS System Plan.

6. Region 11 Chicago EMS does not serve a rural population or utilize volunteer EMS agencies, therefore the region does not utilize the rural population staffing credentialing exemption intended for populations of 5,000 or fewer.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Epinephrine Dilution for Shortage
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: August 1, 2022

EPINEPHRINE DILUTION FOR SHORTAGE

I. **PURPOSE:**

To define the proper dilution and administration of Epinephrine during times of drug shortage in the Chicago EMS System.

II. **DEFINITION**:

Epinephrine may be carried in two forms for EMS use:

A. Epinephrine 0.1 mg/ml (1:10,000) prefilled syringe

B. Epinephrine 1 mg/ml (1:1000) vial

Glass ampules should not be used for medication administration by EMS.

III. **USE:**

A. Epinephrine 0.1 mg/ml (1:10,000) prefilled syringe is the preferred formulation to administer IV epinephrine when indicated by EMS protocols.

B. For shortages of the Epinephrine prefilled syringe, Epinephrine from the 1 mg/ml (1:1000) vial may be used after one of the below Epinephrine Dilution Procedure methods.

IV. **EPINEPHRINE DILUTION PROCEDURE:**

There are two methods that can be used to dilute the epinephrine:

A. Method 1: Place a 23-gauge needle on the end of a saline flush - 0.9% Sodium Chloride Injection (10 mL prefilled syringe) and discard 1 mL from the syringe. Remove the plastic top of the vial and clean with an alcohol wipe. Draw up 1 mL of 1 mg/mL (1:1000) epinephrine from the vial into the syringe. Gently swirl the medication. The syringe now contains 0.1 mg/mL (1:10,000) Epinephrine.

B. Method 2: Remove the plastic top of the epinephrine vial and clean with an alcohol wipe. Draw up 1 mL of 1 mg/mL (1:1000) Epinephrine from the vial into a 10 mL syringe using a 23-gauge needle. Draw up 9 mL from a bag of 0.9% Sodium Chloride IV Solution. Gently swirl the medication. The syringe now contains 0.1 mg/mL (1:10,000) Epinephrine.

V. HOSPITAL REPLACEMENT:

A. Hospitals should prioritize Epinephrine prefilled syringes for EMS replacement.

B. Hospitals that are unable to replace Epinephrine prefilled syringes may replace EMS providers with an "Epinephrine Dilution Kit" containing the following:

1. Epinephrine 1 mg/mL (1:1000) vial
2. 23-gauge needle
3. Alcohol wipe
4. Saline flush – 0.9% Sodium Chloride Injection (10 mL prefilled syringe) OR Syringe (10 mL)

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Initiation of Patient Care
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

INITIATION OF PATIENT CARE

I. **PURPOSE**

To define the initiation and transition of patient care by EMS personnel.

II. **DEFINITIONS**

A. Medical Negligence: Occurs when a healthcare provider's actions or inactions are below the level of care that a similarly trained professional would have provided under the same circumstances or when the provider fails to fulfill their professional obligations.

B. Patient Abandonment: A form of medical negligence that involves the termination of a patient/provider relationship without the patient's consent and at a time when continuing care is still needed.

III. **EQUIPMENT**

A. When responding to all requests for out-of-hospital care, the EMS personnel (EMR, EMT, Paramedic) must take the following to the initial contact with the patient:

1. Quick response bag
2. Conveyance device
3. AED or cardiac monitor/defibrillator
4. Oxygen bag

B. EMS personnel must bring in the monitor/defibrillator for any known cardiac or respiratory calls.

IV. **POLICY**

A. Appropriate care, as directed by the Region 11 EMS System Protocols and Policies, should be initiated at the point of patient contact unless the patient refuses or scene safety cannot be secured. This includes care given by ALS or BLS Fire Suppression Companies before the arrival of an ALS ambulance.

B. Additional personnel should be requested as needed for patient care and conveyance.

C. Advanced Life Support (ALS) level of care includes application of the cardiac monitor. Obtain IV access and administer oxygen as indicated. **The cardiac monitor must remain attached to the patient during transportation into the hospital and care endorsed to the emergency department staff.**

D. ALS care should be initiated according to the following guidelines:

1. Adult patient with abnormal vital signs, regardless of complaints.

   a. Pulse <60 or >110; or irregularity
   b. Respiration <10 or >24
   c. Systolic Blood Pressure >180 or <100
   d. Diastolic Blood Pressure >110
   e. Pulse Ox <94%

2. Any patient with a potentially life threatening condition which exists or might develop during transport. Examples of situations in which ALS care is indicated include, but are not limited to:

   a. Altered mental status/unresponsive
   b. Suspected acute coronary syndrome or other cardiac emergencies, including arrhythmias/palpitations
   c. Seizures or postictal state
   d. Suspected stroke or TIA
   e. Syncope or Near Syncope
   f. Shortness of Breath/Difficulty Breathing
   g. Complications of Pregnancy or Childbirth
   h. GI Bleeding
   i. Traumatic Injury Meeting Trauma Field Triage Criteria
   j. Overdose/Poisoning
   k. Burns >10%
   l. Moderate to Severe Allergic Reaction/Anaphylaxis

E. Scene Safety: If scene safety is not a certainty, or if dealing with an uncooperative patient, the requirements to initiate assessment and full ALS care may be waived in favor of assuring that the patient is transported to an appropriate medical facility. Clearly document the reasons for deviations in care.

F. Once patient care is initiated, it should be continued unless:

   a. The patient meets criteria for refusal under the Consent/Refusal or Service Policy.
   b. Approval is granted by Online Medical Control; or
   c. Care has been transferred to higher level personnel at the receiving hospital.

G. Abandonment or neglect of a patient that requires emergency care is criteria for suspension as per the EMS System Participation Suspension Policy.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Interaction with an Independent Physician / Nurse on Scene
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

INTERACTION WITH AN INDEPENDENT PHYSICIAN / NURSE ON SCENE

I. PURPOSE

To clearly delineate the roles of all personnel at a scene to provide the highest quality of patient care.

II. POLICY

A. Only personnel licensed to perform in the prehospital setting, and who are members of Region 11 Chicago EMS, are allowed to perform patient care unless approved by Online Medical Control.

B. EMS personnel who are confronted by individuals wanting to render assistance at the scene of the emergency should follow these guidelines:

1. If assistance is needed, the senior EMS officer should contact Online Medical Control and advise that there are on scene healthcare providers (physician or nurse) from outside of Region 11 Chicago EMS.

2. Non-system personnel will function under the senior EMS personnel at their level of licensure.

3. When EMS personnel establish patient contact, they also establish a "healthcare provider/patient relationship" between the patient and the EMS Medical Director or Base Station ECP as a designee.

   In cases where the patient's personal physician is physically present, EMS personnel should respect the previously established healthcare provider/patient relationship.

4. If there is a disagreement between the EMS personnel and the physician on the scene regarding the care to be given to the patient, Online Medical Control should be consulted.

5. EMS personnel shall follow the direction of the Base Station ECP.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Interaction with Law Enforcement at a Crime Scene
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

INTERACTION WITH LAW ENFORCEMENT AT A CRIME SCENE

I. PURPOSE

To define responsibilities of EMS personnel with patient assessment at a crime scene and interactions with law enforcement.

II. POLICY

A. EMS and law enforcement are often dispatched together for incidents involving patients and criminal situations including suicide, accidental death or suspicious circumstances of a death.

B. The role of law enforcement is to investigate the crime and preserve evidence.

C. The role of EMS is to assess and treat the patient.

In circumstances where there is an active investigation, EMS should work with law enforcement to facilitate performing a patient assessment and any treatment indicated while maintaining the evidence at the scene.

D. If law enforcement is not on the scene and safety of the EMS personnel is a concern, patient care and transport may be delayed until law enforcement can secure the scene. Initiate patient assessment and treatment per Region 11 EMS Protocols.

E. Assess patients for traumatic injuries incompatible with life or traumatic arrest plus asystole per the Determination of Death/ Withholding of Resuscitative Measures Policy.

F. Maintain evidence at the crime scene

1. If circumstances require the alteration of the scene for patient assessment, inform law enforcement.

2. Avoid unnecessary contact with physical objects at the scene.

3. Anything carried onto the scene including bandages or packaging should be removed by EMS when leaving the scene. Do not remove anything else from the scene.

4. If it is necessary to cut through the clothing of the patient, avoid cutting through tears, bullet holes, or other damaged or stained areas of clothing.

5. Do not wash or clean the patient's hands or areas with bullet wounds.

6. During exposure of the patient during assessment, expended bullets can be found in the clothing of the patient (especially when heavy winter clothing is worn). These items of evidence may be lost during evaluation or transportation. Any evidence should be turned over to law enforcement and documented on the patient care report.

7. In hanging or asphyxiation cases, avoid cutting through or untying knots in the hanging device or other materials unless necessary to free the patient.

8. In stabbing cases, leave any impaled object in place for both medical reasons and evidence collection.

G. Document observations at the crime scene on the patient care report. Include name and star number or badge number of law enforcement personnel on scene.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Large Gathering / Special Events
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: August 1, 2018

LARGE GATHERING/SPECIAL EVENTS

I. A minimum of 60 days prior to any large gathering/special event, each Provider Agency shall submit a completed IDPH Special Event Request Application to their respective Resource Hospital, which will include the following:

A. Ambulance license number, VIN, and level of care

B. Names and license numbers for EMS staff

C. Event name, date, hours, location, and expected attendance

D. Outline of the medical plan for the event

E. Map of the receiving hospitals

F. EMS system communication plan

II. **At large scale/special events, only those patients who are in need of further medical attention, but still refuse transport will be called into Online Medical Control. All other refusals will be documented on a run report.**

III. **Within 10 days following the large scale/special event, the Provider Agency shall submit a report to their respective Resource Hospital outlining those refusals not called in, as well as the number of the number and categories of patient encounters and transports. (Specified by EMS System Quality Improvement/Assurance Program policy).**

IV. EMS agencies providing staffing within Region 11 that are from an outside system should:

A. Have understanding of the specialty receiving centers.

B. Provide medical staffing plans to the regional EMS Medical Directors Consortium (MDC) for coordination and planning prior to the event.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Management of Multiple Patient Incidents
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

MANAGEMENT OF MULTIPLE PATIENT INCIDENTS

I. MULTIPLE PATIENT INCIDENT (MPI)

A. Definition: An incident where multiple patients (3 or more) exist and the EMS response is able to provide the adequate numbers of responders, EMS shall provide standard levels of care and transportation. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a complete assessment, hospital contact, and transport decision as per Region 11 Protocols and Policies for each individual patient.

B. MPI General Concepts

1. Scene safety is a universal consideration.

2. Field to hospital communication for each individual patient shall be either Online Medical Control to a Region 11 EMS Base Station or Pre-notification to the receiving hospital (per Field to Hospital Communication Policy).

3. Patient care reports to be completed as per policy.

C. Incident Priorities

1. First arriving unit on scene

   a. Scene size-up and activation of additional resources. The first arriving officer (EMS or Fire) may initiate an MPI response.
   b. Primary triage as per Attachment 1 “Region 11 Modified START/JumpSTART Triage Algorithm”:
      i. “Red” (Immediate)
      ii. “Yellow” (Delayed)
      iii. “Green” (Minimal)
      iv. “Black” (Deceased)

2. Life saving (focused) interventions that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest (pleural) decompression if within the responder’s scope of practice and only if the necessary equipment is immediately available.

D. Scene Management

1. Goal of Scene Management: Primary triage of patients with focused interventions with further treatment and transport prioritizing the most critical patients first.

2. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

3. Treatment: Each patient should receive a primary and secondary survey and treatment per Region 11 EMS Protocols.

   a. Trauma Patients should have the Trauma Field Triage Criteria applied (per policy) to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.
      i. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged "Red" and be transported to the appropriate Level 1 Trauma Center.
      ii. Patients that meet **Mechanism of Injury** or **High Risk Populations** criteria should be triaged "Yellow" and be transported to the appropriate Level 1 Trauma Center.
   b. Medical patients should be reassessed and triage level adjusted as indicated.
   c. First responders (EMS, Fire, Law Enforcement, etc.) that become ill or injured during the incident should be triaged and treated as above and will be given priority transport.

4. Transport: Begin transport of the most critical ("Red") patients to the closest, most appropriate hospital.

   a. After the most immediate priority ("Red") patients have been transported, the delayed prioity ("Yellow") patients should be transported next, and then minimal priority ("Green") patients.
   b. Ambulances may transport multiple "Green" or "Yellow" patients in the same vehicle for resource utilization subject to the availability of proper patient safety restraints. This may be done only after primary and secondary survey with medical stabilization. The maximum number of patients transported per ambulance should be one "Red", two "Yellow", or four "Green".
   c. After complete assessment, patients that meet criteria for withholding resuscitation (per Determination of Death/Withholding of Resuscitative Measures Policy) may be categorized as deceased ("Black") and left on scene, unless the situation warrants removal.

5. Communication: Each transporting ambulance shall contact the appropriate hospital for Online Medical Control or pre-notification (per Field to Hospital Communication Policy).

II. EMS PLAN RESPONSE

A. Definition: The number of patients exceeds routine operational capacity of a Multiple Patient Incident (per Section I) wherein additional dispatch of EMS resources is required to provide normal levels of care and transportation. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a subsequent complete assessment and patient care per Region 11 Protocols and Policies. Specific hospital contact and transport decisions will be followed as defined in this section.

B. The EMS response is based on the scale of the incident and may include several levels, each corresponding to a specific number of ambulances and support personnel assigned. In Region 11 – Chicago EMS Systems, this is defined as an "EMS Plan 1, 2, or 3".

1. EMS Plan 1 = 5 ambulances

2. EMS Plan 2 = 10 ambulances

3. EMS Plan 3 = 15 ambulances

C. EMS Plan Response General Concepts:

1. Scene safety is a universal consideration.

2. For larger events such as an EMS Plan 2 or 3, triage tags (or other patient acuity identifier) should be used and patient tracking should be implemented.

3. An EMS Communications Officer will conduct initial field to hospital communication. Additional communication as detailed below (*see Communication section*).

4. The Resource Hospital (RH) with geographical jurisdiction over the incident (as per the Resource and Associate Hospital Policy Map) will be the Command Hospital for the EMS Plan response unless an alternate RH is designated based on operational needs.

5. Patient care reports to be completed as per policy.

D. Incident Priorities

1. First arriving unit on scene

   a. Scene size-up, activation of additional resources, and communication of need for EMS Plan activation. The first arriving officer (EMS or Fire) or OEMC may initiate an EMS Plan response.
   b. Primary triage as per Attachment 1 "Region 11 Modified START/JumpSTART Triage Algorithm":
      i. "Red" (Immediate)
      ii. "Yellow" (Delayed)
      iii. "Green" (Minimal)
      iv. "Black" (Deceased)

2. Life saving (focused) interventions that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest (pleural) decompression if within the responder's scope of practice and only if the necessary equipment is immediately available.

3. Establish a Casualty Collection Point (CCP) or treatment area if the situation warrants.

E. Scene Management

1. Goal of Scene Management: To maintain a consistent response structure that can be scaled or adapted for any type and size of incident.

2. Triage: All patients should receive a primary triage based on the Region 11 Modified START/JumpSTART Triage Algorithm. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

3. Treatment Area: A Treatment Area should be set up when the number and type of patients exceeds the number of ambulances available for immediate transport. A Treatment Officer at the level of paramedic, should be identified to manage this area and provide repetitive secondary triage and treatment as appropriate. Each patient should receive a primary and secondary survey and treatment per Region 11 EMS Protocols.

   a. Trauma patients should have the Trauma Field Triage Criteria applied (as per policy) to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.
      i. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged "Red" and be transported to the appropriate Level 1 Trauma Center.
      ii. Patients that meet **Mechanism of Injury** or **High Risk Populations criteria** should be triaged "Yellow" and be transported to the appropriate Level 1 Trauma Center.
   b. Medical patients should be reassessed and triage level adjusted as indicated.
   c. First responders (EMS, Fire, Law Enforcement, etc.) that become ill or injured during the incident should be triaged and treated as above and will be given priority transport.

4. Transport Area: Begin transport of the most critical or immediate priority ("Red") patients to the closest, most appropriate hospital. This is managed by the Transport Officer.

   a. After the immediate priority ("Red") patients have been transported, the immediate priority ("Yellow") patients should be transported next, and then minimal priority ("Green") patients.
   b. Ambulances may transport multiple "Green" or "Yellow" patients in the same vehicle for resource utilization subject to the availability of proper patient safety restraints. This may be done only after completing the primary and secondary survey with medical stabilization. The maximum number of patients transported per ambulance should be one "Red", two "Yellow", or four "Green".
   c. After complete assessment, patients that meet criteria for withholding resuscitation (as per Determination of Death/Withholding of Resuscitative Measures Policy) may be categorized as deceased ("Black") and left on scene unless the situation warrants removal.

5. Communication

a. There should be an initial communication with the Resource (Command) Hospital for Online Medical Control of the incident. There should be secondary individual ambulance communication as a pre-notification report to the receiving hospital. This may be limited in a large incident such as an EMS Plan 3 and above.
b. An EMS Communications Officer at the level of a paramedic should be identified to contact the Command Hospital. For large, complex, evolving incidents, there should be early notification to the Command Hospital.

c. After triage is complete, or in the case of a large scale event where triage may continue, the EMS Communications Officer will contact the Command Hospital to notify the ECRN/ECP of the EMS Plan Response and convey the following information:
    i. Location of the incident
    ii. Nature of the incident
    iii. Number of patients
    iv. Adult or pediatric
    v. Patient triage category
    vi. Ambulance transporting each patient

d. The EMS Communications Officer, in consultation with the Command Hospital, will discuss a transport plan based on triage category and nature and complexity of the incident.
e. The ECRN/ECP will assist with coordinating destination of special situations including transportation of family groups, unaccompanied minors, to a hospital on diversion, or any complex situation as requested by the EMS Communications Officer.
f. The ECRN/ECP will provide the receiving hospital an initial notification of the incoming patients.
g. The transporting ambulance should provide the receiving hospital a brief, updated pre-notification report while enroute, stating that the patient is from an EMS Plan response.
h. The EMS Communications Officer should notify the Command Hospital when the EMS Plan is secured or completed.

6. Receiving Hospitals

a. Distribution of patients will be based on the scale of the incident, patient triage category, and hospital capability.
b. Hospitals may receive a combination of patients in multiple triage categories.
c. Hospital Distribution for a Plan Response:
    i. Each hospital should be prepared to receive a potential **initial** distribution of 2 “Red” patients, 2 “Yellow” Patients, and 4 “Green” Patients.
    ii. This initial distribution may be higher to maintain family unification or based on the capacity of a receiving hospital.
    iii. In the event of an incident with a high number of “Green” patients (low speed bus collision or gas inhalation) a hospital may receive multiple “Green” patients.
    iv. Additional transport needs beyond this will be assessed with the individual hospital based on the incident. The EMS Communications Officer will contact the

Command Hospital with additional patient updates and the Command Hospital should contact the receiving hospitals as needed to assess capacity.

d. Hospitals will continue to receive transports from other simultaneous EMS incidents.
e. Hospitals on ALS bypass may receive patients transported from an EMS Plan Response. Hospitals on trauma bypass shall have capabilities assessed by the Command Hospital. Hospitals on Internal Disaster bypass should not receive patients from an EMS Plan Response (per policy).

f. Trauma patients meeting Trauma Field Triage Criteria (per Trauma Patient Destination Policy) should be transported to the appropriate Level 1 Trauma Center.

7. Quality Improvement - All EMS Plans will be reviewed by the responding agency and the Resource (Command) Hospital with feedback given to involved personnel.

III. MASS CASUALTY INCIDENT (MCI)

A. Definition: The number of patients or type of situation has overwhelmed the operational ability of the provider wherein the number of patients and nature of their injuries make the normal prehospital level of stabilization and care unachievable, and/or available resources are insufficient to manage the scene under normal operating procedures.

B. MCI General Concepts

1. Triage tags (or other patient acuity identifier) and electronic tracking are to be used on all patients.

2. Communication will be handled by the EMS Communications Officer and the Command Hospital as defined in the previous section for EMS Plan Response.

C. Incident Priorities: Initial incident operations should be per EMS Plan response activation.

1. Primary triage as per Attachment 1 “Region 11 Modified START/JumpSTART Triage Algorithm”:

a. “Red” (Immediate)
b. “Yellow” (Delayed)
c. “Green” (Minimal)
d. “Black” (Deceased)

D. Scene Management

1. Additional resources may be requested by the Incident Commander to assist with the incident.

2. The Chicago Fire Commissioner or designee may request:

a. Mutual Aid Box Alarm System (MABAS)

b. Private Provider Emergency Response System (PPERS)

3. Communication

a. The Command Hospital will manage patient distribution.

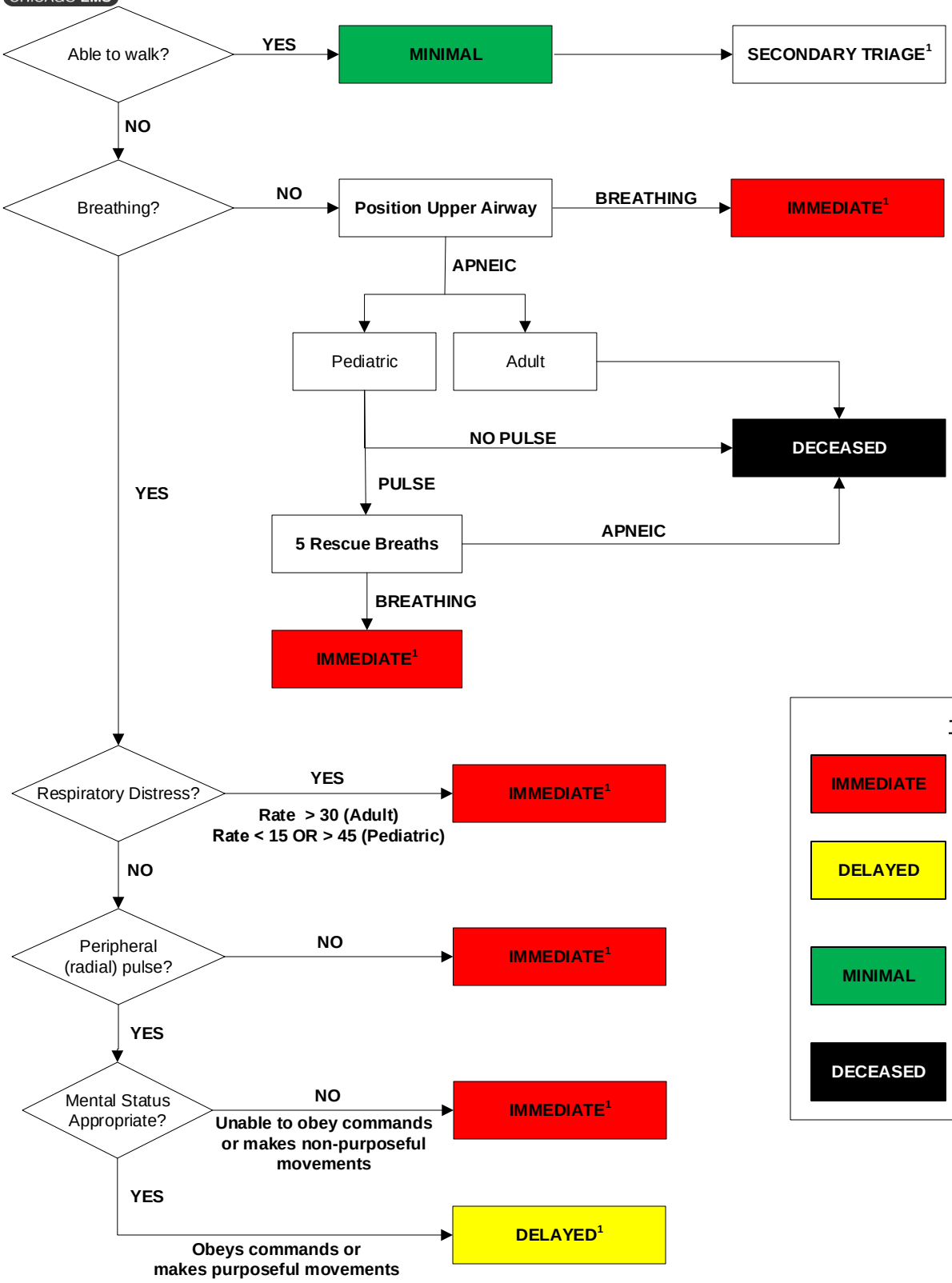
b. The Resource Hospital Coordinating Center (RHCC) hospital will be notified by the Command Hospital.
c. The RHCC will assist with incident communications and assessing hospital capacity as the situation warrants.

4. Transportation of the most critically injured trauma patients should be prioritized to Level 1 Trauma Centers unless these hospitals have provided notification they are overwhelmed. Activation of Helicopter EMS (per the Helicopter EMS Utilization Policy) may assist with distribution.

a. Ambulances may transport multiple patients in the same vehicle for resource utilization.
b. Transportation decisions should attempt to evenly distribute patients to area hospitals and not overburden one facility.
c. PPERS may also be activated for hospital decompression.
d. Alternate transport vehicles and destinations may be utilized and will be coordinated by the EMS Medical Director.

5. Quality Improvement: MCI events will be reviewed by the responding agencies and the Region 11 EMS Medical Directors.

REGION 11 MODIFIED START/JumpSTART TRIAGE ALGORITHM



Triage Categories

IMMEDIATE	Obvious threat to life or limb and requires immediate medical attention
DELAYED	Condition in need of definitive medical care, but is not likely to decompensate rapidly if care is delayed
MINIMAL	Minor injuries and can tolerate extended delays in treatment without increasing the risk of mortality
DECEASED	No respirations following basic airway maneuvers

1- **Life-Saving (Focused) Interventions** that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest decompression if within the responder's scope of practice and only if the necessary equipment is immediately available.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Medication Administration Cross Check (MACC)
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: August 1, 2022

MEDICATION ADMINISTRATION CROSS CHECK (MACC)

I. PURPOSE

To define the proper use of Medication Administration Cross Check (MACC) in the Chicago EMS System.

II. DEFINITION

The Medication Administration Cross Check (MACC) is a team-based communication method to standardize the medication verification process and reduce medication errors.

III. USE

A. Safe medication administration is a process that optimally involves two EMS providers to collaboratively cross check the administration of medication.

B. When two EMS providers are available, MACC should be used by both EMTs and Paramedics prior to medication administration on all events.

C. When only one EMS Provider is available, the MACC cannot be applied.

D. If Provider 1 is a Paramedic and Provider 2 is an EMT, the MACC procedure should still be used with a slight alteration to the role of Provider 2. Provider 2 should visually verify the drug name, concentration, and expiration date.

IV. PROCEDURE

A. Provider 1 initiates the procedure by stating “Medication Cross Check”.

B. Provider 2 responds that he or she is “Ready”. It is important to avoid using ambiguous responses such as “okay” and to participate in an engaged manner.

C. Provider 1 states the phrase “I am going to give . . .” and provides the following information: the dose, drug name, route, reason/indication. If there is concurrence from Provider 2, continue the cross check procedure. If there is not concurrence, stop and resolve any disagreement at this point.

D. If Provider 2 agrees, he or she responds with the question “Are there contraindications?”

E. Provider 1 must check the expiration date if he or she has not done so already, verify that the patient's vital signs are appropriate, and any drug allergies. Provider 1 should either respond by saying "No contraindications" or by stating and discussing the presence of any contraindications.

F. If Provider 2 concurs, he or she responds with the question "What is your volume?" or "Quantity?" for pills/tablets.

G. Provider 1 should state the drug concentration, the volume he or she intends to deliver, and should show the container to Provider 2.

H. If Provider 2 agrees and makes a positive visual verification, he or she should respond with the phrase "I agree; give it".

V. CONSIDERATIONS

A. Contraindications include:

1. Verification of appropriate vital signs;

2. Known patient allergies; and

3. Expiration date.

B. If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it must be resolved prior to continuing the cross check.

C. Provider 2 can authorize the administration of the medication.

D. The Medication Administration Cross Check must be completed prior to the administration of any medication when two EMS providers are available.

E. If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.

F. Avoid ambiguous statements or confirmations like "okay".

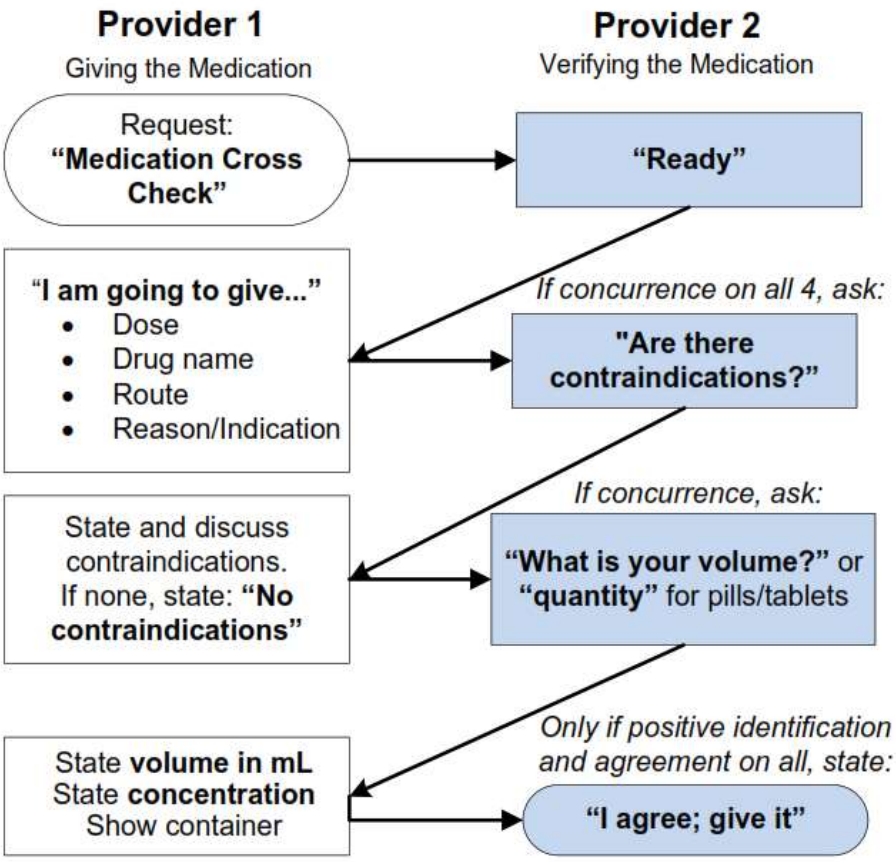
VI. DOCUMENTATION

Use of the Medication Administration Cross Check (MACC) should be documented in the patient care report.

VII. REPORTING

Medication administration errors should be reported to the receiving hospital.

Medication Administration Cross Check



- "**Contraindications**" include: 1) verification of appropriate vital signs, 2) known patient allergies, and 3) expiration date.
- If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it must be resolved prior to continuing the cross check.
- Provider 2 can authorize the administration of the medication.
- The Medication Administration Cross Check must be completed prior to the administration of any medication when two EMS providers are available.
- If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.
- Avoid ambiguous statements or confirmations like "okay."

RED RULE of Medication Administration
(A Duty to Avoid Causing UNJUSTIFIABLE Harm)
NEVER give the contents of a syringe that is not labeled or without visualizing the vial from which it was immediately drawn.

Adapted with permission from Wichita-Sedgwick County EMS System
Approved: Region 11 EMS Medical Directors Consortium
Effective: August 1, 2022

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Notification of the Coroner / Medical Examiner
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

NOTIFICATION OF THE CORONER / MEDICAL EXAMINER

I. PURPOSE:

To establish a procedure for how and when to call the Coroner or Medical Examiner in Region 11 Chicago EMS.

II. COOK COUNTY MEDICAL EXAMINER ORDIANCE

A. Under the Cook County Medical Examiner's Ordinance Number 15-5145, any EMS provider, who becomes aware of a death that a reasonable person would conclude may have occurred under any of the circumstances listed below shall immediately report such death to the Office of the Medical Examiner **or any law enforcement officer** within one hour of their becoming aware of the death.

1. Criminal violence;
2. Suicide;
3. Accident;
4. Suddenly, when in apparent good health;
5. Unattended by a practicing, licensed physician, other than apparent natural deaths;
6. Suspicious or unusual circumstances;
7. Unlawful fetal death under Public Act 101-0013;
8. Poisoning or attributable to an adverse reaction to drugs and/or alcohol;
9. Diseases constituting a threat to public health;
10. Disease, injury or toxic agent resulting from employment;
11. During medical diagnostic or therapeutic procedures that do not include death as a reasonable possible outcome;
12. In any prison or penal institution;
13. When involuntarily confined in jail, prison, hospitals or other institutions or in Police custody;
14. When any human body is to be cremated, dissected or buried at sea;

15. Unidentified human remains;

16. When a dead body is brought into a new medico-legal jurisdiction without proper medical certification.

B. No person who becomes aware of a death of the type described above, shall remove, cause to be removed, or release for removal, the deceased person from the place of their death without first reporting the death. The deceased person shall not be removed from the place of their death until the Medical Examiner gives approval for that removal.

C. EMS providers are excused from the duty to report a death only if they reasonably believe, based upon information presented to them, that the death has already been reported to the Medical Examiner.

D. No dead human body whose death may be subject to investigation, or the personal property of such a deceased person, shall be handled, disturbed, embalmed or removed from the place of death by any person except with the permission of the Medical Examiner, unless the same shall be necessary to preserve such body from damage or destruction, or to protect life, safety, or health.

E. Any person who knowingly violates any provision of this ordinance is subject to fines and legal charges.

III. NOTIFICATION AND SCENE MANAGEMENT

A. In the case of a prehospital death, EMS Providers shall notify the Chicago Police Department (CPD). CPD will notify the Office of the Medical Examiner in accordance with Police General Order – Processing Deceased Persons.

B. Preservation of crime scene elements may be appropriate (see Interaction with Law Enforcement at a Crime Scene Policy).

C. In situations where determination of death is done by EMS providers in accordance with the Region 11 Determination of Death / Withholding of Resuscitative Measures Policy, the name of the EMS Medical Director may be used for Medical Examiner documentation.

IV. SPECIAL CIRCUMSTACES

A. The body shall not be moved and the scene shall not be disturbed or altered in any way. The body may, however, be moved to verify the absence of vital signs, to perform an adequate assessment, or to gain access to a viable patient involved in the same incident.

B. EMS providers should not remove lines or tubes from unsuccessful cardiac arrest resuscitation attempts.

C. If there is a delay in the arrival of law enforcement the appropriate supervisor should be notified for escalation.

D. In situations where there is an order for the termination of resuscitation (see Termination of Resuscitation Policy) and the deceased is in a public place or unsafe scene, CPD should be called to take custody of the body. In the rare circumstance where transport is needed, EMS may transport the patient to the closest comprehensive emergency department. The base station should notify the receiving hospital that they are receiving a patient whose resuscitation was terminated in the field.

REGION 11 CHICAGO EMS SYSTEM
REQUIRED DRUG, EQUIPMENT AND SUPPLY (DES) INVENTORY

REGION 11 CHICAGO EMS SYSTEM
REQUIRED DRUG, EQUIPMENT AND SUPPLY (DES) INVENTORY

ALL EXCHANGE ITEMS MUST BE IMMEDIATELY AVAILABLE TO THE EMERGENCY CARE PERSONNEL SO AS NOT TO DELAY THEIR RETURN TO SERVICE.

APPROVAL OF SIMILAR TYPE EQUIPMENT MUST BE MADE BY THE EMS MEDICAL DIRECTORS CONSORTIUM

In the event of transport of a patient with a suspected communicable disease, the following items must be made available to the EMT or paramedic for use:

* An EPA-registered disinfectant or surface disinfectant wipes
* Additional ambulance cleaning supplies as needed

The number in the "No. of items" column indicates the minimum quantity of the drug, supply or exchange equipment that must be carried on each EMS vehicle in Region 11.

"X"s in the indicated columns convey the following meanings:

HOSPITAL: It is the responsibility of the Participating Hospital to replace the drug, supply or exchange the equipment item as indicated.

PROVIDER - Private: It is the responsibility of the Provider to replace the drug, supply or exchange the equipment item indicated.

Provider - CFD: This piece of equipment is unique to the Chicago Fire Department. The CFD is the only provider in the system required to have this drug, supply or piece of equipment in their inventory. The CFD is responsible for the replacement of this item.

CONTROLLED SUBSTANCE: These drugs are controlled substances.

MEDICATIONS

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	Controlled Substance	
3	X				X		Adenosine, 6 mg / 2 ml, injection, prefilled syringe or vial
3	X			X	X		Albuterol, 0.083%, 2.5 mg / 3 ml, inhalation, vial
3	X				X		Amiodarone, 150 mg / 3 ml, injection, vial
1	X			X	X		Aspirin, 81 mg, chewable, bottle
3	X				X		Atropine Sulfate, 1 mg / 10 ml, injection, prefilled syringe
1	X				X		Calcium Chloride, 10%, 1 gram / 10 ml, injection, prefilled syringe
1	X				X		Dextrose, 10%, 25 grams / 250 ml water OR 50 grams / 500 ml water, injection
1	X				X		Diphenhydramine HCl (Benadryl), 50 mg / 1 ml, injection, vial
3	X				X		Epinephrine (Adrenalin) 1:1,000 (1 mg / ml), injection, vial
6	X				X		Epinephrine 1:10,000 (0.1 mg / ml), injection, prefilled syringe
1	X				X	X	Fentanyl citrate (Sublimaze), 100 mcg / 2 ml, injection, vial
1	X				X		Glucagon (GlucaGen), 1 mg solvent with 1 ml solute (kit only), injection
1	X			X	X		Glucose Gel (Glutose 15), Net weight of gel 37.5 grams, oral, tube
2	X			X	X		Ipratropium bromide (Atrovent), 0.5 mg / 3 ml, inhalation, vial
2*	X				X	X	Midazolam (Versed), 10 mg / 2 ml, injection, vial
1	X				X		Ondansetron (Zofran), 4 mg / 2 ml, injection, vial
1	X				X		Ondansetron (Zofran), 4 mg, oral disintegrating tablet (ODT)
2	X			X	X		Naloxone (Narcan), 2 mg / 2 ml, injection, prefilled syringe
1	X				X		Nitroglycerin (Nitrostat), 0.4 mg, sublingual tablets, bottle
2	X				X		Sodium Bicarbonate, 8.4%, 50 mEq / 50 ml, injection, prefilled syringe
2	X				X		Tranexamic Acid (TXA), 1000 mg / 10 ml (1 gram), injection, vial
1			X		X**		Hydroxocobalamin (Cyanokit), 5 gram vial reconstituted with 200 ml of 0.9% Sodium Chloride, infusion

1							**Region 11 Approved Intramuscular (IM) Epinephrine Kit (containing at minimum):**
	X			X			*2 - Epinephrine (Adrenalin) 1:1,000 (1 mg / ml), vial*
	X			X			*2 - 23 gauge needle (1 inch)*
	X			X			*2 - Syringes, 1 ml*
	X			X			*2 - Alcohol wipes*
	X			X			*2 - Packages of 2X2 gauze bandages*
	X			X			*2 - Band-Aids*
	X			X			*1 - Measuring tape device*
		X	X	X			*1 - Pouch or small bag/container to hold kit contents*
		X	X	X			

*** ALS Non-Transport = 1**
****Ambulance Only**

AIRWAY & VENTILATION EQUIPMENT

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	
						AIRWAY MANAGEMENT
2 ea.	X			X	X	Airway, Oropharyngeal (Sizes: 0/50mm, 1/60mm, 2/70mm, 3/80mm, 4/90mm, 5/100mm)
1 ea.	X			X	X	Airway, Nasopharyngeal (Sizes: 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34 French)
1	X			X	X	i-gel Supraglottic Airway, Size 1 (Neonate)
1	X			X	X	i-gel Supraglottic Airway, Size 1.5 (Infant)
1	X			X	X	i-gel Supraglottic Airway, Size 2 (Pediatric - Small)
1	X			X	X	i-gel Supraglottic Airway, Size 2.5 (Pediatric - Large)
1	X			X	X	i-gel Supraglottic Airway O2 Resus Pack, Size 3 (Adult - Small)
1	X			X	X	i-gel Supraglottic Airway O2 Resus Pack, Size 4 (Adult - Medium)
1	X			X	X	i-gel Supraglottic Airway O2 Resus Pack, Size 5 (Adult - Large)
4	X			X	X	Water based lubricant (single packet)
1		X	X		X	Magill Forceps, Adult
1		X	X		X	Magill Forceps, Pediatric
						INTUBATION
1 ea.	X				X	Endotracheal Tube, sterile, cuffed (Sizes: 3.0 mm, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0)
1	X				X	Stylet, Adult
1	X				X	Stylet, Pediatric
2	X				X	Airway Tube Holder
2		X	X		X	Laryngoscope Handle, with fiber optic and/or LED light source (disposable)
1		X	X		X	# 1 Miller Straight Laryngoscope Metal Blade (disposable)
1		X	X		X	# 2 Miller Straight Laryngoscope Metal Blade (disposable)
1		X	X		X	# 3 Miller Straight Laryngoscope Metal Blade (disposable)
1		X	X		X	# 2 Macintosh Curved Laryngoscope Metal Blade (disposable)
1		X	X		X	# 3 Macintosh Curved Laryngoscope Metal Blade (disposable)
1		X	X		X	# 4 Macintosh Curved Laryngoscope Metal Blade (disposable)
						OXYGEN ADMINISTRATION
3	X			X	X	Nasal Cannula, Adult
3	X			X	X	Nasal Cannula, Pediatric
2	X			X	X	Non-Rebreather Mask, Adult
2	X			X	X	Non-Rebreather Mask, Pediatric
2	X			X	X	Simple Face Mask, Infant
						OXYGEN EQUIPMENT
1		X	X	X	X	Main (On-Board) Oxygen Cylinder (Size H, K or M)
4		X	X	X	X	Portable Oxygen Cylinder (Size D or E)
1		X	X	X	X	Oxygen Regulator Seal (O-Ring)
2		X	X	X	X	Adaptor for Oxygen Tubing (on-board and portable)
1		X	X	X	X	Oxygen Tank Key
1		X	X	X	X	Dial Flow Meter / Regulator for 25 LPM
						VENTILATION
1	X			X	X	Adult Size Bag-Valve-Mask Ventilation Unit, with transparent adult mask
1	X			X	X	Child Size Bag-Valve-Mask Ventilation Unit, with transparent child mask
1	X			X	X	Infant Size Bag-Valve-Mask Ventilation Unit, with transparent infant mask
1	X			X	X	Transparent Neonatal Mask
						SUCTION
2 each	X			X	X	Suction Catheters, sterile, single use with thumb suction control port (Sizes 6, 8, 10, 12, 14, 16, 18 French)
3	X			X	X	Semi-rigid Pharyngeal Suction Tips (Yankauer)
2	X			X	X	Suction Connecting Tubing
2		X	X	X	X	Suction Cannisters, 1000 ml (or larger)
1		X	X	X	X	Portable Suction Unit
1		X	X	X	X	Onboard Suction Device

AIRWAY & VENTILATION EQUIPMENT (CONTINUED)

OTHER

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	
2	X				X	Adapter for In-Line Nebulization, 22 mm to 14 mm I.D.
2	X				X	Adapter for In-Line Nebulization, 22 mm to 22 mm I.D.
1	X				X	CPAP Mask - Flow Safe II EZ Deluxe (adult)
2	X			X	X	Nebulizer (Acorn Type) with T-Piece Adapter, Oxygen Tubing, Mouthpiece and Flextube
1	X			X	X	Aerosol Mask, Adult (for nebulization)
1	X			X	X	Aerosol Mask, Pediatric (for nebulization)
2		X	X	X	X	Viral/Bacterial Filter (22 mm X 15mm / 22 mm OD)

ASSESSMENT EQUIPMENT

BLOOD PRESSURE

1		X	X	X	X	Blood Pressure Cuff, Large Adult
1		X	X	X	X	Blood Pressure Cuff, Adult
1		X	X	X	X	Blood Pressure Cuff, Child
1		X	X	X	X	Blood Pressure Cuff, Infant
2		X	X	X	X	Stethoscope
1		X	X	X	X	Pediatric Stethoscope
1		X	X	X	X	Gauge(s) for Blood Pressure Cuffs, appropriately calibrated

CARDIAC

1		X	X		X	Cardiac Monitor / Defibrillator with Spare Battery
1		X	X	X		AED with Adult and Pediatric Pads
1		X	X		X	Patient Cables: 4 lead and 12 lead
2		X			X	Rolls of ECG Paper
4	X				X	Electrodes, Monitoring, Adult, Set of 3
4	X				X	Electrodes, Monitoring, Pediatric, Set of 3
2	X			X	X	Zoll Adult CPR Stat Padz
2	X				X	Zoll One Step Pediatric CPR Padz
1		X	X	X		Zoll Pedi-padz II (Pediatric AED)
2	X			X	X	Disposable Razor

OTHER

1		X	X	X	X	Penlight
1		X	X	X	X	Glucometer with lancets, alcohol swabs, test strips, band-aids
1		X	X	X	X	Pulse Oximetry with Adult and Pediatric Sensors
6	X				X	Masimo Neonatal / Adult Pulse Oximeter Adhesive Sensor
1		X	X		X	CO Reusable Sensor
2	X				X	Microstream Advance Adult-Pediatric Intubated CO2 Filter Line

TRAUMA EQUIPMENT

DRESSINGS

2	X			X	X	Elastic Bandages, 4" (ACE Wrap)
2	X			X	X	Elastic Bandages, 6" (ACE Wrap)
1			X	X	X	Hyfin Vented Chest Seal - twin pack
10	X			X	X	Gauze, soft, self-adhering (4" x 5 yards) - Kerlix
20	X			X	X	Gauze Pads, 4" x 4", sterile
6	X			X	X	ABD Dressings, 5" x 9"
2	X			X	X	Vaseline Gauze, 4" x 6" or 3" x 9"
6	X			X	X	Trauma Dressing (12" x 30")
2		X	X	X	X	Burn Sheets, individually wrapped
2	X			X	X	Adhesive Tape Roll, 1"
2	X			X	X	Adhesive Tape Roll, 2"

TRAUMA EQUIPMENT (CONTINUED)

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	
						HEMORRHAGE CONTROL
2			X	X	X	Pressure Dressing 6" (Emergency Trauma Dressing or Israeli Bandage)
2			X	X	X	Pressure Dressing 4" (Emergency Trauma Dressing or Israeli Bandage)
2	X			X	X	Tourniquet - CAT
2			X	X	X	Quickclot EMS Rolled Gauze Hemostatic Dressing or Combat Gauze
						SPLINTING
1	X			X	X	Leg Traction Device, Adult Size, (Hare or approved similar device)
1	X			X	X	Leg Traction Device, Pediatric Size, (Hare or approved similar device)
2		X	X	X	X	Extremity Splints, Adult, Long (moldable - SAM or equivalent)
2		X	X	X	X	Extremity Splints, Adult, Short (moldable - SAM or equivalent)
2		X	X	X	X	Extremity Splints, Pediatric, Long (moldable - SAM or equivalent)
2		X	X	X	X	Extremity Splints, Pediatric, Short (moldable - SAM or equivalent)
5	X			X	X	Triangle Bandage or Arm Slings
						EXTRICATION
2	X			X	X	Long Spine Board, with 3 sets of torso straps
2				X	X	Spider Straps (or similar device)
2	X			X	X	Cervical Collar, Adult, Adjustable (either StifNeck Select by Laerdal or Ambu)
2	X			X	X	Cervical Collar, Pediatric, (either StifNeck Select by Laerdal or Ambu)
1	X			X	X	Cervical Collar, Infant (if pediatric collars are non-adjustable)
2	X			X	X	Blanket Rolls or Disposable Head Immobilization Device
1	X			X	X	KED Device, straps, case
						OTHER
2000ml	X			X	X	Sterile Solution (Normal Saline) for Irrigation, plastic bottles for a total of 2,000 ml
1	X			X	X	Sterile water (for drinking), plastic bottle, 1000 ml
1		X	X	X	X	Trauma Shears
1		X	X	X	X	Triage Tags, (Disaster Tags), SMART, package
1		X	X	X	X	Region 11 Modified START/JumpSTART Triage Algorithm Card (current version: 2020)
2	X				X	ARS (Air Release System) Kit or 14 gauge X 3.25" angiocatheter
2	X				X	16 - 18 gauge X 1.5 - 2 inch, catheter-over-needle device (for pediatric pleural decompression)

MEDICATION ADMINISTRATION

						INTRAVENEOUS
4	X				X	0.9% Sodium Chloride IV Solution, plastic bag, 1000 ml
4	X				X	IV Tubing, Macrodrip, 10 drops/mL, needleless connector and split septum port
4 ea.	X				X	IV Catheter (14, 16, 18, 20, 22, 24 gauge), catheter-over-needle device, 1 - 2 inches
5	X				X	Saline Locks
2	X				X	Needleless Hub Device
5	X				X	Needles, 18 Gauge x 1.5 inch
5	X				X	Needles, 23 Gauge x 1 inch
5	X				X	Needles, 23 Gauge x 1.5 inch
5	X				X	Needles, 25 Gauge x ⅝ inch
2	X				X	Syringes, 1 ml
2	X				X	Syringes, 3ml
2	X				X	Syringes, 10 ml
2	X				X	Padded Armboards
2	X				X	Tourniquets
1	X			X	X	Box of Alcohol Prep Pads, disposable
1	X			X	X	Box of Band-Aids, 1" width
5	X				X	IV Dressing (Tegaderm or similar type)
2		X	X	X	X	IV Holders or Hooks, such as: ceiling mounted or perko clips
3	X				X	Saline Flush - 0.9% Sodium Chloride Injection, 10 mL, pre-filled syringe

MEDICATION ADMINISTRATION (CONTINUED)

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	
						INTRAOSSEOUS
1		X	X		X	EZ-IO Driver
1	X				X	EZ-IO Needle, Pink (15mm) + Stabilizer Kit
2	X				X	EZ-IO Needle, Blue (25 mm) + Stabilizer Kit
1	X				X	EZ-IO Needle, Yellow (45mm) + Stabilizer Kit
						OTHER
2	X			X	X	Mucosal Atomization Device (MAD)
1	X				X	Buretrol Infusion Set

OBSTETRIC / PEDIATRIC EQUIPMENT

2	X			X	X	Obstetrical kit, sterile - with bulb syringe
1	X			X	X	Infant hat or head cover
1	X			X	X	Gloves, Sterile, Pair, Size 7 or 7.5
1	X			X	X	Gloves, Sterile, Pair, Size 8 or 8.5
1	X			X	X	Silver Swaddler or baby bunting mylar blanket
1		X	X		X	Region 11 EMS Pediatric Resuscitation Chart (current version: 2023)
1		X	X		X	Broselow Tape (current version: 2019) OR Dose by Growth Tape (current version: 2020)

PERSONAL PROTECTIVE EQUIPMENT (PPE)

1	X		X	X	X	Gloves, Non-Sterile, disposable, box
2	X		X	X	X	Isolation Gowns, Long Sleeve
2	X		X	X	X	N-95 Masks, NIOSH Approved
10	X		X	X	X	Face Mask (Surgical), disposable
2		X	X	X	X	Safety Glasses, Splash Protective (or) Goggles

INFECTION CONTROL EQUIPMENT

1	X			X	X	BioHazard Bag
1		X	X	X	X	Paper Towels, roll or package of C-fold type
1		X	X	X	X	Sharps Container, puncture resistant
1		X	X	X	X	Hand Sanitizer
1	X			X	X	Topical Germicide, bottle

PATIENT TRANSPORT EQUIPMENT

1		X	X	X	X	Patient Stretcher, with 3 sets of straps and over-shoulder straps
1		X	X	X	X	Chair Stretcher, with 3 sets of straps
1		X	X	X	X	Scoop Stretcher, including manufacture required safety restraints
1		X	X	X	X	Pediatric Specific Restraint System or Age/Size Appropriate Car Safety Seat
2	X			X	X	Cot Sheets
2	X			X	X	Blankets
4		X	X	X	X	Restraints (two pair, arm and leg, for four-point restraint)

COMMUNICATION EQUIPMENT

1		X	X	X	X	Ambulance to Hospital Radio Communication Capability
1		X	X	X	X	Cellular Telephone
1		X	X	X	X	Electronic Patient Care Report Documentation Device
10		X	X	X	X	Paper Documentation Back-Up (Region 11 EMS approved form)
1		X	X	X	X	UHF Portable Radio with Carrying Case and Remote Speaker / Microphone

OTHER EQUIPMENT

No. of Items	Hospital Replacement	Provider - Private Replacement	Provider - CFD Replacement	BLS	ALS	
1		X	X	X	X	Body Bag, disposable
1	X			X	X	Bedpan
6	X			X	X	Cold Packs
6	X			X	X	Convenience Bags OR Emesis Basin
1	X			X	X	Facial Tissue, box
2		X	X	X	X	Fire Extinguishers (5 lbs)
1		X	X	X	X	Flashlight w/Batteries
2	X			X	X	Hot Packs
1		X	X	X	X	Medication Administration Cross Check (MACC) Card (current version: 2022)
1		X	X	X	X	Sign / Sticker, IDPH "Complaint Hotline"
1		X	X	X	X	Sign / Sticker, "Illinois Poison Center"
1		X	X	X	X	Sign / Sticker, "No Smoking"
1		X	X	X	X	Sign / Sticker, "Seat Belt Required"
1		X	X	X	X	Sign / Sticker, IDOT "Safety Inspection" on windshield
1		X	X	X	X	Region 11 EMS Protocols, Policies and Procedures - Electronic Access
1	X			X	X	Urinal
1		X	X	X	X	Wrecking bar (24" minimum)

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Reporting Abused and Neglected Patients
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

REPORTING ABUSED AND NEGLECTED PATIENTS

I. PURPOSE

To identify patients who are victims of abuse and neglect (including children, adults, adults age 60 and over, and those with disabilities) and to provide guidelines for prompt treatment and appropriate referral to support services.

II. DEFINITIONS

A. Physical Abuse: Intentional bodily harm or injury.

B. Sexual Abuse: Any act of sexual contact that a person suffers from, submits to, participates in, or performs as a result of force, violence, threats, fear, deception or without having legally consented to the act.

C. Psychological Abuse: Provoking a fear of violence. This includes name calling, verbal assaults, or violent behaviors such as hitting inanimate objects.

D. Neglect: Failure of a parent or caretaker to meet "minimal standards" for providing adequate supervision, food, clothing, medical care, shelter or other basic needs.

E. Domestic Violence**:** A pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship. Can also be referred to as intimate partner violence (IPV), dating abuse, or relationship abuse.

F. Child Abuse or Neglect**:** Mistreatment of a child under 18 years old by a parent, caregiver, relative or any person responsible for the child's welfare.

G. Mandated Reporter: An individual required by law to report cases of abuse or neglect when they have reasonable cause to believe that a child, an adult age 60 or over, or someone with a disability who otherwise is not capable of reporting the abuse or neglect themselves, know to them in their professional capacity may be abused or neglected. EMS personnel are considered mandated reporters under Illinois law.

H. Human Trafficking: Involves the use of force, fraud, or coercion to obtain some type of labor or commercial sex act, or in which the person performing the commercial sex act is under 18 years of age.

III. POLICY

A. Suspected Child Abuse or Neglect

1. Under the Illinois Abused and Neglected Child Reporting Act, all EMS personnel are considered "mandated reporters" and are therefore ***required*** to report cases of

suspected child abuse or neglect to the Illinois Department of Children and Family Services (DCFS). State law protects the confidentiality of reporters and any mandated reporter acting in good faith shall be granted immunity from civil liability. However, any mandated reporter who fails to report suspected child abuse or neglect may be subject to legal penalties.

2. Reporting of cases of suspected child abuse or neglect should be done as soon as possible through the **DCFS Child Abuse and Neglect Hotline at 1-800-25-ABUSE**.

3. Guidelines for identifying suspected child abuse and neglect:

    a. Discrepancy between history of injury and physical exam.
    b. Prolonged interval between injury and the seeking of medical help.
    c. History/suspicion of repeated trauma.
    d. Parents or guardians respond inappropriately or do not comply with or refuse evaluation, treatment or transport of child.
    e. A child who does not seek comfort from parents or guardians.
    f. Poor nutritional status.
    g. Environment that puts the child in potential risk.

4. The following injuries are physical signs that should raise the suspicion of child abuse and indicate the need for more investigation:

    a. Perioral and perinasal injuries
    b. Fractures of long bones in children under three years of age
    c. Multiple soft tissue injuries
    d. Frequent injuries such as old scars, multiple bruises and abrasions in varying stages of healing
    e. Injuries such as bites, cigarette burns, rope marks
    f. Trauma to genital or perianal areas
    g. Sharply demarcated burns in unusual areas

5. Treatment of Suspected Child Abuse/Neglect

    a. Treat obvious injuries.
    b. If the parent or guardian refuses to let you treat and/or transport the child, remain at the scene. Contact OLMC and request police assistance. Request that the officer place the child in protective custody and assist with transport.
    c. A law enforcement officer, physician or a designated Department of Children and Family Services (DCFS) employee may take or retain temporary protective custody of the child.

B. Suspected Abuse or Neglect of Adults Age 60 Older and People With Disabilities

1. Under the Illinois Adult Protective Services Act, all EMS personnel are considered "mandated reporters" and are therefore ***required*** to report cases of suspected abuse or neglect of adults age 60 or older or people with disabilities age 18-59, if they believe that the adult is not capable of reporting the abuse or neglect themselves. State law protects the confidentiality of reporters and any mandated reporter acting in good faith shall be granted immunity from civil liability. However, any mandated reporter who fails to report the suspected abuse or neglect may be subject to legal penalties.

2. Reporting of suspected abuse or neglect:

    a. To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18-59 **call the statewide, 24-hour Adult Protective Services Hotline: 1-866-800-1409.**
    b. For residents who live in nursing facilities, **call the Illinois Department of Public Health's Nursing Home Complaint Hotline: 1-800-252-4343.**
    c. For residents who live in Supportive Living Facilities (SLFs), **call the Illinois Department of Healthcare and Family Services' SLF Complaint Hotline: 1-800-226-0768.**

3. If there is reason to believe that an adult patient has been abused or neglected, EMS personnel shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.

C. Suspected Domestic Violence or Abuse

1. EMS personnel and other mandated reporters are **not** required by law to report suspected cases of domestic violence or abuse to adult patients. However, under the Illinois Domestic Violence Act all EMS personnel are required by law to provide immediate and adequate information regarding services available to victims of suspected domestic violence or abuse.

    a. National Domestic Violence Hotline: 1-800-799-SAFE (https://www.thehotline.org/)
    b. Illinois Domestic Violence Hotline: 1-877-863-6338 (https://the-network.org/knowledge-center/#availableResources)
    c. Chicagoland Domestic Violence Hotline: 1-877-863-6338 (https://www.chicago.gov/city/en/depts/fss/provdrs/dom_violence/svcs/domestic_violencehelpline.html)

2. If there is a reason to believe a patient is a victim of domestic violence and/or abuse, the Paramedic/EMT shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.

D. Human Trafficking

1. Recognize the key indicators of human trafficking which include:

    a. Does the person appear disconnected from family, friends, community organizations, or houses of worship?Has a child stopped attending school?
    b. Has the person had a sudden or dramatic change in behavior?
    c. Is a juvenile engaged in commercial sex acts?
    d. Is the person disoriented or confused, or showing signs of mental or physical abuse?
    e. Does the person have bruises in various stages of healing?
    f. Is the person fearful, timid, or submissive?
    g. Does the person show signs of having been denied food, water, sleep, or medical care?
    h. Is the person often in the company of someone to whom he or she defers? Or someone who seems to be in control of the situation, e.g., where they go or who they talk to?
    i. Does the person appear to be coached on what to say?
    j. Is the person living in unsuitable conditions?
    k. Does the person lack personal possessions and appear not to have a stable living situation?
    l. Does the person have freedom of movement? Can the person freely leave where they live? Are there unreasonable security measures?
2. Not all indicators listed above are present in every human trafficking situation, and the presence or absence of any of the indicators is not necessarily proof of human trafficking.

3. Reporting suspected human trafficking

    a. **Do not attempt to confront a suspected trafficker directly or alert a victim to your suspicions.** Your safety, as well as the victim's safety, is paramount.
    b. Contact local law enforcement directly or call the confidential tip line at:**1-866-DHS-2-ICE (1-866-347-2423)** to report suspicious criminal activity to the U.S. Immigration and Customs Enforcement (ICE) Homeland Security Investigations (HSI) Tip Line 24 hours a day, 7 days a week, every day of the year.
    c. **The National Human Trafficking Hotline (NHTH) number is 1-888-373-7888 or can be accessed by texting HELP or INFO to BeFree (233733).** The NHTH can help connect victims with service providers in the area and provides training, technical assistance, and other resources. The NHTH is a national, toll-free hotline available to answer calls from anywhere in the country, 24 hours a day, 7 days a week, every day of the year. The NHTH is not a law enforcement or immigration authority and is operated by a nongovernmental organization funded by the Federal government.

E. Documentation

1. EMS personnel shall report suspicions of abuse or neglect to the Emergency Department physician and/or charge nurse and/or police and document on the patient care report.

2. Clearly document history and physical findings, environmental surroundings, patient interaction with others on scene, and discrepancies in the history.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Restraints
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: August 1, 2018

RESTRAINTS

I. Hard or soft restraints may be used only as a therapeutic measure to prevent a patient from causing physical harm to self or others. In no event shall restraints be utilized to punish or discipline a patient.

II. Procedure

A. At no point, should the EMS personnel place themselves in danger. Additional manpower or police backup should be requested as needed.

B. EMS personnel may initiate application of restraints when appropriate.

C. Document the reason for the initiation of restraints on the patient care report.

D. Apply restraints:

1. Necessary force (minimum required) can be applied to neutralize the amount of force exerted by the patient. All attempts should be made to avoid injury to the patient and EMS personnel.

2. The patient must never be restrained in prone position.

3. Full restraint requires the application of a restraint to each limb.

E. The patient must be observed constantly by a paramedic or EMT-B while restrained.

F. Document neurovascular status to all extremities after application and every 15 minutes thereafter.

G. Handcuffs are to be applied by police officers **ONLY**. When the transportation of a patient who is hand cuffed is required, the police officer who has the key to the handcuffs must remain with the patient at all times.

Reference:

"Mental Health and Development Code", Illinois Revised Statue 1983, Chapter 91 1/2. Section 2-108; 2-109; and 2-201 (and its amendments).

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Safe Transport of Children by EMS
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

SAFE TRANSPORT OF CHILDREN BY EMS

I. PURPOSE

A. To define the safe transport of children by EMS personnel in a ground ambulance.

B. To prevent forward motion and possible ejection with a primary focus to secure the torso; and provide support for the head, neck, and spine of all children transported by ambulance.

II. DEFINITIONS

A. Child Restraint System (CRS): Any device (including child safety seat, booster seat, or harness) that is designed for use in a motor vehicle to restrain, seat, or position children who weigh 65 pounds (30 kilograms) or less and are certified to the federal motor vehicle safety standard prescribed by the National Highway Traffic Safety Administration for child restraints.

B. Spinal Motion Restriction (SMR): Attempting to maintain the head, neck, and torso in anatomic alignment and independent from device use.

III. POLICY

A. EMS provider agencies in the Region 11 Chicago EMS System that transport children should develop specific policies and procedures to address the methods, training (initial and continuing), and equipment to safely transport children.

B. There are specific considerations for varied situations when a child needs transport to a hospital including:

1. Uninjured and not ill
2. Ill or injured, but requiring no intensive interventions or monitoring
3. Requiring intensive interventions or monitoring
4. Requiring spinal motion restriction and/or lying flat
5. Multiple patients

C. No children should be transported unrestrained (such as held in arms or lap).

D. No children should be transported on the bench seat.

E. When the number of patients exceeds the ability to provide adequate care with existing EMS providers and ambulances, or to secure child patients as described in the following recommendations, EMS providers should request additional transportation resources that can respond in a timely manner.

IV. **TRANSPORT SITUATIONS**

A. Uninjured and Not Ill

1. When EMS has an injured or ill parent, guardian, or caregiver who needs transportation to the hospital with uninjured and not ill children on scene – it is best to leave the child in the care of a responsible adult.

2. If the child needs to accompany the patient to the hospital, transport the child with appropriate child restraint system depending on the age and size of the child.

B. Injured or Ill

1. Requiring No Intensive Interventions or Monitoring

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.

2. Requiring Intensive Interventions or Monitoring

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.
   b. If the child's condition requires medical interventions, which requires the removal of some restraints, the restraints should be re-secured as quickly as possible as soon as the interventions are completed and it is medically feasible to do so.

3. Requiring Spinal Motion Restriction and/or Lying Flat

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.
   b. Apply a pediatric cervical collar or use towel rolls to stabilize neck and torso movement.

C. Multiple Patients

1. If possible, for multiple patients, transport each as a single patient according to the guidance shown for the above transport situations.

2. For mother and newborn, transport the newborn in an approved size-appropriate child restraint system. The mother should be properly secured to the cot.

3. A child passenger, especially a newborn, must never be transported on an adult's lap. Newborns must always be transported in an appropriate child restraint system. Never allow anyone to hold a newborn during transport.

V. CHILD RESTRAINT SYSTEMS

A. The device(s) should cover, at minimum, a weight range of between five (5) and 99 pounds (2.3 - 45 kg), ideally supporting the safest transport possible for all persons of any age or size.

B. Only the manufacturer's recommendations for the weight/size of the patient should be considered when selecting the appropriate device for the specific child being transported.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: SEMSV EMS Bus Program
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: August 15, 2024

SEMSV (SPECIALIZED EMS VEHICLE) EMS BUS PROGRAM

I. PURPOSE

A. To describe a SEMSV (Specialized EMS Vehicle) Program for an EMS Bus serving the City of Chicago and Region 11, as licensed under the University of Chicago - Chicago South EMS System, per IDPH regulations.

B. To ensure proper medical oversight of patient care and transportation for a SEMSV (Specialized EMS Vehicle) Program.

II. DEFINITIONS

A. SEMSV**:** A "Specialized Emergency Medical Services Vehicle" (SEMSV) is a vehicle or conveyance that is not an ambulance as defined in the EMS Act, but is primarily intended to provide emergency care and transportation to ill or injured patients by means of air, water, or ground transportation.

B. SEMSV Program: A program operating within an EMS System, pursuant to a program plan, submitted to and certified by IDPH, using specialized emergency medical services vehicles to provide emergency care and transportation to ill or injured persons.

C. SEMSV/EMS System Medical Director: The physician who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part of.

D. EMS Bus: A vehicle with capacity to transport up to eleven patients secured supine on a litter or stretcher and six seats for accompanying EMS personnel, equipped with medication and supplies for patient care.

III. POLICY

A. Per IDPH Administrative Code Section 515.920, *SEMSV Program Licensure Requirements for all Vehicles:*

1. The SEMSV should be available 24 hours per day, every day of the year except when service is committed to another medical response or unavailable due to maintenance requirements.

2. The SEMSV Program shall provide prehospital emergency services within its service area on a per-need basis without regard to the patient's ability to pay for the service.

3. The SEMSV Program shall be supervised and managed by a Medical Director, who shall be a physician with appropriate experience in EMS.

B. SEMSV Resource Description

1. The SEMSV EMS Bus is a Chicago Fire Department resource named “8-8-12”.

2. The SEMSV EMS Bus is maintained and operated by the Division of EMS Logistics, who is responsible for daily inventory and restocking of the medication, equipment, and supplies.

3. The SEMSV EMS Bus will be dispatched through the Office of Emergency Management and Communication (OEMC) for any large incident at the level of an EMS Plan 2 or above, or as requested by the Chicago Fire Department Incident Commander.

4. The SEMSV EMS Bus will be driven to the incident or planned event by personnel from the Division of EMS Logistics and remain with the bus while deployed.

5. The EMS Bus shall be operated by personnel with a valid Illinois Class B non-CDL (Commercial Driving License).

6. The SEMSV EMS Bus is a resource under the Mutual Aid Box Alarm System (MABAS) agreement.

C. SEMSV Utilization

1. Primary Utilization

   a. The SEMSV EMS Bus will primarily be utilized as a staged resource for planned special events.
   b. The SEMSV EMS Bus may be used for patient care or warming and cooling of individuals.

2. Secondary Utilization

   a. The SEMSV EMS Bus will secondarily be utilized as an additional resource for large incidents.
   b. The SEMSV EMS Bus should be utilized as a stationary patient care area near a casualty collection point.
   c. In the event of an incident beyond an EMS Plan 3, the SEMSV EMS Bus may be used for appropriate patient transport, as defined in this policy.

IV. PRIMARY UTILIZATION – PLANNED SPECIAL EVENTS

A. Staffing

1. At a minimum, two paramedics will be assigned to the unit for patient care.

2. Additional EMS personnel may be assigned as needed.

B. Patient Flow

1. All individuals requesting or potentially needing medical evaluation or treatment are considered patients and require a full assessment and documentation on a patient care report.

2. If a patient that is initially evaluated on the SEMSV EMS Bus needs additional medical care or hospital transport, the EMS personnel on the SEMSV EMS Bus will request an ambulance and transfer patient care.

C. Medical Direction

1. The SEMSV shall be listed on the IDPH Special Event form for review by the EMS System.

2. Patient contacts should be assessed and treated, with the appropriate contact with Online Medical Control, per Region 11 Policy.

V. SECONDARY UTILIZATION – LARGE INCIDENT RESPONSE

A. Staffing

1. At a minimum, two paramedics will be assigned to the unit for patient care.

2. As the incident evolves, additional EMS personnel may be added to maintain adequate patient staffing.

3. There will be one paramedic for every two yellow patients and one paramedic for every four green patients. Patients that are triaged red should be prioritized for treatment and transport by ambulance.

B. Patient Flow

1. The SEMSV EMS Bus may be staged near a casualty collection point for stationary patient care.

2. All patients should receive a primary triage based on the Region 11 Modified START/JumpSTART Triage Algorithm. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

   a. Red “Immediate”: Obvious threat to life or limb and requires immediate medical attention.
   b. Yellow “Delayed”: Condition in need of definitive medical care, but is not likely to decompensate rapidly if care is delayed, these patients may not be ambulatory.
   c. Green “Minimal”: Minor injuries and can tolerate extended delays in treatment without increasing the risk of mortality, these patients are ambulatory.
   d. Black “Deceased”: No respirations following basic airway maneuvers.

3. SMART triage tags should be used for patient identification and tracking.

4. Patients that have a primary triage category of green or yellow may be moved from the Casualty Collection Point (CCP) to the SEMSV EMS Bus. Patients that have a primary triage category of red will move from the CCP to an ambulance for transport.

5. Patients that enter the SEMSV EMS Bus can be assessed in seats or supine in litters.

6. Each patient should have a secondary triage with a complete assessment in the SEMSV EMS Bus.

7. Patients should be assessed for any Trauma Field Triage Criteria (per Trauma Patient Destination Policy).

8. Patients that meet any of the Region 11 Trauma Field Triage Criteria or on reassessment require an upgrade in care should be transferred to an ambulance for transport to the hospital.

9. Documentation of the initial vital signs, assessment, and interventions should be on SMART triage tags or verbally provided to another equal or higher level EMS provider if there is a transfer of patient care.

C. Transport Considerations

1. Trauma Patients should have the Trauma Field Triage Criteria applied (per policy) to identify critical patients requiring transport to a Level 1 Trauma Center.

   a. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged “Red” and be transported to the appropriate Level 1 Trauma Center.
   b. Patients that meet **Mechanism of Injury** or **High-Risk Populations** criteria should be triaged “Yellow” and be transported to the appropriate Level 1 Trauma Center.

2. Patients that meet Region 11 Trauma Field Triage Criteria should be transported by ambulance to Level 1 Trauma Centers.

3. In the event of an EMS Plan 3, the SEMSV EMS Bus may be used as a transportation resource for yellow or green tag patients that are ambulatory and do not meet Region 11 Trauma Field Triage Criteria, and require transportation to the closest appropriate hospital.

D. Medical Direction

1. The ranking EMS Chief on scene will determine the need to use the SEMSV EMS Bus as a transportation resource as per this policy.

2. The Command Hospital for the incident will be notified on the use of the EMS Bus by the EMS Chief or the EMS Communications Officer on scene.

3. The EMS Communications Officer or highest-ranking paramedic on the EMS Bus will provide a brief report of individual patient information including assessment findings, treatment provided, and triage category to the Command Hospital.

4. The Command Hospital, in consultation with the EMS Communications Officer or highest-ranking paramedic on the EMS Bus and/or the Regional Hospital Coordinating Center (RHCC) as indicated, will determine transport destination.

5. Patient distribution from the EMS Bus will optimally be divided between the two most appropriate hospitals for low acuity patients to not overwhelm one hospital.

6. The Command Hospital will provide an initial notification to the receiving hospital(s) regarding the SEMSV EMS Bus transport, including patient information and estimated time of arrival.

7. The highest-ranking transporting paramedic will provide the receiving hospital with a brief, updated pre-notification report of the patients transported to that facility, stating that the patients are from an EMS Plan response.

8. The highest-ranking transporting paramedic will contact the Command Hospital as required for any changes in patient condition during transport.

VI. EQUIPMENT AND MEDICATIONS

A. Patient Stations: There are 11 individual patient stations which include:

1. Supine litter with two safety belts (10) or secured stretcher (1) with safety belts

2. Oxygen wall unit

3. Suction canister with tubing and catheters

4. Cardiac monitoring:

   a. Each station has an AED Pro with 4 lead cables
   b. Each unit with adult and pediatric pads

5. Vital sign assessment:

   a. Blood pressure cuff
   b. Stethoscope
   c. Pulse oximeter

B. Patient Assessment Area: There are 2 seats near the rear of the EMS Bus used for patient assessment and monitoring only and not for transport which include:

1. Oxygen wall unit
2. Suction canister with tubing and catheters
3. Cardiac monitor/defibrillator
4. Vital sign assessment

C. Equipment/Supplies

1. Quick Response Bags (QRB):

   a. Four adult bags
   b. Two pediatric bags

2. Large Traumatic Injury (TTI) Bag

3. Cabinets with additional supplies:

   a. Oxygen administration
   b. Hemorrhage control
   c. Splinting
   d. Cervical collars

D. Medications

1. Six complete medication boxes, per Region 11 ALS list.

2. Three secured boxes for controlled substances.

E. Conveyance Devices

1. Each litter is removable from the wall brackets.
2. One stretcher is secured inside the bus for conveyance of patients inside and out of the EMS Bus.

VII. PATIENT TREATMENT PROTOCOLS AND POLICIES

A. Patient care on the SEMSV EMS Bus shall follow all Region 11 EMS Protocols, Policies, and Procedures as defined in this section.

B. Patient Age:

1. The SEMSV EMS Bus can treat patients of all ages.

2. Prior to transportation, all patients must be secured appropriately with safety belts.

C. Management of Multiple Patient Incidents (MPI) Policy

1. For large incidents, each patient should have a primary and secondary triage assessment performed and a triage tag applied.

2. **EMS Plan Response**: The number of patients exceeds routine operational capacity of a Multiple Patient Incident, wherein dispatch of additional resources is required to **provide normal levels of care and transportation**. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a subsequent complete assessment and patient care per Region 11 Protocols and Policies.

3. The SEMSV EMS Bus may be used as an additional transport vehicle resource for low acuity and ambulatory patients at an EMS Plan 3 or larger incident.

4. **Mass Casualty Incident**: The number of patients or type of situation has overwhelmed the operational ability of the provider, wherein the number of patients and nature of their injuries make the normal prehospital level of stabilization and care unachievable, and/or available resources are insufficient to manage the scene under normal operating procedures.

D. Trauma Patient Destination Policy

1. Patients shall have a full assessment performed prior to transport.

2. Patients transported on the SEMSV EMS Bus shall not meet any Region 11 Trauma Field Triage Criteria.

E. Conveyance of Patients Policy

1. Patients should be appropriately conveyed into the EMS Bus by stair chair or stretcher, up the ramp and into the rear door of the vehicle.

2. Patients should be carefully transferred to the litters, maintaining any spinal motion restriction as indicated.

3. Patients should be secured with safety belts prior to transport.

4. Paramedics should be seated with safety belts prior to transport.

F. Spinal Care Protocol and Spinal Motion Restriction (SMR) Procedure

1. Patients should be assessed for spinal injury as per Spinal Care Protocol.

2. Patients requiring spinal motion restriction should be secured to and transported to an ambulance stretcher or litter with cervical collar in place.

G. Controlled Substance Requirements Policy

1. Controlled substances will be stored at EMS Logistics.

2. On deployment of the SEMSV EMS Bus, the controlled substance box will be moved to a locked cabinet on the bus.

3. When the controlled substances are removed from the locked cabinet, the medications should always remain under the Paramedic's direct supervision.

H. Consent and Refusal of EMS Service Policy

1. Patients should be assessed for decision making capacity.

2. Refusals should be called into Online Medical Control, per regional policy.

I. Medical Records Documentation and Reporting Policy

A. An individual patient care report shall be completed for each patient that receives medical care from EMS personnel on the SEMSV EMS bus.

VIII. TRAINING

A. EMS personnel will receive training on this Region 11 Policy and any corresponding Chicago Fire Department policy on the SEMSV EMS Bus 8-8-12.

B. Only personnel that have completed the training shall perform patient care on the SEMSV EMS Bus.

IX. QUALITY ASSURANCE

A. Each deployment of the SEMSV EMS bus will be reviewed by the MARC Division, EMS Operations, and the SEMSV/EMS System Medical Director.

B. For every time the SEMSV EMS Bus is deployed, a QA/QI report will be completed post deployment and submitted to the EMS System and IDPH. The report will include the number of patients, patient symptoms, treatment provided, disposition, issues and resolutions, and identified opportunities for improvement and training.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: School Incidents with Minor Patients
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

SCHOOL INCIDENTS WITH MINOR PATIENTS

I. In situations of a report of suspicious illnesses (multiple ill or injured children, i.e., fumes, food poisoning) at a school facility, EMS personnel will assess and treat patients as follows:

A. **Category I:** Patients in facility with actual exposure and one or more children having complaints of illness and/or injury

1. Patients will be assessed and treated according to the Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without complaints will be managed as in Category II.

B. **Category II**: Patients in facility with potential exposure/actual exposure and no complaints

1. Document on PCR.

2. The school representative will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

C. **Category III**: Patients in facility with no direct exposure and/or complaints

1. Document on PCR.

2. The school representative will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

II. In situations of a motor vehicle collision involving a school bus with children on board, EMS personnel will assess and treat patients as follows:

A. **Category I:** A significant mechanism of injury occurred where one or more children have injuries

1. Injured patients will be assessed and treated according to the Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without injuries will be managed as in Category III.

B. **Category II:** No mechanism of injury exists that can be reasonably expected to cause significant injuries. There may be patients with minor injuries.

1. Injured patients will be assessed and treated according to Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without complaints will be managed as in Category III.

C. **Category III:** No mechanism of injury exists that can be reasonably expected to cause injury and the patients have no complaints

1. Document on PCR.

2. The school representative and/or bus driver will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Termination of Resuscitation
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 1, 2022

TERMINATION OF RESUSCITATION

I. Termination of Resuscitation may be considered in the following circumstances:

A. Adult (≥ 18 years of age) patient in cardiac arrest (unresponsive, pulseless, apneic)

1. Excludes traumatic arrest, possible hypothermia, and pregnant patients.

2. No other reversible cause of cardiac arrest identified.

3. No return of spontaneous circulation has been achieved after at least 20 minutes of prehospital resuscitation as per Cardiac Arrest Management (ICCA) Protocol – BLS/ALS.

B. Initial rhythm is asystole or pulseless electrical activity (PEA).

1. Confirmed in two different leads.

2. For patients in PEA, bradycardic rhythms with a wide QRS complex are more consistent with terminal cardiac rhythms. Faster, narrow QRS complex rhythms may indicate ROSC.

C. IV or IO access is established.

1. Epinephrine 1 mg IV every 5 minutes.

2. 3 total doses of Epinephrine have been administered.

D. Advanced airway established.

1. Supraglottic airway or endotracheal tube.

E. End Tidal CO2 (ETCO2) capnography attached with number and waveform reading.

1. ETCO2 values persistently less than 10 mmHg or decreasing (downward trend) of more than 25% despite resuscitation indicate a poor prognosis.

II. If all of the above criteria are met:

A. Contact Medical Control

B. Request termination of resuscitation from ECP or ECRN.

C. If order for termination approved, terminate resuscitation

D. If order for termination not approved, continue resuscitation or plan for transport as per

discussion with ECP or ECRN.

III. If the order for termination is approved and the deceased is in ***a home or private residence*:**

A. Notify family members of death and provide grief counseling as appropriate per Death Notification Procedure – BLS/ALS, using the GRIEV_ING method.

B. Contact Chicago Police Department (if not already present on scene).

C. Give relevant information to the police officer on scene.

D. Police will assume custody of body and arrange body aftercare with either the Cook County Medical Examiner or with the family and a private funeral home.

IV. If the order for termination is approved and the deceased is in ***a public place or unsafe scene, CPD should be called to take custody of the body.*** *In the rare circumstance where* transport is needed, transport the patient to the closest comprehensive emergency department. The base station should notify the receiving hospital that they are receiving a patient whose resuscitation was terminated in the field.

V. If the order for termination is approved and the deceased is ***in a healthcare facility*** (i.e. nursing home, hospice, rehabilitation hospital), no transport is required and body aftercare will be assumed by the facility.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Use of Latex-Free Supplies
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

USE OF LATEX-FREE SUPPLIES

I. PURPOSE

To define use of latex-free supplies during EMS patient care.

II. DEFINITIONS:

A. Latex: Refers to natural rubber latex, the product manufactured from a milky fluid derived from the rubber tree, *Hevea brasiliensis*.

B. Latex Allergy: A reaction to certain proteins in latex rubber.

III. POLICY:

A. Many medical products or devices such as catheters, gloves, adhesive tape, and syringes are made of latex and can trigger an allergic reaction in sensitive individuals.

B. When possible, EMS should use latex free products including gloves.

C. Ask patients about latex allergy or check medical alert bracelets.

D. Latex allergy symptoms range from skin irritation to life-threatening anaphylaxis.

E. Treat latex allergy as per the Anaphylaxis and Allergic Reaction Protocol.

Reference: Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health (NIOSH), Latex Allergy A Prevention Guide, https://www.cdc.gov/niosh/docs/98-113/

REGION 11
CHICAGO EMS SYSTEM
POLICIES

TRANSPORTATION

Burn Patient Destination
Cardiac Arrest Patient Destination
Critical Airway
Ebola Virus Disease – Viral Hemorrhagic Fever (EVD-VHF) Patient Destination
EMS Transport of Law Enforcement Dogs
EMS Transport of Service/Support Animals
Helicopter EMS (HEMS) Utilization
Hospital Diversion/Ambulance Bypass or Resource Limitation
Interfacility Transfer
Patient Destination
Pediatric Patient Destination
Perinatal (Obstetric/Neonatal) Patient Destination
Response to a System-Wide Crisis
Securing a Weapon Prior to Transport
STEMI Patient Destination
Stroke Patient Destination
Suspected COVID-19 Patient Triage and Transport
Systems of Care
Trauma Patient Destination
Ventricular Assist Device (VAD) Patient Destination
Veteran Patient Destination

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Burn Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

BURN PATIENT DESTINATION

I. PURPOSE

1. Identify patients with significant or complex burns and transport to a Burn Center.

2. Identify patients with burns and trauma and transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

II. DEFINITIONS

Burn Center: Hospitals that provide high quality patient care to burn patients from the time of injury through rehabilitation.

III. BURN PATIENT DESTINATION CRITERIA

A. Patients with the following criteria should preferentially be transported to a Burn Center:

1. Thermal Burns
   a. Full thickness burns
   b. Partial thickness burns with Total Body Surface Area (TBSA) 10% or more
   c. Partial or full thickness burn involving the face, hands, genitalia, feet, perineum, or over any joints
   d. Patients with burns and other comorbidities (including pre-existing medical condition)
   e. Circumferential burns
2. Inhalation injury
3. Pediatric burns (age less than 16 years old)
4. Chemical injuries
5. Electrical injuries
   a. High voltage ($\geq$ 1000 V) electrical injuries
   b. Lightning injury

B. Patients with the following criteria should be transported to most appropriate Level 1 Trauma Center:
   a. Patients with burns and concomitant traumatic injuries

C. For situations where there concern for an impending loss of the airway or worsening clinical condition, transport patient to the closest Emergency Department. Contact Online Medical Control (OLMC) as needed for destination questions.

IV. HOSPITAL COMMUNICATION

A. Online Medical Control is required for all burn patients.

B. Document time of hospital notification.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Burn Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

BURN CENTERS

John H. Stroger, Jr. Hospital of Cook County*****
Loyola University Medical Center
UChicago Medicine

***** Current status of Burn Capable

Updated: 11/14/23

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Cardiac Arrest Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 1, 2022

CARDIAC ARREST PATIENT DESTINATION

I. Patients in cardiac arrest from a medical cause should have field resuscitation following the Cardiac Arrest Management (ICCA) Protocol – BLS/ALS.

II. OLMC contact should be made during ongoing resuscitation from the scene. The following options should be discussed with the ECP or ECRN:

A. Continue field resuscitation for a defined period/task achievement and re-contact base station.

B. Transport of patient with Return of Spontaneous Circulation (ROSC).

C. Transport of patient with ongoing resuscitation.

D. Termination of resuscitative efforts (age ≥ 18 years).

III. EMS Field providers and base station physicians should make every effort to achieve ROSC before transporting the patient to the hospital with ongoing resuscitation. This recognizes the fact that ongoing resuscitation in the back of a moving ambulance is sub-optimal.

IV. Termination of Resuscitation may be considered for all adult (non-traumatic) cardiac arrest patients with initial rhythms of either asystole or pulseless electrical activity (PEA) who do not respond to field resuscitative efforts (see Termination of Resuscitation Policy).

V. Patients with ROSC should be treated according to the Adult and Pediatric Post-ROSC Care Protocol - ALS.

VI. Adult patients with ROSC, or any adult patient where the decision is made to transport to the hospital with ongoing resuscitation (only after discussion with OLMC), should be transported to the closest STEMI Center (see STEMI Patient Destination Policy for a list of STEMI Centers).

VII. Pediatric patients with ROSC, or any patient where the decision is made to transport to the hospital with ongoing resuscitation (only after discussion with OLMC), should be transported to the closest EDAP certified emergency department (see Pediatric Patient Destination Policy for list of EDAP hospitals).

VIII. Pregnant patients greater than 20 weeks gestation or with a visibly gravid abdomen should be transported to the closest STEMI Center that is also a Level III Perinatal Center (see Perinatal (Obstetric/Neonatal) Patient Destination Policy for a list of Level III Perinatal Centers).

IX. Ventricular assist device (VAD) patients should only be transported to a VAD Center (see Ventricular Assist Device (VAD) Patient Destination Policy for a list of VAD Centers).

X. In the event that the closest STEMI Center, EDAP hospital, Level III Perinatal Center or VAD Center is on ALS bypass, the “T+5 minute” rule should be followed, i.e. if the transport time to

the next closest appropriate specialty center is greater than an additional 5 minutes, the patient should be transported to the appropriate specialty center on ALS bypass (see Hospital Diversion / Ambulance Bypass or Resource Limitation Policy).

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Critical Airway
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: January 6, 2014

CRITICAL AIRWAY

I. All Region 11 Participating Hospitals collectively contribute to the safety of patients transported by EMS providers. In rare circumstances it may be necessary for EMS providers to require a Participating Hospital to assist in the emergency airway stabilization of patients being transported to another Participating Hospital.

II. **NON-TRAUMA AIRWAY POLICY (STEMI OR STROKE TRANSPORTS):**

A. In the event that a patient under EMS care cannot be intubated or effectively ventilated using either supraglottic airway or bag mask ventilation, the transporting ambulance may use discretion in revising the transport destination. In these rare "cannot ventilate" scenarios, the Paramedic should contact online medical control, to determine the closest appropriate facility for emergency airway stabilization and further care.

III. **TRAUMA AIRWAY POLICY:**

A. In the event a trauma patient cannot be ventilated effectively by EMS providers during transport to a Trauma Center, EMS providers should contact online medical control to determine if diverting to another non-trauma center hospital for airway assistance/stabilization is advised. Whenever possible, the transporting EMS providers/base station should notify the non-trauma center hospital of the need for trauma airway stabilization in advance of arrival.

B. In the event that a trauma patient is diverted to a non-trauma center for emergency airway stabilization, the transporting ambulance will remain with the patient and will continue the transport to the intended/closest trauma center upon stabilization of the airway by the participating non-trauma center hospital. The non-trauma center hospital should notify the receiving Trauma Center of the airway stabilization provided. The EMS providers must also re-contact the assigned Resource Hospital base station with an update to ensure that the receiving Trauma Center is also notified by the Resource Hospital of airway stabilization, transport delay, and revised ETA.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Ebola Virus Disease – Viral Hemorrhagic Fever (EVD-VHF) Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EBOLA VIRUS DISEASE – VIRAL HEMORRHAGIC FEVER (EVD-VHF) PATIENT DESTINATION

I. The Centers for Disease Control and Prevention (CDC) and the Chicago Department of Public Health (CDPH) issue specific guidance for screening, care and transport of patients who present with Ebola Viral Disease or Viral Hemorrhagic Fever (EVD-VHF) symptoms.

II. Patients who are considered "high risk" for EVD-VHF **MUST MEET THE FOLLOWING CRITERIA:**

A. Recent travel from a country with widespread EVD-VHF transmission, as noted by the CDC, IDPH and/or CDPH.

AND

B. At least one of the following symptoms:

1. Fever
2. Abdominal pain
3. Diarrhea
4. Vomiting
5. Unusual bleeding (from the eyes, nose, gums)
6. Muscle pain (myalgia)
7. Headache
8. Feeling weak or tired

III. Any patient who meets BOTH of the above criteria for a suspect EVD-VHF should be transported to a hospital designated as a "Specialized Pathogen Treatment Center (SPTC)" for confirmatory testing ONLY after the proper infection control precautions are established.

IV. For any patient with travel history and symptoms as above, EMS personnel should notify their EMS supervisor who will communicate with the Resource Hospital, RHCC, and CDPH to safely coordinate and plan transportation of the patient to a Specialized Pathogen Treatment Center.

V. **Proper PPE use and training is critical to protect EMS personnel and prevent the spread of infection. Refer to the EMS Guidelines for Infection Control Policy for specific details on PPE, patient care and transport considerations, and ambulance decontamination.**

VI. EMS personnel may directly contact the Base Station of the Specialized Pathogen Treatment Center with the positive screening criteria and pertinent patient information.

VII. Any invasive procedure (i.e. glucometer, IV start, advanced airway) should not be performed unless required for patient stabilization.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Transport of Law Enforcement Dogs
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS TRANSPORT OF LAW ENFORCEMENT DOGS

I. DEFINITIONS

A. Law Enforcement Dog**:** A dog owned or used by a law enforcement department or agency in the course of the department or agency's work which includes the following:

1. Search and rescue dog
2. Service dog
3. Accelerant detection canine
4. Other dog that is in use by a county, municipal, or state law enforcement agency

B. Canine Handler: A professional who provides training and care for canines and is responsible for the dog during routine operations and when injured.

II. EMS RESPONSIBILITIES

A. Law Enforcement Dogs

1. **EMS personnel should not attempt to handle or treat a conscious law enforcement dog without a trained canine handler or agency representative to assist with the animal.**
2. Ask the canine handler to apply the dog's muzzle if available.
3. Under normal conditions, agency or department canine handlers or supervisors have vehicles equipped to transport an ill or injured canine to an appropriate veterinary facility.
4. In the rare event this is not available, an EMT or Paramedic may transport a law enforcement dog that has been injured in the line of duty to a veterinary clinic or similar facility if there are no persons requiring medical attention or transport at that time.
5. **When transporting a law enforcement dog in an ambulance, the dog's handler, another canine handler, or a representative from the agency who owns the canine should accompany the canine during transport to the veterinary emergency facility.**
6. EMS personnel may provide basic level first aid and supportive care to an injured law enforcement dog. The provision of ALS care is not authorized and is not permitted unless the individual EMS provider is also appropriately licensed under the Illinois Veterinary Medicine and Surgery Practice Act (225 ILCS 115).

a. Oxygen and Ventilatory Support: If available, an appropriately sized facemask with oxygen may be applied for a canine with respiratory distress or apnea.
   i. Small canine mask: 3-5 liters
   ii. Large canine mask: 5-7 liters
b. Hemorrhage control: Apply direct pressure and pressure dressing as needed.

7. Each law enforcement department or agency should maintain a list of appropriate and available veterinary emergency facilities with agreements for canine care. Designated local veterinary facilities that will provide emergency treatment of injured law enforcement dogs include:

   a. Partner & Paws (560 Ogden Ave, Lisle, IL 60532)
   b. MedVet (3305 N. California, Chicago, IL 60618)
   c. Bloomingdale Animal Hospital (290 Glen Ellyn Road, Bloomingdale, IL 60108)
   d. Blue Pearl (1050 Bonaventure Dr. Elk Grove Village, IL 60007)

8. Following the transport of a law enforcement dog, EMS personnel should ensure proper and complete decontamination and sterilization of the interior of the ambulance or other EMS vehicle including stretchers, the patient compartment, and all contaminated medical equipment before returning to service.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Transport of Service and Support Animals
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS TRANSPORT OF SERVICE AND SUPPORT ANIMALS

I. DEFINITIONS

A. ADA Requirements - Service Animals**:** The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) in 2010 which contain updated requirements, including the 2010 Standards for Accessible Design.

B. Service Animal**:** Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Examples of service animal tasks include:

1. A person who uses a wheelchair may have a dog that is trained to retrieve objects for them.

2. A person with depression may have a dog that is trained to perform a task to remind them to take their medication.

3. A person with PTSD may have a dog that is trained to lick their hand to alert them to an oncoming panic attack.

4. A person who has epilepsy may have a dog that is trained to detect the onset of a seizure and then help the person remain safe during the seizure.

C. Support Animal**:** An emotional support animal is any animal that provides emotional support alleviating one or more symptoms or effects of a person's disability. Emotional support animals provide companionship, relieve loneliness, and sometimes help with depression, anxiety, and certain phobias, but do not have special training to perform tasks that assist people with disabilities. Emotional support animals are not limited to dogs.

II. EMS RESPONSIBILITIES

A. Service Animals

1. Under the Americans with Disabilities Act (ADA), if a person with a disability requires transportation in an ambulance, accommodations must be made to allow the service animal to accompany the patient to the hospital.

2. A service animal must be under the control of its handler. Under the ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

3. When it is not obvious what service an animal provides, only limited inquiries are allowed. EMS Personnel may ask two questions:

   a. Is the dog a service animal required because of a disability?
   b. What work or task has the dog been trained to perform?

4. EMS Personnel cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

5. In addition to the provisions about service dogs, the Department of Justice's ADA regulations have a separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities and permitting these animals when reasonable.

6. EMS Personnel are not required to provide care for or supervision of a service animal.

B. Support Animals

1. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

2. Support dogs have not been trained to perform a specific job or task and therefore do not qualify as service animals under the ADA.

3. There is no federal legal obligation to allow emotional support dogs to accompany a patient in the ambulance.

4. The decision to allow the patient and dog to remain together is based on the patient's need and ability to control the animal, as well as the crew's ability to transport the dog safely.

C. Transport of Service and Support Animals

1. EMS personnel should notify the receiving hospital that they are transporting a patient with a service or support animal.

2. Following the transport of a service or support animal, EMS personnel should ensure proper and complete decontamination and sterilization of the interior of the ambulance including stretchers, the patient compartment, and all contaminated medical equipment before returning to service.

D. References

1. US Department of Justice, Civil Rights Division: ADA Requirements: Service Animals | ADA.gov

2. Illinois Attorney General, Service Animals: Illinois Attorney General - Service Animals guide (state.il.us)

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Helicopter Emergency Medical Services (HEMS) Utilization
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

HELICOPTER EMERGENCY MEDICAL SERVICES (HEMS) UTILIZATION

I. PURPOSE

A. To minimize loss of life and disability by ensuring timely air medical resources for Region 11.

B. To define the scope in which the Region 11 EMS System will use HEMS for emergency transport of critically injured patients.

C. To provide for safe and coordinated air medical operations with ground responders and hospital resources.

II. POLICY

A. Availability of HEMS

1. HEMS response shall be made available to critically injured persons in Region 11 whenever it is safe, appropriate, and necessary to optimize the care of the patient.

2. The pilot in command of the HEMS aircraft shall have the full authority to abort or decline response to any request for service when mechanical, geographic, weather, or flight conditions might endanger the crew or others.

B. Authorization of HEMS service providers

1. All HEMS operators routinely offering service to or from hospitals located within Region 11 should follow local policies and protocols for patient transport.

2. The closest providers include UCAN (University of Chicago Aeromedical Network) and Lifestar Joliet.

C. Medical Crew Requirements

1. All members of a HEMS medical flight crew must meet training requirements and continuing education as defined in the State of Illinois Administrative Code Section 515.940 “Aeromedical Crew Member Training Requirements.”

D. Ground Crew Requirements

1. All providers operating in the vicinity of helicopters must be trained in helicopter safety operations.

2. Any scene requesting HEMS activation shall have an identified Incident Commander to coordinate the response.

E. Patient Management

1. Ground patient management should follow Region 11 policies and protocols until care is transferred to the flight crew.

2. Medical control for the flight crew members shall be supplied by the HEMS program's Medical Director.

3. Helicopters that do not have a medical flight crew should not transport patients outside of search and rescue operations.

F. HEMS Aircraft Requirements

1. All HEMS aircraft should follow State of Illinois Administrative Code in regards to licensure (515.900, 515.920), medical oversight requirements (515.930), vehicle specifications and operations (515.945), aircraft medical equipment and drugs (515.950).

2. EMS pilot specifications should be in accordance with section 515.935.

G. Authorized Landing Sites

1. HEMS aircrafts shall only land at landing sites meeting one of the following criteria:

    a. Heliports permitted by the Illinois Department of Transportation.
    b. Emergency helispots (landing zones) near the scene of a multi-casualty incident, disaster, or other critical incident. The Incident Commander (IC) shall designate appropriate landing zones at emergency scenes.

H. Communication Policy

1. HEMS should maintain the capacity to communicate with Landing Zone Operations, OLMC, and Receiving Hospital.

2. The designated CFD fire tactical frequency to be used to maintain contact with Landing Zone Operations during an incident will be Ops Channel 8.

    a. Ops Channel 8 is a simplex local tactical channel, which is limited to the proximity of the incident.

III. PROCEDURE

A. There are two field situations which may potentially require HEMS response:

1. Scene response with a critically injured patient (such as prolonged extrication). Activation criteria must include ALL of the following:

   a. Patient meeting Level 1 Trauma triage criteria.
   b. Estimated ground transport time > 25 minutes OR inaccessibility to ground transport.
   c. Anticipation that the transport time would pose additional risk to life or limb.

2. Multiple patient incident

   a. Situations involving multiple patients with severe trauma or burns where the closest receiving centers or local EMS resources are overwhelmed.

B. Initiating HEMS Response

1. The ranking EMS Chief may activate HEMS for a scene response involving a critically injured patient meeting all activation criteria.

2. During a multiple patient incident, the Incident Commander is in charge of all emergency operations on scene. The decision to request EMS aircraft is based on both:

   a. The advice of on-scene ranking EMS Chief in consultation with the Resource Hospital or Regional Hospital Coordinating Center (RHCC); and
   b. The suitability of the scene for helicopter operations.

C. Requesting HEMS

1. The ranking EMS Chief or Incident Commander on scene identifies the need for air medical transport.

2. The OEMC is contacted with the request for HEMS and provided with the scene information.

3. The OEMC will contact the HEMS agency with the response request.

4. EMS field crews shall not call for HEMS directly.

D. Activation

1. The primary air medical response will be the University of Chicago Aeromedical Network (UCAN).

2. If UCAN is unavailable, the UCAN communications center will immediately call Lifestar to determine their availability and connect the OEMC to their dispatch center.

3. The Incident Commander will be notified of the responding helicopter.

E. Required HEMS Request Information

1. The following information must be provided to the OEMC by the Incident Commander (IC) or designee:

   a. Location of incident: Intersection, landmarks, latitude/longitude
   b. Location of anticipated landing zone
   c. Ground contact and designated tactical frequency
   d. EMS Resource Hospital (medical control of scene)
   e. Brief (A MINI) patient report (if the situation permits) that includes the following:
      i. Age of patient(s)
      ii. Mechanism of injury
      iii. Injuries (known or suspected)
      iv. Neurological findings /vital signs
      v. Intervention (intubation, IVs, etc.)

F. Mobilization

1. HEMS will respond within a 15 minute call to arrival time interval. If a 15 minute ETA is not possible, the OEMC will be notified.

2. When HEMS is mobilized, the OEMC will notify the ground crew.

G. Ground Crew Deployment

1. For scenes requesting HEMS, the Incident Commander will determine and activate appropriate ground crew deployment.

2. The Incident Commander will coordinate the Landing Zone (LZ) support.

3. The Incident Commander or designee shall communicate with HEMS on Ops Channel 8 once in the proximity of the incident.

4. The ground crew should maintain the landing zone perimeter and not enter unless accompanied by the HEMS flight crew. After landing the helicopter, the HEMS crew

will bring their equipment and stretcher to the ambulance. EMS will provide a patient report and transfer the patient to the HEMS crew's equipment and stretcher

H. Destination

1. Determined by the HEMS crew as the closest appropriate trauma or specialty center that is capable of receiving helicopter transports.

2. The EMS aircraft will contact the receiving hospital with pertinent patient information.

I. Air-to-Ground Communications

1. The OEMC will contact the UCAN Communications center with HEMS request.

2. Landing zone operations to/from EMS aircraft will be by the designated tactical frequency (based on the proximity to the incident) identified by Incident Commander.

J. Standby Request

1. For field situations potentially needing HEMS activation, a ‘standby request’ can be made. This allows for early determination of aircraft availability, weather check, and a prompt response.

2. The OEMC or Ranking EMS Chief may place HEMS on standby.

K. Quality Improvement

1. Activation of HEMS is a sentinel event and the M.A.R.C. office will notify the Region 11 EMSMD Continuous Quality Improvement (CQI) Committee for case review.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Hospital Diversion / Ambulance Bypass or Resource Limitation
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: January 16, 2024

HOSPITAL DIVERSION/ AMBULANCE BYPASS OR RESOURCE LIMITATION

I. BACKGROUND

A. Hospital diversion of ambulances (bypass) should be based on a significant resource limitation, disaster event, or active threat.

B. Each hospital should have a protocol that addresses peak census, surge, and hospital diversion/ambulance bypass and current status should be updated in EMResource.

C. The decision to go on diversion/bypass or resource limitation should be based on meeting the following criteria per IDPH:

1. Lack of an Essential Resource: All reasonable efforts to resolve the essential resource limitation have been exhausted including, but not limited to:

a. Consideration for using appropriately monitored beds in other areas of the hospital;
b. Limitation or cancellation of elective patient procedures and admissions to make available surge patient care space and redeploy clinical staff to surge patients;
c. Actual and substantial efforts to call in appropriately trained off-duty staff; AND
d. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.

D. Bypass status may NOT be honored or deemed reasonable if hospitals in a geographic area are on peak census or bypass status and/or transport time by an ambulance to the nearest facility is identified to exceed 15 minutes.

E. When a hospital is on bypass, the next geographically closest hospital without a declared resource limitation/disaster will be considered the “closest” hospital for EMS transport destination.

F. In a situation where diverting an ALS patient adds 5 or more additional minutes of transport time to the closest hospital not on bypass, that patient may be transported to the closest hospital on ALS bypass, barring extenuating circumstances.

II. MONITOR AND REVIEW

A. The hospital will do constant monitoring to determine when the hospital diversion/ambulance bypass or Resource Limitation condition can be lifted. Such monitoring and decision making

shall include clinical and administrative personnel with adequate hospital authority. Efforts to address hospital issues using all available resources to resolve bypass as soon as such patients can be safely accommodated.

B. The Illinois Department of Public Health (IDPH) can remove or override a hospital's bypass status at any time.

C. IDPH shall investigate the circumstances that caused a hospital in an EMS System to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable.

D. Ambulance service providers will be responsible for assuring their EMS personnel are kept informed of existing hospital diversion/ambulance bypass and resource limitations in the EMS system.

E. Hospitals shall update their bypass status/resource limitation every 2 hours in the EMResource system and make every effort to manage resources efficiently. **If a hospital finds it necessary to stay on bypass for longer than 2 hours, the IDPH EMS Regional Coordinator must be contacted directly for review at 312-636-0241.**

III. REASON/ELIGIBILITY FOR RESOURCE LIMITATION OR DIVERSION/BYPASS STATUS

A. **Resource Limitation**: Systems of care patients including Stroke and STEMI. This is not a bypass status, but a notification and request to the EMS System.

1. No available or monitored beds within traditional patient care and surge patient care areas with appropriate monitoring for patient needs;

2. Unavailability of trained staff appropriate for patient needs; and/or

3. No available essential diagnostic and/or intervention equipment or facilities essential for patient needs.

B. **ALS Bypass:** In determining whether a hospital's decision to go on bypass/resource limitation status is reasonable, the following should be considered:

1. The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;

2. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and

3. The approved hospital protocols for peak census, surge, and bypass at the time that the decision to go on bypass status was made.

4. Note that BLS transports are not diverted for ALS bypass

C. **Trauma Bypass: For Level 1 Trauma Centers or Level 1 Pediatric Trauma Centers**

1. All staffed operating rooms are in use or fully implemented with on-call teams, and at least one or more of the procedures is an operative trauma case;

2. The CT scan is not working; or

3. The general bypass criteria listed above.

D. **Bypass Override**: Can override the above for bypass

1. At the discretion of Online Medical Control, participating hospitals may still receive patients when on resource limitation or bypass. This may occur if it is determined that such a triage decision is in the best interest of a particular patient or the community at large. Situations that might (but do not automatically) warrant such a decision include:

   a. Life threatening situations requiring the patient be transported to the closest hospital because the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility DO NOT outweigh the increased risks to the patient from the transport to a more distant facility.
   b. Incident requiring a multiple ambulance response (i.e. EMS Plans, Mass Casualty Events, etc.).

E. **Internal Disaster**

1. An internal disaster (including but not limited to fire, flood, power failure, active threat) has occurred in the hospital at the time that the decision to go on bypass status was made;

2. ALS and BLS transports are diverted.

3. Hospitals with a declared bypass status due to an internal disaster will not have their status over-ridden to accept any patient by EMS.

F. **System-Wide Crisis**

1. In the event of a system-wide crisis, refer to the Response to a System-Wide Crisis Policy and notify the Regional Hospital Coordinating Center (RHCC).

G. **Declared Local or State Disaster**

1. During a declared local or state disaster, hospitals may only go on bypass status if they have received prior approval from IDPH. Hospitals must complete or submit the following prior to seeking approval from IDPH for bypass status:

   a. EMResource must reflect current bed status;
   b. Peak census policy must have been implemented 3 hours prior to the request of bypass;
   c. Hospital and staff surge plans must be implemented;
   d. The following hospital information shall be provided to IDPH:
      i. Number of hours for in-patient holds waiting for bed assignment;
      ii. Longest number of hours wait time in Emergency Department;
      iii. Number of patients in waiting area waiting to be seen;
      iv. In-house open beds that are not able to be staffed;
      v. Percent of beds occupied by in-patient holds;
      vi. Number of potential in-patient discharges;
      vii. Number of open ICU beds; and
      viii. Additional steps taken to address the challenges.
   e. The IDPH Regional EMS Coordinator will review the above information along with hospital status in the region and determine whether to approve bypass for 2 hours, 4 hours, or an appropriate length of time as determined by the IDPH Regional EMS Coordinator, or to deny the bypass request. A bypass request may be extended based on continued assessment of the situation, including status of surrounding hospitals, with the IDPH Regional EMS Coordinator and communication with the requesting hospital. A hospital may be denied bypass based on regional status or told to come off bypass if an additional hospital in the geographic area requests bypass.

IV. NOTIFICATION PROCESS

A. Notification of Hospital Status Change: The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass/resource limitation decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at https://emresource.juvare.com/login.

1. Submit status update through EMResource including initial, continuing or resolution of bypass/diversion status. This will alert IDPH and all Region 11 and surrounding region hospitals of the status change.

   a. If unable to access EMResource, contact your hospital EMResource administrator to address the issue.

2. Notify Chicago Office of Emergency Communications (OEMC)/911 Center.

3. Notify respective Resource Hospital Base Station (for Participating and Associate hospitals; Resource Hospitals notify geographical next closest Resource Hospital).

4. Alert private ambulance services that normally service the facility

5. Ambulance service providers will be responsible for assuring their EMS personnel are kept informed of existing resource limitations in the system.

6. If a hospital finds it necessary to stay on bypass for longer than 2 hours, the IDPH EMS Regional Coordinator must be contacted directly for review at 312-636-0241.

B. The hospital shall document any inability to access EMResource by contacting their Resource Hospital EMS Coordinator, Chicago Department of Public Health, and IDPH Division of EMS during normal business hours.

V. IDPH SANCTIONS FOR HOSPITAL DIVERSION/AMBULANCE BYPASS

A. IDPH may impose sanctions upon determination that the hospital unreasonably went on bypass status in violation of the EMS Act as set forth in Section 3.140 of the Act, upon IDPH determination that the hospital unreasonably went on bypass status in violation of the EMS Act.

B. Reference: *IDPH EMS Administrative Code Section 515.315 Bypass or Resource Limitation Status Review*

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Interfacility Transfer
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

INTERFACILITY TRANSFER

I. PURPOSE

To define the EMS responsibilities for patient transport in an interfacility transfer.

II. DEFINITION

A. Interfacility Transfer: Any transfer, after initial assessment and stabilization, from and to a health care facility. Examples would include hospital to hospital; clinic to hospital; hospital to rehabilitation; and hospital to long-term care.

B. EMTALA (Emergency Medical Treatment and Labor Act): Federal law that requires hospitals with Emergency Departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status and governs how patients may be transferred from one hospital to another.

III. POLICY

A. Patient Care

1. Federal legislation clearly requires the transferring facility and physician to be responsible for arranging the proper mode and level of transport with the appropriate level of EMS personnel.

2. In Region 11, EMS personnel must follow the EMS Protocols, Policies, and Procedures that are approved by the EMS Medical Director and are credentialed at their level of licensure.

3. Once patient care is initiated, EMS personnel are to maintain ongoing patient care until responsibility is assumed by equal or higher level personnel at the receiving facility.

B. Scope of Practice

1. Interfacility transfers of patients that require medication or equipment outside of the defined Region 11 EMT or Paramedic EMS Scope of Practice Policy shall require appropriate facility staff to accompany the patient during transport.

2. Additional healthcare personnel assisting in the transport of a patient in an ambulance that are not employed by the EMS provider agency, including but not limited to a Registered Nurse, Physician or technician are acting under the responsibility and liability of the transferring facility.

C. Level of Care

1. **BLS (Basic Life Support)** – Basic emergency care including oxygen, monitoring of

vital signs and saline lock.

2. **ALS (Advanced Life Support)** – Advanced emergency care including oxygen, monitoring of vital signs, intravenous fluids, intravenous medication including pain medications, cardiac rhythm monitoring, advanced airway management and capnography monitoring, advanced assessment and interpretation skills, cardiac arrest management.

3. **CCT (Critical Care Transport)** – Advanced scope of paramedic care including ventilator management, vasoactive and continuous infusion medication management, blood product management, chest tube management, central and arterial line management.

D. Hospital Communication

1. Transports to the Emergency Department require a pre-notification call.

2. Online Medical Control must be contacted in the following circumstances:

   a. Acute deterioration in patient status enroute;
   b. Medical-legal issues needing immediate clarification;
   c. Concerns between transferring physician orders and established Region 11 Policies, Protocols and Procedures.

E. Documentation

1. Follow the Medical Records Documentation and Reporting Policy for any patient care provided by EMS personnel.

2. When a transport team is involved and no patient care is provided by EMS personnel, a brief description of the reason for transport is required.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PATIENT DESTINATION

I. PURPOSE

To define the destination of a patient and selection of the receiving facility.

II. DEFINITION

A. Closest Appropriate Facility: Closest facility with the capability to care for that patient and in the patient's best interest which is based on Systems of Care criteria, established medical care, or patient preference.

III. POLICY

A. Determination of Patient Destination

1. In any emergency situation, the patient should be transported by ambulance to the closest appropriate facility, as defined in the EMS Act.

2. After patient assessment, EMS should determine the closest appropriate facility for transport based on the following:

    a. Patient meets criteria for hospital destination per Systems of Care Policy, including STEMI and Cardiac Arrest, Stroke, Trauma, VAD, Perinatal, and Pediatrics;
    b. Patient has established medical care at a facility to maintain continuity of care; and
    c. Patient preference

3. Patient preference and/or patient medical home may be taken into consideration if it does not conflict with Systems of Care criteria, if the patient is unstable, or if it is potentially detrimental to EMS system operations.

4. If the closest appropriate facility is on bypass or diversion status, EMS should follow the Hospital Diversion / Ambulance Bypass or Resource Limitation Policy.

5. Online Medical Control may be contacted for any questions or issues in determining the closest appropriate hospital.

6. If the patient/legal guardian refuses transport to the closest appropriate facility, EMS providers must follow these guidelines:

    a. Make sure the patient/legal guardian is notified of and understands the risks and benefits of their decision to be transported to a facility other than the closest appropriate facility.
    b. Document the patient/legal guardian's refusal of transport to the closest appropriate facility.
    c. If the patient requires additional emergency care, remain with the patient at the

scene until additional EMS providers are available to transport the patient.

d. The patient will be cared for at the highest level of care to meet their needs. The level of care is not downgraded due to the patient's refusal to be transported to the closest appropriate facility.

B. **Destination Facilities**

1. EMS may transport to EMS System approved locations including:

   a. Hospitals with Comprehensive Emergency Department services (see Participating Hospital Responsibilities Policy)
   b. Alternate destinations under pilot program status or as an interfacility transfer
      i. Licensed mental health facilities
      ii. Urgent or immediate care
   c. Other field treatment locations, as approved, for special events

2. Patient destination location should be documented on the patient care report.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Pediatric Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PEDIATRIC PATIENT DESTINATION

I. PURPOSE

A. Identify pediatric patients with complex conditions that require transport to a designated Pediatric Critical Care Center (PCCC).

B. Identify pediatric patients with emergency conditions that require transport to a designated Emergency Department Approved for Pediatrics (EDAP).

C. For pediatric trauma criteria and Level 1 Pediatric Trauma Centers, refer to the Trauma Patient Destination Policy.

II. PEDIATRIC CENTERS

A. Pediatric Critical Care Center (PCCC)

1. Hospitals that have a pediatric intensive care unit (PICU) and can provide specialty inpatient services for the pediatric patient.

2. All PCCC level centers must also maintain EDAP status.

B. Emergency Department Approved for Pediatrics (EDAP)

1. Hospitals that can provide comprehensive emergency services and meet pediatric emergency care requirements.

2. Pediatric emergency care requirements include appropriately trained staff, effective processes (policies, guidelines, training requirements, and quality improvement initiatives), and resources (medications, supplies, and equipment) to care for children who present to the emergency department (ED).

C. Emergency Department Without Pediatric Designation

1. Hospitals that can stabilize and may transfer pediatric patients.

III. PEDIATRIC DESTINATION CRITERIA

A. **Pediatric Critical Care Center (PCCC)**

1. Pediatric stroke

2. Other complex conditions that require specialty care in consultation with online medical control

B. **Emergency Department Approved for Pediatrics (EDAP)**

1. Pediatric cardiac arrest (preferentially PCCC)
2. Status epilepticus
3. Brief Resolved Unexplained Event (BRUE)
4. Abandoned newborn

C. **Emergency Department Without Pediatric Designation**

1. Low acuity conditions

IV. HOSPITAL COMMUNICATION

A. All pediatric patient transports are considered Systems of Care patients and require contact with Online Medical Control.

B. When possible, preferential transport to the pediatric patient's medical home can facilitate timely and efficient care.

C. Region 11 Hospitals that are Base Stations with PCCC capabilities may be contacted preferentially for Online Medical Control including refusals.

1. Ann & Robert H. Lurie Children's Hospital of Chicago
2. UChicago Medicine Comer Children's Hospital

REGION 11 PCCC/EDAP CENTERS

PEDIATRIC CRITICAL CARE CENTER (PCCC)

Advocate Christ Medical Center
Advocate Lutheran General Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago*****
Loyola University Medical Center
UChicago Medicine Comer Children's Hospital*****
UI Health

EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP)

Advocate Illinois Masonic Medical Center
Ascension Saint Francis Hospital
Ascension Saint Joseph Hospital, Chicago
Ascension Saints Mary & Elizabeth Medical Center - St. Mary Campus ONLY
John H. Stroger, Jr. Hospital of Cook County*****
Loyola MacNeal Hospital
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Rush University Medical Center
Saint Anthony Hospital
West Suburban Medical Center

The following Region 11 Emergency Departments are **NOT** designated by the Illinois Department of Public Health Emergency Medical Services for Children (EMSC) program as having the essential resources and capabilities in place to meet the emergency and critical care needs of seriously ill children:

Advocate Trinity Hospital
Ascension Resurrection Medical Center
Community First Medical Center
Endeavor Health Swedish Hospital
Holy Cross Hospital
Humboldt Park Health
Insight Hospital and Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Administration Medical Center
Loretto Hospital
Provident Hospital of Cook County
Roseland Community Hospital
Saint Bernard Hospital & Health Care Center
South Shore Hospital
Thorek Memorial Hospital
Weiss Memorial Hospital

***Region 11 Pediatric Level I Trauma Centers**

Updated 12/22, 7/23, 12/23, 9/24

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Perinatal (Obstetric/Neonatal) Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PERINATAL (OBSTETRIC/NEONATAL) PATIENT DESTINATION

I. OBSTETRIC PATIENTS: All pregnant patients greater than 20 weeks gestation with obstetrical related emergencies such as, but not limited to: abdominal pain, contractions, vaginal bleeding, ruptured membranes, or immediately postpartum are to be transported to an appropriate Perinatal Center (see attachment 1).

A. High Risk Obstetric Patients

1. Transport pregnant patients between 20-30 weeks gestation with an obstetrical related complaint to the closest Level III Perinatal Center unless the patient is deemed unstable for additional transport time. If the patient is deemed unstable the patient should be transported to the closest Perinatal Center.

   A patient is considered "unstable" if they exhibit any of the following:
   - Display crowning or a presenting part at the perineum
   - Have brisk vaginal bleeding
   - Have abnormal vital signs
   - Exhibit altered mental status.

   If there is any question about the "stability" of a pregnant patient, Online Medical Control should be contacted to assist with destination decisions.

2. Pregnant woman with an obstetrical related complaint stating she has been deemed a "high risk" obstetrical patient that requires care or delivery at a Level III Perinatal Center should be transported to the closest Level III unless she is unstable as defined above.

II. NEONATAL PATIENTS

A. Full term newborns (39 weeks estimated gestation age or more) should be transported to a Level II or Level III Perinatal Center.

B. Preterm newborns (less than 39 weeks estimated gestation age) should be transported to a Level III Perinatal Center.

III. In rare and unusual circumstances, at the EMS personnel's discretion, in consultation with OLMC, the patient may be transported to the closest appropriate facility for stabilization.

Attachment 1: Perinatal Centers

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Perinatal (Obstetric/Neonatal) Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

Attachment 1

PERINATAL CENTERS

LEVEL III PERINATAL CENTERS

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Ascension Saint Joseph Hospital, Chicago
John H. Stroger, Jr. Hospital of Cook County
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
Rush University Medical Center
UChicago Medicine
UI Health

LEVEL II PERINATAL CENTERS

Advocate Trinity Hospital
Ascension Resurrection Medical Center
Ascension Saints Mary & Elizabeth Medical Center - Saint Mary Campus
Endeavor Health Swedish Hospital
Humboldt Park Health
Loyola MacNeal Hospital
OSF Little Company of Mary Medical Center
Roseland Community Hospital
Saint Anthony Hospital
West Suburban Medical Center

NO OBSTETRIC SERVICES AVAILABLE

Ann & Robert H. Lurie Children's Hospital of Chicago
Ascension Saint Francis Hospital
Community First Medical Center
Edward Hines, Jr. Veterans Affairs Hospital
Holy Cross Hospital
Insight Hospital & Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Affairs Medical Center
Loretto Hospital
Provident Hospital of Cook County
South Shore Hospital
St. Bernard Hospital
Thorek Memorial Hospital
Weiss Memorial Hospital

Updated: 7/28/23, 12/12/23; 5/8/24

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Response to a System-Wide Crisis
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

RESPONSE TO A SYSTEM-WIDE CRISIS

I. A variety of crises may occur that create intense demand for EMS and Emergency Department resources within the Region 11 Chicago EMS Systems. Such crises may include a mass casualty incident, a heat emergency, a respiratory infection surge or pandemic, or a terrorist act involving a nuclear, biological, chemical or industrial agent which overloads Emergency Department resources.

II. **When faced with an impending or actual system-wide crisis, the following procedure should be followed**:

A. Any EMS System participant suspecting or knowing of an event that could precipitate a system-wide crisis should contact the Resource Hospital. Awareness of a system-wide crisis may originate with any EMS system participant, including an ambulance service provider (e.g., mass casualty incident), EMS personnel (e.g., heat emergency), or a participating hospital (e.g., respiratory infection surge).

B. The Resource Hospital EMS Coordinator and EMS Medical Director will assess the information and seek confirmation prior to declaring a system-wide crisis.

C. Once a system-wide crisis is confirmed, the Resource Hospital will:

1. Notify the following:

a. Other EMS Coordinators and EMS Medical Directors in Region 11
b. Regional Hospital Coordinating Center (RHCC) Coordinator
c. The RHCC will notify IDPH
d. The RHCC will notify CDPH
e. Region 11 ambulance service providers, as indicated
f. The RHCC will notify adjacent RHCC Coordinators

2. Assure that participating hospitals within the EMS System are informed of the crisis, and request that steps be taken to avoid hospital diversion/ambulance bypass, and alert them to the possibility of having to mobilize additional staff and resources and/or implement internal surge plans.

3. Provide ongoing monitoring of the situation and assist with communication between the hospitals, ambulance service providers, and appropriate governmental agencies.

III. System-Wide Crisis Response Coordination

A. The Regional Hospital Coordinating Center (RHCC) serves as the lead entity responsible for coordinating health and medical emergency response in its region as part of the regional health care coalition.

B. Regional health care coalitions may also be involved, which are groups of hospitals, local health departments, and emergency management personnel that serve a pivotal role in assisting during a pandemic or disaster response and are a crucial resource to hospitals when they are experiencing surges or resource limitations.

C. The RHCC, in coordination with the regional health care coalition, may coordinate distribution of resources during a public health emergency to hospitals and health care providers.

D. The Resource Hospital EMS Coordinator, EMS Medical Director, and RHCC Coordinator, together with the OEMC and the CFD Deputy Fire Commissioner, will closely monitor the overall EMS System operational impact.

E. CFD may request the help of private ambulance service providers as well as activate additional staff and equipment.

IV. Syndromic Surveillance of Patients with Similar Symptoms

A. If a participating hospital is noting a trend of increased frequency of similar symptoms, including potential drug overdoses, the Resource Hospital EMS Coordinator or EMS Medical Director shall be notified.

B. The Resource Hospital EMS Coordinator and RHCC Coordinator will monitor the situation and, if necessary, notify IDPH, CDPH and ambulance service providers.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Securing A Weapon Prior To Transport
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

SECURING A WEAPON PRIOR TO TRANSPORT

I. PURPOSE

1. To define the process for securing a weapon by licensed EMS personnel within Region 11.

2. To safely assess and provide medical care for individuals carrying a weapon or firearm.

II. DEFINITIONS

A. Weapon**:** A firearm or other object that is designed or used for inflicting bodily harm or physical damage.

B. Firearm Concealed Carry Act**:** An Illinois law that allows individuals with a license to legally carry a firearm except in defined prohibited areas.

III. EMS RESPONSIBILITIES

A. Safety

1. If there is any concern of scene safety, EMS personnel should retreat to a safe zone and call for law enforcement.

2. EMS personnel should not attempt to unload or render the firearm safe; this is the responsibility of law enforcement.

B. Securing the Firearm

1. Prior to transport, the individual should leave the firearm or weapon appropriately secured at home.

2. If this is not possible, law enforcement should be contacted to secure the firearm or weapon prior to transport.

3. If law enforcement is not immediately available, the firearm or weapon should ideally be secured in a locked location in the ambulance prior to transport.

C. Hospital Communication

1. During the pre-notification call to the receiving hospital, the paramedic should state “I have a firearm (or weapon) secured on board” and ask to notify hospital security or the public safety team prior to arrival.

2. Upon arrival in the Emergency Department and after patient care is transferred, the weapon should be transferred to hospital security or the public safety team.

3. Under the Illinois Firearm Concealed Carry Act, a licensee may not knowingly carry a firearm into prohibited areas which include a public or private hospital or hospital affiliate, mental health facility, or nursing home.

IV. LAW ENFORCEMENT OFFICERS

A. If assisting EMS with patient care in an ambulance, a law enforcement officer should maintain custody of their firearm.

B. If a law enforcement officer is the patient in an ambulance, another officer shall take custody of their firearm.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: STEMI Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: January 18, 2019

STEMI PATIENT DESTINATION

I. Patients that meet STEMI Center field triage criteria as listed (see attachment 1) should be transported to the closest STEMI center.

II. In the event the closest STEMI center is on ALS bypass, the “T+5 minute” rule should be followed, i.e. if the transport time to the next closest STEMI center is greater than an additional 5 minutes, the patient should be transported to the STEMI center on ALS bypass (see Hospital Diversion / Ambulance Bypass or Resource Limitation Policy).

Patients meeting STEMI center field triage criteria as listed (see attachment 1) should not be transported to a STEMI center which has notified Region 11 Base Stations regarding a temporary cardiac cath lab resource limitation; they should instead be transported to the next closest STEMI center.

Attachments:
1. STEMI Center Field Triage Criteria
2. List of STEMI Centers

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: STEMI Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: January 18, 2019

Attachment 1

STEMI CENTER FIELD TRIAGE CRITERIA

The following patients should be transported to a STEMI center:

I. Patients with ST-Elevation Myocardial Infarction (STEMI) criteria on 12-lead ECG:

A. Computer interpretation of 12-lead is any of the following:

1. ***ACUTE MI***

2. ***ACUTE MI SUSPECTED***

3. ***MEETS ST ELEVATION MI CRITERIA***

B. Paramedic interpretation of 12-lead ECG as STEMI (ST elevation of 1 mm in at least two contiguous leads).

C. Base station ECP interpretation of transmitted 12-lead ECG as STEMI.

II. Patients with suspected acute coronary syndrome without STEMI on ECG, that require the capabilities of a STEMI center based on Paramedic or Base Station judgement.

III. Patients with any of the following arrhythmias:

A. Wide complex tachycardia

B. Symptomatic bradycardia with high grade AV block (2nd or 3rd degree heart block)

C. Symptomatic bradycardia requiring transcutaneous pacing

IV. Cardiac arrest patients with ROSC or if/when decision is made to transport to the hospital with ongoing resuscitation.

Attachment 2

STEMI CENTERS

HOSPITAL NAME

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Advocate Trinity Hospital
Ascension Resurrection Medical Center
Ascension Saint Francis Hospital
Ascension Saint Joseph Hospital, Chicago
Ascension Saints Mary & Elizabeth Medical Center - Saint Mary Campus
Community First Medical Center
Endeavor Health Swedish Hospital
Humboldt Park Health
John H. Stroger, Jr. Hospital of Cook County
Loyola MacNeal Hospital
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Rush University Medical Center
UChicago Medicine
UI Health
Weiss Memorial Hospital
West Suburban Medical Center

Updated: 4/6/22, 12/12/23

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Stroke Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

STROKE PATIENT DESTINATION

I. PURPOSE

A. Identify patients with symptoms of stroke based on a stroke screening scale (CPSS) and stroke severity scale (3I-SS).

B. Transport patients to a Primary or Comprehensive Stroke Center based on last known well time and stroke severity.

II. STROKE CENTERS

A. Primary Stroke Center (PSC)**:** Ability to care for patients with acute ischemic stroke.

B. Comprehensive Stroke Center (CSC): Ability to concurrently meet the need of multiple, complex stroke patients with advanced imaging, thrombectomy, and neurosurgery.

III. STROKE SCALES

A. Cincinnati Prehospital Stroke Scale (CPSS) - stroke screening

Facial Droop - Have patient show teeth or smile
- Normal = Both sides of the face move equally
- Abnormal = One side of the face does not move at all

Arm Drift - Have patient close eyes and hold arms out for 10 seconds with palms up
- Normal = Both arms move equally or not at all
- Abnormal = One arm drifts compared to the other

Speech - Have patient say, “You can’t teach an old dog new tricks”
- Normal = Patient uses correct words with no slurring
- Abnormal = Slurred or inappropriate words or mute

B. 3-Item Stroke Scale (3I-SS) - stroke severity

The 3I-SS is scored 0-6. Assign a score from 0 to 2 for each of the three parts of the assessment. Add each section for the total score.

Level of Consciousness (AVPU)
0 = Alert
1 = Arousable to voice only
2 = Arousable to noxious stimuli only, or unresponsive

Gaze Preference
0 = Normal eye movements
1 = Prefers to look to one side, but can move eyes to both sides
2 = Eyes are fixed in one direction

Motor Function
0 = Normal strength in arms and legs
1 = Can lift arm or leg, but cannot hold arm/leg up for 10 seconds
2 = None or minimal movement of arm or leg

IV. STROKE DESTINATION CRITERIA

A. Patients with stroke symptoms are screened with the Cincinnati Prehospital Stroke Scale (CPSS).

B. Patients with an abnormal CPSS or a suspected stroke will be assessed for stroke severity with the 3 Item Stroke Scale (3I-SS).

C. Patients with a 3I-SS score of 4 or more and have a last known well time of less than 24 hours OR an unknown last known well time shall be transported to the closest Comprehensive Stroke Center (CSC).

D. Patients with a 3I-SS score of 3 or less shall be transported to the closest stroke center.

E. Patients with a 3I-SS score of 4 or more and a last known well time greater than 24 hours shall be transported to the closest stroke center.

V. HOSPITAL COMMUNICATION

A. Online Medical Control contact is required for all suspected stroke patients.

B. Document time of hospital notification.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Stroke Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PRIMARY AND COMPREHENSIVE STROKE CENTERS

PRIMARY STROKE CENTERS (PSC)

Advocate Illinois Masonic Medical Center
Advocate Trinity Hospital
Ascension Saint Francis Hospital
Ascension Saint Joseph Hospital, Chicago
Ascension Saints Mary & Elizabeth Medical Center - St. Mary Campus
Community First Medical Center
Endeavor Health Swedish Hospital
Holy Cross Hospital
Humboldt Park Health
Insight Hospital & Medical Center
John H. Stroger, Jr. Hospital of Cook County
Loyola MacNeal Hospital
Mount Sinai Hospital
OSF Little Company of Mary Medical Center
Saint Anthony Hospital
Weiss Memorial Hospital
West Suburban Medical Center

COMPREHENSIVE STROKE CENTERS (CSC)

Advocate Christ Medical Center
Advocate Lutheran General Hospital
Ascension Resurrection Medical Center
Loyola University Medical Center
Northwestern Memorial Hospital
Rush University Medical Center
UChicago Medicine
UI Health

Updated: 12/16/22, 7/31/2023, 12/12/23, 8/5/24

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Suspected COVID-19 Patient Triage and Transport
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: April 3, 2020

SUSPECTED COVID-19 PATIENT TRIAGE AND TRANSPORT

I. PURPOSE

A. Identify patients that require emergency medical care and those that are appropriate for non-transport to a hospital during the COVID-19 pandemic in order to accomplish the following:

1. Provide EMS services to critically ill or high risk populations
2. Minimize disease transmission to the community
3. Protect first responders and healthcare personnel
4. Preserve healthcare system functioning when the system is overwhelmed
5. Ensure proper follow-up and education of patients that are not transported by EMS

II. SUSPECTED COVID-19 TRIAGE AND TRANSPORT

A. COVID-19 should be suspected in patients with history of fever with symptoms of **viral syndrome illness** (cough, nasal/chest congestion, sore throat, body aches).

B. Follow “Suspected COVID-19 Protocol” for initial assessment and treatment.

C. Continue to treat the patient per Region 11 EMS System Protocol and Policies.

D. Triage the patient acuity based on the following established categories (see algorithm attachment)

1. “Red” (Immediate)
   a. Abnormal vital signs
   b. Presence of emergency condition
2. “Yellow” (Delayed)
   a. High risk due to age or comorbidities
   b. Unsafe home situation
3. “Green” (Minor)
   a. Minimal symptoms
   b. Requesting testing
   c. COVID-19 exposure
4. “Black” (Deceased)
   a. Cardiac arrest

b. Not covered on this algorithm

E. Evaluate each COVID-19 patient with a complete assessment including the following criteria:

1. **Age**:
   a. Adult patients are > 18 years old and included in the algorithm
   b. Pediatric patients are not covered on this algorithm

2. **Vital Signs (if YES to any triage "RED")**:
   a. Respiratory rate < 8 or > 24
   b. Oxygen saturation < 94%
   c. Heart rate > 110 bpm
   d. Systolic blood pressure < 100 or > 180 mmHg
   e. Temperature > 100.4 degrees F (if available)

3. **Emergency Condition (if YES to any triage "RED"):**
   a. Chest pain, other than mild with coughing
   b. Shortness of breath with activity
   c. Altered mental status
   d. Syncope
   e. Diaphoresis
   f. Cyanosis

4. **High Risk Factors (if YES to any triage "YELLOW")**:
   a. Age > 60 years old
   b. Diabetes
   c. Pregnant
   d. Chronic heart, lung, or kidney disease
   e. Immunocompromised

5. **Home Criteria (if <u>NO</u> to any triage "YELLOW"):**
   a. Appropriate caregivers are available if needed
   b. Patient has decision making capacity
   c. Patient consents to non-transport
   d. Access to food, water, and other necessities

F. Determine triage category and transport decision

1. Patients with vital sign abnormalities or emergency conditions should be triaged "Red" and transported to the closest Emergency Department with Pre-Notification.

2. Patients with significant risk factors or without appropriate home criteria should be triaged "Yellow" and transported to the closest Emergency Department with Pre-Notification.

3. For any situations where transport is indicated, but the patient refuses transport, consult Online Medical Control while on scene with the patient.

4. Patients that do not meet criteria for vital sign abnormalities, emergency conditions, or risk factors and do meet all of the home criteria should be triaged “Green” and are appropriate for non-transport.

G. Prior to non-transport, the following criteria are mandatory:

1. Online Medical Control is required

2. Follow-Up Plan Established
   a. Primary care provider follow-up available
   b. Referral to Community Health Center if no primary care provider
   c. Provided with CDPH COVID Information Line (312-746-4835)
   d. Instructions to seek medical care if symptoms worsen

3. COVID-19 Resource Packet provided
   a. COVID Educational forms from CDPH that may include and be updated (https://www.chicago.gov/city/en/sites/covid-19/home/resources.html)
      1. What to do if you have COVID-19?
      2. What to do if you have been exposed to someone with COVID-19?
      3. What to do if you have been diagnosed with COVID-19?
      4. What to do if you don’t have health insurance?
      5. Tips on managing anxiety about COVID-19?

4. Refusal form signed by patient

Region 11 Chicago EMS Guidelines for Suspected COVID-19 Patient Triage and Transport

For adult patients with history of fever and symptoms of **viral syndrome illness** (cough, nasal/chest congestion, sore throat, body aches)

VITAL SIGNS

- Respiratory rate < 8 or > 24
- Oxygen saturation < 94%
- Heart rate > 110 bpm
- Systolic blood pressure < 100 or > 180 mmHg
- Temperature > 100.4 °F (if available)

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

EMERGENCY CONDITION

- Chest pain, other than mild with coughing
- Shortness of breath with activity
- Altered mental status
- Syncope
- Diaphoresis
- Cyanosis

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

RISK FACTORS

- Age > 60 years old
- Diabetes
- Pregnant
- Chronic heart, lung, or kidney disease
- Immunocompromised

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

HOME CRITERIA

- Appropriate caregivers are available if needed
- Patient has decision making capacity
- Patient consents to non-transport
- Access to food, water, and other necessities

NO → **Transport to closest appropriate Emergency Department with Pre-Notification**

YES

Patient is appropriate for non-transport

Online Medical Control is required

Follow-Up Plan Established

COVID Resource Packet Provided

For any situation where transport is indicated, but the patient refuses transport, consult Online Medical Control

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Systems of Care
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

SYSTEMS OF CARE

I. PURPOSE

A. To define the Systems of Care for patients transported by EMS within Region 11.

B. To deliver the right resources to the right patient in the right place at the right time.

II. DEFINITIONS

A. System of Care**:** Regionalized care for a patient with a time-critical or specialty condition from EMS assessment to definitive care at a designated hospital facility.

B. Designation: Recognition of a hospital facility to have the capability to provide specialty care services by a state or regional authority.

C. Destination Criteria**:** Defined criteria for EMS to identify patients that should be directly transported to a designated hospital as part of a System of Care.

III. SYSTEMS OF CARE

A. The established Systems of Care with specialty hospital designations for Region 11 are listed below. Refer to each individual policy for specific patient destination criteria.

1. STEMI and Out of Hospital Cardiac Arrest (OHCA) Patient Destination

   a. STEMI Center

2. Stroke Patient Destination

   a. Comprehensive Stroke Center (CSC)
   b. Primary Stroke Center (PSC)

3. Trauma Patient Destination

   a. Level 1 Trauma Center
   b. Level 1 Pediatric Trauma Center

4. Burn Patient Destination

   a. Burn Center

5. Ventricular Assist Device (VAD) Patient Destination

   a. VAD Center

6. Perinatal (Obstetric/Neonatal) Patient Destination

   a. Level III Perinatal Hospital
   b. Level II Perinatal Hospital
   c. No obstetrical services (Level 0)

7. Pediatric Patient Destination

   a. Pediatric Critical Care Center (PCCC)
   b. Emergency Department Approved for Pediatrics (EDAP)
   c. Emergency Department without pediatric designation

See attachment for a complete list of Region 11 EMS Systems of Care Hospital Designations.

IV. OTHER PATIENT DESTINATION CONSIDERATIONS

A. Patients that self-identify as veterans can be transported to a Veterans Affairs Medical Center (VAMC) per policy.

B. Veteran patient transports are preferred for medical care coordination, but not a System of Care.

V. HOSPITAL COMMUNICATION

A. Online Medical Control contact is required for all Systems of Care patients.

B. Document time of hospital notification.

VI. DOCUMENTATION

A. Documentation should include “Systems of Care” as a reason for the destination decision.

B. The hospital designation or capability should be documented as the transport destination.

REGION 11 EMS SYSTEMS OF CARE - HOSPITAL DESIGNATIONS

Hospital	Burn	Pediatrics	Perinatal (Obstetric & Neonatal)	STEMI & Out of Hospital Cardiac Arrest (OHCA)	Stroke	Trauma	Ventricular Assist Device (VAD)
Advocate Christ Medical Center		PCCC	Level III	STEMI Center	CSC	Level I	VAD Center
Advocate Illinois Masonic Medical Center		EDAP	Level III	STEMI Center	PSC	Level I	
Advocate Lutheran General Hospital		PCCC	Level III	STEMI Center	CSC	Level I	
Advocate Trinity Hospital			Level II	STEMI Center	PSC		
Ann & Robert H. Lurie Children's Hospital of Chicago		PCCC	NO OB SERVICES			Level I Pediatric	
Ascension Resurrection Medical Center			Level II	STEMI Center	CSC		
Ascension Saint Francis Hospital		EDAP	NO OB SERVICES	STEMI Center	PSC	Level I	
Ascension Saint Joseph Hospital, Chicago		EDAP	Level III	STEMI Center	PSC		
Ascension Saints Mary & Elizabeth Medical Center - Saint Mary Campus		EDAP	Level II	STEMI Center	PSC		
Community First Medical Center			NO OB SERVICES	STEMI Center	PSC		
Edward Hines, Jr. Veterans Affairs Hospital			NO OB SERVICES				
Endeavor Health Swedish Hospital			Level II	STEMI Center	PSC		
Holy Cross Hospital			NO OB SERVICES		PSC		
Humboldt Park Health			Level II	STEMI Center	PSC		
Insight Hospital & Medical Center			NO OB SERVICES		PSC		
Jackson Park Hospital & Medical Center			NO OB SERVICES				
Jesse Brown Veterans Affairs Medical Center			NO OB SERVICES				
John H. Stroger, Jr. Hospital of Cook County	Burn Capable	EDAP	Level III	STEMI Center	PSC	Level I Level I Pediatric	
Loretto Hospital			NO OB SERVICES				
Loyola MacNeal Hospital		EDAP	Level II	STEMI Center	PSC		
Loyola University Medical Center	Burn Center	PCCC	Level III	STEMI Center	CSC	Level I	VAD Center
Mount Sinai Hospital		EDAP	Level III	STEMI Center	PSC	Level I	
Northwestern Memorial Hospital		EDAP	Level III	STEMI Center	CSC	Level I	VAD Center
OSF Little Company of Mary Medical Center		EDAP	Level II	STEMI Center	PSC		
Provident Hospital of Cook County			NO OB SERVICES				
Roseland Community Hospital			Level II				
Rush University Medical Center		EDAP	Level III	STEMI Center	CSC		VAD Center
Saint Anthony Hospital		EDAP	Level II		PSC		
South Shore Hospital			NO OB SERVICES				
St. Bernard Hospital & Health Care Center			NO OB SERVICES				
Thorek Memorial Hospital			NO OB SERVICES				
UChicago Medicine	Burn Center		Level III	STEMI Center	CSC	Level I	VAD Center
UChicago Medicine Comer Children's Hospital		PCCC	Level III			Level I Pediatric	
UI Health		PCCC	Level III	STEMI Center	CSC		
Weiss Memorial Hospital			NO OB SERVICES	STEMI Center	PSC		
West Suburban Medical Center		EDAP	Level II	STEMI Center	PSC		

PCCC: Pediatric Critical Care Center
EDAP: Emergency Department Approved for Pediatrics

CSC: Comprehensive Stroke Center
PSC: Primary Stroke Center

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Trauma Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

TRAUMA PATIENT DESTINATION

I. PURPOSE

A. Identify patients with significant injury based on the Region 11 Trauma Field Triage Criteria:

1. Injury Patterns
2. Mental Status & Vital signs
3. Mechanism of Injury
4. High-Risk Populations

B. Patients meeting any criteria in the four categories will be transported to the appropriate Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

II. TRAUMA CENTERS

A. Level I Trauma Center – A hospital participating in an approved Emergency Medical Services System and designated by the Illinois Department of Public Health to provide optimal care to all trauma patients. Level 1 Trauma Centers provide all essential services in-house, 24 hours a day.

B. Level 1 Pediatric Trauma Center - A hospital participating in an approved Emergency Medical Services System and designated by the Illinois Department of Public Health to provide optimal care to pediatric trauma patients. Level 1 Pediatric Trauma centers provide all essential **pediatric specialty services** in-house, 24 hours a day.

III. TRAUMA DESTINATION

A. Adult patients: Region 11 EMS defines the adult trauma patient as an injured person aged 16 years and older. Adult patients meeting any trauma criteria using the trauma field triage decision algorithm should be transported to the closest Level I Trauma Center.

B. Pediatric patients: Region 11 EMS defines the pediatric trauma patient as an injured person aged 15 years or less. Pediatric patients meeting trauma criteria using the trauma field triage decision algorithm should be **preferentially** transported to the closest Level I Pediatric Trauma Center.

IV. MULTIPLE PATIENT INCIDENT (MPI) EVENTS

A. During a MPI (Multiple Patient Incident) injured patients should have the Trauma Field Triage Criteria applied to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Trauma Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

1. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged “Red” and be transported to the appropriate Level 1 Trauma Center.

2. Patients that meet **Mechanism of Injury** or **High Risk Populations** criteria should be triaged “Yellow” and be transported to the appropriate Level 1 Trauma Center.

Attachments:
1. Region 11 Trauma Field Triage Criteria
2. Trauma Centers

REGION 11 TRAUMA FIELD TRIAGE CRITERIA

Patients meeting any criteria will be transported to the closest appropriate Level I Trauma Center

Injury Patterns

- Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients
- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

Age 0-9 Years
- SBP < 70mm Hg + (2 x age in years)

Age 10-64 Years
- SBP < 100 mmHg or
- HR > SBP

Age ≥ 65 Years
- SBP < 110 mmHg or
- HR > SBP

Patients meeting these criteria are categorized as "Red"

Mechanism of Injury

- High-Risk Auto Crash
  - – Partial or complete ejection
  - – Significant intrusion (including roof)
    - > 12 inches occupant site OR
    - > 18 inches any site OR
    - Need for extrication of entrapped patient
  - – Death in passenger compartment
  - – Child (age 0-9 years) unrestrained or in unsecured child safety seat
  - – Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, electric powered device, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Hanging/Strangulation
- Fall from height > 10 feet (all ages)

High Risk Populations

Children
- All children ≤ 15 years meeting criteria for transport to a Trauma Center should go to a Level I Pediatric Trauma Center
- Low level falls (age ≤ 5 years) with significant head impact or obvious injury
- Suspicion of traumatic injury secondary to child abuse

Older Adults (Age ≥ 65 Years)
- Low level falls with significant head impact or obvious injury

Other
- Anticoagulant use or bleeding disorder with significant head impact or obvious injury
- Burns in conjunction with trauma
- Pregnancy > 20 weeks should be preferentially transported to a Level I Trauma Center with Level III Perinatal Center capabilities
- EMS or base station judgement

Patients meeting these criteria are categorized as "Yellow"

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Trauma Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: July 10, 2024

Attachment 2

TRAUMA CENTERS

(Pediatric patients are defined as less than 16 years old)

I. **Level I Trauma Centers**:

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Ascension Saint Francis Hospital
John H. Stroger Hospital of Cook County
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
UChicago Medicine

II. **Level I Pediatric Trauma Centers:**

Ann & Robert H. Lurie Children's Hospital of Chicago
John H. Stroger Hospital of Cook County
UChicago Medicine - Comer Children's Hospital

Updated: 4/6/22

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Ventricular Assist Device (VAD) Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: February 24, 2020

VENTRICULAR ASSIST DEVICE (VAD) PATIENT DESTINATION

I. Patients with a Ventricular Assist Device experiencing VAD-related complications or cardiovascular problems should be transported to a VAD center.

II. Patients with a VAD and a non-cardiovascular-related problem should still preferentially be transported to a VAD center if less than 25 minutes transport time.

III. When possible, patients should be transported to the center that placed the VAD (if less than 25 minutes transport time).

IV. Bring all VAD equipment to the hospital.

V. Follow the Ventricular Assist Device protocol when caring for VAD patients.

VAD CENTERS

As of February 24, 2020

Advocate Christ Medical Center
Loyola University Medical Center
Northwestern Memorial Hospital
Rush University Medical Center
UChicago Medicine

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Veteran Patient Destination
	Section: Transportation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

VETERAN PATIENT DESTINATION

I. PURPOSE

To define the transport of patients that self-identify as veterans to facilities in the Veterans Affairs Healthcare System that participate in the EMS System.

II. DEFINITIONS

A. Veteran: A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

III. POLICY

A. Patients who are military veterans may request to obtain their medical care at facilities within the Veterans Affairs (VA) Healthcare System.

B. Veterans should self-identify their status; no further confirmation is necessary by EMS personnel.

C. There are two facilities under the Veterans Affairs Healthcare System that are Participating Hospitals in Region 11 Chicago EMS:

1. Jesse Brown Department of Veterans Affairs Medical Center

2. Edward Hines, Jr. Veterans Affairs Hospital

D. Both of these facilities are licensed as Comprehensive Emergency Departments under IDPH.

E. Patients that meet criteria set forth in the Systems of Care Policy **should not be** transported to a Veterans Affairs Healthcare facility.

F. Additional determination of the veteran patient destination should be according to the Patient Destination Policy.

REGION 11
CHICAGO EMS SYSTEM
POLICIES

DOCUMENTATION

Medical Records Documentation and Reporting
Patient Confidentiality and Release of Information/Health Insurance Portability and Accountability Act (HIPAA)

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Medical Records Documentation and Reporting
	Section: Documentation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

MEDICAL RECORDS DOCUMENTATION AND REPORTING

I. PURPOSE

To define the minimum data elements and reporting requirements for medical records documentation of an EMS patient care report.

II. DEFINITIONS

A. NEMSIS (National EMS Information System): The National EMS Information System or NEMSIS is a national system to collect, store, and share EMS data in the United States. NEMSIS develops and maintains a national standard for how patient care information resulting from prehospital EMS activations is documented.

B. Illinois Prehospital Data Program: Required electronic data file information about the EMS incident (reason for call, scene location, outcome, etc.), provider/unit/crew member identifiers, unit utilization descriptors (e.g., times and locations), patient information (limited demographics, injury/illness characterization, assessment results), and treatment details (medications, procedures) submitted to the state of Illinois database and exported to NEMSIS.

III. POLICY

A. Data Collection and Submission

1. A patient care report (PCR) shall be completed by each Illinois-licensed transport vehicle service provider for every inter-hospital transport and pre-hospital emergency call, regardless of the ultimate outcome or disposition of the call.

2. One patient care report shall be provided (paper or electronic) to the receiving hospital Emergency Department or health care facility **before leaving the facility** (or within two hours of transfer of patient care.)

3. The EMS System shall designate or approve the patient care report to be used by all of its transport vehicle providers. The report shall contain the minimum requirements as defined by the Illinois Prehospital Data Program and NEMSIS.

4. Region 11 approved short patient care forms must include at minimum the following data elements:

   a. Name of patient;
   b. Age;
   c. Vital Signs;
   d. Chief complaint;
   e. List of current medications;

f. List of allergies;
g. All treatment and interventions;
h. Date; and
i. Time

5. All non-transport vehicle providers shall document all medical care provided and shall submit the documentation to the EMS System within 24 hours. The EMS System shall review all medical care provided by non-transport vehicles and shall provide a report to IDPH upon request.

6. The transport vehicle provider shall submit patient care report data to the EMS System. When an EMS System is unable to import data from one or more providers, those providers may, with EMS System approval, submit their patient care report data directly to IDPH. IDPH will make the patient care report data available to the EMS System upon request. Every EMS System and EMS provider approved to submit data directly shall electronically submit all patient care report data to IDPH by the 15th day of each month. The monthly report shall contain the previous month's patient care report data. Third party software shall be validated by the Department to ensure compatibility with the Department's data specifications. Third party software shall not be used until the Department's validation is complete.

B. Documentation Requirements

1. The patient care report is an **OFFICIAL LEGAL DOCUMENT** and must be reviewed and signed by all EMS personnel participating in the care of the patient.

2. All assessments, procedures, and medications must be documented in the patient care report.

3. Cardiac rhythm and capnography monitoring data shall be uploaded to the electronic patient care report when the monitor is applied to the patient including the following situations: cardiac arrest, STEMI, 12 lead ECG, advanced airway, cardioversion, defibrillation, and pacing.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Patient Confidentiality and Release of Information / Health Insurance Portability and Accountability Act (HIPAA)
	Section: Documentation
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PATIENT CONFIDENTIALITY AND RELEASE OF INFORMATION / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I. DEFINITIONS

A. HIPAA Law: Emergency Medical Services (EMS) follows the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule. The HIPAA Privacy Rule standards address the use and disclosure of individuals' health information, also known as “protected health information”, by organizations subject to the Privacy Rule, who are also be referred to as "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

B. Protected Health Information (PHI): The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The HIPAA Privacy Rule calls this information "protected health information (PHI").

C. Individually Identifiable Health Information: Information, including demographic data, that relates to:

1. The individual's past, present or future physical or mental health or condition;

2. The provision of healthcare services to the individual;

3. The past, present, or future payment for the provision of health care to the individual; and

4. Information that identifies the individual OR for which there is a reasonable basis to believe that it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

II. DISCLOSURE OF PHI UNDER THE HIPAA PRIVAVCY RULE

A. When participating in treatment, payment, or operations activities, EMS providers may use or disclose PHI that is necessary to conduct those activities without patient authorization. EMS providers should use or disclose only the minimum amount of PHI necessary to accomplish the required task.

B. The HIPAA Privacy Rule generally does not apply to law enforcement officers, so they cannot violate HIPAA. Necessary PHI can generally be released to law enforcement when

related to a crime or where required by state law. EMS agency policies regarding this should be followed.

III. **SAFEGUARDING EMS PATIENT CONFIDENTIALITY**

A. The confidentiality of information pertaining to a patient must be safeguarded by all EMS system participants, per the law and in compliance with hospital and/or ambulance service provider policy at all times.

B. The confidentiality of patient record information should include, but not be limited to, the names of the patients and their medical status.

C. The patient may request, in writing, a copy of the patient care report through the respective ambulance service provider. Receiving hospitals shall not turn over a copy of the ambulance run report to the patient or a patient's family member.

D. Copies of prehospital audio records, log sheets, and patient care reports must be provided by system participants to the Resource Hospital on request.

E. During a multiple patient incident or multiple patient transport, confidentiality must be maintained when collecting individual patient information.

Reference: U.S. Department of Health and Human Services, Summary of the HIPAA Privacy Rule, https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

REGION 11
CHICAGO EMS SYSTEM
POLICIES

EMS EDUCATION

EMS Competency Testing
EMS Continuing Education (CE) Requirements
(including IDPH EMS CE Relicensure Recommendations)
EMS Lead Instructor

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Competency Testing
	Section: EMS Education
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS COMPETENCY TESTING

I. REQUIREMENTS

A. Region 11 EMS providers will complete EMS education and skill testing as required by the EMS Medical Director's Consortium.

B. Successful completion of EMS Competency Testing is a minimum score of 75 percent.

II. CONTENT OF EMS COMPETENCY TESTING

A. Written questions will be focused on Region 11 EMS System Protocols, Policies, and Procedures with content following the National EMS Education Standards.

B. Skill testing will follow the EMS scope of practice per licensure level under Region 11.

III. NOTIFICATION OF TEST RESULTS

A. Exam scores will be provided on the day of testing or it may be reviewed at a later date by the Resource Hospital.

IV. FAILURE OF EXAM

A. Any portion of the exam that is not successfully completed after the first attempt will be reviewed by the Resource Hospital EMS Coordinator or designee with the EMS provider.

B. The exam review and retesting must be scheduled with the Resource Hospital EMS Coordinator or designee. It is the responsibility of EMS personnel to schedule this review.

C. Exam review and retesting shall be completed within 60 days from the date of the initial failure.

D. The retest will be administered by the EMS Coordinator or the EMS Medical Director (or designee) of the respective Resource Hospital and graded immediately upon completion.

E. Upon completion of the exam, EMS personnel will be notified verbally of the examination results and will subsequently receive written confirmations.

F. If a passing grade is not achieved, notification of failure on the retest will be sent by regular mail and email. This will include a notification that failure of a third test will result in suspension of medical privileges. Employers of these individuals will be notified of retest examination failures and possibly of suspension of medical privileges within four weeks.

G. The third test shall be accomplished within the subsequent four-week period. It is the responsibility of the EMS personnel to schedule the retest with the Resource Hospital EMS Coordinator or designee.

H. It is the responsibility of the EMS personnel to review relevant content and prepare for the third and final exam.

I. The third test will be administered by the EMS Coordinator or EMS Medical Director (or designee) of the respective Resource Hospital and graded immediately upon completion.

J. EMS personnel will immediately be notified verbally of the examination results and will subsequently receive written confirmation.

K. In the event of failure of the third test, the EMS personnel's medical privileges shall be suspended. The respective employer will be notified immediately regarding the individual's status upon completion of the third test.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Continuing Education (CE) Requirements
	Section: EMS Education
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS CONTINUING EDUCATION (CE) REQUIREMENTS

I. Continuing education (CE) given by or approved by the Resource Hospital within Region 11 is considered “In-System CE.” Any other CE courses are considered “Out-of-System CE.”

II. Region 11 follows the “IDPH EMS Continuing Education Relicensure Recommendations” for each specific activity, documentation, and CE hours recommended.

   A. “Life Support Courses” require card or certificate for documentation.

   B. “Locally offered CE programs” require certificate with IDPH site code.

   C. National EMS CE programs with CAPCE (Commission on Accreditation for Prehospital Continuing Education) approved CE hours.

   D. Other CE hours are reviewed by the Resource Hospital.

III. All “Locally offered CE programs” for EMS continuing education require submission by a licensed EMS Lead Instructor to the Resource Hospital for review and IDPH site code approval.

   A. Content should follow the National EMS Education Standards.

   B. Course submissions should include objectives, content, and method of testing/verification.

   C. Complete applications should be submitted to the Resource Hospital at a minimum of 90 days prior to anticipated start date.

IV. For all EMT and Paramedic Continuing Education hours, Region 11 EMS follows IDPH recommendations including:

   A. EMT Core Content Category Hours, at minimum, per 4-year licensure period (total 80 hours):

      1. Preparatory (2 hours)

      2. Airway Management and Ventilation (10 hours)

      3. Patient Assessment (6 hours)

      4. Trauma (8 hours)

      5. Cardiology (12 hours)

      6. Medical (16 hours)

7. Special Considerations – Neonatal, Pediatrics, Obstetrics, Gynecology (12 hours)
8. Geriatrics (2 hours)
9. Operations (2 hours)
10. Elective (10 hours)

B. Paramedic Core Content Category Hours, at minimum, per 4-year licensure period (total 120 hours):

1. Preparatory (4 hours)
2. Airway Management and Ventilation (12 hours)
3. Patient Assessment (8 hours)
4. Trauma (12 hours)
5. Cardiology (16 hours)
6. Medical (20 hours)
7. Special Considerations – Neonatal, Pediatrics, Obstetrics, Gynecology (16 hours)
8. Geriatrics (4 hours)
9. Operations (4 hours)
10. Elective (20 hours)

C. Each CE certificate should be uploaded in the appropriate category as defined on the certificate.

V. Documentation of all EMS CE should be uploaded by the EMS provider into their Vector Solutions – EMS Medical Directors Consortium profile.

VI. CE certificate requirements:

A. Course name

B. Date

C. Participant name

D. Number of hours

E. Course instructor name and signature

F. Training site location

G. Education format: online or in-person

H. Core content category (if approved within Region 11)

I. IDPH site code number or CAPCE approval

VII. Other EMS CE may be approved if there is a valid Illinois EMS CE site code and/or Commission on Accreditation for Prehospital Continuing Education (CAPCE) approved CE hours.

A. Courses that do not meet these requirements must be approved by the EMS Medical Director prior to uploading to Vector Solutions.

VIII. IDPH licensed EMS providers that are credentialed to work in another EMS System should designate their status with the Resource Hospital noting their “Primary EMS System for CE and Relicensure” and their “Secondary EMS System.”

IX. IDPH EMS Continuing Education Relicensure Recommendations

A. See next page.

State of Illinois
Illinois Department of Public Health

Illinois Department of Public Health
Division of EMS & Highway Safety
www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Emergency Medical Systems
Continuing Education Relicensure Recommendations

This Continuing Education (CE) list is NOT intended to be all-inclusive and should be considered as CE Recommendations ONLY. A wide variety of educational programs, seminars, online offerings, and workshops that are not listed below may also meet the intent of national standards for EMS continuing education.

Standard Documentation required to validate completion for all CE in Illinois: CE certificate, course card, or sign-in roster signed by instructor or authorizing person to include: name of participant; date; times; topic(s); number of CE hours awarded; and Illinois site code, CECBEMS, and/or medical or nursing accrediting body number. All CE hours awarded must be approved by the EMS Medical Director.

Calculating hours for AEMT/EMT-I and EMT: The hours listed in this document are for Paramedics (based on 100 hours in 4 years).
AEMT and EMT-I: Multiply required hours for Paramedics by 0.8 (80 hours in 4 years). **EMT:** Multiply required hours for Paramedics by 0.6 (60 hours in 4 years).
NOTE: EMS personnel should verify the continuing education requirements within their EMS System(s). EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

Activity	Documentation	Hours Recommended	Comment
Initial education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation and course schedule	Hr/Hr up to 16 hours for each course	
Advanced Trauma Life Support, Teaching EMS-related courses/ CE, Wilderness EMS Training, TEMS, MIH Community PM, Critical Care PM	Standard documentation and course schedule	Hr/Hr for EMS content of course	May not exceed 20% of total hours for one subject area. Educators may not get credit for presenting the same topic/lecture multiple times. Up to 50% of total hours may be earned by teaching participants at a lower level of licensure. Should be considered on a case by case basis for any topics in EMS education standards
Refresher/renewal education (Life Support courses): ABLS, ACLS, AMLS, EMPACT, ITLS, NRP, PALS, PEPP (ALS), PHTLS etc., CPR instructor	Standard documentation and course schedule	Hr/Hr up to 8 hours	
EMTs: PEPP (BLS) course	Standard documentation and course schedule	Hr/Hr up to 8 hours	
Pediatric related CE	Standard documentation and course schedule	Hr/Hr up to 16 hours max	Pediatric education now has much greater emphasis than in the 1998 DOT curriculum. Illinois recommends 16 hours in 4 yrs. Topics include: Pediatrics, Neonatology, Gynecology and Obstetrics.
Initial courses: CPR Instructor, Emergency Vehicle Operators course, Emergency Medical Dispatch course	Standard documentation and course schedule	Hr/Hr up to 12 hours max	
Locally offered CE programs	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Audit of entry level EMT, AEMT, Paramedic courses	Standard documentation	Hr/Hr to max content hours	Unlimited hours if subject matter is at the appropriate level for the participant's license. May not exceed 20% of total required hours in one subject area, e.g., cardiac, trauma, rescue, etc.

Activity	Documentation	Hours Recommended	Comment
Clinical preceptor or evaluator	Signed letter from EMS Coordinator or lead instructor	Hr/Hr to max hours allowable	May not exceed 20% of total minimum required CE hours.
Emergency Preparedness	Written statement of participation from EMSC/EMS MD or exercise director.	Hr/Hr up to 12 hours (Paramedic/PHRN) 10 hours (EMT-I) 8 hours (EMT)	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.
College courses: Health-related courses that relate to the role of an EMS professional (A&P, assessment, physiology, biology, chemistry, microbiology, pharmacology, psychology, sociology, nursing/PA courses, etc.)	Catalog description of course and evidence of successful completion through minimum grade of C (official transcripts or evidence from school)	Hr/Hr 1 college credit = 8 CEU	May not exceed 20% of total hours for one subject area. Should be considered on a case by case basis for any topics in EMS education standards.
Participation/observation in surgery, physical therapy, childbirth, autopsy, etc.	Written statement of participation from: clinical unit leader, preceptor or physician validating attendance	Hr/Hr up to max of 5 hours	Max 5 hours must be part of an approved educational experience or include defined educational objectives.
Seminars/Conferences: EMS related education approved by CECBEMS or medical or nursing accrediting body	Copy of agenda/program plus certificate of attendance	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Commercial CE: Electronic digital media (e.g. videotapes/CDs), journal articles with publication dates of 5 years or less prior to the date of CE completion. Approved by CECBEMS or medical or nursing accrediting body	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Trauma Nurse Specialist or TNS Review Courses: May audit for CE with prior approval of TNS Course Coordinator to ensure space availability	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area. Course covers multiple areas of A&P, fluid & electrolytes, acid base balance, shock pathophysiology and systems trauma appropriate for PMs and PHRNs for full credit.
ECRN Course (apart from Life Support courses): May audit for CE with prior approval of Course Lead Instructor to ensure space availability	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area. Course may cover multiple across the spectrum of EMS appropriate for PMs and PHRNS for full credit
On-line options Webinars and on-line offerings with subject matter found in the EMS Education Standards [e.g. sponsored by a governmental agency (infectious diseases, emergency preparedness) legal experts (documentation HIPAA) organizations or commercial offerings].	Standard documentation	Hr/Hr to max content hours	May not exceed 20% of total minimum required hours in one subject area,

The below table outlines Illinois recommendations of Core Content breakdown during each relicensure period for Paramedics (hours for AEMT, EMT-I and EMT should be calculated accordingly).
Note: EMS System Medical Directors may require their EMS personnel to obtain EMS Continuing Education above the minimum requirements as outlined in Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

CORE CONTENT	*ILLINOIS RECOMMENDED HOURS*	*CORE CONTENT*	*ILLINOIS RECOMMENDED HOURS*
Preparatory	8 hours in 4 years	Medical	20 hours in 4 years
Airway Management & Ventilation	12 hours in 4 years	Special Considerations (Neonatology, Pediatrics, Gynecology, Obstetrics)	16 hours in 4 years
Patient Assessment	8 hours in 4 years	Geriatrics	4 hours in 4 years
Trauma	12 hours in 4 years	Operations	4 hours in 4 years
Cardiology	16 hours in 4 years		
		TOTAL	**100 hours in 4 years**

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Lead Instructor (LI)
	Section: Education
	Approved: EMS Medical Directors Consortium
	Effective: July 15, 2020

EMS LEAD INSTRUCTOR (LI)

I. LEAD INSTRUCTOR (LI) INITIAL LICENSE APPLICATION

A. **In the Region 11 Chicago EMS System, and per IDPH, all education, training and Continuing Education (CE) courses for EMTs, Paramedics, ECRNs, EMRs and EMDs shall be coordinated by at least one approved Illinois EMS Lead Instructor (LI). A program that includes education, training or CE for more than one type of EMS Personnel may use one EMS LI to coordinate the program. A single EMS LI may simultaneously coordinate more than one program or course.**

B. To be eligible for an Illinois EMS LI license, the applicant shall meet at least the following minimum experience and education requirements:

1. A current Illinois license as an EMT, Paramedic, RN or physician;

2. A minimum of four years of experience in EMS or emergency care;

3. At least two years of documented teaching experience (CPR, ACLS, PALS, PHTLS, EMT or Paramedic etc.);

4. Documented EMS classroom teaching experience with a recommendation for LI licensure by an EMS MD or licensed LI;

5. Documented successful completion of the Illinois EMS Instructor Education Course or equivalent to the National Standard Curriculum for EMS Instructors (NAEMSE Lead 1 Course) as approved by IDPH.

C. The LI applicant shall complete the Region 11 EMS Lead Instructor Application that describes the above requirements and details regarding their teaching experience (available online at https://chicagoems.org/lead-instructor/). This includes course dates and roles in the course teaching and administration. This application and copy of the successful Course Completion Certificate of the Lead Instructor course should be sent to the Resource Hospital.

D. Once the criteria are met to the standards of the Resource Hospital, the EMS Medical Director signs the IDPH Lead Instructor Initial/Renewal EMS Medical Director Authorization Form.

E. The candidate is responsible for completing the IDPH EMS Systems Renewal Notice/Child Support/Personal History Statement (available online at https://chicagoems.org/lead-instructor/) and submitting it to their Resource Hospital.

F. The Resource Hospital is responsible for completing the Transaction Card for the license.

G. The Resource Hospital will submit the complete application packet to IDPH.

H. Once the complete application packet is received by IDPH, they will notify the LI applicant with instructions for online payment.

I. Once issued, the EMS Lead Instructor license should be added as a credential to the Target Solutions platform to track CE hours and renewal.

II. LEAD INSTRUCTOR (LI) LICENSE RENEWAL APPLICATION

A. All LI license renewal applicants will receive a renewal letter from IDPH 60 days prior to their expiration date. The letter will contain information for renewal and a PIN ID number required for online payment.

B. All EMS LIs shall attend an IDPH approved review course whenever revisions are made to the national EMS education standards.

C. To apply for relicensure, the EMS LI shall submit the following to their Resource Hospital at least 60, but no more than 90 days, prior to the LI's license expiration:

1. Documentation of at least 40 total hours of continuing education.

    a. There should be at least 20 hours of “Instructor Related Education” which is related to the development, delivery, and evaluation of education programs.
    b. There should be at least 20 hours related to the “Classroom Time” as documented on a course roster or verification letter.

2. Documentation of attendance at an IDPH-approved national EMS education standards update course, if applicable

3. Completed IDPH EMS Systems Renewal Notice/Child Support/Personal History Statement (available online at https://chicagoems.org/lead-instructor/).

4. Once the criteria are met, the EMS Medical Director signs the IDPH Lead Instructor Initial/Renewal EMS Medical Director Authorization form.

5. The Resource Hospital will submit to IDPH the Lead Instructor Initial/Renewal EMS Medical Director Authorization Form and a new license will be issued to the individual.

D. A LI that has not been recommended for relicensure shall be provided with a written statement from the EMS MD stating the reason for the withholding of the endorsement.

1. The license of a LI who has failed to complete the renewal application requirements for the EMS System and IDPH shall be invalid on the expiration date of the license. An individual shall not function as an EMS LI on an expired license.

2. A LI whose license has expired may, within 60 days after the expiration of the license, submit all relicensure requirements and the required fees, including a late fee, online or by certified check or money order.

3. A LI whose license has expired after 60 days of expiration should follow the process for a new license application.

III. LEAD INSTRUCTOR (LI) LICENSE SUSPENSION AND EXPECTATIONS

A. IDPH may suspend, revoke or refuse to issue or renew the approval of an EMS LI license, after an opportunity for a hearing, when findings show one or more of the following:

1. The EMS LI has failed to conduct a course in accordance with the curriculum of the Region 11 EMS System;

2. The EMS LI has failed to comply with protocols and polices of the Region 11 EMS System.

B. The EMS LI shall be responsible for the following:

1. Understanding the process and requirements for site code applications in the Region 11 EMS System;

2. Ensuring that no EMS education course begins until after IDPH issues its formal written pre-approval, which shall be in the form of a numeric site approval code; and

3. Ensuring that all materials presented to participants comply with National EMS Education Standards, as modified and approved by Region 11 and IDPH. Methods of assessment or intervention that are not approved by both the EMS System and the Department shall not be presented.

REGION 11
CHICAGO EMS SYSTEM
POLICIES

EMS PERSONNEL

Ambulance Licensing Requirements
Community Paramedic
Emergency Medical Dispatcher (EMD)
EMS Mandatory Continuing Education
EMS Personnel Licensing Requirements
EMS Personnel Reinstatement
EMS Preceptor
EMS Provider Impairment and Substance Abuse
EMS Scope of Practice
EMS System Entry
EMS System Inventory Requirements
EMS System Participation Suspension
EMS System Review Board
EMT and Paramedic Reciprocity
Inactive Status
Occupational Exposure to an Infectious Disease
Paramedic Field Internship Program
Prehospital Registered Nurse (PHRN), Prehospital Physician Assistant (PHPA) and Prehospital Advanced Practice Registered Nurse (PHAPRN)
Primary and Secondary EMS System
Vaccine Administration

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Ambulance Licensing Requirements
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

AMBULANCE LICENSING REQUIREMENTS

I. PURPOSE

To establish ambulance licensing requirements for EMS agencies participating in Region 11 Chicago EMS.

II. VEHICLE DESIGN

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

B. A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by IDPH, as long as the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred.

III. EQUIPMENT REQUIREMENTS

A. All ambulances and non-transport units functioning in Region 11 Chicago EMS shall meet equipment requirements as determined by IDPH and the EMS Medical Director and in alignment with the current approved Region 11 Drug, Equipment and Supply (DES) List.

B. Any medications carried on the ambulance shall include both adult and pediatric doses.

C. All ambulances shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

D. Each ambulance shall have reliable ambulance-to-hospital communications capability including radio and cellular phone.

IV. OPERATIONAL REQUIREMENTS

A. Personnel requirements are defined in the EMS Staffing Policy.

B. An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the EMS Systems Act (210 ILCS 50/) and its Rules and Regulations.

C. A licensee shall operate its ambulance service 24 hours a day, every day of the year. Each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS or BLS level, and the coverage shall meet the ambulance licensing requirements set forth by IDPH.

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

    a. A current roster shall also be submitted that lists the System authorized EMTs, Paramedics, PHRNs, or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date and telephone number, and shall state whether the person is scheduled to be on site or on call.
    b. An actual or proposed four-week staffing schedule shall also be submitted that covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

2. Licensees shall obtain the EMS Medical Director's approval of their vehicles' hours of operation prior to submitting an application to IDPH. The EMS Medical Director may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

3. A vehicle service provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.

D. For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required as listed in the IDPH National Emergency Medical Services Information System (NEMSIS) Prehospital Dataset.

E. A vehicle service provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.

F. A vehicle service provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers.

G. A vehicle service provider shall not operate its ambulance at a level exceeding the level for which it is licensed.

H. IDPH will inspect ambulances each year. If the vehicle service provider has no violations of IDPH ambulance licensing requirements that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it, IDPH will inspect the vehicle service provider's ambulances in alternate years, and the vehicle service provider may, with IDPH's prior approval, self-inspect its ambulances in the other years. The vehicle service provider shall use IDPH's inspection form for self-inspection. This does not prevent IDPH from conducting unannounced inspections.

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

J. Patients, individuals who accompany a patient, and EMS Personnel may not smoke while inside an ambulance or Specialized EMS Vehicle (SEMSV). IDPH may impose a civil penalty on an individual who violates this rule.

V. EMS SYSTEM PROGRAM PLAN

A. Each licensed EMS vehicle (ambulance and non-transport units) operates under an EMS System as defined in the EMS System Program Plan.

B. Administrative assignments for the Chicago Fire Department are listed on Attachment 1 – Region 11 Resource Hospitals CFD Administrative Assignments.

C. Private EMS Providers should define the licensed EMS vehicles and personnel operating under each EMS System.

Region 11 Resource Hospitals
CFD Administrative Assignments

Chicago North EMS System #1103

- **ALS Ambulances:** 2-6-7-13-16-20-26-31-32-39-40-46-47-48-56-59-61-73
- **ALS Companies:** E9-E10-E11-E12-E55-E59-E71-E78-E79-E83-E91-E102-E108-E124-E125-T12-T55-T58-TL63
- **BLS Companies:** E7-E56-E69-E70-E86-E89-E94-E106-E110-E112-E119-T9-T13-T22-T25-T38-T44-T47-T53-T56-T57-TL21-TL23-SQ2-SQ7-HAZMAT 512

Chicago South EMS System #1113

- **ALS Ambulances:** 5-9-14-22-24-25-29-30-36-37-38-49-50-51-55-57-60-70-71-72-76-79
- **ALS Companies:** E46-E47-E54-E60-E62-E72-E73-E74-E82-E84-E93-E97-E115-E116-E122-E120-E126-MC8812
- **BLS Companies:** E45-E63-E75-E80-E81-E104-T17-T20-T27-T30-T34-T37-T42-T49-T51-T61-T62-TL16-TL24-SQ5
- **Mobile Integrated Healthcare (MIH) Unit**

Chicago Central EMS System #1108

- **ALS Ambulances:** 1-3-4-11-19-28-35-41-42-43-44-53-62-65-66-68-74
- **ALS Companies:** E1-E2-E4-E8-E13-E18-E19-E23-E26-E29-E30-E39-E43-E49-E50-E57-E98-E123-T2-T29 688-689 (seasonal)
- **BLS Companies:** E5-E14-E28-E51-E16-E22-E35-E42-E45-E103-T1-T3-T4-T6-T7-T8-T11-T15-T18-T19-T28 T33- TL5-TL10-TL39-AT8-SQ1-DIVE Truck 687-HAZMAT 511
- **MARC Division**
- **EMS Training**

Chicago West EMS System #1178

- **ALS Ambulances:** 8-10-12-15-17-18-21-23-27-33-34-45-52-54-58-63-64-67-69-75-77-78-80
- **ALS Companies:** E34-E38-E64-E68-E76-E88-E95-E99-E113 -E117-E127-E129-T32-T36-T40-T41-T45-T60-MMRT (Bike and Cart Teams)
- **BLS Companies:** E15-E32-E44-E65-E92-E96-E101-E107-E109-E121-T26-T31-T35-T46-T48-T31-T50-T52-T59 TL14-TL54
- **Surge Ambulances:** 150-151-152-153-154-155-156-157-158-159
- **Reserve Ambulance:** 101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134
- **EMS Logistics**

Revised: August 2023

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Community Paramedic
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 11, 2020

COMMUNITY PARAMEDIC

I. PURPOSE:

To define the role of the Community Paramedic (CP) within a Mobile Integrated Healthcare (MIH) Program in the Region 11 EMS System.

II. DEFINITION:

A Community Paramedic (CP) is a licensed Paramedic that completes a standardized Community Paramedic education program through an approved college or university and operates as an advanced paramedic in the provision of health education, monitoring and services beyond the roles of traditional emergency care and transport. Community Paramedic education programs using the North Central EMS Institute Community Paramedic curriculum are recognized by the Region 11 EMS System.

III. ROLE:

The Community Paramedic will assist individuals in overcoming healthcare barriers by identifying and mitigating gaps in their health and wellness needs and evaluation of specific disease processes. The Community Paramedic coordinates with community resources to support relationships between the patient and medical and social services. Community Paramedics are credentialed by the Region 11 EMS System to work in an IDPH approved Mobile Integrated Healthcare Program.

IV. CREDENTIALING:

To be credentialed as a Community Paramedic by the Region 11 EMS System, the candidate must:

A. Maintain a current IDPH Paramedic license;

B. Have two years minimum of field experience as a Paramedic;

C. Successfully complete a Community Paramedic education program with certificate from a Region 11 approved program that includes clinical experience provided under the supervision of the EMS Medical Director;

D. Submit a letter of interest to the EMS Medical Director;

E. Submit a letter of recommendation in support of the candidate from a mentor that supports the recommended qualities as listed below;

F. Attend a Region 11 EMS orientation session for the MIH Program;

G. Practice in accordance with the Region 11 Community Paramedic Protocols;

H. Complete an additional 12 hours of Continuing Education every year at the Paramedic level that is focused on Community Paramedic topics.

V. MOBILE INTEGRATED HEALTHCARE (MIH) PROGRAM PARAMEDIC SELECTION:

Community Paramedics are advanced Paramedics that require a specialized knowledge base and essential characteristics to ensure success in the role. Community Paramedics credentialed within Region 11 are eligible to participate in an approved Mobile Integrated Healthcare (MIH) Program as defined by the EMS Agency, the EMS System, and IDPH. The following are recommended qualities that Community Paramedics should display:

A. Proficient patient assessment skills;

B. The ability to work collaboratively as a member of a healthcare team;

C. Good communication and social skills;

D. Empathy;

E. Acceptable EMS System and EMS Agency personnel file upon review.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Emergency Medical Dispatcher (EMD)
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMERGENCY MEDICAL DISPATCHER (EMD)

I. EMD LICENSURE

A. To apply for licensure as an EMD, the individual shall request that the EMS System submit the following to IDPH:

1. A completed electronic transaction form recommending initial licensure as an EMD; and

2. Documentation of successful completion of a training course in emergency medical dispatching that meets or exceeds the national curriculum of the United States Department of Transportation for EMS Dispatchers or its equivalent.

B. Reciprocity shall be granted to an individual who is licensed as an EMD in another state and who meets IDPH requirements.

C. An individual who is certified or recertified by a national certification agency shall be licensed as an EMD if he or she meets IDPH requirements.

D. The EMD license shall be valid for a period of four years.

E. A licensed EMD shall notify IDPH within 30 days after any changes in name or address. Notification may be in person or by mail, phone, fax or electronic mail. Addresses may be changed through IDPH's online system. Name and gender changes require legal documents (i.e. marriage license or court documents).

F. A person may not represent himself or herself, nor may an agency or business represent an agent or employee of that agency or business, as an EMD unless licensed by IDPH as an EMD.

II. EMD PROTOCOLS

A. The EMD shall use the IDPH-approved emergency medical dispatch priority reference system (EMDPRS) protocol selected for use by his or her agency and approved by the EMS Medical Director. Pre-arrival support instructions shall be provided in a non-discriminatory manner and in accordance with the EMDPRS established by the EMS Medical Director of the EMS System in which the EMD operates.

B. EMD protocols shall include:

1. Complaint-related question sets that query the caller in a standardized manner;

2. Pre-arrival instructions associated with all question sets;

3. Dispatch determinants consistent with the design and configuration of the EMS System and the severity of the event as determined by the question sets; and

4. Post-dispatch instructions with all question sets.

5. Informing the caller requesting an emergency vehicle of the estimated time of arrival when this information is requested by the caller.

C. If the dispatcher operates under the authority of an Emergency Telephone System Board established under the Emergency Telephone System Act, the protocols shall be established by the Board in consultation with the EMS Medical Director.

D. The EMD shall provide pre-arrival instructions in compliance with protocols selected and approved by the system's EMS Medical Director and approved by IDPH.

E. IDPH and the EMS Medical Director shall approve EMDPRS protocols that meet or exceed the requirements set forth by IDPH and the National Highway Traffic Safety Administration (NHTSA) Emergency Medical Dispatch: National Standard Curriculum.

III. EMD RELINCENSURE

A. To apply for relicensure, the EMD shall submit the following to IDPH no less than 30 days before the licensure expiration date:

1. An approval signed by the EMS Medical Director recommending recertification; and

2. Proof of completion of at least 12 hours annually of medical dispatch continuing education.

B. The EMD shall file a written or electronic application for renewal with IDPH no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the expiration of the license may not be processed by the expiration date and will be subject to a late fee.

C. An EMD whose license has expired may, within 60 days after the license expiration date, complete all relicensure requirements and submit relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met and there are no pending or sustained disciplinary actions against the EMD, IDPH will relicense the EMD.

D. An EMD who has not been recommended for relicensure by the EMS Medical Director shall independently submit to IDPH an application for recertification. The EMS Medical Director shall provide the EMD with a copy of the appropriate form to be completed.

IV. EMD EDUCATION PROGRAMS

A. IDPH-approved emergency medical dispatch training programs shall be conducted in accordance with the standards of the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum or equivalent.

B. Applications for approval of EMD education programs shall be filed with IDPH on IDPH-approved forms. The application shall contain, at a minimum, the name of the applicant, agency and address, type of education program, Lead Instructor's name and address, and dates of the education program.

C. Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class. A description of the text book being used and passing score for the course shall be included with the application. The application shall be made on a form provided by IDPH and will include, but not be limited to, the following:

1. Name of applicant, agency and address;
2. Lead Instructor's name, license number, address and contact information;
3. Name and signature of the EMS Medical Director and the EMS System Coordinator;
4. Type of education program;
5. Dates, times and location of the education program (submit course schedule);
6. Goals, objectives and course outline;
7. Methods, materials and text books;
8. Content and time consistent with the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum and additional course curricula required by IDPH. Initial or modified course syllabi shall be approved by IDPH;
9. Description of evaluation instruments (student, clinical units, faculty and programs); and
10. Requirements for successful completion, when applicable.

D. All EMD education, training, and CE courses shall be coordinated by at least one approved EMS Lead Instructor. The EMS Lead Instructor shall be approved by IDPH.

E. EMD training programs shall be conducted by instructors licensed by IDPH as an EMT or Paramedic who:

1. Are, at a minimum, licensed as emergency medical dispatchers;
2. Have completed am IDPH-approved course on methods of instruction;
3. Have previous experience in a medical dispatch agency; and

4. Have demonstrated experience as an EMS instructor.

F. Any change in the EMD education program's EMS Lead Instructor shall require that an amendment to the application be filed with IDPH.

G. Questions for all quizzes and tests to be given during the EMD education program shall be prepared by the EMS Lead Instructor and available for review by IDPH upon request.

H. All approved programs shall maintain course and student records for seven years. The records shall be made available to IDPH for review upon request.

V. EMERGENCY MEDICAL DISPATCH AGENCY CERTIFICATION

A. To apply for certification as an emergency medical dispatch agency, the person, organization or government agency that operates an emergency medical dispatch agency shall submit the following to IDPH:

1. A completed emergency medical dispatch agency certification form that includes name and address;

2. Documentation of the use on every request for medical assistance of an emergency medical dispatch priority reference system (EMDPRS) that complies with IDPH requirements and is approved by the EMS Medical Director.

3. Documentation of the establishment of a continuous quality improvement (CQI) program under the approval and supervision of the EMS Medical Director. The CQI program shall include, at a minimum, the following:

a. A quality assistance review process used by the agency to identify EMD compliance with the protocol;
b. Random case review;
c. Regular feedback of performance results to all EMDs;
d. Availability of CQI reports to IDPH upon request; and
e. Compliance with the confidentiality provisions of the Medical Studies Act.

B. A person, organization, or government agency shall not represent itself as an emergency medical dispatch agency unless the person, organization, or government agency is certified by IDPH as an emergency medical dispatch agency.

VI. EMERGENCY MEDICAL DISPATCH AGENCY RECERTIFICATION

A. To apply for recertification, the emergency medical dispatch agency shall submit an application to IDPH at least 30 days prior to the certification expiration date. The application shall document continued compliance with Section V above.

VII. REVOCATION OR SUSPENSION OF EMD OR EMERGENCY MEDICAL DISPATCH AGENCY CERTIFICATION

A. The EMS Medical Director shall report to IDPH whenever an action has taken place that may require the revocation or suspension of a license issued by IDPH.

B. Revocation or suspension of an EMD license or emergency medical dispatch agency certification shall be in accordance with rules and regulations set forth by IDPH.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Mandatory Continuing Education
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS MANDATORY CONTINUING EDUCATION

I. It is the responsibility of the EMS provider to complete any mandatory Region 11 EMS CE assignment as directed by the EMS Medical Directors. Specific details of EMS Mandatory Continuing Education are detailed in memo format by the EMS Medical Directors. EMS Continuing Education can be in the form of "Online CE Assignments" or "In-Person CE Modules".

A. Mandatory Online CE Assignments

1. Mandatory CE assignments will be assigned through the Vector Solutions – EMS Medical Directors Consortium site.

2. EMS providers in Region 11 must complete all mandatory CE assignments within the specified date and time written in the accompanying memo from the EMS Medical Directors.

3. EMS providers that do not achieve a 75% score after three attempts on the quiz will not receive credit for the assignment and must contact their Resource Hospital for review.

4. For an EMS provider to be considered complete, a passing score of 75% and a certificate of completion from the assignment must be obtained.

5. In situations where there is a failure to complete the mandatory CE requirements, the process is detailed below.

B. Mandatory In-Person CE Modules

1. There will be no make-up dates upon completion of a module.

2. If the EMS provider fails to attend the mandatory scheduled module without prior notice and approval by the EMSMD or EMS System Coordinator, they must schedule time with the EMS Coordinator to complete the mandatory CE module.

3. This will be scheduled based on the availability of the EMS System Coordinator.

4. In situations where there is a failure to complete the mandatory CE requirements, the process is detailed below.

II. Failure to Complete Mandatory CE Requirements

A. At the conclusion of a mandatory CE assignment or module, the EMS provider will receive written notification from the EMS System Coordinator via the email associated with their Vector Solutions – EMS Medical Directors Consortium site. This email serves as an official notification of the failure to comply with deadline requirements and includes the intent to suspend from System Participation. The EMS provider employer agency will be copied on

the email notification.

B. Failure to complete a mandatory assignment or module by the deadline, will result in an administrative fee of $100/CE credit hour.

C. After the deadline of the mandatory assignment or module, there is a 15 day grace period to complete the CE requirements and arrange payment of the administrative fee with the EMS provider's assigned EMS System Coordinator (per the profile in Vector Solutions).

D. Failure to complete requirements of the mandatory CE and administrative fee payment within the 15 day grace period, will result in suspension of System Participation in Region 11.

E. This grace period serves as an opportunity for the EMS provider to have due process prior to suspension of System Participation in Region 11. Refer to the Region 11 EMS System Participation Suspension Policy for additional details.

F. The suspension of EMS System Participation will continue until the EMS provider completes all the requirements as noted above.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Personnel Licensing Requirements
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS PERSONNEL LICENSING REQUIREMENTS

I. EMS PERSONNEL RESPONSIBILITIES:

A. All EMS personnel are responsible for maintaining copies of continuing education certificates as required by the Illinois Department of Public Health (IDPH) and your Resource Hospital for relicensure.

B. Each EMS provider within Region 11 must maintain an active account on the Vector Solutions – EMS Medical Directors Consortium site. This allows the Resource Hospital to track and verify continuing education hours.

1. Proof of valid continuing education hours meeting IDPH and EMS System requirements over a 4-year license period MUST be reviewed and verified by the Resource Hospital PRIOR to relicensure (per EMS Continuing Education Requirements Policy).

2. Each continuing education course may only be submitted once per licensure period.

C. All EMS personnel are **SOLELY RESPONSIBLE** to track their respective date of relicensure and to adhere to the IDPH and EMS System relicensure requirements.

D. Maintain current CPR certification.

E. Inform IDPH, your Resource Hospital and employer, in writing, of a change of address and/or employer within 72 hours. EMS providers must also simultaneously update their profile on the Vector Solutions – EMS Medical Directors Consortium site.

F. At the time of initial licensure or renewal, all license holders shall report all new felony convictions to their assigned Resource Hospital and IDPH in writing within seven (7) days after the conviction.

G. Carry your current EMS license and photo identification while on duty at all times.

H. Upon receipt of a renewed EMS license, a copy should be uploaded to the Vector Solutions – EMS Medical Directors Consortium site under the credential section.

I. Any Region 11 EMS provider must report, on their own time, to the EMS Medical Director (EMSMD) or EMS Coordinator as requested for patient care review.

II. CONTINUING EDUCATION (CE) RESPONSIBILITIES:

A. Emergency Medical Dispatchers (EMDs) must complete 12 hours of EMS system-approved EMD specific CE per year for a total 48 hours per licensure period.

B. Emergency Medical Responders (EMRs) must complete 6 hours of EMS system-approved

CE per year for a total of 24 hours per licensure period.

C. EMTs must complete 20 hours of CE per year of EMS system approved CE per licensure period for a total of 80 hours per licensure period.

D. Paramedics must complete 30 hours of CE per year of EMS system approved CE for a total of 120 hours of CE per licensure period.

E. Emergency Communications Registered Nurses (ECRNs) must complete 8 hours of EMS system approved CE per year for a total of 32 hours per licensure period.

F. Any EMS personnel must complete additional and specific CE mandated by the EMSMD to address individual needs on their own time.

G. It is the responsibility of the EMS provider to complete any mandatory Region 11 EMS CE assignment as directed by the EMS Medical Director's Consortium (refer to EMS Mandatory Continuing Education Policy).

III. RENEWAL OF LICENSURE

A. The Illinois Department of Public Health Division of EMS and Highway Safety maintains the policy regarding all EMS license renewals.

1. IDPH normally mails a "Renewal Form" to all EMS personnel at their respective **home address**. In this mailing IDPH will provide a **PIN number** and **address of the IDPH EMS website**. On the IDPH EMS website, personnel will find an "ONLINE LICENSING AND RENEWAL LINK."

2. Using the "ONLINE LICENSING AND RENEWAL LINK", EMS personnel MUST COMPLETE the "Child Support and Felony Conviction Reporting" statement.

3. The online form will direct you to notify your Resource Hospital that you are applying for renewal. The Resource Hospital must then verify that submitted hours are valid, the appropriate amount of hours for relicensure are completed, the Child Support Statement and Felony Conviction Statement are submitted, and approve EMS personnel for licensure in the IDPH data base.

4. If EMS personnel DO NOT meet any or all of the IDPH relicensing requirements (i.e. the required amount of continuing education hours, not current with CPR certification, or have NOT completed the IDPH EMS web relicensing requirement) YOU WILL NOT BE RECOMMENDED FOR RELICENSURE.

5. It is solely the responsibility of EMS personnel to follow the IDPH instructions for re-licensure. EMS personnel must contact their respective Resource Hospital regarding their submission of the online application for relicensure and submit the appropriate amount of required continuing education hours.

6. It is recommended that online renewals be completed no later than 2 weeks prior to expiration date. It is recommended that renewal by mail be completed no later than 4 weeks prior to expiration date. Failure to complete renewals in a timely manner may delay delivery of the new license prior to expiration of the expiring license.

7. If renewal requirements have not been met, the personnel's license will expire.

8. License renewal fees will be assessed and paid to IDPH. These fees may be paid online.

IV. VOLUNTARY REDUCTION/ UPGRADE OF LICENSURE

A. Licensure Downgrade: In the event EMS personnel wish to voluntarily downgrade their current license status, the following procedure will be followed:

1. The Paramedic must submit a written request to the EMSMD at least 30 days prior to the expiration of his/her current license.

2. The Paramedic must be up to date in continuing education requirements for his or her licensure level.

3. The Paramedic must surrender the original license to the EMSMD.

4. Following approval of the EMSMD, the request will be forwarded to the IDPH for review.

B. License Upgrade After Downgrade: To upgrade a previously reduced license, the EMS personnel will utilize the following procedure:

1. Notify the EMSMD in writing of request to upgrade their license to the previously held status.

2. The EMSMD will review the request, current status, continuing education requirements, and make any recommendations for additional requirements necessary to upgrade the license.

3. The EMSMD will identify required CE and successful completion of a written and skills component prior to recommending upgrade to previous licensure. Educational and testing fees will apply.

4. When all requirements have been met, the EMSMD will notify IDPH in writing to upgrade the EMS personnel's previously held status.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Personnel Reinstatement
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS PERSONNEL REINSTATEMENT

I. REINSTATEMENT

A. A IDPH licensed EMD, EMR, EMT, Paramedic or ECRN whose license has been expired for less than 36 consecutive months, and had been active in Region 11 under an EMS System, may submit an application for reinstatement by IDPH by completion of the following:

1. Submit proof of completion of CE hours.

2. Receive a positive recommendation in writing from the EMS Medical Director verifying competency of all skills at the level of licensure.

3. Successfully complete an IDPH approved test for the level of EMS license to be reinstated, in accordance with Section 515.530.

4. A fee will be assessed as per IDPH and may be assessed by the Resource Hospital.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Preceptor
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS PRECEPTOR

I. DEFINITION

A. The EMS preceptor is a clinical role model, mentor and evaluator for EMS students in the field setting.

B. The EMS preceptor must have thorough knowledge of the Region 11 EMS Protocols, Policies, and Procedures.

II. PREREQUISITES

A. Required:

1. One year experience as a licensed Paramedic within Region 11 EMS or alternate experience.
2. No sustained complaints in the Paramedic's file within the past 12 months.
3. Professional references.
4. Recommendation by the Paramedic's EMS Coordinator and EMS Medical Director.
5. Approval by the EMS Medical Directors Consortium.

B. Preferred:

1. EMS teaching experience (CPR, initial or continuing EMT or Paramedic education courses)
2. CPR instructor certification
3. ACLS certification
4. ITLS or PHTLS certification
5. PEPP or PALS certification
6. Licensed IDPH Lead Instructor or National Association of EMS Educators (NAEMSE) Instructor Course 1 (IC1) certificate.
7. Regularly performing direct EMS patient care or responsible for ensuring quality patient care.

C. Preceptors are reviewed annually by the EMS Medical Director’s Consortium.

III. CONTINUING EDUCATION HOURS FOR CLINICAL PRECEPTING OF AN EMS STUDENT

A. Preceptors must attend an annual Preceptor Workshop

1. Curriculum includes educational theory, strategies, and development.

2. Content is specific to the EMS education program hosting the EMS Preceptor.

3. Continuing education (CE) hours are provided for successful completion of the Preceptor Workshop.

B. Preceptors that have been approved by Region 11 may earn additional continuing education (CE) hours for clinical precepting of an EMS student if there is both:

1. An assigned EMS student for field internship; and

2. Completion of EMS student evaluations.

C. Preceptors may earn 6 hours of EMS CE each year in the elective core content category for this role.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Provider Impairment and Substance Abuse
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS PROVIDER IMPAIRMENT AND SUBSTANCE ABUSE

I. PURPOSE

To ensure patient and coworker safety through the rapid identification of prehospital personnel who are impaired or displaying signs and symptoms of a substance abuse disorder and removing them from the patient care environment.

II. DEFINITIONS

A. Impairment: A condition where any of the body's sensory, cognitive, or motor functions or capabilities are altered, diminished, or affected due to the use of alcohol and/or drugs.

B. Substance Abuse Disorder: A pattern of harmful use of any substance for mood altering purposes. This can include the use of alcohol, prescription and over-the-counter drugs, illegal drugs, and controlled substances.

III. POLICY

A. Region 11 Chicago EMS recognizes that substance abuse as a health-related disorder. However, EMS system providers and patients may suffer adverse effects in the presence of providers whose work performance is below acceptable standards due to alcohol or drug use or impairment. Therefore, any EMS provider found to be under the influence of drugs and/or alcohol shall be deemed unfit to work and relieved of duty until the situation is investigated.

B. This policy does not prohibit EMS providers from possessing, using or being under the influence of medication that a physician had prescribed for them as long as the medications are used for prescribed purpose, in prescribed dosages, and do not compromise the EMS provider's professional duty and patient care.

C. The use, sale, or distribution of drugs and alcohol while representing the Region 11 Chicago EMS System, or reporting to work under the influence drugs and/or alcohol is grounds for disciplinary action up to and including suspension under the EMS System Participation Suspension Policy.

D. The use, sale, purchase, transfer, theft, or possession of an illegal drug is a violation of the federal law. This includes, but is not limited to, illegal drug and prescription medications or controlled substances not being used for the prescribed purpose, by the correct person, or using the correct dose.

E. Anyone in violation of illegal drug activities while on or off duty will be referred to law enforcement, the EMS System Medical Director, and IDPH by the employer agency.

F. Impaired EMS Providers

1. All employers and EMS agencies with EMS personnel in the Region 11 EMS System must have a policy to address EMS personnel who are suspected to be impaired while on duty.

2. Whenever an EMS provider is suspected to be under the influence of drugs and/or alcohol, the provider shall be relieved from duty and the incident should be immediately reported to the EMS System Medical Director, as well as the provider's supervisor. Findings will be forwarded to IDPH by the Resource Hospital. Concerns of this nature are confidential.

3. Prior to returning to duty, any individual removed from duty by his/her employer for documented reasons of impairment, must have documentation forwarded to the EMS System Medical Director that he/she is medically and psychologically capable of resuming EMS System participation.

G. EMS Provider Substance Abuse

1. All employers and EMS agencies with EMS personnel in the Region 11 EMS System must have a policy addressing substance abuse by EMS System personnel while on duty.

2. If EMS providers with suspected substance abuse disorder do not attempt to correct problems related to their drug and/or alcohol use, they will be subject to disciplinary action up to and including suspension in accordance with the EMS System Suspension Policy. Findings will be forwarded to IDPH by the Resource Hospital.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS Scope of Practice
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS SCOPE OF PRACTICE

I. PURPOSE

To define the EMS scope of practice for licensed health care personnel at the level of Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), and Paramedic within Region 11.

II. DEFINITION

Scope of Practice: A legal description of the distinction between licensed health care personnel and the lay public as well as among the different levels of licensed health care professionals.

III. FRAMEWORK

The National EMS Scope of Practice Model establishes a framework that determines the range of skills and roles that an individual possessing a State of Illinois EMS license is authorized to do in an EMS System. This is based on the fact that education, certification, licensure, and credentialing are four separate, but related activities.

A. **Education**: Includes all cognitive, psychomotor, and affective learning that individuals have undergone including initial EMS education, continuing education, and informal learning.

B. **Certification**: An external verification of competencies that an individual has achieved to assure safe and effective patient care and involves an examination process (example: National Registry certification).

C. **Licensure**: Represents legal authority granted by the State of Illinois for an individual to practice patient care at a certain level of EMS practitioner (example: IDPH license for EMR, EMT, Paramedic).

D. **Credentialing**: Clinical determination of a physician EMS Medical Director for an EMS practitioner to work in an EMS System (example: EMS system entry and competency testing).

IV. EMS SCOPE OF PRACTICE:

As defined in the National EMS Scope of Practice Model and shown below, an individual may only perform a skill or role for which that person is:

A. Educated (has been trained to perform the skill or role); AND

B. Certified (has demonstrated competence in that skill or role); AND

C. Licensed (has legal authority issued by the State of Illinois to perform the skill or role); AND

D. Credentialed (has been authorized by the EMS Medical Director to perform that skill or role).

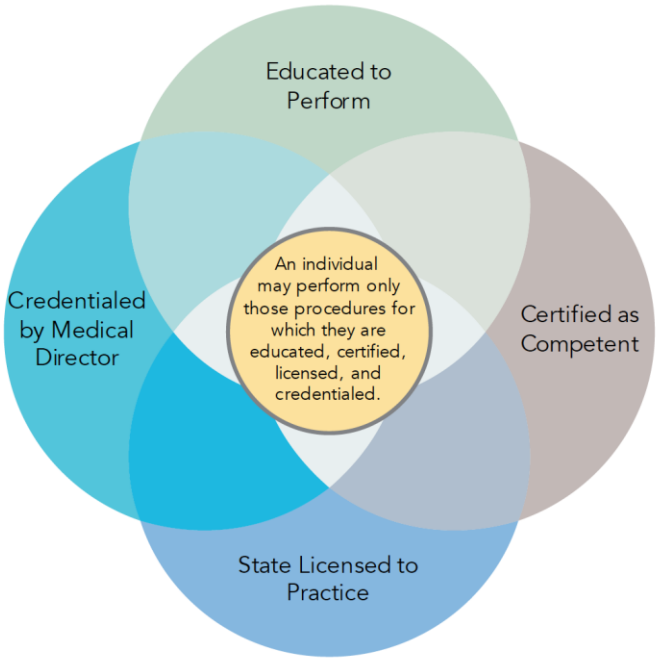


Image adapted from 2019 National EMS Scope of Practice Model, National Highway Traffic Safety Administration Office of EMS - https://www.ems.gov/national-ems-scope-of-practice-model/

V. DESCRIPTION OF EMS LICENSURE LEVELS

A. **Emergency Medical Responder (EMR):** An out-of-hospital practitioner whose primary focus is to initiate immediate lifesaving care to patients while ensuring patient access to the Emergency Medical Services (EMS) system. EMRs possess the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response or working with higher-level medical personnel.

B. **Emergency Medical Technician (EMT):** A health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, and apply the basic knowledge and skills necessary to provide patient care and medical transportation to and from an emergency or other health care facilities.

C. **Paramedic:** A health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, and apply the basic and advanced knowledge and skills necessary to determine patient physiologic, psychological, and psychosocial needs, administer medications, interpret and use diagnostic findings to

implement treatment, provide complex patient care, and facilitate referrals and/or access to a higher level of care when the needs of the patient exceed the capability level of the paramedic. Paramedics commonly facilitate medical decisions at an emergency scene and during transport.

D. While the Illinois EMS Act recognizes EMT-Is and A-EMTs as additional EMS licensure levels, Region 11 Chicago EMS does not recognize them in their EMS Systems.

VI. REGION 11 CHICAGO EMS

A. Region 11 Chicago EMS is comprised of 4 EMS System Medical Directors (collectively "Chicago EMS") that credential EMRs, EMTs, and Paramedics to work under defined regional EMS Protocols, Policies, and Procedures.

1. **EMS Protocols**: Patient care guidelines written for all levels of EMS practitioners.

2. **EMS Policies**: Scene management and destination guidelines written for all levels of EMS practitioners.

3. **EMS Procedures:** Defines the procedures authorized by level of EMS licensure.

VII. IDPH REGULATIONS

A. Any person currently licensed as an EMT or Paramedic may only perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in IDPH Section 515.550, and the requirements of the EMS System in which he or she practices, as contained in the approved System Polices and Protocols. IDPH may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not to exceed 180 days.

B. EMS Personnel who have successfully completed an IDPH-approved course in automated external defibrillator operation, and who are functioning within an IDPH-approved EMS System, may use an automated external defibrillator according to the standards of performance and conduct prescribed by IDPH in Section 515.550, and the requirements of the EMS System in which they practice, as contained in the approved System Policies and Protocols.

C. An EMT or Paramedic who has successfully completed an IDPH-approved course in the administration of epinephrine shall be required to carry epinephrine with him or her as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System.

D. An EMR, EMT, or Paramedic may only practice as an EMR, EMT, or Paramedic or utilize his or her EMR, EMT, or Paramedic license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction

of the EMS Medical Director. For purposes of this section, a "pre-hospital emergency care setting" may include a location that is not a health care facility, which utilizes EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMT or Paramedic's level of care, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS Medical Director.

E. This does not prohibit an EMR, EMT, or Paramedic from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS Medical Director. This also does not prohibit an EMT or Paramedic from seeking credentials other than his or her EMT or Paramedic license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer.

F. A student enrolled in an IDPH-approved EMS Personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the EMS System and IDPH, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified RN or a qualified EMS Personnel, only when authorized by the EMS Medical Director.

VIII. REFERENCES

A. National EMS Scope of Practice Model 2019: (https://www.ems.gov/pdf/National_EMS_Scope_of_Practice_Model_2019.pdf)

REGION 11 CHICAGO EMS SCOPE OF PRACTICE

	Emergency Medical Responder (EMR)	EMT (BLS)	Paramedic (ALS)
Skill: Patient Assessment / Management			
Blood Glucose Monitoring		X	X
Medical Patient Assessment		X	X
Neurologic Patient Assessment		X	X
Patient Restraint		X	X
Pediatric Assessment		X	X
Stroke Patient Assessment		X	X
Trauma Patient Assessment		X	X
Skill: Airway / Ventilatory Management			
Airway – Nasal		X	X
Airway – Oral		X	X
Airway Opening (head tilt-chin lift, jaw thrust)		X	X
Bag Valve Mask (BVM)		X	X
Capnography (monitoring and interpretation)			X
CPAP			X
Endotracheal Intubation			X
Foreign Body Removal (Magill forceps)			X
I-gel Supraglottic Airway		X	X
Oxygen Therapy		X	X
Suction Upper Airway		X	X
Skill: Cardiac Management			
Cardiac Arrest Management (ICCA)		X	X
Cardiac Monitoring (12 lead Electrocardiogram (ECG) acquisition and transmission)			X
Cardiac Monitoring (4 lead)			X
Death Notification			X
Defibrillation (automatic)	X	X	X
Manual Defibrillation			X
Synchronized Cardioversion			X
Transcutaneous Pacing			X
Skills: Trauma Management			
Cervical Collar Application		X	X
Chest Seal Application (HyFin Vent)		X	X
Hemorrhage Control (direct pressure)		X	X

Hemorrhage Control (pressure dressing)		X	X
Hemorrhage Control (tourniquet)		X	X
Hemorrhage Control (wound packing)		X	X
Joint Splinting		X	X
Long Bone Splinting		X	X
Pleural (Chest) Decompression			X
Spinal Motion Restriction (SMR)		X	X
START / JumpSTART triage		X	X
Traction Splinting		X	X
Skills: Medication Administration/Access			
Access Indwelling Catheters and Central IV Ports			X
Buretrol			X
Inhaled		X	X
Intramuscular (Autoinjector)		X	X
Intramuscular (IM)		X	X
Intranasal (IN)		X	X
Intraosseous (IO) Insertion			X
Intravenous (IV) Insertion			X
Intravenous Medication Administration			X
Medication Administration Cross Check (MACC)		X	X
Mucosal / Sublingual			X
Nebulized (aerosolized)		X	X
Oral			X
Vaccine Administration			X
Skills: Obstetric / Pediatric Management			
Assisted Delivery (childbirth)		X	X
Neonatal Resuscitation		X	X
Pediatric Measuring Tape / Medication Dosing			X

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS System Entry
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS SYSTEM ENTRY

I. PREREQUISITES

A. EMS System Entry is the process of education, written testing, and skill verification of an applicant to the Region 11 EMS Protocols, Policies and Procedures in order to be credentialed to provide prehospital patient care under the EMS Medical Director.

B. A licensed EMS provider, prior to entering Region 11, is considered an "applicant" to the EMS system.

C. Applicants are required to have a current CPR certification and an IDPH EMS license as below:

1. Emergency Medical Dispatcher (EMD)
2. Emergency Medical Responder (EMR)
3. Emergency Medical Technician (EMT)
4. Paramedic
5. Emergency Communications Registered Nurse (ECRN)

D. Applicants are required to work for an EMS agency within Region 11.

E. Additional requirements:

1. Current and valid government issued identification.
2. Letter of good standing from the last EMS system in which the applicant worked.

II. EMS SYSTEM ENTRY PROCESS

A. EMS System Entry Orientation

1. The EMS agency will schedule a date for EMS System Entry with the Resource Hospital EMS Coordinator.
2. The initial EMS System Entry orientation session with the Resource Hospital EMS Coordinator, EMS Medical Director or designee will include:
   a. Overview of Region 11 EMS Protocols, Policies, and Procedures
   b. Review materials for studying
   c. Details of the EMS System Entry exam

d. Instructions for creating a Vector Solutions – EMS Medical Directors Consortium account (for EMTs and Paramedics)
e. Expectations on EMS continuing education tracking and IDPH relicensure
f. Process for scheduling the EMS System Entry exam within two weeks of the initial orientation

B. EMS System Entry Exam

1. EMS System Entry testing will consist of a written examination and skills validation.

2. All EMS System Entry testing must be completed within 21 calendar days, unless prior arrangements have been made.

3. The minimum passing score is 75% on both the written examination and skill validation. A score of less than 75% on either section requires a retest within two weeks.

4. It is the responsibility of the EMS provider to review the failed exam or skill and perform focused self-education prior to retesting.

5. There will be two retesting opportunities to complete EMS System Entry. Applicants that fail retesting may repeat the EMS System Entry process after 3 months with proof of re-education during that time.

III. EMS PROVIDER STATUS

A. Individuals that are able to maintain continuing education requirements are considered to remain “participating” in the EMS System.

B. Individuals that are not able to maintain continuing education requirements for a period of <u>less than twelve months</u> due to a medical leave, change in EMS system, or change in employer are considered to be “not participating” in the EMS System and will be required to successfully complete any mandatory EMS Continuing Education assignments prior to returning to EMS System Participation.

C. Individuals that are not able to maintain continuing education requirements for a period of <u>twelve months or greater</u> due to a medical leave, change in EMS system, or change in employer are considered to be “not participating” in the EMS System will be required to complete the full EMS System Entry process including any mandatory EMS Continuing Education assignments prior to returning to EMS System Participation.

D. It is the responsibility of the EMS provider and their employer to notify the Resource Hospital EMS System Coordinator in these situations.

IV. CREDENTIALING

A. After successful completion of EMS system entry requirements, the licensed EMS provider will be credentialed to provide medical care within Region 11.

B. In order to maintain credentials, EMS providers must complete all mandatory EMS education and skills requirements as defined by the EMS System Medical Director.

C. EMTs and Paramedics must maintain a Vector Solutions – EMS Medical Directors Consortium account in order to remain credentialed in Region 11.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS System Inventory Requirements
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS SYSTEM INVENTORY REQUIREMENTS

I. PURPOSE

To define the responsibilities of the EMS provider and the EMS agency in maintaining drugs, equipment and supplies as defined by the EMS System and managed by the EMS agency.

II. POLICY

A. Each EMS personnel is responsible for completing a daily inventory review and report on **all licensed EMS vehicles involved with delivering patient care.**

B. A daily inventory form will be completed on a daily basis and available for review to the Resource Hospitals on a 24/7 basis.

C. A monthly report will be available for review by the Resource Hospital to verify compliance of daily inventory and weekly supply inventory.

D. Only medication, equipment, and supplies as listed on the Region 11 Drug, Equipment, and Supply list or otherwise approved by the Resource Hospital can be used for patient care.

E. The daily inventory inspections must include the following components:

1. Medications will be inspected on a daily basis and inventory form completed.

2. All airway equipment, cardiac equipment, and response bags will be inspected on a daily basis and inventory form completed.

3. It is the responsibility of the EMS provider to notify their supervisor for any expiring medication or supplies within one month of expiration.

4. It is the responsibility of the EMS agency to internally manage and replace the stock of expiring medication and equipment in advance of the expiration date.

5. It is the responsibility of the EMS agency to internally manage and replace the stock of expiring medication (with the exception of Controlled Substances as detailed below) and equipment in advance of the expiration date.

III. CONTROLLED SUBSTANCES

A. Controlled substances should be carefully inspected daily and an inventory form should be signed and dated by each ALS company as per the Controlled Substance Requirements Policy.

B. Expiring Controlled Substances should be replaced within seven calendar days at the assigned Resource or Associate Hospital as defined in the Controlled Substance Requirements Policy.

C. Any damage, loss, tampering or expired controlled substances should be immediately brought to the attention of the Resource Hospital EMS Coordinator and the EMS agency supervisor in verbal and written format. Findings will be forwarded to IDPH.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS System Participation Suspension
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS SYSTEM PARTICIPATION SUSPENSION

I. An EMS MD may suspend from participation within the EMS System any EMS Personnel, EMS Lead Instructor (LI), 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 EMS Act).

II. EMS System Participation Suspensions are based on one or more of the following:

A. Failure to meet the education or relicensure requirements as defined by IDPH or the EMSMD;

B. Violation of the EMS Act or any rule or regulation under the Act;

C. Failure to comply with the Region 11 EMS System Protocols, Policies, and Procedures;

D. Violation of the EMS System's standards of care;

E. Failure to maintain proficiency in the level of skills for which he or she is licensed;

F. During the provision of emergency services, engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud or harm the public;

G. Intoxication or use of illegal drugs while on duty including controlled substances or other drugs or stimulants that adversely affect the delivery, performance or activities of patient care;

H. Intentional falsification of any medical documents or reports, or making misrepresentations involving patient care;

I. Abandoning or neglecting a patient requiring emergency care;

J. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility or other work place location;

K. Performing or attempting emergency care, techniques or procedures without proper permission, licensure, training or supervision;

L. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay;

M. Medical misconduct or incompetence or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care;

N. Physical impairment to the extent the individual cannot physically perform the emergency care for which the individual is licensed, as verified by a physician, unless the person is on inactive status pursuant to Illinois Department of Public Health (IDPH) regulations;

O. Mental impairment to the extent that the individual cannot exercise the appropriate judgment, skill and safety for performing the emergency care for which the individual is licensed, as verified by a physician, unless the person is on inactive status pursuant to IDPH regulations;

P. Conviction of an Illinois Class X, Class 1 or Class 2 felony or out-of-state equivalent; or

Q. Failure to report a felony conviction to the assigned Resource Hospital within seven days after the conviction.

III. EMS System Participation Suspension Process

A. Except in cases of immediate suspension, the EMS MD shall provide the individual, individual provider or other participant with a written explanation of the reason for the suspension; the terms, length and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.

B. EMS System Participation Suspensions related to failure to successfully complete a mandatory Continuing Education assignment or module, as defined in accompanying memo by the EMS Medical Directors, shall be accompanied by written notice emailed to the suspended participant from the EMSMD. Refer to the Region 11 EMS Mandatory Continuing Education Policy for further details.

C. The suspended participant shall have the opportunity to request a review of the suspension by a board designated by the System, or directly to the State EMS Disciplinary Review Board for immediate suspensions.

D. The EMS provider's employer will be notified of an EMS System Participation Suspension (see Region 11 System Review Board Policy).

E. If the licensed EMS Personnel is known to have dual participation with another EMS System, that EMS System will be notified of the system suspension.

IV. Immediate EMS System Participation Suspension

A. An EMS MD may immediately suspend an EMR, EMD, EMT, Paramedic, ECRN, PHRN, PHAPRN, PHPA, LI, or other individual or entity if he or she finds that the continuation in practice by the individual or entity would constitute an imminent danger to the public. The suspended individual or entity shall be issued an immediate verbal notification, followed by a written suspension notice by the EMS MD that states the length, terms and basis for the suspension (Section 3.40(c) of the Act).

1. Within 24 hours following the commencement of the suspension, the EMS MD shall deliver to IDPH, by email, a copy of the suspension notice and copies of any written materials that relate to the EMS MD's decision to suspend the individual or entity.

2. Within 24 hours following the commencement of the suspension, the suspended individual or entity may deliver to IDPH, by email, a written response to the suspension notice and copies of any written materials that the individual or entity feels are appropriate.

3. Within 24 hours following receipt of the EMS MD's suspension order or the individual entity's written response, whichever is later, the IDPH Director or the Director's designee, shall determine whether the suspension should be stayed (put off) pending an opportunity for a hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The IDPH Director or the Director's designee, shall issue this determination to the EMS MD, who shall immediately notify the suspended individual or entity. The suspension shall remain in effect during this period of review by the IDPH Director or the Director's designee.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS System Review Board
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

EMS SYSTEM REVIEW BOARD

I. Upon receipt of a Notice of EMS System Participation Suspension from the EMS Medical Director, the EMS personnel or ambulance service provider, or other system participant shall have fifteen days to request a hearing before the System Review Board, by submitting a written request to the EMS Medical Director and EMS System Coordinator via e-mail. Failure to request a hearing within fifteen days shall constitute a waiver of the right to a Local System Review Board Hearing. The decision of the EMSMD shall be considered final and the EMS System Participation Suspension shall commence.

II. The Resource Hospital shall designate the Local System Review Board for the purposes of conducting a hearing to the individual or entity participating within the EMS System that has received the Suspension Notice. The Local System Review Board will consist of at least three members, one of whom is an Emergency Department Physician with the knowledge of EMS, and one of whom is an EMT or Paramedic, and one of whom is of the same professional category as the individual EMS personnel, individual ambulance service provider, or other EMS System participant requesting the hearing.

III. The hearing shall commence as soon as possible but within at least 21 days after receipt of a written request. The suspended participant shall be notified by e-mail of the date, time and place of the hearing and shall receive a copy of this policy. For good cause, the hearing may be changed upon advance request by one of the parties.

IV. The Board shall review and consider any testimony and documentation related to the suspension which is offered by either the EMSMD or the suspended party.

V. The EMSMD and the suspended party may both elect to have legal counsel representation.

VI. A hearing held by the System need not be formal in legal terms, nor need it adhere to established rules of evidence. The hearing shall be conducted in a fair and objective manner under procedures outlined:

A. Each party to the proceedings shall have the right to select a person to represent him/her and be present at the hearing at his/her own expense. Any rights of participation, review or commentary extended to the counsel for the EMS System will be similarly extended to the same degree to the representative for the suspended participant.

B. At the hearing, the EMSMD or the counsel for the EMS System shall present such witnesses and evidence, as they deem appropriate to uphold the suspension. The suspended participant or his/her representative may present such witnesses and evidence, as the suspended participant deems appropriate. The System Review Board will direct questions to all concerned parties in order to gather all of the facts and pertinent information.

C. The System Review Board shall review and consider any testimony and documentation related to the issue at hand which is offered by either party to the suspension issue. Only current allegation may be presented unless previous information illustrates a pattern of

behavior or practice. Each party shall have the right to submit evidence explaining or refuting the charges as well as the right to question the witnesses.

D. The EMSMD shall arrange for a certified shorthand reporter to make a stenographic record of the hearing. A copy of the hearing transcription shall be made available to any involved party so requesting at the party's expense. The transcript, all documents or materials received as evidence during such hearing, and the System Review Board's written decision shall be retained in the custody of the Resource Hospital EMS office and shall be maintained in confidence.

E. The suspended participant, the EMSMD and/or legal counsel(s) shall be allowed to listen to all testimony, but shall not be allowed admittance to the discussion and decision process of the System Review Board. However, they may be present after the decision is reached, and the System Review Board's recommendations are announced, if the decision can be reached immediately.

F. Witnesses may only be present during their testimony or when making their statement, and shall be instructed not to discuss the situation with any other witness.

VII. The Board shall state, in writing, its decision to affirm, modify or reverse the suspension including a statement detailing the duration and grounds for the decision. Such decision shall be sent via email to the EMSMD and the EMS personnel, ambulance service provider or other system participant within five business days after the conclusion of the hearing.

VIII. The EMSMD shall notify the Chief of the Division of EMS and Highway Safety at the Illinois Department of Public Health (IDPH), in writing, of a decision by the System Review Board to either uphold, reverse or modify the EMSMD's suspension of an EMS personnel, ambulance service provider or other system participant from participation within the EMS System, within five business days after the System Review Board's decision is received.

IX. The EMS System shall implement a decision of the System Review Board unless that decision has been appealed to the State EMS Disciplinary Review Board.

X. A request for review by the State EMS Disciplinary Review Board shall be made in writing by email to the Chief of the Division of EMS and Highway and Safety at IDPH, within ten business days after receiving the System Review Board's decision. A copy of the System Review Board's decision shall be enclosed. Requests for review shall only be made by an EMS System participant whose suspension order was affirmed or modified by the System Review Board. If reversed or modified, the EMSMD can request a review.

XI. Upon receipt of a valid request for review, the Chief of the Division of EMS and Highway Safety at IDPH shall convene a State EMS Disciplinary Review Board to review the decision of the System Review Board.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMT and Paramedic Reciprocity
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMT AND PARAMEDIC RECIPROCITY

I. PURPOSE

To allow for an EMT or Paramedic licensed or certified in another state, territory or jurisdiction of the United States seeking licensure in Illinois to apply to IDPH for licensure by reciprocity, using an IDPH-approved form and available on the IDPH website: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/emsreciprocityapplication.pdf

II. DEFINITION

Reciprocity: Allows EMTs and Paramedics who are licensed in another state, the military, and/or by the National Registry of Emergency Medical Technicians (NREMT) to apply for licensure in Illinois using a streamlined process.

III. STATE TO STATE RECIPROCITY

A. The reciprocity application shall contain the following information:

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

2. A written statement of satisfactory completion of an education program that meets or exceeds the requirements of IDPH;

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

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

B. IDPH will review requests for reciprocity to determine compliance with the applicable provisions of IDPH Section 515.610. CE hours from the state of current licensure will be prorated based on the expiration date of the current license.

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

D. Following licensure by reciprocity, the individual must comply with the requirements of IDPH Section 515.590 for relicensure.

IV. NREMT RECIPROCITY AND PROVISONAL SYSTEM STATUS

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

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

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

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

V. REGION 11 CHICAGO EMS

This policy applies specifically to EMTs and Paramedics, as Region 11 Chicago EMS does not recognize the A-EMT and EMT-I licensure levels within their EMS Systems.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Inactive Status
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

INACTIVE STATUS

I. INACTIVE STATUS

A. Prior to the expiration of their current license, EMS personnel may request to be placed on inactive status.

B. This request must be made in writing by the EMS personnel to the respective Resource Hospital EMS Medical Director (EMSMD) and shall include the individual's name and contact information, current license level and number with expiration date, and circumstances requiring inactive status using the IDPH approved form, "EMS Inactive Request".

C. All CE requirements must be up to date prior to granting the inactive status.

D. If the EMSMD approves, the request will be submitted to the Illinois Department of Public Health that the individual be placed on inactive status.

E. For independent license holders, IDPH will review and confirm that relicensure requirements have been met by the date of the application for inactive status.

F. IDPH will review requests for inactive status and notify the EMSMD in writing of its decisions.

G. During Inactive Status, the individual shall not perform at any level of EMS provider.

II. RETURN TO ACTIVE STATUS

A. When EMS personnel request to return to active status, they **MUST REACTIVATE** in the EMS System that put them on inactive status.

B. EMS personnel requesting reactivation must complete the following:

1. Submit a letter of intent.

2. Successfully complete all components of the Region 11 EMS System Entry Policy.

3. Meet as determined by the EMS Coordinator to set timelines for and monitor progress toward completion of all system entry requirements.

4. Complete all mandatory modules held during the individual's inactive status and any others deemed necessary by the EMSMD or EMS Coordinator.

C. A reactivation fee will be assessed by the Resource Hospital based upon the amount of CE necessary.

D. After completion of the required CE, the EMS MD shall confirm that the applicant has been examined (physically and mentally) and found capable of functioning within the EMS System; that the applicant's knowledge and psychomotor skills are at the active EMS level for that individual's license; and that the applicant has completed any education and evaluation deemed necessary by the EMS MD and approved by the Department. If the inactive status was based on a disability, the EMS MD shall also verify that the applicant can perform all critical functions of the requested license level.

E. EMS Personnel whose inactive status period exceeds 48 months shall pass an IDPH approved licensure examination for the requested level of license upon recommendation of an EMS MD.

F. Upon review, IDPH may reinstate the individual to active status and establish a new licensing period.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Occupational Exposure to an Infectious Disease
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

OCCUPATIONAL EXPOSURE TO AN INFECTIOUS DISEASE

I. PURPOSE

To define methods to protect EMS personnel from significant or high-risk occupational exposure to an infectious disease and notification of the EMS agency designated infection control officer (DICO) after exposure.

II. POLICY

A. OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASE

1. Initial and ongoing training in the types of available PPE and demonstrated proficiency in donning and doffing of PPE is critical to EMS personnel safety.

2. Prevention of exposures is critical. Extraordinary care should be used to prevent exposures from needles and other sharp instruments.

3. Per OSHA, best practices for preventing sharps and needlestick injuries include:

    a. Plan safe handling and disposal before any procedure.
    b. Use safe and effective needle alternatives when available.
    c. Use needles with engineered sharps injury protection (SESIPs).
    d. Always activate the device's safety features.
    e. Do not pass used sharps between workers.
    f. Do not recap, shear, or break contaminated needles.
    g. Immediately dispose of contaminated needles in in properly secured, puncture-resistant, closable, leak-proof, labeled sharps containers.
    h. Complete Bloodborne Pathogens training.

4. Appropriate barrier precautions should be used when cleaning, disinfecting, or disposing of contaminated equipment, supplies, and ambulance surfaces.

5. EMS personnel who have any areas of open skin from any cause shall have these areas covered with a moisture proof covering prior to any patient contact.

6. Significant blood or body fluid exposures for EMS personnel include blood, bloody saliva or urine, or amniotic fluid exposure to eyes, mucous membranes, non-intact skin or by needle stick or bites.

7. The exposed area should be irrigated or flushed with large amounts of water or saline.

8. The blood borne pathogen exposure (BBPE) should be reported to the EMS personnel's immediate supervisor as soon as possible.

9. When significant exposures have occurred, the involved EMS personnel should be evaluated by a physician **at the same Emergency Department where the source patient was transported**.

10. EMS personnel should be assessed regarding possibility of post-exposure prophylaxis or treatment depending on the agent and exposure. Post-exposure prophylaxis is seldom indicated with the exception of direct contact with patients confirmed to have Neisseria meningitidis or after a needle stick or other high-risk exposure to an HIV positive source patient. Prophylaxis may be considered in unprotected exposures to special pathogens in consultation with infectious disease experts.

11. EMS agencies should standardize pre-exposure immunization requirements for personnel in accordance with public health vaccination recommendations. It is recommended that EMS personnel have appropriate immunizations or knowledge of prior illness to the following: hepatitis B, measles, mumps, rubella, pertussis/whooping cough, chicken pox, tetanus, diphtheria, and polio.

12. Each EMS agency shall have a policy addressing infectious disease exposures. The policy should be available for review by the EMS Medical Director and the Illinois Department of Public Health (IDPH).

13. Each EMS agency should follow OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) as amended pursuant to the 2000 Needlestick Safety and Prevention Act, which is a regulation that prescribes safeguards to protect workers against health hazards related to bloodborne pathogens.

B. NOTIFICATION OF POTENTIAL EXPOSURE TO AN INFECTIOUS DISEASE

1. EMS personnel are considered "Emergency response employees (EREs)" and are at risk of exposure to potentially life-threatening infectious diseases through contact with patients during emergencies. Part G of the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that medical facilities provide EREs with notification of when they may have been exposed to potentially life-threatening infectious diseases while transporting or serving patients in an emergency.

2. NIOSH (**National Institute for Occupational Safety and Health)** has developed a list of potentially life-threatening diseases, including emerging infectious diseases, to which EREs may be exposed while transporting or serving emergency patients taken to a medical facility (Table 1).

3. Medical facilities that receive and treat patients in an emergency or ascertain the cause of death are responsible for routinely notifying and responding to requests pertaining to any determinations that a patient in an emergency has a listed potentially life-threatening infectious disease, as described in the NIOSH guidelines.

4. When a medical facility determines that a patient in an emergency has a potentially life-threatening disease to which the ERE may have been exposed to (see Table 1 below), the medical facility shall, in writing, notify the ERE agency's designated infection control officer (DICO) no later than 48 hours after a confirmed diagnosis (in accordance with the Illinois Hospital Licensing Act, 210 ILCS 85/6.08)

5. If an ERE believes he or she has been exposed to any potentially life-threatening disease on the NIOSH list, and has transported, attended, treated, or assisted the patient pursuant to the emergency, the ERE may initiate a request for notification from the medical facility to which the patient was transported.

Table 1: NIOSH List of Potentially Life-Threatening Infectious Diseases to Which Emergency Response Employees May Be Exposed, by Exposure Type (https://www.cdc.gov/niosh/topics/ryanwhite/#table1)

ROUTINELY TRANSMITTED BY CONTACT OR BODY FLUID EXPOSURES	ROUTINELY TRANSMITTED THROUGH AEROSOLIZED AIRBORNE MEANS[1]	ROUTINELY TRANSMITTED THROUGH AEROSOLIZED DROPLET MEANS[2]	CAUSED BY AGENTS POTENTIALLY USED FOR BIOTERRORISM OR BIOLOGICAL WARFARE
• Anthrax, cutaneous (*Bacillus anthracis*) • Hepatitis B (HBV) • Hepatitis C (HCV) • Human immunodeficiency virus (HIV) • Rabies (Rabies virus) • Vaccinia (Vaccinia virus) • Viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified)[3]	• Measles (Rubeola virus) • Tuberculosis (Mycobacterium tuberculosis)—infectious pulmonary or laryngeal disease; or extrapulmonary (draining lesion) • Varicella disease (Varicella zoster virus)—chickenpox, disseminated zoster	• Diphtheria (Corynebacterium diphtheriae) • Novel influenza A viruses as defined by the Council of State and Territorial Epidemiologists (CSTE)[4] • Meningococcal disease (Neisseria meningitidis) • Mumps (Mumps virus) • Pertussis (Bordetella pertussis) • Plague, pneumonic (Yersinia pestis) • Rubella (German measles; Rubella virus) • SARS-CoV • COVID-19 (SARS-CoV-2)	These diseases include those caused by any transmissible agent included in the HHS Select Agents List . [5] Many are not routinely transmitted human to human but may be transmitted via exposure to contaminated environments. The HHS Select Agents List is updated regularly and can be found on the National Select Agent Registry Web site: http://www.selectagents.gov /

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Paramedic Field Internship Program
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

PARAMEDIC FIELD INTERNSHIP PROGRAM

I. Paramedic students functioning in this capacity do so under contractual agreement between the Chicago Fire Department (CFD), the Resource Hospital(s), and the sponsoring institution (Malcolm X College) hosting the paramedic training program.

II. For the field internship, the paramedic student is assigned to a CFD Paramedic Preceptor that is approved by Region 11.

III. Paramedic students must follow all Protocols, Policies and Procedures under the sponsoring institution training program, the Chicago Fire Department and Region 11 EMS.

IV. A waiver of liability must be completed and on file with CFD and MXC prior to start of internship.

V. Upon successful completion of the field internship, and the student has completed their paramedic training, they will be deemed eligible to take the National Registry Paramedic examination and can apply for Illinois state licensure upon obtaining the NREMT certification

VI. Paramedic students attending an outside Region 11 training program, but are from EMS Employer Agencies within Region 11 may be allowed to complete their field internship requirements as outlined by their program if approved by CFD and the Region 11 EMS Employer Agency's assigned Resource Hospital. The outside training program shall communicate with the Region 11 Resource Hospital and EMS Employer Agency regarding the student's progress. An affiliation agreement is required to be completed and kept on file with the Region 11 EMS Employer Agency, the assigned Region 11 Resource Hospital, and the initial training program located outside of Region 11.

   A. Priority ride time scheduling remains with the Region 11 initial training paramedic program and shall not be affected by outside Region 11 initial training programs.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Prehospital Registered Nurse, Prehospital Physician Assistant, and Prehospital Advanced Practice Registered Nurse
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PREHOSPITAL REGISTERED NURSE (PHRN), PREHOSPITAL PHYSICIAN ASSISTANT (PHPA) AND PREHOSPITAL ADVANCED PRACTICE REGISTERED NURSE (PHAPRN)

I. While the Illinois EMS Act recognizes Prehospital Physician Assistants (PHPA) and Prehospital Advanced Practice Registered Nurses (PHAPRN) as approved licensure levels, Region 11 Chicago EMS does not recognize them in their EMS Systems.

II. To be approved and licensed as a "Prehospital Registered Nurse" (Prehospital RN) an individual shall:

A. Be a licensed RN in good standing and in accordance with the Illinois Department of Financial and Professional Regulation.

B. Have two years of full time clinical practice in Emergency or Critical Care nursing.

C. Have current CPR certification.

D. Complete a supplemental educational curriculum, formulated by the EMS System and approved by IDPH, that consists of:

1. At least 40 hours of classroom and psychomotor education and measurement of competency equivalent to an entry level Paramedic program;

2. Practical education, including but not limited to: advanced airway techniques, ambulance operations, extrication, telecommunications, and prehospital cardiac and trauma care of both the adult and pediatric population; and

3. The Region 11 EMS System Protocols, Policies, and Procedures.

E. Complete a minimum of 10 ALS runs supervised by a licensed EMS System physician or an approved EMS System PHRN or Paramedic only as approved by the EMS Medical Director.

F. Successfully complete the National Registry of EMTs (NREMT) paramedic cognitive examination.

G. After submission of the above components to the Resource Hospital, the transaction form and recommendation for licensure will be submitted to IDPH. The application will include demographic information, social security number, child support statement, felony conviction statement, applicable fees and shall require EMS System authorization.

III. PHRN LICENSE RENEWAL

A. To apply for a four-year license renewal:

1. Submit documentation of CE requirements to the EMS System at minimum 30 days prior to license expiration.

   a. PHRNs shall have a minimum of 120 system approved CE hours in the same core content areas as required for paramedics.
   b. All Region 11 mandatory CE assignments are required.

2. Maintain current CPR certification on file with the Resource Hospital.

3. Maintain current RN License within the State of Illinois on file with Resource Hospital.

III. INACTIVE STATUS

A. Prior to the expiration of the current license, a PHRN may request to be placed on inactive status. The request shall be made in writing to the EMS MD.

B. A PHRN who wants to restore their license to active status shall follow the requirements set forth in Section 515.600.

C. If the PHRN inactive status period exceeds 48 months, the licensee shall re-demonstrate competencies and successfully pass the NREMT Paramedic examination.

D. The EMS MD shall notify the Department in writing of a PHRN's approval, re-approval, or granting or denying of inactive status within 10 days after any change in a PHRN's approval status.

IV. CHANGE IN NAME OR ADDRESS

A. A PHRN shall notify the Department within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax, or electronic mail.

B. Addresses may be changed through the Department's online system: https://emslic.dph.illinois.gov/glsuiteweb/clients/ildohems/private/shared/onlineservices.aspx

C. Names and gender changes require legal documents (marriage license or court documents).

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Primary and Secondary EMS Systems
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

PRIMARY AND SECONDARY EMS SYSTEMS

I. PURPOSE

To define the responsibilities of EMS personnel that work in more than one EMS System.

II. DEFINITIONS

A. Primary EMS System: The EMS System in which the EMS personnel primarily works and renews their EMS license.

B. Secondary EMS System: The EMS System in which the EMS personnel works in a secondary or part-time role and does not renew their EMS license.

III. POLICY

A. It is the responsibility of the EMS personnel to define their Primary and any Secondary EMS System for renewal of EMS licensure to the Resource Hospital(s) at system entry and/or with employment change.

B. For EMS personnel in Region 11, this status should be on record with their Resource Hospital and entered under their Vector Solutions profile.

C. Any EMS personnel with Primary or Secondary EMS System status in Region 11 must complete all mandatory EMS Continuing Education (CE) as per policy.

D. For any status changes in Primary or Secondary EMS System, the EMS personnel should notify the Resource Hospital.

E. If a licensed EMS personnel has dual participation with another EMS System, the Resource Hospital will notify the other EMS System of a system suspension.

F. EMS personnel that do not actively work under an EMS System are considered independent for renewal of licensure.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Vaccine Administration
	Section: EMS Personnel
	Approved: EMS Medical Directors Consortium
	Effective: December 11, 2020

VACCINE ADMINISTRATION

I. **PURPOSE:**

This policy outlines the guidelines for licensed Paramedics within the Region 11 Chicago EMS System to administer vaccines in order to assist state and local partner agencies with mass vaccination efforts as per IDPH (Illinois Department of Public Health) policies.

II. **DEFINITION**:

Vaccines include any vaccines under an IDPH mass vaccination plan.

III. **ROLE:**

Vaccine administration is part of the additional Paramedic scope of practice per IDPH under an approved EMS System Plan.

IV. **TRAINING PROGRAM:**

Training programs shall be approved by the Resource Hospital and include the following components that are specific to the vaccine administered under an approved Vaccination Program.

A. Vaccine Education

1. Pharmacology of vaccine

2. Administration

a. Storage and handling of vaccine
b. Dosage and route of administration
c. Indication or eligibility for administration
d. Contraindication for administration

3. Vaccine side effects or adverse reactions

4. Emergency treatment for vaccine reactions

5. Vaccine Information Statement (VIS)

B. Vaccine Administration Record (VAR) documentation

C. Reporting of possible adverse effects to the Vaccine Adverse Events Reporting System (VAERS)

D. Vaccine Administration procedure skills validation

E. Roster of Paramedics that have completed the training

V. **REPORTING**:

There should be communication between the EMS Agency and the Resource Hospital regarding the site and date that Paramedics are performing vaccine administration.

VI. **QUALITY ASSURANCE:**

A quality assurance plan must be in place for tracking and documenting the use of paramedics performing vaccine administration.

VII. **CONTINUING EDUCATION:**

Annual continuing education is required for paramedics performing vaccine administration.

Paramedic Vaccination Tracking Form

This form must be filled out and sent in to the EMS System after the vaccination event.

Please email this completed form to the Resource Hospital EMS System Coordinator.

EMS Agency Name:	
EMS Agency Address:	
Contact Name:	*Contact Phone Number:*

Vaccine Manufacturer.	*Lot Number:*	*Expiration Date:*

The following paramedics have been approved to administer vaccines in the Region 11 Chicago EMS System. All paramedics listed have gone through Just-In-Time or annual vaccination training for an approved Vaccination Program.

Paramedic Name	*Paramedic License #*	*# of Vaccines Administered*

Signature of Contact: _____ *Date:* _____

REGION 11
CHICAGO EMS SYSTEM
POLICIES

HOSPITAL

Base Station Cardiac Arrest Guidelines
ECP Recognition
ECRN Licensure
Resource and Associate Hospital EMS Communications Standards
Resource Hospital Base Station Override

BASE STATION CARDIAC ARREST GUIDELINES

Patient age, Comorbidities?
Witnessed arrest? Bystander or EMS?
If unwitnessed, is downtime known?
Bystander CPR?
First cardiac rhythm?

Current cardiac rhythm?
Ensure high quality CPR
Advanced airway with ETCO2
Epinephrine IV/IO every 5 minutes

PULSELESS ELECTRICAL ACTIVITY

Evaluate rhythm
- Wide and Slow: Possible terminal rhythm
- Narrow and Fast: Possible ROSC

For dialysis and/or renal failure with possible hyperkalemia, consider **Calcium chloride** and **Sodium Bicarbonate IVP**

For possible opioid overdose, consider **Naloxone**

Consider other reversible causes (H's/T's)

ASYSTOLE

Ensure asystole in multiple leads
Evaluate corresponding ETCO2[1] value

PULSELESS VTACH OR VFIB

Defibrillation every 2 minutes

Amiodarone 300 mg
(peds 5mg/kg) after 3rd shock

Amiodarone 150 mg
(peds 5mg/kg) after 4th shock

Attempt to achieve ROSC
before patient movement/transport

Response to treatment?

NO ROSC / PERSISTENT LOW OR DECREASING ETCO2

Consider field Termination of Resuscitation Criteria
- Adult patient at least 18 years of age
- Non-traumatic cardiac arrest
- No hypothermia or pregnancy
- No reversible cause identified
- No ROSC at any point during minimum 20 minute resuscitation
- Initial cardiac rhythm is non-shockable (Asystole or PEA)
- IV/IO access with at least 3 rounds of Epinephrine
- Advanced airway established with ETCO2[1] capnography

Other prognostic factors that may be considered include:
- Unwitnessed arrests have a lower predicted survival
- A shockable rhythm at any point during resuscitation increases chance of survival
- ETCO2[1] value should be consider in the context of other arrest criteria and should not be used as the sole determining factor in termination vs. transport

ROSC / PERSISTENT HIGH OR INCREASING ETCO2

Transport to a STEMI Center[2,3,4]

- Monitor closely for re-arrest
- Initiate post arrest care
- Check blood glucose
- **12 lead ECG**
- Adults: Maintain SBP ≥ 90 mmHg with fluid bolus Pediatrics: Maintain blood pressure at or above normal for age with 20 ml/kg fluid bolus (see Region 11 Pediatric Resuscitation Card)
- For adults with GCS ≤ 8 initiate targeted temperature management with cold packs

Response to treatment?

YES

NO

For persistent shockable rhythms, consider continued field resuscitation or transport to a STEMI Center[2,3,4] with ongoing resuscitation

1 – Interpretation of ETCO2 Values in Cardiac Arrest

ETCO2 measures ventilation and is a surrogate marker of cardiac output:
- < 10 mmHg may indicate low quality CPR or provider fatigue
- 10-30 mmHg indicates high quality CPR
- Evaluate ETCO2 values and trends such as:
  - Sudden rise in ETCO2 or persistent reading > 30 mmHg may indicate ROSC
  - Values decreasing more than 25% during resuscitation indicate poor prognosis
  - Values persistently < 10 mmHg, despite high quality CPR indicate poor prognosis

3 - Pediatric Considerations

- On scene resuscitation where the patient is encountered should take precedence with the goal of obtaining ROSC before patient movement/transport.
- Field termination of resuscitation is not considered for patients under the age of 18.
- Pediatric patients should be transported to an Emergency Department Approved for Pediatrics (EDAP) (see Pediatric Patient Transport Policy).

2- Obstetric Considerations

For pregnant patients > 20 weeks gestation or with a visibly gravid abdomen:
- Complete the following code tasks on scene: High quality CPR, defibrillation when indicated, IV/IO access with ACLS drug administration and advanced airway placement with ETCO2 monitoring.
- Plan for expedited hospital transport with ongoing resuscitation to the closest STEMI Center that is also a Level III Perinatal Center.
- Contact receiving Level III Perinatal Center and inform them of arrival of pregnant cardiac arrest patient.

4 – Ventricular Assist Device (VAD) Patients

- Should be transported to a VAD Center per Transport of Patients With a Ventricular Assist Device (VAD) Policy.

Effective: December 1, 2022
Chicago Region 11 EMS Medical Directors Consortium

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: ECP Recognition
	Section: Hospital
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

ECP RECOGNITION

I. GUIDELINES FOR EMERGENCY COMMUNICATION PHYSICIAN (ECP) RECOGNITION IN REGION 11:

A. To obtain recognition as an ECP, an individual shall:

1. Be a physician currently licensed in Illinois and regularly involved in online medical control at a Base Station.

2. Complete the Region 11 ECP Base Station Course or equivalent as determined by the EMSMD.

B. To maintain ECP recognition, the physician must review any EMS System Continuing Education updates and remain in good standing with the EMS System.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: ECRN Licensure
	Section: Hospital
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

ECRN LICENSURE

I. Emergency Communications Registered Nurse (ECRN) Licensure

A. Initial licensure:

1. To be licensed as an ECRN, an individual shall:

   a. Be a registered nurse in accordance with the Nurse Practice Act with a minimum of six months Emergency Department nursing experience or appropriate equivalent as approved by the EMS Medical Director (EMSMD)
   b. Current CPR certification
   c. Current ACLS certification
   d. Successfully complete an education curriculum formulated by an EMS System and approved by IDPH, which consists of at least 40 hours of classroom (32 hours) and practical (8 hours field experience on an ambulance supervised by a paramedic) education for both the adult and pediatric population, including telecommunications, and EMS System Protocols, Policies and Procedures.
   e. Complete an orientation conducting EMS radio calls with a licensed ECRN under the supervision of the EMS Coordinator at that hospital.
   f. Meets all requirements mandated by the IDPH Rules and Regulations.

2. The Resource Hospital will submit to IDPH the electronic transaction form and recommendation for initial licensure of an ECRN candidate who has completed and passed all components of the education program and passed the final examination.

B. ECRN Relicensure: The ECRN should submit proof of the following to their hospital EMS Coordinator 90 days prior to license expiration date.

1. Is a registered nurse with an unencumbered license in Illinois.

2. Has completed 32 hours of EMS System approved Continuing Education in a four-year period.

3. Has successfully completed all mandatory Region 11 EMS continuing education.

4. Remains active as an ECRN in the EMS System under Region 11.

5. Completed the IDPH Child Support Form.

6. If the above are completed, the Resource Hospital will submit the ECRN for relicensure with IDPH.

C. Inactive status:

1. Prior to the expiration of the current license, the ECRN may request to be placed on

inactive status. The request shall be made in writing to the EMS Medical Director and shall contain the following information:

a. Name of individual;
b. Date of approval;
c. Circumstances requiring inactive status;
d. A statement that recertification requirements have been met by the date of the application for inactive status;
e. ECRN license number

2. The EMS Medical Director will review and grant or deny requests for inactive status.

3. For the ECRN to return to active status, the EMS Medical Director must document that the ECRN has been examined and found capable of functioning within the EMS System, that the ECRN's knowledge and clinical skills are at the active ECRN level, and that the ECRN has completed any refresher training deemed necessary by the EMS System. If the inactive status was based on a temporary disability, the EMS System shall also verify that the disability has ceased.

4. During inactive status, the individual shall not function as an ECRN.

5. The EMS Medical Director shall notify IDPH in writing of the ECRN's approval, re-approval, or granting or denying inactive status within 10 days after any change in an ECRN's approval status.

II. ECRN Functioning and System Entry

A. A licensed ECRN who is currently functioning in another Region 11 Resource or Associate Hospital or has been active within the last six months and receives a letter of good standing from his/her EMS Coordinator shall meet with his/her current EMS Coordinator or EMSMD for approval and orientation prior to resuming ECRN function.

B. Licensed ECRNs from hospitals outside Region 11 should request a letter of good standing from that hospital and submit it to their Region 11 Resource Hospital and request to take the ECRN System Entry examination.

C. Additional educational requirements may be required by the EMSMD.

III. ECRN Requirements

A. An ECRN shall notify IDPH within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax or electronic mail. Addresses may be changed through IDPH's online system.

B. To maintain ECRN Licensure, the nurse must complete any EMS System Continuing Education updates and remain in good standing with the EMS System.

C. An ECRN may be suspended as per the Region 11 EMS System Participation Suspension Policy.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Resource and Associate Hospital EMS Communications Standards
	Section: Hospital
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

RESOURCE AND ASSOCIATE HOSPITAL EMS COMMUNICATIONS STANDARDS

I. Physician direction and voice orders to EMS personnel and other hospitals participating in the EMS System are provided from the operational control point of a Region 11 Resource or Associate Hospital, which are also known as "EMS Base Stations" and provide Online Medical Control (OLMC) through radio or phone communication.

II. An Emergency Communications RN (ECRN) will request the EMS Medical Director (EMSMD) or designated physician (ECP) consultation in:

   A. Patient clinical care situations; and/or

   B. Complex medical or legal issues and interpretation of the EMS System policies.

III. It is the responsibility of the attending ECP in the emergency department to assure that there is immediate ECP response whenever medical consultation and assistance is requested by EMS.

IV. The EMT/Paramedic may request to speak with the ECP if there are concerns relative to orders received from the ECRN or unique circumstances that require ECP decision-making.

V. All online medical direction calls are recorded for retrospective review for a minimum of 365 days, or consistent with the hospital's record retention policy, whichever is longer.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Resource Hospital Base Station Override
	Section: Hospital
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

RESOURCE HOSPITAL BASE STATION OVERRIDE

I. PURPOSE

To establish a process to contact the Resource Hospital for medical direction to qualify orders from any other source other than the Resource Hospital.

II. DEFINTION

Resource Hospital Override: Situations in which medical direction or orders from an Associate Hospital are requested to be reviewed by the Resource Hospital

III. POLICY

A. To allow EMS personnel to contact a Region 11 Resource Hospital, if in the judgement of the EMS provider, the medical direction or orders for patient treatment:

1. Vary significantly from the approved Region 11 Protocols and Policies;
2. Could result in unreasonable or medically inaccurate treatment causing potential harm to the patient; and/or
3. When there is no response from the Associate Hospital after three attempts to contact.

B. The EMS provider should first clarify the medical direction or order with the ECRN/ECP and advise that it deviates significantly from approved protocols or policies.

C. If there is no resolution, the EMS provider should inform the Associate Hospital that they will contact the Resource Hospital regarding the situation.

D. When calling the Resource Hospital, the EMS provider should inform the ECRN that this is a “Resource Hospital Override” and the ECP should be consulted.

E. The Resource Hospital ECP may consult the EMS Medical Director as needed.

F. After resolution, the Resource Hospital should communicate the decision and outcome to the Associate Hospital.

G. The Resource Hospital EMS Coordinator should be immediately notified and a Request for Clarification (RFC) or Complaint Form is to be completed on the incident.

H. The Resource Hospital EMS Medical Director and the EMS Coordinator will review the incident with all involved individuals, including the Associate Hospital EMS Medical Director and EMS Coordinator in a timely manner.

REGION 11
CHICAGO EMS SYSTEM
POLICIES

QUALITY IMPROVEMENT

EMS System Quality Improvement/Quality Assurance (QI/QA) Plan
IDPH Waiver Provision
Medical Device Malfunction Reporting
Request for Clarification (RFC)/Complaint Investigation
Resolving Regional or System Conflict

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: EMS System Quality Improvement / Quality Assurance (QI/QA) Plan
	Section: Quality Improvement
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

EMS SYSTEM QUALITY IMPROVEMENT / QUALITY ASSURANCE (QI/QA) PLAN

I. PURPOSE

To define the responsibilities of the Emergency Medical Dispatch (EMD) agency, EMS agencies and EMS System to ensure Quality Improvement/Quality Assurance (QI/QA) in Region 11 EMS.

II. POLICY

A. EMD Agency

1. Each Emergency Medical Dispatch (EMD) Agency is required to be certified by IDPH and must have:

    a. An established continuous quality improvement (CQI) program under the approval and supervision of the EMS Medical Director. The CQI program shall include, at a minimum, the following:
        i. A quality assurance review process used by the agency to identify EMD compliance with the protocol.
        ii. Random case review;
        iii. Regular feedback of performance results to all EMDs.
    b. Availability of CQI reports to IDPH upon request; and
    c. Compliance with the confidentiality provisions of the Medical Studies Act.

B. EMS Agency

1. Each EMS Agency participating within the Region 11 EMS System must have an established continuous quality improvement (CQI) program under approval and supervision by the EMS Medical Director. The CQI program shall include, at a minimum, the following:

    a. A quality assurance review process used by the agency to identify patient care gaps and compliance with EMS protocols and policies;
    b. Peer review;
    c. Regular feedback of performance results;
    d. Special event after action reports.
    e. Availability of CQI reports to IDPH upon request.

2. All CQI reports must be submitted to the respective Resource Hospital on a quarterly basis.

3. An annual CQI report that reviews continuous quality improvement (CQI) program goals and performance measures will be submitted to the Resource Hospital within one month following the end of the year.

C. EMS System

1. Quality improvement measures for the EMS System are selected and agreed upon by the EMS Medical Directors, which may include various patient care and operational quality measures based on system need.

2. There will be a quarterly review of the quality improvement measures.

3. Educational activities will be monitored to ensure that the instruction and materials are consistent with National EMS Education Standards.

4. Findings from quality reviews will be used to inform process improvement and will be communicated to system participants through EMS continuing education (CE) updates.

5. Findings from quality reviews will be made available to IDPH upon request.

6. EMS Program Implementation and Oversight: Any new or pilot program implemented within the EMS System will have a QA/QI review for the first year following implementation. Reports will be submitted to the EMS Medical Director on a monthly basis.

7. New Medication, Equipment or Procedure: Any new medication, equipment, or procedure will have a QA/QI review of all related patient encounters for a minimum period of six months. Reports will be submitted to the EMS Medical Director on a monthly basis.

D. IDPH

1. Monitors EMD agency, EMS agency and EMS System QI/QA.

2. May perform unannounced inspection of pre-hospital services.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: IDPH Waiver Provisions
	Section: Quality Improvement
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

IDPH WAIVER PROVISIONS

I. The Illinois Department of Public Health (IDPH) may grant a waiver to any provision of the EMS Act or its Rules and Regulations for a specified period of time that they determine to be appropriate. IDPH may grant a waiver when it can be demonstrated that there will be no reduction in standards of medical care as determined by the EMS MD or IDPH. Waivers shall be valid only for the length of time determined by the Department. For either a single or multiple waiver request, the burden of proof as to the factual basis supporting any waiver shall be on the applicant.

II. Any entity may apply in writing to IDPH for a waiver to specific requirements or standards for which it considers compliance to be a hardship. The application shall contain the following information:

A. The applicant's name, address, and license number (if applicable);

B. The Section of the EMS Act or its Rules and Regulations for which the waiver is being sought;

C. An explanation of why the applicant considers compliance to be a unique hardship, including:

1. A description of how the applicant has attempted to comply with the requirement;

2. The reasons for non-compliance; and

3. A detailed plan for achieving compliance. The detailed plan shall include specific timetables.

D. The period of time for which the waiver is being sought;

E. An explanation of how the waiver will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations; and

F. If the applicant is a system participant, the applicant's EMS MD shall state in writing whether he or she recommends or opposes the application for waiver, the reason for the recommendation or opposition, and how the waiver will or will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations. The applicant shall submit the EMS MD's statements along with the application for waiver. If the EMS MD does not provide written statements within 30 days after the applicant's request, the EMS MD will be determined to be in support of the application, and the application may be submitted to IDPH.

III. An EMS MD may apply to IDPH for a waiver on behalf of a system participant by submitting an application that contains all of the information required above, along with a statement signed by the system participant requesting or authorizing the EMS MD to make the application.

IV. IDPH will grant the requested waiver if it finds the following:

A. The waiver will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations;

B. Full compliance with the statutory or regulatory requirement at issue is or would be a unique hardship on the applicant;

C. For EMS Personnel seeking a waiver to extend a relicensure date in order to complete relicensure requirements:

1. The EMS provider has previously received no more than one extension since his or her last relicensure; and

2. The EMS provider has not established a pattern of seeking extensions (e.g., waivers sought based on the same type of hardship in two or more previous license periods);

D. For an applicant other than EMS providers seeking a waiver:

1. The applicant has previously received no more than one waiver of the same statutory or regulatory requirement during the current license or designation period;

2. The applicant has not established a pattern of seeking waivers of the same statutory or regulatory requirement during previous license or designation period; and

3. IDPH finds that the hardship preventing compliance with the particular statutory or regulatory requirement is unique and not of an ongoing nature;

E. For a hospital requesting a waiver to participate in a System other than that in which the hospital is geographically located:

1. Documentation that transfer patterns support the request; and

2. Historic patterns of patient referrals support the request.

IV. When granting a waiver, IDPH will specify the statutory or regulatory requirement that is being waived, any alternate requirement that the waiver applicant shall meet, and any procedures or timetable that the waiver applicant shall follow to achieve compliance with the waived requirement.

V. IDPH will determine the length of any waiver that it grants, based on the nature and extent of the hardship and will consider the medical needs of the community or areas in which the waiver applicant functions.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Medical Device Malfunction Reporting
	Section: Quality Improvement
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

MEDICAL DEVICE MALFUNCTION REPORTING

I. PURPOSE

To define the medical device reporting requirements by EMS personnel for the Food and Drug Administration (FDA) under the Safe Medical Devices Act of 1990.

II. DEFINITIONS

A. Medical Device: Any instrument, apparatus or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body. This includes, but is not limited to ventilators, cardiac monitors, electronic equipment, patient restraints, syringes, catheters, diagnostic test kits and reagents, disposables, components, parts, or accessories.

B. Malfunction: Failure of a device to meet its performance specifications or to perform as intended.

C. Medical Device Reporting (MDR) Regulation of 1995: Contains mandatory requirements for manufacturers, importers, and device user facilities (includes hospital and EMS) to report device related serious injury or death within 10 business days to the manufacturer and/or the Food and Drug Administration (FDA).

D. MDR Reportable Event: An event about which a user facility becomes aware of information that reasonably suggests that a device has or may have caused or contributed to a death or serious injury.

E. MDR Authority: The Food and Drug Administration (FDA) has criminal and civil penalty to enforce MDR requirements.

III. POLICY

A. Any individual who witnesses, discovers, or otherwise becomes aware of information that reasonably suggests that a medical device has caused or contributed to the morbidity and mortality of the patient or EMS personnel is responsible to:

1. Report the incident to their immediate supervisor; and

2. Complete a Request for Clarification (RFC) within 24 hours.

B. Medical device malfunction is a mandatory reportable event by the EMS personnel and/or the EMS agency to the Resource Hospital EMS Coordinator and EMS Medical Director.

C. Incident investigation information will be used to complete the FDA Med Watch mandatory or voluntary reporting of adverse events form.

Reference: U.S. Food and Drug Administration, Medical Device Safety, https://www.fda.gov/medical-devices/medical-device-safety.

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Request for Clarification (RFC) / Complaint Investigation
	Section: Quality Improvement
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

REQUEST FOR CLARIFICATION (RFC) / COMPLAINT INVESTIGATION

I. PURPOSE

To define the process to review issues or concerns regarding prehospital patient care within the EMS System.

II. DEFINITION

A. Request for Clarification (RFC): When a system participant requests Resource Hospital review of an incident.

B. Complaint: Problems related to the care and treatment of a patient. For the purposes of this policy, "complaint" means a report of an alleged violation of the EMS Act or its rules and regulation by any system participant, EMS provider, or member of the public.

III. POLICY

A. Any person or system participant may submit a Request for Clarification (RFC) or a complaint regarding an incident.

B. Submitting a RFC/complaint:

1. EMS Providers and EMS System Participants: RFCs/complaints should be submitted to the Resource Hospital on the attached form, but may also be submitted by phone, email, or verbal report with the required information.

2. Patients and Members of the Public: Complaints should be submitted to the IDPH Central Complaint Registry Hotline by calling 800-252-4343 (Monday-Friday 8:30 am – 4:30 pm). For additional information regarding how to file a health care complaint, please visit https://dph.illinois.gov/topics-services/health-care-regulation/complaints.html.

C. Examples of common RFCs/complaints include, but are not limited to:

1. Deviations in EMS protocols or policies;

2. Direction or orders given by Online Medical Control; and/or

3. Problems or incidents related to the care and treatment of a patient

D. The Resource Hospital EMS System Coordinator and EMS Medical Director will review submitted RFC/complaints and obtain information needed to investigate the incident.

E. The name of the complainant shall not be disclosed unless the complainant consents in writing to that disclosure.

F. IDPH may conduct a joint investigation with the EMS Medical Director and EMS Coordinator if a death or serious injury has occurred or there is imminent risk of death or serious injury, or if the complainant alleges action or conditions that could result in a denial, non-renewal, suspension, or revocation of licensure or designation.

G. The EMS Medical Director shall forward the results of any investigation with disciplinary action to IDPH.

H. Documentation of the investigation shall be retained at the hospital in accordance with EMS System improvement policies and shall be available to IDPH upon request. The investigation file shall be considered privileged and confidential in accordance with the Medical Studies Act.

I. The attached Request for Clarification (RFC) or Complaint Form should be copied and available to the public and participants of the EMS system. It should be made accessible at the Resource and Associate Hospital EMS offices and Participating Hospital Emergency Departments.

REGION 11 EMS
REQUEST FOR CLARIFICATION (RFC) OR COMPLAINT FORM

CONFIDENTIAL

THIS IS A CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT.
DO NOT COPY OR MAKE REFERENCE TO ITS COMPLETION IN THE MEDICAL RECORD/PATIENT CARE REPORT.

Date and Time of Occurrence:

EMS Agency and Unit Number: Event or Incident Number:

Hospital or Facility Where the Patient Was Transported:

Hospital Log or Report Number:

EMS Personnel Name(s):

Names of the Patient, Entities, Family Members, and Other Persons Involved:

Relationship of the Complainant to the Patient or the Provider:

Patient Condition and Status:

Details of the Situation:

Name of Person(s) Submitting Form:

Form Submitted To:

Date Form Submitted:

CONFIDENTIAL

REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Resolving Regional or System Conflict
	Section: Quality Improvement
	Approved: EMS Medical Directors Consortium
	Effective: December 6, 2023

RESOLVING REGIONAL OR SYSTEM CONFLICT

I. The EMS Medical Directors of the EMS systems involved will review and develop a plan of action to resolve the conflict.

II. Unresolved issues will be referred to IDPH for review and recommendations.

III. If IDPH determines that a dispute exists between an EMS System, vehicle service provider, Advisory Committee, hospital, EMS MD or between any combination of any elements of these entities and the dispute causes an imminent threat to the availability or quality of emergency pre-hospital care within the State, then IDPH shall have the authority to resolve those disputes, if one party to the dispute requests IDPH intervention in writing. If IDPH receives and approves such a request, then each entity's duly authorized representative shall be given the opportunity to submit written arguments and evidence in support of any potential resolution. IDPH shall have the authority to hear oral arguments and testimony based upon the written submissions. Any decision by IDPH shall be issued in writing and state the basis for the decision, which shall be final and binding upon all parties to the dispute. IDPH will endeavor to issue a written decision within 30 days after receipt of all written submissions and verbal testimony, if verbal testimony is permitted.

IV. This dispute resolution process is not applicable to EMS personnel or members of the public. This process is not applicable to any EMS System Suspension, Local Board of Review, or action by the State EMS Disciplinary Review Board or IDPH.

V. The IDPH Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) shall govern all proceedings.

VI. All final administrative decisions of IDPH hereunder shall be subject to judicial review pursuant to the provisions of the Administrative Review Law [35 ILCS 5/Art. III]. A decision by IDPH in accordance with this Section shall be considered an administrative review decision under Section 3.145 of the Act and shall be subject to judicial review.