

**REGION XI
CHICAGO EMS SYSTEM
POLICIES AND PROCEDURES**



CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

These Policies and Procedures supersede all prior system Policies and Procedures and are written to provide consistent quality care to all the communities served regardless of race, creed, religion, national origin or the ability to pay.

These Policies and Procedures are guidelines for Emergency Medical Services (EMS). They are intended to be the framework of decisions for the EMS system. They are the guidelines for the actions of all EMS personnel within the system. It is understood that deviations from the Policies and Procedures may be necessary in the interest of assuring that a patient receives appropriate care and/or is transported to an appropriate medical facility.

All EMS personnel are responsible for the provisions contained in the Chicago EMS Medical Directors Consortium Policies & Procedures and Standing Medical Orders, and those delineated by the Illinois EMS Act and Rules and Regulations promulgated by Illinois Department of Public Health.

CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

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CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

A. COMMUNICATION

Resource/Associate Hospital Contact...A.1 to A.2

RESOURCE/ASSOCIATE HOSPITAL CONTACT

- I. EMS personnel will initiate contact with the assigned base station hospital in the following cases:
 - A. All advanced life support (ALS) runs; see policy - Initiation of Patient Care
 - B. All runs where the need for ALS vs. basic life support (BLS) care is in question
 - C. All patient refusals of care and/or transport prior to leaving patient
 - D. All transports to specialty centers (see attached list), either at the scene or enroute
 - E. BLS runs where advance notification to receiving hospital may have an important impact
 - F. BLS ambulance on scene with patient requiring ALS care where ALS response is greater than transport to nearest appropriate hospital
 - G. Medical-legal issues, e.g., DOA, DNR, Crime Scene Response, Physician on the Scene, etc.
- II. Contact receiving hospital medical oversight directly if receiving hospital is a Region XI base station hospital.
- III. If contact to assigned Resource/Associate Hospital is unsuccessful:
 - A. Attempt to contact the next nearest Resource/Associate Hospital.
 - B. All attempts at contact must be documented on the patient care report or accepted system approved form.
 - C. 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.
- IV. For multiple victim incidents (MVI), defined as three or more patients in the absence of an EMS plan, the first responding EMS unit shall contact either the Resource Hospital or Associate Hospital.
- V. For EMS Plans I, II, and III, the first responding EMS unit or EMS Chief shall contact the Resource Hospital.

Attachment 1: Outline for Radio Report

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Implementation: 1/1/89; 9/1/93; 3/1/95; 12/1/96; 10/00; 3/1/11; 3/1/16

ATTACHMENT 1

OUTLINE FOR RADIO REPORT

- I. Routine report
 - A. Identify unit and number
 - B. State age & sex
 - C. State chief complaint
 - D. State “routine SMO’s followed”
 - E. Destination and ETA

- II. Detailed report
 - A. Under the following circumstances a detailed report should be given (B)
 - 1. Abnormal vital signs per policy *Initiation of Patient Care B-2*
 - 2. Deviations from SMO’s
 - 3. Upgrades/escalations
 - 4. All transports to specialty centers
 - 5. Unusual circumstances
 - B. Detailed report content
 - 1. Routine report information
 - 2. Vital signs including:
 - a. State of consciousness
 - b. Blood pressure
 - c. Pulse & rhythm
 - d. Respiratory rate & degree of distress
 - e. Pulse oximeter (if indicated)
 - 3. History including:
 - a. Brief history of present illness, including time of onset of symptoms for patients with suspected acute stroke
 - b. Pertinent past history
 - c. Medications applicable to circumstance
 - 4. Allergies, if applicable to circumstance
 - 5. Pertinent physical findings, including Cincinnati Stroke Scale (CSS) for patients with suspected acute stroke
 - 6. Computer interpretation of 12-lead ECG (when obtained). If computer interpretation meets ST Elevation Myocardial Infarction (STEMI) Criteria, state that at the beginning of the report.
 - 7. Treatment initiated
 - 8. Patient response to treatment/reassessment
 - 9. Destination & ETA

NOTE: TRANSMIT REPORT AS QUICKLY AS POSSIBLE

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CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

B. PATIENT CARE

- EMS Staffing...B.1
- Call Disposition...B.2
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- Large Gathering/Special Events B.25
- Use of Controlled Substances...B.26 to B.27
- Conveyance of Patients...B.28 to B.29

EMS STAFFING

- I. Appropriate minimum staffing of:
 - A. a first responder unit shall consist of 2 registered first responders
 - B. an advanced life support (ALS) company shall consist of 1 licensed paramedic and 1 licensed EMT-B
 - C. a basic life support (BLS) ambulance shall consist of 2 licensed EMT-Bs
 - D. an ALS ambulance shall consist of 2 licensed paramedics
- II. The ambulance service provider must petition the Emergency Medical Service Medical Director (EMSMD) for waiver of this System policy. The EMSMD will comment and request consideration by the Illinois Department of Public Health (IDPH).
- III. A licensed paramedic or EMT-B must accompany the patient in the patient compartment at all times.

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Implementation: 1/1/89; 9/1/93; 12/1/96; 10/00; 1/1/10

CALL DISPOSITION

- I. Every 911 dispatch for patient care should be given one of the following dispositions:
 - A. **Patient Transported to Appropriate Emergency Department:** The patient is transported to the Emergency Department.
 - B. **Patient Initiated Refusal** (see Consent/Refusal of Service Policy B.9 - B.11): Online medical control should be contacted for **ALL** refusals of service while the providers are still on scene and with the patient. All events leading to the refusal should be documented in the patient care report. In situations of third party calls wherein the patient has not called 911 and refuses all treatment and contact with EMS personnel, EMS providers should attempt to communicate with the third party caller or contact OEMC to investigate the reason for calling 911.
 - C. **No Patient Found:** EMS providers should make every attempt to identify the person for whom dispatch initiated the EMS response. In the event that the person/911 caller is identified, this should be treated as a refusal and online medical control should be contacted. When no person can be found, base station contact is not required, however all circumstances surrounding the event and a description of efforts to locate the patient must be documented in the patient care report.
 - D. **Patient Deceased on Arrival (DOA)** (see Initiation or Withholding of Resuscitative Measures Policy B.4 - B.5): Online medical control should be contacted while the providers are still on scene. All events should be documented in the patient care report.
 - E. **Cancelled Prior to Arrival on Scene:** In the event that the call is cancelled by dispatch while en route to scene, this should be logged in the CAD.
- II. All patients must be placed into one of the above categories. Online medical control should be contacted to help clarify patient disposition if the situation is unclear.

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INITIATION OF PATIENT CARE

I. Equipment

When responding to all requests for out-of-hospital care, the EMS personnel (First Responder, EMT-B, Paramedic) will take the following to the initial contact with the patient:

1. Quick response bag
2. Stair chair if available or other conveyance device
3. AED or AED 1000 (3 Lead)
4. O₂

EMS personnel will bring in the Monitor/defibrillator for any known cardiac or respiratory arrest calls.

II. Appropriate care, as directed, by Region XI EMS SMO 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 pending the arrival of an ALS ambulance.

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

IV. Advanced Life Support (ALS) care includes, at a minimum, IV access, oxygen, and application of the cardiac monitor or AED 1000. Once inside the ambulance the cardiac monitor will be substituted for the AED 1000. **The cardiac monitor must remain attached to the patient during transportation into the hospital and care endorsed to the emergency department staff.**

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

A. Patient with abnormal vital signs -- regardless of complaints. The following guidelines for adults:

1. Pulse <60 or >110; or irregularity
2. Respiration <10 or >24; or irregularity
3. Systolic Blood Pressure >180 or <100
4. Diastolic Blood Pressure >110
5. Pulse Ox <95%

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

1. Altered mental status/unresponsive
2. Suspected acute coronary syndrome or other cardiac emergencies, including arrhythmias/palpitations
3. Seizures or postictal state
4. Suspected stroke or TIA
5. Syncope or Near Syncope

6. Shortness of Breath/Difficulty Breathing
7. Complications of Pregnancy or Childbirth
8. GI Bleeding
9. Multiple System Trauma
10. Penetrating Trauma, Head, Neck, Torso
11. Overdose/Poisoning
12. Burns >10%

VI. 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. Document clearly the reasons for deviations in care.

VII. Never discontinue care once initiated unless:

- A. approval is granted by the Resource/Associate Hospital or
- B. care has been transferred to higher level personnel at the receiving hospital.

VIII. WHEN IN DOUBT CONSULT WITH Medical Control.

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INITIATION OR WITHHOLDING OF RESUSCITATIVE MEASURES

I. INITIATION OF RESUSCITATION

All EMS personnel practicing within the Chicago EMS System are required to immediately initiate cardiopulmonary resuscitation (CPR), in any victim who is apneic, pulseless, and/or demonstrating signs of inadequate perfusion unless the victim meets criteria for withholding resuscitation.

II. WITHHOLDING RESUSCITATION

A. Resuscitation should be withheld in the following circumstances:

1. Essentially decapitated patients
2. Evidence of rigor mortis without hypothermia
3. Presence of widespread lividity
4. Evidence of tissue decomposition or putrefaction
5. Mummification
6. Frozen state
7. Incineration
8. If patient has been declared dead by the patient's physician (The physician must sign patient care report.)
9. Adult trauma patients (age 16 years or greater), where there is a trauma-related lethal mechanism of injury and the patient is asystolic; excluding:
 - a. Drowning or strangulation,
 - b. Lightning strike or electrocution,
 - c. Situations involving hypothermia,
 - d. Patients with visible pregnancy,
 - e. Medical conditions as the likely cause of cardiac arrest.

B. IN CASES WHERE THE PATIENT'S STATUS IS UNCLEAR AND THE APPROPRIATENESS OF WITHHOLDING RESUSCITATION EFFORTS IS QUESTIONED, EMS PERSONNEL SHOULD INITIATE CPR IMMEDIATELY AND THEN CONTACT THE BASE STATION FOR FURTHER DIRECTION.

C. When resuscitation is withheld, notify:

1. Base station
2. Chicago Police Department -- All notification of the medical examiner is done by the Chicago Police Department in accordance with Police General Order -- Processing Deceased Persons.

D. Disposition of the patient when resuscitation is withheld:

1. For II, A, 1 through 8, notify CPD; transfer custody of the patient to CPD on scene
2. For II, A, 9 (Traumatic cardiopulmonary arrest), depending upon the circumstances, either of the following may be appropriate:
 - a. Transfer custody to CPD on scene. Preservation of crime scene elements may

- be appropriate (refer to Crime Scene Response);
- b. Remove the patient from the scene. This may be appropriate or necessary given the nature of the scene. If so, transport the patient to the closest comprehensive ED. The base station should notify the comprehensive ED of the patient's impending arrival.

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TERMINATION OF RESUSCITATION

- I. Termination of Resuscitation may be considered in the following circumstances:
 - A. Adult patient in cardiac arrest
 1. Excludes traumatic arrest
 2. Excludes hypothermia
 3. No other reversible cause of cardiac arrest identified
 - B. Initial rhythm is asystole or pulseless electrical activity (PEA)
 1. Confirmed in two different leads
 - C. IV or IO access is established
 1. Epinephrine 1 mg IV every 3-5 minutes
 2. 5 total doses of Epinephrine have been administered
 - D. Advanced airway established
 1. King supraglottic airway or endotracheal tube
 - E. ETCO₂ capnography attached with number and waveform reading
- II. If all of the above criteria are met:
 - A. Contact Medical Control
 - B. Request termination of resuscitative measures from ECP or ECRN.
 - C. If order for termination approved, terminate resuscitation
 - D. If order for termination not approved, continue resuscitation and 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
 - 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 Cook County Medical Examiner or with family and private funeral home.
- IV. If the order for termination is approved and the deceased is in **a public place or unsafe scene**, 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.

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ADVANCED DIRECTIVES

I. HEALTH CARE AGENTS/POWER OF ATTORNEY

- 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 order 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 communicate to you. 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. If someone represents to you that they have power of attorney to make medical decisions for the patient, follow these procedures:
 - 1. Begin treatment of the patient.
 - 2. Immediately notify medical control of the possible presence of a health care agent for the patient and keep medical control advised. Follow all subsequent orders of the medical control physician, even if such orders contradict the orders you are receiving from the "agent."
 - 3. 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 medical authority has been given to the agent. Notify medical control 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 transport as soon as possible. Document concerns.

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 unworkable and impractical for field use, where EMS personnel have limited time for analysis and decision making. Therefore, Chicago EMS System EMS personnel shall not follow the instructions contained in a living will or given by any person purporting to be a surrogate for the patient unless instructed otherwise by medical control.

III. DO NOT RESUSCITATE (DNR)/IDPH PRACTITIONERS ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORM

For the purpose of this policy, Do Not Resuscitate (DNR)/POLST Orders are defined as medical orders by a physician or practitioner based on the patient's medical condition and preferences. These orders provide guidance during life threatening emergencies and must be followed by all healthcare providers.

A. The sections of the POLST form are defined as follows:

1. Section "A" of the POLST form refers to Cardiopulmonary Resuscitation. This section notes if the patient wishes to have resuscitation/CPR attempted or if they prefer medical providers do not attempt resuscitation.
2. Section "B" of the POLST Form refers to medical interventions for patients who are NOT in respiratory or cardiac arrest. There are three options of treatment levels:
 - i. **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment (see #2 & #3 below), use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
 - ii. **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment (see #3 below), use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. **Do Not Intubate.** May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit.
 - iii. **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. **Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.**
 - iv. There is also a section for Optional Additional Orders.
3. Section "C" refers to the use of medically administered nutrition.
4. Section "D" refers to documentation of the discussion of the DNR/POLST document and signatures of the patient or legal representative's consent and a witness.
5. Section "E" refers to the signature and date of the patient's health care practitioner.

B. All system EMS personnel are permitted to withhold or withdraw medical care pursuant to a valid DNR/ POLST Order in cardiac arrest situations. Valid DNR/ POLST Orders can be followed by system EMS personnel 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.

C. A valid DNR/POLST Order will contain at least the following information:

1. Name of the patient;
2. Name and signature of attending practitioner;
3. Effective date;
4. The words, "Do Not Resuscitate" or "DNR";
5. Evidence of consent - either:
 - i. Signature of patient or
 - ii. Signature of legal guardian or
 - iii. Signature of durable power of attorney for health care agent or
 - iv. Signature of surrogate decision maker

D. If the required evidence of consent does not appear on the DNR/POLST Order, the order is not valid for prehospital use.

E. When presented with a DNR/POLST Order, follow these procedures:

1. Verify the order contains the criteria for a valid DNR/ POLST Order 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 DNR/POLST Order.
3. Immediately contact medical control and advise them of the presence of a DNR/POLST Order, along with the description of any specific treatments to be withheld that are set forth in the DNR/POLST Order. Always follow orders from medical control, even if they are contrary to the DNR/POLST order.
4. If the order is valid and medical control does not order otherwise, follow the terms of the DNR/POLST order, and attach a copy of the DNR/POLST Order to the patient care report. If it is not possible to attach a copy of the DNR/POLST Order, record all information from the DNR/POLST order on the patient care report.
5. If there is any doubt as to the validity of the DNR/POLST order, treat the patient and transport as soon as possible. Document any concerns in the patient care report.

F. A DNR/POLST Order can be revoked if the order is physically destroyed or verbally rescinded by the physician who signed the order, the patient, or the person who gave written consent to the Order.

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Written: 2007 Taken from "Initiation of Termination of Resuscitative Measures" and "Do Not Resuscitate"

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State of Illinois
Illinois Department of Public Health

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

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address (street/city/state/ZIPcode)		

A **CARDIOPULMONARY RESUSCITATION (CPR)** If patient has no pulse and is not breathing.

Check One **Attempt Resuscitation/CPR** **Do Not Attempt Resuscitation/DNR**
(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

B **MEDICAL INTERVENTIONS** If patient is found with a pulse and/or is breathing.

Check One (optional) **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Optional Additional Orders _____

C **MEDICALLY ADMINISTERED NUTRITION** (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One (optional) Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)** _____

Trial period of medically administered nutrition, including feeding tubes. _____

No medically administered means of nutrition, including feeding tubes. _____

D **DOCUMENTATION OF DISCUSSION** (Check all appropriate boxes below)

Patient Agent under health care power of attorney

Parent of minor Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature (required)	Name (print)	Date
_____	_____	_____

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature (required)	Name (print)	Date
_____	_____	_____

E **Signature of Authorized Practitioner** (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name (required)	Phone
_____	() _____ - _____
Authorized Practitioner Signature (required)	Date (required)
_____	_____

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI
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Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

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

Contact Person Name	Contact Phone Number
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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 orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

- This POLST form should be reviewed periodically and if:
- The patient is transferred from one care setting or care level to another, or
 - or there is a substantial change in the patient's health status, or
 - or the patient's treatment preferences change, or
 - or the patient's primary care professional changes.

Voiding or revoking a POLST Form

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

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

- | | |
|------------------------------------------------------------|-----------------------------------------|
| 1. Patient's guardian of person | 5. Adult sibling |
| 2. Patient's spouse or partner of a registered civil union | 6. Adult grandchild |
| 3. Adult child | 7. A close friend of the patient |
| 4. Parent | 8. The patient's guardian of the estate |

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

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

CONSENT/REFUSAL OF SERVICE

I. PATIENT WITH DECISION-MAKING CAPACITY

- A. A patient with decision-making capacity has the legal right to consent to or refuse some or all of the treatment intended and to consent to or refuse transport.
- B. In every situation when a decision-making patient refuses medical assistance or transportation, employ the following guidelines:
 - 1. Advise the patient of his/her medical condition and explain why the care and/or transport are necessary. Continue to encourage cooperation.
 - 2. Resort to a refusal only as a mechanism for documenting steadfast refusal of treatment and/or transport by conscious, competent adults.
- C. Procedure for Refusals
 - 1. Inform the patient of the risks of refusal and document your attempts to do so along with the patient's ability to comprehend.
 - 2. Have the patient sign the written refusal of transport.
 - a. There should be two (2) witnesses to the refusal if possible. One (1) witness should be the EMT-B/paramedic assigned to the ambulance/ALS 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.
 - 3. 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 the Resource/Associate Hospital while on the scene.
 - 4. "Refusal of service" runs must be called in and documented with the Resource/Associate Hospital while still with the patient unless hostile environment exists; see policy - Patient Transport.
 - 5. For refusal of treatment or any component of treatment, the refusal MUST BE thoroughly documented in the comments section.

II. PATIENT WITHOUT DECISION-MAKING CAPACITY

- A. A patient whose behavior and/or medical condition suggests non-decision-making capacity has neither the right to consent to or refuse care and/or transport. Non-decision-making patients will not be allowed to make health care decisions.
- B. Procedure for Caring for a Patient Suspected to be Non-Decision-Making and Refusing Medical Assistance and/or Transportation

1. Identify yourself and attempt to gain the patient's confidence and initiate care in a non-threatening manner.
2. Consider and attempt to evaluate for decision-making capability and possible causes of non-decision-making capacity. (Initiate treatment as required.) Examples include:
 - 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 Imbalance
 - i. Infections
 - j. Dementia (e.g., acute or chronic organic brain syndrome)
 - k. Psychiatric/behavioral emergencies (e.g., suicidal, inability to care for self, homicidal)
3. Once a patient is judged to be clearly non-decision-making, 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 personal safety of the EMS personnel is assured. Contact Resource/Associate Hospital, police and/or fire department backup as appropriate.
 - b. Try to obtain cooperation through conventional means.
4. If the patient resists care and/or transport:
 - a. Request police and/or fire department backup as needed.
 - b. Contact Resource/Associate Hospital as needed.
 - c. Reasonable force may be used to restrain the patient if the patient is a risk to self or others (see policy - Restraints).
 - 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.

III. 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:
 - a. has obtained a court order of emancipation
 - b. is married
 - c. is a parent
 - d. is pregnant
 - e. 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 the Resource/Associate Hospital 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, proceed as in "C" above.
- E. If a parent or guardian refuses to consent when medical care is indicated:
 - 1. See policy Reporting Abuse and/or Neglected Patients.
 - 2. Advise the Resource/Associate Hospital of the situation while on scene. Request authorization to allow the parent/guardian to sign refusal.
- F. In any situation involving a minor patient, EMS personnel should attempt to solicit a responsible adult to accompany the minor from the scene.

IV. MULTIPLE VICTIMS

- A. To ensure the efficient use of resources, the following documentation process will be utilized at incidents where 3 or more patients are refusing services.
 - 1. If patients are willing to sign a refusal, the Chicago EMS Multiple Victim Release Form I is to be completed.
 - 2. If patients are refusing to sign a refusal, the Chicago EMS Multiple Victim Release Form II is to be completed.
 - 3. One (1) patient care report/ MICU Form, per incident, is to be completed with all Multiple Victim Release Forms.
- B. All multiple victim event refusals must be documented through the Resource Hospital or Associate Hospital.

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Written: 1988

Reviewed: 10/92; 11/95; 1/97; 6/98; 3/00; 4/07; 7/09; 5/11; 8/15

Revised: 10/92; 11/95; 4/96; 1/97; 6/98; 3/00; 4/07; 7/09; 11/17/15

MDC Approval: 1988; 11/5/92; 11/2/95; 6/13/96; 2/6/97; 7/98; 3/00; 12/4/07; 7/09

IDPH Approval: 1988; 11/16/92; 9/17/96; 1/99; 5/00; 10/24/08; 3/5/10; 2/25/16

Implementation: 1/1/89; 9/1/93; 12/1/96; 8/1/99; 10/00; 1/1/11; 3/1/16

SCHOOL INCIDENTS

- 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 screen and manage victims as follows:
 - A. **Category I:** Victims in facility with actual exposure and one or more children having complaints of illness and/or injury
 - 1. Victims will be assessed and treated according to Chicago EMS System Standing Medical Orders with each individual having a completed patient care report
 - 2. Victims without complaints will be managed as in Category II
 - B. **Category II:** Victims in facility with potential exposure/actual exposure and no complaints
 - 1. Contact medical oversight at the Resource Hospital
 - 2. The school representative will assume custody of the children
 - C. **Category III:** Victims in facility with no direct exposure and/or complaints
 - 1. Contact medical oversight at the Resource Hospital
 - 2. The school representative will assume custody of the children
- II. In situations of a motor vehicle crash involving a school bus with children on board, EMS personnel will screen and manage victims as follows:
 - A. **Category I:** A significant mechanism of injury occurred where one or more children have injuries
 - 1. Injured victims will be assessed and treated according to Chicago EMS System Standing Medical Orders with each individual having a completed patient care report
 - 2. Victims 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 victims with minor injuries.
 - 1. Injured victims will be assessed and treated according to Chicago EMS System Standing Medical Orders with each individual having a completed patient care report
 - 2. Victims 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 victims have no complainants
 - 1. The responding EMS ALS personnel will contact Medical Control at the appropriate Resource Hospital for authority to release uninjured children from Categories II and III to the custody of the school representative or bus driver.

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Reviewed: 5/11; 8/15

Revised: 5/11

MDC Approval: 12/4/07; 9/7/10; 6/7/11

IDPH Approval: 10/24/08; 11/24/10; 9/29/11

Implementation: 1/1/10; 1/1/11; 4/1/12

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 unless authorized by base station.
 - 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 handcuffed 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 Statute 1983, Chapter 91 1/2. Section 2-108; 2-109; and 2-201 (and its amendments).

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Supersedes: C-8, Use of Restraints

Written: 10/91

Reviewed: 10/92; 11/2/95; 3/00; 12/06; 4/07; 5/11; 8/15

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Implementation: 7/1/92; 9/1/93; 12/1/96; 10/00; 1/1/10

REPORTING ABUSED AND/OR NEGLECTED PATIENTS

I. CHILDREN

A. Guidelines to be used for suspecting child abuse and neglect:

1. Discrepancy between history of injury and physical exam
2. Prolonged interval between injury and the seeking of medical help
3. History/suspicion of repeated trauma
4. Parents or guardians respond inappropriately or do not comply with or refuse evaluation, treatment or transport of child
5. The apathetic child, e.g., the child who does not seek comfort from parents or guardians
6. Poor nutritional status
7. Environment that puts the child in potential risk
8. The following injuries are physical signs and should raise the suspicion of child abuse and indicate need for more investigation:
 - a. Perioral and perinasal injuries
 - b. Fractures of long bones in children under three (3) years of age
 - c. Multiple soft tissue injuries
 - d. Frequent injuries - 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

B. By Illinois law, (Abuse and Neglected Child Reporting Act) medical personnel are required to report cases of suspected child abuse and neglect. DCFS can be reached at 1-800-25-ABUSE (24 hour phone line).

C. EMS personnel shall report their suspicions to the emergency department physician and/or charge nurse and/or police and document on the EMS medical record.

D. On the patient care report carefully document history and physical findings, environmental surroundings, child's interaction with parents or guardians, discrepancies in the history obtained from the child, bystanders, parents or guardians, etc.

E. Treatment of Suspected Child Abuse/Neglect

1. Treat obvious injuries
2. If parent or guardian refuses to let you treat and/or transport the child, remain at the scene. Contact Resource/Associate Hospital and request police assistance. Request that the officer place the child in protective custody and assist with transport.
3. 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.

4. Any person acting in good faith in the removal of a child shall be granted immunity from any liability as a result of such removal.

II. ELDER ABUSE/NEGLECT or SELF NEGLECT

- A. All EMS personnel who have reasonable cause to believe a geriatric patient may be abused or neglected shall report the circumstances to the appropriate authority upon completion of patient care.
- B. Reporting number for Geriatric Abuse: 1-800-252-8966 (home bound) or 1-800-252-4344 (nursing home).
- C. Report your suspicions to the emergency department physician and/or charge nurse upon arrival.
- D. Carefully document history and physical exam findings as well as environmental and circumstantial data on the patient care report (or accepted system approved form).
- E. If there is reason to believe the geriatric patient has been abused/neglected, EMS personnel shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.

III. DOMESTIC ABUSE/VIOLENCE:

- A. All EMS personnel who have reasonable cause to believe a patient is the victim of domestic assault and/or violence are required by law to provide immediate and appropriate referral information to the patient. This requirement will be fulfilled by the receiving hospital.
- B. If there is a reason to believe a patient is a victim of domestic assault and/or violence, the paramedic/EMT-B shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.
- C. Report your suspicions to the emergency department physician and/or charge nurse.
- D. Carefully document history and physical exam findings as well as environmental and circumstantial data on the patient care report.

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IDPH Approval: 9/17/96; 1/99; 10/24/08; 2/25/16

Implementation: 12/1/96; 8/1/99; 1/1/10; 3/1/16

GUIDELINES FOR PREVENTING DISEASE TRANSMISSION

I. PROTECTING EMS PERSONNEL AND PATIENTS

- A. Universal precautions represent the standard of care and should be routinely used in all patients.
- B. The following precautions represent prudent practice and should be utilized:
 - 1. Routine hand washing after contact with any patient regardless of the use of gloves.
 - 2. Routine use of appropriate barrier precautions during patient care, invasive procedures, and when handling equipment contaminated with blood or other body fluids.
 - 3. Extraordinary care should be used to prevent parenteral exposures from needles and other sharp instruments. After use, needles, disposable syringes, and other sharp instruments should be disposed of by placing them in puncture resistant containers. Needles should not be recapped. If it is absolutely necessary to recap a needle, the one hand technique should be used.
 - 4. Appropriate barrier precautions should be used when cleaning, disinfecting, or disposing of contaminated equipment, supplies, and ambulance surfaces.
 - 5. Healthcare workers 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. When transporting a patient suspected of having an infectious disease transmissible via air (measles, mumps, meningitis, pertussis, influenza or tuberculosis), any personnel likely to have face-to-face contact (within three feet of the patient) should minimally wear a N-95 mask and appropriate eye protection. The patient should wear a surgical mask.
 - 7. EMS personnel are urged to have appropriate immunization or knowledge of prior illness to the following: hepatitis B, measles, mumps, rubella, pertussis/whooping cough, chicken pox, tetanus, diphtheria, and polio.

II. CARE OF AMBULANCE AND EQUIPMENT

A. Ambulance

- 1. Vehicles transporting patients with a potential contagious disease shall be aired out with doors and windows open for five (5) to ten (10) minutes while performing a thorough cleaning and disinfection.
- 2. Equipment and surfaces contaminated with blood or other body fluids, regardless of infectious status, should be cleaned with soap and hot water followed by a disinfectant solution in compliance with OSHA standards.
- 3. Disposable equipment and contaminated linens should be appropriately bagged and disposed of at the receiving hospital per that hospital's policies.

B. Equipment

- 1. Cleaning

- a. Physical removal of soilage should be done on all equipment.
- b. On washable equipment, use a low sudsing detergent with a neutral pH (all participating hospitals and ambulance service providers will have supplies).
- c. Regular household detergents do not have neutral pH and should not be used as they may damage equipment.
- d. Hydrogen peroxide helps loosen dried blood and tissue but will corrode copper, zinc, and brass.
- e. Disinfection cannot take place unless equipment is first cleaned and all organic material present on the surface has been removed.

2. Disinfecting

- a. Disinfecting may be accomplished by employing a 2% glutaraldehyde product. First clean with detergent and then disinfect by soaking in the 2% glutaraldehyde product per the manufacturer's specifications and in compliance with OSHA standards. Rinse with water after soaking.
- b. Disinfecting should be used on items that will frequently come in contact with skin or mucous membranes such as respiratory equipment.
- c. Disinfecting should be used on any nondisposable items that become contaminated with blood or body fluids such as blood pressure cuffs, bed rails, etc.
- d. Instruments and resuscitation devices must be disassembled and soaked for the prescribed times set forth by the ambulance service provider's policy and/or manufacturer's recommendation for their products.
- e. Disinfection and cleaning should be in compliance with the standards set forth by OSHA.

C. Respiratory equipment

1. Laryngoscope blades

- a. Disassemble parts.
- b. Clean with detergent, rinse, and dry.
- c. Soak submerged in 2% glutaraldehyde product for 10-20 minutes (20 minutes required if tuberculosis exposure suspected).
- d. Rinse well with tap water.
- e. Dry with clean paper towels.

2. Automatic Ventilators and other Miscellaneous Equipment: Manufacturer's cleaning instructions should be followed.

III. EXPOSURES

- A. All parenteral (needlestick or cuts) exposures, mucous membrane exposures (splashes in eyes or mouth), or cutaneous exposure involving blood or non-intact skin to blood or body fluids from any patient should be reported to the EMS personnel's immediate supervisor as soon as possible. When significant exposures have occurred, the involved personnel should report to the Emergency Department physician where the patient has been taken. EMS personnel should refer to their employer's policy on reporting exposures.
- B. EMS personnel exposed to measles, mumps, rubella, chicken pox, shingles, herpes zoster, tuberculosis, meningitis, herpes simplex, diphtheria, rabies, anthrax, cholera, plague, polio, hepatitis B, typhus, smallpox, hepatitis C, AIDS, or HIV infection should similarly report the exposure to their employers.
- C. Each ambulance service provider shall have a policy addressing infectious disease exposures. The policy will accompany each ambulance service provider's letter of participation, will be reviewed by the EMSMD or designee and will be submitted as part of the EMS System Plan to the Illinois Department of Public Health (IDPH).

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Implementation: 1/1/89; 9/1/93; 4/1/94; 12/1/96; 10/00; 1/1/10

PHYSICIAN/NURSE ON THE SCENE

EMS personnel, who have established patient contact, have also established a "doctor/patient relationship" between the patient and the EMSMD or designee.

I. PHYSICIAN ON SCENE

- A. EMS personnel at the scene of an emergency may allow a physician to assist with patient care after the licensed physician has identified himself/herself and volunteered to assist with patient care.
- B. In cases where the patient's personal physician is physically present, the EMS personnel should respect the previously established doctor/patient relationship.
- C. Contact the appropriate base station hospital as soon as possible in cases where there is a disagreement between the EMS personnel and the physician on the scene regarding the care to be given to the patient.
- D. The EMS personnel shall follow the directives of the base station ECP.

II. NURSE ON SCENE

EMS personnel at the scene of an emergency may allow a nurse to assist with patient care after the licensed nurse has identified himself/herself and volunteered to assist with patient care.

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IDPH Approval: 1988; 11/16/92; 9/17/96; 1/99; 5/00; 10/24/08

Implementation: 1/1/89; 9/1/93; 12/1/96; 8/1/99; 10/00; 1/1/10

CRIME SCENE RESPONSE

- I. The police are in charge of any crime scene. They have an interest in preserving any physical evidence that may assist in the prosecution of the criminal case; therefore, can refuse admittance to a crime scene. EMT personnel should adhere to the advice and direction of police on the scene in all matters relevant to evidence preservation. However, if doing so directly compromises patient care or if access to the patient is prohibited, immediately notify the Resource/Associate Hospital.
- II. In all cases where a crime, suicide or attempted suicide, accidental death, or suspicious fatality has occurred:
 - A. If police are not on the scene, request their services via radio.
 - B. Assess the scene to determine if conditions permit safe performance of professional medical duties. Treatment and transport should be delayed pending police arrival if the safety of the EMS personnel would be placed in jeopardy.
 - C. Initiate patient assessment and treatment per SMO.
 1. If access to the patient is prohibited, immediately notify the Resource/Associate Hospital.
 2. If the patient meets the criteria for non-initiation of cardiopulmonary resuscitation (see policy - Initiation or Withholding of Resuscitative Measures), do not remove or continue to examine the victim.
 - D. Contamination of the crime scene or damage to/loss of evidence are to be avoided.
 1. If circumstances require the alteration of the scene for the purpose of aiding the victim/patient, the police must be informed.
 2. Avoid unnecessary contact with physical objects at the scene.
 3. Anything carried onto the scene in the way of dressing, wrappings or packages should be removed by the medical team when they evacuate the scene. Do not remove anything from the scene other than those items.
 4. If it is necessary to cut through the clothing of the victim/patient, avoid cutting through tears, bullet holes, or other damaged or stained areas of clothing.
 5. Do not wash or clean the victim/patient's hands or areas which have sustained bullet wounds.
 6. In gunshot cases, be aware that expended bullets can be found in the clothing of the victim/patient (especially when heavy winter clothing is worn). These items of evidence may be lost during examination and/or transportation. Check your vehicle and stretcher after transport. Any items of evidence should be turned over to the **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 airway.
 8. In stabbing cases, any impaled object will be left in place for both medical reasons and evidence collection.
- E. Document observations at the crime scene as soon as possible on the patient care report. Include name and star number/badge number of law enforcement personnel interacted with at the scene.

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IDPH Approval: 1988; 11/16/92; 9/17/96; 5/00; 10/24/08

Implementation: 1/1/89; 9/1/93; 12/1/96; 10/00; 1/1/10

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 the base station. 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 policy H.2, *EMS System Quality Improvement/Assurance Program*).**

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Written: 1988

Reviewed: 10/92; 11/2/95; 5/96; 5/11; 8/15

Revised: 10/92; 8/15

MDC Approval: 1988; 11/5/92; 11/2/95; 6/13/96; 12/4/07; 11/17/15

IDPH Approval: 1988; 11/16/93; 9/17/96; 10/24/08; 2/25/16

Implementation: 1/1/92; 9/1/93; 12/1/96; 1/1/10; 3/1/16

USE OF CONTROLLED SUBSTANCES

For the purpose of this policy, “controlled substances” include diazepam, morphine, and versed.

I. RESPONSIBILITIES OF PARAMEDICS

- A. Each ALS company must perform a daily inventory and sign and date an inventory form for the amount of controlled substances in the ambulance at the beginning of the shift.
- B. Any missing doses, expired doses, or suspected tampering should be immediately brought to the attention of the Resource Hospital EMS Coordinator and the ambulance service provider (e.g., the supervisor of the private ambulance service provider or the duty chief on call for the Chicago Fire Department).

II. RESPONSIBILITIES OF ALL PARTICIPATING HOSPITALS

- A. Each participating hospital will maintain a controlled substance log book which contains information as to which controlled substances were used. Upon completion of the run, all controlled substances used must be documented on the log sheet.
- B. Each participating hospital will accept any residual controlled substances from ambulance personnel and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy. Upon proof of use, each participating hospital will then replace the controlled substance in the ambulance according to the Region XI Drug, Equipment and Supply List.
- C. Missing doses or suspected tampering requires notification of the Resource Hospital EMS Coordinator.

III. ADDITIONAL RESPONSIBILITIES OF RESOURCE HOSPITALS

- A. If the receiving hospital is unable to restock an ambulance, the Resource Hospital will be responsible for restocking that ambulance.
- B. Cases of breakage, leakage or expired drugs shall be handled at the Resource Hospital. Each Resource Hospital will be responsible for documentation and restock of any controlled substance
- C. Missing Doses or Suspected Tampering
 - 1. Situations involving missing doses, suspected missing doses, or suspected tampering must be handled **only** at the Resource Hospital.
 - 2. If a dose is unaccounted for or if it becomes apparent that the drug has been tampered with, the Resource Hospital EMS Coordinator must be notified by the ambulance service provider.
 - 3. The Resource Hospital EMS Coordinator shall investigate the incident as per internal hospital policy (as interpreted by the EMSMD and EMS Director).
 - 4. A replacement will be issued to that vehicle by the Resource Hospital.

5. An investigation and report must be instituted by the ambulance service provider and conclusions or outcomes forwarded to the Resource Hospital EMS Coordinator.

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IDPH Approval: 1988; 11/16/92; 9/17/96; 10/24/08; 9/29/11; 2/25/16

Implementation: 1/1/89; 9/1/93; 12/1/96; 1/1/10; 4/1/12; 3/1/16

CONVEYANCE OF PATIENTS

- I. All patients receiving ALS care transported by ambulance will be secured to the stretcher for safe conveyance during patient transport.
- II. All patients receiving BLS care transported by ambulance will be preferentially secured to the stretcher for safe conveyance during patient transport.
- III. **Do not ambulate patients who:**
 - A. Require advanced life support care per Initiation of Patient Care Policy B-2
 - 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) Complications of pregnancy, signs of labor or delivery, vaginal bleeding
 - (5) Extremely high or low body temperatures (hypothermia or high fever)
 - E. Are injured AND:
 - (1) Who require immobilization
 - (2) For whom ambulation will aggravate existing injury or risk new injury
 - F. Have unique circumstances requiring conveyance

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

IV. PROCEDURE

- A. Approach the patient prepared to transport by stretcher or stair chair.
- B. Evaluate patient for any of the conditions requiring non-ambulatory conveyance (above) and prepare for appropriate conveyance of the patient to the ambulance while performing necessary on scene treatment.
- 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 contact their ambulance service provider and request additional manpower 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 help is necessary.
- F. Document and forward to the ambulance service provider supervisor any problems obtaining requested additional manpower assistance in a timely manner or 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.

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Written: 1/93

Reviewed: 11/2/95; 5/96; 3/00; 12/06; 4/07; 5/11; 10/15

Revised: 3/00; 12/06; 4/07; 10/15

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IDPH Approval: 2/17/93; 9/17/96; 5/00; 10/24/08; 2/25/16

Implementation: 3/15/93; 12/1/96; 10/00; 1/1/10; 3/1/16

CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

C. TRANSPORTATION

- Patient Transport – Private Ambulance Provider...C.1 to C.3
- Patient Transport – Chicago Fire Department...C.4 to C.6
- Trauma Patient Transport...C.7 to C.8
- Transport of Patients with Suspected Acute Stroke...C.9 to C.11
- Transport of Patients with Suspected Acute Coronary Syndrome...C.12 to C.14
- Transport of Cardiac Arrest Patients...C.15
- O.B. Patient Transport...C.16 to C.17
- Transport of Patients with Suspected Ebola Virus Disease...C.18 to C.19
- Helicopter Emergency Medical Services (HEMS) Utilization...C.20 to C.24
- Critical Airway...C.25
- Interhospital/Interfacility Transport...C.26 to C.27
- Notification and Monitoring of Hospital Resource Limitation(s)/Ambulance Bypass...C.28
 to C.32
- Response to a System-Wide Crisis within the Chicago EMS System...C.33 to C.35

PATIENT TRANSPORT - PRIVATE AMBULANCE PROVIDER

I. DISPATCH:

- A. In response to a request for ambulance transport, the private dispatchers will determine the need for ALS or BLS (see policy - Initiation of ALS Care) and send an ambulance capable of providing the appropriate level of care or make the appropriate referral to other private providers or municipalities.
- B. In response to a caller requesting prehospital care, when possible, the caller should be informed when vehicle responses will exceed 6 minutes.
- C. For time critical events such as chest pain, shortness of breath, altered mental status, profuse bleeding, new neurologic deficit less than 6 hours from onset, or cardiac arrest the private dispatcher should recommend the caller contact 911 unless an ALS transport unit can respond within 10 minutes.

II. TRANSPORT:

- A. Once patient contact is made, no patient requesting emergency care and/or transport should be left at the scene without prior approval from the Resource/Associate Hospital.
- B. At no time will advanced life support (ALS) care that was initially established by the first responding ambulance company be relinquished to a basic life support (BLS) service unless prior contact is made to and approval given by the Resource/Associate Hospital.
- C. Hospice patients if after consultation with the Resource Hospital, it is determined that a patient has a valid Do Not Resuscitate (DNR) order, and has made arrangements for palliative care at a hospice or non-hospital facility and is requesting transport to such a facility. This is not to be considered an emergency condition. Resuscitative care should not be initiated in these circumstances.
- D. Patients may be transported to the facility of choice under the following conditions:
 - A. BLS Patients
 - a. Patients requiring a BLS level of service, including those with acute medical conditions requiring only BLS care.
 - b. BLS patients with non-emergency conditions (e.g. bed ridden patients needing transportation assistance to outpatient facilities, routine dialysis, etc.)
 - B. ALS Patients
 - a. *Stable with no risk for deterioration:* Vital signs are within normal limits for the patient's condition. Mental status is normal for the patients.
 - b. *Stable with low risk for deterioration:* Patient may require increase need for assessment such as non-acute changes in vital signs.
 - c. *Stable with medium risk of deterioration:* Patient requires some ALS interventions AND has responded to those interventions, e.g. low blood sugar, hypoxia, dehydration.

d. *Stable with high risk of deterioration:* Patients with advanced airway needs that have been addressed prior to transport, patients on ventilators and patients requiring specialty centers (see attached list).

E. Situations in which ALS or BLS patients may NOT be transported to the facility of choice:

A. Any patient who cannot be stabilized at the transferring facility. Contact medical oversight.

B. Any patient that while enroute to the facility of choice has an acute change in status that requires intervention and those interventions fail to stabilize the patient or can not be performed in the field.

III. BLS Vehicle Responding to a Patient Requiring ALS Care:

A. Contact medical oversight if there is a question regarding most appropriate receiving facility or need for ALS care.

B. Estimate the patient preparation and transport time to the closest appropriate facility.

A. If the established patient preparation and transport time to the closest appropriate facility is less than or equal to five (5) minutes:

a. The BLS vehicle shall transport the patient to the closest appropriate facility without delay.

b. The receiving facility shall be alerted to the unusual transport circumstances via telemetry or MERCI radio. If the receiving facility does not respond to telemetry or MERCI, the BLS vehicle should contact its dispatch.

B. If the estimated patient preparation and transport time to the closest appropriate facility is greater than five (5) minutes:

a. The Resource/Associate Hospital shall be notified immediately.

b. The Resource/Associate Hospital will contact the private provider associated with the BLS vehicle and request availability of an ALS backup.

i. If ALS response is not available in a timely manner by the provider of the BLS vehicle, the Resource/Associate Hospital will directly contact the Office of Emergency Management and Communications OEMC and request from the supervisor on duty a CFD ambulance response.

ii. If the anticipated delay for ALS response is deemed detrimental to patient care, the Resource/Associate Hospital should recommend rapid transport by the BLS vehicle to the closest appropriate facility.

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

IV. Refusal of Transport to the Closest Appropriate Hospital (see policy - Refusal of Service)

When the ALS patient's condition is deemed imminently life-threatening or is such that the patient is likely to deteriorate and might not withstand the longer transportation time, but the patient desires to be transported to a facility that is not the closest appropriate hospital, the patient may be transported to the more distant facility of choice only after consultation with the Resource/Associate Hospital and if one of the following conditions has been met:

- A. The patient is alert, oriented and judged by the EMT to be competent to refuse recommended care and understands the risks associated with transport to the more distant facility.
- B. A durable power of attorney who is present and acting on the individual's behalf understands the risks associated with transport to the more distant facility. (Nursing home and other institutional staff are not appropriate individuals to act on the patient's behalf for the purposes of this decision.)

V. Transferring care from CFD to Private provider:

- A. Upon arrival the private ambulance personnel providing transportation shall have patient sign a release for damages that may be incurred due to prolonged transportation time.
- B. Document verbal report of care per CFD in patient care report.
- C. Prior to transport the private paramedic shall re-contact the Resource/Associate Hospital with patient reassessment for approval to transport.

VI. Interhospital/interfacility transports (see policy): Interfacility transports of patients requiring skills for which EMS personnel are not trained to perform (excluding home care devices) shall require appropriately trained medical personnel to be in attendance of the patient throughout the transport.

VII. Use of intravenous (IV) fluids is considered an ALS procedure. EMT-B's and BLS ambulances may NOT transfer patients with IV's. Patients with IV's must have their intravenous line discontinued or converted to a saline lock prior to transport by a BLS vehicle. Otherwise, an ALS ambulance must be used to transport.

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Implementation: 1/1/89; 9/1/93; 12/1/96; 8/1/99; 10/00; 5/01; 1/1/03; 1/1/10; 3/1/11; 3/1/16

PATIENT TRANSPORT – CHICAGO FIRE DEPARTMENT

I.DISPATCH: In response to a request for prehospital care,

- A. The level of response to be dispatched will be determined by the Office of Emergency Communications personnel in accordance with approved Chicago Fire Department dispatch protocols.
- B. When possible, the caller should be informed when vehicle responses will exceed 6 minutes.

II.TRANSPORT:

- A. The patient will be transported to the nearest appropriate emergency department, unless advised otherwise by the Resource or Associate Hospital medical oversight personnel.
- B. Once patient contact is made, no patient requesting emergency care and/or transport should be left at the scene without prior approval from the Resource/Associate Hospital.
- C. At no time will advanced life support (ALS) care that was initially established be relinquished to a basic life support (BLS) service unless prior contact is made to and approval given by the Resource/Associate Hospital.

III.Refusal of Transport to the Closest Appropriate Hospital (see policy - Refusal of Service)

When the patient desires to be transported to a facility that is not the closest appropriate hospital:

- A. Determine:
 - 1. Need for ALS care.
 - 2. Need for immediate transport.
 - 3. Competency of patient or presence of an individual who has durable power of attorney.
- B. Continue to stress need for transportation and risk of delay.
- C. Estimate the difference in ETA between requested destination and closest appropriate hospital.
- D. Contact the Resource/Associate Hospital and relate the closest appropriate and desired destinations and approximate transport times to each hospital.
 - 1. If only a small difference in transport time exists between the closest appropriate hospital and the desired destination, the Resource/Associate Hospital may authorize transport to the patient's requested destination rather than further delay

care.

2. If a large difference in transport time exists, the approach will vary depending upon patient's condition:

a. Non-competent patients: Patients who are not competent to refuse care may not refuse transportation to the closest appropriate hospital.

b. Competent patients:

i. The Resource/Associate Hospital medical oversight personnel shall attempt to arrange for transport via a private provider vehicle. Such request to a private provider shall be given priority when originating from the Resource/Associate Hospital.

ii. EMS personnel shall have patient sign release for damages that may be incurred due to delay in instituting transportation. Document discussions with the patient in the comment section of patient care report. If patient refuses transport, have the event witnessed.

iii. If a private ambulance is unavailable in a reasonable period of time and/or the requested destination is considered unreasonably distant, the patient will be required to accept transport to the closest appropriate facility or sign for refusal of care (see policy - Refusal of Service).

iv. The patient may be transported to the requested facility at the discretion of the base station as appropriate.

E. If at any time the patient's condition deteriorates to where he/she may be considered incompetent patients may NOT be transported to the facility of choice:

1. Initiate appropriate care and stabilize patient.

2. Re-contact the Resource/Associate Hospital and relate reassessment and interventions.

3. Transport to the closest appropriate hospital without delay.

IV. Transferring care from CFD to Private provider:

A. CFD personnel are to remain on scene and administer care as required until care can be transferred to private ambulance personnel of the same or higher level of care.

Attachment I: List of Hospitals with Comprehensive Emergency Departments

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Written: 1988

Reviewed: 10/92; 11/95; 4/96; 10/98; 3/00; 2/01; 7/01; 2/02; 3/02; 12/06; 4/07; 5/11; 8/15

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Implementation: 1/1/89; 9/1/93; 12/1/96; 8/1/99; 10/00; 5/01; 1/1/03; 1/1/10

HOSPITALS WITH COMPREHENSIVE EMERGENCY DEPARTMENTS

HOSPITAL NAME

Christ Medical Center (Advocate)
Community First Medical Center
Franciscan Health Hammond (Indiana)
Holy Cross Hospital
Illinois Masonic Medical Center (Advocate)
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Administration Medical Center
La Grange Memorial Hospital (Adventist)
Little Company of Mary Hospital & Health Care Centers
Loretto Hospital
Loyola University Medical Center
Lurie Children's Hospital of Chicago (Ann & Robert H.) (Pediatrics Only)
Lutheran General Hospital (Advocate)
MacNeal Hospital
Mercy Hospital & Medical Center
Metro South Medical Center - Blue Island
Mount Sinai Hospital
Northwestern Memorial Hospital
Norwegian American Hospital
Resurrection Medical Center (Presence)
Roseland Community Hospital
Rush University Medical Center
Saint Anthony Hospital
Saint Bernard Hospital & Health Center
Saint Francis Hospital - Evanston (Presence)
Saint Joseph Hospital - Chicago (Presence)
Saints Mary & Elizabeth Medical Center - St. Mary Campus ONLY (Presence)
South Shore Hospital
John H. Stroger, Jr. Hospital of Cook County
Swedish Covenant Hospital
Thorek Memorial Hospital
Trinity Hospital (Advocate)
University of Chicago Medical Center
University of Illinois Hospital and Health Sciences System
Weiss Memorial Hospital
West Suburban Medical Center

NOTE: CFD does not transport to basic or standby emergency departments.

Updated 4/17

TRAUMA PATIENT TRIAGE AND TRANSPORT

- I. Region XI EMS uses a four step trauma field triage decision scheme (reference attachment 1) to identify injured persons requiring transportation directly to a trauma center. The four steps are:

- Step 1: Physiologic Criteria
- Step 2: Anatomic Criteria
- Step 3: Mechanism of Injury Criteria
- Step 4: Special Consideration Criteria

A. Adult Trauma Transports

1. Region XI EMS defines the adult trauma patient as an injured person aged 16 years and older. Adult patients meeting trauma criteria using the decision scheme should be transported to the closest Level I trauma center. Scene time should be kept to a minimum.

B. Pediatric Trauma Transports

1. Region XI EMS defines the pediatric trauma patient as an injured person aged 15 years or less. Pediatric patients meeting trauma criteria using the decision scheme should be preferentially transported to the closest Pediatric Level I trauma center.
2. If the transport time to the closest Pediatric Level I trauma center is anticipated to be greater than 25 minutes, the patient should be transported to the closest Level I trauma center. Scene time should be kept to a minimum.

Attachments:

1. Region XI Trauma Field Triage Criteria
2. Region XI Trauma Transport - Adult and Pediatrics

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Written: Taken from Patient Transport policy 12/06

Reviewed: 1/07; 5/11; 11/12; 3/14; 10/15

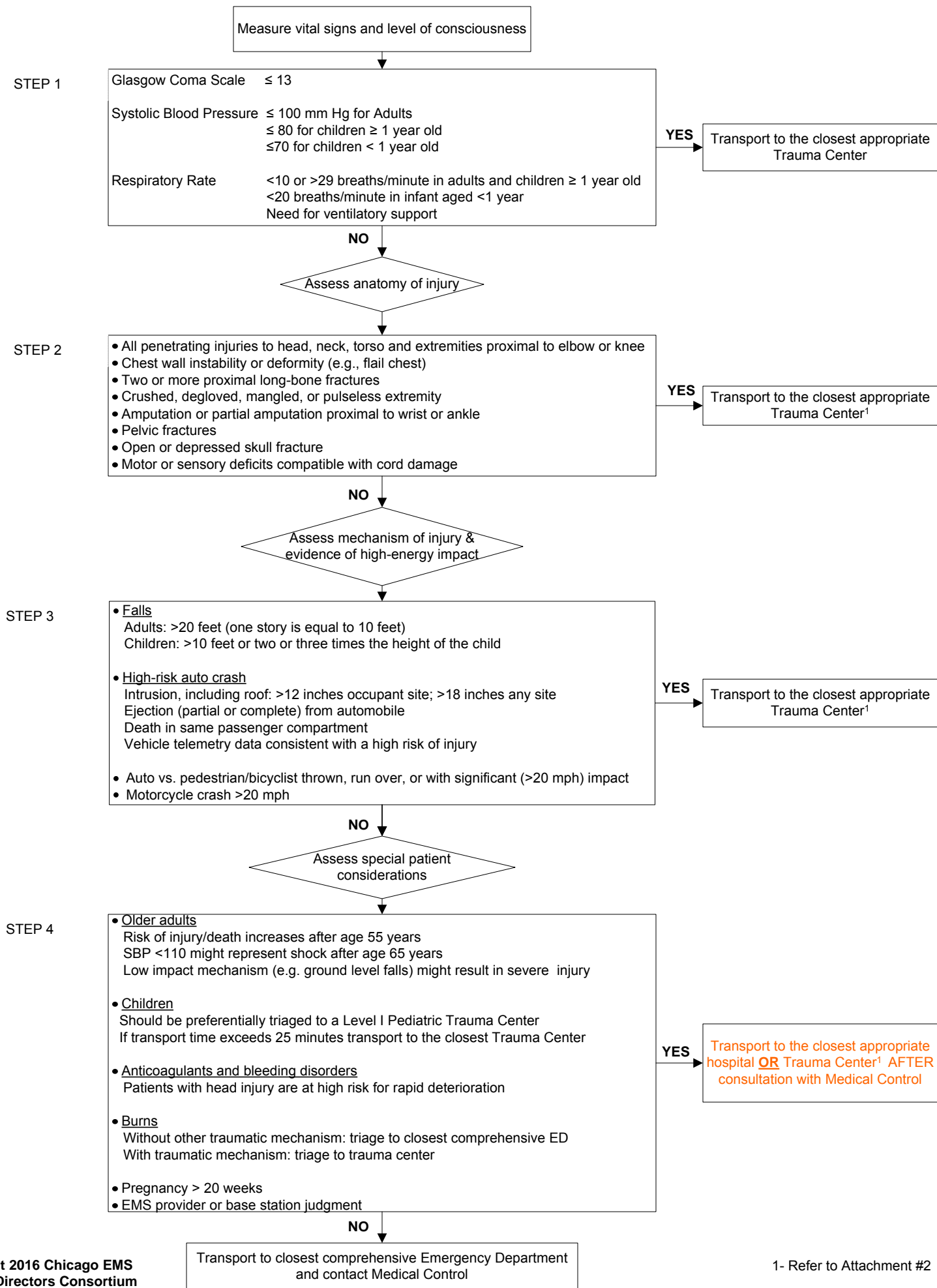
Revised: 11/12; 3/14; 10/15

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IDPH Approval: 10/24/08; 1/31/13; 5/13/14; 2/25/16

Implementation: 1/1/13; 6/1/14; 3/1/16

REGION XI TRAUMA FIELD TRIAGE CRITERIA



REGION XI TRAUMA TRIAGE ADULT AND PEDIATRICS

(Peds = less than 16 years old)

1. Level I Trauma Centers:

**Christ Medical Center (Advocate)
Illinois Masonic Medical Center (Advocate)
John H. Stroger Hospital of Cook County
Loyola University Medical Center
Lutheran General Hospital (Advocate)
Mount Sinai Hospital
Northwestern Memorial Hospital
St. Francis Hospital - Evanston (Presence)**

2. Pediatric Level I Trauma Centers:

**John H. Stroger Hospital of Cook County
Lurie Children's Hospital of Chicago (Ann & Robert H.)
The University of Chicago Medical Center (Comer Children's Hospital)**

TRANSPORT OF PATIENTS WITH SUSPECTED ACUTE STROKE

- I. Patients with stroke symptoms ≤ 6 hours in duration and an abnormality in one of more items of the Cincinnati Stroke Scale (CSS) should be transported to a Primary Stroke Center (PSC)
- II. Patients with a negative or unobtainable CSS may be transported to a PSC if acute stroke ≤ 6 hours in duration is suspected by the Base Station based on any of the following "relative criteria":
 - A. Sudden and persistent alteration of consciousness
 - B. Sudden onset severe headache (especially in association with vomiting +/- systolic BP >200)
 - C. Severe and sudden loss of balance

These criteria are also outlined in the attachments and on the Base Station telemetry log sheets.

Base Station nurses should seek consultation with a Base Station physician for any situation in which there is a question as to the best receiving hospital for a patient with possible stroke symptoms.

- III. Patients who qualify for transport to a PSC by the criteria outlined in I. and II. should be transported to the closest PSC.

In the event the closest PSC is on ALS bypass, the "T + 5 minute" rule should be followed, i.e. if the transport time to the next closest PSC is greater than an additional 5 minutes, the patient should be transported to the PSC on ALS bypass (see Notification and Monitoring of Hospital Resource Limitation(s)/Ambulance Bypass Policy, A.3, VI.)

Patients with suspected acute stroke should not be transported to a PSC which has notified Region XI Base Stations regarding a temporary lack of CT scanners; they should instead be transported to the next closest PSC.

Patients with suspected acute stroke can be diverted to a closer non-PSC ER if the patient is deemed too unstable for the longer transport to a PSC (e.g. inability to oxygenate or ventilate the patient).

Attachments:

1. Summary of Field Triage Criteria
2. List of Primary Stroke Centers

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Written: 3/10

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Revised: 6/10

MDC Approval: 6/1/10

IDPH Approval: 11/24/10

Implementation: 3/1/11

FIELD TRIAGE CRITERIA

1. Patients with stroke symptoms ≤ 6 hours in duration and an abnormality in one of more items of the Cincinnati Stroke Scale (CSS) should be transported to a Primary Stroke Center (PSC)
2. Patients with a negative or unobtainable CSS may be transported to a PSC if acute stroke ≤ 6 hours in duration is suspected by the Base Station based on any of the following "relative criteria":
 - A. Sudden and persistent alteration of consciousness
 - B. Sudden onset severe headache (especially in association with vomiting +/- systolic BP > 200)
 - C. Severe and sudden loss of balance

PRIMARY STROKE CENTERS (PSC)

As of December 14, 2016

HOSPITAL NAME

Christ Medical Center (Advocate)
Community First Medical Center
Illinois Masonic Medical Center (Advocate)
Lutheran General Hospital (Advocate)
Holy Cross Hospital
John H. Stroger, Jr. Hospital of Cook County
Little Company of Mary Hospital and Health Care Centers
Loyola University Medical Center
MacNeal Hospital
Mercy Hospital and Medical Center
MetroSouth Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
Norwegian American Hospital
Resurrection Medical Center (Presence)
Rush University Medical Center
Saint Francis Hospital - Evanston (Presence)
Saint Joseph Hospital - Chicago (Presence)
Saints Mary & Elizabeth Medical Center - St. Mary Campus (Presence)
Swedish Covenant Hospital
Trinity Hospital (Advocate)
University of Chicago Medical Center
University of Illinois Hospital and Health Sciences System
Weiss Memorial Hospital
West Suburban Medical Center

Updated 12/16

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TRANSPORT OF PATIENTS WITH SUSPECTED ACUTE CORONARY SYNDROME

- I. Patients with suspected acute coronary syndrome and a 12-lead ECG meeting ST segment elevation myocardial infarction (STEMI) criteria (see below) should be transported to a STEMI-Receiving Center (SRC).
- II. Patients who qualify for transport to an SRC based on the criterion above should be transported to the closest SRC.

In the event the closest SRC is on ALS bypass, the “T+5 minute” rule should be followed, i.e. if the transport time to the next closest SRC is greater than an additional 5 minutes, the patient should be transported to the SRC on ALS bypass (see Notification and Monitoring of Hospital Resource Limitation(s)/Ambulance Bypass Policy, A.3, VI.)

Patients with suspected acute coronary syndrome and a 12-lead ECG meeting ST segment elevation myocardial infarction (STEMI) criteria (see below) should not be transported to an SRC which has notified Region XI Base Stations regarding a temporary cardiac cath lab resource limitation; they should instead be transported to the next closest SRC.

- III. ST-Elevation Myocardial Infarction (STEMI) Criteria - A 12-lead EKG meets STEMI criteria if any of the below conditions are fulfilled:
 - A. Computer interpretation of the 12-lead is STEMI. This includes, but is not limited to, the following interpretations:
 1. ***ACUTE MI***
 2. ***ACUTE MI SUSPECTED***
 3. ***MEETS ST ELEVATION MI CRITERIA***
 - B. Paramedic interpretation of 12-lead EKG as STEMI, which may include ST segment elevation of at least 1 mm in two contiguous leads
 - C. Base station ECP interpretation of transmitted 12-lead EKG as STEMI

Attachments:

1. STEMI-Receiving Center Field Triage Criteria
2. List of STEMI-Receiving Centers

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Written: 3/10

Reviewed: 6/10; 5/11; 3/12; 3/13; 10/14; 8/15

Revised: 6/10; 3/12; 4/13; 10/14

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IDPH Approval: 11/24/10; 5/4/12; 6/27/13; 5/20/15

Implementation: 3/1/11; 5/15/12; 1/6/14; 6/1/15

STEMI-RECEIVING CENTER FIELD TRIAGE CRITERIA

1. An acute coronary syndrome (ACS) should be considered in patients who have any of the following:
 - A. Typical symptoms: chest pain with or without radiation
 - B. Atypical symptoms: shortness of breath, weakness, abdominal pain, nausea/vomiting, diaphoresis (atypical symptoms are especially common in women, diabetics, and the elderly)
2. If ACS is suspected, a 12-lead ECG should be obtained prior to patient transport. ECG acquisition should not delay care to unstable patients.
3. Patients with suspected acute coronary syndrome and a 12-lead ECG meeting ST segment elevation myocardial infarction (STEMI) criteria (see below) should be transported to a STEMI-Receiving Center (SRC)
4. Cardiac arrest patients who have a return of spontaneous circulation or persistent/refractory ventricular fibrillation/pulseless ventricular tachycardia should be transported to a STEMI Receiving Center (SRC)
5. ST-Elevation Myocardial Infarction (STEMI) Criteria - A 12-lead EKG meets STEMI criteria if any of the below conditions are fulfilled:
 - A. Computer interpretation of the 12-lead is STEMI. This includes, but is not limited to, the following interpretations:
 1. ***ACUTE MI***
 2. ***ACUTE MI SUSPECTED***
 3. ***MEETS ST ELEVATION MI CRITERIA***
 - B. Paramedic interpretation of 12-lead EKG as STEMI, which may include ST segment elevation of at least 1 mm in two contiguous leads
 - C. Base station ECP interpretation of transmitted 12-lead EKG as STEMI
6. All 12-lead EKGs must be attached to the electronic medical record.

STEMI-RECEIVING CENTERS (SRC)

As of October 16, 2015

HOSPITAL NAME

Christ Medical Center (Advocate)
Community First Medical Center
Franciscan Health Hammond (Indiana)
Illinois Masonic Medical Center (Advocate)
Lutheran General Hospital (Advocate)
John H. Stroger, Jr. Hospital of Cook County
Little Company of Mary Hospital and Health Care Centers
Loyola University Medical Center
MacNeal Hospital
Mercy Hospital and Medical Center
MetroSouth Medical Center
Mt Sinai Hospital
Northwestern Memorial Hospital
Norwegian American Hospital
Resurrection Medical Center (Presence)
Rush University Medical Center
Saint Francis Hospital - Evanston (Presence)
Saint Joseph Hospital - Chicago (Presence)
Saints Mary & Elizabeth Medical Center - Saint Mary Campus (Presence)
Swedish Covenant Hospital
Trinity Hospital (Advocate)
University of Chicago Medical Center
University of Illinois Hospital & Health Sciences System
Weiss Memorial Hospital
West Suburban Medical Center

Updated 10/15

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TRANSPORT OF CARDIAC ARREST PATIENTS

- I. Patients in cardiac arrest from a medical cause should have field resuscitation following the Incident Command for Cardiac Arrest Procedure (ALS/BLS I 4.1-4.3).
- II. Base Station contact should be made during ongoing resuscitation from the scene. The following options should be discussed with the Emergency Communications Physician (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
- 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 should be considered for all adult cardiac arrest patients with initial rhythms of either asystole or pulseless electrical activity (PEA) who do not respond to field resuscitative efforts (See Policy B.7-B.8)
- V. Patients with ROSC should be treated according to Adult Post Cardiac Arrest Care and Therapeutic Hypothermia Procedure (ALS I 5.1-5.2)
- VI. Patients with ROSC or refractory Ventricular Fibrillation/Pulseless Ventricular Tachycardia (after discussion with the ECP) should be transported to the closest STEMI-Receiving Center (SRC) (see Policy C.18 for a list of SRCs). Consider transport to a SRC for any patient with ongoing resuscitation.

In the event that the closest SRC is on ALS bypass, the “T+5 minute” rule should be followed, i.e. if the transport time to the next closest SRC is greater than an additional 5 minutes, the patient should be transported to the SRC on ALS bypass (see Notification and Monitoring of Hospital Resource Limitation(s)/Ambulance Bypass Policy, A.3 VI.).

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Implementation: 3/1/16

O.B. PATIENT TRANSPORT

I. 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 a participating hospital designated as an appropriate perinatal facility for obstetrical patients (see attachment IV).

A. High risk OB patients

1. Transport pregnant patients between 20-30 weeks gestation with an obstetrical related complaint to the closest Level III perinatal hospital 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 facility.

In general a “stable” pregnant patient will NOT:

- 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” OB patient that requires care or delivery at one of the Region’s Level III perinatal hospitals should be transported to the closest Level III hospital unless she is unstable as defined above.

II. In rare and unusual circumstances, at the EMS personnel's discretion, in consultation with the base station, the patient may be transported to the closest appropriate facility for stabilization.

Attachment 1: List of Participating Hospitals Designated as Appropriate Perinatal Hospitals for Obstetrical Patients

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Written: Taken from Patient Transport policy 12/06

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Implementation: 1/1/10; 3/1/16

PARTICIPATING HOSPITALS DESIGNATED AS APPROPRIATE PERINATAL HOSPITALS FOR OBSTETRICAL PATIENTS

LEVEL II PERINATAL HOSPITALS

Franciscan Health Hammond (Indiana)	Resurrection Medical Center (Presence)
Holy Cross Hospital	Roseland Community Hospital
Jackson Park Hospital & Medical Center	Saint Anthony Hospital
La Grange Memorial Hospital (Adventist)	Saint Bernard Hospital
Little Company of Mary Hospital & Health Care Centers	Saint Francis Hospital - Evanston (Presence)
MacNeal Hospital	Saints Mary & Elizabeth Medical Center - Saint Mary Campus (Presence)
Mercy Hospital & Medical Center	Swedish Covenant Hospital
Metro South Medical Center - Blue Island	Trinity Hospital (Advocate)
Norwegian-American Hospital	West Suburban Hospital Medical Center

LEVEL III PERINATAL HOSPITALS

Christ Medical Center (Advocate)	Rush University Medical Center
Illinois Masonic Medical Center (Advocate)	Saint Joseph Hospital - Chicago (Presence)
Loyola University Medical Center	John H. Stroger, Jr. Hospital of Cook County
Lutheran General Hospital (Advocate)	University of Chicago Medical Center
Mount Sinai Hospital	University of Illinois Hospital and Health Sciences System
Northwestern Memorial Hospital	

The above hospitals are participating in the Chicago EMS System and are also designated a Level II or Level III Perinatal Hospitals as outlined in the *Illinois Regionalized Perinatal Health Care Code*.

The following Region XI Comprehensive E.D.'s are NOT designated as appropriate perinatal hospitals for obstetrical patients:

Comer Children's Hospital
Community First Medical Center
Loretto Hospital
Lurie Children's Hospital (Ann & Robert H.)
Weiss Memorial Hospital
Provident Hospital of Cook County
South Shore Hospital
Thorek Memorial Hospital

TRANSPORT OF PATIENTS WITH SUSPECTED EBOLA VIRUS DISEASE (EVD)

Note: For patients that meet assessment criteria for high suspicion of Ebola Viral Disease (EVD), this transport policy supersedes other existing medical protocols for patients who do not meet Ebola Viral Disease assessment criteria.

I. The Centers for Disease Control and Prevention (CDC) and the Chicago Department of Public Health (CDPH) have issued specific guidance for screening, care and transport of patients who present with Suspect Ebola Viral Disease (EVD) symptoms.

II. Patients who are considered “high risk” for Ebola **MUST MEET THE FOLLOWING CRITERIA:**

A. Patient who has traveled from a country with widespread Ebola transmission, as noted by the CDC, IDPH and/or CDPH

AND

B. Display one (1) of the following symptoms:

- Fever
- Abdominal Pain
- Diarrhea
- Vomiting
- Unusual Bleeding (i.e. eyes, nose, gums)
- Muscle Pain (Myalgia)
- Headache
- Feeling weak and/or tired

III. Any patient who meets BOTH of the ABOVE CRITERIA for a suspect EVD will be transported to a SPECIALIZED INFECTION CONTROL HOSPITAL

IV. The M.A.R.C Division will communicate to the field via the MDT and/or by email to the EMS Field Chiefs, ADCPs, and Dispatch to determine which Ebola Receiving Center the patient will be transported to.

V. EMS Crews will DIRECTLY CONTACT the Base Station of the Ebola Receiving Center. The EMS crew will relay the positive criteria and pertinent patient findings/information.

VI. Any invasive procedure (i.e. glucometer, IV start, advanced airway) will be discussed with the Base Station of the Ebola Receiving Center PRIOR TO IMPLEMENTATION.

VII. EMS Crews who are in contact with a suspected EVD patient shall wear the appropriate Personal Protective Equipment (PPE), as defined by CDC guidelines.

- VIII.** Patients who do NOT meet the defined “high risk” criteria may be transported to the closest appropriate hospital. Base station contact in this case should be made as per usual protocol.
- IX.** EMS Crews may contact a Base Station of an Ebola Receiving Center for any questions relating to potential “high risk” patients or transport decisions.

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Implementation: 12/30/14; 3/1/16

HELICOPTER EMERGENCY MEDICAL SERVICES (HEMS) UTILIZATION

I. PURPOSE

- A. To minimize loss of life and disability by ensuring timely air medical resources for Region XI.
- B. To define the scope in which the Region XI 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 XI 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 XI should follow local policies and protocols for patient transport.
- 2. The closest providers include UCAN (University of Chicago Aeromedical Network) and Lifestar Chicago.

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 XI 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, the Base Station, 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 victim 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 victim incident, the Incident Commander is in charge of all emergency operations on scene. The decision to request EMS aircraft is based on both:
 - i. The advice of on-scene ranking EMS Chief in consultation with the Resource Hospital or Regional Hospital Coordinating Center (RHCC) and
 - ii. 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.

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 XI EMSMD Continuous Quality Improvement (CQI) Committee for case review.

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CRITICAL AIRWAY

I. All Region XI 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.

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INTERHOSPITAL/INTERFACILITY TRANSPORT

- I. Patients are to be treated during transport in accordance with existing standing medical orders and policies and procedures.
- II. EMS personnel are to maintain ongoing care of the patient until responsibility is assumed by equal or higher level personnel at the receiving facility.
- III. Interhospital/interfacility transports do not routinely need to be called into the Resource/Associate Hospital. If there are any questions concerning the patient to be transported or concerns over medical care enroute, contact the Resource/Associate Hospital.
- IV. The Resource/Associate Hospital must be contacted in the following circumstances:
 - A. Change in patient status enroute that requires intervention;
 - B. Medical-legal issues needing immediate clarification and documentation;
 - C. Concerns between transferring/transporting physician orders and standing medical orders or policies and procedures;
- V. Documentation should be followed as per routine policy for any patient care provided by EMS personnel. Where a transport team is involved and no care is being provided by EMS personnel, a brief description of chief complaint and reason for transport is required.
- VI. Interhospital/interfacility transfers of patients requiring skills for which EMS personnel are not trained to perform (excluding home care devices) shall require appropriate personnel to be in attendance of the patient throughout the transport. The following list of examples is not meant to be all inclusive:
 - A. Respirators/ventilators not approved by the system
 - B. Mechanical infusion pumps (e.g., IVAC, IMED, etc.)
 - C. Intra-aortic balloon pumps, arterial lines, left ventricular assist devices
 - E. Swan-Ganz catheters
 - F. Temporary pacemakers
 - G. Blood or blood product infusions
 - H. Nitroglycerine infusions
 - I. Nitroprusside infusions
 - J. Heparin infusions
 - K. Antiplatelet drug infusions
 - L. Dobutamine infusions
 - M. Antibiotic infusions
 - N. IV fluid additives (e.g., potassium, hyperalimentation, lipids)
 - O. Chest tubes

VII. 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 in attendance.

The EMS Medical Directors of the Chicago EMS System assumes no responsibility for providing the additional EMS personnel; nor when present responsibility for their actions, as this is the transferring physician's domain.

It is recognized that, in the interest of patient care and rapid transport, EMS ambulance service providers may act as agents of the transferring physician and provide access to other healthcare personnel (such as nurses, specialized equipment technicians, respiratory therapists, etc.) to assist in patient transports requiring skills which EMS personnel are not trained or licensed to provide. In this situation, the ambulance service provider must amend its system plan/provider proposal with its respective Resource Hospitals and receive written approval from the Illinois Department of Public Health through the EMS medical director. This amendment must be submitted and approved prior to utilization of any other healthcare personnel. The amendment must describe the roles and responsibilities of these other healthcare personnel as well as their lines of authority.

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IDPH Approval: 1990; 1/5/93; 02/16/95; 9/17/96; 10/24/08

Implementation: 3/31/90; 9/1/93; 7/1/95; 12/1/96; 1/1/10

NOTIFICATION AND MONITORING OF HOSPITAL RESOURCE LIMITATION(S)/AMBULANCE BYPASS

- I. Participating hospitals in the Chicago EMS System have agreed to provide care to all patients presenting to their emergency departments. However, resource limitations may affect the ability of a participating hospital to provide optimal patient care.
- II. Each participating hospital shall have an internal policy addressing peak census and on declaring a resource limitation which establishes guidelines for the appropriate usage and staffing of critical monitored beds in the hospital and delineates procedures for the hospital to follow when faced with a potential or declared resource limitation.
- III. In making the decision to request bypass status, the participating hospital should consider its resource limitations in light of:
 - A. The number of monitored beds available in the hospital,
 - B. Whether an internal disaster has occurred, and
 - C. The number of staff available after following its internal policies on calling in additional staff.

IV. RESOURCE LIMITATIONS/BYPASS REQUEST CRITERION

A. Participating hospitals:

1. ALS Bypass: No monitored beds in the hospital, based on the hospital's internal plan regarding staffing requirements, despite attempts to remedy the situation (i.e., implemented internal peak census policy).
2. Hospital Internal Disaster Bypass: Hospital requires ALS & BLS bypass because despite attempts to remedy the situation hospital's resources are insufficient for even the routine evaluation and care of BLS patients. Examples include, fire, flood, power failure, other physical incapacitation of a hospital.

B. Trauma Centers:

Trauma Centers can request bypass for any of the reason listed below:

1. Lack of staffed operating room availability.
2. Lack of CAT Scan availability.
3. Criteria of Section A above.

A comprehensive emergency department designated as a Level I trauma center may request emergency department bypass status yet remain open to Level I trauma patients.

C. Primary Stroke Centers (PSC's) and STEMI-Receiving Centers (SRC's):

PSC's and SRC's can request bypass as per the criteria in Section A above.

There is no provision in the IDPH EMS Act for PSC's or SRC's to request bypass based on resource limitations (lack of CT scan availability, cath lab resource limitation) not specified in Section A above. However, if a PSC or SRC is experiencing a resource limitation they should follow the notification sequence as outlined in Section V.A (below) informing the specified parties of the resource limitation, its projected duration, and when the limitation is corrected. As per Section V.C (below), the respective Resource Hospital(s) will be responsible for notifying its Associate Hospitals of this resource limitation and when it is corrected.

In the event of lack of availability of a specialty care unit (trauma center, PSC, SRC), the emergency department of that participating hospital shall be regarded as a functioning comprehensive emergency department without specialty care unit capabilities.

V. PROCEDURE FOR NOTIFICATION OF RESOURCE LIMITATION

- A. Whenever a participating hospital or specialty center experiences a limitation in resource availability, the senior hospital administrator or designee will update EMResource (<https://emresource.intermedix.com>) with the specified resource limitation at the time on initiation and at the time of its termination. The status change will simultaneously notify the Illinois Department of Public Health (IDPH), all Region XI and surrounding region hospitals, the Chicago Office of Emergency Communications/911 Center, and private ambulance providers.
- B. In the event a hospital is unable to access the EMResource system, the hospital shall document this inability by immediately contacting the State of Illinois Customer Service Center at 800-366-8768.
 1. If a hospital is unable to update the EMResource System due to internet outage, the hospital MUST notify IDPH via fax to the Division's Central Office at 217-557-3481.
 2. The hospital MUST notify by phone the following entities of the bypass/resource limitation:
 - a. The respective Resource Hospital (for Participating and Associate hospitals)
 - b. Surrounding Resource Hospitals outside of Region XI (for Resource Hospitals)
 - c. Chicago Office of Emergency Communications/911Center
 - d. Private Ambulance services that normally serve that facility

- C. According to the State of Illinois EMS Act, “The IDPH shall investigate the circumstances that caused a hospital 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 resource limitations in the system.
- E. Hospitals shall update their bypass status/resource limitation every 4 hours in the EMResource System and make every effort to manage resources efficiently.

VI. BYPASS AND BYPASS OVERRIDE PROCEDURES

A. **ALS Bypass:**

- 1. When one or more participating hospitals is experiencing resource limitations and has requested ALS bypass status, the closest comprehensive hospital will be considered the closest comprehensive hospital without a declared resource limitation.
- 2. BLS transports are not to be diverted for ALS bypass.
- 3. **ALS Ambulance Exception:** In a situation, where the diverting of an ALS patient adds 5 or more minutes to the transport time to the closest hospital on bypass, that patient will be transported to the closest hospital on bypass, barring extenuating circumstances.

EXAMPLE: Hospitals A and B are on bypass. Hospital C is on normal status. The ETA to the closest hospital (A) is 3 minutes. The transport time to the closest hospital not on bypass(C) is 9 minutes. After discussion with the Resource/Associate Hospital, the ambulance will be ordered to transport the patient to hospital A.

- a. An ambulance must contact the Resource/Associate Hospital to discuss the override for ALS patients.
- b. The receiving hospital must be notified by the Resource/Associate Hospital to expect the patient in an override situation.
- 4. The ALS ambulance exception does not apply to Level 1 trauma patients or to private ambulances.

B. **Internal Disaster Bypass:**

- 1. When one or more participating hospitals are experiencing resource limitations and have requested internal disaster status, the closest comprehensive hospital will be considered the closest comprehensive hospital without a declared resource limitation.
- 2. ALS and BLS transports are both to be diverted.

3. This procedure may apply to Level 1 trauma patients.

C. **Trauma Bypass:** When one or more trauma centers is experiencing resource limitations and has requested trauma bypass status, the closest trauma center will be considered the closest trauma center without a declared resource limitation.

D. **Bypass Override:**

1. Under unusual circumstances and at the discretion of the Resource/Associate Hospital and/or the EMS personnel, participating hospitals may still receive patients or be removed from bypass status with or without warning. 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 more distant facility DO NOT outweigh the increased risks to the patient from the transport to a more distant facility.
 - b. Multiple ambulance response or EMS Plan I - III
2. Likewise, similar discretion may result in the determination not to override a bypass request based on the exceptions noted above. 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.
3. Admission or transfer of the patient once stabilized is the responsibility of the receiving hospital regardless of its current bypass status.

NOTE: Hospitals who have declared bypass due to an INTERNAL DISASTER will NOT be over-riden to accept any patient.

Attachment 1: Section 515.315 Bypass Status Review from the Illinois EMS and Trauma Center Code

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Written:

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Implementation: 9/1/93; 12/1/96; 8/1/99; 10/00; 10/1/05; 1/1/10; 3/1/11; 5/15/12; 3/1/16; 3/1/17

SECTION 515.315 BYPASS STATUS REVIEW

- a. The Department 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. (Section 3.20(c) of the Act)
- b. The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass or resource limitation decision, at both the time of its initiation and at the time of its termination, through status change updates entered into the Illinois Hospital Bypass/State Disaster Reporting System online at www.idphnet.illinois.gov. The hospital shall document any inability to access the System by immediately contacting the State of Illinois Customer Service Center. If a hospital is unable to update the Hospital Bypass System due to internet outage, the hospital shall notify the Department via fax to the Division's Central Office at (217)557-3481.
- c. In determining whether a hospital's decision to go on bypass status was reasonable, the Department shall consider the following:
 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. Whether an internal disaster, including but not limited to a power failure, had occurred in the hospital at the time that the decision to go on bypass status was made;
 3. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and
 4. The approved Regional Protocols for bypass at the time that the decision to go on bypass status was made, provided that the Protocols include subsections (c)(1), (2) and (3) above.
- d. For Trauma Centers only, the following situations constitute a reasonable decision to go on bypass status:
 1. All staffed operating suites 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 CAT scan is not working; or
 3. The general bypass criteria in subsection (c) of this Section.
- e. The Department may impose sanctions, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act. (Section 3.20(c) of the Act)
- f. Each EMS System shall develop a policy addressing response to a system-wide crisis.

(Source: Amended at 37 Ill. Reg. 7128, effective May 13, 2013)

RESPONSE TO A SYSTEM-WIDE CRISIS WITHIN THE CHICAGO EMS SYSTEMS

- I. A variety of crises may occur that create intense demand for EMS and emergency department resources in one or more of the Chicago EMS Systems. Such crises could include a mass casualty incident; a heat emergency; an influenza epidemic; 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 action plan should be followed:
 - A. Any system participant suspecting/knowing of an event that could precipitate a system-wide crisis should contact Resource Hospital medical oversight personnel. 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., influenza epidemic).
 - B. Medical oversight personnel from the Resource Hospital should notify the EMS Coordinator and/or EMS MD.
 - C. The EMS Coordinator/EMS MD will assess the information and seek confirmation prior to declaring a system-wide crisis.
 - D. Once a system-wide crisis is confirmed, the EMS Coordinator/EMS MD will:
 1. Assure that the following have been contacted:
 - a. Other EMS MD's/EMS Coordinators in the Chicago EMS Systems
 - b. The Regional Hospital Coordinating Center (RHCC) Coordinator
 - c. OEMC 312-746-9500 or 312-746-9600 to reach CFD MARC for EMS
 - d. The RHCC will notify IDPH
 - e. The RHCC will notify CDPH - through OEMC (see above), if indicated
 - f. Private ambulance service providers, if indicated
 - g. The RHCC will notify adjacent RHCC Coordinators
 2. Assure that participating hospitals within the System are informed of the crisis, and request that steps be taken to avoid ambulance bypass, and alert them to the possibility of having to mobilize additional staff and resources.
 3. Provide ongoing monitoring of the situation, and assist with communication between the hospitals, ambulance service providers, and appropriate governmental agencies.
 - E. The EMS Coordinator/EMS MD/RHCC Coordinator together with CFD Dispatch at the 911 Center, and the CFD Deputy Fire Commissioner will closely monitor transport times and response times.

1. If transport times begin to exceed 10-15 minutes and ambulance response times become excessive as a result of hospitals being on bypass, the EMS MD, RHCC Coordinator, CFD Deputy Fire Commissioner, and Chief, EMS and Highway Safety of IDPH will again be contacted.
 2. The Chief, EMS and Highway Safety of IDPH and the RHCC Coordinator will contact the ED Charge Nurses and Senior Administrators of the participating hospitals on bypass to advise activation of their Internal Disaster/Patient Surge policies.
- F. CFD may request the help of private ambulance service providers as well as activate additional staff and equipment, according to CFD's internal plan.
- G. All information shall be recorded by the EMS Coordinator/EMS MD/RHCC Coordinator.

III. SAME LIKE SYMPTOMS:

- A. If a participating hospital is noting a trend of increased frequency of same like symptoms, the EMS Coordinator or EMS MD shall be notified.
- B. The EMS Coordinator/RHCC Coordinator will monitor the situation and, if necessary, page the Emergency Officer for IDPH at 1-800-782-7860 and/or call 311 and request the person on call for the CDPH communicable disease division.
- C. All information shall be recorded on the System Wide Crisis Form.

Attachment 1: State System-Wide Crisis Form

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Written: 8/10/95

Reviewed: 8/10/95; 5/96; 10/98; 12/00; 1/07; 5/11; 8/15

Revised: 8/10/95; 5/96; 11/98; 1/01;1/07; 8/15

MDC Approval: 8/10/95; 6/13/96; 12/98; 1/01; 12/4/07; 11/17/15

IDPH Approval: 8/11/95; 9/17/96; Summer 99; 3/01; 10/24/08; 2/25/16

Implementation: 8/11/95; 12/1/96; 8/1/99; 5/1/01; 1/1/10; 3/1/16

**CHICAGO REGION XI EMS SYSTEM
RESPONSE TO A SYSTEM-WIDE CRISIS
EMS PROVIDER/HOSPITAL
WORKSHEET**

Name of Provider/Hospital: _____ Date: _____
Name of Person Reporting: _____ Time: _____

PROVIDERS ONLY:

Number of patients (actual or approximate) transported to Emergency Departments by all ambulances in our service with **same/like** symptoms/complaints in the last six (6) hours:

Any increase in "Response Time" noted? YES _____ NO _____

HOSPITALS ONLY:

Number of patients with **same/like** symptoms/complaints seen in the last six (6) hours:

PROVIDERS AND HOSPITALS:

Common **same/like** symptoms/complaints:

Other pertinent information:

Resource Hospital contacted? YES _____ NO _____

Person contacted at Resource Hospital: _____ Time: _____

How was information reported? Phone: _____ Page: _____ Person-to-person _____

Other: _____

RHCC Hospital contacted? YES _____ NO _____

Person contacted at RHCC Hospital: _____ Time: _____

Organizations/Names/Titles of other persons contacted:

_____ Time: _____
_____ Time: _____
_____ Time: _____

**PLEASE FAX COMPLETED FORM TO THE RESOURCE HOSPITAL AND RHCC
HOSPITAL**

**CHICAGO REGION XI EMS SYSTEM
RESPONSE TO A SYSTEM-WIDE CRISIS
EMS PROVIDER/HOSPITAL
WORKSHEET**

Name of Provider/Hospital: _____ Date: _____
Name of Person Reporting: _____ Time: _____

PROVIDERS ONLY:

Number of patients (actual or approximate) transported to Emergency Departments by all ambulances in our service with **same/like** symptoms/complaints in the last six (6) hours:

Any increase in "Response Time" noted? YES _____ NO _____

HOSPITALS ONLY:

Number of patients with **same/like** symptoms/complaints seen in the last six (6) hours:

PROVIDERS AND HOSPITALS:

Common **same/like** symptoms/complaints:

Other pertinent information:

Resource Hospital contacted? YES _____ NO _____

Person contacted at Resource Hospital: _____ Time: _____

How was information reported? Phone: _____ Page: _____ Person-to-person _____

Other: _____

RHCC Hospital contacted? YES _____ NO _____

Person contacted at RHCC Hospital: _____ Time: _____

Organizations/Names/Titles of other persons contacted:

_____ Time: _____
_____ Time: _____
_____ Time: _____

**PLEASE FAX COMPLETED FORM TO THE RESOURCE HOSPITAL AND RHCC
HOSPITAL**

CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

D. DOCUMENTATION

- Documentation Requirements...D.1
- EMS System Inventory Inspection Policy...D.2
- Confidentiality of Patient Records...D.3

DOCUMENTATION REQUIREMENTS

- I. Whenever contact with a patient/victim is made regardless of treatment or transport, an approved Chicago EMS System run report (or acceptable system approved form) shall be completed in full for each patient/victim.
- II. The patient care report is an **OFFICIAL LEGAL DOCUMENT** and must be reviewed and signed by all pre-hospital personnel participating in the care of the patient/person. Failure to obtain appropriate signatures i.e., patient, legal guardian, hospital representative or witness may result in discipline.
- III. All treatment and/or assessments must be documented regardless of whether transportation occurs.
- IV. The patient care report is to be retained by the ambulance service provider according to internal document retention policy.
- V. The Resource Hospital will receive a copy of the patient care report or access to a printable version of the record.
- VI. The receiving hospital will receive a copy of the patient care report at the conclusion of the run.
- VII. Falsification or failure to document any component of the patient care report will result in discipline.
- VIII. Cardiac monitoring data shall be uploaded to the Electronic Medical Record (EMR) whenever the monitor is applied.

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Written: 1988

Reviewed: 11/92; 11/2/95; 3/00; 12/06; 5/10; 5/11; 8/15

Revised: 11/92; 5/96; 3/00; 12/06; 7/10; 8/15

MDC Approval: 1988; 12/3/92; 11/2/95; 6/13/96; 3/00; 12/4/07; 9/7/10; 11/17/15

IDPH Approval: 1988; 1/5/93; 9/17/96; 5/00; 10/24/08; 11/24/10; 2/25/16

Implementation: 1/1/89; 9/1/93; 12/1/96; 10/00; 1/1/10; 1/1/11; 3/1/16

EMS SYSTEM INVENTORY INSPECTION POLICY

I. Purpose:

Each EMS System Provider will complete daily inventory inspections on **all apparatus involved with delivering patient care.**

- II. A Daily Inventory Inspection Form will be completed on a daily basis and available for review to respective Resource Hospitals on a 24/7 basis.
- III. A monthly report will be submitted to the respective Resource Hospital to verify compliance of daily inventory and weekly supply inventory.
- IV. The daily inventory inspections must include the following components:
 - A. Medications will be inspected on a daily basis and Inspection Form completed.
 - B. All Airway equipment, cardiac equipment, Adult Quick Response Bag (QRB), Pediatric QRB will be inspected on a daily basis and Inspection Form completed.
 - C. If medications, supplies or equipment are maintained with "plastic/aluminum ties/locks"- it is an EXPECTATION the medications, supplies and equipment will be inventoried and inspected on a DAILY BASIS and the ties/locks replaced on the equipment.
 - D. Medications and equipment due to expire will be exchanged WITHIN 7 BUSINESS DAYS according to EMS System Policy. (will need updating to reflect System modification of policy)

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Written: 10/14

Reviewed:

Revised:

MDC Approval: 10/7/14

IDPH Approval: 5/20/15

Implementation: 6/1/15

CONFIDENTIALITY OF PATIENT RECORDS

- I. 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.
- II. The confidentiality of patient record information should include, but not be limited to, the names of the patients and their medical status.
- III. 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.
- IV. Copies of prehospital audio records, log sheets, and patient care reports must be provided by system participants to the Resource Hospital on request.
- V. During a multi-victim incident or multi-victim transport, confidentiality must be maintained when collecting individual patient information.

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Written: 1989

Reviewed: 11/92; 11/2/95; 5/96; 3/00; 12/06; 5/11; 8/15

Revised: 11/92; 5/96; 3/00; 12/06; 8/15

MDC Approval: 10/89; 12/3/92; 11/2/95; 6/13/96; 3/00; 12/4/07; 11/17/15

IDPH Approval: 1989; 1/5/93; 9/17/96; 5/00; 10/24/08; 2/25/16

Implementation: 2/1/90; 9/1/93; 12/1/96; 10/00; 1/1/10; 3/1/16

CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

E. EMS PERSONNEL

System Entry...E.1 to E.2
EMS Personnel Relicensing/Reregistration Requirements...E.3 to E.6
EMS Personnel Reinstatement...E.7
Continuing Medical Education Testing...E.8 to E.9
Out-of-System Continuing Medical Education...E.10 to E.11
Supervised Field Internship with the Chicago Fire Department... E.12
EMS Preceptor...E.13 to E.14
Prehospital RN...E.15 to E.17
Fitness for Duty...E.18
Inactive Status...E.19 to E.20
Suspension...E.21 to E.22
System Review Board...E.23 to E.25

SYSTEM ENTRY

I. ENTRY INTO THE SYSTEM

A. In order for a First Responder or EMD to function within the Chicago Region XI EMS system, the following criteria must be fulfilled BEFORE system function:

1. Current CPR recognition
2. Verification of First Responder or EMD course completion

B. In order for an EMT-B/Paramedic to receive a permit to function within the Chicago Region XI EMS system, the following criteria must be fulfilled BEFORE system function:

Applicants who are graduates from the Chicago Region XI EMT-B/Paramedic training program may be exempt from certain requirements within six (6) months of successful completion of system entry requirements.

1. **DOCUMENTATION:** ALL applicants must submit:

- a. Current State of Illinois EMT-B/Paramedic license
- b. Current CPR recognition
- c. Letter verifying employment (or intent) with a system ambulance service provider
- d. Current valid Driver's License
- e. CME commensurate to time in relicensure period
- f. Letter of good standing from the last EMS system within which the applicant clinically practiced
- g. Documentation that the applicant has not been convicted of an Illinois Class X, Class 1 or Class 2 felony or an out-of-state equivalent offense

2. **CLINICAL EXPERIENCE**

- a. EMS personnel with less than 500 hours clinical experience at the level the applicant is seeking entry into the system must complete a minimum of sixteen (16) hours of supervised ambulance field time prior to being granted a permit to function.
- b. Experienced EMS personnel must submit verification of 500 hours or more at the level the applicant is seeking entry into system.
- c. CFD employees who are hired as FF/Paramedics must have a minimum of sixteen (16) hours of ride time completed on an ALS ambulance with a system approved preceptor prior to being granted a permit to function.

3. **MEETING WITH RESOURCE HOSPITAL COORDINATOR/EMSMD**

- a. The EMT-B/Paramedic or the system entry site will schedule this meeting.
- b. During this meeting, the Resource Hospital EMS Coordinator/EMSMD or designee will explain the system's expectations.
- c. Copies of the following will be distributed:
 - (1) Standing Medical Orders (SMOs)

- (2) Policy and Procedure Manual
- (3) System Entry Exam reference list

- d. Prior to leaving the system entry site during the initial meeting, a time will be scheduled within two (2) weeks to complete the system entry exam.

4. SYSTEM ENTRY EXAM

- a. All system entry testing must be completed within 21 calendar days, unless prior arrangements have been made.
 - b. All incoming EMT-B's/Paramedics must achieve a 75% proficiency level in all sections prior to being issued a permit to function within the Chicago Region XI EMS System. If a score of less than 75% is achieved in any section of the system entry exam, the incoming EMT-B/Paramedics may re-take a separate version of the exam within seven (7) to fourteen (14) days of the failure.
 - c. Re-education is the sole responsibility of the EMT-B/Paramedic. Individuals who fail to achieve a 75% in all sections of the system entry exam will not be permitted to function in the Chicago Region XI EMS System.
- C. Prior to completion of the above criteria, the EMT-B/Paramedic is considered an "applicant" to the system. If an applicant fails to meet the above criteria, the individual will not be permitted to function within the Chicago Region XI EMS System. As an applicant, the individual is not entitled to system due process. Reapplication for system entry may be requested after showing proof of re-education after three (3) months from the date of denial of permit to function.
- D. Individuals that have been non-participatory in the Chicago EMS System for a period of six months or greater due to a change in system, employer or contract status, will be required to complete the system entry process again before being granted a full permit to function.

II. TEMPORARY PERMIT TO FUNCTION (EMT-B/Paramedic): Once successful completion of the system entry exam has been achieved, the Resource Hospital may issue a temporary permit to function to complete the system entry process. Additional meetings and education may be required by the EMSMD prior to issuing a full permit to function.

III. PERMIT TO FUNCTION (EMT-B/Paramedic): Once successful completion of the system entry process has been achieved, a letter will be sent by the Resource Hospital to the EMT-B/Paramedic and/or his/her employer or potential employer. This letter will state that the EMT-B/Paramedic has met system entry requirements and is permitted to function within the Chicago Region XI EMS System as an EMT-B/Paramedic.

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Supersedes: System Entry for Licensed Paramedics; System Entry for Provisional Paramedics

Written: 11/92

Reviewed: 11/2/95; 6/96; 3/98; 5/99; 3/00; 7/04; 12/06; 4/07; 7/10; 5/11; 8/15

Revised: 5/11

MDC Approval: 12/3/92; 11/2/95; 6/13/96; 4/98; 5/99; 3/00; 8/04; 12/4/07; 9/7/10; 6/7/11

IDPH Approval: 1/5/93; 9/17/96; 1/99; Summer 99; 5/00; 9/04; 10/24/08; 11/24/10; 9/29/11

Implementation: 3/1/93; 12/1/96; 8/1/99; 10/00; 1/1/05; 1/1/10; 1/1/11; 4/1/12

REGION XI EMS PERSONNEL RELICENSING /REREGISTRATION REQUIREMENTS

I. EMS PERSONNEL RESPONSIBILITIES:

- A. All EMS personnel are responsible for accruing and maintaining copies of Continuing Education required by the Illinois Department of Public Health and your Resource Hospital for re-licensure. A Resource Hospital may also concurrently track Continuing Education. 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 re-licensure.
- B. All EMS personnel are **SOLELY RESPONSIBLE** to track their respective date of re-licensure and to adhere to the IDPH and EMS System re-licensure requirements (see Section IV: Renewal of Licensure Registration).
- C. Carrying a current EMT-B/Paramedic license and photo identification while on duty at all times.
- D. Providing, within 72 hours of receipt, a copy of any new registration/license and current driver's license to their employer and Resource Hospital.
- E. Maintaining current CPR recognition.
- F. Informing the IDPH, Resource Hospital and employer, in writing, of a change of address and/or employer within 72 hours.
- G. All applicants for any license permit or certification shall fully disclose any and all felony convictions in writing to their assigned Resource Hospital at the time of initial application or renewal.
- H. All license, permit and certificate holders shall report all new felony convictions to their assigned Resource Hospital within seven (7) days after the conviction. Felony convictions shall be reported by means of a letter to the assigned Resource Hospital.

II. CONTINUING MEDICAL EDUCATION (CME) RESPONSIBILITIES:

- A. Emergency Medical Dispatchers must complete 12 hours of system-approved CME per year. Tracking of CME for EMD's will be the responsibility of the individual EMD and the ambulance service provider (employer) or participating dispatch agency.
- B. First Responders must complete 6 hours of system-approved CME per year. Tracking of CME for First Responders will be the responsibility of the individual First Responder and the ambulance service provider (employer).
- C. EMT-B's and Paramedics must complete current hours of CME per year as required by IDPH and respective Resource Hospital. No more than 25% of didactic hours may be in a single topic area.
 - 1. **EMT-B/PARAMEDIC DIDACTIC TIME:** 30 hours total/year

- a. The Chicago Region XI EMS System will approve CME and will offer a variety of CME hours of training in cooperation with the Chicago EMS System.
 - b. Other didactic time must be approved by the EMS Medical Directors Consortium (EMSMD) Education Committee if credit is to be considered (see policy - Out of System CME).
- D. Any EMS personnel must complete specific clinical and/or didactic education mandated by the EMSMD to address individual needs on their own time. This may or may not be applied toward re-licensure requirements at the EMSMD's discretion.
- E. Any EMS personnel must report, on their own time, to the EMSMD or EMS Coordinator as requested for patient care review. CME hours may or may not be given at the option of the EMSMD.
- F. Completion of mandatory regional CME modules.
- 1. There **WILL NOT** be make-up dates upon completion of a module.
 - a. If EMS personnel fail to attend the mandatory scheduled module without prior notice and/or valid excuse approved by the EMSMD or EMS Coordinator, they must make arrangements with the EMS Coordinator to complete the mandatory CME.
 - b. This will be scheduled at the Coordinator's discretion at his/her convenience and availability.
 - c. There will be a charge of \$100.00/hour of CME credit for unexcused absence for mandatory CME make ups. This fee must be submitted to the EMS Coordinator or designee at the beginning of the educational session; **NO PERSONAL CHECKS ACCEPTED.**
 - 2. If the mandatory CME is not completed by EMS personnel by the assigned date, the Resource Hospital will initiate action toward suspension of medical privileges.
 - a. The suspended individual will be reinstated upon completion of the mandatory CME.
 - b. The charge will be \$150.00/hour of CME credit for completion of a module after the suspension date.
 - 3. Failure to comply with these stipulations will result in an individual's inability to function within Region XI's EMS system.

III. NON-ALIGNED EMS PERSONNEL

Non-aligned EMS personnel are individuals who no longer function in EMS Region XI. They have expressed intent to maintain current licensure/CME requirements. An annual fee of \$115.00 will be assessed of these individuals by their Resource Hospital which is payable by cash, money order or certified check (no personal checks). This fee will entitle non-aligned personnel to notifications informing them of CME sessions conducted by EMS Region XI. The goal of the entire Chicago EMS Region XI system is to have all non-aligns renew by January or June of each calendar year. A non-aligned card will be issued for entry into CME offerings. All non-aligned cards will expire on December 31st. Renewal

notices/invoices will be sent to non-aligns two months prior to their expiration.

IV. RENEWAL of LICENSURE /REGISTRATION

- A. Effective September 21, 2012 the Illinois Department of Public Health, Division of EMS and Highway Safety implemented new policy regarding all EMS 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. On the LICENSING AND RENEWAL LINK – 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 verify that submitted hours are valid and the appropriate amount of hours for re-licensure completed Child Support Statement, Felony Conviction Statement and approve EMS personnel for licensure in the IDPH Data Base.
 4. If EMS personnel DO NOT meet any or all of the IDPH re-licensing 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 RE-LICENSURE.
 5. It is solely the responsibility of EMS personnel to follow the IDPH instructions for re-licensure EMS personnel must contact the respective Resource Hospital regarding their submitting the online application for re-licensure, and submit the appropriate amount of required continuing education hours.
 6. It is recommended that on line 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.

V. VOLUNTARY REDUCTION/ UPGRADE OF LICENSURE

- A. LICENSE Downgrade: In the event EMS personnel wish to voluntarily downgrade their current license/registration 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.
 5. The Resource Hospital will validate knowledge and/or skill following a request for licensure change after the provider receives the re-issued license and before the provider may return to participation in the EMS System.
- B. LICENSE UPGRADE FOLLOWING REDUCTION: To upgrade a previously reduced license/registration, 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 will make any recommendations for additional requirements necessary to upgrade the license.
3. The EMSMD will identify required CME and successful completion of a written and clinical 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.

Please see the Region XI EMS Personnel Reinstatement Policy (E.7) for information regarding the reinstatement of licenses expired for less than 36 consecutive months.

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Written:

Reviewed: 11/92, 9/93, 2/16/95, 4/20/95, 6/15/95; 2/96; 6/97; 3/98; 3/00; 12/00; 7/04; 12/06; 9/09; 5/11; 11/11; 2/12; 7/13; 8/15

Revised: 5/11; 11/11; 2/12; 8/13; 8/15

MDC Approval: 6/3/92, 8/6/92, 12/3/92, 9/9/93, 12/2/93, 3/2/95, 7/13/95; 8/96; 7/97; 4/98; 3/00; 12/00; 8/04; 12/4/07; 9/1/09; 6/7/11; 11/1/11; 8/9/13; 11/17/15

IDPH Approval: 6/29/92, 1/5/93, 12/29/93; 9/17/96; 1/99; 5/00; 3/01; 9/04; 10/24/08; 3/5/2010; 9/29/11; 8/20/13; 2/25/16

Implementation: 9/1/93, 01/01/94; 12/1/96; 8/1/99; 10/00; 5/1/01; 1/1/05; 1/1/10; 4/1/12; 1/6/14; 3/1/16

EMS PERSONNEL REINSTATEMENT

- I. REINSTATEMENT: EMS personnel with registrations/licenses who fail to apply for reregistration/relicensing prior to the expiration of the license and whose license has been expired for less than 36 consecutive months, and had been a member in the Region XI EMS System, may submit an application for reinstatement by IDPH by completion of the following:
1. Submit proof of completion of CME hours.
 2. Receive a positive recommendation 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 EMT license sought to be reinstated, in accordance with Section 515.530 (Section 3/50 (d)(5) of the EMS Act).
 4. A fee will be assessed as prescribed by IDPH.

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Written: 2/12

Reviewed: 8/15

Revised:

MDC Approval: 2/2/12

IDPH Approval: 4/20/12

Implementation: 4/20/12

CONTINUING MEDICAL EDUCATION TESTING

I. REQUIREMENTS

- A. Participants in the educational process will complete CME testing as required.
- B. Successful completion is defined as a 75 percent minimum score on each written and practical exam, or at the discretion of the EMSMD, successful completion of courses validating comparable competencies within the reregistration/relicensing period (e.g., ACLS, BTLS, etc.; see policy - Out of System CME).

II. CONTENT OF PROFICIENCY EXAMS

All questions and/or skill demonstrations will be referenced to the knowledge objectives of the DOT EMT Curriculums/National Scope of Practice, CME module content, the Chicago Region XI EMS System SMOs, and Policies and Procedures.

III. NOTIFICATION OF TEST RESULTS

- A. Exam scores may be provided on the day of testing and, if time permits, exams should be reviewed.
- B. If time is limited on the day of testing, the exam may be reviewed at the respective Resource Hospital by contacting the EMS office and arranging an appointment with the EMS Coordinator

IV. FAILURE OF EXAM

- A. Any portion of the exam that is not successfully completed after the first attempt will necessitate review of the exam by the Resource Hospital EMS Coordinator or designee with the EMS personnel.
- B. All reeducation and retesting must be scheduled with the Resource Hospital EMS Coordinator or designee. It is the responsibility of EMS personnel to schedule.
- C. Reeducation and retesting (the second test) shall be completed within 30 days from the date of the initial failure (the first test) or the EMS personnel shall be subject to suspension of their medical privileges.
- D. The retest (the second test) will be administered by the EMS Coordinator or the EMSMD (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 (the second test) will be sent by regular mail (all mailings will be considered delivered unless returned).

This will include a notification that failure of a second retest (the 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 two (2) weeks.

- G. Reeducation and the third test (the second retest) shall be accomplished within the subsequent two-week period. It is again the responsibility of the EMS personnel to schedule with the Resource Hospital EMS Coordinator or his/her designee.
- H. The third test (the second retest) will be administered by the EMS Coordinator or EMSMD (or designee) of the respective Resource Hospital and graded immediately upon completion.
- I. EMS personnel will immediately be notified verbally of the examination results, and subsequently will receive written confirmation.
- J. In the event of failure of the third test (the second retest), 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 second retest (the third test).
- K. At all times, EMS personnel will be afforded due process as delineated in IDPH's Rules and Regulations accompanying the EMS Act.

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Written: Taken from Reregistration/Relicensure 4/07

Reviewed: 9/9/09; 5/11; 8/15

MDC Approval: 12/4/07; 9/1/09

IDPH Approval: 10/24/08; 3/5/2010

Implementation: 1/1/10

OUT-OF-SYSTEM CONTINUING MEDICAL EDUCATION

- I. All Paramedic, EMT-B's, First Responders, and EMD's (both Chicago Fire Department and private ambulance service provider) must obtain at least one half of the total required continuing medical education (CME) hours within the system.
- II. Out-of-system CME, if not "blanket" approved course, must have a thirty (30) day advance approval. If this advance notice cannot be met, the EMS personnel must contact the Resource Hospital EMS Coordinator and present a description of the course attended (i.e., conference flyer, course handout or notes, etc.) and verification of attendance (i.e., certificate of CME, etc.). The EMS Coordinator will then submit the late request to the chairperson of the EMS Medical Directors Consortium Educational Subcommittee for consideration.
- III. No more than 25% of the total required hours will be accepted from education in any single topic area.

IV. BLANKET APPROVED COURSES (See attachment I)

- V. Employment outside of pre-hospital care that is directly related to patient care may be considered for clinical CME. Up to eight (8) hours of clinical time per year may be awarded at an accumulation ratio of 0.5 hr/hr. A copy of the job description and title with a letter from your immediate supervisor noting the hours logged shall be submitted for verification each year.
- VI. Verification of attendance of out of system CME (i.e., certificate of CME credit hours awarded, etc.) shall be submitted by the EMS personnel to the Resource Hospital EMS Coordinator for record keeping purposes.
- VII. Online CME may be approved depending on the Illinois site code and/or the Continuing Education Certifying Board EMS (CECBEMS) and does not exceed 25% of any single topic.
- VIII. EMS personnel in a supervisory role may achieve additional CME hours by performing employer sponsored, EMSMD approved Quality Improvement reviews and other identified administrative duties as approved by the MARC Division and the EMS System. The CME form shall be forwarded to the MARC Division/Private Provider Manager for signature and forwarded to the respective Resource Hospital.

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Implementation: 1/1/89; 9/1/93; 7/1/95; 12/1/96; 8/1/99; 10/00; 5/1/01; 1/1/10; 4/1/12; 3/1/16

BLANKET APPROVED COURSES

Course Title	Maximum hours	Recertification	Hours for Recertification
ABLS (Advanced Burn Life Support)	8	2 years	4
ACLS (Advanced Cardiac Life Support)	4	2 years	4
ACLS (Advanced Cardiac Life Support) Instructor Course	4	One time only	
AHLS (Advanced Hazmat Life Support)	8	2 years	4
APLS (Advance Pediatric Life Support)	8	2 years	4
ATLS (Advanced Trauma Life Support)	8	2 years	4
CPR Instructor Course	4	2 years	
CPR (AHA approved course)	3	2 years	
Disaster Drill (Drill Participant)	3	Per year	
ENPC (Emergency Nurse Pediatric Course)	8	One time only	
GEMS (Geriatric Emergency Medicine)	8	2 years	4
HazMat Awareness Course	4	One time only	
HazMat Operations Course	4	One time only	
ITLS (International Trauma Life Support)	8	2 years	4
NAEMSE (National Association of EMS Educators) Instructor Course	20	One time only	
NALS (Neonatal Advanced Life Support)	4	One time only	
NIMS Courses (National Incident Management)	Hr./hr.	Maximum three courses	
PALS (Pediatric Advanced Life Support)	4	2 years	2
PEPP (Pediatric Education for Prehospital Professionals)	8	2 years	4
PHTLS (Pre-hospital Trauma Life Support)	8	2 years	4
TNCC (Trauma Nurse Core Curriculum)	8	One time only	
TNS (Trauma Nurse Specialist)	20	One time only	

Miscellaneous Approved CME

Clinical Time	Riding on an ALS or CCT ambulance. Must be pre-approved by Resource Hospital
CME Courses with IDPH Approval	Hour for hour in accordance with the IDPH site code
Conferences/Symposiums	Pre-approval required. Approval is granted on a case-by-case basis. Certificate of completion must be submitted.
EMS Instruction	1 hour of CME per 8 hours of documented instruction
FEMA Courses with an EMS Focus	Approval is granted on a case-by-case basis
Health Related College/Graduate Level Education	Approval is granted on a case-by-case basis. Formal transcript must be submitted
On-line CME	Approval dependent on Illinois site code

Revised 9/2014

SUPERVISED FIELD INTERNSHIP WITH THE CHICAGO FIRE DEPARTMENT (PARAMEDIC STUDENTS)

- I. Paramedic students functioning in this capacity do so under contractual agreement between the Chicago Fire Department (CFD), the Chicago EMS Region XI Medical Directors Consortium (MDC), and the sponsoring institution(s) hosting the paramedic training program.
- II. For the duration of the supervised field internship, the Resource Hospital shall optimally assign the student to two (2) paramedic preceptors.
- III. This assignment shall be within the geographical boundaries of one (1) of the Resource Hospitals.
- IV. Following successful completion of the paramedic didactic training program and prior to starting the supervised field internship, a paramedic student will be assigned to a specific Resource Hospital. An orientation with the EMS Coordinator from that hospital will be scheduled. The paramedic student must bring the following documents to the orientation:
 - A. Current state and/or national EMT-B card
 - B. Verification of current CPR recognition
 - C. Driver's license

During the orientation session the student will complete a form that documents that he/she has not been convicted of an Illinois Class X, Class 1 or Class 2 felony or an out-of-state equivalent offense. The student shall report all new felony convictions to their assigned Resource Hospital within seven (7) days after the conviction. Felony convictions shall be reported by means of a letter to the assigned Resource Hospital.
- V. A waiver of liability must be completed and on file with CFD prior to start of internship.
- VI. Upon successful completion of the field internship, the student has completed her/her paramedic training and may elect to sit for the State of Illinois Paramedic or National Registry Paramedic examination to attain licensure.
- VII. Paramedic students from training programs, other than Malcolm X, may be allowed to complete their clinical training requirements as outlined by their program if approved by MARC of CFD and a Resource Hospital. The assigned Resource Hospital shall communicate with the host program regarding the student's progress.

NOTE: Paramedic program students must comply with all provisions and policies promulgated by the hosting institution(s) paramedic training program, those of the CFD and those of the Chicago Region XI EMS System.

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Implementation: 1/1/89; 9/1/93; 12/1/96; 8/1/99; 1/1/10; 4/1/12

EMS PRECEPTOR

- I. The preceptor acts as a resource person, a role model, a facilitator and a guide. The preceptor must have thorough knowledge of the Chicago Region XI EMS System Policies, Procedures, and Standing Medical Orders.

II. PREREQUISITES

A. REQUIRED

1. One (1) year experience as a licensed EMT-B/paramedic in the Chicago Region XI EMS System or alternate experience.
2. No sustained complaints in the EMT-B/paramedic's medical file within the past 12 months.
3. Completion of modular examinations with a minimum score of 80% in each practical station and on each written segment per system policy.
4. Medical references.
5. Recommendation by the EMTB/paramedic's EMS Coordinator and EMS Medical Director.
6. Approval by the EMS Medical Directors Consortium Educational Subcommittee.

B. PREFERRED

1. Current CPR instructor
2. Current ACLS verification
3. Teaching experience in health care delivery (e.g., EMT training, BLS, etc.)
4. ITLS or PHTLS status
5. PEPP, PALS or APLS status
6. IDPH Lead Instructor or National Association of EMS Educators Course
7. The person should regularly provide direct patient care or be responsible for insuring the integrity of patient care.

III. BENEFITS

Continuing educational training hours (TH) will be granted to preceptors at the discretion of the Resource Hospital EMS System Coordinator and will be prorated according to the number of documented training hours of training and/or supervision completed up to 25% of the total required hours annually. The preceptor program offers alternate means of accruing CME credit via the following routes:

A. Paramedic or Other Training Program

- 1 Hour classroom skills training = 1 Clinical CME Hour
- 1 Hour classroom didactic training = 1 Didactic CME Hour

B. Field Internship

- 8 Hours supervising internship = 1 Hour CME = .5 Didactic CME Hours + .5 Clinical CME Hours

C. System Sponsored Preceptor Workshops

Attendance and participation at these workshops may at the EMS Medical Director's discretion preclude the need to attend certain CME modules. Mandatory testing at the CME modules may be waived or will be incorporated as a component of the workshop if deemed necessary by the MDC-Educational Subcommittee.

D. EMS Medical Directors Consortium Educational Programs

1. An EMT-B/paramedic preceptor may acquire CME hours by assisting with instruction in CME programs as approved by the chairperson of the EMSMDC Educational Subcommittee.
2. Attendance at planning/development sessions for CME modules may also be approved for CME credit.

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PREHOSPITAL R.N.

- I. The Illinois Department of Public Health, Division of EMS, Rules and Regulations defines a "Registered Professional Nurse/Prehospital R.N." as a registered nurse who has been approved by the EMS Medical Director in a Department approved EMS System, and who has satisfactorily completed additional supplementary training including, but not limited to, courses in extrication, medical oversight and communications, Advanced Cardiac Life Support, including defibrillation and intubation or its equivalent, and either Trauma Nurse Specialist or their equivalents, as approved by the EMS Medical Director.

- II. It is recognized that the provision of prehospital care requires the acquisition of a specialized body of knowledge and skills. Therefore, all persons licensed or recognized by IDPH to provide prehospital Advanced Life Support will demonstrate the same minimum mastery of cognitive objectives and psychomotor skills as set forth in the U.S. Department of Transportation Standardized Curriculum for Paramedics, irrespective of professional credentials, i.e., Paramedic or Prehospital R.N.

The DOT curriculum provides a national standard for ALS knowledge and skills and is competency-based, e.g., students must demonstrate their ability to perform to acceptable standards in both the classroom and clinical settings (in-hospital and field environments).

- III. Nurses in the Chicago EMS System desiring to be approved as Prehospital R.N.'s shall complete the following requirements:

A. PRE-REQUISITES TO DIDACTIC COMPONENT

1. Current certification as an Emergency Communications R.N. (ECRN) within the Chicago EMS System
2. Registered Professional Nurse with current licensure in the State of Illinois
3. Current CPR recognition
4. Clinical practice in Emergency or Critical Care Nursing (2 years full time employment, approximately 4000 hours)
5. Written approval to ride with, or evidence of employment by an Advanced Life Support Ambulance Service Provider in the Chicago EMS System
6. Complete all system entry requirements at the paramedic level

B. DIDACTIC COMPONENT

1. Prior nursing knowledge and clinical experience may exempt a candidate from selected portions of the curriculum, through competency-based testing.

2. Arrangements will be made to provide the applicant access to a paramedic training course or a portion of that course that includes:
 - a. Division 1, Prehospital Environment, Sections 1 through 7 of the D.O.T. Standard curriculum for paramedics.
 - b. Extrication didactic and practical
 - c. Pharmacokinetics
 - d. Dysrhythmia identification, therapeutic modalities, defibrillation, intubation and

management of cardiac resuscitation (or the American Heart Association ACLS course)

- e. A prehospital trauma support course or its equivalent as approved by the System Medical Director. Some approved courses include BTLS, PHTLS, TNS, and TNCC.
3. Applicants should contact their EMS Resource Hospital Coordinator for full details regarding course requirements, challenge exams and approved equivalencies.

C. SKILLS COMPONENT

Certain skills not inherent to the hospital-based R.N.'s scope of practice must be obtained through the paramedic course curriculum. Mandatory skill competencies are as follows: Airway management skills lab, cardiovascular management skills lab, pediatric intubation/intraosseous infusion skills lab, rescue and patient packaging skills lab, extrication class and lab, trauma procedures skills lab.

D. CLINICAL COMPONENT

1. Prerequisite: individual malpractice insurance to cover EMS activities or documentation of coverage under employer.
2. All Prehospital R.N. applicants must complete or show prior completion of clinical rotation in the following hospital areas within the last year:
 - a. Obstetrics (to include nursery) -- 16 hours
 - b. Operating Room/Anesthesia -- 8 hours
 - c. Pediatrics (ER) -- 16 hours
 - d. ALS Ambulance Observation -- 16 hours

IV. Prehospital R.N. Testing (EMS Rules Section 535.820)

- A. Upon completion of training, the Prehospital R.N. candidate shall be required to pass both didactic and practical examinations, if such examinations are required for paramedics within the System. The Prehospital R.N. examination shall cover the Prehospital R.N. training components and be otherwise equivalent to the paramedic examination.
- B. Each Prehospital R.N. applicant will have to successfully complete all written and practical examinations with a minimum score of 75%. All testing and retesting shall be arranged with the EMS Resource System Coordinator.
- C. Testing and retesting policies shall be equivalent to those for paramedics in the Chicago EMS System (see testing requirements Chicago EMS System Policy manual - EMT Relicensing Requirements)

V. FIELD EXPERIENCE

- A. Once course and testing requirements are successfully completed, Prehospital R.N. candidates must complete the same field internship requirements as student paramedics in the Chicago EMS System within six (6) months of completion of didactic requirements.

- B. This internship must be arranged by the Prehospital R.N. candidate and approved by the MDC Education Subcommittee.

VI. PREHOSPITAL R.N. APPROVAL

- A. Upon successful completion of the preceding requirements, the EMS Medical Director shall add the individual to that list of system approved Prehospital R.N.'s, and notify IDPH.
- B. Applicants who choose to be recognized and are currently licensed as both paramedics and certified emergency communication nurses in compliance with the above requirements and functioning within the Chicago EMS System may apply for additional recognition as a Prehospital R.N.

VII. PREHOSPITAL R.N. RENEWAL

- A. Maintain yearly CME requirements according to System requirements or equivalent (as approved by the EMSMD) for paramedics (see Continuing Medical Education requirements - Chicago EMS System Policy Manual-EMT Relicensing Requirements)
- B. Maintain current CPR recognition on file with Resource Hospital
- C. Maintain current Registered Professional Nurse Licensure within the State of Illinois on file with Resource Hospital
- D. Prehospital R.N.s who have attained this recognition based upon ECRN and paramedic credentials must maintain their current status including all mandatory CME requirements as listed in the policy manual for paramedics and ECRN's. While remaining current with the dual status, no additional requirements will be required unless specifically designated by the EMSMD.

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Implementation: 12/1/96; 8/1/99; 1/1/10

FITNESS FOR DUTY

- I. All ambulance service providers in the Chicago EMS Systems must have a policy to deal with EMS personnel who are suspected to be impaired while on duty.
- II. 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 Medical Director (EMSMD) that he/she is medically and psychologically capable of resuming participation.
- III. Any rule that requires drug testing as a condition for licensure which conflicts or duplicates a provision of a collective bargaining agreement should not apply to any person covered by that collective bargaining agreement.
- IV. Each ambulance service provider shall have a policy addressing substance abuse and felony conviction by system personnel while on or off duty. The policy will accompany each ambulance service provider's letter of participation, will be reviewed by the EMSMD or designee, and will be submitted as part of the EMS System Plan to the Illinois Department of Public Health (IDPH).
- V. Upon notification by the ambulance service provider of impaired EMS personnel, the EMSMD may subject the individual to immediate suspension from system participation and notify IDPH of the suspension.
- VI. System participation may be reinstated upon EMSMD notification of involvement with an EAP which satisfies the employer's requirements for return to duty. IDPH will be notified of the re-instatement.

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Implementation: 9/1/93; 12/1/96; 8/1/99; 10/00; 1/1/10

INACTIVE STATUS

I. INACTIVE STATUS

- A. Prior to the expiration of their current registration/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 licensing date, EMS provider identification number, and circumstances requiring inactive status.
- C. All CME requirements must be up to date prior to granting the inactive status.
- D. If the EMSMD approves, he/she will apply to the Illinois Department of Public Health in writing and request that the individual be placed on inactive status.
- E. EMS personnel requesting inactive status must return the original license to the Illinois Department of Public Health (Department) prior to processing by the Department.
- F. The Department will review requests for inactive status and shall notify the EMSMD in writing of its decisions.
- G. EMS personnel will not function in the capacity with which the inactive license/registration applies.

II. RETURN TO ACTIVE STATUS

- A. When EMS personnel request to return to active status, they **MUST REACTIVATE** in the 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 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. View all mandatory modules held during the individual's inactive status and any others deemed necessary by the EMSMD or Coordinator
 - 5. A field clinical monitoring period of a minimum of 40 hours with a system-approved preceptor after successful completion of all written and clinical system entry requirements
 - 6. Meet with the EMS Coordinator after each 40 hours of completed field time during field clinical monitoring period to discuss prehospital care experiences and review evaluations
 - 7. 4 hours clinical time with the EMSMD and any additional clinical time deemed necessary by the EMSMD
- C. EMS Personnel wishing to reactive after a five year inactive period, will complete the aforementioned requirements as well as the following:

1. Show successful completion of a course/s (e.g., ITLS, ACLS, PEPP) as approved by the EMSMD or EMS Coordinator
 2. Pass a final EMS system exam appropriate for the EMS personnel's level of training
 3. An additional 10 hours of field clinical monitoring per year of inactive status
 4. Other requirements as deemed necessary by the EMSMD
- D. A reactivation fee will be assessed by the Resource Hospital based upon the amount of CME necessary.
- E. After completion of the required CME, the EMSMD will apply to IDPH to request reinstatement of the individual to active status. This application shall be in writing and will include notation that the individual has been examined (physically and mentally) and found capable of functioning within the EMS system. Furthermore, that the individual's knowledge and clinical skills are at active EMS personnel level and that the individual completed any refresher training deemed necessary by the EMSMD. If the inactive status was based on a temporary disability, the EMSMD shall verify that the disability has ceased.
- F. Upon review, IDPH may reinstate the individual to active status and establish a new reregistration/relicensing period.

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Implementation: 2/1/90; 9/1/93; 12/1/96; 8/1/99; 10/00; 5/1/01; 1/1/10

SUSPENSION

- I. THE EMS MEDICAL DIRECTOR (EMSMD) OR DESIGNEE MAY SUSPEND FROM MEDICAL PARTICIPATION WITHIN THE SYSTEM ANY INDIVIDUAL EMS PERSONNEL OR INDIVIDUAL AMBULANCE SERVICE PROVIDER WITHIN THE SYSTEM CONSIDERED NOT TO BE MEETING THE STANDARDS OF THAT APPROVED SYSTEM. DUE PROCESS WILL BE AFFORDED PRIOR TO SUSPENSION, UNLESS CONTINUED PRACTICE WOULD CAUSE IMMINENT HARM TO PATIENTS. Any suspension must be based on one or more of the following:
 - A. Failure to meet the education and training requirements prescribed by the state or EMSMD;
 - B. Violation of the EMS Act or any rule or regulation promulgated under the Act;
 - C. Failure to maintain proficiency in the provision of basic or advanced life support services;
 - D. Failure to comply with the provisions of the system's standing medical orders (SMOs) and/or policies and procedures;
 - E. During the provision of emergency care, engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud or harm the public;
 - F. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such a manner as to adversely affect the delivery, performance or activities in the care of patients requiring medical care;
 - G. Intentional falsification of any medical reports or orders, or making misrepresentations involving patient care;
 - H. Abandoning or neglecting a patient requiring emergency care;
 - I. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility, institution or other work place location;
 - J. Performing or attempting emergency care, techniques or procedures without proper permission, licensure, training or supervision;
 - K. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay;
 - L. Medical misconduct or incompetence or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care;
 - M. Violation of the system's standards of care;
 - N. Physical impairment to the extent the individual cannot physically perform the emergency care and life support functions 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; or
 - O. Mental impairment to the extent that the individual cannot exercise the appropriate judgment, skill and safety for performing the emergency care and life support functions 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 and Illinois Class X, Class 1 or Class 2 felony or out-of-state equivalent.
 - Q. Failure to report a felony conviction to the assigned Resource Hospital within seven (7) days after the conviction.

II. PROCESS:

- A. All suspensions related to failure to attend mandatory continuing education modules shall be accompanied by written notice, hand delivered or via regular mail to the suspended participant from the EMSMD (all mailings will be considered delivered unless returned). A

copy of the suspension notice shall also be forwarded to the provider's employer.

- B. Such notice shall include a statement describing the reason(s) for the suspension and the terms of the suspension.
- 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 medical related immediate suspensions.
- D. The EMS Personnel's employer will be immediately notified of a suspension from system medical participation; see policy - System Review Board. If EMS personnel from the Chicago Fire Department (CFD) are suspended from system medical participation, CFD policies may be imposed as a condition of employment.
- E. If an immediate suspension is warranted*, Resource Hospital documentation must be submitted to the Illinois Department of Public Health (IDPH) within 24 hours after the start of suspension. The suspended participant may also submit relevant material to IDPH within that same period of time.

* Criteria for an immediate suspension (from the State of Illinois EMS Act, Section 515.420): An EMS MD may immediately suspend an individual, individual provider or other participant if he or she finds that the information in his or her possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS MD which states the length, terms and basis for the suspension.

- F. For immediate suspensions, the suspended participant has the right to bypass the system review board and go directly to the State EMS Disciplinary Review Board.
- G. For suspensions which do not include a finding by the EMSMD of an imminent danger to the public, the EMSMD shall issue a written notice to the EMS personnel, ambulance service provider or other system participant which includes a statement describing the reason(s) for suspension, the terms of the suspension, and the opportunity for a hearing before the system review board prior to the commencement of the suspension.

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Implementation: 9/1/93; 12/1/96; 8/1/99; 10/00; 1/1/2010; 4/1/12

SYSTEM REVIEW BOARD

- I. Upon receipt of a Notice of Suspension from the EMS Medical Director, the EMS personnel or ambulance service provider, or other system participant shall have fifteen (15) days to request a hearing before the System Review Board, by submitting a written request to the EMSMD via certified mail. Failure to request a hearing within fifteen (15) days shall constitute a waiver of the right to a System Review Board Hearing. The decision of the EMSMD shall be considered final and suspension shall commence.
- II. The Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an Emergency Department Physician with the knowledge of EMS, and one of whom is an EMT-B/paramedic, and one of whom is of the same professional category as the individual EMS personnel, individual ambulance service provider, or other 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 certified return receipt mail or personal service 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 order. Such decision shall be sent via certified mail or personal service to the EMSMD and the EMS personnel, ambulance service provider or other system participant within 5 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 (5) business days after the System Review Board's decision is received. Such notice shall include, if applicable, a statement detailing the duration of and grounds for the suspension.
- IX.** A recommendation to IDPH by an EMSMD to deny, suspend or revoke the license of a participant within an EMS System is not subject to the provisions of this section, unless such recommendation forms the basis for suspension pursuant to the EMS Act.
- X.** 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.
- XI.** A request for review by the State EMS Disciplinary Review Board shall be made in writing by certified mail to the Chief of the Division of EMS and Highway and Safety, IDPH, within ten (10) 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 review.
- XII.** Upon receipt of a valid request for review, IDPH, Division of EMS and Highway Safety shall convene a State EMS Disciplinary Review Board to review the decision of the System Review Board.

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Written:

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CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

F. HOSPITAL

Resource Hospital Base Station Override...F.1

ECRN/Physician Backup...F.2

Participating Hospital Responsibilities...F.3 to F.4

Recognition, Rerecognition and Suspension of ECRN/ECP...F.5 to F.7

RESOURCE HOSPITAL BASE STATION OVERRIDE

- I. The Resource Hospital has the authority to monitor calls of its Associate Hospital(s):
- II. In the event the Resource Hospital attending physician (ECP) believes the care being directed by medical oversight at the Associate Hospital is not in the best interest of the patient or is in violation of policy and procedures, the Resource Hospital may directly take over medical oversight communications.
- III. In the event that the Paramedic/EMT-B believes that the ECRN/ECP of the Associate Hospital is inappropriate or there is a question about the treatment being ordered, he/she may request a Resource Hospital Override.
- IV. Following this communication, the EMS Coordinator of the Resource Hospital is to be immediately notified. The Informational Report/Request for Clarification Form is to be completed and forwarded to the Resource Hospital EMS Coordinator by a mechanism agreed upon.
- V. The Resource Hospital EMS Medical Director (EMSMD) and the EMS Coordinator will review the circumstances of the override with all involved individuals including the Associate Hospital EMS Medical Director and EMS Coordinator in a timely manner.

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ECRN/PHYSICIAN BACKUP

- I. An Emergency Communications RN (ECRN) will request the EMS medical director (EMSMD) or designated physician (ECP) consultation in:
 - A. Situations requiring significant deviation from the standing medical orders.
 - B. Patient care situations involving complex medico-legal issues and/or interpretation of the system's policies. Examples may include:
 1. Refusal of care/transport
 2. Crime scene
 3. Question regarding/deviation from a do not resuscitate order (DNR)
 4. Patient/family request to go to other than the closest appropriate hospital
 5. Any situation requiring ambulance bypass (e.g., the closest hospital has notified the base station of a resource limitation) where there is concern as to whether bypass is in the best interest of patient care
 6. Any situation in which there is a question as to the best receiving hospital for a patient who needs or may benefit from a specialty center (e.g., traumatized patient, patient with suspected acute stroke, patient whose 12-lead EKG meets STEMI criteria)
 7. Whenever there is concern as to the advisability of an invasive and potentially hazardous procedure (e.g., cardioversion of an awake patient, needle cricothyrotomy, needle thoracostomy)
 8. Whenever EMS personnel, patient or family members request consultation with a physician
 9. Any situation in which there is a physician at the scene involved in providing care
 10. Any other situation in which additional medical consultation is believed to be needed by the ECRN
 11. Termination of resuscitative measures
- II. It is the responsibility of the senior ECP in the emergency department to assure that there is immediate ECP response whenever medical consultation and assistance is requested.
- III. The EMT-B/paramedic may request to speak with the ECP if there are concerns relative to orders received from the ECRN and/or unique circumstances he/she believes necessitate ECP decision-making.

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PARTICIPATING HOSPITAL RESPONSIBILITIES

I. DRUG, SUPPLY & EQUIPMENT INVENTORY

- A. Each participating hospital is required to replace all drugs, supplies and exchange equipment as designated by the Chicago EMS System Required Drug, Supply and Equipment Inventory List. This includes the replacement of drugs and supplies for non-transported termination of resuscitation patients that would have otherwise been transported to the hospital. Failure to replace will result in an administrative fee in addition to the cost of the item.
- B. All exchange items should be immediately available to the EMT-B and paramedic so as not to delay their return to service.
- C. The following items must be made available to the EMT-B and paramedic for use and exchange in the event of transport of a patient with a suspected communicable disease:
 - 1. Cleaning detergent (low sudsing, neutral pH)
 - 2. Standard household bleach with provisions to prepare fresh 1:10 solutions
 - 3. Cidex (or EPA approved equivalent)
- D. Controlled Substances
 - 1. Each participating hospital shall keep a controlled substance log. The log should document: patient's name, ambulance name and number, paramedic's name, drug used, dosage, etc.
 - 2. Each participating hospital shall accept any excess of controlled substance from ambulance personnel and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy.
 - 3. Upon proof of use, each participating hospital will then replace the controlled substance to the ambulance personnel.

II. BED AVAILABILITY

- A. When transfer of care requires a bed in the emergency department one should be made available upon arrival as not to delay the ambulance from returning to service. The EMS provider should notify the Charge Nurse or ED Supervisor when delayed greater than 15 minutes for a bed.
- B. Each participating hospital is required to report their bed availability according to the Illinois Department of Public Health (IDPH) provisions.

- III. **COMMUNICABLE DISEASE/SIGNIFICANT EXPOSURE:** Compliance with the Illinois Hospital Licensing Act and Requirements to allow for prehospital care ambulance service providers to be notified when EMS personnel have transported a patient and have been potentially exposed to a contagious disease.

IV. CONTINUOUS QUALITY IMPROVEMENT: Participating hospitals have the responsibility to notify the Resource/Associate Hospital EMS Coordinator of any problems involving prehospital care. The Informational Report/Request for Clarification Form may be copied and employed to facilitate this purpose.

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RECOGNITION, RERECOGNITION AND SUSPENSION OF ECRN/ECP

I. GUIDELINES FOR EMERGENCY COMMUNICATIONS REGISTERED NURSE (ECRN) RECOGNITION/RERECOGNITION/INACTIVE STATUS

A. Recognition:

1. To be approved as an ECRN, an individual shall:
 - a. Be a registered nurse in accordance with the current Illinois Nursing Act with a minimum of one (1) year emergency department nursing experience or appropriate equivalent as approved by the EMS Medical Director (EMSMD)
 - b. Current ACLS recognition
 - c. Successfully complete an educational curriculum formulated by an EMS System and approved by the Department, which consists of at least 40 hours -- Classroom (minimum 32 hours) and practical training (8 hour clinical on the ambulance) -- for both the adult and pediatric population, including telecommunications, system standing medical orders and policies and procedures.
 - d. Complete a competency-based internship conducting actual medical oversight calls under the supervision of a recognized ECRN or ECP.
 - e. Meet and maintain all requirements mandated by the IDPH Rules and Regulations.
2. An acknowledgement will be awarded from the Resource Hospital after completion of the ECRN transaction card and above requirements. The individual will be submitted to IDPH for state recognition.
3. The EMS Medical Director shall approve an individual as an ECRN for four years.

B. Rerecognition: The EMS Medical Director shall re-approve ECRNs every four years if the ECRN:

1. Is a registered nurse in accordance with the current Illinois Nursing Act.
2. Has completed 32 hours of continuing education in a four-year period.
3. Has successfully completed the mandatory continuing education to keep abreast of any system function changes and is encouraged to complete 8 hours of ambulance ride time every 4 years.
4. Remains active as an approved ECRN in the system.
5. Has returned a complete Child Support Form to the Resource Hospital

6. Current ACLS recognition

C. Inactive status:

1. Prior to the expiration of the current approval, 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 recognition
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 (physically and mentally) 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 the Department 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. GUIDELINES FOR EMERGENCY COMMUNICATION PHYSICIAN (ECP) RECOGNITION/RERECOGNITION IN REGION XI:

A. To be approved as an ECP, an individual shall:

1. Be a physician currently licensed in Illinois and regularly involved in the provision of emergency medical services, and approved by the EMSMD.
2. Complete the system physician's base station course or equivalent as determined by the EMSMD.
3. Be required to maintain the necessary continuing education to keep abreast of any system function changes.

B. As long as the physician remains active as an ECPs in the system and completes any mandatory continuing education, and has no sustained complaints he/she will continue to be certified.

III. TRANSFERRING ECRN

A. A Chicago system ECRN who is currently functioning in another Chicago system

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. Nurses who have successfully completed a similar ECRN course of training at another Resource Hospital, outside the Chicago EMS System, which is deemed comparable by the EMSMD, and are issued a letter by that hospital that they are currently a recognized ECRN in good standing may be allowed to challenge the system exam.
- C. Additional educational requirements may be required by the EMSMD.

IV. SUSPENSION OF MEDICAL OVERSIGHT FUNCTION

- A. A nurse or physician may be suspended from medical oversight function upon verbal notification of the EMSMD. After verbal notification the person shall receive written notification designating the reasons for the suspension, terms of the suspension, the means for dispute resolution and due process procedures.

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CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

G. MISCELLANEOUS

IDPH Waiver Provision...G.1
RFC...G.2 to G.3
Medical Device Reporting...G.4

IDPH WAIVER PROVISION

- I. The Illinois Department of Public Health (IDPH) allows ambulance service providers to petition for a waiver if unreasonable hardship results from compliance with any requirement of the EMS Act or its Rules and Regulations.
- II. A petition shall be in writing on the IDPH form, and contain the following information:
 - A. An explanation as to why the waiver is necessary.
 - B. A written description of an alternate means of handling the matter.
 - C. A projected target date for compliance with the requirement in the petition to be waived.
- III. The ambulance service provider shall submit the petition to the EMS medical director (EMSMD). The EMSMD will present the petition to the Chicago EMSMD Consortium for review. The EMSMD will submit the petition with recommendation to IDPH for consideration.
- IV. The petition will be resubmitted to the Resource Hospital on an annual basis.

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IDPH Approval: 1988; 1/5/93; 9/17/96; 10/24/08

Implementation: 1/1/89; 9/1/93; 12/1/96; 1/1/10

REQUEST FOR CLARIFICATION

- I. A Request for Clarification (RFC) is to be used for the purpose of improving communication and understanding between the participants of the Chicago EMS System.
- II. Examples of use include but are not limited to:
 - A. Questions regarding usage and/or deviations in policies and procedures and/or standing medical orders
 - B. Questionable orders communicated from Resource/Associate Hospital to EMS personnel
 - C. Anticipation of misunderstanding relative to patient care, e.g., personality conflicts, etc.
 - D. Patient care and/or services above and beyond the call of duty provided by EMS personnel.
- III. The Request for Clarification Form should be copied and readily used by participants of the system. It should be accessible at the Resource/Associate Hospital EMS offices and participating hospital emergency departments.
- IV. Upon completion of the form a copy should be maintained by the author and the original forwarded to the Resource Hospital EMS office. This form is part of the quality control process and is protected under the Medical Studies Act.

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Implementation: 1/1/89; 9/1/93; 12/1/96; 1/1/10

REQUEST FOR CLARIFICATION FORM

(THIS IS A CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT. DO NOT COPY OR MAKE REFERENCE TO ITS COMPLETION IN THE MEDICAL RECORD/PATIENT CARE REPORT/JOURNAL.)

Date & Time of Occurrence: _____

Ambulance Service/Unit: _____

Event or Run #: _____

Hospital Log#: _____

Patient Name: _____

EMS Personnel Name: _____

Summary of Events: _____

Signature(s) of Person(s) Initiating Report: _____

Report Submitted To: _____

FOLLOW UP REPORT (FOR RESOURCE HOSPITAL USE ONLY): _____

EMS System Coordinator: _____

EMS Medical Director: _____

CONFIDENTIAL

MEDICAL DEVICE REPORTING

- I. A medical device is 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, with the exception of drugs. This includes but is not limited to ventilators, monitors, electronic equipment, patient restraints, syringes, catheters, diagnostic test kits and reagents, disposables, components, parts, accessories, etc.
- II. 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 prehospital personnel is responsible to:
 - A. Report the incident to their immediate supervisor.
 - B. Complete an RFC as soon as possible.
- III. The Resource Hospital EMS Coordinator should be informed as soon as possible.

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CHICAGO EMS SYSTEM POLICIES AND PROCEDURES

H. REGIONAL POLICIES

Protocol for Resolving Regional or Inter-System Conflict...H.1
EMS System Quality Improvement/Assurance Program...H.2 - H.3

PROTOCOL FOR RESOLVING REGIONAL OR INTER-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. The chairperson of the EMS Advisory Committee for Region XI will be appraised of continued conflict by the EMS Medical Director in his/her region and he/she will communicate with the Chairperson(s) of the EMS Advisory Committee(s) for the other Region(s) involved.

- III. Unresolved issues will be referred to IDPH for review and recommendations.

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IDPH Approval: 1/99; 10/24/08

Implementation: 8/1/99; 1/1/10

EMS SYSTEM QUALITY IMPROVEMENT/ASSURANCE PROGRAM

I. Purpose:

Each EMS System Provider will submit a Quality Improvement /Assurance Plan/Program to their respective Resource Hospital. This plan must include a detailed plan addressing patient care gaps that are identified by the EMS Medical Directors, EMS Resource Hospital, Provider or other EMS System affiliated agency.

II. The Quality Improvement /Assurance Plan/Program must include the following components:

- A. Indicator(s) selected and agreed upon by EMS Medical Directors/Consortium.
- B. Peer Review
- C. Specific % of runs/information to be reviewed is based on a specific number of runs/information on a monthly basis. The % of runs/information reviewed will be directed by the EMS Medical Directors/Consortium.
- D. Specific % of runs/information to be reviewed will be for each level of care provided (ALS and BLS) and for transport and non-transport vehicles.

III. Standing Quality Improvement/Assurance Indicators:

- A. Response Times - must have a consistent tracking measurement (benchmarked by National Standards and agreed upon by EMS Medical Directors/Consortium)
- B. Refusals not Called to Base Station for Large Scale / Special Events – must be submitted to respective Resource Hospital within 10 days post-event.
- C. Large Scale/Special Events- Will have a Quality Assurance review of patient data to include:
 - 1. Number of patient transports
 - 2. Number of patients seen not requiring medical treatment
 - 3. Categories of patient encounters (i.e. trauma, suspected ETOH, suspected Overdose etc.)
 - 4. Any additional information deemed appropriate by the EMS Medical Directors/Consortium.
 - 5. A report must be submitted to respective Resource Hospital within 10 days post-event.
- D. Any new program implemented within the EMS System will have a QI review for the first year following implementation. QI reports will be submitted to the EMS Medical Directors/Consortium on a monthly basis.
- E. Any new medication, equipment or procedure will have a Quality Assurance review of all related patient encounters for a minimum period of four (4) months. QA reports will be submitted to the EMS Medical Directors/Consortium on a monthly basis.

IV. All Quality Improvement /Assurance Plan/Program reports must be submitted to the respective Resource Hospital on a MONTHLY basis and be available to the Resource Hospitals / EMS Medical Directors Consortium upon request.

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