Passavant Area Hospital EMS System

Prehospital Policies Manual

Developed February 2014

Implemented April 2014

PASSAVANT EMS SYSTEM
PREHOSPITAL POLICIES MANUAL

Table of Contents

FOREWORD

Passavant Area Hospital believes in providing patient focused, quality driven care. As an extension of that entity, Passavant Area Hospital EMS system is passionate about providing excellent care. Recently, a step towards modernizing the practice of EMS was taken by Passavant Area Hospital's affiliate Memorial Medical Center EMS system as it updated it's protocols. We applaud that effort and are proud of our affiliate for taking that step. Those updates which our own system's leaders, namely myself and Jeanne Curry assisted in updating were created with the hope of serving as a model for other systems such as our own. Now, the time has come for us to draw from those changes in an effort to reflect what we believe research indicates are the current best practices of pre-hospital medicine in the Passavant Area Hospital EMS system. While some things have been updated or changed to reflect practice of pre-hospital EMS that is unique system, our protocols will closely resemble those of the Memorial Medical Center EMS System. We believe this collaboration will benefit our patients by allowing them to receive the best care from the best providers.

As with the Memorial Medical Center EMS system protocols, the intent of this manual is to create a team approach to pre-hospital care. We believe the new protocols will result in optimum patient care that is competent, up-to-date, efficient, and effective. The focus of this manual is on providing safe, well-planned care for the patients we serve as well as maintaining a safe environment for the pre-hospital care provider. Providers may also find this manual to be useful as a study guide and helpful reference when necessary.

Without the ground work provided by those at the Memorial Medical Center EMS system in their updated protocol manual, we would not have these protocols today. We also acknowledge the PAEMS system that provided the prototype manual from which the updated protocol manual of the Memorial Medical Center EMS system was created. Specifically, the leadership of Matthew Jackson, MD should be mentioned. Without his knowledge, experience, and enthusiasm this update to our current protocols would not be possible. I would also like to thank Sara Fricke, EMT-P, EMS System Coordinator for Memorial Medical Center EMS System for her countless hours of hard work in helping to format, revise, foster support for, and implement those protocols. We also graciously acknowledge her assistance with updating these protocols you find here.

I would like to take a moment to also thank Passavant Area Hospital EMS Coordinator Jeanne Curry for her hard work and dedication to the Passavant Area Hospital EMS System. This updated protocol manual would not be possible without her expertise. The Passavant Area Hospital EMS system is fortunate to have such a great coordinator. As a result of her work, she is recognized as a leader in the hospital, community, and even in the region.

I am honored to present this new and updated protocol manual. Please feel free to give us feedback regarding these protocols. We value your ideas as well as the time you spend caring for our patients.

Sincerely,

Nathan Jones, M.D.,
EMS Medical Director,
Passavant EMS System

All guidelines and information contained herein is intended solely for use within the Passavant EMS System. No other set of guidelines or any other system's protocols, policies, or procedures shall supersede the guidelines set forth in this manual or be utilized in place of this manual by any provider in the Passavant EMS System without explicit approval of the Passavant EMS System Medical Director.

EMS Medical Director
Nathan Jones, M.D.

Alternate Medical Director
Scott Boston, M.D.

Contact Numbers for Area Resource Hospitals

Resource Hospital

Passavant Area Hospital

EMS Office	217-245-9541 x3929
Medical Control	217-245-6813
Emergency Department	217-479-5587
Dispatch	217-243-6211

Area Resource Hospitals

Memorial Medical Center

EMS Office	217-788-3973
Medical Control	217-788-3028
Emergency Department	217-788-3030
Transfer Services	877-622-7829

St. John's Hospital

EMS Office	217-544-6464 x44103
Medical Control	217-753-1089
Emergency Department	217-544-6464 x44101

Blessing Hospital

EMS Office	217-223-8400 x6593
Medical Control	217-224-7743
Emergency Department	217-223-8400 x6500

Levels of PreHospital Care

Levels of Prehospital Care
EMS Services

First Responder Services defines a preliminary level of prehospital emergency care as outlined in the First Responder National Curriculum of the National Highway Transportation Safety Administration and any modification to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. First Responder care includes: ***CPR, AED services, monitoring vital signs, administration of oxygen and bleeding control.***

Basic Life Support (BLS) Services defines a level of prehospital and inter-hospital medical services as outlined in the Basic Life Support National Curriculum of the National Highway Transportation Safety Administration and any modification to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. BLS emergency and non-emergency care includes: ***Basic airway management, CPR, AED services, control of shock & bleeding and splinting of fractures.*** BLS services may be enhanced with the administration of System-approved medications and the KING LTS-D Airway.

Intermediate Life Support (ILS) Services defines a level of prehospital and inter-hospital medical services as outlined in the Intermediate Life Support National Curriculum of the National Highway Transportation Safety Administration and any modifications to that curriculum specified in rules adopted by IDPH pursuant to the EMS Act. ILS emergency and non-emergency care includes: ***Basic life support care, intravenous fluid therapy, oral intubation, EKG interpretation, 12-lead acquisition, defibrillation procedures and administration of System-approved medications.***

Advanced Life Support (ALS) Services defines a level of prehospital and inter-hospital medical services as outlined in the Paramedic Life Support National Curriculum of the National Highway Transportation Safety Administration and any modifications to that curriculum specified in the EMS Act. ALS emergency and non-emergency care includes: ***Basic and intermediate life support care, ACLS electrocardiography and resuscitation techniques, administration of medications, drugs & solutions, use of adjunctive medical devices, CPAP, chest decompression and intraosseous access.***

Levels of Prehospital Care
Prehospital Personnel

1. A currently licensed FR-D, EMT-B, EMT-I, EMT-P or PHRN may perform emergency and non-emergency medical services as defined in the EMS Act and in accordance with his or her level of education, training and licensure. Prehospital personnel must uphold the standards of performance and conduct prescribed by the Department (IDPH) in rules adopted pursuant to the Act and the requirements of the EMS System in which he or she practices, as contained in the approved System Program Plan.

2. A person currently licensed as an EMT-B, EMT-I or EMT-P may only use their EMT license in prehospital/inter-hospital emergency care settings or non-emergency medical transport situations under the written directions of the EMS Medical Director.

3. **First Responder - Defibrillator (FR-D):** Provides care consistent with the definition of a First Responder service and within the context of Standing Medical Orders (SMOs) or Standard Operating Procedures (SOPs). First Responder care should be focused on assessing the situation and establishing initial care.

   First Responders who provide medical care in the Passavant EMS System must be trained in the use of an AED and hold a *First Responder/Defibrillator (FR-D)* recognition card from the Illinois Department of Public Health (IDPH). Each agency is responsible for downloading a code summary and forwarding that information to the receiving hospital (along with the PCR).

4. **Emergency Medical Technician – Basic (EMT-B):** Provides care consistent with the definition of a BLS service and within the context of SMOs or SOPs. This may include interventions involving airway access/maintenance, ventilatory support, oxygen delivery, bleeding control, spinal immobilization and splinting isolated fractures.

   EMT-B attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation. In addition, EMT-Bs may assist the patient in self-administering prescribed Nitroglycerin (NTG), Proventil (Albuterol) or an Epi-Pen pending an ALS response. EMT-Bs who are System-certified and functioning with an approved B-Med agency may carry and administer various approved medications and the KING LTS-D Airway.

   AEDs are required on BLS vehicles officially incorporated into the EMS System Plan. Each agency is responsible for downloading a code summary and forwarding that information to the receiving hospital (along with the PCR).

Levels of Prehospital Care
Prehospital Personnel

5. **Emergency Medical Technician – Intermediate (EMT-I):** Provides care consistent with the definition of an ILS service and within the context of SMOs or SOPs. This may include all BLS skills, along with intravenous fluid therapy, oral intubation, EKG interpretation, 12-lead acquisition, defibrillation procedures and administration of System-approved medications. EMT-I attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation.

6. **Emergency Medical Technician – Paramedic (EMT-P):** Provides care consistent with the definition of an ALS service and within the context of SMOs or SOPs. This includes all BLS and ILS skills, advanced EKG skills with prompt intervention using Advanced Cardiac Life Support (ACLS), administration of System-approved medications & IV solutions, proper use of System-approved adjunctive medical devices (*e.g.* CPAP) and performance of advanced medical procedures (*e.g.* needle chest decompression and intraosseous access). The patient's condition and chief complaint determine the necessity and extent of ALS care rendered. Consideration should be given to the proximity of the receiving hospital. The EMT-P level may be enhanced to include selected critical care medications and skills for inter-facility transfers.

7. **Prehospital RN (PHRN):** The Illinois EMS Act (1995) defines a PHRN as "a registered professional nurse licensed under the Illinois Nursing Act of 1987 who has successfully completed supplemental education in accordance with rules adopted by the Department (IDPH) pursuant to the Act, and who is approved by an EMS Medical Director to practice within an EMS System as emergency medical services personnel for Prehospital and inter-hospital emergency care and non-emergency medical transports".

NOTE: Prehospital personnel are required to provide copies of their IDPH license and all certifications to both the agency and the EMS System. A new copy must be submitted to the EMS Office and to any agency with whom the provider is currently functioning when the license or certification is renewed.

It is the agency's responsibility to track expiration dates, to ensure that the appropriate documentation is in the agency personnel file and to ensure that copies have been provided to the EMS Office prior to the license or certification expiration. If the appropriate documents are not on file, the provider will not be allowed to function in the System.

Provider Responsibilities

Agency Responsibilities Policy

Listed below is a summary of the important responsibilities of the provider agencies that are in the Passavant EMS System. This list is based on the System manuals and IDPH rules and regulations. These responsibilities are categorized into four major areas: ***Operational Requirements, Notification Requirements, Training & Education Requirements*** and ***Additional Reports and Records Requirements***. Some items have been repeated to stress the importance of compliance.

Operational Responsibilities

1. A provider agency must comply with minimum staffing requirements for the level and type of vehicle. Staffing patterns must be in accordance with the provider's approved system plan and in compliance with Section 515.830(f).

2. No agency shall employ or permit any member or employee to perform services for which he or she is not licensed, certified or otherwise authorized to perform (Section 515.170).

3. Agencies that utilize First Responders and Emergency Medical Dispatchers shall cooperate with the System and the Department in developing and implementing the program (Section 515.170).

4. A provider agency must comply with the Ambulance Report Form Requirements Policy, including Prehospital patient care reports, refusal forms and any other required documentation.

5. Agencies with controlled substances must abide by all provisions of the Controlled Substance Policy including: *maintaining a security log, maintaining a Controlled Substance Usage Form and* ***reporting any discrepancies to the EMS Office***.

6. Notify the EMS Office of any incident or unusual occurrence which could or did adversely affect the patient, co-worker or the System **within 24 hours** via incident report form.

Agency Responsibilities Policy

Notification Requirements

An agency participating as an EMS provider in the Passavant EMS System must notify the Resource Hospital, (Passavant Area Hospital), of the following:

1. Notify the System in **any** instance when the agency lacks the appropriately licensed and System-certified personnel to provide 24-hour coverage. Transporting agencies must apply for an ambulance staffing waiver if the agency is aware a staffing shortage is interfering with the ability to provide such coverage.

2. Notify the System of agency personnel changes and updates **within 10 days**. This includes addition of new personnel and resignations of existing personnel.

   Rosters must include: *Name/level of provider, license number, expiration date, current address, phone number, date of birth, and level licensure status*.

3. Notify the System anytime an agency is not able to respond to an emergency call due to lack of staffing. The report should also include the name of the agency that was called for mutual aid and responded to the call.

4. Notify the System of **any** incident, via incident report within 24 hours, which could or did adversely affect the patient, co-worker or the System.

5. Provide the EMS Office with updated copies of FCC Licenses and Mutual Aid Agreements upon expiration.

6. Notify the System of any changes in medical equipment or supplies.

7. Notify the System of any changes in vehicles. Vehicles must be inspected by the System and the appropriate paperwork must be completed ***prior*** to the vehicle being placed into service.

8. Notify the System if the agency's role changes in providing EMS.

9. Notify the System if the agency's response area changes.

10. Notify the System if changes occur in communication capacities or equipment.

Agency Responsibilities Policy

Training and Education Responsibilities

1. Twenty-five percent (25%) of all EMT continuing education must be obtained through classes taught or sponsored by the Resource Hospital, Passavant Area Hospital.

2. Appoint a training officer. The EMS training officer should be an IDPH Lead Instructor. The training officer (or approved designee) will be required to attend mandatory training officer in-services.

3. Develop a training plan which meets the requirements for re-licensure and System certification as detailed in the *Continuing Education and Re-licensure Requirements Policy*.

4. Submit the agency's training plan (along with a current roster) annually to the EMS Office for System and Department (IDPH) approval. The applications are due by October 1st for the following training year.

5. Any changes made to an approved training application must be communicated to the EMS Office prior to the training.

6. Maintain sign-in rosters for all training conducted and provide participants with certification of attendance.

7. Conduct System mandatory training annually as per EMS Office notification.

Additional Reports and Records Responsibilities

1. Comply with Passavant EMS System Quality Assurance Plan, including agency self-review, submission of incident reports, submission of patient care reports, maintain controlled substance security logs and usage tracking forms. Logs must be made available upon request of EMS Office personnel.

2. Maintain glucometer logs. Testing should be done a minimum of once per week, any time a new bottle of strips is put into service and any time the glucometer is dropped. Glucometer logs should be kept in the ambulance (or other vehicle) and must be made available upon request of EMS Office personnel.

3. All agencies and agency personnel are to comply with all of the requirements outlined in HIPAA regulations with regard to protected health information.

Agency Responsibilities Policy

NOTE: Prehospital personnel are required to provide copies of their IDPH license and all certifications to both the agency and the EMS System. A new copy must be submitted to the EMS Office and to any agency with whom the provider is currently functioning when the license or certification is renewed.

It is the agency's responsibility to track expiration dates, to ensure that the appropriate documentation is in the agency personnel file and to ensure that copies have been provided to the EMS Office prior to the license or certification expiration date. If the appropriate documents are not on file, the provider will not be allowed to function in the System.

Professional Conduct & Code of Ethics Policy

The following are guidelines for interaction with patients, other caregivers and the community:

- **Respect for Human Dignity** – Respect all patients regardless of socio-economic status, race, belief systems, financial status or background. Dignity includes greeting, conversing, respectful mannerisms, and protecting physical privacy.

- **Maintain Confidentiality** – Respect every person's right to privacy. Sensitive information regarding a patient's condition or history should only be provided to medical personnel involved in the patient's care, with an immediate need-to-know. Sensitive information regarding our profession may only be provided to those with a right to know. This includes no electronic dissemination or publication of information referencing patients or calls.

- **Professional Competency** – Provide the patient with the best possible care by continuously improving your knowledge base, skills, and maintaining continuing education and required certifications. Protect the patient from incompetent care by knowing the standard of care and being able to identify those who do not.

- **Safety Awareness & Practice** – Protect the health and well-being of the patient, yourself, your co-workers and the community by constantly following safety guidelines, principles and practices.

- **Accountability for Your Actions** – Act within the scope of your practice and training, realize your individual limitations, and accept responsibility for both satisfactory and unsatisfactory actions.

- **Loyalty & Cooperation** – Demonstrate devotion to your profession by promoting professional image through competency and efficiency and honesty. Strive to improve morale when possible and refrain from publicly criticizing.

- **Personal Conduct** – Demonstrate professionalism by maintaining high moral and ethical standards, and by maintaining good personal hygiene. Do not participate in behavior that would discredit you, your co-workers and the profession.

Professional Conduct & Code of Ethics Policy

Code of Ethics

(Applies to ALL Prehospital providers)

Professional status as an Emergency Medical Technician is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician.

As an Emergency Medical Technician, I solemnly pledge myself to the following code of professional ethics:

- A fundamental responsibility of the EMT is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.
- The EMT provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color or status.
- The EMT does not use professional knowledge and skills in any enterprise detrimental to the public well-being.
- The EMT respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
- The EMT, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the EMT has the never-ending responsibility to work with concerned citizens and other healthcare professionals in promoting a high standard of emergency medical care to all people.
- The EMT shall maintain professional competence and demonstrate concern for the competence of other members of the EMS healthcare team.
- An EMT assumes responsibility in defining and upholding standards of professional practice and education.

Professional Conduct & Code of Ethics Policy

Code of Ethics (continued)

- The EMT assumes responsibility for individual professional actions and judgment, both in all aspects of emergency functions, and knows and upholds the laws which affect the practice of the EMT.

- An EMT has the responsibility to be aware of and participate in matters of legislation affecting the EMS System.

- The EMT, or groups of EMTs, who advertise professional service, does so in conformity with the dignity of the profession.

- The EMT has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an EMT.

- The EMT will work harmoniously with and sustain confidence in EMT associates, the nurses, the physicians, and other members of the EMS healthcare team.

- The EMT refuses to participate in unethical procedures and assumes responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Agency Compliance Waiver Policy

If compliance with IDPH Rules and Regulations of the Passavant EMS System Policies results in unreasonable hardship, the EMS provider agency shall petition the Memorial EMS System and IDPH for a temporary rule waiver.

The format for waiver petition shall be as follows:

Part 1	Cover letter, to include: *agency name, IDPH agency number, agency official(s), agency designated contact person, telephone number, statement of the problem and proposed waiver*.
Part 2	Explanation of why the waiver is necessary.
Part 3	Explanation of how the modification will relieve problems that would be created by compliance with the rule or policy as written.
Part 4	Statement of and justification for the time period (maximum one year) of which the modification will be necessary. This section must also include a chronological plan for meeting total compliance requirements. a) Staffing waivers require local newspaper advertisement explaining staffing shortage, mention that there will be "*no reduction in standard of care*", and a request for new volunteers/ employees. b) Submit a copy of 60-day staffing schedule.

The petition should be submitted to the Passavant EMS System Medical Director for review and approval. The IDPH Regional EMS Coordinator will then review the petition. If needed, the Illinois Department of Public Health may request review of the petition by the State Advisory Board. These recommendations will be forwarded to the Director of IDPH for final action. **Waivers will be granted only if there is NO reduction in the standard of medical care.**

Agency Advertising Policy

EMS agencies are expected to advertise in a responsible manner and in accordance with applicable legislation to assure the public is protected against misrepresentation.

No agency (public or private) shall advertise or identify their vehicle or agency as an EMS life support provider unless the agency does, in fact, provide service as defined in the EMS Act and has been approved by IDPH.

No agency (public or private) shall disseminate information leading the public to believe that the agency provides EMS life support services unless the agency does, in fact, provide services as defined in the EMS Act and has been approved by IDPH.

Any person (or persons) who violate the EMS Act, or any rule promulgated pursuant there to, is guilty of a Class C misdemeanor.

A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in such advertisement the hours of operation for those vehicles, if individual vehicles are not available twenty-four (24) hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate twenty-four (24) hours a day.

It is the responsibility of all Passavant EMS System personnel to report such infractions of this section to the EMS Medical Director.

System Certification Policy

It is the responsibility of the Resource Hospital to confirm the credentials of the System's EMS providers. System certification is a *privilege* granted by the EMS Medical Director in accordance with the rules and regulations of the Illinois Department of Public Health.

System Certification Process

1. A System applicant must hold a State of Illinois license or be eligible for State licensure. EMS providers transferring in from another system or state must have all clinical and internship requirements completed prior to System certification. *Transferring into the Passavant EMS System to complete internship requirements of an EMT training program is prohibited.*

2. The System applicant must be a member of or in the process of applying for employment with a Passavant EMS System provider agency. The System agency must inform the EMS Office of the applicant's potential for hire or membership to their agency.

3. A *Pre-Certification Application* must be completed and submitted to the EMS Office.

4. The System applicant must also submit copies of the following:

    - IDPH license (FR-D, EMT, Intermediate, Paramedic, or PHRN)
    - National Registry certification (if applicable)
    - ACLS (Intermediate, Paramedic)
    - PHTLS or ITLS (Intermediate, Paramedic)
    - PEPP or PALS (Intermediate, Paramedic)
    - CPR {AHA Healthcare Provider OR American Red Cross} (FR-D, EMT, Intermediate, Paramedic or PHRN)
    - Letter of reference from current EMS Medical Director
    - Resume´ (education and employment history)

5. Upon System review of the *Pre-Certification Application*, EMS Office personnel will conduct a pre-interview with qualified applicants.

6. The System applicant must pass the appropriate Passavant EMS System Protocol Exam with a score of **80% or higher**. The applicant may retake the exam with the approval of the EMS Medical Director. A maximum of two (2) retakes are permitted.

7. Successfully complete any practical skills evaluations required by the EMS Medical Director.

System Certification Policy

System Certification Process (continued)

8. Upon successful completion of the above requirements, the System applicant (ILS, ALS, including PHRN) must meet with the EMS Medical Director for final approval. Once approval is granted, the applicant will receive a letter of System certification.

9. Satisfactory completion of a **90-day** probationary period is required once System-certification is granted.

10. The EMS Medical Director reserves the right to deny System provider status or to place internship & field skill evaluation requirements on any candidate requesting System certification at any level.

Note: Passavant EMS System applicants from another system or state have a "grace period" of *6 months* to obtain certification in PEPP or PALS. **All other certifications must be current** in order to enter the System.

Maintaining System Certification

In addition to minimum continuing education requirements for re-licensure, EMS providers in the Passavant EMS System must maintain the following:

First Responder / Defibrillator (FR-D)	ALL First Responders providing EMS care must upgrade to and maintain FR-D status. *Current* AHA Healthcare Provider or ARC Professional Rescuer CPR card
EMT-Basic (EMT-B)	*Current* AHA Healthcare Provider or ARC Professional Rescuer CPR card Successfully complete periodic System protocol testing and skills evaluation

System Certification

Maintaining System Certification

EMT-Intermediate, (EMT-I) **EMT-Paramedic, (EMT-P)**	*Current* AHA Healthcare Provider or ARC Professional Rescuer or ARC Professional Rescuer CPR card
Prehospital RN (PHRN)	ITLS or PHTLS
	PEPP or PALS
	ACLS
	Active member of Passavant EMS System agency
	Successfully complete periodic System protocol testing and skills evaluation

Maintaining of current certifications and tracking of expiration dates is ultimately the responsibility of the individual provider. Agency training officers will be *assisting* with monitoring these certifications and reporting to the EMS Office. However, these individuals are not *responsible* for any certifications other than their own.

Failure to maintain *current* certification in ACLS, ITLS/PHTLS, PEPP/PALS, CPR or any other System certification may result in **suspension** of the individual in violation if an extension has not been applied for and granted through the EMS Office. In either case, **the individual will be required to take a full provider course in the lapsed certification and will NOT be allowed to simply take a refresher course for certification**. Suspended individuals will remain on suspension until proof of current certification is presented to the EMS Office.

System Certification Policy

System Resignation / Termination

A System participant may resign from the System by submitting a written resignation to the EMS Medical Director.

A System participant who resigns from or is terminated by a System provider agency has a 60-day grace period to re-establish membership/active status with another System provider agency. If the participant does not do this within the 60-day time period, then the individual's System certification will be re-categorized or terminated.

An EMS provider requesting to re-certify in the Passavant EMS System will be required to repeat the process for initial certification.

Provider Status

Active Provider – A FR-D, EMT or PHRN is considered an active provider if he/she:

- Is System-certified at the level of his/her IDPH licensure level.
- Is active and functions at his/her certification level with a Passavant EMS System agency providing the same level of service.
- Maintains all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.

Sub-certified Provider – An EMT is considered to be a sub-certified provider if he/she:

- Is System-certified at a level other than his/her IDPH licensure level.
- Is active and functions as a provider with a Passavant EMS System agency at a level of service other than his/her IDPH licensure level.
- Maintains all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.

System Certification Policy

Provider Status

- RESTRICTIONS:
    - A sub-certified EMS provider may only function within the scope of practice of the individual's System certification and the provider level of the EMS agency.
    - A sub-certified EMS provider is **prohibited** from performing skills the individual is not *System-certified* to perform regardless of the IDPH licensure level.
    - A sub-certified provider is restricted to identifying himself/herself as a provider at his/her level of System certification when functioning with a Passavant EMS System agency (this includes uniform patches and name tags).
    - A sub-certified provider shall apply for *independent* re-licensure if System certifications are not met for the IDPH licensure level.

Inactive (Non-participating) Provider – An EMT is considered to be inactive if he/she:

- Was previously system-certified but has not functioned with a Passavant EMS System agency for greater than 90 days.
- Maintains IDPH continuing education requirements.
- RESTRICTIONS:
    - An inactive provider is **prohibited** from identifying himself/herself as an EMS provider in the Passavant EMS System.
    - An inactive provider is **prohibited** from performing skills or providing care that he/she is not System-certified to perform.
    - An inactive provider must apply for independent re-licensure with IDPH.

Re-Licensure Requirements Policy

Re-Licensure Process

1. To be re-licensed as an EMS provider, the licensee shall submit the required documentation for renewal with the Resource Hospital (EMS Office) at least **60 days** prior to the license expiration date. Failure to complete continuing education requirements and/or failure to submit the appropriate documentation to the EMS Office at least 60 days prior to the license expiration date may result in delay or denial of re-licensure. **The licensee will be responsible for any late fees or class fees incurred as a result.**

2. The EMS Office will review the re-licensure applicant's continuing education records. If the individual has met all requirements for re-licensure and approval is given by the EMS Medical Director, the EMS Office will submit a renewal request to IDPH.

3. A licensee who has not been recommended for re-licensure by the EMS Medical Director will be instructed to submit a request for independent renewal directly to IDPH. The EMS Office will assist the licensee in securing the appropriate renewal form.

4. IDPH requires the licensee to certify on the Renewal Notice (Child Support/Personal History Statement), **under penalty of perjury**, that he or she is not more than 30 days delinquent in complying with a child support order and previous felon status (Section 10-65(c) of the Illinois Administrative Procedure Act [5 ILCS 100/10-65(c)]). The provider's social security number must be provided as well.

5. The license of an EMS provider shall terminate on the day following the expiration date shown on the license. An EMS provider may **NOT** function in the Passavant EMS System until a copy of a *current* license is on file in the EMS Office.

6. An EMS provider whose license has expired may, **within 60 days after license expiration**, submit all re-licensure material and a fee of $50.00 in the form of a *certified check* or *money order* made payable to IDPH (Note: personal checks, cash or credit cards will NOT be accepted). If all continuing education and System requirements have been met and there is no disciplinary action pending against the EMS provider, the Department may re-license the EMS provider.

Re-Licensure Requirements Policy

Re-Licensure Process (continued)

7. Any EMS provider whose license has expired for a period of more than **60 days and less than 36 months** may be allowed to retest for their license renewal (written and skills test) after a review of the situation by the Medical Director and IDPH. This only applies to a State of Illinois license for EMT (Section 3.50(d)(5) of the Illinois Administrative Procedure Act [5 ILCS 100/3.5(d)(5)]).

   **NOTE: Failure to re-license at any level does not "automatically" drop a provider to a lower level of certification (e.g. An EMT does not automatically become a First Responder, etc.). Once a provider's license has expired, he or she is no longer an EMS provider at ANY level and cannot provide medical care in the System or the State.

8. Requests for extensions or inactive status must be submitted on the proper IDPH form and forwarded to the EMS Office at least 60 days prior to expiration. Extensions are granted only in very limited circumstances and are handled on a case by case basis. NOTE: The EMS Medical Director may mandate additional CEU requirements during the extension period.

9. At any time **prior to the expiration of the current license**, an EMT-I or EMT-P may revert to the EMT-B status for the remainder of the license period. The EMT-I or EMT-P must make this request in writing to the EMS Medical Director & the Department and must submit their original **current** EMT-I or EMT-P license to the Department. To re-license at the EMT-B level, the provider must meet all of the EMT-B requirements for re-licensure.

10. At any time **prior to the expiration of the current license**, an EMT-B may revert to the First Responder/Defibrillator (FR-D) status for the remainder of the license period. The EMT-B must make this request in writing to the EMS Medical Director & the Department and must submit their original **current** EMT-B license to the Department. To re-license at the FR-D level, the provider must meet all of the FR-D requirements for re-licensure.

11. The provider must submit a copy of their new IDPH license to their agency(s) and to the EMS Office. Failure to do so will result in ineligibility to function in the System.

Re-Licensure Requirements Policy

General Continuing Education Requirements

Passavant EMS System requires:

1. Twenty-five percent (25%) of the didactic continuing education hours required for re-licensure (as an EMS provider, at any level in the Passavant EMS System) must be earned through attendance at System-taught courses or System approved courses sponsored by the Passavant EMS Office or courses taught by a System-approved instructor.

2. No more than seventy-five percent (75%) of the continuing education hours required for re-licensure will consist of hours obtained from the same site code.

3. No more than twenty-five percent (25%) of the continuing education hours required for re-licensure will consist of any single subject area (*i.e.* shock, diabetic emergencies, etc.).

4. EMS providers (all levels) must attend at least one (1) continuing education program that reviews Passavant EMS System and Regional Policies, Standing Medical Orders and Operating Procedures as part of the four-year, 25% Passavant EMS System continuing education requirements. Such review will also be required with protocol updates.

5. No more than thirty hours (25%) of on-line CE will be accepted for re-licensure.

6. EMS continuing education credits must have an *approved* IDPH site code or be approved by the Passavant EMS Medical Director.

7. Continuing education credits approved for EMS Systems within IDPH EMS Region 3 will be accepted by the Passavant EMS System.

8. Prior approval must be obtained from the EMS Medical Director for continuing education programs from other IDPH regions or from other states, including national symposiums.

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

Emergency Medical Dispatcher (EMD)	A minimum of forty-eight (48) hours of continuing education that review the core EMD curriculum and includes review of Passavant EMS System protocols. The dispatch certification-training program recognized by the local Emergency Telephone System Board (ETSB) may have specific requirements for re-certification.
First Responder/Defibrillator (FR-D)	A minimum of twenty-four (24) hours of continuing education that review the core First Responder curriculum and includes review of Passavant EMS System protocols. Current CPR/AED certification {American Heart Association (AHA) Healthcare Provider or ARC Professional Rescuer CPR card} Functioning within a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director"

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

EMT-Basic (EMT-B)	A minimum of sixty (60) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses Passavant EMS System Protocols Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card} Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director" Must meet Passavant EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

EMT-Intermediate (EMT-I)	A minimum of eighty (80) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses Passavant EMS System Protocols Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card} Current certification in International Trauma Life Support (ITLS) or Prehospital Trauma Life Support (PHTLS). Current certification in Advanced Cardiac Life Support (ACLS) Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS) Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director" Must meet Passavant EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

EMT-Paramedic (EMT-P)	A minimum of one hundred (10 0) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses Passavant EMS System Protocols Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card} Current certification in International Trauma Life Support (ITLS) or Prehospital Trauma Life Support (PHTLS) Current certification in Advanced Cardiac Life Support (ACLS) Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS) Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director" Must meet Passavant EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

Prehospital RN (PHRN)	A minimum of one hundred twenty (120) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses Passavant EMS System Protocols Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card} Current certification in International Trauma Life Support (ITLS), Prehospital Trauma Life Support (PHTLS), Trauma Nurse Core Curriculum (TNCC) or Trauma Nurse Specialist (TNS) Current certification in Advanced Cardiac Life Support (ACLS) Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS) Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director" Must meet Passavant EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

Re-Licensure Requirements Policy

Summary of Re-licensure Requirements

Emergency Communications RN (ECRN)	A minimum of thirty-two (32) hours of continuing education, seminars and workshops addressing both adult & pediatric care and at least one (1) continuing education program which addresses Passavant EMS System Protocols Current CPR/AED certification {AHA Healthcare Provider or ARC Professional Rescuer CPR card} Current certification in International Trauma Life Support (ITLS), Prehospital Trauma Life Support (PHTLS), Trauma Nurse Specialist (TNS), or Trauma Nurse Core Curriculum (TNCC) Current certification in Advanced Cardiac Life Support (ACLS) Current certification in Pediatric Education for Prehospital Providers (PEPP) or Pediatric Advanced Life Support (PALS) Functioning with a "State approved EMS System providing the licensed level of life support services as verified by the Passavant EMS System Medical Director" Must meet Passavant EMS System certification (provider status) requirements to be recommended for re-licensure by the EMS Medical Director

EMS

Communications & Documentation

Off-Line Medical Control, Standing Medical Orders & Protocols Policy

The Prehospital Care Manual, as developed by the EMS Medical Director, reflects nationally recommended treatment modalities for providing patient care in the prehospital setting. This Prehospital Care Manual, containing Standing Medical Orders, Protocols, Policies & Procedures, is intended to establish the standard of care which is expected of the Passavant EMS System provider.

1. Standing Medical Orders, Protocols, Policies & Procedures contained in this Prehospital Care Manual are the written, established standard of care to be followed by all members of the Passavant EMS System for treatment of the acutely ill or injured patient.

2. The EMS provider will initiate patient care under these guidelines and contact Medical Control in a timely manner for consultation regarding treatment not specifically covered by standing orders, in addition to those protocols that specify on-line physician's order. Diligent effort must be made to contact Medical Control in a timely manner via cellular telemetry, landline phone or VHF MERCI radio. Delay or failure to contact Medical Control for required on-line orders is a quality assurance indicator.

3. These Standing Medical Orders will be utilized as Off-Line Medical Control under the following circumstances:

    - For conditions covered by this protocol manual.

    - In the event communication cannot be established or is disrupted between the Prehospital provider and Medical Control.

    - In the event that establishing communications would cause an inadvisable delay in care that would increase life threat to the patient.

    - In the event the Medical Control physician is not immediately available for communication.

    - In the event of a disaster situation, where an immediate action to preserve and save lives supersedes the need to communicate with hospital-based personnel, or where such communication is not required by the disaster protocol.

4. Inability to contact Medical Control should not delay patient transport or the provision of life-saving therapies. Patient destination and transport decisions are set forth in these Standing Medical Orders / Protocols.

On-Line Medical Control Policy

On-Line Medical Control

On-line Medical Control is designed to provide immediate medical direction and consultation to the Prehospital EMS provider in accordance with established patient treatment guidelines and policies in this manual.

On-line Medical Control is utilized to involve the expertise of an Emergency Department Physician in the treatment plans and decisions involving patient care in the Prehospital setting.

1. EMS communications requiring on-line contact with Medical Control shall be conducted using **cellular telemetry**.
2. Incoming telemetry calls will usually be answered by an Emergency Communications Registered Nurse (ECRN). The ECRN may request guidance from an Emergency Department Physician if orders or consultation are needed.
3. *Pre-hospital personnel in need of on-line Medical Control shall notify the ECRN the need to speak to the Emergency Department Physician at the initiation of the report.*
4. ***Passavant EMS agencies and providers will no longer be allowed to accept orders from any other hospital. All orders must come from Medical Control at Passavant.***
5. Use of **telemetry** is required for patient care requiring interventions beyond the *Routine BLS, ILS or ALS* standing medical orders. Situations requiring Medical Control contact include, but are not limited to:

    - Any time an order is specifically required for BLS, ILS or ALS medications as outlined in the protocol.
    - Any time orders are needed for certain defined *procedures*.
    - Any instance an EMS provider desires *physician involvement*.
    - Any situation that involves *bypassing* a closer hospital.
    - Anytime an EMS provider feels a *deferral* is warranted.
    - Anytime a Field Training Instructor (FTI) feels a student needs to further develop communication skills.
    - **When a pre-hospital 12-Lead EKG is acquired that shows wide-complex tachycardia or consultation is needed regarding an EKG**.
    - Circumstances involving a Death on Scene (DOS) or cases involving advanced directives (DNR et al).
    - High risk refusals (*see next page*).
    - *First Responder* low risk refusals (*see item #10 of this policy*).
    - Use of restraints (including handcuffs).
    - Trauma cases or potential trauma cases (based on mechanism of injury).

On-Line Medical Control Policy

On-Line Medical Control (Continued)

6. **"Telemetry" calls** include all medical complaints requiring Medical Control contact, refusals, traumas and consultations.

7. **"Trauma Traffic"** includes calls that are related to injuries or mechanisms of injury that meet (or potentially meet) *Minimum Trauma Field Triage Criteria* (see *Critical Trauma Procedure*). Trauma traffic **does not include refusals** (including accident refusals).

8. **"MERCI" calls** are made via MERCI radio and called directly to the receiving hospital (or in cases where telemetry communication is not possible and consult with a physician is necessary). MERCI communication is adequate for patient care that does not require interventions beyond *Routine BLS, ILS or ALS Care*. Specifically, patients that have received only oxygen, monitor, IV and/or medications without the need for additional orders or in cases where Medical Control contact is not required.

   - If MERCI traffic prevents contact with the receiving hospital, the Resource Hospital (Passavant Area Hospital) may be contacted for assistance in proper routing of communications.
   - If the receiving hospital deems that further care is necessary or requests additional interventions be performed, the EMS provider should contact Medical Control. Only Medical Control (ED Physician or ECRN) at the resource hospital (Passavant) may give orders.
   - If the receiving hospital requests discontinuation of treatment established by the prehospital provider, Medical Control contact should be established.

9. **High Risk Refusals** require Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High risk refusals involve cases where the patient's condition may warrant delivery of care in accordance with implied consent of the *Emergency Doctrine* or other statutory provision. **High risk refusals** include, but are not limited to:

   - Head injury (based on mechanism or signs & symptoms)
   - Presence of alcohol and/or drugs
   - Anytime medications are given and patient refuses transport
   - Significant mechanism of injury (e.g. rollover MVA)
   - Altered level of consciousness or impaired judgment
   - Minors (17 years old or younger, regardless of injury or illness)
   - Situations that involve bypassing a closer hospital
   - Paramedic initiated refusals (patient wants to be transported but the paramedic feels it is unnecessary).

On-Line Medical Control Policy

On-Line Medical Control (Continued)

10. **Low Risk Refusals** do not require Medical Control consultation (for BLS, ILS & ALS levels) if the prehospital provider determines that the patient meets the *Low Risk Criteria* and there is no doubt that the patient understands the risk of refusal. The patient cannot be impaired and must be able to consent to the refusal. Medical Control should be contacted if there are any concerns about the patient's ability to refuse. **Low risk** refusals may include:

    - Slow speed auto accidents with no intrusion into patient compartment, low mechanism of injury, and no patient injury beyond minor scrapes and bruises.
    - Fall from standing without other medical conditions and no extreme of age.
    - Isolated injuries not related to an auto accident or other significant mechanism of injury
    - False calls or "third party" calls where no illness, injury or mechanism of injury is apparent.
    - Lifting assistance or "public assist" calls (for which EMS is called for assistance in moving a patient from chair to bed, floor to bed, car to home, etc.). This assumes the EMS agency is routinely called to assist this patient, the patient is assessed to ensure there is no complaint or injury and there has been no significant change in the patient's condition. EMS crews must complete a patient care report indicating all assessment findings and assistance rendered.

11. **If the EMS provider has not been able to contact Medical Control** via cellular telemetry, telephone or MERCI radio, the EMS provider will initiate the appropriate protocol(s). Upon arrival at the receiving hospital, an incident report must be completed and forwarded to the EMS Office within 24 hours of the occurrence. This report should document all aspects of the run with specific details of the radio/communications failure and initiation of the Passavant EMS System *Standing Medical Orders and Standard Operating Procedures*.

12. First Responders may handle **low risk** refusals only (as defined above). **Under no circumstance should a First Responder take a *high risk* refusal**.

Radio Communications Protocol

Radio communications is a vital component of prehospital care. Information reported should be concise and provide an accurate description of the patient's condition as well as treatment rendered. Therefore, **a complete patient assessment and set of vital signs should be completed prior to contacting Medical Control or the receiving hospital.**

Regardless of the destination, **early** and **timely** notification of Medical Control or the receiving hospital is essential for prompt care to be delivered by all involved.

Components of the Patient Report

1. Unit identification
2. Destination & ETA
3. Age/sex
4. Chief complaint
5. Assessment (General appearance, degree of distress & level of consciousness)
6. Vital signs:
    - Blood pressure (**auscultated** *or palpated if unable to auscultate)
    - Pulse (rate, quality, regularity)
    - Respirations (rate, pattern, depth)
    - Pulse oximetry, if indicated
    - Pupils (size & reactivity)
    - Skin (color, temperature, moisture)
7. Pertinent physical examination findings
8. SAMPLE History
9. Treatment rendered and patient response to treatment

NOTE: Items listed in red should be transmitted without delay.

If Medical Control contact is necessary to obtain physician orders (where indicated by protocol), diligent attempts must be made to establish base station contact via:

1. Cellular telemetry (Medical Control) to 217-245-6813
2. Telephone landline direct (Emergency Department) to 217-479-5587
3. MERCI radio
4. Dispatch direct line to 217-243-6211

If unable to establish contact, then initiate protocol. If Medical Control contact is not necessary, contact the receiving hospital via MERCI.

Patient Right of Refusal Policy

A patient may refuse medical help and/or transportation. Once the patient has received treatment, he/she may refuse to be transported if he/she does not appear to be a threat to themselves or others. ***Any person refusing treatment must be informed of the risks of not receiving emergency medical care and/or transportation***. NOTE: Family members cannot refuse transportation of a patient to a hospital unless they can produce a copy of a *Durable Power of Attorney for Healthcare*.

Refusal Process

1. Assure an accurate patient assessment has been conducted to include the patient's chief complaint, history, objective findings and the patient's ability to make **sound** decisions.

2. Explain to the patient the risk associated with his/her decision to refuse treatment and transportation.

3. Secure Medical Control approval of **high risk refusals** (low risk refusals for First Responders) in accordance with the *Online Medical Control Policy*.

4. Complete the *Against Medical Advice/Refusal Form* and have the patient sign the form. If the patient is a minor, this form should be signed by a legal guardian or *Durable Power of Attorney for Healthcare*. **NOTE**: Parental refusals may be accepted by voice contact with the parent (i.e. by telephone) if the EMS provider has made reasonable effort to confirm the identity of the parent and the form may be signed by an adult witness on scene. This should be clearly documented on the refusal form and in the patient care report.

5. If available, it is preferable to have a police officer at the scene act as the witness. If a police officer is not present, any other bystander may act as a witness. However, his/her name, address & telephone number should be obtained and documented.

6. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and refuses to sign the release, clearly document the patient's refusal to sign the report. Also, have the entire crew witness the statement and have an additional witness sign your statement, preferably a police officer. Include the officer's badge number and contact Medical Control.

7. The top (white) original of the *AMA/Refusal Form* is maintained by the agency securing the refusal. The **yellow** copy is forwarded to the EMS Office with the appropriate copies of the patient care report. The patient is provided with the **pink** copy of the *AMA/Refusal Form*.

Date _____ **PASSAVANT EMS SYSTEM - PATIENT REFUSAL FORM** IL Run Record # _____

Unit ID # _____ Vehicle Lic # _____ Amb Svc / Agency _____ ☐ ALS ☐ ILS ☐ BLS ☐ FR

Location of Call _____ ☐ Trans ☐ Non-trans

TIME INFORMATION (24 HOUR)

_____ Call received
_____ Dispatched
_____ Enroute
_____ Minutes - dispatched to enroute
_____ Arrive at scene
_____ # Minutes - enroute to at scene
_____ Depart scene
_____ # Minutes - Time on scene
_____ Arrive at destination
_____ # Minutes - transport

NATURE OF CALL

☐ Cardiac Arrest ☐ DOA
☐ Trauma ☐ DNR/Adv Dir
☐ Medical ☐ Hosp to Hosp
☐ Other: _____

HOW WAS TX ORDERED

	TX PROT	MED CON	OTHER
IV	☐	☐	☐
MEDS	☐	☐	☐
ETT	☐	☐	☐

Patient name (Last, First, MI)

Home address

City State Zip

Phone number ( ) Social Security #

Patient's weight _____

Age Sex DOB

PATIENT STATUS

Patient complaint: _____

Past Medical History: _____

SKIN MOIST
☐ Normal
☐ Dry
☐ Diaphoretic

SKIN COLOR
☐ Normal
☐ Cyanotic
☐ Pale/ashen
☐ Flushed

SKIN TEMP
☐ Normal
☐ Hot
☐ Cool
☐ Cold

PUPILS
☐ Equal / reactive

LEFT	RIGHT
☐ Dilated	☐ Dilated
☐ Constrict	☐ Constrict
☐ Non-Reac	☐ Non-Reac

IMMOBILIZATION ASSM'T PULSE / MOTOR / SENSORY

BEFORE		AFTER
☐	Present	☐
☐	Absent	☐

ABDOMEN
☐ Soft
☐ Tight/rigid
☐ Distended
☐ Tender

LEVEL OF CONSCIOUSNESS
☐ Conscious / alert
☐ Responds verbal
☐ Responds pain
☐ Unconscious

LUNG SOUNDS

L		R
☐	Clear	☐
☐	Diminished	☐
☐	Rales	☐
☐	Rhonchi	☐
☐	Wheezes	☐

ALLERGIES NKA ☐

MEDS PATIENT NOW TAKING:

VITALS

TIME	B/P	P	R	POX	INIT

ECG RHYTHM

TIME	RHYTHM/DEFIB	INIT

ACKNOWLEDGEMENT AND RELEASE OF LIABILITY FOR ALL HEALTHCARE PROVIDERS

I, _____, hereby acknowledge and release the above mentioned emergency service provider and its emergency personnel, Passavant Area Hospital, and all EMS System physicians, nurses, agents, and personnel of any liability for my refusal not to accept further treatment. I acknowledge that I have been advised of and understand the risks of not accepting Emergency Treatment and/or Transportation to the nearest hospital facility, which I am refusing. I have been advised as follows:

- That I should receive emergency medical treatment and transportation to a hospital facility, which I am refusing.
- That having received emergency medical treatment, I am refusing further aid or transport to a medical facility.
- I am refusing all medical assessment, treatment and transport.
- That my failure to seek treatment and transport could result in permanent injury, impairment, disability and could lead to death.
- I certify that I have the ability to understand and appreciate the consequences of making decisions regarding medical treatment and the ability to reach an informed decision.

Signature of Patient / Person Authorizing Refusal Date Time

Witness Date Time

Printed Name Date Time

Witness Date Time

REFUSAL TO SIGN RELEASE STATEMENT

The above patient was informed and read the above release from medical responsibility clause and was asked to sign due to his/her refusal of Emergency Medical Services. The above patient was informed of the risks of not receiving Emergency Medical Assessment, Treatment and/or Transportation to the nearest medical facility, and still slated his/her refusal to sign the above. The above-described patient has the ability to understand and appreciate the consequences of making decisions regarding medical treatment and the ability to reach an informed decision and sufficient understanding to make responsible decisions concerning the medical care of his/her person.

Witness Date/time

Witness Date/time

ADDITIONAL ASSESSMENT AND TREATMENT: _____

RESPONSE TO CARE: ☐ Condition improved ☐ No change ☐ Deteriorated

ASSISTANCE AT SCENE
☐ Police Dept. ☐ BLS/ILS ☐ Other: _____
☐ Fire Dept. ☐ First resp ☐ ALS

ROAD COND: ☐ Dry ☐ Wet ☐ Snow ☐ Ice ☐ Fog

TRAFFIC COND: ☐ Light ☐ Med ☐ Heavy ☐ Train

RECEIVING HOSPITAL: _____
The above patient was transferred to my care at _____
Signature/Title: _____ Date: _____ Time: _____

CREW SIGNATURES:
1. _____ IL # _____
2. _____ IL # _____
3. _____ IL # _____
4. _____ IL # _____

EMS-20 4/14

White Copy, *PROVIDER;* Yellow Copy, *RESOURCE HOSPITAL;* Pink Copy, *PATIENT*

Page 1 of 1

Incident Reporting Policy

Prehospital care providers shall complete a Passavant EMS System (or the individual agency) *Incident Report Form* whenever a System related issue occurs. In order to properly assess the situation and determine a solution to the issue, the following information needs to be provided on the form:

1. Date of occurrence
2. Time the incident occurred
3. Location of the incident
4. Description of the events
5. Personnel involved
6. Agency and/or institution involved
7. Copy of the patient care record and/or any other related documents

Incident Report Process

1. All incident report forms shall be given to the EMS provider's immediate supervisor, training officer, or quality assurance coordinator who will assess the incident and will forward the report to the Passavant EMS System Coordinator.

2. The EMS System Coordinator will review the incident and notify the EMS Medical Director and the appropriate course of action will be determined.

3. The EMS provider originating the report will be notified of the resolution.

Incident Report Indicators

Situations requiring EMS Office notification include: (see attached form)

- "Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or the System."
- Any deviation from Passavant EMS System policies, procedures or protocols.
- **Medication errors**
- **Treatment errors**
- Delays in patient care or scene response
- Operating on protocol when Medical Control contact was indicated but unavailable
- Violence toward EMS providers that results in injury or prevents the provider from delivering appropriate patient care
- Equipment failure (e.g. cardiac monitor, glucometer)

Incident Reporting Policy

Incident Report Indicators (continued)

- Inappropriate Medical Control orders
- Repeated concerns/conflicts between agencies, provider/physician or provider/hospital conflicts
- Patterns of job performance that indicate skill decay or knowledge deficiencies affecting patient care

Situations subject to review and resolution at the agency level include:

- Conflicts between employees
- Conflicts between agencies (that do not impact patient care)
- Operational errors (that do not impact patient care)
- Behavioral issues (that do not impact patient care)

Passavant AREA HOSPITAL EMS

Unusual Occurrence/ Incident Report

Patient Name or MRN	Equipment Involved	Event Date	Event Time	Report Date	Report Time	Incident Location

Dispatch Info	Additional Agencies/ Departments/ Units Involved

Description of Unusual Occurrence or Incident

Agency Printed name Signature

Possible way in which situation could have been avoided

Witness: ☐Completing Additional Report	Witness: ☐Completing Additional Report	Witness: ☐Completing Additional Report

EMS Office Date Report Received:	Initial Actions Taken by EMS Office
☐Follow-Up Needed Completed by:	

Additional Notes ☐ EMS Medical Director ☐ Other:

This is not part of the EMS Patient Record

EMS-47 4/14

EMS Patient Care Reports Policy

Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. **It is imperative that written documentation is left with the patient at the receiving facility**.

Patient Care Reports

1. All EMS providers/agencies involved must complete a patient care report for each patient contact or *request* for response (*e.g.* agency is cancelled en route to a call then a "cancelled call" chart must be completed).

2. Ideally, a patient care report will be completed in its entirety and provided to the receiving hospital's Emergency Department immediately after transferring care to the ED staff and **prior to** departing the hospital.

3. If the Patient Care Reports (PCR) cannot be completed prior to departing the ED, then a Passavant EMS System provider must ensure that the receiving nurse assumes care and has been given verbal report of all patient care rendered by the EMS provider. The patient care report should then be completed and faxed to the ED as soon as possible after the call (within the shift).

4. Documentation must be completed on System approved forms and/or System approved electronic reporting systems.

5. Failure to leave written documentation will be reported to the EMS Office by ED personnel. Agencies and/or personnel failing to comply with documentation requirements will be reported to the EMS Medical Director and corrective action may be taken to assure documentation policies and procedures are followed.

6. Non-transport agencies must complete patient care documentation immediately following the call**.**

7. Copies of all patient care reports must be provided to the EMS Office.

Patient Confidentiality & Release of Information Policy

All Passavant EMS System personnel are exposed to or engaged in the collection, handling, documentation or distribution of patient information. Therefore, all EMS personnel are responsible for the protection of this information.

Unnecessary sharing of confidential information will not be tolerated. EMS personnel must understand that breach of confidentiality is a serious issue that carries legal implications due to laws governing privacy (HIPAA). Corrective action **will** be taken including System suspension or termination.

Confidential Information Guidelines

1. **Written and Electronic Documentation**

   a) Confidentiality is governed by the "*need to know*" concept.

   b) Only Passavant EMS System personnel and hospital medical staff **directly involved** in a patient's care or personnel involved in the quality assurance process are allowed access to the patient's medical records and reports. Authorized medical records and billing personnel are allowed access to the patient's medical records and reports in accordance with hospital and EMS provider policies.

   c) Requests for release of patient care related information (from third party payers, law enforcement personnel, the coroner, fire department or other agencies) should be directed to the EMS agency's medical records department.

2. **Verbal Reports**

   a) Passavant EMS System personnel are **not** to discuss any specific patient information in public areas.

   b) EMS providers should not discuss any confidential information regarding patient care with friends and relatives or friends and relatives of the patient. This includes hospitalization of a patient and/or the patient's condition.

   c) Information gained from chart or case reviews for the purpose of education, research, quality improvement or quality assurance is considered confidential.

Patient Confidentiality & Release of Information Policy

Confidential Information Guidelines (continued)

3. **Radio Communications**

   a) No patient name will be mentioned in the process of prehospital radio transmissions utilizing MERCI radio.

   b) Customarily, when calling in a "direct admit" the patient's initials can be included in the radio report. This is necessary for identification and is acceptable to transmit.

   c) Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.

4. **Communication at the Scene**

   a) Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and en route.

   b) EMS personnel should limit bystanders at the scene of an emergency. Law enforcement personnel may be called upon to assist in maintaining bystanders at a reasonable distance.

GENERAL PATIENT ASSESMENT & MANAGEMENT/

EMS OPERATIONS

Patient Destination Policy

Patients should be transported to the closest appropriate hospital. A patient (or the patient's *Power of Attorney for Healthcare*) does have the right to make an informed decision to be transported to a hospital of choice. This decision should be respected unless the risk of transporting to a more distant hospital outweighs the medical benefits of transporting to the closest hospital. *A trauma patient may benefit from transport directly to the closest appropriate **Trauma Center** rather than the closest geographically located hospital*.

Patient Hospital Preference Guidelines

Bypassing the nearest hospital to respect the patient's hospital choice is a decision based on medical benefits and associated risks and should be made in accordance with:

1. Urgency of care and risk factors based on:
    - Mechanism of injury (physiologic factors)
    - Perfusion status and assessment findings (anatomical factors)
    - Transport distance and time (environmental factors)
2. Medical Control consultation
3. Capacity of the nearest facility or facility of choice
4. Available resources of the transporting agency
5. Traffic and weather conditions

The patient's hospital preference may be honored if:

- There are no identifiable risk factors.
- The patient has a secure airway.
- The patient is hemodynamically stable.
- The patient has been advised of the closer hospital.
- Medical Control approves.

The EMS provider will explain the benefits versus the risks of transport to a more distant hospital and contact Medical Control for approval. The patient (or representative) must sign a Passavant EMS System *AMA/Refusal Form* documenting that the patient understands the risks. **No transporting service shall bypass a hospital in order to meet an ALS intercept unless approved by Medical Control**.

Patient Destination Policy

Trauma Patient Guidelines

All **trauma patients** fall under the American College of Surgeons *Field Triage Decision Scheme*. Any trauma patient who meets the ACS Field Triage Guidelines shall be transported to the Level 1 Trauma Center unless otherwise directed by Medical Control.

- If a patient is unconscious and meets ACS Field Triage guidelines for trauma, the patient will be taken to the highest level trauma center available.
- If a patient has an altered level of consciousness and meets ACS Field Triage guidelines for trauma, the patient will be taken to the highest level trauma center available.
- If a patient is alert and oriented to person, place & time with stable vital signs, and does not meet potential trauma criteria based on mechanism of injury the patient may be taken to the hospital of his/her choice in accordance with *Patient Hospital Preference Guidelines*.
- If a family member or any other person is at the scene of an emergency and can readily prove Durable Power of Attorney for Healthcare, he/she can request that the patient be transported to a specific hospital in accordance with Patient Hospital Preference Guidelines.
- If a parent requests that a child (less than 18 years of age) who meets ACS Field Triage guidelines be taken to a specific hospital, Medical Control must be contacted for the final decision.

Transfer and Termination of Patient Care Policy

Patient abandonment occurs when there is termination of the caregiver/patient relationship without consent of the patient and without allowing sufficient time and resources for the patient to find equivalent care. This is assuming, and unless proven otherwise, there exists a need for continuing medical care and the patient is accepting the treatment.

EMS personnel must not leave or terminate care of a patient if a need exists for continuing medical care that must be provided by a knowledgeable, skilled and licensed EMS provider **unless** one or more of the following conditions exist:

1. Appropriate receiving hospital personnel assume medical care and responsibility for the patient.
2. The patient or legal guardian refuses EMS care and transportation (In this instance, follow the procedure as outlined in the *Patient Right of Refusal Policy*).
3. EMS personnel are physically unable to continue care of the patient due to exhaustion or injury.
4. When law enforcement personnel, fire officials or the EMS crew determine the scene to be unsafe and immediate threat to life or injury hazards exist.
5. The patient has been determined to be dead and all policies and procedures related to death cases have been followed.
6. If Medical Control concurs with a DNR order.
7. Whenever specifically requested to leave the scene due to an overbearing need (*e.g.* disasters, triage prioritization).
8. Medical care and responsibility for the patient is assumed by comparably trained, certified and licensed personnel in accordance with applicable policies.

If EMS personnel arrive on scene, establish contact and evaluate a patient who then refuses care, the EMS crew shall conduct termination of the patient contact in accordance with the *Patient Right of Refusal Policy* and *On-Line Medical Control Policy*.

EMS personnel may leave the scene of an illness or injury incident, where initial care has been provided to the patient and the **only** responsibility remaining for the EMS crew is transportation of the patient or securing a signed refusal, if the following conditions exist:

1. Delay in transportation of another patient (i.e. trauma patient) from the same incident would threaten life or limb.

2. An occurrence of a more serious nature elsewhere necessitates life-saving intervention that could be provided by the EMS crew (and without consequence to the original patient).

3. More appropriate or prudent transportation is available.

Transfer and Termination of Patient Care Policy

4. Definitive arrangement for the transfer of care and transportation of the initial patient to other appropriate EMS personnel must be made prior to the departure of the EMS crew. The alternate arrangements should, in no way, jeopardize the well-being of the initial patient.

During the transport of a patient by ambulance, should the EMS crew come across a separate emergency or incident requiring ambulance assistance; the local EMS system will be activated. Crews involved in the treatment and transportation of an emergency patient are not to stop and render care. The priority is to the patient onboard the ambulance.

In the event you are transporting the patient with more than two (2) appropriately trained prehospital personnel, you may elect to leave one medical attendant at the scene to render care and the other personnel will continue to transport the patient to the receiving facility.

In the event there is not a patient onboard the ambulance and an emergency situation is encountered requiring ambulance assistance; the crew may stop and render care. However, the local EMS agency should be activated and their jurisdiction respected.

Transition of Care Policy

A smooth transition of care between EMS providers is essential for optimum patient care. First Responder and BLS non-transport crews routinely transfer care to transporting EMS providers. The transfer of advanced procedures presents unique concerns for both the EMS provider relinquishing patient care as well as the EMS provider assuming patient care. A smooth transition between providers is essential for good patient care. Cooperation between all EMS personnel is encouraged and expected.

Patient Care Transition Procedure

1. EMS providers arriving at the scene of a call shall initiate care in accordance with the guidelines provided in this manual. The EMS provider must maintain a constant awareness as to what would be the best course of action for optimum and compassionate patient care. *Focus should be placed on conducting a thorough patient assessment and providing adequate BLS care*. The benefit of remaining on scene to establish specific treatments versus prompt transport to a definitive care facility should be a consideration of each patient contact.
2. Once on scene, the EMS transporting agency shall, in conjunction with Medical Control, be the on-scene authority having jurisdiction in the determination of the patient care plan. The rank or seniority of a *non-transport provider* shall not supersede the authority vested in the transporting EMS provider by the EMS Medical Director.
3. Upon the arrival of the transporting agency, the non-transport provider should provide a detailed verbal report to the transporting provider and then **immediately transfer care to the transporting provider**. The non-transport provider may continue the establishment of BLS/ILS/ALS procedures with the concurrence of the transporting provider.
4. The transport provider should obtain report from the non-transport provider and conduct a thorough patient assessment. Treatment initiated by the non-transport provider should be taken into consideration in determining subsequent patient care steps.
5. If the provider has initiated advanced procedures, then the transport provider should verify the integrity of the procedure prior to utilizing it for further treatment (*e.g.* verify patency of peripheral IVs and ETTs should be checked for proper placement). *Transporting crews shall not arbitrarily avoid the use of (or discontinue) an advanced procedure established by non-transport personnel*. Rationale for discontinuing an established procedure should be documented on the patient care report.

6. Properly licensed and System-certified providers may be utilized to establish ILS/ALS procedures with the concurrence of the transporting provider. EMS personnel are encouraged to use all responders for efficiency in coordinating patient care.

Intercept Policy

When a patient's condition warrants the highest level of available care, in-field service level upgrades shall be utilized to optimize patient care. "*In-field service level upgrades*" as referred to in this policy implies services above the level of care provided by the initial responding agency. If a patient's condition warrants a higher level of care and an advanced level is available, then the more advanced agency will be called for immediate assistance. Conditions warranting advanced assistance include:

- Trauma patients entrapped with extrication required.
- Patients with compromised or obstructed airways.
- Full arrests.
- Patients exhibiting signs of hypoxemia (*e.g.* respiratory distress, restlessness, cyanosis) unrelieved by oxygen.
- Patients with altered mental status/altered level of consciousness.
- Chest pain of cardiac nature unresolved with rest, oxygen and/or nitroglycerin.
- Patients exhibiting signs of decompensated shock (BP<100mmHg, pallor, diaphoresis, altered LOC, tachypnea).
- Unconscious or unresponsive patients (other than a behavioral episode).
- Any case in which the responding agency or Medical Control deems that advanced care would be beneficial to patient outcome.
- Pediatric cases with any of the conditions listed above.

If the primary response area is covered by any combination of BLS, ILS or ALS, the highest level of service available shall be utilized for any patient whose condition warrants advanced level care. ILS may be utilized if, and only if ALS is unavailable.

When determining the need for advanced assistance, consideration should be given to the following:

- Transport time to the hospital – Units with less than a 10 minute transport time to the hospital may complete transport without an intercept.
- **Early activation** - Diligent efforts should be made to request an intercept as early as possible. This could include simultaneous dispatch of an advanced unit to the scene of the emergency.
- Rendezvous site – Intercepts should be done in a safe area, away from traffic.
- Availability of resources – Units used for intercept should be in direct travel to the receiving hospital. Transportation shall not be delayed due to an intercept not being available. Patients should not be transported via a longer route in order to obtain an intercept.
- Decisions for or against requesting an intercept should be in the best interest of the patient based on his/her *current* medical condition, not past medical history.

Intercept Policy

Regardless of the response jurisdiction, if two (2) different agencies with different levels of care are dispatched to and arrive on the scene of an emergency, *the agency with the highest certification level shall assume control of the patient*.

Safety will be emphasized throughout the intercept and during the transfer of care. Intercepts should not take place on heavily traveled roadways if at all possible. Rendezvous sites should be predetermined by operating procedures or unit-to-radio contact. Sites that should be considered include parking lots, safe shoulders or on side streets.

The following guidelines also apply:

- Pertinent patient information should be transmitted to the intercepting personnel prior to rendezvous (*i.e.* nature of the problem, vitals).
- It is recommended that patients not be transferred from ambulance-to-ambulance. The higher-level personnel, along with proper portable equipment, shall board the requesting agency's ambulance. Exceptions to this need to be documented by the higher level agency along with the rationale for the transfer. If the patient is to be transferred, patient safety must be ensured taking into consideration weather, traffic, patient privacy, patient stability and ability to care for all potential patient needs.
- The higher level personnel will oversee patient care with the assistance of the requesting agency's personnel.
- Once the higher level personnel have boarded the requesting agency's ambulance, the higher level provider will determine the transport code for the remainder of transport:

    - Code 1 (Signal 1) = Emergency transport with lights and sirens in operation.
    - Code 2 (Signal 2) = Transport without lights and sirens and obeying all normal traffic laws.

NOTE: Transport should never be done using lights only or sirens only (follow the "*all or nothing*" rule).

Coroner Notification Policy

In accordance with Section 10.6, Chapter 31 of the Illinois Revised Statutes – Coroners:

1. Every law enforcement official, funeral director, **ambulance attendant**, hospital director of administration or person having custody of the body of a deceased person, where the death is one subjected to investigation under Section 10 of this Act, and any physician in attendance upon such a decedent at the time of his death, shall notify the coroner promptly. Any such person failing to notify the coroner promptly shall be guilty of a Class A misdemeanor, unless such person has reasonable cause to believe that the coroner had already been notified.

2. Deaths that are subject to coroner investigation include:

    - Accidental deaths of any type or cause
    - Homicidal deaths
    - Suicidal deaths
    - Abortions – criminal or self-induced maternal or fetal deaths
    - Sudden deaths – when in apparent good health or in any suspicious or unusual manner including sudden death on the street, at home, in a public place, at a place of employment, or any deaths under unknown circumstances may ultimately be the subject of investigation.

3. The coroner (or his/her designee) should be provided the following information:

    - Your name
    - Your EMS service
    - Location of the body or death
    - Phone number and/or radio frequency you are available on
    - Brief explanation of the situation

4. Once this information has been provided, wait for the coroner (or his/her designee) to arrive for further instructions. EMS crews may clear the scene if law enforcement is on the scene and no other emergency exists.

5. Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified.

6. If a patient is determined to be dead during transport, note the time & location and record this information on the patient care report. Immediately contact the coroner to discuss death jurisdiction. **Do not cross county lines with a patient that has been determined to be dead.**

Reporting and Control of Suspected Crime Scenes Policy

EMS providers should be aware of law enforcement's concern for preserving, collecting and using evidence. Anything at the scene may provide clues and evidence for the police.

1. Immediately notify law enforcement of any suspected crime scene (this does not necessarily include petty crimes or traffic violations).

2. If the victim is obviously dead, then he or she should remain undisturbed if at all possible.

3. Do not touch, move or relocate any item at the scene unless absolutely necessary to provide treatment to an injured, viable victim. Mark the location of any item that must be moved so the police can determine its original position.

4. Restrict access to the scene of onlookers or other unauthorized personnel on the premises of the crime.

5. Observe and note anything unusual (*e.g.* smoke, odors, or weapons), especially if the evidence may not be present when law enforcement arrives.

6. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt care to the patient. Remember that your role is to provide emergency care, not law enforcement.

7. Keep detailed records of the incident, including your observations of the victim and the scene of the crime. Lack of records about the case can be professionally embarrassing if called to testify.

Physician (or Other Medical Professional) On Scene Policy

Only personnel licensed to perform care in the prehospital setting and certified in the Passavant EMS System are allowed to provide advanced patient care (*e.g.* intubation, IV access, medication administration, pacing, etc.) at the scene unless approved by Medical Control.

An on-scene physician (or other medical professional) does **not** automatically supersede the EMS provider's authority. Patient care shall not be relinquished to another person or provider unless approved by the EMS Medical Director or Medical Control.

1. If a professed, duly licensed medical professional (*e.g.* physician, nurse, or dentist) wishes to participate in and/or direct patient care on scene, the EMS provider should contact Medical Control and inform the base station physician of the situation.

2. If the medical professional on scene (including the patient's primary care physician) has properly identified himself/herself and wishes to direct patient care, approval must be granted by the Medical Control Physician prior to EMS personnel carrying out the on-scene medical professional's requests or orders. If care is relinquished to the professional on scene, he/she **must** accompany the patient to the hospital. This procedure should be explained to the provider prior to contacting Medical Control.

3. If an on-scene physician orders procedures or treatments that the EMS provider believes to be unreasonable, medically inaccurate, and/or outside the EMS provider's standard of care, the EMT should refuse to follow such orders and re-establish contact with Medical Control. In all circumstances, the EMS provider shall avoid any order or procedure that would be harmful to the patient.

4. If an on-scene medical professional (or any person *claiming* to be a healthcare provider) is obstructing EMS efforts or is substantially compromising patient care, the EMS provider should redirect the interfering person, request law enforcement assistance and communicate the situation to Medical Control.

5. If EMS personnel or nursing staff from another system or jurisdiction (other than a requested intercept or mutual aid) are at the scene and request to provide or assist with patient care, excuse them from the scene if their assistance is not needed. If assistance is needed, these personnel may provide assistance with the supervision of the agency having jurisdiction of the scene. Passavant EMS System policies, procedures and protocols must be followed regardless of the assisting EMS personnel's authorized level of care.

Region 3 School Bus Policy

Incidents involving school buses pose unique challenges to the EMS provider in assuring proper release of uninjured children. Once Medical Control confirms that the minor children are not injured, the custody and responsibility for these children will remain with the responding EMS provider until the children are transferred to parents, legal guardians, school officials or the hospital. If no procedure exists to have children transferred to a parent, legal guardian or school official, then these children will need to be transported to the hospital.

On arrival at the scene, EMS personnel shall determine the category of the incident and request appropriate resources. EMS must also accomplish a complete assessment of the scene to include at least:

1. Mechanism of injury
2. Number of patients
3. Damage to the vehicle
4. Triage as outlined in the System Plan

Once this has been accomplished, then the patients may be assigned to one of the following categories:

CATEGORY A: Significant mechanism of injury (*i.e.* rollover, high-speed impact, intrusion into the bus, etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have significant injuries or significant injury is present in one or more children. *All children in this category must be transferred to an appropriate hospital unless a Passavant EMS System refusal form is signed by a parent or legal guardian*.

CATEGORY B: Suspicious mechanism of injury (*i.e.* speed of impact, some intrusion into the bus, etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have minor injuries or minor injury in one or more children exists <u>with no obvious mechanism of injury that could reasonably be expected to cause significant injuries</u>. *EMS personnel must complete the EMS Multiple Casualty Release Form and secure a signature of an appropriate school official*.

CATEGORY C: No obvious mechanism of injury – school bus occupancy indicates no injuries may be present and that the release of uninjured children may be the only EMS need. No injuries are found to be present in any of the children. *EMS personnel must complete the EMS Multiple Casualty Release Form and secure a signature of an appropriate school official*.

CATEGORY D: If the pediatric patient(s) have special healthcare needs and/or communication difficulties, then all of these patients must be transported to the hospital for evaluation unless approval for release is received from Medical Control or a parent/legal guardian has signed the approved refusal form.

Region 3 School Bus Policy

1. After determining the category of the incident, EMS personnel shall determine the extent of EMS involvement and **contact Medical Control**.

2. Adults, victims 18 years and older, and occupants of other vehicles will be treated or released in accordance with routine System operating procedures.

3. If Medical Control has approved usage of this policy/plan, then each provider will implement their procedure for contacting parents, legal guardians or appropriate school officials to receive custody of uninjured children.

4. The approved system *Multiple Casualty Release Form* for school bus incidents must be utilized for all children who will not be transported.

5. Each child transported must have a completed run report.

6. One run report indicating the nature of the incident, etc. shall be completed and must include all information regarding the incident including the number of patients released. Keep a copy of this report with the release form or with refusal forms signed by the parents.

7. A parent, legal guardian or appropriate school official must be given a copy of the refusal/release form.

8. Any parent or legal guardian who arrives on scene to remove and assume responsibility for their child will be requested to sign an individual refusal form.

9. EMS providers shall use reasonable means to contact the parents or school officials. This could include use of telephone, cellular phone or direct contact by law enforcement. If contacted by phone, EMS providers shall take reasonable means to confirm the identity and authority of the parent, legal guardian or school official.

10. Once the identity and authority of the parent, legal guardian or school official has been established, the EMS provider may release the child to that individual or alternate transport source. School officials will follow their established program for informing parents or legal guardians regarding the incident.

11. <u>The health and safety of the child is the primary concern</u>. It is the responsibility of the EMS provider to assure that the child is returned to the parent or placed on the school's alternate transport vehicle. If the EMS provider on scene determines a child should receive a physician evaluation or be offered medical care, the child **will be transported** to the hospital unless a parent or legal guardian is on scene and consents to refusal.

Region 3 School Bus Policy

12. Each prehospital agency in the Passavant EMS System who may likely respond to a school bus incident must contact the school superintendents in their district to obtain the name and title of the "appropriate school official" who may take responsibility for the child on the bus involved in the incident.

13. Copies of documentation must be forwarded to the EMS Office for review within 24 hours of utilization of this policy.

School Bus Incident Form/ EMS Multiple Casualty Release Form

All individuals on the bus age 18 and older should sign in the indicated space adjacent to their name when uninjured. Parent/legal guardian should sign in the indicated space adjacent to their child's name when the child is uninjured. Signature indicates agreement that no injury has been suffered and no transportation is required to the hospital.

Date:	Location:	School District:		Bus Number
Time of incident:	Department Alarm/ Run Number	Total Patients	Total transported	Total Refused

Adult Name	**Function/Role**	**Address & Phone Number**	**Signature**

Child/ Student Name	**Age/ Birth Date**	**Address & Phone Number**	**Signature of ≥18 Parent or Guardian**

The children/students listed above have been determined to be uninjured. Medical control has been contacted and approved release to the custody of school officials (parent/ guardian) or to self if age ≥ 18.

_____ _____
Name of EMS Provider Name of School Authorized Representative

_____ _____
EMS Signature Date School Representative Signature Date

Notice of Emergency Medical Services Response to a Minor

Date:

From (Agency & Phone Contact):

Child's Name:

Members of our Emergency Medical Services agency were called to evaluate your son/ daughter/ ward today as a result of a bus collision/incident.

After responding to the above incident, we evaluated your child. Based on our assessment and statements made by the child, it was determined that he or she did not require emergency care and/or transportation to an emergency department at that time.

Whereas your child is a minor, it is our duty to inform you of this incident so that an informed decision can be made as to whether follow-up evaluation with a physician is desired.

The child was released to a designated school representative who accepted further responsibility for him or her.

If you desire additional information, please contact our agency at the above phone number.

WELL-BEING OF THE EMS PROVIDER

Infectious Disease Control Policy

The following procedure has been established in accordance with the Illinois State Statutes, Centers for Disease Control recommendations and OSHA standards. All Passavant EMS System agencies should have a specific exposure control program and post exposure plan.

Protective Measures

1. The use standard precautions in all patient contacts are an effective means of avoiding exposure to body fluids. Prehospital responders should don protective gear prior to entering a scene or situation that may increase the risk of exposure to body fluids or other infectious agents.

2. Perform hand hygiene, prior to and following patient contact at a minimum, regardless of the use of gloves or other barriers. Proper hand hygiene is one of the most effective infection control measures for prehospital personnel. Hand hygiene can be performed with soap and water or waterless hand sanitizer.

3. EMS personnel should consult their agency's exposure control program for specific guidelines in the type of protective gear to be worn.

Exposure

Bloodborne Pathogen Exposure is defined as a:

1. Contaminated needle or sharp instrument break through the skin.
2. Blood/body fluids splash into mucous membrane including mouth, nose, or eye.
3. Blood/body fluid splash to non-intact skin.

Communicable Disease Exposure is defined as:

1. Unprotected exposure to any of the diseases listed under Notification of Ambulance Personnel Exposed to Communicable Disease.

Post Exposure Management

If a potential bloodborne pathogen exposure incident occurs the emergency service responder should:

1. Thoroughly cleanse the exposed area with soap and water, if possible or waterless hand sanitizer immediately.

2. If exposed, the eyes and/or mouth of the emergency service responder should be thoroughly rinsed with water.

Infectious Disease Control Policy

3. Emergency service responder should immediately seek treatment at the emergency department where the source patient was transported. If the source patient was not transported to an emergency department, treatment should be sought at a local hospital's emergency department.

4. Upon notification from emergency service responder that an exposure occurred in the prehospital setting prior to or during transport to Passavant Hospital, the Emergency Department physician will provide the initial assessment of the exposure, testing and prophylaxis, if needed. Follow-up care and counseling of the exposed emergency service responders shall be the responsibility of the provider agency.

5. If the Emergency Department physician determines a bloodborne pathogen exposure has occurred, appropriate testing will be completed on the source patient, if possible.

6. If the emergency service responders delay reporting the potential exposure, it will be the responsibility of the employing provider agency to obtain medical evaluation as outlined in their exposure control plan and procedure.

7. Source patient testing results will be communicated to the individual designated in the employing provider agency's plan.

8. Emergency service responder is responsible to complete the *Prehospital Responders Exposure Notifications* form. The completed form should be sealed in an envelope and addressed with the words "Attention EMS Coordinator" and leave with the emergency department charge nurse. The charge nurse will forward the envelope to the EMS Coordinator. The emergency service responder is responsible to provide a copy to his/her supervisor.

9. Results of tests performed on the source patient shall be made available to the exposed EMS provider's private or occupational physician while maintaining confidentiality of all persons involved.

10. All findings or diagnosis shall remain confidential.

Questions concerning exposure control program requirements or post exposure procedures should be directed to the EMS provider's supervisor, training officer or infection control department.

Infectious Disease Control Policy

Notification of Ambulance Personnel Exposed to Communicable Disease

1. Infection Control or Emergency Department, upon learning that a patient has a reportable infectious or communicable disease, will notify EMS Coordinator who will check the record to determine if any pre-hospital agencies were involved with the patient. When determined that contact with the patient, EMS Coordinator will notify the agency for further follow-up and complete required forms.
2. The EMS Coordinator will notify the employing agency of the exposed employee's names and the communicable disease. The source patient's name will not be divulged. It is the responsibility of the employing agency to provide the employee follow-up with his/her private or occupational physician.
   Notification will:

   List names of personnel listed on the prehospital care report form.
   The patient's diagnosed disease.
   The date the patient was transported.
   A statement that the information is maintained as confidential medical record.
   A statement that it is the responsibility of the provider agency to contact all personnel involved in the pre-hospital or inter-hospital care and transport of the patient.

3. Exception: For confirmed diagnosis of AIDS, ARC or HIV, the letter of notification will only be sent if emergency service responders have indicated on the pre-hospital care report that they may have had contact with the patient's blood or body fluid, or if hospital personnel have reason to know of a possible exposure to blood or body fluids.

4. Specified diseases requiring notification of EMS personnel by the Infection Control Department include:

Infectious Disease Control Policy

5. Specified diseases requiring notification of EMS personnel by the Infection Control Department include

- Acquired Immunodeficiency Syndrome (AIDS)*
- AIDS-Related Complex (ARC)*
- Anthrax
- Chickenpox
- Cholera
- Diphtheria
- Hepatitis B
- Hepatitis C
- Hemorrhagic fevers
- Herpes simplex
- Human Immunodeficiency Virus (HIV) infection*
- Measles
- Novel influenza virus
- Meningococcal infections
- Mumps
- Plague
- Polio
- Rabies (human)
- Rubella
- Smallpox
- Coronavirus (SARS, MERS-CoV)
- Smallpox
- Tuberculosis (TB)
- Typhus (louse-borne)
- Q-fever

***For confirmed diagnosis of AIDS or HIV, the letter of notification will not be sent unless emergency personnel indicate that they may have had blood or body substance exposure.**

6. When a hospital patient with a listed communicable disease is to be transported by ambulance personnel, the hospital staff sending the patient shall inform the ambulance personnel of any precautions to be taken to protect against exposure to disease. If a significant exposure occurs, the ambulance personnel shall immediately report the incident as indicated above.

7. The *Hospital Licensing Act* requires any information received in the notification process be handled in accordance with confidentiality policies and procedures.

Infectious Disease Control Policy

COMMUNICABLE DISEASE INCIDENT FORM

Exposed emergency personnel providing care:

☐ Police ☐ Firefighter/First Responder ☐ EMT/Paramedic/PHRN

☐ Other: _____

Name of EMS Provider Exposed: _____

Home Address: _____

City/State/Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Name of Agency: _____ Run #: _____

Name of Supervisor: _____Phone #: _____

Patient's Name: _____ Date/Time of Transport: _____

Type of Significant Exposure (Circle):

Parenteral (e.g. needle stick) Mucous membranes (e.g. eyes, mouth)

Significant skin exposure to blood, urine, saliva, bile, semen, vomit (e.g. open sores, cuts)

Other (explain): _____

Additional Comments:

_____

_____

_____

Post Exposure Procedure

1. Immediately notify your supervisor.
2. Notify the emergency department charge nurse when you arrive at the hospital with the patient.
3. Complete this form and make two (2) copies.
4. **Place the original in an envelope, seal and write "Attention EMS Coordinator" on the front of the envelope.**
5. Give the sealed envelope to the emergency department charge nurse that the patient was transported to.
6. Provide your supervisor with a copy.

Infectious Disease Control Policy

Prehospital Responders Communicable Disease Exposure Notification

Exposed emergency personnel providing care:

__ Police ___ Firefighter/First Responder ___EMT/Paramedic/PHRN

__ Other

Name of communicable disease: _____

Name of Employing Agency: _____

Name of pre-hospital emergency personnel exposed:

_____ _____

Name of Individual Completing Notification **Date**

Section 6.08 of The Illinois Hospital Licensing Act, requires you to maintain this information as a confidential medical record. Disclosure of this information may, therefore, result in civil liability for the individual or company breaching the patient's confidentiality or both.

Follow-up care and counseling of the exposed personnel shall be the responsibility of the Prehospital provider agency and shall be carried out without delay upon notification of exposure.

If you have any questions regarding this patient, please contact me at 245-9541, extension 3929, or Infection Control Department at extension 3307.

Latex Allergy Policy

A latex allergy is recognized as a significant problem for specific patients and healthcare workers. There are two (2) types:

- **Systemic** – Immediate reaction (within 15 minutes). Symptoms include generalized rash, wheezing, dyspnea, laryngeal edema, bronchospasm, tachycardia, angioedema, hypotension and cardiac arrest.

- **Delayed** – Delayed reaction (6 to 48 hours). Symptoms include contact dermatitis such as local itching, edema, erythema (redness), blisters, drying patches, crushing & thickening of the skin, and dermatitis that spreads beyond the skin initially exposed to the latex.

Persons at risk include patients with spina bifida, patients with urogenital abnormalities, workers with industrial exposures to latex, healthcare workers, persons with multiple surgeries, persons with frequent urinary procedures and persons with a history of predisposition to allergies.

Suspected Latex Allergy

1. Assess for suspected latex sensitivity by asking the following:

   "*Do you react to rubber bands or balloons? Describe.*"

2. Initiate interventions for *Known Latex Sensitivity* if the latex sensitivity screen response suggests a latex hypersensitivity.

3. Notify the receiving hospital of suspected latex hypersensitivity.

4. Follow orders as per the *Allergic/Anaphylactic Reaction Protocol*.

Known Latex Allergy

1. Obtain a patient history and ask the patient to describe their symptoms of latex hypersensitivity.

2. Monitor the following signs and symptoms:

   - Itching eyes
   - Feeling of faintness
   - Hypotension
   - Bronchospasm/Wheezing
   - Nausea/Vomiting
   - Abdominal cramping
   - Facial edema

Latex Allergy Policy

Known Latex Allergy (continued)

- Flushing
- Urticaria
- Shortness of breath
- Generalized itching
- Tachycardia
- Feeling of impending doom

3. Notify the receiving hospital of known latex sensitivity.

4. Follow orders as per the *Allergic/Anaphylactic Reaction Protocol*.

5. Remove all loose latex items (*e.g.* gloves, tourniquets, etc.) and place in a closed compartment or exterior storage panel.

6. Utilize available latex-free supplies when preparing to care for or transport the latex-sensitive patient. The latex-free supplies must be on the ambulance (or other apparatus) and readily available.

7. Cover the mattress of the cot with a sheet so that no areas of the mattress are exposed.

8. DO NOT administer any medications through latex IV ports.

9. Wrap all tubing containing latex in kling before coming into contact with the patient (*e.g.* stethoscope tubing, BP cuff tubing, etc.).

Substance Abuse Policy

The Passavant EMS System considers substance abuse (drug and/or alcohol dependency) to be a health problem and will assist any System provider who becomes dependent on drugs and/or alcohol. The System, and ultimately our patients, will suffer the adverse effects of having a prehospital care provider whose work performance and attendance are below acceptable standards. Any employee whose substance abuse problems jeopardize the safety of patients, co-workers or bystanders shall be deemed "unfit to work". Any prehospital care provider involved in the Passavant EMS System who voluntarily requests assistance with a personal substance abuse problem will be referred to the EMS Medical Director for assessment and referral for treatment when necessary.

Testing for Drugs & Alcohol

The Passavant EMS System does not require employees to submit to blood and/or urine testing for drugs and/or alcohol as a routine part of their employment physical examination. However, individual agencies may require testing as part of the application process.

Any prehospital care provider may contact the EMS Medical Director (or his/her designee) if he/she has reasonable cause to suspect that a co-worker is under the influence of drugs and/or alcohol while on duty. The EMS Medical Director may choose to require the System provider to submit to a blood alcohol test and/or blood/urine toxicology screening. The cost of this testing procedure may be billed to the provider's agency, or in the case of a student, the requesting agency. Disputes related to billing of drug testing should not delay the procedure(s).

1. If a System provider who is required to submit to testing for drugs and/or alcohol refuses to cooperate, he/she will be subject to disciplinary action for insubordination (up to and including termination from the System).

2. Anyone caught tampering with, or attempting to tamper with his/her test specimen (or the specimen of any other prehospital care provider) will be subject to immediate termination from the System.

3. If any of the test results are positive, the EMS Medical Director will interview the provider. The EMS Medical Director will consult with the provider's agency to determine if referral to an assistance program shall occur.

    - The **first** occurrence will result in a referral of the prehospital care provider to the appropriate assistance program and the provider will be subject to disciplinary action as determined by the EMS Medical Director in consultation with the provider's agency/employer.

    - The **second** occurrence will result in disciplinary action as determined by the EMS Medical Director in consultation with the provider's agency/employer and may result in suspension of the provider's license and/or System certification.

Substance Abuse Policy

Testing for Drugs & Alcohol (continued)

- The progress of employees with substance abuse problems who have been referred to an assistance program will be closely monitored by their agency/employer and the EMS Medical Director. The provider must successfully complete the entire required rehabilitative program and maintain the preventative course of conduct prescribed by the assistance program. He/she must attend the appropriate after-care program(s) and provide verification of compliance with the program requirements, including additional drug testing as determined by the EMS Medical Director and the agency/employer.

4. If the test results are negative, a conference with the EMS Medical Director and the provider's agency/employer will be held to determine what future action, if any, will be taken.

5. If the prehospital care provider refuses to correct his/her health problems, he/she shall be subject to disciplinary action that pertains to all System providers who cannot, or are not, performing their job duties and responsibilities at acceptable levels.

The use, sale, purchase, transfer, theft or possession of an illegal drug is a violation of the law. *Illegal drug* means any drug which is (a) not legally obtainable or (b) legally obtainable but has not been legally obtained. The term *illegal drug* includes prescription drugs not legally obtained and prescription drugs legally obtained but not being used for prescribed purposes. Anyone in violation will be referred to law enforcement, licensing and/or credentialing agencies when appropriate.

Critical Incident Stress Management (CISM) Team Procedure

There are certain emergencies that may have a lasting emotional effect on EMS personnel. These include emergencies involving children, co-workers, familiar or particularly close persons, multiple death situations and disaster incidents. The *Critical Incident Stress Management Team* is an important resource in assisting EMS personnel in coping with stressful experiences.

1. EMS providers of the Passavant EMS System involved in an unusually stressful incident can contact the *Critical Incident Stress Management Team.*

2. The CISM Team members have specialized training in providing pre-incident education, on-scene support services, defusing, demobilization, formal debriefings, one-on-one debriefings, follow-up services and specialty briefings.

3. Debriefings and stress management services are most effective when conducted within 72 hours of the incident.

4. The CISM Team may be contacted through the EMS System Office.

EMS SUPPLIES

EMS Equipment & Supplies Policy

Passavant EMS System providers must maintain response vehicles in a manner that will limit mechanical breakdown, provide a clean environment and be engineered for compliance with OSHA standards. Providers must also have minimum equipment and supplies specified by IDPH and the EMS Medical Director.

1. EMS providers shall notify the EMS Office and IDPH of any new or replacement vehicles (including temporary loaner vehicles).
2. Initial response vehicles (First Responder and BLS Non-transport units) shall be equipped and stocked in accordance with the IDPH *Non-Transport Vehicle Inspection Form*.
3. Ambulance (transporting) vehicles must meet general standards as specified on the IDPH *Ambulance Inspection Form* and be in compliance with DOT Standard KKK-A-1822D.
4. BLS transporting vehicles shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *Passavant EMS System Agency Supply List*.
5. ILS providers shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *Passavant EMS System Agency Supply List* and *Additional ILS Equipment List*.
6. ALS providers shall be equipped and supplied in accordance with the IDPH *Ambulance Inspection Form* and in accordance with Section 515.830 of IDPH Rules and Regulations. Additional requirements have been set forth by the EMS Medical Director as well. Refer to the *Passavant EMS System Agency Supply List* and *Additional ALS Equipment List*.
7. The addition of new equipment not listed on a specific EMS provider level checklist **requires approval by the EMS Medical Director**. In addition, the EMS Medical Director must be notified of and approve any change in AEDs or cardiac monitoring equipment as well as any changes in communications equipment that may affect Base Station communications.

Illinois Department of Public Health
Division of Emergency Medical Systems and Highway Safety
Non-transport Vehicle Inspection Form

Provider name ____ Region ___ - ___ Provider number ___ ___

Provider address ____ City/State/ZIP ____

Vehicle year/Manufacturer ____ Vehicle address ____ V.I.N. (last four nos.) ____

ALS ILS B/D BLS FR/D FR (Level of care (circle one)) ____ Local I.D. ____ EMS system ____ / / Date

Vehicle type (check one) ❑ Engine ❑ Pumper ❑ Squad ❑ Truck ❑ Other (describe in comments section)

Vehicle class (check one) ❑ Primary (staffed 24 hrs./7 days) ❑ Assist (staffed as available)

❑ Initial ❑ Annual ❑ Self-inspection ❑ 3rd party ❑ Complaint ❑ Other (see comment form) ❑ Waiver (attached)

❑ Issue license ❑ Reinspection required (non-life threatening equipment problems) ❑ **Advisory** DO NOT OPERATE UNTIL REPAIRED/ REINSPECTED

Legal action required for the following: ❑ A condition has been identified that could result in harm to the public. This vehicle should be removed from service until all corrections are made, a reinspection is conducted and IDPH approves (see comment form).

First Responder Equipment

- ❑ Triangular bandages/Arm slings
- ❑ Roller bandages, self-adhering (4" X 5 yd.)
- ❑ Trauma/universal dressings
- ❑ Sterile gauze pads (4" X 4")
- ❑ Vaseline gauze/Occlusive bandages (3" X 8")
- ❑ Bandage scissors
- ❑ Automatic defibrillator (requires EMS system approval)
- ❑ Adhesive tape rolls
- ❑ Blanket
- ❑ Isolation bag
- ❑ OSHA personal protection items (face/eye mask, gowns)
- ❑ Upper extremity splints
- ❑ Lower extremity splints
- ❑ Oxygen equipment with adult, child, infant masks (one each); cylinder is to be full
- ❑ Non-porous disposable gloves
- ❑ Adult squeeze bag-valve-mask with adult and child mask
- ❑ Child squeeze bag-valve-mask with child and infant mask
- ❑ Oropharyngeal airways (adult, child, infant)
- ❑ Pediatric lower extremity splints

First Responder Optional Equipment

- ❑ Stabilizing device for impailed object/Tourniquet

All Other Non-Transports (In addition to above equipment)

- ❑ Oxygen flowmeter/Regulator for 15 lpm
- ❑ Delivery tubing
- ❑ Nasopharyngeal airways (sizes 12-30 f w/lubricant)
- ❑ Manually operated suction device (IDPH approved)
- ❑ Flashlight
- ❑ Long backboard
- ❑ Cervical collars (adult, child, infant, peds)
- ❑ Blood pressure cuffs (adult, child, infant) with gauges
- ❑ Stethoscope
- ❑ Burn sheet (individually wrapped)
- ❑ Sterile solution (1000cc) in plastic bottles or bags
- ❑ Obstetrical kit, sterile with head cover
- ❑ Cold packs
- ❑ EMS run forms
- ❑ Equipment to allow communication with hospital
- ❑ ILS/ALS system approved equipment (drug box, airway equipment, monitor/defibrillator)

COMMENTS:

As owner/representative, I agree to provide medical care in compliance with the Emergency Medical Services Act rules and regulations, 24 hours a day, every day of the year. Each vehicle will be staffed by at least two emergency medical technicians, pre-hospital R.N.s or physicians on all emergency calls. If this vehicle is operated at the intermediate or paramedic level, it will be staffed by at least one person with the appropriate license for the level of care at which the vehicle is being operated and one other emergency medical technician, pre-hospital R.N. or physician.* I agree to provide emergency service within my service area on a per need basis without regard to a patient's ability to pay.
(*State minimum requirements; EMS systems may require a higher level of staffing.)

Pre-hospital care provider/Owner or representative signature and title ____ Illinois Department of Public Health representative signature and title ____

Printed by Authority of the State of Illinois • P.O. #336144 5M 8/08

Passavant EMS First Responder Supply List

(Use in conjunction with IDPH Non-Transport Vehicle Inspection Form)

- ☐ 5 Triangular bandages/Arm slings
- ☐ 10 Rolls kling/Self-adhering roller bandages
- ☐ 6 Trauma dressings
- ☐ 20 Sterile 4x4s
- ☐ 2 Vaseline gauze
- ☐ 1 Pair trauma shears
- ☐ 2 Rolls of adhesive tape
- ☐ 2 Blankets
- ☐ 1 Isolation bag
- ☐ 2 Sets of protective gowns, goggles & face/eye shields (OSHA requirements)
- ☐ 2 Long adult extremity splints/Sam splints
- ☐ 2 Short adult extremity splints/Sam splints
- ☐ 2 Long pediatric extremity splints/Sam splints
- ☐ 2 Short pediatric extremity splints/Sam splints
- ☐ 1 Full primary oxygen cylinder (minimum “D” size)
- ☐ Oxygen flow meter/regulator for 15 L/min
- ☐ 2 Adult non-rebreather masks
- ☐ 2 Child non-rebreather masks
- ☐ 1 Infant mask
- ☐ 2 Nasal cannulas
- ☐ 1 Box large gloves
- ☐ 1 Box medium gloves
- ☐ 1 Box small gloves
- ☐ 1 Adult BVM
- ☐ 1 Child BVM
- ☐ 1 Infant BVM
- ☐ 1 Complete set oropharyngeal airways
- ☐ 1 Adult BP cuff
- ☐ 1 Child BP cuff
- ☐ 1 Infant BP cuff
- ☐ 1 Stethoscope
- ☐ 1 Long backboard
- ☐ 1 CID/Head blocks or towel rolls
- ☐ 1 Set of spider straps
- ☐ 2 Adult Cervical collars (adjustable)
- ☐ 2 Child Cervical collars (adjustable)
- ☐ 1 Burn sheet
- ☐ 1000mL Sterile saline/sterile water (exp. _____)

- ☐ 1 AED
- ☐ 2 Sets of adult defibrillation pads (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (if available) (exp. _____)
- ☐ Battery charger or spare battery
- ☐ 1 Razor

Signature: _____ Date: _____

Passavant EMS BLS Non-Transport Supply List

(Use in conjunction with IDPH Non-Transport Vehicle Inspection Form)

- ☐ 5 Triangular bandages
- ☐ 10 Rolls kling/Self-adhering roller bandages
- ☐ 6 Trauma dressings
- ☐ 20 Sterile 4x4s
- ☐ 2 Vaseline gauze
- ☐ 2 Rolls of adhesive tape
- ☐ 2 Blankets
- ☐ 1 Isolation bag
- ☐ 2 Sets of protective gowns, goggles & face shields
- ☐ 2 Long adult extremity splints/Sam splints
- ☐ 2 Short adult extremity splints/Sam splints
- ☐ 2 Long pediatric extremity splints/Sam splints
- ☐ 2 Short pediatric extremity splints/Sam splints
- ☐ 1 Box small gloves
- ☐ 1 Box medium gloves
- ☐ 1 Box large gloves
- ☐ 1 Full primary oxygen cylinder (min. "D" size)
- ☐ Oxygen flow meter/regulator for 15 L/min
- ☐ 2 Adult non-rebreather masks
- ☐ 2 Child non-rebreather masks
- ☐ 1 Adult BVM
- ☐ 1 Child BVM
- ☐ 1 Infant BVM
- ☐ 2 Nasal cannulas
- ☐ Suction unit (or manually operated suction unit)
- ☐ 1000mL Sterile saline/water (exp. _____)
- ☐ 6 Cold packs

- ☐ 1 Infant mask
- ☐ Provider to hospital communication equipment
- ☐ 10 *Passavant Non-Transport Forms*
- ☐ 1 Sterile OB Kit
- ☐ 1 Roll of aluminum foil or silver swaddler
- ☐ 1 Complete set of oropharyngeal airways
- ☐ 1 Complete set of nasopharyngeal airways (sizes 12-30F w/ lubricant)
- ☐ 1 Adult BP cuff
- ☐ 1 Child BP cuff
- ☐ 1 Infant BP cuff
- ☐ 1 Stethoscope
- ☐ 2 Long backboards (only 1 required for SEMSV)
- ☐ 2 CIDs w/ head blocks or towel rolls
- ☐ 2 Sets of spider straps or back board straps (3/set)
- ☐ 2 Rigid adjustable c-collars (or varied adult sizes)
- ☐ 1 Rigid adjustable c-collar (or varied peds sizes)
- ☐ 2 Individually wrapped burn sheets
- ☐ 1 Flashlight
- ☐ 1 SAM Sling Pelvic wrap device

- ☐ 1 AED (Not required for ILS & ALS)
- ☐ 2 Sets of adult defibrillation pads (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (if available) (exp. _____)
- ☐ Battery charger or spare battery
- ☐ 1 Razor

- ☐ 1 Glucometer
- ☐ 1 Bottle of glucometer strips (exp. _____)
- ☐ 10 Alcohol preps
- ☐ 10 Lancets (safety lancets with a retracting needle)
- ☐ 1 Bottle testing solution (exp. _____)
- ☐ Glucometer log (minimum of 1 time/week testing

Medications

(See BLS Medication List)

- ☐ 2 Adult nebulizer masks
- ☐ 1 Pediatric nebulizer mask
- ☐ 3 King LTS-D Airway Device (one each of size 3, 4 and 5)
- ☐ 2 Nebulizer kits
- ☐ 2 Atomizer syringes or adaptors

Signature: _____ Date: _____

Additional ILS Non-Transport Supply List

(Use in conjunction with Passavant EMS BLS Non-Transport Supply List)

Airway Bag

- ☐ 1 Pair Magill forceps
- ☐ 1 Laryngoscope handle
- ☐ 1 (Each size 1-4) laryngoscope blade – straight
- ☐ 1 (Each size 1-4) laryngoscope blade – curved
- ☐ 1 (Each size 6.0-8.5) Cuffed endotracheal tubes
- ☐ Spare laryngoscope handle batteries (stored in a plastic container)
- ☐ 1 Adult end-tidal CO_2 detector
- ☐ 1 Commercial ETT holder
- ☐ 1 10mL syringe
- ☐ 1 Adapter for ETT Albuterol administration
- ☐ 3 Sterile semi-rigid pharyngeal suction tips
- ☐ 1 Sterile 6-8F suction catheter
- ☐ 1 Sterile 10-12F suction catheter
- ☐ 1 Sterile 14-18F suction catheter
- ☐ 1 Suction tubing

☐ *King LTS-D size 2, 2.5 3, 4 and 5, must be in the airway bag

IV Therapy Equipment – Drug Box

- ☐ 2 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Pre-filled saline flushes
- ☐ 1 Tubex syringe
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 5 IV Start Kits
- ☐ 5 Veniguards (Tegaderm)
- ☐ 2 (15gtts) IV tubing
- ☐ 2 (1000mL Bags) 0.9% Normal Saline
- ☐ 10 2x2s (or 4x4s)
- ☐ 4 Tourniquets
- ☐ 1 Roll of tape

Monitoring Equipment

- ☐ Cardiac monitor/defibrillator w/ screen and printing capability; 12-Lead acquisition and transmission capabilities (in place of AED)
- ☐ 2 Set of adult defibrillation pads (required) (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (required) (exp. _____)

Other Equipment

- ☐ 3 (1mL) syringes
- ☐ 3 (3mL) syringes
- ☐ 3 (10mL) syringes
- ☐ 1 (30mL) syringe
- ☐ 1 (60mL) syringe
- ☐ 2 Sets **soft** restraints

Medications

(See ILS Medication List)

Signature: _____ Date: _____

Additional ALS Non-Transport Supply List

(Use in conjunction with Passavant EMS BLS Non-Transport Supply List)

Airway Bag

- ☐ 1 Pair adult Magill forceps
- ☐ 1 Pair pediatric Magill forceps
- ☐ 1 Large laryngoscope handle
- ☐ 1 Small laryngoscope handle
- ☐ 1 (Each size 1-4) laryngoscope blade – straight
- ☐ 1 (Each size 1-4) laryngoscope blade – curved
- ☐ 1 (Each size 6.0-8.5) cuffed endotracheal tubes
- ☐ 1 (Each size 2.5-5.5) un-cuffed ET tubes
- ☐ Spare laryngoscope handle batteries (stored in a plastic container)
- ☐ 1 Adult end-tidal CO_2 detector
- ☐ 1 Pediatric end-tidal CO2 detector
- ☐ 1 Commercial adult ETT holder
- ☐ 1 Commercial pediatric ETT holder
- ☐ 1 10mL syringe
- ☐ 1 Adapter for ETT Albuterol administration
- ☐ 2 CPAP circuits (1 can be stored in vehicle)
- ☐ 1 CPAP flow generator
- ☐ 1 Salem sump tube (18F)
- ☐ 1 Catheter tip syringe (60mL)
- ☐ 3 Sterile semi-rigid pharyngeal suction tips
- ☐ 1 Sterile 6-8F suction catheter
- ☐ 1 Sterile 10-12F suction catheter
- ☐ 1 Sterile 14-18F suction catheter
- ☐ 1 Suction tubing

☐ *King LTS-D Device size 2, 2.5, 3, 4 and 5 must be in the airway bag

IV Therapy Equipment – Drug Box

- ☐ 2 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Pre-filled saline flushes
- ☐ 1 Tubex syringe
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 5 IV Start Kits
- ☐ 5 Veniguards (Tegaderm)
- ☐ 2 (15gtts) IV tubing
- ☐ 2 (1000mL Bags) 0.9% Normal Saline
- ☐ 4 Tourniquets
- ☐ 1 Roll of tape

Monitoring Equipment

- ☐ Cardiac monitor/defibrillator w/ screen and printing capability; 12-Lead acquisition and transmission capabilities; pacing capability; Synchronized cardioversion capability (in place of AED)
- ☐ 2 Set of adult defibrillation pads (required) (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (required) (exp. _____)

Other Equipment

- ☐ 3 (1mL) syringes
- ☐ 3 (3mL) syringes
- ☐ 3 (10mL) syringes
- ☐ 1 (30mL) syringe
- ☐ 1 (60mL) syringe
- ☐ 1 (60gtts) IV tubing
- ☐ 1 Chest decompression kit with valve device
- ☐ 1 Jamshidi IO needle
- ☐ 1 EZ-IO drill
- ☐ 2 Adult (25mm, 45 mm EZ-IO needles
- ☐ 2 Pediatric (15mm) EZ-IO needles
- ☐ 2 EZ IO Stabilizers
- ☐ 2 Sets **soft** restraints

Medications

(See ALS Medication List)

Signature:_____
Date:_____

Passavant EMS Ambulance Supply List

(Use in conjunction with IDPH Ambulance Inspection Form)

On-Board Equipment (at minimum)

- ☐ Wheeled cot w/ 3 sets of straps + over-the-shoulder straps along w/ 3 point fastener for the cot
- ☐ 1 stair chair/ portable stretcher
- ☐ Full primary oxygen cylinder (minimum "M" size)
- ☐ 3 Adult nasal cannulas
- ☐ 3 Child nasal cannulas
- ☐ 3 Adult non-rebreather masks
- ☐ 3 Child non-rebreather masks
- ☐ 2 Infant masks
- ☐ Suction (obtains 300mm within 4 seconds)
- ☐ Suction canister (1000mL)
- ☐ 2 sterile semi-rigid pharyngeal suction tips
- ☐ 1 Complete set of sterile suction catheters (6-18F)
- ☐ 2 Suction tubing
- ☐ 1 Adult BVM
- ☐ 1 Child BVM
- ☐ 1 Infant BVM
- ☐ 1 Neonate Mask
- ☐ 1 Large adult BP cuff
- ☐ 1 Adult BP cuff
- ☐ 1 Child BP cuff
- ☐ 1 Infant BP cuff
- ☐ 2 Stethoscopes
- ☐ 1 Complete oropharyngeal airway kit
- ☐ 1 Complete nasopharyngeal airway kit (12-34F)
- ☐ 5 Packets water-soluble lubricant
- ☐ 1 Pair trauma shears
- ☐ 2 Long adult extremity splints/Sam splints
- ☐ 2 Short adult extremity splints/Sam splints
- ☐ 2 Long pediatric extremity splints/Sam splints
- ☐ 2 Short pediatric extremity splints/Sam splints
- ☐ 1 Adult traction splint
- ☐ 1 Pediatric traction splint
- ☐ 1 KED
- ☐ 2 Rigid Adjustable c-collars (adult)
- ☐ 2 Rigid Adjustable c-collar (peds)
- ☐ 2 Long spine boards
- ☐ 2 Sets of spider straps or straps (3/set)
- ☐ 2 Sets CIDs w/ head blocks or towel rolls
- ☐ 1 SAM Sling Pelvic wrap device
- ☐ 6 Trauma dressings
- ☐ 20 Sterile 4x4s
- ☐ 10 Rolls of kling/Self-adhering roller bandages
- ☐ 2 Vaseline gauze
- ☐ 2 Rolls of tape
- ☐ 5 Triangular bandages/slings
- ☐ 2 Individually wrapped burn sheets
- ☐ 2000mL Sterile saline/water (exp._____)
- ☐ 1 Quart drinking water (may sub sterile water)
- ☐ 2 Emesis basins
- ☐ 1 CPR mask w/ safety valve
- ☐ 6 Cold packs
- ☐ 6 Hot packs
- ☐ 1 Disposable urinal
- ☐ 1 Disposable bed pan
- ☐ 2 *Emergency Childbirth Record* Forms
- ☐ 1 Sterile OB kit
- ☐ 1 Roll of aluminum foil or silver swaddler
- ☐ 1 Child/infant car seat
- ☐ 1 Broselow tape or Pedi-Wheel (most current)
- ☐ Pediatric trauma score reference
- ☐ IDPH Complaint hotline posted for patient viewing
- ☐ Poison control number displayed
- ☐ 2 Sets of **soft** restraints
- ☐ 2 Pillows
- ☐ 2 Pillowcases
- ☐ 2 Sheets
- ☐ 2 Blankets
- ☐ 4 Towels
- ☐ 1 Box small gloves
- ☐ 1 Box medium gloves
- ☐ 1 Box large gloves
- ☐ 2 Sets of protective gowns, goggles & face shields
- ☐ 1 Latex allergy kit (non-latex gloves, BP cuff sleeve, stethoscope w/ non-latex tubing)
- ☐ 10 *Passavant Preliminary Run Report* forms
- ☐ 10 IDPH ambulance run report forms
- ☐ 1 Large red biohazard bag
- ☐ 1 Sharps container
- ☐ 1 Flashlight
- ☐ 2 – 5lb *ABC* fire extinguishers
- ☐ 1 Cell phone
- ☐ Ambulance to hospital radio equipment
- ☐ Wrecking bar/goggles
- ☐ 1 Box *Zip lock* bags
- ☐ 1 Box Kleenexes or toilet tissue

Passavant EMS Ambulance Supply List

(Use in conjunction with IDPH Ambulance Inspection Form)

Portable Equipment

- ☐ 1 Full primary oxygen cylinder (minimum "D" size) w/ dial flow meter/regulator for 15 L/min
- ☐ 1 Full spare oxygen cylinder
- ☐ 1 Adult non-rebreather mask
- ☐ 1 Child non-rebreather mask
- ☐ 1 Infant mask
- ☐ 1 Adult nasal cannula
- ☐ 1 Child nasal cannula
- ☐ 2 Nebulizer kits
- ☐ 1 Adult BVM
- ☐ 1 Child BVM
- ☐ 1 Infant BVM
- ☐ Pulse oximeter w/ both adult and pediatric probes
- ☐ 1 Portable suction unit
- ☐ 3 Sterile semi-rigid pharyngeal suction tips
- ☐ 1 Complete set of sterile suction catheters (6-18F)
- ☐ 1 Suction tubing
- ☐ 1 Complete oropharyngeal airway kit
- ☐ 1 Complete nasopharyngeal airway kit (12-34F)
- ☐ 5 Packets water-soluble lubricant

- ☐ 3 King Airway LTS-D (one of each size 3, 4, 5) (must be in the airway kit)
- ☐ 2 Nebulizer kits
- ☐ 2 Adult nebulizer masks
- ☐ 1 Pediatric nebulizer mask
- ☐ 2 Atomizer syringes or adaptors

- ☐ 1 AED w/ screen (Not required for ILS & ALS)
- ☐ 2 Sets of adult defibrillation pads (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (if available) (exp. _____)
- ☐ Battery charger or spare battery
- ☐ 1 Razor

- ☐ 1 Glucometer
- ☐ 1 Bottle of glucometer strips (exp. _____)
- ☐ 10 Alcohol preps
- ☐ 10 Lancets (safety lancets with a retracting needle)
- ☐ 1 Bottle testing solution (exp. _____)
- ☐ Glucometer Log (minimum of 1 time/week testing)

Medications

(See medication list for the appropriate level)

Signature: _____ **Date:** _____

Illinois Department of Public Health
Emergency Medical Systems

Ambulance Inspection Form

Provider: _____ **License#:** _____

Garage Address: _____

VIN: _____ **Level of Care:** _____ **Local ID:** _____ **EMS System#:** _____

Inspection Type: _____ **Inspected By:** _____

Inspection Date: _____ **Inspection Status:** _____ **Action:** _____

Patient Transport Equipment

[1] Wheeled multi-level cot w/3 sets of straps+ over shoulder straps ☐

[2] 3-Point fastener for cot ☐

[3] Cot fits securely in fastener ☐

[4] Secondary stretcher w/3 sets of straps ☐

Main On-Board Oxygen Equipment

[5] Main (on-board) oxygen cylinder not empty --- volume (psi): _____ ☐

[6] Adult size non-rebreather oxygen mask (minimum 1) ☐

[7] Child size oxygen mask (minimum 1) ☐

[8] Infant size oxygen mask (minimum 1) ☐

[9] Adult size nasal cannulas (minimum 3) ☐

[10] Child size nasal cannulas (minimum 3) ☐

Portable Oxygen Equipment

[11] Portable oxygen cylinder: (minimum size 'D') --volume (psi): _____ ☐

[12] Dial flowmeter/regulator for 15 lpm ☐

[13] Full spare portable oxygen cylinder (minimum size 'D') ☐

[14] Quick-release, crash-stable mounting racket for portable oxygen cylinders ☐

[15]Adult size non-re-breather oxygen mask (minimum 1) ☐

[16]Child size oxygen mask (minimum 1) ☐

[17] Infant size oxygen mask (minimum 1) ☐

[18] Adult size nasal cannulas (minimum 1) ☐

[19] Child size nasal cannulas (minimum 1) ☐

Suction and Airway Equipment

[20] Onboard suction capable of obtaining 300 mmHg suction within 4 seconds of clamping tube ☐

a) Vacuum level can be adjusted ☐

b) Collection bottle holds 1000 ml ☐

[21] Two packages suction tubing capable of reaching second patient being transported on squad bench ☐

[22] Portable battery operated suction capable of obtaining 300 mmHg suction within 4 seconds of clamping tubing ☐

a) Capable of charging from vehicle 12-volt DC/115-volt AC ☐

OR

b) Operated from internal rechargeable battery ☐

c) Operates for 20 continuous minutes (perform if battery sounds weak)

OR

d) Manually operated suction device (IDPH approved) ☐

[23] Sterile, single-use suction catheters, two each size: 6,8,10 12,14,16,18-french with thumb suction control port (one set with on-board suction; one set with portable suction) ☐

[24] Semi-rigid pharyngeal suction tips, with thumb suction control port, three (3) ☐

[25] Airway, oropharyngeal – adult, child and infant sizes 00-5) ☐

[26] Airway, nasopharyngeal, sizes 12-34 french ☐

[27] Lubricant for nasopharyngeal airways ☐

Resuscitation Equipment

[28] Adult size squeeze bag-valve-mask ventilation unit with transparent adult mask (minimum one) ☐

[29] Child size squeeze bag-valve-mask ventilation unit with child, infant and newborn transparent masks (minimum one) ☐

[30] CPR mask with safety valve to prevent backflow of expired air and secretions (minimum one) ☐

Resuscitation Equipment (continued)

[31] Automated External Defibrillator (AED) with Adult and Pediatric Capability ☐
a) Adult AED Pads ☐
b) Pediatric AED Pads ☐
OR

[32] Cardiac Monitor capable of defibrillation, with Adult and Pediatric Capability ☐
a) Adult AED Pads ☐
b) Pediatric AED Pads ☐

Extrication/Immobilization/Splinting Equipment

[33] Long spine board (72" x 16" minimum) with 3 sets of torso straps ☐

[34] Short spine board 32" x 16" minimum) with two (9-foot) torso Straps, one child strap and one head strap ☐
OR

[35] Vest type wrap around extrication device ☐

[36] Infant size rigid cervical collar (minimum one) ☐

[37] Child size rigid cervical collar (minimum one) ☐

[38] Small adult size rigid cervical collar (minimum one) ☐

[39] Medium adult size rigid cervical collar (minimum one) ☐

[40] Large adult size rigid cervical collar (minimum one) ☐
OR

[41] Rigid cervical collar adjustable to adult sizes (minimum one) ☐

[42] Rigid cervical collar adjustable to pediatric sizes (minimum one) ☐

[43] Traction splint, adult ☐

[44] Traction splint pediatric ☐

[45] Extremity splints, adult, 2 long ☐

[46] Extremity splints, adult, 2 short ☐

[47] Extremity splints, pediatric, 2 long ☐

[48] Extremity splints, pediatric, 2 short ☐

[49] Restraints, 2 pair (arm and leg) for 4-point restraint ☐

[50] Wrecking bar (24" minimum) ☐

[51] Goggles ☐

Assessment Equipment

[52] pulse oximeter with adult and pediatric capability/probes ☐

[53] Blood pressure cuff, large adult ☐

[54] Blood pressure cuff, adult ☐

[55] Blood pressure cuff, child ☐

[56] Blood pressure cuff, infant ☐

[57] Gauge(s) for blood pressure cuffs appropriately calibrated ☐

[58] Stethoscopes, two (2) ☐

[59] Flashlight, for patient assessment, minimum one (1) ☐

[60] Adequate lighting to allow patient assessment ☐

[61] Electric clock with sweep second hand ☐

Medical Supplies

[62] Trauma dressings (12" x 30"), Six (6) ☐

[63] Gauze pads 4" x 4"), sterile, Twenty (20) ☐

[64] Gauze, soft, self-adhering (4" x 5 yards), ten (10) rolls ☐

[65] Vaseline gauze (3" x 8"), Two (2) ☐

[66] Adhesive tape, two (2) rolls ☐

[67] Triangle bandages or slings, five (5) ☐

[68] Bandage shears (minimum 1) ☐

[69] Burn sheets (clean, individually wrapped), two (2) ☐

[70] Cold packs (3) ☐

[71] Obstetrical kit, sterile (minimum 1, pre-packaged with instruments and bulb syringe) ☐

[72] Thermal absorbent blanket and head cover OR aluminum foil OR appropriate heat reflective material (one per OB kit) ☐

[73] Sterile solution (normal saline) in plastic bottles or bags, 2000cc ☐

[74] Drinking water, 1 quart (may substitute 1000 cc sterile water) ☐

[75] Epinephrine, adult ☐

[76] Epinephrine, pediatric ☐

[77] Pediatric equipment/drug dosage sizing tape, current ☐
OR

[78] Pediatric equipment/drug age/weight chart ☐

[79] Pediatric trauma score reference ☐

[80] Emesis basin or bag (minimum 1) ☐

[81] Bedpan (one) ☐

[82] Urinal (one) ☐

[83] Child and infant car seats OR convertible car seat ☐

Personal Protective Equipment (PPE)

[84] Impermeable biohazard-labeled isolation bag, minimum 1 ☐

[85] Nonporous disposable gloves ☐

[86] Face masks, minimum 1 per crew member ☐

[87] Eye protection (face shields or safety glasses/protective eyewear), minimum 1 per crew member ☐

Linens

[88] Pillows, minimum 2 ☐

[89] Sheets, minimum 2 ☐

[90] Blankets, minimum 2 ☐

[91] Pillowcases, minimum 2 ☐

Communication

[92] Ambulance emergency run reports with data required by IDPH, Minimum 10 ☐

OR

[93] Electronic documentation with paper backup ☐

[94] Illinois Poison Center Number ☐

[95] IDPH Center Complaint Hotline number (must be posted where visible to patient ☐

[96] Ambulance-to-hospital radio tested and working ☐

Safety/General Vehicle

[97] Patient area is clean ☐

[98] Equipment in patient area is secured/crash-stable ☐

[99] Flashlight, Minimum 1 ☐

[100] Fire extinguishers (5 pound ABC, two (2), with current service Tag ☐

[101] Emergency warning lights operational ☐

[102] Siren operational ☐

[103] Flood lights operational ☐

[104] Current IDOT – issued Safety Inspection sticker on windshield ☐

[105] No visually apparent issues which would compromise the Safety of the patient, the ambulance personnel or the public ☐

Inspector's Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Revised August 2012

BLS Medication List

BLS Medications – *Minimum Requirements*

Unit Stock	*Medication*	*Supplied*	*Expiration Date(s)*
2	**Albuterol (Proventil)**	**2.5mg/3mL unit dose**	**1.** **2.**
4	**Aspirin (ASA)**	**4 – 81mg chewable tablets**	**1.** **2.** **3.** **4.**
1	**Epi-Pen Auto-injector**	**0.3mg pre-filled injector**	
1	**Glucagon**	**1mg & diluent unit dose**	
1	**Nitroglycerin (NTG)**	**1 bottle – 0.4mg**	
3	**Oral Glucose**	**15g tube**	**1.** **2.** **3.**
1	**Narcan**	**2mg/mL ampule**	
1	**Epi-Pen Junior Auto-injector**	**0.15 mg pre-filled injector**	
1	**Zofran (Ondansetron)**	**8 mg ODT**	

Passavant EMS ILS Ambulance Supply List

(Use in conjunction with IDPH Ambulance Inspection Form & Passavant EMS Ambulance Supply List)

Airway Bag

- ☐ 1 Pair Magill forceps
- ☐ 1 Laryngoscope handle
- ☐ 1 (each size 1-4) Laryngoscope blade – straight
- ☐ 1 (each size 1-4) Laryngoscope blade – curved
- ☐ 1 (each size 6.0-8.5) Cuffed endotracheal tubes
- ☐ Spare laryngoscope handle batteries
- ☐ 1 10mL syringe
- ☐ 1 Adult end-tidal CO_2 detector
- ☐ 1 Adult commercial ETT holder
- ☐ 1 Adapter for ETT Albuterol administration

☐ *King LTS-D device size 2, 2.5, 3, 4 and 5, must be in the airway bag

IV Therapy Equipment – Drug Box

- ☐ 2 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Pre-filled saline flushes
- ☐ 1 Tubex syringe
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 5 IV Start Kits
- ☐ 5 Veniguards (Tegaderm)
- ☐ 2 (15gtts) IV tubing
- ☐ 2 (1000mL Bags) 0.9% Normal Saline
- ☐ 10 2x2s (or 4x4s)
- ☐ 4 Tourniquets
- ☐ 1 Roll of tape

IV Therapy Equipment – Vehicle

- ☐ 2 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Pre-filled saline flushes
- ☐ 1 Tubex syringe
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 10 IV Start Kits
- ☐ 10 Veniguards (Tegaderm)
- ☐ 4 (15gtts) IV tubing
- ☐ 4 (1000mL Bags) 0.9% Normal Saline
- ☐ 10 2x2s (or 4x4s)
- ☐ 4 Tourniquets

Monitoring Equipment

- ☐ Cardiac monitor/defibrillator w/ screen and printing capability; 12-Lead acquisition and transmission capabilities (in place of AED)
- ☐ 2 Set of adult defibrillation pads (required) (exp. _____)
- ☐ 1 Set of pediatric defibrillation pads (required) (exp. _____)

Other Equipment

- ☐ 2 (1mL) syringes (in vehicle & drug box)
- ☐ 2 (3mL) syringes (in vehicle & drug box)
- ☐ 2 (10mL) syringes (in vehicle & drug box)
- ☐ 1 (30mL) syringe (vehicle)
- ☐ 1 (60mL) syringe (vehicle)

Medications

(See ILS Medication List)

Signature: _____ **Date:** _____

ILS Medication List

ILS Medications – *Minimum Requirements*

Unit Stock	*Medication*	*Supplied*
3	**Adenocard (Adenosine)**	**6mg/2mL vial**
2	**Albuterol (Proventil)**	**2.5mg/3mL unit dose**
1	**Aspirin (ASA)**	**4 – 81mg chewable tablets**
3	**Atropine**	**1mg/10mL pre-filled syringe**
2	**Dextrose 50% (D50)**	**25g/50mL pre-filled syringe**
6	**Epinephrine 1:10,000**	**1mg/10mL pre-filled syringe**
1	**Epi-Pen Auto-injector**	**0.3mg pre-filled injector**
2	**Glucagon**	**1mg & diluent unit dose**
4	**Lidocaine**	**100mg/5mL pre-filled syringe**
2	**Narcan (Naloxone)**	**2mg/2mL ampule**
1	**Nitroglycerin (NTG)**	**1 bottle – 0.4mg**
1	**Zofran (Ondansetron)**	**8 mg ODT**
Controlled Substance Container		
2	**Versed (Midazolam)**	**5mg/5mL vial**

Passavant EMS ALS Ambulance Supply List

(Use in conjunction with IDPH Ambulance Inspection Form & Passavant EMS Ambulance Supply List)

Airway Bag

- ☐ 1 Pair adult Magill forceps
- ☐ 1 Pair pediatric Magill forceps
- ☐ 1 Large laryngoscope handle
- ☐ 1 Small (pediatric) laryngoscope handle
- ☐ 1 (Each size 1-4) laryngoscope blade – straight
- ☐ 1 (Each size 1-4) laryngoscope blade – curved
- ☐ 1 (Each size 6.0-8.5) cuffed endotracheal tubes
- ☐ 1 (each size 2.5-5.5) un-cuffed ET tubes
- ☐ Spare laryngoscope handle batteries
- ☐ 1 10mL syringe
- ☐ 1 Adult end-tidal CO_2 detector
- ☐ 1 Pediatric end-tidal CO_2 detector
- ☐ 1 Commercial adult ETT holder
- ☐ 1 Commercial pediatric ETT holder
- ☐ 1 Adapter for ETT Albuterol administration
- ☐ 1 CPAP circuit
- ☐ 1 CPAP flow generator
- ☐ 1 Salem sump tube (18F)
- ☐ 1 Catheter tip syringe (60mL)

☐ *King LTS-D device size 2, 2.5, 3, 4 and 5, must be in the airway bag

IV Therapy Equipment – Drug Box

- ☐ 2 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Pre-filled saline flushes
- ☐ 1 Tubex syringe
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 5 IV Start Kits
- ☐ 5 Veniguards (Tegaderm)
- ☐ 2 (15gtts) IV tubing
- ☐ 2 (1000mL bags) 0.9% Normal Saline
- ☐ 1 (60gtts) IV tubing
- ☐ 10 2x2s (or 4x4s)
- ☐ 4 Tourniquets
- ☐ 1 Roll of tape

Signature / Date:_____

IV Therapy Equipment – Vehicle

- ☐ 4 (Each size 22g – 14g) IV catheters
- ☐ 2 Saline locks
- ☐ 5 (2-3mL) Saline flushes
- ☐ 2 Tubex syringes
- ☐ 5 (18g & 25g) Hypodermic needles
- ☐ 10 Alcohol preps
- ☐ 10 IV Start Kits
- ☐ 10 Veniguards (Tegaderm)
- ☐ 4 (10gtts) IV tubing
- ☐ 4 (1000mL Bags) 0.9% Normal Saline
- ☐ 1 (60 gtts) IV tubing
- ☐ 10 2x2s (or 4x4s)

Monitoring Equipment

☐ Cardiac monitor/defibrillator w/ screen and printing capability; 12-Lead acquisition and transmission capabilities; Pacing capability; Synchronized cardioversion capability (in place of AED)

Other Equipment

- ☐ 2 (1mL) syringes (in vehicle & drug box)
- ☐ 2 (3mL) syringes (in vehicle & drug box)
- ☐ 2 (10mL) syringes (in vehicle & drug box)
- ☐ 1 (30mL) syringe (vehicle)
- ☐ 1 (60mL) syringe (vehicle)
- ☐ 1 Chest decompression kit with valve device
- ☐ 1 Jamshidi IO needle (drug box)
- ☐ 1 EZ-IO drill
- ☐ 2 Adult (25 mm, 45 mm) EZ-IO needles
- ☐ 2 Pediatric (15 mm) EZ-IO needles
- ☐ 1 Spare CPAP circuit (vehicle)
- ☐ 1 Spare Salem sump tube (18F) (vehicle)

Medications

(See ALS Medication List)

ALS Medication List

ALS Medications – *Minimum Requirements*

Unit Stock	*Medication*	*Supplied*
3	**Adenocard (Adenosine)**	**6mg/2mL vial**
3	**Albuterol (Proventil)**	**2.5mg/3mL unit dose**
1	**Amiodarone**	**150 mg/3 mL with 100 mL D5W for infusion**
1	**Aspirin (ASA)**	**4 – 81mg chewable tablets**
3	**Atropine**	**1mg/10mL pre-filled syringe**
3	**Atrovent (Ipratropium)**	**0.5mg/2.5mL unit dose**
2	**Benadryl (Diphenhydramine)**	**50mg/1mL pre-filled syringe**
2	**Dextrose 50% (D50)**	**25g/50mL pre-filled syringe**
1	**Dopamine**	**400mg/250mL in D5W**
2	**Epinephrine 1:1000**	**1mg/1mL ampule**
6	**Epinephrine 1:10,000**	**1mg/10mL pre-filled syringe**
1	**Glucagon**	**1mg & diluent unit dose**
4	**Lidocaine**	**100mg/5mL pre-filled syringe**
2	**Narcan (Naloxone)**	**2mg/2mL ampule**
1	**Nitroglycerin (NTG)**	**1 bottle – 0.4mg**
2	**Ondansetron (Zofran)**	**4mg/2mL vial**
1	**Ondansetron (Zofran)**	**8 mg ODT**
2	**Sodium Bicarbonate**	**50 mEq/50mL pre-filled syringe**
Controlled Substance Container		
1	**Fentanyl**	**100mcg/2mL vial**
2	**Morphine**	**4mg/1mL tubex**
2	**Versed (Midazolam)**	**5mg/5mL vial**

Controlled Substance Policy

The Passavant EMS System recognizes the importance of medications carried on the ambulances in relationship to patient care. It is also important to understand the risks involving the potential abuse and addiction of controlled substances and to have tracking mechanisms in place.

1. All controlled substances will be kept inside each ambulance/apparatus within the drug box.

2. At the beginning of a shift, the on-coming paramedic (or intermediate at the ILS level) will verify that the controlled substance tag is secure and the tag number is to be verified with the log.

3. After assuring the tag is intact and the number corresponds with the log, the paramedic must sign the controlled substance shift log.

4. If the tag is **not** intact or the number is not verifiable, a complete inventory should be taken immediately, a supervisor shall be notified and an incident report will be completed and forwarded to the Passavant EMS Office.

5. Controlled substances shall be available for inspection by IDPH, Passavant EMS office, or any other authorized individual.

6. Each usage of a controlled substance must be documented on the proper "Controlled Substance Administration & Waste Documentation Form". All of the following information is to be completed:
    - Drug Administered – the drug must be selected
    - Date of administration
    - Time of administration
    - EMS Box Number
    - Patient Name
    - Drug amount given
    - Drug amount wasted
    - Paramedic signature (or intermediate signature at the ILS level)
    - Witness signature (RN or MD at the receiving hospital)
    - Physician Authorizing

7. The Drug Box shall be inspected at each shift change to insure the integrity of the locks and that the box is not past the expiration date listed on the box. If the integrity of the lock or is past the expiration date, the box will be returned and exchanged at Passavant Pharmacy.

Controlled Substance Policy

8. By signing the log (at ALS agencies), the paramedic is ensuring that the following controlled substances are secure:

    - **1 – Fentanyl 100mcg/2mL vial/tubex**
    - **2 – Morphine 4mg/1mL tubex/vials**
    - **2 – Versed 5mg/5mL vial**

9. By signing the log (at the ILS level), the intermediate is ensuring that the following controlled substance is secure:

    - **2 – Versed 5 mg/5 mL vial**

10. Any controlled substance that has not been administered must be properly disposed of. The amount wasted must be noted on the log and witnessed by a nurse or physician at the receiving hospital.

11. Controlled substances (e.g. Fentanyl, Morphine, Versed) will be restocked at Passavant Area Hospital via the Box Exchange Process.

Controlled Substance Policy

EMS System Drug Box Exchange Process

1. All EMS System Drug Boxes will be restocked by the Pharmacy during hour of operation to ensure proper controlled substance handling and control, outdate and recall management, and proper billing
2. The used box will be brought to the Pharmacy as soon as possible after its use. Boxes will be placed in the locked cabinet in EMS Communications after hours and brough to the pharmacy when open. All IV fluids, tubing, needles, syringes and non drug items will be restocked before the box is brought to pharmacy
3. Each box will go through the Pharmacy Refill Process utilizing the "EMS Medication Box Checklist" that is inside each EMS box.
    a. All medications will be replaced one for one and the expiration date will be checked on all medications
    b. A new "EMS Medication Box Checklist" will be placed in the restocked drug box
    c. A label will be placed on top of the restocked box (lower right hand corner) indicating :
        i. the expiration date of the box. (Determined by the medication with the shortest expiration date)
        ii. Initials of the checking Pharmacist
        iii. Date on which the box was checked
    d. The used check list will be kept with the restocked box until it is picked up by the paramedic
    e. The EMS Department will be notified that the box is ready for pick up
    f. Upon Pick up the Paramedic will sign the used "EMS Medication Box Checklist" This sheet becomes a permanent Pharmacy Record. These sheets are used for tracking purposes and are stored in the Pharmacy End of the Month Records
    g. A summary of medications used by each EMS agency will be sent to the Accounting Department at the end of each month. The Accounting Department will issue a bill for replacement drugs to the ambulance provider at a charge of cost plus ten percent.
    h. EMS boxes will be kept in locked areas and rotated to ensure even usage.
    i. EMS boxes where outdating is eminent will be returned to the Pharmacy three working days (i.e. Monday-Friday) before the expiration date listed on the box. The box will go through the normal restocking processes and all medications pending outdate will be replaced one for one with a new supply
    j. A copy of all EMS forms (run sheets) will be maintained by the EMS office.

Drug Shortage Policy

Due to the demand, expirations and other limiting factions, drug shortages seem to be a reality of the medical world in which we function. While seeking other supply options should always be explored there are times when shortages of desired medications cannot be alleviated and alternatives must be used. It would be impossible to plan for all possible shortages within this protocol manual. Instead providers must be ever aware that this issue exists and be attentive that attempts to address such shortages may be more or less obvious to providers. Therefore, providers must always be alert when pulling medications and verify the **six rights** before administering any medication. The following steps shall be followed:

1. In the event of a known or anticipated shortage the pharmacy will contact the EMS Office with the drug affected by the shortage and anticipated time frame of the shortage. A staff pharmacist and the EMS Medical Director will discuss the situation and develop a plan for responding to the shortage. This plan could include:
    a. Changing the concentration of a drug that is already used by EMS. (I.e. EMS carries Morphine 4mg/4mL but instead will be given 10mg/1 mL.)
    b. Using a different concentration such that the drug will be given differently. (I.e. Dextrose 50% is not available but D10 will be given to be infused over 15 minutes.)
    c. Using an alternative drug that can be can be reconstituted to make the unavailable drug. (i.e. Giving Epi 1:1,000 and 10 mL of Normal Saline with directions for making Epi 1:10,000)
    d. Giving a replacement drug. (I.e. Lidocaine is not available but Amiodarone is. Amiodarone is provided with training given to all affected agencies.)
    e. Not replacing a drug that is affected by shortage. (I.e. Narcan is affected by shortage; but no suitable replacement is available. Treatment would need to proceed to next step in protocol sequence.)
2. This plan will be communicated to all affected agencies and include any necessary training information.
3. This plan will be communicated to all affiliated hospital pharmacies.
4. Notice will be posted at the Metro Drug Box storage in the EMS Communication where EMS providers obtain their drug boxes. .
5. When the shortage is over notice will be given to all affected agencies and previously posted, notices will be removed from the refill areas.

Notes: