IDPH Region IV

Southwestern Illinois EMS System, Memorial Hospital

System Policy Manual

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IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

EMERGENCY MEDICAL SERVICES

POLICY AND PROCEDURE MANUAL

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IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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EMERGENCY MEDICAL SERVICES

SOUTHWESTERN ILLINOIS EMS SYSTEM

I. Purpose:

To establish the participants of the Southwestern Illinois EMS System and their level of participation.

II. Policy

A. The Southwestern Illinois EMS System is comprised of the following:

1. Hospitals

a) Memorial Hospital, Belleville – Resource Hospital, RHCC for the Edwardsville Region
b) St. Elizabeth's Hospital, Belleville – Associate Hospital
c) Touchette Regional Hospital
d) Memorial Hospital, Chester
e) Red Bud Regional Hospital, Red Bud
f) Sparta Community Hospital, Sparta
g) St. Joseph's Hospital, Breese

2. EMS Transport Services

a) ALS

(1) Abbott EMS*
(2) Breese EMS
(3) Columbia EMS
(4) Dupo EMS
(5) Mascoutah EMS
(6) Medstar EMS*
(7) Millstadt EMS
(8) Monroe County EMS
(9) New Baden EMS
(10) O'Fallon EMS*

***Also have ALS Non-Transport Capability**

b) BLS

(1) New Athens EMS

(2) Sugar Creek EMS

3. First Responders

a) Aviston FD
b) Beckemeyer-Wade Township
c) Carlyle FPD
d) Caseyville FD
e) Casino Queen, Inc.
f) Clin-Clair FPD
g) Coulterville First Responders
h) Evansville Fire Department
i) French Village FPD
j) Germantown FPD
k) Hecker FPD
l) Hoffman FPD
m) Hollywood Heights FPD
n) Huey-Ferrin-Boulder FPD
o) Marissa First Responders
p) Prairie Du Pont FPD
q) Prairie Du Rocher FD
r) Red Bud FD
s) Region IV Regional Medical Emergency Response Team (RMERT)*
t) Sante Fe (Bartelso) FPD
u) Southwestern IL College
v) St. Libory FD
w) State Park FD
x) Steelville PD/FRD
y) Tilden FPD
z) Valmeyer FPD
aa) Wheatfield Township FD

***ALS Capabilities**

4. EMD Agencies

a) St. Clair Co 911
b) Abbott EMS
c) Medstar EMS
d) City of Columbia
e) Monroe Co. Sheriff's Office
f) Clinton Co. Sheriff's Office

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EMERGENCY MEDICAL SERVICES

MISSION STATEMENT

I. Purpose:

To state the mission statement of the Southwestern Illinois EMS System

II. Mission Statement

It is the mission of the Southwestern Illinois EMS System to deliver state-of-the-art pre-hospital care. Working together as one system, we will strive to minimize death and suffering of those we serve. In pursuit of excellence, individual services are encouraged to seek CAAS accreditation.

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EMERGENCY MEDICAL SERVICES

SYSTEM PARTICIPANTS RESPONSIBILITIES

I. Purpose:

To establish the responsibility of all participants within the Southwestern Illinois EMS System be familiar will all current and new policies the system places into this manual.

II. Policy

A. This Policy Manual shall be maintained at each ambulance service's base(s) of operation. All System personnel are responsible for being familiar with the contents of the Policy Manual. In the event that amendments are made to the Policy Manual, they will be distributed to each ambulance service's base(s) of operation. All System personnel are also responsible for familiarization with all Policy Manual amendments.

B. Communication of updates regarding System and Regional activities will be posted in the EMS Room:

1. Quarterly System Advisory Council Meetings
2. General Mail and Email
3. Quarterly Field Training Officer/QI Meetings
4. Bi-annual System In-service/Informational Meetings
5. Resource Hospital EMS Room bulletin board
6. EMT/PHRN/ECRN educational classes.

C. In addition, mandatory in-services will be scheduled for appropriate EMS personnel regarding the addition of changes in medications, equipment, or procedures.

D. The Southwestern Illinois EMS System relies upon a system of self-reporting with regard to any limitations on the provision of patient services. If any EMS personnel, providers or entities are incapable of providing services, they should promptly report the same in writing to the Illinois Department of Public Health, the EMS System Medical Director, and the EMS System Coordinator as soon as possible.

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EMERGENCY MEDICAL SERVICES

PROFESSIONALISM

I. Purpose:

To establish a standard of professionalism for all Emergency Medical Services (EMS) personnel participating under the supervision of the Southwestern Illinois EMS System and Memorial Hospital.

II. Policy

A. It is a privilege for all of us to function within the Southwestern Illinois EMS System. The level of trust that individuals within the population we serve place in us during their time of greatest need cannot be understated. Therefore, it is imperative that we conduct ourselves appropriately at all times and in all places, on or off duty.

B. Participants of the Southwestern Illinois EMS System are in the unique position of representing their communities and services, and themselves to the general public. As such, their conduct and appearance, along with their performance and attitude, directly reflect upon the quality and success of the hospital's and community's involvement in the provision of pre-hospital and emergency department care.

C. Providers will, at all times, conduct themselves in a professional manner. In so doing, they will avoid discussion of cases, arguments, disagreements, and other negative comments in the presence of patients and/or family members or other hospital personnel. Relationships with patients, hospital personnel and other providers will be on a professional level at all times while in the course of delivery of emergency medical care.

D. Uniforms shall be dictated by each agency. All shall be clean, neat, and professional in appearance. In addition, the EMS System patch, signifying the appropriate skill level, will be visibly displayed on the left shoulder area or above the breast pocket on the uniform shirt. Further, EMT/PHRN students must display the System patch with the student rocker and student name badge while performing student observation time, clinical, or field experience.

E. System providers shall maintain personal grooming consistent with a clean, neat, and professional image, i.e. fingernails, hair, cologne, and jewelry.

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EMERGENCY MEDICAL SERVICES

PATIENT RIGHTS & DISCRIMINATION

I. Purpose

To establish a plan for all participants in the Southwestern Illinois EMS System to treat all patients with the same standard of care and respect.

II. Policy:

A. Patients shall be treated with the utmost respect, in a caring and professional manner at all times. Intent for the good of the patient shall be the precipice on which all of our actions and decisions are based.

B. No member of the Southwestern Illinois EMS System will discriminate against any individual based on race, creed, sex, age, physical disability, disease process, national origin, religious beliefs, or economic status.

C. Each member of the Southwestern Illinois EMS System will provide a process that informs patients of their rights, responsibilities and risks regarding available healthcare services.

D. Patient transport to other healthcare facilities is based entirely on the condition and needs of the patient and the ability and the availability of the organization to provide the services along with the approval of the patient. The patient's economic condition will not be a deciding factor in the decision for the transport.

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EMERGENCY MEDICAL SERVICES

PATIENT CONFIDENTIALITY

I. Purpose:

To establish that all agencies and personnel participating within the Southwestern Illinois EMS System will adhere to the most current Health Insurance Portability and Accountability Act (HIPAA) other requirements as described.

II. Policy:

A. No names of patients or medical personnel may be mentioned on radio transmissions unless absolutely necessary.

B. Patient report forms should be kept in a secure area to maintain confidentiality.

C. Care must be given to protect the patient's confidentiality in all situations. Specifics of patients or events must not be discussed outside of normal operational necessity.

D. Camera Use

1. Providers are only permitted to use cameras or other picture-taking or image generating devices authorized by his/her agency while rendering patient care. These devices are intended to be used for medical purposes only, such as to document the position of vehicles and patients at the scene of an accident or to document mechanism of injury for use by the receiving facility to assist in guiding treatment. No other picture-taking devices including PDA's, cameras, cell phones, or other personal computers shall be used by personnel while rendering patient care.

2. All on-scene photography shall be for clinical and/or documentation purposes only and conducted only at the direction of agency personnel in charge at the scene or by medical command.

3. Any photographs containing individually identifiable information are covered by the HIPAA Privacy Rule and must be protected in the same manner as patient care reports and other such documentation.

4. Any on-scene images and any other images taken by a provider while rendering patient care shall be considered a portion of the patient's

medical record and are not the property of the individual staff member. This includes any image inadvertently taken with a staff member's personally owned cell phone, camera, or other digital imaging device.

5. No images taken by a provider may be used, printed, copied, scanned, emailed, posted, shared, or distributed in any manner. This prohibition includes posting photos on personal web or on other public safety agency web sites, or emailing images to friends, colleagues, or others in the EMS industry.

6. When possible, copies of all images taken shall be printed and affixed to the system and agency's copies of run reports. All remaining images (electronic and print) shall be destroyed.

E. Failure to comply with this policy constitutes unprofessional/unethical behavior and may result in suspension, revocation and/or denial of licensure.

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EMERGENCY MEDICAL SERVICES

PARTICIPANT DESCRIPTIONS & RESPONSIBILITIES

I. Purpose:

To establish the levels of hospital participation and the responsibilities associated with them

II. Policy:

The Resource Hospital for the Southwestern Illinois EMS System is Memorial Hospital, Belleville. The Resource Hospital has the authority and the responsibility for the Southwestern Illinois EMS System, as outlined in the IDPH-approved EMS System Program Plan.

A. The Resource Hospital, through the EMS Medical Director, coordinates the clinical aspects, operations and educational programs. Responsibilities of the Resource Hospital include:

1. Agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

2. Maintaining a Program Plan and Policy Manual in accordance with the provisions of the EMS Act and minimum standards and criteria established in rules adopted by IDPH pursuant to the EMS Act.

3. Educate or coordinate the education of EMT personnel in accordance with the requirements of the EMS Act, rules adopted by IDPH pursuant to the EMS Act, and the EMS System Program Plan.

4. Notify IDPH of EMT provider personnel who have successfully completed requirements for licensure testing and re-licensure by the Department.

5. Educate or coordinate the education of Emergency Medical Dispatcher candidates, in accordance with the requirements of the EMS Act, rules adopted by IDPH pursuant to the EMS Act, and the EMS System Program Plan.

6. Establish or approve protocols for pre-arrival medical instructions to callers by System Emergency Medical Dispatchers who provide such instructions.

7. Educate or coordinate the education of Pre-Hospital RN and ECRN candidates, in accordance with the requirements of the EMS Act and the EMS System Program Plan.

8. Approve First Responder, EMT-B, EMT-I, EMT-P, and Pre-Hospital RN and ECRN candidates to practice within the System, and reapprove personnel every 4 years in accordance with the requirements of IDPH and the System Program Plan.

9. Establish protocols for the use of Pre-Hospital RNs within the System.

10. Establish protocols for utilizing ECRNs and physicians licensed to practice medicine in all of its branches to monitor telecommunications from, and give voice orders to, EMS personnel, under the authority of the EMS Medical Director.

11. Monitor emergency and non-emergency medical transports within the System, in accordance with rules adopted by IDPH pursuant to the EMS Act.

12. Utilize levels of personnel required by IDPH to provide emergency care to the sick and injured at the scene of an emergency, during transport to a hospital or during inter-facility transport and within the hospital emergency department until the responsibility for the care of the patient is assumed by the medical personnel of a hospital emergency department or other facility within the hospital to which the patient is first delivered by System personnel.

13. Utilize levels of personnel required by IDPH to provide non-emergency medical services during transport to a health care facility and within the health care facility until the responsibility for the care of the patient is assumed by the medical personnel of the health care facility to which the patient is delivered by System personnel.

14. Establish and implement a program for System participant information and education, in accordance with rules adopted by IDPH pursuant to the EMS Act.

15. Establish and implement a program for public information and education, in accordance with rules adopted by IDPH pursuant to the EMS Act.

16. All other hospitals which are located within St. Clair, Monroe, Randolph, and Clinton Counties and which have standby, basic or comprehensive level emergency departments must function in the Southwestern Illinois EMS System as either an Associate Hospital or Participating Hospital and follow all System policies specified in the System Program Plan, including but not limited to the replacement of drugs and equipment used by providers who have delivered patients to their emergency departments.

17. All hospitals within the Southwestern Illinois EMS System have a duty to self-report to both the Resource Hospital, IDPH, and the other

participating members of the System any significant changes in the appropriateness of their care. The Resource Hospital has no duty to verify the capabilities of a hospital properly licensed under the Act who holds themselves out as capable of receiving patients.

B. The Associate Hospital for the Southwestern Illinois EMS System is St. Elizabeth's Hospital, Belleville. An "Associate Hospital" shall provide the same clinical and communications services as the Resource Hospital, but shall not have the primary responsibility for personnel training and System operations. It shall have a basic or comprehensive emergency department with 24-hour physician coverage and a functioning intensive care and/or cardiac care unit. Responsibilities of the Associate Hospital include:

1. Commit to meet the System's educational standards for ECRNs. The Associate Hospital is the only hospital other than the Resource Hospital authorized to provide voice orders either by an ED physician or an Emergency Communications Registered Nurse (ECRN).

2. Agree to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System or other EMS system whose ambulances transport to them.

3. Agree to use the standard treatment orders as established by the Resource Hospital.

4. Agree to follow the operational policies and protocols of the System.

5. Agree to collect and provide relevant data as determined by the Resource Hospital.

6. Designate an individual as Associate Hospital EMS Coordinator – an EMT-P or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the Southwestern Illinois EMS System, in accordance with the IDPH-approved EMS System Program Plan.

7. Designate an Associate Hospital EMS Medical Director – a physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the Southwestern Illinois EMS System, in accordance with the IDPH-approved EMS System Program Plan.

C. All other hospitals listed above are Participating Hospitals within the Southwestern Illinois EMS System. Responsibilities of Participating Hospitals include:

1. Agree to replace medical supplies and provide for equipment exchange for System vehicles.

2. Allow the Department, the EMS Medical Director, and the EMS System Coordinator access to all records, equipment, vehicles and personnel during their activities evaluating the EMS Act.

3. Agree to collect and provide relevant data as determined by the Resource Hospital.

III. The activities of the Southwestern Illinois EMS System are facilitated by a number of regional and state committees:

A. Southwestern Illinois EMS System Advisory Committee

1. This committee meets on a quarterly basis to advise the Southwestern Illinois EMS Medical Director. Bylaws are as follows:

2. The meetings will be governed by Roberts Rules of Order.

3. The committee will be chaired by the EMS System Administrator.

4. Each EMS service gets one vote.

5. The meeting is open to everyone. However, each service shall appoint one person to vote each meeting. He/she need not be the same person at each meeting in order to accommodate all of our busy schedules.

6. As our associate hospital, St. Elizabeth's Hospital gets one vote.

7. A matter shall be approved by a majority vote.

8. In the event of a tie vote on an issue, the Chairman shall vote on behalf of the Resource Hospital. Other than in such instance, the Resource Hospital shall not cast a vote.

9. There is no quorum. Business will proceed regardless of attendance.

10. As with any advisory council, some decisions must be made unilaterally without or against the opinion of the advisory council. However, the EMS Medical Director will make every effort to follow the recommendations and opinions of the advisory council.

11. Decisions made by the advisory council that are put into effect by the EMS Medical Director and EMS Coordinator shall be binding for the entire system... not just the services present at the meetings. So, attendance is highly suggested.

12. These rules may be altered by a majority vote by the advisory council.

13. St. Clair Co 911 (not the individual PSAPs), Monroe Co Sheriff's Office, Abbott, Medstar, and Clinton Co Sheriff's office may vote on issues pertaining to EMD.

14. First responder organizations may vote on issues pertaining to first responders.

B. Region IV EMS Medical Director's Committee

1. Comprised of the EMS Medical Directors designated by Resource Hospitals within Region IV.

2. This Committee shall address, at minimum:

   a) Regional standing medical orders.

b) Protocols for patient transports and transfers.

c) A Regional disaster preparedness plan.

d) Regional standardization of continuing education requirements.

e) Regional standardization of DNR policies and protocols for Power of Attorney for Healthcare.

f) Protocols for disbursement of department grants.

g) Protocols to integrate EMS for Children into delivery of emergency services within the region.

h) Policies regarding school bus accidents.

C. Region IV EMS Advisory Committee

1. Comprised, at a minimum, of the Region IV EMS Medical Director's Committee, the Chair of the Regional Trauma Committee, a representative from an Associate Hospital, EMS System Coordinators from each Resource Hospital within Region IV, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within Region IV, one administrative representative of a vehicle service provider from each system within the region, one EMTB, one EMTP, one PHRN, and one RN currently practicing win an emergency department within Region IV. At least one of the administrative representatives of vehicle service providers shall represent a private vehicle service provider. The IDPH Region IV EMS Coordinator shall serve as a non-voting member.

2. This Committee shall address, at minimum:

a) Provide advice to the Region IV Medical Director's Committee regarding activities listed above.

b) Every 2 years, the members of the Region's EMS Medical Directors Committee shall rotate serving as Committee Chair, and select the Associate Hospital, Participating Hospital and vehicle service providers which shall send representatives to the Advisory Committee, and the EMTs/Pre-Hospital RN and nurse who shall serve on the Advisory Committee.

D. The **Region IV EMS Coordinator** is a designee of the Chief, Division of EMS and Highway Safety of IDPH. He or she shall facilitate the activities of the above committees and ensure compliance with IDPH Rules and Regulations.

E. Regional IV Trauma Advisory Committee

1, Consists of the Trauma Center Medical Director for the Region IV Trauma Centers (SLU Hospital and Cardinal Glennon Children's Hospital), the EMS Medical Directors, the EMS System Coordinators, one representative each from a public and private vehicle service provider within Region IV, an administrative representative from each Region IV

Trauma Center, one EMT, one Emergency Physician, and one Trauma Nurse Specialist (TNS) currently practicing in a Region IV Trauma Center. The IDPH Region IV EMS Coordinator serves as a non-voting member of the Region IV Trauma Advisory Committee.

2. Every 2 years, the members of the Trauma Center Medical Directors Committee rotate serving as Committee Chair, and select the vehicle service providers, EMT, emergency physician, EMS System Coordinator and TNS who shall serve on the Advisory Committee.

3. Advise the Trauma Center Medical Directors regarding:

   a) The identification of Regional Trauma Centers (Adult and Pediatric).

   b) Protocols for inter-system and inter-region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their department classifications and relevant Regional Considerations.

   c) Regional trauma standing medical orders.

   d) Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing or diversion to any hospital trauma center or Regional trauma center which are consistent with individual System Bypass of diversion protocols and protocols for patient choice or refusal.

   e) The identification of which types of patients can be cared for by Level I and Level II Trauma Centers.

   f) Criteria for inter-hospital transfer of trauma patients, including pediatric patients.

   g) The treatment of trauma patients in each trauma center within Region IV.

h) The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to IDPH.

i) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients.

F. **State EMS & Trauma Advisory Committees** serve similar functions on a state level. Specific information regarding these committees may be found within the EMS Act and IDPH's rules.

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EMERGENCY MEDICAL SERVICES

POSITION DESCRIPTIONS

I. Purpose:

To establish the required positions and requirements for those positions for the Southwestern Illinois EMS System

II. Policy

A. EMS Medical Director

1. The EMS Medical Director will be a graduate of an approved medical school accredited by the liaison committee on medical education, be licensed to practice medicine in all of its branches, and will have completed an approved residency program. The EMS Medical Director will also be ACLS and ATLS certified.

2. The EMS Medical Director will also have/obtain experience on an EMS pre-hospital unit, be knowledgeable of and possess the skills taught to paramedic students, and have/obtain experience instructing all levels of EMT students.

3. The medical and legal responsibility for the operation of the EMS System rests with the EMS Medical Director. All personnel functioning in the system do so under his/her delegated authority. The EMS Medical Director, in addition to this responsibility, is also responsible for the following:

   a) Development of standing treatment protocols to be used in the EMS System and ensure that they are being properly followed.

   b) Development of lists of drugs, equipment, and supplies to be utilized by system personnel and to be carried on the pre-hospital units.

   c) Remain current all necessary System approvals.

   d) Supervision of all personnel involved in the EMS System.

e) Designation of a physician to serve as Alternate EMS medical director.

f) Serve as a member of the Southwestern Illinois EMS System Advisory Committee, Region IV Trauma Advisory Committee, Region IV EMS Medical Director's Committee, and Region IV EMS Advisory Committee.

g) Review of CQI activities with the EMS System Coordinator.

h) Notify IDPH of all changes in personnel providing pre-hospital care.

i) Enforce the compliance of the System policies and procedures by the system participants.

j) Licensure (initial and renewal) of System personnel.

4. The EMS Medical Director is empowered to suspend or to modify the participation of any individual functioning in the EMS system.

B. EMS Alternate Medical Director

1. The physician designated by the EMS Medical Director to perform the above duties in the absence of the EMS Medical Director.

C. EMS System Coordinator

1. The EMS System Coordinator will be a registered nurse or EMT-P licensed in the state of Illinois. This individual will have a diverse background in critical care, be knowledgeable in the care of the critically ill or injured patient, will be ACLS & ITLS-certified, and have a background of experience in the field care of pre-hospital patients. The individual should also have a history of extensive involvement in the instruction of critical care practices.

2. The EMS System Coordinator is responsible for the following:

a) Ambulance and equipment checks of provider agencies on an initial, annual, and unannounced basis.

b) System data collection and statistical analysis.

c) System quality assurance collection.

d) Arrange system review board meetings.

e) Provide continuing education for EMT-B/I/P, PHRN and ECRN's within the Southwestern Illinois EMS System.

f) Process licensure forms to IDPH as approved by the EMS Medical Director.

g) Process applications for an upgrade of pre-hospital care from services.

h) Act as chairman of the EMS run review meetings.

i) Assist in problem solving for the system.

j) Coordination of reciprocity procedures for EMT-B/I/P and PHRN's.

k) Communicates on an ongoing basis with the EMS Medical Director regarding EMS policies/procedures/operations.

l) Coordination of hospital/community activities.

m) Assist in the coordination of hospital sponsored ACLS, ITLS, and PALS programs

n) Act as a resource person to the staff nurses and pre-hospital care providers.

0) Report to the EMS Medical Director for or on any matter as deemed necessary.

p) Keep records for all personnel in the EMS System and collecting pertinent program data and statistics.

D EMS Educator

1. The EMS Educator is responsible for the following:

a) Keep a current record of students.

b) Interview prospective EMT-P students.

c) Supervision of student field internships.

d) Provide continuing education for EMT-B/I/P and ECRN.

e) Coordinate and instruct EMT and EMT-P courses.

f) Coordinate and conduct classroom skill labs.

g) Coordinate and supervise clinical experience of students.

h) Educate field units and the ED on radio/telemetry communication.

i) Coordinate texts, syllabi, supplies, and handouts for class.

j) Schedule classes and clinical experience for students.

k) Communicate on an ongoing basis with the EMS System Coordinator and EMS Medical Director regarding EMS policies/procedures/operations.

l) Assist in the instruction of hospital sponsored ACLS, ITLS, and PALS programs.

E. EMS Administrative Director

1. The EMS Administrative Director will be the administrative director designated by the Resource Hospital**.**

2. The EMS Administrative Director's responsibilities will be to collaborate with the EMS Medical Director, EMS System Coordinator, and ED Director on the following:

a) Administrative problem-solving for the system.

b) Public relations as related to the pre-hospital care providers

c) Development and ongoing operations of the EMS system.

d) Overseeing budgetary needs for educational supplies/equipment.

e) Overseeing budgetary needs for communication equipment of medical control.

f) Serve as chair of the Southwestern Illinois EMS System Advisory Committee.

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EMERGENCY MEDICAL SERVICES

COMMUNICATION POLICIES

I. PURPOSE:

To establish communication system for the Southwestern Illinois EMS System.

II. General Operations

The Southwestern Illinois EMS System communication system utilizes the following to interface with ambulances, hospitals, ESDA, and existing systems:

A. Resource Hospital (Memorial Hospital): Cellular, UHF and VHF communications.

B. Associate Hospital (St. Elizabeth's Hospital): Cellular, UHF and VHF communications.

C. Participating Hospitals: VHF communications.

D. Both VHF and UHF consoles at Memorial Hospital are equipped with voice activated CD recorders that automatically record any VHF/UHF communications.

E. All EMS telecommunication equipment within the Southwestern Illinois EMS System must be configured to allow the EMS Medical Director or designee, to monitor all ambulance-to-hospital and hospital-to-ambulance communications within the system.

1. All telecommunication equipment must be maintained to minimize breakdowns. Both the Resource and Associate Hospital have maintenance agreements with a local vendor, which provides for routine as well as 24 hr. emergency repairs of VHF and UHF radios. Resource/Associate Hospital telecommunications operating personnel are to contact a repair person immediately should a breakdown occur.

2. All hospitals in the Southwestern Illinois EMS System have been advised to communicate hospital-to-hospital on VHF frequency 155.280, particularly in the event of telephone failure.

3. UHF Freq:Med Chan:

			Tx	Rx	PL
Primary	=	7	463.150	468.150	203.5 Hz
Secondary	=	6	463.125	468.125	203.5 Hz
Tertiary	=	3	463.050	468.050	203.5 Hz
State Wide	=	8	463.175	468.175	203.5 Hz

4. VHF Frequencies:

		Tx/Rx	PL
Primary	=	155.160	203.5 Hz
Secondary	=	155.340	210.7 Hz

5. Ambulances have an option to utilize IREACH to communicate with fire/police agencies.

6. Resource Cellular Numbers:

   a. UHF Console: 233-4598 & 233-4757
   b. VHF Console: 233-4797

7. Associate Cellular Number:

   a. UHF Console: 234-9816

8. Operation Control Point

   a. Communications will be answered promptly by an ECRN or Emergency Physician. The ECRN or Emergency Physician shall answer as follows:

      i. Identify Hospital's name.
      ii. Repeat the transmitting unit's call letters.
      iii Give orders/directions promptly and courteously.
      iv. Keep communications to a minimum.
      v. Do not voice names of EMS personnel or patients.
      vi. Call ED physician to the operational control point per ECRN policy.
      vii. End taped communication with date, time, and call letters.

9. In an effort to establish timely radio contact, when an ECRN or physician is not available, a secretary within the Emergency Department may answer at the operational control point but all information must be provided to an ECRN or physician prior to termination of radio contact.

10. Pre-hospital Communications

a. Communications will be transmitted to medical control as soon as feasible utilizing the following:

   i. Identify Hospital's name.
   ii. State unit identifier (call letters) and level of care.
   iii. Give BRIEF report to include only necessary information.
   iv. Be courteous and professional at all times.
   v. Echo all orders to the ECRN or MD.
   vi. Do not voice names of EMS personnel or patients.
   vii. Voice ETA and identify receiving facility.
   viii. Advise medical control of re-contact number if situation warrants.
   ix. End taped communications with unit identifier.

b. ALS communications should occur on the UHF radio or ALS cellular phone patch when possible.

c. BLS communications should occur on the VHF radio or BLS cellular phone patch when possible.

d. Outbound calls are desired when responding to calls on potentially critical patients near the hospital (where transporting ETAs would be short).

11. All communications must be documented completely and accurately in the radio communications log book posted at the operational control point.

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Signature_____

EMERGENCY MEDICAL SERVICES

COMMUNICATION – MEDICAL CONTROL

I. Purpose:

A. To establish a mechanism for participants to be able to seek advice from EMS Medical Director or designee.

II. Policy:

A. All personnel functioning in the System do so under the authority of the Illinois Department of Public Health and the EMS Medical Director.

B. In the absence of the EMS Medical Director, the physician staffing the ED at Memorial Hospital shall be considered the Southwestern Illinois EMS Physician with all of the authority necessary to conduct the daily operations of the system.

C. All Southwestern Illinois EMS System personnel must be familiar with the field operations, treatment, and operational protocols, and all equipment used in the performance of these tasks.

D. All personnel in the Southwestern Illinois EMS System must meet the requirements of the System and be approved by the EMS Medical Director.

E. Only the EMS Medical Director and/or an approved designee, including physicians and ECRNs in the ED of the Resource Hospital or Associate Hospital may give patient treatment orders over VHF (MERCI), UHF, or telephone to field personnel.

F. The ECRN has the authority, delegated by the EMS Medical Director, without first notifying the EMS Medical Director or his designee (the ED physician), to initiate emergency care in accordance with the field treatment protocols.

G. Once the EMS Medical Director or the medical control physician designee has arrived at the radio, the ECRN and physician shall continue to utilize the field treatment protocols as a patient treatment guide during the EMS call

H. Except for the placement of an IV or treatment with oxygen, only the EMS Medical Director or Medical Control Physician can initiate orders outside of the pre-hospital SOGs. Orders requiring a physician include, but are not limited to the following:

1. When EMS requests physician direction.
2. High-risk refusals (see Section 9).
3. Situations related to medico-legal issues.
4. Requests for medications/procedures outside of the provider's SOGs or scope of practice.
5. All pre-hospital termination of resuscitation.
6. When the ECRN is unfamiliar with any system protocol or if an unusual event or occurrence presents outside the realm of the Southwestern Illinois EMS System SOGs/Treatment Protocols.
7. When the patient's condition is deteriorating and System SOGs/Treatment Protocols have been exhausted.'
8. When DNR/Advanced Directive Orders are requested.
9. When pronouncement of death is required.
10. Request for diversion/bypass to another facility.

I. In the event that physician authorization is required, the name of the physician shall be documented with the order in the log book. It is suggested that the EMS crew ask for and document the name of the ED physician providing the order.

J. Treatment protocols are to be considered the standing orders of the EMS Medical Director and are to be followed by field personnel whenever contact with the resource hospital is impossible, or where a delay in patient treatment would be of harm to the patient.

K. The Associate Hospital is authorized to provide orders only:

1. For patients being transported to the Associate Hospital, or
2. In the event of communication failure with the Resource Hospital.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 202
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

COMMUINICATION – MEDICAL CONTROL OVERRIDE

I. Purpose:

A. To establish a mechanism for participants to qualify orders from any other source than the resource hospital.

II. Policy:

A. To allow the EMT/PHRN to contact the Southwestern Illinois EMS System Resource Hospital if, in the judgment of the provider, orders for patient treatment:

1. Vary significantly from the provider's SOGs.

2. Could result in unreasonable or medically inaccurate treatment causing potential harm to the patient.

3. Could result in undue delay in initiating transport of a critically ill patient (greater than 20 minutes).

4. When there is no response from the Associate Hospital after three attempts to contact.

B. This pertains to:

1. Orders for patient care given by the Associate Hospital during transport to the Associate Hospital.
2. Orders for patient care given by any hospital for inter-facility transfers.

III. Procedure:

A. Clarify the order.

1. Advise the Physician/ECRN issuing the order that the order is not allowed or deviates significantly from approved SOGs.

2. Advise the Physician/ECRN that you will contact the Southwestern Illinois EMS System Resource Hospital for guidance/orders.

B. After medical control guidance has been completed:'

1. For patients being transported to the Associate Hospital, the Resource Hospital Medical Control Physician shall notify the Associate Hospital Medical Control physician that an override was initiated and completed. All pertinent information shall be conveyed to the Associate Hospital medical control regarding an update on the patient's medical status and the pre-hospital treatment rendered. The Associate Hospital shall be given an Estimated Time of Arrival of the patient to their facility.

2. For patients requiring inter-facility transfer, the Resource Hospital Medical Control Physician shall discuss the patient's management with the transferring physician and determine an appropriate course of action. Note that it is the responsibility of the transferring physician to determine a suitable destination facility and arrange accordingly, not that of the Medical Control physician.

C. Only those physicians listed below may grant or deny a request for Resource Hospital Medical Control Override:

1. EMS Medical Director.

2. Associate EMS Medical Director.

3. On-duty Emergency Department Physician at Memorial Hospital, Belleville.

D. Any override of medical orders shall be submitted in writing via the "Incident Report Form", and promptly presented to the Southwestern Illinois EMS Medical Director.

E. In the unlikely event that further consultation is needed, the EMS Medical Director (or his Alternate when he is unavailable) may be contacted. Final authority rests with the EMS Medical Director on all matters.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 203
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

COMMUNICATION – DIRECT SCENE OBSERVATIONS

I. Purpose:

To establish policy on direct scene observation with in the Southwestern Illinois EMS System.

II. Policy:

A. The EMS System Coordinator, EMS Educator, EMS Medical Director, or his designee may respond directly to agencies' emergency scenes to monitor the quality of patient care.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 204
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Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

REGION IV GUIDELINES FOR RESOURCE/ASSOCIATE HOSPITAL MEDICAL CONTROL*

I. Purpose:

To establish guidelines for Resource/Associate Hospitals Medical Control.

II. Policy:

In order to facilitate and expedite both pre-hospital and hospital patient care, guidelines have been set forth to allow pre-hospital ambulance providers to directly contact any Resource/Associate Hospital in Region IV for patient orders when transporting to that Resource/Associate Hospital.

General Guidelines:

1. ILS and ALS units en route to an Associate or Resource Hospital within Region IV may directly contact that hospital for patient orders and/or report.

2. BLS providers will continue to call their patient reports directly to the receiving hospital.

3. The providers own System Resource Hospital may always be contacted for unusual problems or guidance/assistance.

4. Any problem/complaints should be documented on the “Incident Report Form” and delivered to the providers EMS System Coordinator. (See Section 13.)

*** Region-Wide Policy**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL WELL-BEING & CISD

I. Purpose:

To establish a standard of personnel well-being and use of Critical Incident Stress Debriefing.

II. Policy

A. EMS providers often work long hours caring for others in difficult environments. In doing so, we often fail to take appropriate care of ourselves. It is imperative, as healthcare providers in a stressful and physically demanding environment, to keep ourselves well nourished, well rested, and physically fit.

B. Taking care of ourselves includes maintaining seemingly small ideals such as proper lifting techniques, abstinence from smoking, and regular visits to a physician. However, maintaining good health doesn't simply involve our physical selves. We must be emotionally and mentally well. Exhaustion and the stress of what we see and do on a daily basis takes a great toll on our bodies, not to mention compromises the care that we deliver to our patients. A provider may, at any time, contact the Emergency Medical Services (EMS) Office for assistance with these matters.

C. In addition, the use of Critical Incident Stress Debriefing cannot be overlooked. While seemingly simple in nature, Critical Incident Stress Debriefing (CISD) is VERY beneficial to providers. The EMS Office will arrange for CISD at any point when requested. Please make the EMS Office aware of any particularly stressful scenes. These include, but are certainly not limited to calls involving children, coworkers or close acquaintances, grotesque scenes, multiple fatalities, or when providers are subjected to a series of stressful calls within a short period of time. Also, providers may, at times, suffer undue stress to seemingly mundane calls, i.e. routine cardiac arrest. The stress from these incidents can be as debilitating as that encountered on a "once-in-a-career call". These providers may personally contact the EMS Office for assistance. Coworkers are also encouraged to contact the EMS Office for assistance if you notice a provider who seems to be going through a difficult time and may be in need of assistance.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

EDUCATION, CERTIFICATION, LICENSING & CREDENTIALING

I. Purpose:

To establish the standard for education, Certification, and Credentialing.

II. Policy:

What's the difference? (Taken from the National EMS Scope of Practice.)

A. Education includes all of the cognitive, psychomotor, and affective learning that providers have undergone throughout their lives. This includes entry-level and continuing professional education, as well as other formal and informal learning. Clearly, many individuals have extensive education that, in some cases, exceeds their EMS skills or roles.

B. Certification is an external verification of the competencies that an individual has achieved and typically involves an examination process. While certification exams can be set to any level of proficiency, in health care they are typically designed to verify that an individual has achieved minimum competency to assure safe and effective patient care.

C. Licensure represents permission granted to an individual by the State to perform certain restricted activities. Scope of practice represents the legal limits of the licensed individual's performance. States have a variety of mechanisms to define the margins of what an individual is legally permitted to perform.

D. Credentialing is a local process by which an individual is permitted by a specific entity (medical director) to practice in a specific setting (EMS agency). Credentialing processes vary in sophistication and formality.

E. For every individual, these four domains are of slightly different relative sizes: However, one concept remains constant: an individual may only perform a skill or role for which that person is:

1. educated (has been trained to do the skill or role), AND

2. certified (has demonstrated competence in the skill or role), AND

3. licensed (has legal authority issued by the State to perform the skill or role), AND

4. credentialed (has been authorized by medical director to perform the skill or role).

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Effective Date: 2/11
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Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

SOUTHWESTERN ILLINOIS EMS SYSTEM CREDENTIALING FOR NEW PROVIDERS AND RECIPROCITY CANDIDATES

I. Purpose:

To establish the requirements for credentialing of new providers and reciprocity candidates for the Southwestern Illinois EMS System.

II. Policy

A. All applicants for credentialing in Region IV Southwestern Illinois EMS System shall complete an application. Providing false, inaccurate, or misleading information on the credentialing application shall be immediate grounds for termination and/or suspension from the EMS System.

B. Requirements for credentialing include:

1. All personnel (FR, EMT-B/I/P, PHRN) must complete the Application for Credentialing Form and submit to the EMS System Coordinator.

2. All personnel must submit a copy of a current Illinois license at his/her respective level of provider.

3. All personnel must submit a copy of a current CPR for Healthcare Provider card.

4. EMT-P and PHRN candidates must submit a copy of a current ACLS, PALS, and ITLS cards.* PHRN candidates may substitute TNS or TNCC certification.

5. All personnel must pass the written SOG exam with a minimum 80% score.

   a) No more than total of 2 attempts, after which the candidate is disqualified for 3 months.

b) A minimum of 24 hours between attempts.

c) If it is determined that a candidate cheated during an examination, he/she is disqualified from further attempts for one year.

6. All personnel must function, on average, 24 hours per month within the EMS System.

7. For reciprocity candidates, a recommendation from the medical director or EMS system coordinator of the previous system must be included or forwarded to the EMS Office.

   a) Reciprocity candidates from outside of Region IV must also complete five acceptable runs with a Field Training Officer.

   b) Acceptable runs are those which clearly demonstrate critical thinking and/or the application of EMT-P level skills. This will be determined jointly by the EMS System Coordinator and EMS Educator. Any concerns shall be referred to the EMS Medical Director.

   c) Reciprocity candidates must receive a positive recommendation from the Field Training Officer.

8. For providers seeking reciprocity from outside of the State of Illinois, please download and complete the IDPH State Reciprocity Candidate Form available on the Region IV Website: www.ilemsregion4.com

***Reciprocity candidates from outside of Region IV may seek a 6 month waiver of ITLS certification. He/she may begin functioning within the Southwestern Illinois EMS System without ITLS certification. However, he/she must be enrolled and participate in the next ITLS course offered within Region IV.**

Southwestern Illinois EMS System
Application for Credentialing

EMS Agency: Primary _____

Secondary _____

Provider Name: _____ _____ _____
Last First MI

Address: _____

_____

Phone: _____

Alt Phone: _____

Email address: _____

Certification level: _____ _____ _____
License Number Expiration Date

CPR for Healthcare Provider Expiration: _____

ACLS Expiration: _____

ITLS Expiration: _____

PALS Expiration: _____

Attach copies of all certifications and Illinois license.

_____ _____
Candidate Signature Date

_____
For Office Use Only:

Written SOG Exam Results _____

Completion of Five Acceptable Runs if from outside Region IV Yes/No

Approved for Credentialing Yes/No

Providing false, inaccurate, or misleading information shall be immediate grounds for termination and/or suspension from the EMS System.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS303
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

RELICENSURE REQUIREMENTS

I. Purpose:

To establish mandatory requirements to relicense as a participant of the Southwestern Illinois EMS System.

II. Policy

All EMTs; B's must complete 60 hours, EMT-I's 80 hours and Paramedic's 100 hours every of continuing education four years to include both adult and pediatric care.

A. All continuing education hours submitted must be at the licensure/re-licensure level.

1. 50 hours is to be acquired within the first 2 years.
2. No more than 25% may be within the same subject area.
3. A minimum of 12 hours must be in pediatric topics.
4. A total of up to 25 hours may be acquired through, teaching continuing education classes.
5. A total of 25 hours may be obtained through acceptable online continuing education.
6. Online continuing education must be CECBEMS accredited or approved by the EMS Office.
7. Up to 25 hours may be acquired for clinical field supervision as a Field Training Officer.

8. Continuing education units must have prior System approval and/or an Illinois Department of Public Health site code.

9. First Responders must complete 8 hours of continuing education ANNUALLY.

10. Continuing Education hours must be obtained at the level of training licensed at.

B. For all personnel within the fire service, remember that IDPH may issue CEUs (limited) for fire-related classes such as technical rescue classes, HAZMAT classes, etc.

C. Complete all mandatory in-services.

D. Function on an average of 24 hours per month within the EMS System.

E. Pass the re-licensure SOG exam with a minimum score of 80%.

F. Must certify on the Department renewal application form, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order.

G. Re-licensure documentation concerning continuing education programs or activities, form completion and a certified check or money order payable to IDPH for the relicensure fee, which is to be submitted 30 days prior to license expiration.

H. Providers whose licensure has expired for a period of more than 60 days shall be required to reapply for licensure. A provider whose licensure has expired may, within 60 days after registration expiration, submit all re-registration material as required and the requisite fee charged by IDPH in the form of a certified check or money order (cash or personal check will not be accepted). If all materials are in order and there is no disciplinary action pending against the provider, the department will re-license the provider.

I. Providers not recommended for re-licensure by the EMS Medical Director must independently submit IDPH an application for renewal. The EMS Office will provide the appropriate form to be completed and returned to the Illinois Department of Public Health**.**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS
Effective Date: 2/11
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Reviewed: 1/15
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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

MANDATORY CONTINUING EDUCATION

I. Purpose:

To establish mandatory continuing education for all participants of the Southwestern Illinois EMS System.

II. Policy

A. All providers must maintain a current CPR for Healthcare Provider card at all times. Providers may NOT function without current CPR certification.

B. All personnel must, at some point, have taken a HAZMAT Awareness course. Providers are encouraged to repeat the course periodically to maintain awareness and to obtain CEUs. Technical Rescue Awareness, though not required, is strongly suggested.

C. EMT-I/P, PHRN's must maintain ITLS certification. (PHRN's may substitute TNS or TNCC.)

1. A 6 month extension may be requested from the EMS Office for extenuating circumstances such as significant illness or injury, military deployment, etc. that would not permit course participation. Request for extension does NOT guarantee approval.

D. EMT-P/PHRN's must maintain ACLS certification.

1. A provider may continue to function at the ALS level IF he/she is enrolled in an ACLS course scheduled within 3 days of his/her expiration date.

2. Otherwise, providers may NOT function at the ALS level without current ACLS certification.

3. The EMS Coordinator or EMS Medical Director may grant an extension if extenuating circumstances exist. Request for extension does NOT guarantee approval, and it must be emphasized that highly extenuating

circumstances shall be present for approval. Approval for extensions will be a rarity, NOT the norm.

E. Effective January 1, 2012, all EMT-P and PHRN functioning within the Southwestern Illinois EMS System shall have PALS or PEPP certification.

F. Airway Education

1. All EMT-I/P, PHRN shall provide documentation of at least 2 intubations per year (in the pre-hospital setting, ED, or OR). It is highly desirable for personnel to obtain many more intubations each year. However, the EMS Office recognizes that the increasing rarity of endotracheal intubation with the advent of CPAP in the pre-hospital setting and the increased usage of supraglottic airway devices in the OR may limit a provider's exposure to endotracheal intubation. Providers are further encouraged to practice regularly at their place of employment or at Memorial Hospital on mannequins. Providers may also request OR time to obtain continuing exposure, experience, and education.

2. Any provider unable to obtain two endotracheal intubations annually will be required to remediate at the Southwestern Illinois EMS System's annual airway refresher training to be offered each January.

3. Providers unable to obtain either two endotracheal intubations annually or complete the annual airway refresher training will not be allowed to intubate in the pre-hospital setting until remediation is completed. He/she may continue to function as a EMT-I/P/PHRN, including the use of sedative agents to facilitate King LT placement.

4. Providers with limited success rates in endotracheal intubation will be contacted by the EMS Office to remediate in the OR.

5. Providers unable to maintain an average of 24 hours per month within the System must seek permission to remain active within the Southwestern Illinois EMS System. Further, they will not be allowed to intubate without express permission from the EMS Medical Director. They may, however, continue to function as an EMT-I/P/PHRN with permission including the use of sedative agents to facilitate King-LT placement.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL RECORDS

I. Purpose:

To establish that individual participates of the Southwestern Illinois EMS System are responsible to maintain and update individual continuing educational records.

II. Policy

A. It is the sole responsibility of the individual First Responder, EMD, EMT, PHRN, and ECRN to:

1. Maintain and update their continuing education records.

2. Keep current in all required certifications, registrations and/or licensure.

3. Advise the EMS Department and IDPH, in writing, regarding changes in name, address and phone number.

B. All First Responders, EMD, EMT-B initial student records will be kept by the Lead Instructor or Teaching Agency for seven years. All EMT-I, EMT-P, PHRN, and ECRN initial student records will be kept by the Resource Hospital for seven years.

C. All EMT-B, EMT-I, EMT-P, PHRN and ECRN continuing education records submitted to the EMS Department will be kept for four years.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Effective Date: 2/11
Supersedes:
Reviewed: 3/15
Revised: 3/15
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

FIELD TRAINING OFFICERS

I. Purpose:

To establish initial requirements to obtain designation as a Field Training Officer (FTO), and requirements to maintain designation as a FTO within the Southwestern Illinois EMS System.

II. Policy

A. Field Training Officers have the duty to supervise and instruct students and reciprocity candidates in the pre-hospital setting.

B. In the event of a disaster, FTOs shall preferentially be selected for leadership roles. (See Section 15.)

C. While caring for critically ill or injured patients in the presence of multiple paramedics, FTOs shall assume control of the patient's care, delegating responsibilities to other paramedics. A FTO need not necessarily accompany each critical patient during transport if other paramedics/PHRNs are present that may assume this responsibility.

D. FTOs may obtain up to 25 hours of continuing education every 4 years for maintaining FTO status.

E. Lead Training Supervisors shall be appointed by the EMS System Coordinator/EMS Medical Director.

F. Initial Requirements**:**

1. Maintain a valid license and all mandatory continuing education listed above.

2. Remain in good standing with the Southwestern Illinois EMS System.

3. Exemplary field skills and documentation skills as verified by the EMS System Coordinator.

4. Experience in teaching/training/supervision of EMS personnel.

5. Recommendation of the EMS System Coordinator.

6. Pass an SOG/Treatment Protocol exam with a 90% or better.

7. Demonstrate verbal teaching skills (with the EMS Educator or EMS System Coordinator monitoring) by accomplishing one of the following:

   a) Teach approximately one hour lecture/in-service to EMS personnel.

   b) Possess current ACLS, PALS or ITLS, or LeadInstructor status (for EMT-P/PHRN FTOs).

   c) Prior documented recent EMS teaching experience approved by EMS System Coordinator.

8. Attend an orientation class with EMS System Coordinator.

9. Approval of EMS Medical Director.

10. Additional Requirements:

    a) Active Paramedic/ PHRN in good standing in the System for two years with 2500 hours field experience on an ALS System Vehicle.

    b) Recommendation by the Lead Training Supervisor and two other active Paramedic/ PHRN Field Training Officers with at least one year supervisory experience.

    c) Supervise a provisional EMT-P/ PHRN in an “arrest scenario” in the company of the EMS System Coordinator or EMS Medical Director or his/her designee.

G. EMT-B Field Training Officers

1. The EMS System Coordinator shall appoint a limited number of BLS FTOs to attend quarterly Field Training Officer meetings for the purpose of disseminating information and maintaining Continuous Quality Improvement.

2. Additional Qualifications:

   a) One year field experience.

H. Maintenance of FTO status:

1. In order to maintain status as an EMT-P/ PHRN FTO's must:

   a) Continue to actively supervise students in a field, classroom, or lab setting.

   b) Attend at least two quarterly Field Training Officer's meeting yearly. Or FTO status in both systems (Memorial and Anderson) attend at least one Field Training Officer meeting and one Peer Run Review.

   c) Remain active and in good standing in the System with an average run time of 72 hours per month average per year.

   d) Maintain the highest standards of professionalism, knowledge, and skills.

   e) Complete field critiques within 48 hours after the shift ends.

   f) Pass the SOG exam with a 90% when relicensing EMST-P/ PHRN License.

2. An FTO who does not run in the EMS system more than 6 months, but less than one year must:

   a) Have ALS run time of at least 864 hours in the past year.

   b) Pass the SOG exam with a 90% to be reinstated.

3. An FTO who does not run in the EMS system more than one year or who does not meet the criteria in section (8b) must reapply.

4. Failure to maintain requirements will be reviewed by the EMS Coordinator and EMS Medical Director for possible revocation.

I. Current FTO's in Anderson System:

1. FTO's from the Anderson Hospital EMS System will be given FTO reciprocity into the Southwestern Illinois EMS System with a letter of good standing from the Anderson Hospital EMS System Coordinator.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Effective Date: 2/11
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Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

EMS LEAD INSTRUCTORS

I. Purpose:

To establish responsibility, and qualification for EMS Lead Instructors.

II. Policy

A. Lead Instructors shall be responsible for coordinating all education, training and continuing education courses for EMT-B, EMT-I, EMT-P, Pre-hospital RN, ECRN, First Responder and EMDs.

B. A program may use more than one EMS Lead Instructor. A single EMS Lead Instructor may simultaneously coordinate more than one program or course.

C. To apply for the position of EMS Lead Instructor, the candidate shall submit:

1. Documentation of experience and education in accordance with section (c) below;

2. The fee required by IDPH in the form of a money order or certified check made payable to the Illinois Department of Public Health (cash or personal check will not be accepted).

3. A letter from the EMS Medical Director recommending approval for the Lead Instructor candidate to conduct EMS courses.

4. An EMS Lead Instructor application form prescribed by the Illinois Department of Public Health, which shall include, but not be limited to name, address, and resume.

D. Qualifications:

1. A current license as an EMT-B, EMT-I, EMT-P, RN or physician.

2. A minimum of four years of experience in pre-hospital emergency care.

3. At least two years of documented teaching experience.

4. Documented classroom teaching experience, i.e., ITLS, PHTLS, CPR, Pediatric Advance Life Support (PALS).

5. Documented successful completion of the NAEMSE EMS Instructor course or similar course approved by IDPH.

E. Upon the applicant's completion of the NAEMSE EMS Instructor course or similar course approved by IDPH and completion of the EMS Lead Instructor examination with a score of at least 80%, the Illinois Department of Public Health will approve the individual as an EMS Lead Instructor. The approval will be valid for four years.

F. Renewal:

1. The EMS Lead Instructor shall submit to the Department of Public Health at least 60 days, but no more than 90 days, prior to the approval expiration.

2. A letter of renewal of support from an EMS Medical Director indicating that the EMS Lead Instructor has satisfactorily coordinated programs for the EMS System at any time during the four year period.

3. Documentation of at least 10 hours of continuing education annually, (Program used to fulfill other professional continuing education requirements, i.e., EMT, Nursing may also be used to meet this requirement.

G. Lead Instructor Reciprocity Requirements:

1. Possess a current Illinois license as an EMT-B, EMT-I, EMT-P, RN, or physician.

2. A minimum of four years of experience in pre-hospital emergency care.

3. At least two years of documented teaching experience.

4. Completion of a National Association of EMS Educators (NAEMSE) course or equivalent.

5. Completion of an EMS educators course examination with a passing score of at least 80%.

6. Letter of support from the EMS Medical Director.

H. Suspension/Revocation:

1. The Department of Public Health shall, in accordance with Section 515.160 of the rules and regulations, suspend or revoke the approval of an EMS Lead Instructor, after an opportunity for a hearing, when findings show the EMS Lead Instructor has failed:

a) To conduct a course in accordance with the curriculum prescribed by the EMS Act.

b) To comply with protocols prescribed by the EMS Act.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

SPECIAL DESIGNATIONS

I. Purpose:

To establish special designations for paramedic participants that work with specialized teams within their scope as an EMS provider.

II. Policy

A. Rescue Medic Program

1. The Rescue Medic Program is being developed in order to recognize those individuals who have a particular interest in caring for patients at the Technical Rescue scene.

2. Requirements include:

   a) Active participation within the Southwestern Illinois EMS System as an EMT-P in good standing.

   b) Active participation in a HAZMAT or Technical Rescue Team within Region IV.

   c) Completion of Operations level training in Vehicle & Machinery (optional), Rope, Confined Space, Trench, and Structural Collapse Rescue.*

   d) Completion of HAZMAT Operations level training.*

3. Duties:

a) The Rescue Medic will respond with a Regional HAZMAT or Technical Rescue Team within Region IV to provide care for patients and medical support for team members.

b) Rescue Medics will be recognized by the Southwestern Illinois EMS System by providing a specialized patch for all uniforms.

c) At scenes of technical rescue incidents, care of entrapped patients will be deferred to the Rescue Medic by all other care providers, including FTOs.

*__Note that Illinois OSFM standards are required, but OSFM certification is not necessary.__

B. HAZMAT Medic Program

1. The HAZMAT Medic Program is being developed in order to recognize those individuals who have a particular interest in caring for patients at the HAZMAT scene.

2. Requirements include:

a) Emergency Medical Operations for CBRNE Incidents or Advance Hazmat Life Support

b) HAZMAT Awareness (online)

c) HAZMAT Operations

d) HAZMAT Technician A

e) Technical Rescue Awareness (online)

3. Duties:

a) The HAZMAT Medic will respond with a Regional HAZMAT team within Region IV to provide care for patients and providers in and around a hazardous materials environment.

b) Pending IDPH approval, the EMT-P who has successfully completed HAZMAT Operations and Advanced HAZMAT Life Support will be afforded additional medications and SOGs for use when responding with the HAZMAT Team.

C. Tactical Medic Program

1. The Tactical Medic Program is being developed in order to recognize those individuals who have a particular interest in caring for patient in the tactical environment.

2. Requirements include:

   a) Active participation within the Southwestern Illinois EMS System as an EMT-B/I/P in good standing.

   b) Active participation in a tactical team within Region IV.

   c) Completion of CONTOMS or an equivalent course approved by the EMS Medical Director.

3. Duties:

   a) The Tactical Medic will respond with a Regional Tactical Team to provide care for patients in austere environments and medical support for team members.

   b) Only Tactical Medics operating with a Regional Tactical Team may enter the warm/hot zone of a potentially violent scene, and only with the express approval of the Tactical Team Commander.

   c) The Tactical Medic will utilize an abridged version of the proposed IDPH Tactical EMS Policies.

   d) Pending IDPH approval, the Tactical Medic will be granted additional SOGs for use when responding with the Tactical Team.

D. Critical Care EMT-P

1. The Critical Care EMT-P Program is being developed in order to recognize those individuals who have a particular interest in caring for the most critically ill patients.

2. Requirements include:

   a) Active participation within the Southwestern Illinois EMS System as an EMT-P in good standing.

   b) Completion of a CCEMT-P or equivalent course approved by the EMS Medical Director.

3. Duties:

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS309
Effective Date: 2/11
Supersedes:
Reviewed: 3/15
Revised: 3/15
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SEVICES

PERSONNEL

FIRST RESPONDER AND EMT INITIAL EDUCATION REQUIREMENTS

I. Purpose:

To establish an education requirement for First Responders and Basic participants in the Southwestern Illinois EMS System.

II. Policy:

A. The curricula for all courses shall follow the National EMS Core Content, National EMS Scope of Practice Model, and National EMS Education Standards.

B. Requirements for First Responder and EMT-B Courses within the Southwestern Illinois EMS System

1. Entrance Requirements:

   a) Register with sponsoring agency.

   b) Current CPR for Healthcare Provider certification.

2. Attendance Requirements

   a) No more than 8 hours of absence for First Responder students.

   b) No more than 10 hours of absence for EMT-B students.

3. FR-D Grade Breakdown:

a) The CCEMT-P will excel at care of the most critically ill and injured patients.

b) Pending IDPH approval, the CCEMT-P will be granted numerous additional medications and SOGs for use on a daily basis.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS310
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL EDUCATION REQUIREMENTS

I. Purpose:

To establish an education requirement for hosting First Responders and Basic courses in the Southwestern Illinois EMS System.

II. Policy:

A. Requirements for Hosting a First Responder or EMT-B Training Course

1. The "Training Program Application Form" (Site Code) must be received by IDPH 60 days in advance. Complete and submit to the Southwestern Illinois EMS System Coordinator for approval and signature. The EMS System Coordinator will then forward to IDPH. Allow ample time for System approval/mailing prior to the 60 day deadline. Attach the following:

    a) Completed "Class Schedule for EMT Basic Program"
    b) Course syllabus
    c) Simple resume or qualifications for teaching a certain module for NON-Lead Instructors

2. Submit to System EMS Coordinator an "Attendance Roster" within 10 days after the first class.

3. Forward the following to the EMS Coordinator within 10 days of course completion for review and advancement to IDPH for licensure:

    a) Course completion roster
    b) Didactic requirements
    c) Clinical requirements
    d) Completed Child Support form
    e) Completed Transaction form

a) Test Average: 50%
b) Final Practical: 25%
c) Final Written: 25%

4. EMT-B Grade Breakdown:

a) Assignments: 10%
b) Quizzes: 10%
c) Test Average: 25%
d) Final Practical Exam: 30%
e) Final Written Exam: 25%

5. The grading scale for this program is:

a) A = 94-100
b) B = 86-93
c) C = 77-85
d) D = 70-76
e) F = 69 or less

6. Completion Requirements:

a) Must maintain an overall 80% average.
b) Must pass the final exam with at least 80%.

7. Must successfully pass all practical testing stations.

8. Practical Exams shall include, but not be limited to:

a) Trauma and Medical Assessment
b) CPR
c) Airway Adjuncts
d) Bandaging
e) Splinting
f) Immobilization
g) AED

9. EMT-B Students must complete 10 hours of ED observation.

10. EMT-B Students must also successfully complete the state licensure exam and/or National Registry Exam approved by IDPH.

4. Submit to EMS Coordinator an “Attendance Roster” including final grade within 10 days after last class. The passing grade is 80%.

5. Give each student who successfully completes and passes the course a “Certificate of Attendance” with the Department site code on it.

6. Maintain class and student records for seven years.

****** Licenses will be issued by IDPH, Springfield.**

Note: The Lead Instructor assumes total responsibility for ensuring that the Course is taught professionally and in accordance with the National Standard Curriculum.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS311
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised: 1/15
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL EDUCATION REQUIREMENTS
SOUTHWESTERN ILLINOIS EMS SYSTEM PARAMEDIC PROGRAM

I. Purpose:

To establish an education requirement paramedic program in the Southwestern Illinois EMS System.

II. Policy:

A. The Southwestern Illinois EMS System will adopt the current education requirements required by the Southwestern Illinois College. The most current approved being attached as an appendix 1.

Southwestern Illinois College

Emergency Medical Services Programs:

Fall Paramedicine Program

Didactic: ***EMS 205, EMS 206, EMS 207, &EMS 208***

Clinical: ***EMS 210, EMS 211, 212, 213***

Field Internship: ***EMS 220, EMS 221, EMS 222, EMS 223,& EMS 224***

2014-2015Student Handbook

Welcome to the Southwestern Illinois College EMS Program

Dear ParamedicStudent,

We commend you on your decision to continue your EMS knowledge and career with Southwestern Illinois College and want to welcome you. The development of the EMS programs and these Paramediccourses represents a collaborative effort between Southwestern Illinois College, both regional EMS systems, several local hospitals, and various private and municipal EMSagencies. Your entry in the program now represents the expansion of this collaborative effort to include you, the student. We look forward to working with you to provide you with a high quality educational experience.

The information in the pages of this handbook is designed to help you during your enrollment in the program. We have outlined our expectations, including general outlines of the program and courseas well as your responsibilities. The material is drawn from a number of sources, including but not limited to the State Emergency Medical Services Rules and Regulations, U.S. Department of Transportation EMT Standards and Curriculum, IDPH, and applicable laws and guidelines.

We believe that all Paramediccourses, including ours, are academically and physically rigorous. Therefore, you will need to devote a great deal of time to the course. The course requires that you are motivated and responsible for your own learning. As faculty members, we serve as your resource persons. You will need to attend all class sessions, participate in group discussions, practice in the skills lab,take part in clinical experiences in hospitals and other community agencies, and participate in field internship programs in order to meet the goals of the program.

The Paramedic Instructor and EMS Programs Coordinator are available to you for academic advising concerning your career goals.

We look forward to working closely with you in your preparation for a successful career in EMS.

Curt Schmittling
EMS Program Coordinator

Julie Muertz
Dean of Health Sciences and Homeland Security

Jay Johns
Memorial Hospital EMS Educator

Dr. Brummer
Medical Director

Table of Contents

Introduction

Southwestern Illinois College's EMS Programs prepare students for varying levels of pre-hospital care in emergency medicine. The most basic level of care is provided by the Emergency Medical Technician. An EMT is prepared to care for patients at the scene of an accident and while transporting patients to the hospital under the supervision of a physician. The EMT is able to assess a patient's condition and manage respiratory, cardiac, and trauma emergencies. To become an Illinois licensed EMT, students must be at least 18 years of age and have a high school diploma or GED. They must successfully complete the seven-credit hour EMS 110 – Emergency Medical Technician course and pass either the state or national EMT examination prior to licensure and practice.

The highest level of support in pre-hospital patient care is provided by the Paramedic, who also works under the direct supervision of an emergency room physician via radio dispatch/telephone. Paramedics receive extensive training in patient stabilization that may include but is not limited to administration of medications and advanced life support measures – including conducting and interpreting electrocardiograms (EKGs), electrical interventions to support cardiac functions, performing intubations and administering appropriate intravenous fluids and/or medications.

Mission, Values and Goals

Southwestern Illinois College Mission

Southwestern Illinois College upholds the dignity and worth of all people and believes that learning is a life-long process which enhances the quality of life. The college provides for individual growth through educational excellence and active partnerships with students and the community.

EMS programs Mission

The EMS programs at Southwestern Illinois College provides students with the toolsand structure needed to develop basic and advance skills to provide medical care toindividuals in a variety of settings. The program has milestones that students are requiredto meet or exceed that evaluate the developmental progress of the students and provideseducators the feedback for educational modification as student needs change.

Southwestern Illinois College Core Values

As a people, as a learning community and as an institution we will reflect and practice those values integral to higher education and to the well-being of our region:

- **Student Success**
  We recognize that student success is the ultimate measure of our effectiveness. We will achieve this end by providing an environment that nurtures learning and meets students' needs.

- **Respect for People**
  We will treat each other with dignity, fairness and understanding; value open discussion; and respect the ideas and opinions of others.
- **Value of Education**
  We will promote the value of education throughout our institution and our communities by providing quality programs and services that empower learners to achieve their goals, strengthen their self-esteem and independence, and provide the means for improving their economic well-being and quality of life.
- **Integrity**
  We will strive to ensure that our actions are in accord with our standards, that we are honest with one another, and that we follow through on our promises and obligations.
- **Excellence**
  We will at all times do our best to merit recognition as a premier community college and will recognize the excellence that is attained by our faculty, staff, and students.
- **Fairness**
  We will practice fairness by establishing clear standards and expectations for students, faculty, and staff and ensuring that those standards are applied uniformly.
- **Lifelong Learning**
  We believe that education does not end when a degree is earned and that not all learners seek a degree. We will therefore strive to create a learning community that is open-ended and committed to providing opportunities for continuous learning.
- **Affordability**
  We will provide a high-value, affordable education that does not compromise on quality. We will make a collective effort to be value-minded stewards using resources with wisdom and promoting appropriate community partnerships.
- **Accountability**
  We are accountable for our performance. We will establish high standards of academic, institutional, and personal professional practice and will commit ourselves to the regular evaluation of our effectiveness and to a regular program of development and self-improvement.

Paramedic Program Educational Goal

The goal of the Southwestern Illinois College – Memorial Hospital Paramedic Program is to prepare competent entry-level Emergency Medical Technician – Paramedics in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains.

Paramedic ProgramEducational Objectives

The paramedic program at Southwestern Illinois College will graduate studentsthat can:

- Demonstrate basic life support skills designed to preserve life.
- Demonstrate advanced life support skills designed to preserve life.
- Communicate with healthcare professionals in a manner set by the medicalcommunity.
- Demonstrate basic writing skills in order to convey medical documentationthrough the collection of data.
- Demonstrate proficiency in use of Basic Life Support (BLS) equipment.
- Demonstrate proficiency in use of Advanced Life Support (ALS) equipment.
- Explain and educate individuals in the role of the Emergency Medical Services(EMS) within the profession of Emergency Care as well as within the healthcareteam.
- Explain basic and advanced human anatomy, physiology & development and how it is relevantto providing emergency medical care.
- Communicate and/or educate family, friends, or lay personnel in a professional,compassionate, and respectful manner.
- Provide age appropriate care as it relates to emergency medicine.
- Display professional behaviors complimentary to the profession through soundethical decision making.
- Practice emergency medical skills within the scope of Southwestern Illinois EMS System Guidelines (SOG's), and under the supervision of a Medical ControlPhysician.
- Recognize when patient's needs are outside of the Paramedic's scope of practice anddirecting patient care to appropriate care.
- Maintain safe, effective working environment/conditions and respondappropriately in a medical emergency.
- Practice emergency medicine under the scope of practice set forth by the NationalHighway Transportation Safety Board.

Accreditation Status

Southwestern Illinois College is accredited through the Higher Learning Commission's (HLC) Academic Quality Improvement Project (AQIP). As an AQIP institution, continuing accreditation is contingent on an ongoing cycle of self-examination; identification of programmatic and institutional needs; and a program of positive action that leads to self-improvement. Extending an uninterrupted streak to 70 years, SWIC was re-accredited through 2016. This seven-year extension is the maximum allowed for colleges and universities selected to participate in the HLC's AQIP program.

The Southwestern Illinois College – Memorial Hospital Paramedic Program currently holds a Letter of Review from the Committee on Accreditation for EMS Educational Programs (CoAEMSP) through the Commission on Accreditation of Allied Health Programs (CAAHEP). This Letter or Review signifies that the program is seeking full accreditation, and has met preliminary standards. This allows eligibility for the National Registry of Emergency Medical Technicians – Paramedic examination to current students.

Program Faculty & Locations

Southwestern Illinois College EMS Program Coordinator
Curt Schmittling
Office: BCMC 2441
Office Phone (618) 222-5343
curt.schmittling@swic.edu

Paramedic Program Faculty

Jay Johns – EMS Educator, Clinical Coordinator
Memorial Hospital
(618) 257-5873
jay.johns@swic.edu ; jjohnsIII@memhosp.com

Julie Valerius
Monroe County EMS
julie.valerius@swic.edu

Charles Parmley
North Technical High School
charles.parmley@swic.edu

Paramedic Course Locations

Students will receive a class schedule and locations packet during the first day of class

Primary Location

Memorial Hospital Auditorium
4500 Memorial Dr.
Belleville, IL. 62226
The hospital auditorium is located in the basement of the hospital at the far south end.

Alternate Location

Southwestern Illinois College
2500 Carlyle Rd
Belleville, IL 62221

ProgramEligibility

1. **Valid Illinois Emergency Medical Technician License:**Provide copy. Student must be currently licensed in the state of Illinois as an EMT in good standing.

2. **Valid Driver's License or State Issued Identification Card**: If you do not have either of these, other government issued photo IDs may be accepted.

3. **Age Requirement for Licensure**: Although there is no requirement for beginning the course, a student must be at least 18 years of age at the time they complete the course in order to be eligible for state and national licensure. In addition, students must possess a high school diploma or GED at the time they are seeking Illinois state licensure.

4. **Prerequisites:** Math 094 (Basic Algebra), Biology 105 or its equivalent with a grade of "C" or above, and be eligible to take English 101. Math 094 is a prerequisite to Biology 105.Most new students need to take the COMPASS placement test to determine their math and English level. College level math and English courses taken at another college or university may qualify. Please contact the Program Coordinator as soon as possible for details. Students must have all transcripts and a transcript evaluation request form submitted to enrollment services at Southwestern Illinois College in order to get credit for these courses.

5. **General Physical and Psychological Expectations:** Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by frequently having to walk, stand, lift, carry, and balance at times, in excess of 125 pounds. Motor coordination is necessary because over uneven terrain, the patient's, the provider's, and other workers' well-being must not be jeopardized. The provider must be able to deal with adverse and often dangerous situations which include responding to calls in districts known to have high crime and mortality rates. Self-confidence is critical, as is a desire to work with people, solid emotional stability, a tolerance for high stress, and the ability to meet the physical, intellectual, and cognitive requirements demanded by this position.

Criminal Background and Drug Testing

Requirements for Students to Participate in Clinical Experience for Health Sciences Programs

Clinical facilities and/or hospitals are requiring that the following checks/testing be completed on students prior to engaging in any clinical experience at their facilities:

A. Criminal Background Check
B. Search to confirm the individual's name is not on the Disqualification list for the Department of Health and Senior Services, Division of Family Services (DFS) and the Office of Inspector General (OIG).
C. Urine Drug Test

IMPORTANT NOTICE – REQUIRES IMMEDIATE ACTION ON YOUR PART IF YOU HAVE CRIMINAL HISTORY & ARE APPLYING TO AHEALTH SCIENCES PROGRAM

Criminal Background Check

Prior to clinical experience courses, background checks are conducted for IL, MO, and every state in which the student has resided or worked since the age of 18 years. Paperwork and fees for criminal background checks will be provided in one of the first few classes. Students who do not submit completed paperwork and for the criminal background check will not be allowed to continue to attend class until all necessary forms and fees are collected. A history of certain criminal convictions will prohibit students from participation in the clinical portion of the program. **A complete list of disqualifying offenses/convictions can be found at the Illinois Department of Public Health (IDPH) website: idph.state.il.us/nar/**. Fines, probation, or conditional discharge are convictions and will appear on a criminal history check. If you are unsure as to whether an arrest resulted in a conviction, contact the county in which you were arrested and speak to a representative in the Circuit Clerk, State's Attorney's office, or your attorney.

To participate in the clinical portion of the program, admitted students with criminal convictions will be required to present an IDPH waiver upon college request. The college runs the background checks during the first few weeks of the course.

It typically takes 8-12 weeks to receive a waiver determination from IDPH. Students who are unable to produce a waiver for their criminal conviction-during the above timeframes-will be exited from the program and are not eligible for refund of tuition or lab fees.

Applicants should be aware that obtaining a waiver does not guarantee program admission, and that not every clinical facility accepts the IDPH waiver, therefore obtaining the waiver is not a guarantee that the clinical portion of the program can be completed. It is

certain that without the waiver, the clinical sites will not permit direct patient contact and program completion is not possible.

Applicants should also be aware that less than half of those who apply for an IDPH waiver receive one. Each waiver application is reviewed on an individual basis. In general, a waiver is not granted in the following circumstances: 1. The crime committed involved an elderly or disabled person; 2. There are more than 2 similar crimes; 3. The crime involves murder, sexual assault, aggravated battery, armed robbery, exploitation of a child, child pornography or kidnapping; or 4. The offense occurred less than 2 years ago.

Students may call 217-785-5133 to request a waiver application from IDPH. Students who have concerns regarding the above regulations are encouraged to discuss the matter with the program coordinator as soon as possible.

Disqualification List

A search will be conducted to confirm the student's identification information is not on a Government registry including but not limited to the: Disqualification list for the MO Department of Health and Senior Services, Division of Family Services (DFS) and the Office of Inspector General (OIG). Other sites may be added upon the requirements of the clinical facilities.

Urine Drug Testing

Random drug testing is completed prior to clinical experience courses for all students enrolled in identified Health Sciences programs: Medical Assistant, Medical Laboratory Technology, Nursing, Physical Therapist Assistant, Radiologic Technology, Respiratory Care, and EMT / Paramedic. Students are granted 48 hours to have drug tests completed upon notification from SWIC. Tests are conducted at any Quest laboratories in the St. Louis or metro-east region. Locations can be found by accessing www.questdiagnostics.com.

Costs for all checks are the responsibility of the student. Background checks (includes states of IL & MO only) & drug testing will cost approximately $87. Additional fees are incurred for counties outside of IL & MO for previous work and/or residence history.

Depending on the requirements of the clinical facilities, other Health Sciences programs may also require listed background checks and drug testing.

S**tudents who are dismissed for a positive criminal background check, drug test or listing on a government registry are not eligible for refund of tuition or lab fees.**

Essential Functions and Technical Standards

Paramedics must have excellent judgment and be able to prioritize decisions and act quickly in the best interest of the patient while following the physician's directives. They need strong communication skills – spoken and written, and the ability to function independently in a non-structured environment that is constantly changing. They must possess good physical stamina, endurance, and body condition that would not be adversely affected by frequently having to walk, stand, crawl, lift, carry, and balance at times, in excess of 125 pounds.

The Paramedic Program at Southwestern Illinois College is a rigorous and intense program that places specific requirements and demands on the students enrolled in the program. The mission of the program is to provide students with the tools and structure needed to develop basic and advanced skills to provide medical care to individuals in a variety of settings. The following abilities and expectations must be met by all students admitted to the Paramedic Program. In the event a student is unable to fulfill these technical standards, with or without reasonable accommodation, the student will not be admitted into the program.

Compliance with the program's technical standards does not guarantee a student's eligibility for the NREMT or state certification exam.
Students enrolled in the Paramedic Program must demonstrate:

1. The mental capacity to assimilate, analyze, synthesize, integrate concepts and problem solve to formulate assessment and therapeutic judgments and to be able to distinguish deviations from the norm;
2. Sufficient postural and neuromuscular control, sensory function, and coordination to perform appropriate physical examinations using accepted techniques; and accurately, safely and efficiently use equipment and materials during the assessment and treatment of patients;
3. The ability to communicate effectively and sensitively with patients and colleagues, including individuals from different cultural and social backgrounds; this includes, but is not limited to, the ability to establish rapport with patients and communicate judgments and treatment information effectively. Students must be able to understand and speak the English language at a level consistent with competent professional practice;
4. The ability to record the assessment results and subsequent treatment clearly and accurately;
5. The capacity to maintain composure and continue to function well during periods of high stress;
6. The perseverance, diligence and commitment to complete the paramedic program as outlined and sequenced;
7. Flexibility and the ability to adjust to changing situations and uncertainty in clinical situations;
8. Affective skills and appropriate demeanor and rapport that relate to professional education and quality patient care.

Students in the Paramedic Program will be required to understand and meet these technical standards or believe that, with certain accommodations, they can meet the standards. The student should notify the instructor as soon as possible about any physical restrictions specified by their physician due to any injury or medical condition, including pregnancy, which develops during the course or program.

If a student states he/she can meet the technical standards with accommodation, then the College will determine whether it agrees that the student can meet the technical standards with reasonable accommodation; this includes a review of whether the accommodations requested are reasonable, taking into account whether accommodation would jeopardize clinician/patient safety, or the educational process of the student or the institution, including all coursework, clinical experiences and internships deemed essential to graduation.

General Program Information

Program Description

The programconsists of threecourse sections: didactic (lecture/lab), clinical (inhospital& ambulance), and field internship (ALS ambulance field runs). Hour requirements, course dates and deadlines are detailed in the program schedule distributed at the beginning of the program.

Didactic / LabSection

The didactic section consists of lecture presentations and psychomotor skill labs. Successful completion of all written work and skills evaluations are required to successfully complete the course. Goals of the didactic section include development of core foundations in cognitive and psychomotor knowledge in anatomy, physiology, pathophysiology, assessment, pharmacology, trauma, medical complaints, and treatment modalities in order to prepare students to interface with real patients in the clinical section of the program and as a competent practitioner.

The didactic section is composed of four courses; EMS 205 Paramedicine I, EMS 206 Paramedicine II, EMS 207 Paramedicine III, and EMS 208 Paramedicine IV. Students will attend classes on Tuesdays and Thursdays as well as occasional scheduled nontraditional class dates. Students will receive a schedule and syllabus at the beginning of these courses that outline dates and topics.

Student learning is evaluated through homework assignments, quizzes, written tests, and practical skills tests.

Clinical Section

The clinical section of the Paramedic curriculum provides students with real world patient experiences of all age groups in the varied nature of ill and injured patients in a supervised hospital or ambulance setting. While in the clinical site, students must comply with the policies and procedures of the affiliated hospital or host facility. Students must also display professional attitudes toward patients, family members, preceptors, and other employees of the host facilities at all times. They must participate actively and seek out learning opportunities. Students are rotated through clinicals in the emergency department, pediatric settings, intensive care unit, obstetrical unit, behavioral health, and surgical departments. They function under direct supervision of the EMS educator, physicians and registered nurses.

The clinical section is composed of four courses; EMS 210 Paramedic Clinical Practice I, EMS 211 Paramedic Clinical Practice II, EMS212 Paramedic Clinical Practice III, and EMS213 Paramedic Clinical Practice IV.Students will participate in assigned clinical time each month whichmay include day, evening, night, and weekend shifts so that the student will receive education and experience that closely simulates actual care functions. Obstetrical clinicals are incorporated into the Emergency Department clinicals. Students will contact Labor & Delivery during their Emergency Department clinicals and will attend when deliveries are anticipated. This procedure was enacted to reduce unnecessary down time during clinicals.

Clinical booklets will be issued for each clinical and these booklets contain clinical objectives, rules and regulations, a section for student comments, a section to be completed by the preceptor, and a section for the preceptors comments.

To successfully complete the clinical phase, the student must have submitted for review the required number of patient assessments, skills, and signed clinical evaluation sheets. Documentation of clinical experience patient contactdata and a shift preceptor evaluation must be entered into the FISDAP system within 48 hours. Missing documentation will prevent the student from successfully completing the clinical section of the course. All clinical experiences will take place in approved affiliate locations. Successful completion of the clinical segment is required to successfully complete the program.

Clinical dates and times are scheduled through the EMS Educator. The EMS Educator will work to ensure that the clinical schedule stays on track however, in the event an inevitable circumstance arises the EMS Educator reserves the right to cancel or change clinical times when necessary. Clinical sites reserve the right to change schedules when necessary.

The student is required to complete all clinical experiences as outlined in the curriculum. Failure of the student to satisfactorily complete all clinicalsmay result in the inability to progress in the program or test for licensure.Completion of all assigned patient contact criteria and skills is required prior to finishing the program.

The student should perform tasks (skills) in conjunction with their current skill stage and what they are able to accomplish at a particular point. As the student successfully advances through the Paramedic program and achieves minimal competency in newly learned skills through lecture, demonstration, and hands on practical's the student will receive skills letters giving the student permission to perform clearly defined skills within the scope of the Southwestern Illinois EMS System Standard Operating Guidelines. The student will only perform approved skills under the direct supervision of the EMS educator, physicians, or registered nurses. Skills are broken down into seven stages designed to build on one another as the student advances. Stage 1 is the most basic stage and is limited to EMT-Basic skills. Stage 7 is the final and most advanced stage with the student performing the all of the skills of a fully functional paramedic. A synopsis of the stages is contained in the *Field Internship Manual.*

Field Internship Section

The field internship section of the Paramedic curriculum provides students with real world patient experiences of all age groups in the varied nature of ill and injured patients in a supervised field setting. While in the field internship setting, students must comply with the policies and procedures of the Memorial Hospital Paramedic program the EMS agency. Students must also display professional attitudes toward patients, family members, preceptors, and other employees of the host facilities at all times. They must participate actively and seek out learning opportunities. Students will participate in both emergency and nonemergency calls. They function under direct supervision of a Southwestern Illinois EMS System Field Training Officer or an Anderson Hospital Field training Officer.

The field internship section is composed of five courses; EMS 220 Field Internship I, EMS 221 Field Internship II, EMS 222 Field Internship III, EMS 223 Field Internship IV, and EMS224 Filed Internship V. Students will participate in a minimum of 48 hours of field internship time each month. The EMS agency that the student is affiliated with will work with the student in scheduling field internshipshifts and may include day, evening, night, and weekend shifts. Shifts may be of varying durations based on the schedules and policies of the EMS agency. Examples of typical EMS shifts include but are not limited to 8 hours, 10 hours, 12 hours, and 24 hour shifts.

To successfully complete the field internship phase, the student must have submitted for review the required number of patient assessments, skills, and signed evaluation sheets. Documentation of field experience data will be submitted to the EMS educator by the Lead Field Training officer of the EMS agency that the student is affiliated with. The student is responsible for discussing their field performance with their field training officer, completing the student portion of the field evaluation form, complete a paper or an electronic patient care report, and obtain the signature of the field training officer verifying field internship hours performed. The field internship monthly time form should be completed and submitted to the EMS Educator no later than the seventh day of the following month. Failure to do so will result in a 10% per week penalty for the rotation. All patient contact data and a shift preceptor evaluation must be entered into the FISDAP system within 48 hours from the end of the field shift.Missing documentation will prevent the student from successfully completing the clinical section of the course. All clinical experiences will take place with the assigned EMS agency, only with a field training officer, and as a third person on the ambulance. Successful completion of all assigned patient contact criteria and skills is required for program and/or course completion.

The field internship courses are broken down three phases. EMS 220 Field Internship I is the observation phase. EMS 221 Field Internship II, EMS 222 Field Internship III, and EMS 223 Field Internship IV are the instructional phase. EMS 224 Field Internship V is the evaluation phase. The student will receive a copy of the Southwestern Illinois EMS System Field Internship Manual for Paramedic Students and FTO’s provides in depth course descriptions and expectations. Below is a brief description of the field internship courses.

The Observational Phase of the field internship is broken into two parts. The first part is the 1-2 month period during which the FTO serves as a template for the students. The FTO serves as the team leader during this period. In that role, the FTO demonstrates to the students how they are to perform in the field (out-of-hospital environment).The FTO should also delegate tasks (skills) to the student based upon the students current skill stage and what they are able to accomplish at a particular point. The purpose of this period is to demonstrate to the students the roles and responsibilities they will assume as team leaders and team members. The length of this portion is determined by the FTO as they see how the student is progressing and to allow the student adequate opportunity to watch the FTO demonstrate the team leader role. This portion should not exceed two months.

The second portion of the observational phase lasts 2-3 months and is where the student begins the transition into the role of team leader. The FTO should allow the student to be team leader on

more routine calls. On more advanced calls, the FTO should assume the role of team leader initially. The FTO should continue to delegate tasks (skills) to the student based upon the student's current skill stage and what they are able to accomplish at a particular point. The FTO may choose to allow the students to alternate as team leader and team member as the student gains confidence in this role. The student should keep progressing toward being team leader on all calls at the end of this phase.

The Instruction Phase of the field internship is the period during which the FTO will no longer assume the role of team leader. The students will serve as the team leader on a unit. During this period the FTO will still provide direction in the form of feedback and prompting. When necessary, the FTO will prompt the student to improve skill performance.

During this period, a Critique Form will be completed on each patient contact. An overall competently proficient, satisfactory, needs improvement or unsatisfactory grade will be assigned to each form. A student may still achieve a satisfactory grade even if a prompt was received during the patient contact. The FTO, however, always has the authority to score any prompted skill performance as unsatisfactory. The student should continue to perform tasks (skills)in conjunction with their current skill stage and what they are able to accomplish at a particular point.

In order to successfully complete this portion of the field instruction phase a student must successfully manage set numbers of patient contacts, priority 1- 3 level calls, and select skills.

The Evaluation Phase follows successful completion of the instruction phase of the field internship. Ideally, the FTO will serve primarily as an evaluator of each student's performance. There will be little intervention by the FTO unless the FTO must intervene to ensure that the patient receives timely and appropriate care. A prompt given during the evaluation phase may result in an unsatisfactory score if the prompt was to correct an error that was critical to patient care. Generally, whenever a student is prompted more than one time (for critical competencies only) he/she will receive a needs improvement or an unsatisfactory overall score.

In order to successfully complete this portion of the field instruction phase a student must successfully manage set numbers of patient contacts, priority 1- 3 level calls, and select skills. Rubrics for each course are contained in the *Field Internship Manual.*

The student should perform tasks (skills) in conjunction with their current skill stage and what they are able to accomplish at a particular point. As the student successfully advances through the Paramedic program and achieves minimal competency in newly learned skills through lecture, demonstration, and hands on practical's the student will receive skills letters giving the student permission to perform clearly defined skills within the scope of the Southwestern Illinois EMS System Standard Operating Guidelines. The student will only perform approved skills under the direct supervision of the EMS educator, physicians, FTOs or registered nurses. Skills are broken down into seven stages designed to build on one another as the student advances. Stage 1 is the most basic stage and is limited to EMT-Basic skills. Stage 7 is the final and most advanced stage with the student performing the all of the skills of a fully functional paramedic. A synopsis of the stages is contained in the *Field Internship Manual.*

Program Costs

Please visit www.swic.edu/EMS or contact the EMS Program Coordinator's Assistant Candice Rodgers at 618-235-2700, ext. 5355 or Candice.Rodgers@swic.edu for current program costs.

Ethics and Standards of Conduct

Due to the high standards of the Southwestern Illinois CollegeEMS programsand EMS professions, student conduct must reflect professionalism, integrity and responsibility at all times. The following section sets forth ethical standards, standards of conduct, and examples of misconduct subject to disciplinary action (including termination from the course and/or program).

Ethical Standards

Students are expected to meet the following ethical standards while in the EMS programs:

- EMTs and paramedics are health care professionals regardless of whether or not they receive monetary compensation for their work. Thus, an EMT/paramedic is bound by the highest standards of professional conduct and ethics. The program will not tolerate a breach of these standards by its students. Certain acts may be so serious that they subject the student to immediate dismissal without progressive discipline.

- Students must conduct themselves in an ethical manner throughout the classroom, and clinical portions of the program. Failure to adhere to these standards may result in termination from the program. Violation of these standards includes, but is not limited to, stealing, cheating, or breach of patient confidentiality (HIPAA Laws).

Professional Behavior

The conduct of the EMT and paramedic student reflects upon the individual, his or her agency, the program, and the EMS profession. Therefore, the student must conduct him/herself in a professional and responsible manner at all times as described below.

Professional Behavior/Attributes include:

- **Leadership.** Self-confidence, established credibility, ability to remain in control, ability to communicate, willingness to make a decision, willingness to accept responsibility for the consequences of the team's action.

- **Integrity.** Consistent honesty; being able to be trusted with the property of others or with confidential information; complete and accurate documentation of patient care and learning activities.

- **Empathy.** Showing compassion for others; responding appropriately to the emotional response of patients and family members; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.

- **Self-motivation.** Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement;consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner; taking advantage of learning opportunities; participating in tutoring sessions; and completing prescribed remediation.

- **Appearance & Personal Hygiene.** Appropriate, neat, clean and well-maintained clothing and uniform; good personal hygiene and grooming.

- **Self-confidence.** Demonstrating the ability to trust personal judgment; demonstrating an awareness of strengths and limitations; exercising good personal judgment.

- **Communication Skills.** Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations

- **Time Management Skills.** Consistent punctuality; completing tasks and assignments on time.

- **Diplomacy in Teamwork.** Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.

- **Respect.** Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.
- **Patient Advocacy.** Not allowing personal bias to or feelings to interfere with patient care; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.

- **Careful Delivery of Service.** Mastering and refreshing skills; performing complete equipment checks; demonstrating careful and safe ambulance operations; following policies, procedures, and protocols; following orders.

Liability

Students enrolled in an EMS program course with a clinical and/or field internship component are covered by Southwestern Illinois College's general and professional liability policy to the extent that the student is acting in the course and scope of his or her education or training. Additional coverage and uninsurable events including gross negligence are the responsibility of the student. The student's employer may provide an additional insurance policy for the student as well. The student can purchase private supplemental insurance at his/her own cost.

Payment and Enrollment

Students enrolled in an EMS program must maintain in good standing with financial obligations to Southwestern Illinois College. Any student who fails to pay for their classes, make payment arrangements with the college business office or pay the mutually agreed upon installments will be dropped from current courses or will be prevented from registering for consecutive courses in the program by the college. Any student either dropped for non-payment,ineligible to register or who is not registered for any reason will not be permitted to attend classroom, clinical and/or field internship sessions until the issue is resolved and they are registered. In order to prevent being dropped or have negative service indicator on their college account, the student should regularly check their student email account, SWIC eStorm account and make all arranged payments on time. Potential issues such as financial hardships or aid concerns should be addressed with the college before they become problems. In addition, students in the paramedic program will not be permitted to test for certification or licensure until all academic requirements are met and students are in good standing to receive their certificate or degree which includes financial obligations.

Misconduct

Students are subject to disciplinary action up to and including expulsion from the course, program or the college entirely for violations of the Southwestern Illinois College Student Conduct Code as outlined in the *Student Rights and Conduct Policy and Student Handbook*distributed throughout the college and available online at www.swic.edu.

The Student Conduct Code also outlines other possible sanctions, disciplinary proceedings and student grievance procedures. All students should obtain a copy of this document and become familiar with its contents. Failure of the student to familiarize themselves with this document does not constitute a reason to disregard or violate this policy.

Disciplinary Procedures

Progressive discipline is a process for dealing with student-related behavior that does not meet expected and communicated performance standards. The primary purposes for progressive discipline are to assist the student to understand that a performance problem or opportunity for

improvement exists and to ensure the safety and welfare of staff, students, and patients. Examples of progressive discipline are listed below however depending on the nature and severity of the disciplinary issue the order in which discipline is administered may be subject to change. For disciplinary action regarding attendance and grades please refer to those policies.

Adherence to policies is approved by the EMS Educator, SWIC EMS Programs Coordinator, EMS System Coordinator, and EMS Medical Director.

- Disciplinary reprimand from the EMS Educator: an oral conference or written reprimand from the EMS Educator noting the seriousness of the violation will be documented and placed in the student's file.

- A documented counseling session with the SWIC EMS Programs Coordinator with a potential outcome of:

    1. Probation: A probationary period will be put in place in some situations. If the student is placed on probation the student will sign an agreement as to the conditions of the probationary period.

    2. Suspension: The student will be suspended from classroom, clinical and/or field sessions for a specified amount of time.

    3. Expulsion:The student will be dropped from the Paramedic Program either with or without the option of reapplying to the Paramedic Program in the future.

- Please note that, students may be subject to <u>immediate</u> discipline, including expulsion from the program, when necessary, for but not limited to the following offenses:

    - Under the influence of drugs/drug abuse.
    - Under the influence of alcohol/alcohol abuse.
    - Insubordination.
    - Being physically and/or verbally abusive to others.
    - Sexual harassment
    - Cheating
    - Forgery or falsification on program and/or agency documents
    - Behavior deemed detrimental to patient care.
    - Theft or attempted theft of the property of others including but not limited to fellow students, faculty, staff, hospitals, clinical settings, ambulance services, and Southwestern Illinois College.
    - Exceeding their scope of practice in any situation.
    - Any patient privacy violation <u>no matter where it occurs</u>.

Withdrawal/Dismissal Policy

When a student withdraws from, is dropped by the program, or is ineligible to progress; the student will contact the primary instructor for an exit interview. At the interview, the student and instructor will document the reason for withdrawal, dismissal or non-progression along with possible recommendations / requirements concerning readmission.

Readmission Policy

Students who withdraw, do not pass or are ineligible to progress at the completion of a course may be eligible to attempt the program again. Past repeating students have expressed that an adjustment in their schedules, better preparation, and an improved realization of programexpectations have contributed to their success on the second attempt.

Students should be aware of the following when considering readmission:

- Readmission into the program is not guaranteed. Faculty and the coordinator reserve the right to deny or approve re-entry based upon thereason for withdrawal, dismissal or non-progression; curricular changes and/or space availability.
- Faculty and the coordinator may require the student to pass proficiency exams to ensure retention of knowledge and/or psychomotor skills prior to a decision on re-entry.
- Faculty and /or the coordinator may require the student to submit a letter outlining changes that have been made to better navigate the demands of the program.
- Faculty and the coordinator may require the student to repeat additional courses or the entire program based upon the reason for withdrawal, dismissal or non-progression; curricular changes and/or space availability.
- Students may be able to reattempt to complete an unsuccessful portion of the program a maximum of one time within one yearwith coordinator approval.
- Any student who is not successful after the reattempt or who waits longer that one year must repeat the entire program.

Conflict of Interest during Field Internship

Students are encouraged to use good judgment when choosing a field internship site or FTO and avoid selecting an organization or individual who may present with a conflict of interest, real or perceived. In some cases, the student may be prohibited from using a site or FTO due to a potential conflict of interest. These include, but are not limited to:

An FTO who is a:

- family member
- close friend
- romantic partner
- business partner
- subordinate

OR

An organization where the student has:

- a business stake
- current litigation
- been previously terminated

A student identified to be in a situation with a potential, real or perceived conflict of interest will be referred to the EMS Program Coordinator, EMS System Coordinator or EMS Medical Director. Students determined to be in an identified conflict of interest situation will be asked to select a different field internship site or FTO. In addition, any runs completed during the conflict of interest situation may be disallowed. Flagrant breeches of this policy may be subject to disciplinary action as identified in that section of this manual.

Decorum

Classroom

- Students are to consider the lecture material as an important source of learning in addition to reading and viewing materials assigned and/or suggested by the faculty. Lecture materials are presented by faculty members responsible for the course or by guest lecturers.

- Patient confidentiality will be maintained at all times. Any breech of patient confidentiality will result in expulsion from the Paramedic Program.

- Fire pagers must be turned off during class.

- Mobilephones and wireless devices must be turned off and stowed away during class and skills labs. Calls and text messages are not to be answered and students are not to leave the classroom during lecture or skills to receive or return calls. In the event of a significant incident such as a sick child or gravely ill family member, a student may inform the instructor prior to class and will be allowed to leave the room to answer or return calls.

- Audio recording devices may be permitted during lectures only with permission of the lecturer. No recording devices (cell phones, personal recording devices, etc.) are allowed out or on your person during reviews or testing. Students are not to assume the privilege of taping presentations of either guest lecturers or faculty members in the program. Student video recording or photography is prohibited. Any photos taken for program use will be taken by the instructor, coordinator or school photographer.

- Students must be prepared for class each day. Students should have appropriate learning tools and implements such as: texts, pen, pencil, paper, notebooks, policy manuals, skills manuals, etc. On skills days, students should always wear a watch with second hand, have a stethoscope, and have their skills manuals with them.

- Regularly scheduled breaks will be given throughout the class period. These breaks should be used for returning pages or phone calls, using the restrooms, obtaining snacks or beverages, or smoking. Disrupting the class for any reason other than an emergency will not be tolerated. Special circumstances must be prearranged with the instructor.

- Students should use every effort to avoid cursing or using suggestive language in the program courses. Excessive cursing or suggestive language will be construed as disruptive behavior or disorderly conduct and subject to disciplinary action in accordance with the *Southwestern Illinois College Student Conduct Code*.

- Smoking and use of tobacco products of any kind is not permitted in any SWIC building, Memorial Hospital, clinical sites or near the entrances. Smoking is only permitted in assigned areas; proper disposal of cigarette butts is required.

- Reasonable food and drink are allowed in the classroom so long as their consumption does not interfere with the instructor's lesson or other students' ability to concentrate. Food that is noisy or smelly may not be consumed in the classroom. Sunflower seeds will be banned if shells are found on the floor.

- Students are not permitted to use facility equipment, including phones, fax machines, staff or faculty computers, or copiers. Students must not enter any faculty office or area without faculty permission. Designated areas of the facility as defined by the faculty are off limits.

- While on breaks, students must respect other students, faculty, and staff with their activities. The facility is used for many other classes and activities. Please be respectful.

- Students must respect the physical property of the facility and its cleanliness. All student areas should be neat and clean prior to leaving the facility at the end of class. Students must wipe down their work surface and put their chair up at the end of class each day.

- Faculty or staff should be notified of any facility issues so that timely maintenance or repair can occur. Housekeeping responsibilities will be shared by the students and explained further during the first day of class.

- After all breaks, students must return to the classroom or skills group on time. Infractions will be subject to the tardiness policy.

- Students must not sleep in class. Students may stand (not sit) in the back of the classroom if needed to remain attentive.

- Personal computers will be allowed in the classroom with permission of the instructor for academic purposesonly.

- The Program is committed to reduce, reuse, and recycle. Memorial Hospital has recycle bins for paper and aluminum at this time. Recycle bins for glass, plastic and aluminum

cans exist throughout the SWIC building and should be used by students and faculty. Students must not throw recyclables into regular trash bins.

- Posts made by students to social media sites such as Facebook, Myspace, Instagram, etc. concerning classroom activities, program personnel or fellow students will be subject to the same scrutiny as comments made in class. Posts that are unprofessional, overtly negative, demeaning, or inappropriate may be subject to disciplinary action.

Maintenance of Classroom Facility

The classrooms at Southwestern Illinois Collegeand off-campus affiliates should be cared for with respect and dignity. If you are responsible for or you see a mess, clean it up. Clean-up and set-up of skills equipment is the students' responsibility under the direction of the faculty.

Expectations include but are not limited to:

- Keeping the classroom free of trash and debris.
- Wiping work surfaces at the end of each day.
- Pushing chairs in and returning all classrooms to an equal or better condition than it was found.
- Putting chairs, tables and equipment in lab area away at the end of each day.
- Keeping lab areas clean and in order.
- Keeping equipment storage areas clean, organized and free of debris.

Clinical and Field Sites

Students are required to actively participate in patient care that they are trained to do while being supervised. Students are also encouraged to ask questions of the clinical and fieldstaff in order to maximize their learning and gain a further understanding of medical problems and treatments. During the clinical and fieldrotations, students are expected to arrive and report early to their shift, and to leave late. This habit will lead to a positive and professional perception of the student's work ethic and effort.In the clinical and fieldsettings, students should be helpful with staff and patient assistant functions. While it is not the primary focus of the clinical and fieldrotations, students should offer, where appropriate, to assist with patient transportation, patient hygiene activities and equipment restocking. This will help the staff and student develop better rapport and teamwork.

Students should also familiarize themselves with clinical and field site specific rules and expectations and adhere to these at all times. During clinical and field shifts, students are subject to the same ethics, standards of conduct and decorum as in the classroom and lab. Clinical and field preceptors may terminate a shift at any time and send a student home if the student is found to be late, unsafe, unprofessional, disrespectful, improperly dressed or those who violate patient privacy standards. Students who are asked to leave their clinical or field rotation will be subject to disciplinary action and may receive a failing grade for that section resulting in the inability to test for licensure.

Students in the clinical and field internship phases should have with them at all times:

- pen in working order
- pocket sized notepad or scratch paper
- stethoscope
- watch

Patient contact and clinical or field site evaluation forms should be brought to every clinical shift. It is the student's responsibility to have preceptors sign the necessary forms prior to leaving the site for that shift. It is also the student's responsibility to enter complete clinical and field patient data and a

shift preceptor evaluation into the FISDAP system within 48 hours of the shift. Any student who fails to obtain the required signatures or complete the FISDAP entries within the required time will need to repeat the clinical or field shift.

Online

Many of the EMScourses offered through Southwestern Illinois College have a Web-based classroom component. This area is to be considered an extension of the classroom and treated accordingly. If you're like many people, this may be your first experience with an online course. You may have taken some courses before, and you may also have had experience with some form of electronic communication, but a Web-based course is a new area of social interaction, and as such it has its own rules for interacting with others. This guide is intended to be an overview of appropriate etiquette for interaction in this new environment.

Disembodied Discussions

A key distinguishing feature of an online course is that communication occurs solely via the written word. Because of this, the body language, voice tone, and instantaneous listener feedback of the traditional classroom are all absent. These facts need to be taken into account both when contributing messages to a discussion and when reading them. Keep in mind the following points:

- **Tone Down Your Language**. Given the absence of face-to-face clues, written text can easily be misinterpreted. Avoid the use of strong or offensive language and the excessive use of exclamation points. If you feel particularly strongly about a point, it may be best to write it first as a draft and then to review it, before posting it, in order to remove any strong language.

- **Keep A Straight Face.**In general, avoid humor and sarcasm. These frequently depend either on facial or tone of voice cues absent in text communication or on familiarity with the reader.

- **Be Forgiving.**If someone states something that you find offensive, mention this directly to the instructor. Remember that the person contributing to the discussion is also new to this form of communication. What you find offensive may quite possibly have been unintended and can best be cleared up by the instructor.

- **The Recorder Is On.**Think carefully about the content of your message before contributing it. Once sent to the group, there is no taking it back. Also, although the grammar and spelling of a message typically are not graded, they do reflect on you, and your audience might not be able to decode misspelled words or poorly constructed sentences. It is a good practice to compose and check your comments in a word-processor before posting them.

- **Test for Clarity.**Messages may often appear perfectly clear to you as you compose them, but turn out to be perfectly obtuse to your reader. One way to test for clarity is to read your message aloud to see if it flows smoothly. Try reading it to another person before posting.

- **Netspeak.**Although electronic communication is still young, many conventions have already been established. DO NOT TYPE IN ALL CAPS. This is regarded as shouting and is out of place in a classroom. Acronyms and emoticons (arrangements of symbols to express

emotions) are popular, but excessive use of them can make your message difficult to read. Some common ones include:

A Course is a Course

You may be familiar with many of the previous points if you have participated in other forms of electronic communication in the past. But Web-based courses have some added constraints not present in other arenas. Keep in mind these additional four points:

- **Remember Your Place.**A Web-based classroom is still a classroom, and comments that would be inappropriate in a regular classroom are likely to be inappropriate in a Web-based course as well. Treat your instructor and your fellow students with respect.

- **Brevity Is Best.**Be as concise as possible when contributing to a discussion. Web-based courses require a lot of reading, and your points might be missed if hidden in a flood of text. If you have several points that you want to make, it might be a good idea to post them individually, in several more focused messages, rather than as a single, lengthy, all-encompassing message.

- **Stick To the Point.**Contributions to a discussion should have a clear subject header, and you need to stick to the subject. Don't waste others' time by going off on irrelevant tangents.

- **Read First, Write Later.**Don't add your comments to a discussion before reading the comments of other students unless the assignment specifically asks you to. Doing so is tantamount to ignoring your fellow students and is rude. Comments related to the content of previous messages should be posted under them to keep related topics organized, and you should specify the person and the particular point you are following up on.

University of Wisconsin, ."Online Etiquette."*University of Wisconsin Colleges Online*. 2010. Web. 23 Jun 2010. <http://online.uwc.edu/technology/onletiquette.asp>.

Attendance

Attendance during all phases of the program is critical because of the nature of the material to be presented and the required commitment of outside professionals in the program. The following rules are strict. This is necessary due to the limited duration of the program and the large number of hours that must be completed for State of Illinois standards.

Three Strike Absence Policy

The paramedic program understands that occasionally students have illnesses or emergencies that arise during their time in the program that may require them to have absences from the classroom, clinical or field portions of the program. However, student attendance is vitally important to his or her success in the program. In addition, absences from didactic, lab, clinical or field sessions create unnecessary work and difficulties for the program faculty and preceptors. In order to keep absences to a minimum, the paramedic program has adopted a three strike absence policy. The policy is detailed as follows:

- Students will be allowed only 3 total absences during each of the following clusters. Absences in any setting (didactic, clinical or field) will count toward the total of 3. (Please note that this does not mean 3 absences in each course, it means 3 total for the entire cluster):
    - EMS 205, 210, 220
    - EMS 206, 207, 211, 212, 221, 222
    - EMS 208, 213, 223, 224
- After the 3 absences have been taken, the student will be placed on probation for the duration of the cluster. Further unexcused absences will result in disciplinary action up to and including withdrawal from the program.
- Excused absences may be allowed only after the original absences have been used. Absences may be excused for the following reasons with written and dated documentation:
    - Death in the family
    - Extended illness
    - Military obligations
    - Other emergencies subject to approval by the program coordinator
- The three strike policy does not apply to ACLS, PALS, ITLS and other mandatory mini courses or in-services. Tardiness or absence from any part of these sessions will result in disciplinary action up to and including withdrawal from the program. Excused absences may be considered by the program coordinator in the decision to discipline.
- No call/no shows for clinical or field shifts are not subject to the three strike policy and will result in the student being placed on probation for the rest of the program. Further no call/no shows will result in disciplinary action possibly including withdrawal from the program.
    - A no call/ no show will be defined for this manual as failure to notify the EMS educator and preceptor and/or hospital personnel at least 1 hour prior to the start of the clinical or field shift.
- Once a clinical or field shift is scheduled, two cancellations will be considered an absence.

Tardiness Policy

The paramedic program expects all students to be on time for classroom, clinical and field sessions. In addition, tardiness shows disrespect for instructors, preceptors and fellow students. Tardiness is defined as arriving five minutes after the official class/shift start time or leaving before the official class/shift time has ended or returning after the specified time from breaks.In order to keep tardiness to a minimum, the paramedic program has adopted the following policy:

- Twotardies will be considered one absence.
- Tardies greater than 30 minutes are considered one half absence.
- Tardies greater than two hours will be considered a full absence.

The following are additional attendance requirements for each portion of the program.

Classroom

All lectures and skills sessions build on material from prior lectures and skills sessions. Without a strong foundation in this prior material, it is extremely difficult to attain and master the new material or skill. It is the student's responsibility to obtain the information from any lecture or practical session missed. The course instructor may require the student to perform additional assignments to make up information missed.

- The student should notify the EMS Educator of intended absence prior to the start of class.
- Attendance at all classroom sessions is required. Attendance is verified by signing the attendance roster before the start of each class session. Students who are not signed in by the specified time will be determined to be late or absent and subject to the three strike policy.

ACLS / PALS / ITLS and Other Mandatory Mini Courses

Specific attendance requirements for ACLS, PALS, ITLS,FS160, FS280 and other mandatory courses for completion of the paramedic program are covered in the **Grading and Requirements** section of this handbook

Clinical Sessions

Clinicals represent real life practice and applications of what the student has learned from classroom lectures and skills practical's. Clinicals are a time to gain patient related experiences and utilize skilled practitioners to gain insight and information. Clinical time should be maximized by the student showing a willingness to learn and having an assertive attitude.

- Attendance at all clinical sessions is required. Attendance is verified by the preceptor in the assigned clinical booklet. All portions of the clinical booklet need to be completed for the student to receive credit for the clinical.

- Cancelled or missed clincals must be rescheduled only through the EMS educator. Students who reschedule clinical sessions will be placed at the end of the scheduling list.

- Tardiness for a clinical session shift is extremely unprofessional and may cause the student to forfeit the entire shift at the discretion of the preceptor and clinical site.

- Clinical sessions should not be scheduled immediately after an ambulance shift or a field internship shift. This presents a high potential of being tardy due to a late trip. Enough time should be left to avoid this situation.

Field Internship

The field internship represents real life practice and applications of what the student has learned from classroom lectures and skills practical's. During the field internship the student experiences patient related experiences and learns how to apply classroom and practical skills in the field under the skilled guidance of a field training officer. Field Internship time should be maximized by the student showing a willingness to learn and having an assertive attitude.

- Attendance at all scheduled field time is required. It is the responsibility of the student to schedule their monthly field time with ambulance service. Schedule request should be submitted to the ambulance service at least 30 days in advance.

- Students should plan to arrive at least 30 minutes prior to the scheduled shift in order to begin daily inspections of the ambulance equipment.

- Scheduled field internship dates must be submitted to the EMS educator at the beginning of each month. Attendance for the month will be verified with the Lead FTO and the signature, times, and FTO comments on the monthly hour log form.

- Tardiness for a field internship shift is extremely unprofessional and may cause the student to forfeit the entire shift at the discretion of the FTO and field site.

- Field internship shifts should not be scheduled immediately after a work shift. This presents a high potential of being tardy due to a late trip. Enough time should be left to avoid this situation.

- If the student arrives at the field internship site for a shift and finds that no FTO is available due to a schedule change, illness, etc., the student should have the shift supervisor or Lead FTO notify the EMS educator preferable via email.

- The field run hour log form must be submitted to the EMS Educator no later than the 7th of each month. Failure to do so will result in a 5% per day grade deduction being assessed.

Adverse Weather Paramedic Class/College Closing Policy

The Memorial Hospital Paramedic program follows the SWIC Adverse Weather Policy.

In the event of poor weather conditions, SWIC could take one of the following actions:

- Follow the "Snow Schedule" and open at 10 a.m. See information below.
- Cancel day classes and reopen for evening classes.
- Be open for day classes, but close for evening classes.
- Cancel both day classes and evening classes.

Information regarding the use of the Snow Schedule or closure due to weather conditions will be posted on the college's homepage and broadcast on these stations:

Television	Radio	website
FOX 2 (KTVI)	KMOX-AM 1120	SWIC.edu
KMOV-TV Channel 4	WHCO-AM 1230	www.ksdk.com
KSDK-TV Channel 5	WIL 92.3	

Also, students may sign up on eSTORM for SWIC Alert to receive text or e-mail messages about emergencies such as weather-related campus closures.

Snow Schedule Information:

Under the "Snow Schedule," all campuses will open at 10 a.m. Classes scheduled to be in session at that time will be held for the remainder of their scheduled session. Students and instructors should report to those classes.

Holidays

The Paramedic program does not observe every holiday that Southwestern Illinois College observes. Students who choose to do clinical time and/or field internship time on a holiday may do so. The following holidays are observed for the classroom portion of the Paramedic program.

- Labor Day
- Veterans Day
- Thanksgiving
- Christmas
- New Years Day
- Easter Sunday
- Memorial Day
- Fourth of July

Dress Code

Appropriate attire is necessary to instill a professional attitude among students and create a professional appearance for visiting instructors, potential employers, prospective students and other health care professionals. Students must comply with the general policy listed below as well as any specific guidelines of the off-campus facilities and clinical agencies.

General Grooming Policy

- Students must be neatly groomed with clean hair, nails and clothing. Use of cosmetics must be appropriate and not excessive. Students must avoid excessive use of perfume, cologne and after-shave lotion. Fingernails must be clean, neatly trimmed and not too long to interfere with job duties. Nail polish, if worn, must be kept in good condition.

- Students should be freshly bathed with hair and mustaches neat and clean. Body odor is to be controlled and deodorant used. Teeth should be clean.

- Hair should be pulled up or back if long and should be of a natural color.

- Clean, well-fitting, conservative clothing is required.

- Tight fitting garments are not acceptable.

- Clothes that reveal midriffs or are low cut that reveal body parts or tattoos on the torso while bending over are unacceptable.

- Visible underwear or undergarments are unacceptable.

- Sunglasses may not be worn inside the building.

- Conservative jewelry is permitted, usually one pair of small stud earrings. Large or open earrings, visible necklaces visible body piercings,or body modification appliances (including tongue piercings) are not permitted during lab, clinical or field sessions for safety reasons. Students with unusual piercings or body modification appliances should consult the EMS Instructor or Program Coordinator prior to clinical and field sessions for suggestions. Note: No piercings or body modification appliances can be visible during the St. Louis Children's Hospital clinical or students will be sent home.

- Tattoos should be covered during clinical and field sessions. Students with tattoos in difficult to cover places or excessive tattoos should consult the EMS Instructor or Program Coordinator prior to clinical and field sessions for suggestions. Note: No tattoos can be visible during the St. Louis Children's Hospital clinical or students will be sent home.

- Students must wear a dark colored shoe that is clean and displays a professional appearance. Shoes and shoelaces, stockings or socks must be clean. Thong sandals, flip/flops, clogs, high heels, slippers and open-toed shoes are not acceptable for students at any time as they pose a safety risk during lab sessions.

- Special dress requirements may be outlined by your instructor for specific activities.

- Caps or hats must not be worn at any time in the clinical settings

- In the event that the Paramedic Instructor determines you do not meet the dress/hygiene code the student will be removed from class for that day and you will receive an absence.

Classroom/ Lab/Practical Attire

In addition to the General Grooming Policy, proper attire includes:

- Specific blue uniform button up shirts with the Southwestern Illinois EMS System patch and student rocker on the left sleeve and state of Illinois EMT patch on the left sleeve are required. Silver EMS insignia pins are required on each collar of the uniform. The color of blue is specific and no other color of blue is permitted. For uniform specifics please contact:

Char Wild
Heroes in Style
1148 Royal Heights Rd.
Belleville, IL.62226
(618) 235-1066

- Blue pants are required and may be in the form of dress slacks or EMS pants.

- Dress shoes or EMS boots must be black and in good condition.

- T-shirts or undershirts worn beneath the uniform shirt must be blank and free of any print whatsoever.

- A black belt is to be worn with your pants.

- Students must wear their Memorial Hospital Paramedic student photo ID badge during classroom and clinical time.

- The class uniform will be worn at all times including classroom and practical days and courses.

- Anyone who arrives to class in anything besides the required dress code attire will be sent home.

- Class uniforms are not to be worn to clinicals or field internship sessions.

Clinical Attire

In addition to the General Grooming Policy, proper attire includes:

- White button-down or polo shirt/blouse with no writing or logos (any T-shirts or undershirts worn under this should be white and free from any writing or logos)
- Black or navy blue slacks that are clean and free of rips, holes and frayed edges
- Black dress shoes or boots that are polished, sturdy and have a closed toe and heel.
- Jewelry should be worn at a minimum (i.e. 1 pair of stud earrings in ear lobes, wedding ring and watch only) (absolutely no tongue piercings are allowed)
- Tattoos should not be visible
- Black belt with shirt tucked into pants at all times
- The Memorial Hospital Paramedic student photo ID badge must be attached to the front pocket of the lab coat.
- Hats of any kind are not allowed during clinicals
- Scrubs will only be worn during the advanced airway clinical in the operating room. The scrubs will be issued to the student the day of the clinical and will be returned at the end of the clinical that day. At no other times will scrubs be permitted.

Field Internship Attire

In addition to the General Grooming Policy, proper attire includes:

- During supervised field runs, the student is expected to wear the agency designated uniform.
- EMS pants may be substituted for dress slacks.
- Student Paramedic patches must be worn on the left sleeve or above the left breast pocket.
- Illinois EMT or National Registry EMT patches may be worn on the right sleeve.
- Name pins, tags or badges are to be worn at all times.
- Shoes should be clean, sturdy, comfortable, and cover the entire foot. Boots are recommended.
- Black belt with shirt tucked into pants at all times.

Grading& Requirements

The student is expected to maintain a 77% ("C") overall average. Any student who has a grade point less than 77% at semester end shall be dropped from the Paramedic Program and will be ineligible to continue or complete the program

In the event the student drops below a 77% overall average at midterm evaluations, the instructor and student will develop an action plan with the intent of correcting and improving on deficiencies. Continued deficiencies may result in the student being dropped from the Paramedic program.

Methods of evaluation in this program include written examinations, practical examinations and comprehensive final exams. A breakdown of assignments, test and scoring weights is available on the individual course syllabus. Rubrics for clinical and field courses are available in Appendix C of this manual.

Grading Scale:

100% to 94%	=	A
93% to 86%	=	B
85% to 77%	=	C
76% to 70%	=	D
<70%	=	F

Affective Domain Grade

The affective domain grade is calculated at the end of class and is meant to reflect overall participation and professionalism demonstrated throughout class. The course instructor will take into account such things as, but not limited to, absences, tardies, early departures, discussion participation (classroom and online), practical participation, clinical comments, pertinent questioning, timeliness of assignment completion, volunteerism, teamwork and overall professional behavior.

Homework and Quizzes

Handwriting must be legible. If any part of your work is not legible you may lose points on your work and may be required to rewrite your work to the point that it is legible. Point deduction depends on the severity of the infraction. Illegible handwriting on field runs may result in the field run deemed unacceptable.

Correct spelling is a must. Incorrect spelling may result in a loss of points on your work. Incorrect spelling on field runs may cause the field run to be deemed unacceptable. (Keep a regular & medical dictionary at your disposal)

Homework, quizzes, and patient care reports should all be done in black ink. Black ink is to be used for written tests except when scantron sheets are used. Number 2 pencils will be used on scantron sheets.

At semester end the student will be given the option to drop one homework grade and one quiz grade.

Written Testing Policy

Students should make every effort to attend and be on time for testing days.**A missed test due to tardiness or absence will need to be made up within the next five business days.** After that, a 10% per day score reduction will be assessed. A student who arrives over 15 minutes late for a test will need to make up the test at a later date. Only one make up test will be given per student per semester unless a documented emergency has occurred. This will be verified by the instructor or program coordinator. The accepted grade for any retake will be the average of the old and new scores, no matter which is higher

Final Practical Exam Policy

The final practical exam is meant to ensure competency in required national skills, found in Appendix A, prior to licensure testing. Final practical exam day can be extremely stressful for the student. Evaluators present that day are there to merely ensure competency, not to intimidate or play mind games with students. In order to do well on this exam, students should maximize their time in the lab by taking every opportunity to practice these skills during practicalsessions throughout the class.

If necessary, retesting will follow the retest policy of the National Registry of Emergency Medical Technicians.

Students will be given a booklet with the test/skill sheets that will be utilized during the final practical exam. There will be a total of 8 testing stations using the following skill sheets:

- Dynamic Cardiology (ACLS Mega Code)
- Dynamic Cardiology (Original)
- Static Cardiology
- Alternate Airway Device (Supraglottic Airway)
- Direct Endotracheal Intubation - Adult
- Direct Endotracheal Intubation - Pediatric
- Patient Assessment - Medical
- Patient Assessment - Trauma (ITLS Structure)

The test proctor will grade the students electronically via FISDAP utilizing these test/skill sheets. These test/skill sheets can be accessed at any time from your FISDAP account by following these instructions:

- Type www.fisdap.net in your web browser
- Sign In: User name and password
- Click Accounts
- Scroll down to Program Settings and evaluations and
- Click Program Evaluations
- You will see a the following heading: Which of these forms would you like to use

- Click on arrow and scroll down until you find the form you are looking for
- Click on the form you have chosen
- Click Go (Blue button)

Airway Management Competency

The following has been adopted based on the recommendation the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions:

The paramedic student should establish airway competency by mastering the following:

1. Adequately assess, establish, maintain and monitor the airway throughout patient contact
2. Perform basic airway management, including the use of basic maneuvers and airway adjuncts.
3. Prepare and perform advanced airway management
4. Demonstrate psychomotor skill proficiency related to all levels of airway management
5. Perform airway management in various environments, including laboratory, clinical and field
6. Verify correct placement of airway devices utilizing the following assessments and adjuncts: direct visualization (preferred), capnography (preferred), indirect visualization, chest sounds, abdominal sounds, oxygen saturation, changes in level of consciousness, skin color, and vital signs
7. Demonstrate critical thinking and clinical judgment regarding total airway management decision making

Based on current research, the paramedic student should have no fewer than fifty (50) attempts at airway management across all age levels (neonate, infant, pediatric and adult). And, in order to demonstrate airway competency, the student should be 100% successful in their last twenty (20) attempts at airway management.

Fifty attempts at airway management will occur across lab sessions with static airway manikins, as well as the required endotracheal intubation placements on live patients and with the iStan high fidelity simulation manikin.

Generally the airway competency sequence will be accomplished in the following order:

1. Forty (40) successful peer-reviewed lab practice sessions with a static airway manikin of:

    - Ten (10) adult/infant/child oropharyngeal airway placements
    - Ten (10) adult endotracheal intubation placements
    - Ten (10) infant/child endotracheal intubation placements
    - Ten (10) adult King LT placements

2. Three (3) instructor-reviewed lab sessions of each adult intubation, pediatric intubation, adult King LT placement.
3. Two (2) instructor-led lab sessions of each needle transtracheal ventilation and surgical cricothyriodotomy

4. At least three (3) endotracheal intubations on a human cadaver
5. Ten (10) instructor-reviewed sessions of adult endotracheal intubation with the iStan high fidelity manikin in various scenarios
6. Upon successful completion of the above, the student will have one 8 hour Operating Room clinical session where they will assist or perform learned airway management techniques on as many live patients as possible with the supervision of a qualified preceptor.
7. Upon successful completion of the above, the student is able to perform supervised advanced airway management techniques in ER clinicals and on field internship runs

Any unsuccessful airway management that causes the student to fall below the 100% success rate in their last twenty (20) attempts will need to be remediated with 20 additional lab practice sessions in a combination of adult intubation, pediatric intubation, and adult King LT placements as created by the paramedic instructor and medical director.

Minimum Clinical / Field Patient Contact and Skill Requirements

In order to complete the Paramedicine Program, the student must have documentation of a minimum number (shown below) of the following patient contacts and skills either in a clinical or field setting:

Patient Contacts	Minimum Required
Ages	
Adult (Age 18-64 yrs)	100
Geriatrics (Age 65+ yrs)	70
Pediatrics (Age 0-17 yrs)	30
Newborn (Age 0-2 mo)	2
Infant (Age 2 mo-1 yr)	2
Toddler (Age 1-3 yrs)	3
Preschooler (Age 3-6 yrs)	4
School Age (6-13 yrs)	6
Adolescent (13-17 yrs)	6
Complaint	
Medical	80
Chest Pain/Cardiac	25
Altered Mental Status	25
Abdominal Pain	25
Breathing Problem/Respiratory	25
Psychiatric	25
Change in Responsiveness	10
OB	10
Trauma	25

Clinical/Field Skill	Minimum Required
IV/IO	50
Live Intubation	1
iStan Intubations	10
Medication Administration	40
Successful Field Team Leads	30

Electronic Data Collection

The Southwestern Illinois College – Memorial Hospital Paramedic Program utilizes the FISDAP online data collection system as the primary means to track student patient contacts; schedule lab, clinical and field shifts; perform skill competencies; and a capstone exam.

- Each student will receive training on and will maintain a program funded FISDAP account throughout their time in the program.
- Students are required to keep their account up to date and enter all clinical and field patient contact information and an evaluation of the preceptor for that shift within 48 hours of the end of that shift.
- Use of the online FISDAP system requires that students have a reliable internet connected device available to them in order to meet this deadline.
- This deadline will be strictly adhered to as grading and course/program completion requirements depend on evaluation of this data by program personnel.
- Violation of this policy will follow a three strike approach each cluster
    - Clusters consist of:
        - EMS 205, 210, 220
        - EMS 206, 207, 211, 212, 221, 222
        - EMS 208, 213, 223, 224
    - First infraction will result in a verbal warning
    - Second infraction will result in a written warning placed in the student file
    - Third infraction will result in the student being placed on probation for the duration of the cluster with a letter of probation in the student file
    - Subsequent infractions will result in refusal to open locked shifts (loss of patient contacts) and may result in further disciplinary action up to and including receiving a failing grade for the course or termination from the program.

    - Documented emergencies or extenuating circumstances will be reviewed by the program coordinator and instructor prior to disciplinary action being taken.
- Any student who anticipates difficulty obtaining internet access on a consistent basis should contact the program coordinator before a problem arises
- Any student who has an temporary internet access problem should contact the course instructor immediately.

ACLS / PALS / ITLS and Other Mandatory Mini Courses

ACLS/PALS/ITLS are mandatory courses for completion of the paramedic program and for continued practice as a paramedic. These courses are offered through Belleville Memorial Hospital, and are scheduled to correspond with topics covered in the program. In addition, several classroom and lab periods are used prior to these courses for preparation in order to help you successfully pass them. However, these courses are challenging and require a significant amount of effort and attention on your part. Due to time constraints within the program it is imperative that you successfully pass these courses as scheduled. The following guidelines will be adhered to concerning ACLS, PALS, and ITLS:

- All students must attend the ACLS, PALS, and ITLS courses as scheduled during their time in the program.
- All students must pass the ACLS, PALS, and ITLS courses in order to test for licensure or certification.
- Tardies or absences from any part of ACLS, PALS, and ITLS will result in a failure of the course.
- Any student who fails ACLS, PALS, or ITLS must complete another approved course as soon as possible.
- Any student who fails ACLS, PALS, or ITLS is responsible for any fees incurred while repeating the course.
- Any student who fails ACLS, PALS, or ITLS will receive an Incomplete "I" as their grade in that didactic course until the student completes another approved course.
- The student will have a maximum of 2 attempts to pass each ACLS, PALS, and ITLS course with any repeated course completed within 3 months of the initial failure.

FS280 - Hazardous Materials Awareness and FS160 – Technical Rescue Awareness are mandatory courses for the completion of the paramedic program. These courses are offered through the Southwestern Illinois College Fire Science program. Each of these courses is scheduled during your time in the program. Due to time constraints within the program it is imperative that you successfully pass these courses as scheduled. The following guidelines will be adhered to concerning FS280 & FS160:

- All students must attend the FS280 & FS160 courses as scheduled during their time in the program unless they have completed them in prior coursework.
- All students must pass the FS280 & FS160 courses in order to test for licensure or certification.
- Tardies or absences from any part of FS280 & FS160 will be subject to the three strike policy.
- Any student who does not complete the FS280 & FS160 final exam will receive a failing grade.

- Any student who fails FS280 & FS160 must complete another approved course as soon as possible.
- The student will have a maximum of 2 attempts to pass each FS280 & FS160.
- Prior coursework may be accepted for this mandate.
    - Higher levels of Haz-Mat and Technical Rescue training may be accepted for the requirement.
    - It is the responsibility of the student to notify the EMS program coordinator at least one month prior to the course(s) if they have previously completed the course(s) or a higher level through SWIC (EMS program coordinator will verify)
    - Students who have taken either course or a higher level previously through another entity must submit documentation proving completion at least 1 month prior to the course.
    - For classes taken in Illinois, only certificates from the State of Illinois Fire Marshal's Office will be accepted for credit awards.
    - Other certificates or documentation must be approved by the Fire Science Program Coordinator.
    - Students who do not submit prior coursework documentation 1 month prior must complete FS280 & FS160 with their cohorts.

Other mandatory in-services or seminars may be required for course completion. Schedules of these will be provided at the beginning of the program. The following guidelines will be adhered to concerning these:

- All students must attend the in-services and/or seminars as scheduled during their time in the program.
- Tardies or absences from any part of these in-services and/or seminars will be subject to the three strike policy.

Capstone Exam

The Southwestern Illinois College – Memorial Hospital Paramedic Program utilizes the FISDAP online paramedic readiness exam "blue" in order to document capstone completion and readiness for the national certification or Illinois state licensure exams.

- The student will have two attempts at the "blue" readiness exam to score the minimum of a 70 in order to be eligible for the national certification or Illinois state licensure exams.
- Students are responsible to pay for the FISDAP paramedic readiness exams.
- Students who fail to score a 70 on the exam will have two more attempts, with each of these attempts reducing the students score in the final EMS224 course by 10%.
- Students who fail to pass the exam with a 70 after 4 attempts will receive a failing grade in EMS224 and must repeat the entire program.

Program Completion Requirements Summary

The EMS programs at Southwestern Illinois College are committed to graduating qualified EMTs and paramedics. In keeping with that obligation, we have adopted the following criteria to unsure graduate competency prior to licensure testing. These criteria are consistent with standards set by the Illinois Department of Public Health and the Southwestern Illinois EMS System.

- ***All students are required to have a 77% ("C") or better as their final grade in all courses order to be eligible to continue/complete the program or to sit for the state or national paramedic exam.***

- ***All students must successfully complete and/or maintain American Heart Association Healthcare Provider CPR, International Trauma life Support (ITLS), Advanced Cardiac Life Support (ACLS), & Pediatric Advanced Life Support (PALS)certifications in order to continue in or complete the program.***

- ***Students must have successfully completed FS280 – Hazardous Materials Awareness and FS160 – Technical Rescue Awareness in order to complete the program.***

- ***All patient contact requirements for clinical experience and field internship must be met before any student will be allowed to sit for state or national paramedic exam.***

- ***All students must meet the airway competency requirements must be met before any student will be allowed to sit for state or national paramedic exam.***

- ***All didactic, clinical and field internshiprequirements must be completed before any student will be allowed to sit for state or national paramedic exam.***

- ***All students must complete the Online Mandated Reporter Training at* www.state.il.us/dcfs**

- ***All students must complete the NIMS certification levels IS 100.a, 200.a, 700.a & 800.b though the FEMA independent study program in order to successfully complete the program (more information will be provided in the course).***

- ***All students are required to successfully complete a practical skills evaluation and examination at the conclusion of the program in order to be eligible to sit for the state or national paramedic exam.***

- ***All students must complete the FISDAP paramedic blue readiness exam with a specified minimum score after all other program requirements are completed and prior to being released to test for a national certification or Illinois license.***

Students must meet ALL of the criteria listed above in order to test for licensure either at the state or national level.

Incomplete Grades

All students should make every effort to complete all coursework, clinical and field requirements on time. Incomplete grades may be issued for extenuating circumstances. Each situation will be evaluated on a case by case basis by the program coordinator and medical director. A student receiving an incomplete will not be permitted to register for the next subsequent course. Incomplete grades will only be given for extenuating circumstances at the discretion of the EMS Educator and Program Coordinator. A student may receive a failing grade if all classroom, clinical or field requirements are not met within the allotted timeframe. In the event the student is granted an incomplete, a timeframe not to exceed 100 days from the date the incomplete was issued will be given to the student to complete the required work. Any student not completing the requirements outlined within that timeframe will receive a failing grade. Since several of the courses run progressively and concurrently, a student may not be able to continue in the program until all incomplete requirements are met. The student will need to complete the requirements as soon as possible to enroll and complete the next course in the sequence prior to the end date. In the event the requirements are not completed in a timely manner, the student will be unable to continue in the program. Readmission is not guaranteed. Students should refer to the withdrawal/dismissal and readmission policies within this manual.

Obtaining Licensure

Once a student successfully completes the course, they will be eligible to take the written examination for National Certification or State licensure. Southwestern Illinois College strongly suggests all students take the National Registry of EMTs written and practical Paramedic exams for National Certification. Registration for a National exam will be explained in class and is detailed at www.nremt.org. Once a student successfully completes this exam, they can apply for an Illinois Paramedic license, or any other state they wish to practice in, by visiting their local EMS System office. A student must obtain state licensure in order to practice in that state. Students may opt to take the Illinois State Paramedic exam instead of the National exam. Information on this exam can be found at www.idph.state.il.us/ems/. All certification and exam fees are the responsibility of the student.

The student seeking paramedic licensure must:

- Successfully complete the didactic courses with a “C” or higher as the final grade in EMS 205, 206, 207, and 208.
- Successfully complete all clinical requirements with a final grade of “C” or higher in EMS 210, EMS 211, EMS 212, & EMS 213.
- Successfully complete all field internship program requirements with a final grade of “C” or higher in EMS 220, EMS 221, EMS 222, EMS 223, & EMS 224.
- Successfully complete all practical testing stations of the System/State Practical Examination.
- Receive approval for Paramedic Testing by the EMS Educator.

- Participate in an exit interview with the EMS Medical Director or his designee prior to Paramedic Licensure Testing.
- Successfully complete the FISDAP Paramedic Blue readiness exam with a score of 70 or higher.

Continuing Education Units (CEUs)

In order to remain nationally certified, a Paramedic must complete 72 hours of continuing education, including an approved refresher course, within the recertification period. In order to remain Illinois licensed, a Paramedic must complete 120 hours of continuing education within the recertification period.

Financial Aid

The Southwestern Illinois College EMT course and paramedic courses are eligible for financial aid. The Financial Aid and Student Employment Office at (618) 235-2700 x 5288 will assist with your efforts to obtain the resources needed to further your education. They will inform you of your options and process your financial aid.

The financial aid handbook located at www.swic.edu/finaid-handbook/ is designed to be used in conjunction with The Student Guide published by the U.S. Department of Education, available from our office or at www.studentaid.ed.gov. Together, these references will answer the majority of your questions. If you need financial aid assistance, please contact this office.

For refund questions as well as dates for refund percentages, reference the refund policy in the most current college catalog or www.swic.edu. For refund information for those on contact the Financial Aid Office

Veteran's Services

SWIC Veterans Services Office assists veterans and their dependents with obtaining federal and state education benefits.

SWIC Veterans Services Office Locations

- Belleville Campus 618-222-5226
- Sam Wolf Granite City Campus 618-641-6636

Applications may be submitted at the SWIC office on Scott Air Force Base. However, questions should be directed to one of the two Veterans Services Office locations.

Claims must be submitted each term or semester after enrollment.

Basic Registration Process for Students New to SWIC

1. See a counselor to establish your program of study.
2. Register for classes that fit into your program of study.
3. Have transcripts from your military branch of service and any colleges sent to:
   Southwestern Illinois College Enrollment Services
   2500 Carlyle Ave.
   Belleville, IL 62221
4. Visit one of the SWIC Veterans Services Office locations for claims processing.

Exposure Control and Injury Policy

The health and safety of all students is important. It is important that students know and understand exposure and injury procedures and strictly follow them. It is the student's responsibility to follow safe work practices and infection control guidelines. Students providing care to patients will be instructed in the proper precautions to follow.

Procedure for Exposure

1. Wash your hands, arms, face, etc. immediately and thoroughly with soap and water if you have had unprotected contact with blood and/or body fluid/substances. If eyes or mucous membranes have been exposed, flush with water/saline.
2. Report injury, illness, or exposure such as a needle stick or a splash immediately to the preceptor and to the course instructor.
3. If the exposure occurs in a clinical setting, the student should use the protocols available in the clinical agency to which you are assigned.
4. If the student deems that the injury requires immediate evaluation or treatment, the student should follow the procedures for illness and injury on the next page.
5. If the student deems that the injury does not require immediate evaluation or treatment, it is recommended that the student seek medical attention within 72 hours of exposure.
6. Complete the required notification forms and submit them to the program coordinator within 24 hours of the exposure.
7. Any evaluation, treatment or follow-up will be done at the discretion of the student and their physician
8. Students are responsible for maintaining their own medical health coverage and for all expenses concurrent to any and all physical examinations, laboratory testing, and treatment due to exposure, illness, or injury.

Procedure for Illness or Injury in the On-campus Setting

1. Call Public Safety (Ext 5555(BV), 6672(GC), 8888(RB)) or dial 911 (if indicated).
2. Report injuries or exposures immediately to the instructor who will notify the program coordinator.
3. If medical treatment is required, the student should seek medical attention at an emergency room or other medical facility. Students may choose to see their own physician if non-emergent
4. Complete the required notification forms and submit to the program coordinator within 24 hours of the incident.
5. Students are responsible for maintaining their own medical health coverage and for all expenses concurrent to any and all physical examinations, laboratory testing, and treatment due to exposure, illness, or injury.

ProcedureforIllnessor Injury in the Off-campus or Clinical Setting

1. Call 911 (if indicated) or the facility emergency number.
2. Report injuries or exposures immediately to the instructor or preceptor.

3. If in a clinical setting, the preceptor should notify the course instructor as soon as possible who will contact the program coordinator.
4. If medical treatment is required, the student should be referred to an emergency room or other medical facility. Students may choose to see their own physician if non-emergent
5. Complete the required notification forms and submit to the program coordinator within 24 hours of the incident.
6. Students are responsible for maintaining their own medical health coverage and for all expenses concurrent to any and all physical examinations, laboratory testing, and treatment due to exposure, illness, or injury.

Personal Insurance Coverage

Students are responsible for maintaining their own health and accident insurance coverage and for all expenses concurrent to any and all physical examinations, laboratory testing, and treatment due to exposure, illness, or injury. For those without coverage wishing to purchase insurance, the following options are available:

- **Belleville Campus:** You can purchase accident and sickness insurance through a student insurance carrier. The college does not endorse the plan but makes it available to students who find the program useful. For information, contact the assistant to the vice president for Instruction, Room 3260 MC, or call 618-235-2700, extension 5211.
- **Sam Wolf Granite City Campus**: Informational brochures are available in room 416. Call 618-931-0600, ext. 6612.
- **Red Bud Campus**: Contact the Student Development office or call 618-282-6682, ext. 8114.

Appendix A
Study Suggestions

How to Study in This Program

In general it will be necessary for you to read the chapter from your textbook prior to the class date and come to class prepared to listen to a lecture regarding the material and how to apply this information when functioning in the street in an actual EMS setting. Some of the material will be covered by performance competencies in the laboratory. In other words, you will read about it, you will hear about it, you will see it done, then you will do it.

Self-Management

Review this manual and the other course materials frequently. Then consider what you want to accomplish in this course and what it will take to accomplish it. Once you have set achievable goals for yourself, plot out how to achieve them. Ask yourself, "What do I have to do to complete this course successfully? How can I make the best use of my time? What part of the day/week is best for me to study?" Also, consider where you will study. Using an area that is free from distractions or outside interruptions will increase your learning efficiency. Try to pace your workload evenly. Do not try to "cram" for a test all at once. It will probably not work. Consider blocking out time to study in the same way you block out hours to work.

Reading to Learn

Reading to learn is a specialized form of reading. It requires more effort than other forms of reading, especially reading for entertainment. Using the following steps will improve your understanding of the material you read.

- **Read with a Purpose.** Determine the purpose of your reading. Are you reading for the general idea? For the structure of an argument? For scrutiny of detail, inference, and application? Adjust your reading speed and process accordingly.

- **Scan the Text.** Textbooks are divided and subdivided into units and chapters, each with their own titles and headings. First, read the introduction to the text and any summaries. Surveying the structure of the text will help you understand and organize the concepts you will be reading. This process also works for reading other types of course material.
- **Preview for the General Idea.** Preview the chapter to get a general idea of the material. Look at the headings, photos, sketches, and tables. Before you begin to read the material, look over the glossary or key terms for new and already familiar concepts. Have available a medical dictionary to look up any unfamiliar terms.

- **Question the Text.** Formulate questions about the text. Change headings or titles into a question. The headings should reflect the main ideas of the text. When you have completed a section, see if you can answer the questions. What new questions did these raise? As a paramedic, developing leads is accomplished by the same method. You talk to the patient. He or she may provide information that leads to another train of thought. You ask a different question. These actions raise other logical questions. Developing logical leads and following them to their logical conclusion is part of what being a paramedic is really all about.

- **First Reading.** Read the text, concentrating on the main ideas. You may want to underline or highlight them. At this point, however, focus only on the main ideas, not the details.

- **Re-read to Check Understanding.** At the end of each section, summarize the main ideas, then restate the concepts in your own words. If you are confused, don't feel bad, we've all been there or are going to be there. Go back and reread the part you don't fully understand. When you have finished reading, go back and make notes, margin notes, or underline (highlight) key phrases in the book.

Other techniques students sometimes find useful are to visualize the information as you read it, relate it to something you already know, read or think out loud, and discuss the reading with someone else.

Review

Review the information in the text by rereading your notes, questions, and any exercises that have been assigned. Some other review techniques are to use index cards to review key terms, recite the information out loud, and explain the information to someone else. Use your classmates for discussion forums and review sessions.

Reading Techniques Include the Following

• Determine your purpose for reading
• Review the text (titles, photos, summaries, intro)
• Read for main ideas
• Turn titles and headings into questions
• Summarize in your own words
• Reread, visualize, relate, think aloud
• Review

Making Useful Notes

Making useful notes from lectures and readings is important. Making useful notes as an investigator is essential. You should be able to return to your notes months and years later and know exactly what occurred. Always answer who, what, where, when and how, if possible.

To make your notes useful for learning, try the following:

- **Prior to class:** Complete assigned readings and make an organized set of notes. Include any questions raised by the readings.
- **During class:** Lectures generally blend your instructors' insights with the materials from the readings. If you have completed the readings and written an organized set of notes, you should be able to take notes from the lecture selectively.
- **After class:** Rewrite notes to include insights and questions raised.
- **Periodically:** Review and rewrite notes to clarify issues.

Appendix B

Skills Sheets

The National Registry sheets adapted by FISDAP data collection system are used for skills testing. These can be access through your student account. In the event a skill is not available, supplemental skill sheets will be provided to you in advance of practicing any skills. Additional skill sheets have been developed utilizing the AAOS ALS Skills review book, and finally some miscellaneous resources.

Skills utilizing a testing sheets are:

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Appendix C

Student Evaluations

Please be aware that additional evaluation forms may be developed or current evaluation forms may be updated for the purpose of improving your learning experience and evaluating needs and changes to the program.

These evaluations will be presented periodically throughout the year as they become available and timing is appropriate.

Southwestern Illinois College

PROFESSIONAL BEHAVIOR EVALUATION

Student's Name: _____

Date of evaluation: _____

1. INTEGRITY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent honesty; trusted with the property of others; trusted with confidential information; accurate documentation of student learning activities.		
2. EMPATHY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Showing compassion for others; responding appropriately to the emotional response of patients and others; demonstrating respect for others; demonstrating a calm, compassionate, and helpful demeanor toward those in need; being supportive and reassuring to others.		
3. SELF - MOTIVATION	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Taking initiative to complete assignments; taking initiative to improve and/or correct behavior; taking on and following through on tasks without constant supervision; showing enthusiasm for learning and improvement; consistently striving for excellence in all aspects of patient care and professional activities; accepting constructive feedback in a positive manner.		
4. APPEARANCE AND PERSONAL HYGIENE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Clothing and uniform is appropriate, neat, clean and well maintained; good personal hygiene and grooming.		
5. SELF - CONFIDENCE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Demonstrating the ability to trust personal judgment; demonstrating an awareness of strengths and limitations; exercises good personal judgment.		
6. COMMUNICATIONS	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Speaking clearly; writing legibly; listening actively; adjusting communication strategies to various situations		
7. TIME MANAGEMENT	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Consistent punctuality; completing tasks and assignments on time.		

8. TEAMWORK AND DIPLOMACY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Placing the success of the team above self interest; not undermining the team; helping and supporting other team members; showing respect for all team members; remaining flexible and open to change; communicating with others to resolve problems.		
9. RESPECT	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Being polite to others; not using derogatory or demeaning terms; behaving in a manner that brings credit to the profession.		
10. PATIENT ADVOCACY	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Not allowing personal bias to or feelings to interfere with patient interaction; placing the needs of patients above self interest; protecting and respecting patient confidentiality and dignity.		
11. DELIVERY OF CARE	Competent [ ]	Not yet competent [ ]
Examples of professional behavior include, but are not limited to: Mastering and refreshing skills; performing complete equipment checks; following policies, procedures, and protocols; following orders.		

Use the space below to explain <u>any</u> "not yet competent" ratings. When possible, use specific behaviors, and corrective actions.

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Student Instructor

Research Paper Rubric

Objective/Criteria	Performance Indicators			
	Below Expectations	**Meet Expectations**	**Above Expectations**	**Exceptional**
Spelling/Grammar	(14 points) Many spelling and or grammar mistakes, making the paper difficult to understand.	(16 points) Some spelling and or grammar mistakes, but the paper is able to be understood.	(18 points) Few spelling and or grammar errors.	(20 points) Free from spelling and grammar errors.
Pertinent Content	(35 points) Content is not pertinent to the topic and shows no comprehension of the material. Content does not address paper criteria.	(40 points) Content is pertinent to the topic and shows minimal comprehension of the material. Content does not address some of the paper criteria.	(45 points) Content is pertinent to the topic and shows comprehension of the material. Content addresses paper criteria.	(50 points) Content is pertinent to the topic and shows advanced comprehension of the material. Content fully addresses paper criteria.
Organization	(21 points) Unclear or no purpose statements with disorganized presentation.	(24 points) Clear statements and concise overview, somewhat organized. Unclear transitions and sequencing.	(27 points) Clear statements are included, and is well organized. There are good transitions and sequencing.	(30 points) Previous criteria, and attractive layout and design in a publishable format.
				out of 100

EMS210 Grading Rubric

	Unacceptable 0	Below Expectations 1	Needs Improvement 2	Meets Expectations 3	Exceeds Expectations 4	Exceptional 5
Patient Assessment and Management	Applied appropriate assessment and management techniques on no patients of varying ages.	Applied appropriate assessment and management techniques on less than 50% of patients of varying ages.	Applied appropriate assessment and management techniques on less than 80% of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 25% or more of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 50% or more of patients of varying ages.
Triage	Did not demonstrate an appropriate approach to and principles of patient triage.	Demonstrated an appropriate approach to and principles of patient triage less than 50% of the time	Demonstrated some approach to and principles of patient triage less than 90% of the time	Demonstrated an appropriate approach to and principles of patient triage 90% or more of the time.	Demonstrated an appropriate approach to and principles of patient triage 90% or more of the time and in an excellent manner 25% of the time.	Demonstrated an appropriate approach to and principles of patient triage 90% or more of the time and in an excellent manner 50% of the time.
Affective- Teamwork, Appearance, Paperwork	Did not Demonstrate the ability to operate as an effective health care team member.	Demonstrated the ability to operate as an effective health care team member less than 50% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.
Patient Communi-cation	Did not display effective and empathetic communication skills with patients, their families and health care team members.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 50% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 90% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% of the time or more	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 25% or more of the time	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 50% or more of the time
Advanced Skills	Did not demonstrate proper techniques for learned paramedic skills on patients of varying ages.	Demonstrated effective techniques for learned paramedic skills on patients of varying age less than 50% of the time.	Demonstrated proper techniques for learned paramedic skills on patients of varying ages less than 80% of the time.	Demonstrated the proper techniques for learned paramedic skills on patients of varying ages 80% or more of the time.	Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 25% or more of the time	Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 50% or more of the time

This rubric is a guide for grading only.

Successful completion of the course requires that the student meet established standards as outlined in the handbook and clinical booklet

EMS211 Grading Rubric

	Unacceptable 0	Below Expectations 1	Needs Improvement 2	Meets Expectations 3	Exceeds Expectations 4	Exceptional 5
Patient Assessment and Management	Applied appropriate assessment and management techniques on no patients of varying ages.	Applied appropriate assessment and management techniques on less than 50% of patients of varying ages.	Applied appropriate assessment and management techniques on less than 80% of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 25% or more of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 50% or more of patients of varying ages.
Special Population Assessment and Management	Did not Identify and demonstrate an appropriate functional approach in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 50% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 80% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations 80% or more of the time.	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 25% or more of the time in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 50% or more of the time in the assessment of patients of special populations
Affective- Teamwork, Appearance, Paperwork	Did not Demonstrate the ability to operate as an effective health care team member.	Demonstrated the ability to operate as an effective health care team member less than 50% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.
Patient Communi-Cation	Did not display effective and empathetic communication skills with patients, their families and health care team members.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 50% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 90% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% of the time or more	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 25% or more of the time	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 50% or more of the time
Advanced Skills	Did not demonstrate proper techniques for learned paramedic skills on patients of varying ages.	Demonstrated effective techniques for learned paramedic skills on patients of varying age less than 50% of the time.	Demonstrated proper techniques for learned paramedic skills on patients of varying ages less than 80% of the time.	Demonstrated the proper techniques for learned paramedic skills on patients of varying ages 80% or more of the time.	Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 25% or more of the time	Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 50% or more of the time

This rubric is a guide for grading only.

Successful completion of the course requires that the student meet established standards as outlined in the handbook and clinical booklet

1

EMS212 Grading Rubric

	Unacceptable 0	Below Expectations 1	Needs Improvement 2	Meets Expectations 3	Exceeds Expectations 4	Exceptional 5
Patient Assessment and Management	Applied appropriate assessment and management techniques on no patients of varying ages.	Applied appropriate assessment and management techniques on less than 50% of patients of varying ages.	Applied appropriate assessment and management techniques on less than 80% of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 25% or more of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 50% or more of patients of varying ages.
Special Population Assessment and Management	Did not Identify and demonstrate an appropriate functional approach in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 50% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 80% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations 80% or more of the time.	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 25% or more of the time in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 50% or more of the time in the assessment of patients of special populations
Affective- Teamwork, Appearance, Paperwork	Did not Demonstrate the ability to operate as an effective health care team member.	Demonstrated the ability to operate as an effective health care team member less than 50% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.
Patient Communi-Cation	Did not display effective and empathetic communication skills with patients, their families and health care team members.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 50% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 90% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% of the time or more	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 25% or more of the time	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 50% or more of the time
Advanced Skills	**Did not demonstrate proper techniques for learned paramedic skills on patients** of varying ages.	**Demonstrated effective techniques for learned paramedic skills on patients of varying age less than 50% of** the time.	**Demonstrated proper techniques for learned paramedic skills on patients of varying ages less than 80%** of the time.	**Demonstrated the proper techniques for learned paramedic skills on patients of varying ages 80% or more** of the time.	**Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 25% or** more of the time	**Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 50% or more of the** time

This rubric is a guide for grading only.

Successful completion of the course requires that the student meet established standards as outlined in the handbook and clinical booklet

EMS213 Grading Rubric

	Unacceptable 0	Below Expectations 1	Needs Improvement 2	Meets Expectations 3	Exceeds Expectations 4	Exceptional 5
Patient Assessment and Management	Applied appropriate assessment and management techniques on no patients of varying ages.	Applied appropriate assessment and management techniques on less than 50% of patients of varying ages.	Applied appropriate assessment and management techniques on less than 80% of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 25% or more of patients of varying ages.	Applied appropriate assessment and management techniques on 80% or more and excellent assessment and management techniques on 50% or more of patients of varying ages.
Special Population Assessment and Management	Did not Identify and demonstrate an appropriate functional approach in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 50% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations less than 80% of the time.	Identified and demonstrated an appropriate functional approach in the assessment of patients of special populations 80% or more of the time.	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 25% or more of the time in the assessment of patients of special populations	Identified and demonstrated an appropriate functional approach 80% or more and demonstrated an excellent functional approach 50% or more of the time in the assessment of patients of special populations
Affective- Teamwork, Appearance, Paperwork	Did not Demonstrate the ability to operate as an effective health care team member.	Demonstrated the ability to operate as an effective health care team member less than 50% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.
Patient Communi-Cation	Did not display effective and empathetic communication skills with patients, their families and health care team members.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 50% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members less than 90% of the time.	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% of the time or more	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 25% or more of the time	Displayed effective and empathetic communication skills with patients, their families and health care team members 90% or more and in an excellent manner 50% or more of the time
Advanced Skills	**Did not demonstrate proper techniques for learned paramedic skills on patients** of varying ages.	**Demonstrated effective techniques for learned paramedic skills on patients of varying age less than 50% of** the time.	**Demonstrated proper techniques for learned paramedic skills on patients of varying ages less than 80%** of the time.	**Demonstrated the proper techniques for learned paramedic skills on patients of varying ages 80% or more** of the time.	**Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 25% or** more of the time	**Demonstrated the proper technique for learned paramedic skills on patients of varying ages 80% or more and in an excellent manner 50% or more of the** time

This rubric is a guide for grading only.

Successful completion of the course requires that the student meet established standards as outlined in the handbook and clinical booklet

1

EMS 220 – Paramedicine I					
Objective/Criteria	**Performance Indicators**				
	Not Done 0 points	**Below Expectations 35 points**	**Meets Expectations 41 points**	**Above Expectations 46 points**	**Exceptional 50 points**
Ride Hours	Less than 192 approved hours were accomplished within the specified time frame.	Less than 192 approved hours were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 192 approved hours were accomplished within the specified time frame	More than 192 approved hours were accomplished within the specified time frame	192 or more approved hours were accomplished within the specified time frame
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

EMS 220
Criteria for successful completion
Completed at least 192 approved run time hours
Affective performance
A skill success rate of at least 50% for IV's and other skills (per attempt)-Unsatisfactory = Remediation

Instructional Phase					
EMS 221 – Paramedicine II					
Objective / Criteria	**Performance Indicators**				
	Not Done 0 points	**Below Expectations 18 points**	**Meets Expectations 20 points**	**Above Expectations 23 points**	**Exceptional 25 points**
Patient Contacts	Less than 5 approved patient contacts were accomplished within the specified time frame.	Less than 5 approved patient contacts were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 5 approved patient contacts were accomplished within the specified time frame	More than 5 approved patient contacts were accomplished within the specified time frame	7 or more approved patient contacts were accomplished within the specified time frame
Priority Level	Completed less than 2 Priority 2 or better patient contacts.	Completed less than 2 Priority 2 or better patient contacts, but a medical director approved performance indicator assessment was completed*	Completed at least 2 Priority 2 or better patient contacts.	Completed more than 2 Priority 2 or better patient contacts.	Completed 4 or more Priority 2 or better patient contacts.
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

*Any Medical Director approved performance indictor assessment is only given after all traditional methods of accomplishing the goal have been exhausted and the student shows a strong commitment to reach the goal. The assessment is only given at the discretion of the instructor, program coordinator and medical director

Instructional Phase					
EMS 221 – Paramedicine II					
Objective / Criteria	**Performance Indicators**				
	Not Done 0 points	**Below Expectations 18 points**	**Meets Expectations 20 points**	**Above Expectations 23 points**	**Exceptional 25 points**
Patient Contacts	Less than 5 approved patient contacts were accomplished within the specified time frame.	Less than 5 approved patient contacts were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 5 approved patient contacts were accomplished within the specified time frame	More than 5 approved patient contacts were accomplished within the specified time frame	7 or more approved patient contacts were accomplished within the specified time frame
Priority Level	Completed less than 2 Priority 2 or better patient contacts.	Completed less than 2 Priority 2 or better patient contacts, but a medical director approved performance indicator assessment was completed*	Completed at least 2 Priority 2 or better patient contacts.	Completed more than 2 Priority 2 or better patient contacts.	Completed 4 or more Priority 2 or better patient contacts.
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

*Any Medical Director approved performance indictor assessment is only given after all traditional methods of accomplishing the goal have been exhausted and the student shows a strong commitment to reach the goal. The assessment is only given at the discretion of the instructor, program coordinator and medical director

Instructional Phase					
EMS 222- Paramedicine III					
Objective/Criteria	**Performance Indicators**				
	Not Done 0 points	**Below Expectations 18 points**	**Meets Expectations 20 points**	**Above Expectations 23 points**	**Exceptional 25 points**
Patient Contacts	Less than 5 approved patient contacts were accomplished within the specified time frame.	Less than 5 approved patient contacts were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 5 approved patient contacts were accomplished within the specified time frame	More than 5 approved patient contacts were accomplished within the specified time frame	7 or more approved patient contacts were accomplished within the specified time frame
Team Leadership	Completed patient contacts with less than 50% success rate.	Completed patient contacts with less than 50% success rate, but a medical director approved performance indicator assessment was completed*	Completed patient contacts with at least 50% success rate.	Completed patient contacts with at least 60% success rate.	Completed patient contacts with at least 70% success rate.
Priority Level	Completed less than 2 Priority 2 or better patient contacts.	Completed less than 2 Priority 2 or better patient contacts, but a medical director approved performance indicator assessment was completed*	Completed at least 2 Priority 2 or better patient contacts.	Completed more than 2 Priority 2 or better patient contacts.	Completed 4 or more Priority 2 or better patient contacts.
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

*Any Medical Director approved performance indictor assessment is only given after all traditional methods of accomplishing the goal have been exhausted and the student shows a strong commitment to reach the goal. The assessment is only given at the discretion of the instructor, program coordinator and medical director

Instructional Phase					
EMS 223- Paramedicine IV					
Objective/Criteria	**Performance Indicators**				
	Not Done 0 points	**Below Expectations 18 points**	**Meets Expectations 20 points**	**Above Expectations 23 points**	**Exceptional 25 points**
Patient Contacts	Less than 5 approved patient contacts were accomplished within the specified time frame.	Less than 5 approved patient contacts were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 5 approved patient contacts were accomplished within the specified time frame	More than 5 approved patient contacts were accomplished within the specified time frame	7 or more approved patient contacts were accomplished within the specified time frame
Team Leadership	Completed patient contacts with less than 60% success rate.	Completed patient contacts with less than 60% success rate, but a medical director approved performance indicator assessment was completed*	Completed patient contacts with at least 60% success rate.	Completed patient contacts with at least 70% success rate.	Completed patient contacts with at least 75% success rate.
Priority Level	Completed less than 3 Priority 2 or better patient contacts.	Completed less than 3 Priority 2 or better patient contacts, but a medical director approved performance indicator assessment was completed*	Completed at least 3 Priority 2 or better patient contacts.	Completed more than 3 Priority 2 or better patient contacts.	Completed 5 or more Priority 2 or better patient contacts.
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

*Any Medical Director approved performance indictor assessment is only given after all traditional methods of accomplishing the goal have been exhausted and the student shows a strong commitment to reach the goal. The assessment is only given at the discretion of the instructor, program coordinator and medical director

Evaluation Phase					
EMS 224 – Field Experience V					
Objective/Criteria	**Performance Indicators**				
	Unsatisfactory Course Failure	**Below Expectations 18 points**	**Meets Expectations 20 points**	**Above Expectations 23 points**	**Exceptional 25 points**
Patient Contacts	Less than 15 approved patient contacts were accomplished within the specified time frame.	Less than 15 approved patient contacts were accomplished within the specified time frame, but a medical director approved performance indicator assessment was completed*	At least 15 approved patient contacts were accomplished within the specified time frame	More than 15 approved patient contacts were accomplished within the specified time frame	20 or more approved patient contacts were accomplished within the specified time frame
Team Leadership	Completed patient contacts with less than 75% success rate.	Completed patient contacts with less than 75% success rate, but a medical director approved performance indicator assessment was completed*	Completed patient contacts with at least 75% success rate.	Completed patient contacts with at least 80% success rate.	Completed patient contacts with at least 85% success rate.
Priority Level	Completed less than seven Priority 2 or better and two priority 1 or better patient contacts.	Completed less than seven Priority 2 or better and two priority 1 or better patient contacts, but a medical director approved performance indicator assessment was completed*	Completed at least seven Priority 2 or better and two priority 1 or better patient contacts.	Completed more than seven Priority 2 or better and more than two priority 1 or better patient contacts.	Completed ten or more Priority 2 or better and three or more priority 2 or better patient contacts.
Affective Performance – (Paperwork, promptness, appearance, etc.)	Demonstrated the ability to operate as an effective health care team member less than 80% of the time.	Demonstrated the ability to operate as an effective health care team member less than 90% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 25% of the time.	Demonstrated the ability to operate as an effective health care team member 90% or more and in an excellent manner 50% of the time.

*Any Medical Director approved performance indictor assessment is only given after all traditional methods of accomplishing the goal have been exhausted and the student shows a strong commitment to reach the goal. The assessment is only given at the discretion of the instructor, program coordinator and medical director.

Appendix D

Student Clinical

&

Field Internship Evaluations

All clinical and field internship shifts must have a completed evaluation form completed. They are located on the FISDAPshift page in a drop down box.

Appendix E
Miscellaneous Forms

STUDENT
PROGRAM RESOURCE SURVEY

Southwestern Illinois College

The purpose of this survey instrument is to evaluate our program resources. The data compiled will aid the program in an ongoing process of program improvement.

INSTRUCTIONS: Consider each item separately and rate each item independently of all others. Circle the rating that indicates the extent to which you agree with each statement. Please do not skip any rating. If you do not know about a particular area, please circle N/A.
5 = Strongly Agree 4 = Generally Agree 3 = Neutral (acceptable) 2 = Generally Disagree 1 = Strongly Disagree N/A = Not Applicable

I. PERSONNEL RESOURCES (PROGRAM FACULTY)

A.	**FACULTY TEACH EFFECTIVELY**:						
	1. In the classroom	5	4	3	2	1	N/A
	2. In the laboratory	5	4	3	2	1	N/A
	3. In the clinical area	5	4	3	2	1	N/A
B.	**FACULTY NUMBER IS ADEQUATE:**						
	1. In the classroom	5	4	3	2	1	N/A
	2. In the laboratory	5	4	3	2	1	N/A
	3. In the clinical area	5	4	3	2	1	N/A
C.	**FACULTY MEMBERS HAVE GOOD RAPPORT WITH STUDENTS**.	5	4	3	2	1	N/A
D.	**FACULTY MEMBERS ARE WILLING TO HELP STUDENTS WITH ACADEMIC NEEDS.**	5	4	3	2	1	N/A
E.	**FACULTY ENSURE STUDENT REPRESENTATION ON THE ADVISORY COMMITTEE**.	5	4	3	2	1	N/A

Comments:_____

_____

_____

II. PHYSICAL RESOURCES

A.	**INSTRUCTIONAL RESOURCES: CLASSROOMS**						
	1 Are adequate in size.	5	4	3	2	1	N/A
	2. Have adequate lighting.	5	4	3	2	1	N/A
	3. Contain adequate seating.	5	4	3	2	1	N/A
	4. Have adequate ventilation.	5	4	3	2	1	N/A
	5. Are provided with appropriate equipment to support effective instruction.	5	4	3	2	1	N/A

INSTRUCTIONS: Consider each item separately and rate each item independently of all others. Circle the rating that indicates the extent to which you agree with each statement. Please do not skip any rating. If you do not know about a particular area, please circle N/A.
5 = Strongly Agree 4 = Generally Agree 3 = Neutral (acceptable) 2 = Generally Disagree 1 = Strongly Disagree N/A = Not Applicable

B. INSTRUCTIONAL RESOURCES: LABORATORY

1.	Is adequate in size	5	4	3	2	1	N/A
2.	Has adequate lighting	5	4	3	2	1	N/A
3.	Has adequate seating	5	4	3	2	1	N/A
4.	Has adequate ventilation	5	4	3	2	1	N/A
5.	Is equipped with the amount of equipment necessary for student performance of required laboratory exercises.	5	4	3	2	1	N/A
6.	Is equipped with the variety of equipment necessary for student performance of required laboratory exercises.	5	4	3	2	1	N/A
7.	Is equipped with the amount of supplies necessary for student performance of required laboratory exercises.	5	4	3	2	1	N/A
8.	Is equipped with the variety of supplies necessary for student performance of required laboratory exercises.	5	4	3	2	1	N/A
9.	Activities prepare the student to perform effectively in the clinical setting.	5	4	3	2	1	N/A
10.	Is accessible to students outside regularly scheduled class times.	5	4	3	2	1	N/A

Comments:_____

_____

_____

III. LEARNING RESOURCES

A. LIBRARIES (SCHOOL AND CLINICAL AFFILIATES LIBRARIES)

1.	The program faculty and/or the library personnel, offer orientation and demonstration of the library services.	5	4	3	2	1	N/A
2.	The institutional library personnel provide assistance to the students when needed.	5	4	3	2	1	N/A
3.	The libraries provide sufficient materials to support classroom assignments.	5	4	3	2	1	N/A
4.	The library hours are convenient to student schedules.	5	4	3	2	1	N/A
5.	Program assignments require the use of library resources.	5	4	3	2	1	N/A

B. STUDENT INSTRUCTIONAL SUPPORT SERVICES (TUTORS, COMPUTER LAB. ETC.)

1	Tutors provide assistance to the students when needed.	5	4	3	2	1	N/A
2.	Audiovisual and computer equipment are available to students for class assignments and activities.	5	4	3	2	1	N/A
3.	Computer resources are adequate to support the curriculum.	5	4	3	2	1	N/A
4.	Student Instructional Support Services are readily accessible to all students.	5	4	3	2	1	N/A

Comments:_____

_____

_____

INSTRUCTIONS: Consider each item separately and rate each item independently of all others. Circle the rating that indicates the extent to which you agree with each statement. Please do not skip any rating. If you do not know about a particular area, please circle N/A.
5 = Strongly Agree 4 = Generally Agree 3 = Neutral (acceptable) 2 = Generally Disagree 1 = Strongly Disagree N/A = Not Applicable

IV. CLINICAL RESOURCES

A. CLINICAL ROTATIONS

1. Facilities
   a. The clinical facilities offer an adequate number of procedures for the student to meet clinical objectives. 5 4 3 2 1 N/A
   b. The clinical facilities offer an adequate variety of procedures for the student to meet clinical objectives. 5 4 3 2 1 N/A
   c. The clinical facilities provide a variety of current equipment. 5 4 3 2 1 N/A
2. Experiences
   a. Each clinical rotation is of sufficient length to enable the student to complete clinical objectives. 5 4 3 2 1 N/A
   b. Each clinical rotation provides sufficient number of hands-on patient interaction 5 4 3 2 1 N/A
   c. Clinical rotations are sufficient to provide overall equivalent competencies for all students 5 4 3 2 1 N/A

B. CLINICAL PERSONNEL

1. Students are adequately oriented to assigned clinical areas and procedures. 5 4 3 2 1 N/A
2. Clinical personnel are sufficiently knowledgeable to provide student instruction. 5 4 3 2 1 N/A
3. Clinical personnel allow the students to observe and participate in patient care 5 4 3 2 1 N/A
4. Clinical personnel provide learning opportunities for the Student 5 4 3 2 1 N/A
5. Clinical personnel are readily available to assist students when needed. 5 4 3 2 1 N/A

Comments:_____

_____

_____

V. ADDITIONAL COMMENTS

OVERALL RATING:

Please rate the OVERALL quality of the resources supporting the program. ***(Circle one)***

5 = Excellent 4 = Very Good 3 = Good 2 = Fair 1 = Poor

Based on your experience, which program resources provided you with the most support?

Based on your experience, which program resources could be improved?

Please provide comments and suggestions that would help to improve the program's overall resources.

Thank You!**Date:** _____

Southwestern Illinois College
EMS Program Incident Report

(Report to be filed with Program Coordinator preferably within 24 hours of incident)

Date of Report: ___/___/_____ Date & Time of Incident: ___/___/_____ ___:___

Location: _____

Person Making Report: _____

Role: ☐ Instructor ☐ Student ☐ Other_____

Witnesses to Incident: _____

Describe the incident with as much detail as possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____

Southwestern Illinois College – EMS Programs
Bloodborne Pathogen Exposure Report

Recommend evaluation of exposure incident to be done by health care professional within 72 hours.

1. Student Name: _____
2. Date of Incident: _____
3. Description of student activities during the exposure incident: _____

_____

_____

_____

4. The route of exposure was:

a. needlestick with contaminated needle to _____

b. piercing of skin with contaminated sharp to _____

c. splashing/ spraying of blood or other potentially infectious material to_____

d. other: _____

_____

5. Describe the circumstances under which the exposure incident occurred: _____

_____

_____

6. If identification of source individual is not prohibited by law, name of source individual:

_____

7. Can repetition of the exposure incident be minimized by instituting a new practical control or method of operation: YES ☐ NO ☐
8. If the answer to item 7 is yes, describe the action which should be taken in the future:

_____

_____

Instructor Signature:_____ **Date: ____/_____/_____**

Coordinator Signature:_____ **Date ____/_____/_____**

Candidate/Student	

Candidate/Student Checklist of Required Documents

Education Verification	
	High school diploma or GED /College transcripts (Does not have to be official transcript however transcript will be verified with college)

Vaccination/Tests Checklist	
	Tuberculosis Test (Within 1 month of start of program)
	Measles (MMR) – Note: If you have had the MMR Vaccine- Measles, Mumps, & Rubella is Complete
	Mumps (MMR)
	Rubella (MMR)
	Hepatitis B (3 Vaccines) Series must be completed or at least started by August 01, 2013
	Tetanus (Less than 10 years old)
	Chicken Pox (Varicella)
	Physical exam (Within 1 month from start of program) Physician should use their own physical form or they can write that you are clear to attend on a prescription pad.
	Any Known Allergies?
Note: When the annual flu vaccine becomes available it is highly recommended that you receive the vaccine. Those who elect not to get the flu vaccine may be required to wear a face mask during all Clinicals for student and patient protection.	

Licenses/Certifications/Proof of Medical Insurance	
	Illinois EMT-Basic License
	Driver's license
	Current CPR Card
	Medical Insurance Card

Ambulance Agreement/Ambulance Experience Hour Verification Form	
	Three copies signed by student and ambulance service manager
	Ambulance Experience Hour Verification Form

Copies of Certificates of Required Mandatory Online Courses	
	NIMS 100
	NIMS 200
	NIMS 700
	NIMS 800
	Mandated Reporter (DCFS)

Human Biology Status	
	Copy of transcript with grade of C or better
	(OR)
	Proof of enrollment in Biology 105 - Summer 2013 or Fall 2013 Semesters
Note: If you took Human Biology at another college you must meet with SWIC Counseling Department to verify that your Biology Course (s) meet or exceed the requirements of SWIC Biology 105	

Forms to be signed in class on Monday August 19, 2013	
	Paramedic program patient confidentiality form
	Memorial Hospital Confidentiality booklet
	Receipt of Memorial Hospital/Southwestern Illinois College Paramedic Program Handbook Signature

Forms to be signed in class on Monday August 19, 2013	
	Hazardous Materials Awareness
	Technical Rescue Awareness

Appendix F
Signature Sheets

SOUTHWESTERN ILLINOIS COLLEGE
EMS PROGRAMS

STUDENT ACKNOWLEDGEMENT of PROGRAM POLICIES and COURSE SYLLABUS

I, _____, have been informed of the policies and requirements established within the EMS Programs at Southwestern Illinois College. I acknowledge that I have a clear understanding of, and agree to abide by, all policies and requirements of the program as outlined in the Student Handbook. I further attest that I have read and understand the course syllabus and agree to abide by the contents.

_____ _____

Student Signature Date

TECHNICAL STANDARDS STATEMENT of UNDERSTANDING

I certify that I have read and understand the technical standards for selection listed in this manual, and I believe to the best of my knowledge that I meet each of these standards without accommodation. I understand that if I am unable to or become unable to meet these standards I will not be admitted into the program at this time and be referred to Southwestern Illinois College Special Services.

_____ _____

Student Signature Date

STUDENT MEDICAL INSURANCE STATEMENT of UNDERSTANDING

Iunderstand that as a student enrolled in the EMS Programs at Southwestern Illinois College I am not considered an employee of Southwestern Illinois College or any of the sites where I will be doing clinical time, practical skills training or field internship. Therefore, I am not covered by any Workers' Compensation plan.

I understand that I will be personally responsible for any medical expenses incurred due to injury or illness resulting from participation in Emergency Services Program training, during either the didactic or clinical portions of the program.

I agree to release and hold Southwestern Illinois College harmless from any claim or injury arising out of the EMS Programs.

_____ _____

Student Signature Date

SOUTHWESTERN ILLINOIS COLLEGE
EMS Programs
RELEASE OF LIABILITY

Whereas, _____ is presently enrolled as a student in the EMT or Paramedic Programs at Junior College District No. 522, St. Clair, Washington, Monroe, Madison, Randolph, Bond, and Perry Counties, Illinois, and

Whereas, it is normal and incident to being in associated with the health related fields that there could be exposure to illness, disease, or injury, and

Whereas, the undersigned recognizes that possible exposure to said illness, disease or injury and acknowledges that said exposure would not be the responsibility of said Junior College District No. 522 or the cooperating hospitals, agencies, school districts, nursing homes, outpatient facilities, and rehabilitation institutes, etc,

Therefore, in consideration of being offered and my taking the program as offered by said Junior College District No. 522, I hereby release and agree to hold harmless said Junior College No. 522 and their respective Boards, administrative staffs, medical, dental, and nursing staffs, faculty, coordinators, directors, instructors, supervisors, and all personnel and employees, of and from any and all claims or injuries occasioned by any illness, disease, or injury incurred or contracted or caused by activities connected with said courses.

_____
Student Printed Name

_____ Date: _____
Student Signature

SOUTHWESTERN ILLINOIS COLLEGE
EMS PROGRAMS

STUDENT CONFIDENTIALITY
ACKNOWLEDGEMENT AND AGREEMENT

As a student, I recognize that through my assignment at a clinical healthcare facility/for an ambulance service, I will have contact with or be responsible for health information that is protected by federal and state laws. By definition, Protected Health Information (PHI) includes but is not limited to patient-related records, access to computerized financial, patient or employee-related data, business activities and civil/legal actions involving the facility/service, its patients and its staff. It may exist in a variety of forms, such as electronic, oral, written, or photographic, and all forms of information are protected. Southwestern Illinois College classifies the following types of actions as a violation of the facility/services' confidentiality policies:

1. The sharing or obtaining of specific patient information with anyone or for any reason except as is necessary for treatment, payment or healthcare operations as they relate to emergency medical services.
2. The reviewing of patient medical records except as is necessary to complete the clinical assignment.
3. The discussing of criminal, civil and other legal actions involving the facility/service.
4. The releasing of unauthorized business and/or patient-related information to anyone except as authorized by a representative of the facility/service.

I agree to behave professionally and ethically at all times. While at the site/service, I agree to abide by the facility/service policies and procedures. I agree not to directly or indirectly disclose or remove confidential information without proper authority. I understand that if I breach or compromise this agreement, I will subject myself to the immediate termination of my assignment at the facility/with the ambulance service and termination from the Paramedic course. Upon expulsion for any reason, or at any time upon request, I agree to return any and all patient confidential information in my possession.

_____
Student Printed Name

_____ Date: _____
Student Signature

_____ Date: _____
Witness Signature

SOUTHWESTERN ILLINOIS COLLEGE
EMS PROGRAMS

Review of Departmental Records

This section authorizes the EMS programs faculty to allow access of all my departmental records to official site visitors for accreditation purposes. This access is for the determination of compliance with established guidelines for the administration of the program. Information is utilized for CAAHEP or CoAEMSP visitors to assess the program and provide validity to reports sent by faculty.

_____ Date: _____
Student Signature

FERPA Release Form
(Family Educational Rights and Privacy Act)

If you wish to give the Southwestern Illinois College EMS Programs instructors and coordinator permission to discuss your records with another party(parents, spouse, employer, etc.) please complete this authorization form. These records couldinclude, but are not limited to, academic performance and grades.

I hereby give Southwestern Illinois College EMS Programs permission to discuss my records with the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Student Name (Printed) Student ID

_____ _____/_____/_____
Student Signature Date

SOUTHWESTERN ILLINOIS COLLEGE
EMS PROGRAMS

Participation in Prehospital Care and Education Research

The Southwestern Illinois College EMS Programs are committed to prehospital care and educational research. During your EMS-related courses, we would be interested in using data that has been collected about your experience in our course(s). This data is meant to help measure your learning and provide your instructors with better tools to assist you and future students in improving the didactic, clinical and field experiences. Currently, your data is confidential and can only be viewed by your instructor(s).

The EMS Programs would like your permission to anonymously use your data for research purposes. Your name and other identifying information will not be linked in any way to the data so that your privacy is protected. Only the computer programmer(s) and your instructor(s) will have any student identified information, and by both accreditation rules and Institutional Review Board requirements, neither are permitted to share any information about you without your expressed, informed consent.

Your participation in prehospital research is entirely voluntary; it will not cost you anything and does not pose any risk to your physical or psychological safety, but will be critical in the improvement of EMS education programs. There is a pressing need for more research in EMS education. Instructors are making decisions about your and future EMS education programs without having evidence to substantiate those choices.

Your consent to allow us to use your anonymous data in this research is voluntary. Your refusal to allow us to use your data will involve no penalty or loss of any privileges/benefits to which you are currently entitled. You are free to withdraw your consent at any time.

____ I DO consent to having my anonymous data used for research purposes.

____ I do NOT consent to having my anonymous data used for research purposes.

Additionally, the EMS Programs would like to obtain your permission to release your anonymous data to other person(s) or college(s) who may want to do prehospital educational research. The release of this anonymous data would involve no cost or risk to you.

____ I DO consent to having my anonymous data released to other person(s) or college(s) for research purposes only.

____ I do NOT consent to having my anonymous data released to other person(s) or college(s) for research purposes only.

Student Name: _____ Date:_____

Student Signature: _____

SOUTHWESTERN ILLINOIS EMS SYSTEM
EMS PROGRAMS

Student Standards

I _____, have received, read, and fullyunderstand the policies set forth in the student standards. I hereby agree to abide by those standards.

I have received a copy of the Memorial Hospital/Southwestern Illinois College Paramedic Program Academic Standards Rules and Regulations booklet.

I understand that the policies contained in this manual may be amended by the Paramedic Instructor or Program Coordinator at any time. In the event of a policy change I will be notified of any changes in writing.

I am aware that I may receive additional policies in writing that are not contained within this booklet.

_____
(Student Signature)

_____
(Paramedic Instructor Signature)

_____
(Date)

Paramedic Class Patient Confidentiality

Student Acknowledgement and Agreement

As a student in the Paramedic Class at Memorial Hospital I recognize that through my assignments and clinicals, I will have contact with or be responsible for information that is considered confidential.

Confidential information includes but is not limited to patient-related care records, access to patient or employee-related data, business activities and civil/legal actions involving MemorialHospital, its patients and staff.

MemorialHospital classifies the following types of actions as violations of its confidentiality policies:

1. The sharing or obtaining of specific patient information with anyone or for any reason except as is necessary in completing program requirements.

2. The reviewing of patient medical records except as is necessary to complete program requirements.

3. The discussing of criminal, civil and other legal actions involving the hospital, its patients or staff.

4. The releasing of unauthorized business and/or patient-related information to anyone except as authorized through a written agreement.

5. The sharing of employee-related information including but not limited to disciplinary actions, salary, and demographic information.

I agree not to directly or indirectly disclose or remove confidential information without proper authority. I understand that if I breach or compromise this agreement, I will subject myself to the termination of my relationship with MemorialHospital and will be dropped from the Paramedic Program and will be permanently barred from ever reapplying to the Memorial Hospital Paramedic Program. I also understand that I may face civil and criminal consequences for my actions.

In the event that there is an alleged breach of patient privacy the case will be reviewed by the Southwestern Illinois EMS System Coordinator and the EMS Medical Director. Upon completion of the review they will make a determination in the case.

Name _____

Signature_____

Date _____

Candidate/Student	

Candidate/Student Checklist of Required Documents

Education Verification	
	High school diploma or GED /College transcripts (Does not have to be official transcript however transcript will be verified with college)

Vaccination/Tests Checklist	
	Tuberculosis Test (Within 1 month of start of program)
	Measles (MMR) – Note: If you have had the MMR Vaccine- Measles, Mumps, & Rubella is Complete
	Mumps (MMR)
	Rubella (MMR)
	Hepatitis B (3 Vaccines) Series must be completed or at least started by August 01, 2013
	Tetanus (Less than 10 years old)
	Chicken Pox (Varicella)
	Physical exam (Within 1 month from start of program) Physician should use their own physical form or they can write that you are clear to attend on a prescription pad.
	Any Known Allergies?
Note: When the annual flu vaccine becomes available it is highly recommended that you receive the vaccine. Those who elect not to get the flu vaccine may be required to wear a face mask during all Clinicals for student and patient protection.	

Licenses/Certifications/Proof of Medical Insurance	
	Illinois EMT-Basic License
	Driver's license
	Current CPR Card
	Medical Insurance Card

Ambulance Agreement/Ambulance Experience Hour Verification Form	
	Three copies signed by student and ambulance service manager
	Ambulance Experience Hour Verification Form

Copies of Certificates of Required Mandatory Online Courses	
	NIMS 100
	NIMS 200
	NIMS 700
	NIMS 800
	Mandated Reporter (DCFS)

Human Biology Status	
	Copy of transcript with grade of C or better
	(OR)
	Proof of enrollment in Biology 105 - Summer 2013 or Fall 2013 Semesters
Note: If you took Human Biology at another college you must meet with SWIC Counseling Department to verify that your Biology Course (s) meet or exceed the requirements of SWIC Biology 105	

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	Memorial Hospital Confidentiality booklet
	Receipt of Memorial Hospital/Southwestern Illinois College Paramedic Program Handbook Signature

Forms to be signed in class on Monday August 19, 2013	
	Hazardous Materials Awareness
	Technical Rescue Awareness

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS312
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL EDUCATION REQUIREMENTS
PRE-HOSPITAL RN EDUCATION AND LICENSURE

I. Purpose:

To establish an education requirement Pre-Hospital RN (PHRN) course in the Southwestern Illinois EMS System.

II. Policy:

A. Entrance Requirements for PHRN:

1. Current RN licensure in the State of Illinois

2. Minimum of two years ED, ICU, or field experience within three years of initial application is strongly preferred.

3. Letter of support from ALS agency providing field experience.

B. Requirements for Licensure:

1. Completion of an IDPH-approved PHRN course.

2. Demonstrate didactic and practical knowledge of emergency medicine and Southwestern Illinois EMS System treatment protocols.

3. Pass final written exams with an 80%.

4. Pass practical exam in accordance with established guidelines for EMT-P's.

5. Current certification as either an ACLS Provider or Instructor.

6. Current ITLS, TNS, or TNCC certification.

7. Field experience may commence upon successful completion of the System/State Practical Exam and will be commensurate with that of EMT-P students:

    a) The provisional PHRN will complete a minimum of 10 acceptable runs as determined by the EMS Educator and the EMS Medical Director. Individuals have one year to complete their field internship.

    b) The provisional PHRN must obtain a positive recommendation from the Field Training Officer.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS313
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature _____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL EDUCATION REQUIREMENTS EMERGENCY MEDICAL DISPATCHER (EMD) EDUCATION & LICENSURE

I. Purpose:

To establish an education requirement Emergency Medical Dispatcher (EMD) course in the Southwestern Illinois EMS System.

II. Policy:

A. Emergency Medical Dispatchers within the Southwestern Illinois EMS System, operate under the Emergency Telephone System Board established under the Emergency Telephone System Act.

B. The education and training protocols shall be established by the Board in consultation with the Southwestern Illinois EMS System Medical Director.

C. EMD certification and EMD protocols follow the Advanced Medical Priority Dispatch System EMD Training Program. All EMDs must obtain MPDS certification and IDPH registration.

D. EMD Recertification and continuing education requirements will follow the Advanced Medical Priority Dispatch System EMS Training Program Requirements.

E, The Emergency Medical Dispatcher must maintain current EMD certification and current IDPH registration.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS314
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL EDUCATION REQUIREMENTS
EMERGENCY COMMUNICATIONS REGISTERED NURSE (ECRN)
EDUCATION & LICENSURE

I. Purpose:

To establish an education requirement Emergency Communications Registered Nurse (ECRN) course in the Southwestern Illinois EMS System.

II. Policy:

A. Entrance Requirements:

1. Current RN Licensure in the State of Illinois
2. Minimum of two years ER or ICU experience
3. Current CPR completion card
4. Current certification as either an ACLS provider or instructor
5. Current certification of TNS, TNCC, or ITLS.

B. Requirements for Licensure:

1. Forty-hour didactic and practical course of instruction for the adult and pediatric population.

2. The training course shall include:

a) 4 Hours – Telecommunications
b) 4 Hours – System Standard Operating Procedures
c) 4 Hours – System Treatment Protocols
d) 4 Hours – EMS System Policies
e) 8 Hours – ACLS/CPR Provider Course
f) 8 Hours – Field Experience

g) Successful completion of the ECRN training course, field and clinical experience, and written examination with a minimum score of 80%.

C. Requirements for ECRN re-licensure every four (4) years:

1. All requirements must be completed and submitted 30 DAYS IN ADVANCE to the EMS System Coordinator.

2. Licensed Registered Nurse in the State of Illinois.

3. 32 Hours of continuing education.

4. Pass a written examination with a minimum score of 80%. Exam format shall include, multiple choice and matching type questions.

5. Eight (8) hours field experience.

6. ACLS/CPR certified

7. ITLS/TNS/TNCC certified

D. A licensee who has not been recommended for re-licensure by the EMS Medical Director must independently submit to the Department an application for renewal. The EMS Medical Director or his designee shall provide the licensee with a copy of the appropriate form to be completed.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS315
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

INACTIVE STATUS

I. Purpose:

To establish requirement for participants of the Southwestern Illinois EMS System to request inactive status.

II. Policy:

A. Prior to the expiration of the current licensure/certification, the EMT-B/I/P, PHRN or ECRN, may request to be placed on inactive status. The request shall be made in writing (See Request for Inactive Status Form) to the EMS Medical Director and shall contain the following information:

1. Name of individual.

2. Date of approval/licensure.

3. Licensure type (i.e. EMT-B/I/P, PHRN, ECRN).

4. License number.

5. Circumstances requiring inactive status.

6. A statement that re-licensure requirements have been met by the date of the application of inactive status.

7. Current licensure submitted with the “Request for Inactive Status” form.

B. After review and approval of inactive status request by the EMS Medical Director, the request will be reviewed by the Illinois Department of Public

Health. IDPH will notify the EMS Medical Director in writing of the department's decision.

C. During inactive status the EMT/PHRN/ECRN may not function at any level.

D. To return to Active Status, the provider must:

1. Pass the written SOG test.

2. Complete five acceptable runs.

3. Obtain approval by the supervising Field Training Officer.

4. Provide copies of current CPR for Healthcare Providers, ACLS, ITLS, and PALS (as appropriate for level of licensure).

5. Complete any required retraining, education and field performance deemed necessary by the EMS Medical Director.

6. Complete a practical skills exam, as deemed necessary by the EMS Coordinator and/or EMS Medical Director.

7. If the inactive status was granted based on a disability, a letter from the provider's treating physician must be provided stating that the disability is resolved or no longer limits the provider's ability to function in the pre-hospital setting.

E. EMS Coordinator shall submit a transaction card to the Department verifying reactivation.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS316
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

VOLUNTARY REDUCTION OF LICENSE

I. Purpose:

To establish requirement for participants of the Southwestern Illinois EMS System to request inactive status.

II. Policy:

A. Any time prior to the expiration of a current license, an EMT-I or EMT-P may revert to EMT-B or EMT-I status for the remainder of the license period. The EMT-I or EMT-P must make this request in writing to the EMS Office as well as IDPH. The EMT-I or EMT-P will be required to submit their current license to the Illinois Department of Public Health. The Department will issue a new license as an EMT-I or EMT-B, depending upon the reduction level requested. To relicense at the EMT-I or EMT-B level, the individual must then meet the requested re-licensure level requirements.

B. An EMT-I or EMT-P who has reverted to EMT-B or EMT-I status may subsequently relicense within a four year period as an EMT-I or EMT-P, upon the recommendation of the EMS Medical Director who has verified:

1. Pass the written SOG test.

2. Complete five *acceptable* runs.

3. Obtain approval by the supervising Field Training Officer.

4. Provide copies of current CPR for Healthcare Providers, ACLS, ITLS, and PALS (as appropriate for level of licensure).

5. Complete any required retraining, education and field performance deemed necessary by the EMS Medical Director.

6. Complete a practical skills exam, as deemed necessary by the EMS Coordinator and/or EMS Medical Director.

B. If the reduction was granted based on a disability, a letter from the provider's treating physician must be provided stating that the disability is resolved or no longer limits the provider's ability to function in the pre-hospital setting.

C. At any time prior to the expiration of the current license, an EMT-B may similarly revert to First Responder status for the remainder of the license period.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS317
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

REMEDIATION & SUSPENSION OF PROVIDERS

I. Purpose:

To establish a method of remediation & suspension of providers in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

A. Providers within the Southwestern Illinois EMS System are expected to maintain a proper and professional manner in the delivery of patient care. Personnel whose conduct deviates from this will be given an opportunity to correct their conduct. The EMS System Coordinator will assist in this effort. A conference will be held with the individual; disciplinary action will be taken based on the outcome of the conference and the nature, seriousness, and circumstances surrounding the individual's misconduct.

B. In case of serious misconduct, in the sole judgment of the EMS Medical Director, the EMS Medical Director may immediately suspend an individual for an indefinite time from the EMS System. The appeal process for the same is set forth herein.

C. The normal progression of disciplinary action shall be as follows:

1. Verbal Warning: The EMS Medical Director or designee shall inform the individual of reported misconduct, discuss means of correction and inform the individual of the consequences if the misconduct is not corrected. Documentation of this conference will be placed in the individual's file.

2. Written Warning: The EMS Medical Director or designee shall inform the individual in writing about the misconduct. The individual shall be requested to sign the warning indicating it was received. A conference shall take place between the EMS Medical Director or designee, EMS System Coordinator, and the individual. At that time, the reported misconduct, means of correction, and consequences of continued misconduct shall be explained and discussed. Documentation of the

written warning and conference may be placed in the individual's file indefinitely.

3. Suspension: System suspension shall follow the written warning in instances where the individual has failed to correct a misconduct. Instances where suspension is the first disciplinary action taken are outlined in the following policy.

D. The EMS Medical Director may suspend from participation within the EMS System or discipline any individual, individual provider, or other participant within the EMS System not considered to be meeting the standards of the Southwestern Illinois EMS System. Those standards include:

1. Failure to meet the education and training requirement prescribed by IDPH or by the EMS Medical Director including failure to complete previously required remediation.

2. Any violation of the Illinois EMS Act.

3. Failure to maintain proficiency in the provision of basic, intermediate or advanced life support services

4. Failure to comply with any provision of the system's program plan approved by IDPH.

5. Engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public.

6. Intoxication or personal misuse of intoxicating liquors, narcotics, controlled substances or other drugs including stimulants in such manner as to adversely affect the delivery, performance, or activities in the care of patients requiring medical care.

7. Intentional falsification of any medical reports or orders, making misrepresentation involving patient care, or engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

8. Abandoning or neglecting a patient requiring emergency care.

9. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, healthcare facility, institution or other work place location.

10. Performing or attempting emergency care, techniques, or procedures without proper permission, certification, training or supervision.

11. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay.

12. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.

13. Violation of the System's standards of care.

14. Physical or mental impairment to the extent that he/she cannot physically perform emergency care or cannot exercise appropriate judgment, skill and safety for performing emergency care, unless the person is an EMT-B/I/P or PHRN on inactive status pursuant to IDPH regulation.

15. Remediation may consist of, but is not limited to:

16. Research paper.

17. Being reassigned to a FTO for supervision.

18. Clinical rotations (hospital, etc.).

19. Mega-code scenarios.

20. Skills verifications.

21. Clinical interview with the EMS Medical Director.

E. Notification of suspension:

1. The EMS Medical Director shall issue a written notice via US Mail (at the most recent address on file with the EMS Office) to the individual or provider of the suspension.

2. The notice will include a statement describing the reason(s) for the suspension, the terms, length, and condition of the suspension, and the date the suspension will commence, unless a hearing is requested.

F. A request for a hearing, via certified mail, must be submitted within 15 days to the EMS Medical Director. Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.

G. The Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an Emergency Department Physician with knowledge of EMS, one of whom is an EMT, and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. No person or entity with prior direct knowledge of the incident may serve on the Local System Review Board of an event.

H. The hearing shall commence within 21 days after receipt of the written request. A Certified Court Reporter shall take down the proceedings and prepare a transcript. The transcript shall be the official record of the proceedings. All documents received by the Local System Review Board during the hearing shall be attached to the official transcript.

I. The Local System Review Board shall state in writing its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS Medical Director and the individual,

individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing. The decision of the Board shall be effective immediately upon publication.

J. The transcripts, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System.

K. The EMS Medical Director shall notify the Illinois Department of Public Health in writing, of the Local System Review Board's decision within five days after it is issued.

L. If the Local System Review Board affirms or modifies the EMS Medical Director's suspension order, the individual, individual provider or other participant shall have the opportunity for a Review of the Local Board's decision of the State EMS Disciplinary Review Board.

M. If the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for review of the Local Board's decision by the State EMS Disciplinary Review Board.

N. Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the Local Board's decision or the EMS Medical Director's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed.

O. An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information in his or her possession indicates that the continuation in practice by an EMT or the provider would constitute an imminent danger to the public. The suspended First Responder, EMT-B/I/P/PHRN or other provider shall be issued an immediate verbal notification followed by a written suspension order to the First Responder, EMT-B/I/P/PHRN or other provider by the EMS Medical Director which states the length, terms and basis for the suspension.

P. Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger or fax, a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the First Responder, EMT-B/I/P/PHRN or provider.

Q. Within 24 hours following the commencement of the suspension, the suspended First Responder, EMT-B/I/P/PHRN or provider may deliver to the Department by messenger or fax, a written response to the suspension order and copies of any written material which the First Responder, EMT-B/I/P/PHRN or provider feels relate to that response.

R. Within 24 hours following receipt of the EMS Medical Director's suspension order or the First Responder, EMT-B/I/P/PHRN or provider's written response,

whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the First Responder, EMT-B/I/P/PHRN or provider's opportunity for hearing or review in accordance with the EMS Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended First Responder, EMT-B/I/P/PHRN or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.

S. The Director, after providing notice and an opportunity for an administrative hearing to the applicant or licensee, shall deny, suspend or revoke a license or refuse to relicense any person as a First Responder, EMT-B/I/P/PHRN in any case in which he or she finds that there has been a substantial failure to comply with the provisions of the EMS Act. Such findings must show one or more of the following:

1. The First Responder, EMT-B/I/P/PHRN, has not met continuing education or re-licensure requirements.

2. The First Responder, EMT-B/I/P/PHRN, has failed to maintain proficiency in the level of skills for which he or she is licensed.

3. The First Responder, EMT-B/I/P/PHRN, during the provision of medical services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public (e.g., use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status)

4. The First Responder, EMT-B/I/P/PHRN, has failed to maintain or has violated standards of performance and conduct as prescribed by IDPH or his/her System's Program Plan.

5. The First Responder, EMT-B/I/P/PHRN, is physically impaired to the extent that he or she cannot physically perform the skills and functions for which he or she is licensed, as verified by a physician, unless the person in on inactive status.

6. The First Responder, EMT-B/I/P/PHRN, is mentally impaired to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the functions for which he or she is licensed, as verified by a physician, unless the person is on an inactive status.

7. The First Responder, EMT-B/I/P/PHRN, has violated the EMS Act.

8. The First Responder, EMT-B/I/P/PHNR, has demonstrated medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care.

9. The First Responder, EMT-B/I/P/PHRNs, license has been revoked, denied or suspended by IDPH.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS318
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

ABUSE OF CONTROLLED SUBSTANCES BY SYSTEM PERSONNEL

I. Purpose:

To establish a reporting procedure for any witnessed abuse of controlled substances bby system personnel.

II. Policy:

A. Any system participant witnessing above said detrimental behavior while the individual in question is on duty must report the circumstances immediately to the individual's supervisor and the EMS Coordinator.

B. The circumstances surrounding the incident must be documented in writing and presented to the EMS Coordinator and/or EMS Medical Director within 24 hours of the incident utilizing the "Incident Report Form".

C. The EMS Coordinator will promptly initiate an investigation.

D. The EMS Medical Director may issue an immediate suspension upon reasonable belief than an abuse of controlled substances has occurred. The normal appeal process for the same may be initiated by the suspended individual.

E. In the event that any rule of the Department or EMS Medical Director that required testing for drug use as a condition for licensure as a First Responder, EMT-B, EMT-I, EMT-P or PHRN conflicts with or duplicates a provision of a collective bargaining agreement that requires testing for drug use, that rule shall not apply to any person covered by the collective bargaining agreement.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

SUSPENSION OF AN EMS PROVIDER/SERVICE

I. Purpose:

To establish guidance on suspension of provider/ service in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

A. Grounds for suspension of an EMS Provider/Service include, but are not limited to:

1. Evidence of continued disregard for documentation and data collection procedures. This includes consistent incomplete documentation of or failure to timely submit the required CQI data or run reports.

2. Evidence of failure to maintain dependable operation status for vehicle and/or equipment as required by IDPH and Southwestern Illinois EMS System Policies.

3. Evidence of failure to maintain the stock or supply of equipment and material as required by IDPH and Southwestern Illinois EMS System Policies.

4. Failure to adhere to commitments made in the services' proposal and application for service.

5. A reasonable belief by the EMS Medical Director that the continued participation by the Provider constitutes an unacceptable risk of imminent harm to the population served by the Provider.

B. All suspensions of an EMS Provider/Service shall be made in accordance with the above suspension policy and IDPH rules and regulations, with the interests of the population served by the provider/service at the forefront.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

AMBULANCE INSPECTIONS

I. Purpose:

To establish guidance on ambulance inspections in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

A. All ambulances and alternate response vehicles in the Southwestern Illinois EMS System will carry the equipment and supplies as listed above. Alternate response vehicles such as supervisor vehicles shall use the equipment list for BLS or ALS ambulances (as appropriate). A waiver may be obtained for equipment that is not conducive to an alternate response vehicle, i.e. a stretcher.

B. All ambulances and alternate response vehicles will be inspected annually. Random inspections may be conducted at any time and without advance notice thereof. All inspections will be by the EMS System Coordinator or designee.

C. Southwestern Illinois EMS System providers will perform equipment and supply inspections on a daily basis.

1. First responder organizations may inspect equipment on a less frequent basis as determined by the organization's call volume. However, inspections will occur weekly, at minimum. This includes inspection of all AEDs.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

PERSONNEL REQUIREMENT FOR AMBULANCES

I. Purpose:

To establish guidance on ambulance inspections in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

A. Each ambulance shall be staffed by a minimum of two EMTs, PHRNs, or physicians on all emergency calls.

B. Each Basic Life Support vehicle shall be staffed by a minimum of one EMT-Basic and one other EMT-B/I/P, PHRN, or physician.

C. Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one EMT-I, EMT-P, PHRN or physician and one other EMT-B/I/P, PHRN, or physician.

D. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one EMT-P, PHRN, or physician and one other EMT-B/I/P, PHRN, or physician.

E. Each ambulance provider that operates an emergency transport vehicle shall ensure, through written agreement with the Southwestern Illinois EMS System, that the agency providing emergency care at the scene and en route to the hospital meets the requirements.

F. A provider shall routinely provide care at a level not exceeding the level for which the ambulance is licensed (basic life support, intermediate life support, advanced life support), unless such vehicle is operated pursuant

to an EMS System-approved in-field service level upgrade. Exceptions to this rule:

1. When a patient being transported by a BLS ambulance staffed with an EMT-P or PHRN and the patient appears to be in immediate jeopardy of life or limb, the EMT-P or PHRN may use the equipment at hand on the BLS ambulance to render limited ALS care within the EMT-P or PHRN's scope of practice.

2. EMT-P personnel credentialed to provide a more advanced level of ALS care within the Southwestern Illinois EMS System (CCEMT-P personnel approved for the SCT ambulances) may utilize the SCT protocols at any time, on any ALS unit. (The credentials follow the individual, not the specific SCT ambulance.)

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

PERSONNEL

ALTERNATE RESPONSE VEHICLES – AMBULANCE ASSISTANCE VEHICLES

I. Purpose:

To establish guidance on alternate response vehicles in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

A. Ambulance assistance vehicles are dispatched *simultaneously* with an ambulance and assist with patient care prior to the arrival of the ambulance. These assistance vehicles include fire engines, trucks, squad cars, or chief's cars that contain the staff and equipment required by this section. These vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available.

B. These vehicles shall be identified by the agency as a program plan amendment outlining the type and level of response that is planned.

C. The vehicle shall not be a primary response vehicle but a supplementary vehicle to support EMS services.

D. The vehicle shall be classified as ALS, ILS, BLS, or First Responder.

E. The vehicle shall be equipped accordingly utilizing the equipment lists provided in Section III.

F. The vehicle shall ideally be staffed with personnel licensed at the vehicle's level of licensure. In the event that a provider licensed at a lower level of care responds in an alternate response vehicle, he/she may only perform skill commensurate with his/her scope of practice.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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EMERGENCY MEDICAL SERVICES

PERSONNEL

SOUTHWESTERN ILLINOIS EMS SYSTEM
EQUIPMENT AND DRUG LISTS

I. Purpose:

To establish required equipment and supplies required for ambulances and alternate response vehicles in the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations.

II. Policy:

SOUTHWESTERN ILLINOIS EMS SYSTEM
FIRST RESPONDER
EQUIPMENT AND DRUG LIST

Service: _____ Unit: _____ Level: _____ Date Received: _____

FIRST RESPONDER	**Required**	**Present**
Triangular bandage	5	_____
Roller type bandage (4 inch)	10	_____
Universal dressing (Trauma Dressing)	5	_____
Gauze pads (4x4s Sterile)	20	_____
Occlusive dressing (Vaseline Gauze 3x8)	2	_____
Bandage scissors	1	_____
Adhesive tape	2	_____
Stick (for impaled object/tourniquet)	1	_____

Blanket	2	_____
Obstetrical Kit , sterile head cover	1	_____
Upper extremity splint (Adult & Pediatric)	1 ea.	_____
Lower extremity splint (Adult & Pediatric)	1 ea.	_____
Oxygen equipment and masks (Adult, Child & Neonate)	1 ea.	_____
Nasal Cannula	3	_____
Burn Sheets	3	_____
Adult Bag-Valve Mask ventilation unit	1	_____
Child/Infant Bag-Valve Mask ventilation unit	1	_____
Oropharyngeal airway (Adult, Child, Infant)	1 ea.	_____
Oropharyngeal airways (adult, child)	1 ea	_____
Cold packs/Hot packs	3 ea.	_____
Pediatric, Small, Medium, Large C-Collars	1 ea.	_____
Long Back Board with 3 sets Straps	1	_____
Vest Type Extrication Device (KED)	1	_____
AED (optional)	1	_____
B/P Cuff Adult, Child and Infant size	1 ea.	_____
Stethoscopes	2	_____
Manual Suction Device (V-Vac may be utilized)	1	_____
Face/Eye mask, gowns	2 ea.	_____
Gloves, nonporous	1	_____
Gloves, latex free	1	_____
Bioterrorism Treatment Guidelines	1	_____
Poison Control Number 1-800-222-1222		_____

Reviewed By: _____

Date: _____

Optional equipment for first responders includes, Duodotes/Mark I kits (Contact the EMS Office for requisite training.), commercial tourniquets.

SOUTHWESTERN ILLINOIS EMS SYSTEM
BASIC LIFE SUPPORT
EQUIPMENT AND DRUG LIST

Service: _____ Unit: _____ Level: ____ Date Reviewed: _____

BASIC LIFE SUPPORT	**Required**	**Present**
Transportation Equipment and Bedding		
Emergency Response to Terrorism-Basic ConceptsBook	1	_____
System Emergency Run Reports	10	_____
Primary Pt. Cot	1	_____
Secondary Pt. Stretcher or Convertible Stair Chair	1	_____
Pillows	2	_____
Pillow Cases	2	_____
Sheets	2	_____
Blankets	2	_____
Child/Infant Car Seat	1	_____
O2 and Suction Supplies		
Main O2 Tank with Pressure Gauge, PSI	1	_____
Portable O2 Tank with Pressure Gauge, Regulator/Dial Type Flow Meter, Delivery Tube and dual 50psi Ports	1	_____
Spare Portable O2 Tank	1	_____
Adult, Child & Infant Size BVM Vent. Unit with Transparent Adult, Child & Infant Size Mask	1 ea.	_____
CPR Mask with One-Way Valve	1	_____
AED	1	_____
Adult, Child & Infant Size Airway Oropharyngeal Airways	1 ea.	_____
Nasal Cannulas	3	_____
Adult, Child and Neonate O2 Masks (Transparent, disposable)	1 ea.	_____
Portable Suction Unit (Must obtain 200mm Hg and Operate 20 Min. Minimum)	1	_____

Suction Catheters Sizes 6, 8, 10, 12, 14 and 18Fr.	2 ea.	_____
Tonsil Tip Suction Catheters	3	_____
Immobilization and Assessment		
Lower Extremity Traction Splint Adult and Pedi Sizes Or 1 which is approved for Adult & Pedi (ex. Sager)	1	_____
BP Cuff Adult, Child and Infant Sizes	1 ea.	_____
Stethoscopes	2	_____
Penlight	1	_____
MAST Suit (Optional)	1	_____
Long Back Board with 3 Sets Straps	1	_____
Short Spine Board with 2, 9-foot Torso Straps Or Vest Extrication Device (KED)	1	_____
Bandage Shears	1	_____
Long and Short Adult Extremity Splints	2	_____
Long and Short Pediatric Extremity Splints	2	_____
Pediatric, Small, Medium, Large Size C-Collars	1	_____
Set Arm and Leg Restraints	1	_____
Medical Supplies		
Trauma Dressings	6	_____
4 x 4 Sterile	15	_____
4 inch Roller Gauze	6	_____
Vaseline Gauze (3 x 8 in.)	2	_____
Rolls Tape	2	_____
Triangular Bandages	5	_____
Burn Sheets (Clean, Individually Wrapped)	2	_____
1000cc Bottles Sterile 0.9% NaCl or 4-500cc Bottles	2	_____
OB Kit (Sterile)	1	_____
Cold Packs	3	_____

Hot Packs	3	_____
Emesis Basin	1	_____
Bottle Drinking Water (1qt.) Sterile Water May Be Substituted	1	_____
Biohazard and Miscellaneous		
Box Gloves (Non porous)	1	_____
Latex-Free Gloves		
Red Biohazard Bag (Impermeable)	1	_____
Face Protection Device May Be Mask/Eye Combo or Face Shields	1	_____
Pediatric Dosage Tape or Wheel	1	_____
Plastic Baby Bottle with Nipple	1	_____
Bed Pan	1	_____
Urinal	1	_____
Body bag	1	_____
24in Wrecking Bar	1	_____
Pair Goggles	1	_____
Flashlight	1	_____
Fire Extinguishers, 51lb. Minimum, 1 in Driver Compartment And 1 in Patient Area (ABC, Dry Chemical)	2	_____
Poison Control Resource Number 1-800-222-1222	1	_____

SUPPLIES PROVIDED BY MEMORIAL HOSPITAL	**Required**	**Present**
Aspirin 80mg/chewable tab.	12	_____
Epinephrine Pen Auto Injector Adult 0.3mg	1	_____
Epinephrine Pen Auto Injector Pediatric 0.15mg	1	_____
Oral Glucose (one tube – 15grams)	1	_____

Reviewed By: _____

Optional equipment for BLS ambulances includes nasopharyngeal airways, Duodotes/Mark I kits (Contact the EMS Office for requisite training.), commercial tourniquets.

SOUTHWESTERN ILLINOIS EMS SYSTEM
INTERMEDIATE LIFE SUPPORT
EQUIPMENT AND DRUG LIST

Service: _____Unit: _____ Level: ____ Date Reviewed:_____

INTERMEDIATE LIFE SUPPORT PURCHASED BY PROVIDER	**Required**	**Present**
Semi-Automatic Defibrillator (If approved by EMS System)	1	_____
Mobile VHF radio system	1	_____
Cellular Phone (Not Required)	Optional	_____
McGill Type Forceps	1	_____
Laryngoscope Handles	2	_____
Laryngoscope Blades:		
Straight		
#1	1	_____
#2	1	_____
#3	1	_____
#4	1	_____
Curved		
#2	1	_____
#3	1	_____
#4	1	_____

A.
B.

SUPPLIES PROVIDED BY MEMORIAL HOSPITAL
AIRWAY SUPPLIES

Endotracheal Tubes		
#3 mm uncuffed	2	_____
#4 mm uncuffed	2	_____
#5 mm uncuffed	2	_____

#6 mm	2	_____
#7 mm	3	_____
#8 mm	3	_____
#9 mm	2	_____
ET Tube Stylets		
Adult	2	_____
Pediatric	2	_____
King LT (#3, #4, #5)	1 ea.	_____
IV ADMINISTRATION SETS		
Standard (15 gtt/cc)	6	_____
Dial-A-Flow (used for pediatric patients and with all medicated drips)	2	_____
ANGIOCATHS		
#14 gauge	6	_____
#16 gauge	6	_____
#18 gauge	8	_____
#20 gauge	8	_____
#22 gauge	6	_____
#24 gauge	6	_____
NEEDLES		
19 gauge 1 inch	8	_____
Blunt Tip 1 inch	8	_____
Intraosseous	2	_____
SYRINGES		
12cc with 21 gauge needle	6	_____
BLOOD TUBES		
Yellow Top	2	_____

Green Top	2	_____
Purple Top	2	_____

IV FLUIDS

N/S (.9 Sodium Chloride) 1000cc	6	_____
L/R (Lactated Ringers) 1000cc	4	_____
Normal Saline Flush 2cc	10	_____

MISCELLANEOUS SUPPLIES

IV Start Kits	10	_____
Op Site / Tegaderm Dressing	5	_____
PRN Adaptors	10	_____
Tubex	2	_____
Large Sharp Container	1	_____
Small Sharp Container	1	_____

MEDICATIONS

Aspirin 80mg/chewable tab.	12	_____
Epinephrine Pen Auto Injector Adult 0.3mg	1	_____
Epinephrine Pen Auto Injector Pediatric 0.15mg	1	_____
Oral Glucose (one tube – 15grams)	1	_____

Reviewed By: _____

Optional equipment for ILS ambulances includes nasopharyngeal airways, Duodotes/Mark I kits (Contact the EMS Office for requisite training.), commercial tourniquets.

SOUTHWESTERN ILLINOIS EMS SYSTEM
ADVANCED LIFE SUPPORT
EQUIPMENT AND DRUG LIST

Service: _____ Unit: _____ Level: _____ Date Reviewed: _____

ADVANCED LIFE SUPPORT

PURCHASED BY PROVIDER	**Required**	**Present**
Monitor/ Defibrillator With telemetry capability	1	_____
Mobile UHF radio system or UHF-compatible Cellular telephone system	1	_____
Portable Vent (Optional)	1	_____
Pulse Oximeter	1	_____
Glucose Monitoring Device	1	_____
McGill Type Forceps	1	_____
Laryngoscope Handles	2	_____
Laryngoscope Blades:		
Straight		
#1	1	_____
#2	1	_____
#3	1	_____
#4	1	_____
Curved		
#2	1	_____
#3	1	_____
#4	1	_____

SUPPLIES PROVIDED BY MEMORIAL HOSPITAL

AIRWAY SUPPLIES	**Required**	**Present**
ET Tube Stylets		
Adult	2	_____
Pediatric	2	_____
Endotracheal Tubes		
#3 mm uncuffed	2	_____
#4 mm uncuffed	2	_____
#5 mm uncuffed	2	_____
#6 mm	2	_____
#7 mm	3	_____
#8 mm	3	_____
#9 mm	2	_____
King LTD (#3, #4, #5)	1 ea.	_____
CPAP Mask (#5, #6) with Manometers	1 ea.	_____
IV ADMINISTRATION SETS		
Standard (15 gtt/cc)	6	_____
Dial-A-Flow (used for pediatric patients and with all medicated drips)	2	_____
ANGIOCATHS		
#14 gauge	6	_____
#16 gauge	6	_____
#18 gauge	8	_____
#20 gauge	8	_____
#22 gauge	6	_____
#24 gauge	6	_____

NEEDLES		
19 gauge 1 inch	8	_____
Blunt Tip 1 inch	8	_____
Intraosseous	2	_____
SYRINGES		
12 cc with 21 gauge needle	6	_____
3 cc with 21 gauge needle	6	_____
1 cc (TB) with 25 gauge needle	6	_____
BLOOD TUBES		
Yellow or Red Top	2	_____
Green Top	2	_____
Purple Top	2	_____
IV FLUIDS		
N/S (.9 Sodium Chloride) 1000cc	6	_____
L/R (Lactated Ringers) 1000cc	4	_____
MISCELLANEOUS SUPPLIES		
IV Start Kits	10	_____
Op Site / Tegaderm Dressing	5	_____
Transtracheal Jet Ventilation Kit	1	_____
Turkel Chest Decompression Kit	1	_____
PRN Adaptors	10	_____
Tubex	2	_____
Large Sharp Container	1	_____
Small Sharp Container	1	_____
MEDICATIONS		
Adenosine 6mg/2cc	4	_____
Albuterol Kit (2.5mg/3cc)	3	_____

Amiodarone 150/30ml 50mg/mL	6		_____
With D5W 100cc	1		_____
Aspirin 80mg/chewable tab.		12	
_____			
Atropine 1mg/10cc Prefill	6		_____
Calcium Chloride 10%/10cc (Prefill)	2		_____
Decadron 10mg	2		_____
Dextrose 50% (Prefill)	3		_____
Diazepam 10mg/2cc (Prefill)	2		_____
Diphenhydramine 50mg/1cc	2		_____
Dopamine 400mg/250cc drip (Premix)	1		_____
Epinephrine 1:1000 1mg/1cc (30cc vial)	2		_____
Epinephrine 1:10,000 1mg/10cc	8		_____
Etomidate ml vial 2mg/ml	3		_____
Glucagon 1mg/mL		1	
_____			
Lasix 40mg/4cc		2	
_____			
Lasix 100mg/10cc	2		_____
Lidocaine 2% 20mg/ml 5ml vial (Only for use with IO Drill)	2		_____
Magnesium Sulfate 1-2gm With D5W 50cc	2 – 1gm		_____
Morphine Sulfate 4mg/1cc (Prefill)	5		_____
Narcan 2mg/2cc (Prefill)	3		_____
Nitroglycerine Tabs or Spray	1		_____
Nitroglycerine Paste 1 inch pre-packaged	2		_____
Normal Saline for Injection 30cc	2		_____
Normal Saline Flush 2cc	10		_____

Oral Glucose (one tube – 15grams)	1	_____
Sodium Bicarbonate 50mEq/50cc (Prefill) _____	2	
Thiamine 100mg/2ml	1	_____
Toradol 30mg/ml	3	_____
Vasopressin 40 Units _____	2 – 20 Units	
Versed 5mg or 10mg/2ml	2	_____
Zofran 4mg/mL IM/IV	2	_____
Zofran 4mg disintegrating tab	4	_____
Zofran 8mg disintegrating tab		

Reviewed By: _____

Optional equipment for ALS ambulances includes nasopharyngeal airways, Duodotes/Mark I kits (Contact the EMS Office for requisite training.), commercial tourniquets.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS400
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

EMS RESPONSE

I. Purpose:

To establish guidelines in EMS responses and diversion from non-urgent calls within the Southwestern Illinois EMS System.

II. Policy:

A. EMDs will dispatch ambulances and first responders urgent (with lights and sirens) or non-urgent according to MPDS protocols approved by the EMS Medical Director.

B. EMS units dispatched with a non-urgent response will not upgrade to an urgent response unless:

1. Public safety personnel on scene request an urgent response.

2. The communications center determines that the patient's condition has changed necessitating an urgent response**.**

B. An EMS unit may divert from a current non-urgent call to a higher priority urgent call **ONLY IF**:

1. The EMS unit can reach the location of the higher priority before other responding units.

2. The EMS unit happens upon what appears to be a higher priority call.

3. An EMS unit may bypass what appears to be a lower priority situation and continue to the originally assigned call.

4. The diverting EMS unit must notify the EMS dispatch center that they are diverting to the higher priority call.

5. The diverting EMS unit ensures that the dispatch center dispatches an EMS unit to their original call.

6. Once a call has been diverted, the next EMS unit dispatched must respond to the original call. A call should not ideally be diverted more than one (1) time.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS401
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

EMS RESPONSE

MUTUAL AID

I. Purpose:

To establish guidelines for participating agencies within the Southwestern Illinois EMS System to develop and maintain mutual aid agreements.

II. Policy:

A. All providers within the Southwestern Illinois EMS System will assure proper maintenance, development, revision, and adherence to mutual aid agreements between all transport and non-transport providers in the Southwestern Illinois EMS System.

B. These mutual aid agreements shall be written agreements between provider agencies that ensure a continuum of care during peak-load periods and personnel shortages. Cooperation among all EMS agencies must supersede geographical, political, and historical boundaries.

C. All agencies will maintain current written mutual aid agreement with other transport providers to be followed when a call for service is received and the agency called is:

1. Not available to respond to an emergency in a timely manner (on a call, personnel shortage).

2. Is a non-transport provider.

3. Unable to respond.

4. Distance to call location is closer to another provider.

D. Development/Revision of mutual aid agreements will be based upon the immediate needs of the community the provider agency is serving. Such development/revisions will be conducted in a timely manner to assure and maintain proper response mechanisms.

E. Mutual aid agreements should reflect the optimum level of care and response that can be provided to the caller. Ideally the agreement should be with the provider agency/agencies that are in the primary (6 min response) and secondary (6 to 15 min response) coverage areas.

F. Mutual aid agreements should describe methods of providing EMS service which include single and dual vehicle response and the level(s) of the response/transport vehicles

G. All agencies will adhere to mutual aid agreements as they were agreed upon. Personnel involved in the implementation of these agreements (i.e. dispatchers) should be kept informed of changes in the agreements so that proper operations are adhered to.

H. When the need arises to use/implement a mutual aid agreement, the caller should be notified of such and told that there may be a delay in response time. The caller should then be given an estimated time of arrival when requested**.**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS402
Effective Date: 2/11
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Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature _____

EMERGENCY MEDICAL SERVICES

EMS RESPONSE

ALS ASSIST GUIDELINES FOR BLS/ILS UNITS (IN-FIELD SERVICE UPGRADES)

I. Purpose:

To establish guidelines for participating agencies within the Southwestern Illinois EMS System to provide in-field service upgrades.

II. Policy:

A. Any BLS unit may request ALS assistance to render a higher level of patient care for any patient.

B. A request for ALS assistance shall be implemented en route to the call when a call is received for a potentially critically ill or injured patient, i.e. a patient in cardiac arrest. Most commonly, the request for ALS assistance will occur at the end of the scene size-up.

C. Suggested criteria for requesting ALS assistance include, but are not limited to:

1. Patients with compromised or obstructed airways.
2. Respiratory distress or arrest.
3. Cardiac arrest.
4. Symptoms of acute coronary syndrome: chest pain, SOB, etc.
5. Altered level of consciousness.
6. Diabetic emergency.
7. Seizure or postictal state.

8. Pregnancy with imminent delivery.

9. Poisoning/overdose.

10. Major Trauma including, but not limited to:

    a) Multiple injuries or isolated severe injuries or pain.
    b) Trauma patients with entrapment.
    c) Major burns or those with potential respiratory involvement.

11. Medical or trauma patients exhibiting signs of shock (altered mental status, hypotension, diaphoresis, tachypnea).

12. Any patient meeting criteria in Region IV Appendix A, B, or D. (See Section XI.)

13. Any case deemed by the responding agency or Medical Control as beneficial to patient outcome.

D. If there is uncertainty regarding the need for ALS assistance, request ALS! Err on the side of the patient.

1. Consideration should be given to the following:

    a) Transport time to hospital.
    b) Rendezvous site.
    c) Availability of resources.
    d) Interventions needed (defibrillation, airway, drugs).

E. If, at any time, the BLS unit has the ability to arrive at the hospital within five minutes, ALS assist can be canceled UNLESS the patient has a compromised airway. (This includes unresponsive patients, patients in respiratory or cardiac arrest, or in whom impending respiratory or cardiac arrest is suspected.)

F. All other cases require request for ALS intercept. The BLS unit shall call for ALS assist as soon as it is evident that ALS care is needed. The BLS unit will NOT delay transportation to the ED to await ALS assist. Rendezvous en route is appropriate in these circumstances.

G. BLS ambulance personnel at the scene of an emergency shall allow ALS ambulance personnel at the scene access to the patient for the purpose of assessing whether ALS care is warranted.

H. ALS personnel will have control of the scene.

I. If the ALS personnel determine that the patient requires advanced life support care, the BLS personnel shall transfer the care of that patient to the ALS personnel. Higher level personnel shall assume in-field responsibility for the patient during the remainder of a pre-hospital transport.

J. EMT-P/PHRN personnel may, on an ALS assist, temporarily transfer the ALS equipment to the BLS vehicle. A vehicle upgraded as per protocol will be

recognized by IDPH as approved for the higher level of service during the remainder of the patient transport.

K. Medical Control should be contacted for clarification should patient care issues or concerns arise.

L. The BLS unit will complete a State run record to include all assessments and treatments carried out while the patient was in their care. The BLS unit should conclude their report indicating they relinquished care to the appropriate ALS unit.

M. The ALS unit will complete a State run record to include all assessments and treatments carried out while the patient was in their care.

N. The highest standards of patient care and professionalism at the scene will be maintained at all times. The care and safety of the patient is the highest priority. Should any conflict arise, submit an Incident Report to the EMS Coordinator.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS500
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

ON SCENE

NATIONAL INCIDENT MANAGEMENT SYSTEM

I. Purpose:

To establish guidelines for all participants to be trained and understand the use of the National Incident Management System.

II. Policy:

A. In accordance with Homeland Security Presidential Directive #5, all Southwestern Illinois EMS System providers are required to obtain ICS-100 and FEMA IS-700 certification. Note that this is a minimum requirement. Providers are encouraged to obtain further ICS and FEMA training.

B. First line supervisors and Field Training Officers are also required to obtain ICS-200 certification. Higher level supervisors and officers – those individuals who would reasonably be anticipated to assume larger leadership roles during a disaster – should obtain ICS-100, ICS-200, ICS-300, ICS-400, FEMA IS-700, and FEMA IS-800.

C. All activities within the Southwestern Illinois EMS System shall follow the principles of the National Incident Management System.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS501
Effective Date: 2/11
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Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

ON SCENE

SCENE TIMES

I. Purpose:

To establish guidelines for all participants in regards to scene times.

II. Policy:

A. The recommended on scene time is 20 minutes or less on all medical emergency patients.

B. The recommended on scene time is 15 minutes or less on all STEMI patients and acute CVA patients.

C. The recommended on scene time is 10 minutes or less for all major trauma patients.

D. It is understood that isolated exceptions can and do occur in the chaotic pre-hospital environment. Document on the Patient Report Form when and why an on scene time exceeds the recommended maximum.

E. IV and medication administration are initiated in accordance with the patient's condition and needs. It is possible that a short ETA to a hospital may not allow time to complete all ALS interventions.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

ON SCENE

INTERACTION WITH PHYSICIAN/NURSE ON SCENE

I. Purpose:

To establish guidelines for all participants in regards to scene times.

II. Policy:

A. Only personnel credentialed within the Southwestern Illinois EMS System and provisional personnel such as students or reciprocity candidates are allowed to perform advanced medical care in the pre-hospital setting.

B. Any nurse or medical personnel at the scene not credentialed within the Southwestern Illinois EMS System may assist with Basic Life Support procedures only. The only exceptions are personnel delegated by a transferring physician to accompany a critically ill or injured patient in order to maximize the patient's care en route to the receiving facility.

C. If identity of the healthcare provider is not obvious, pre-hospital providers are encouraged to ask for identification and/or proof of licensure.

D. Physician On Scene*

1. EMS personnel will inform the attending physician of the need to accompany the patient in the ambulance to the hospital.

2. If the attending physician is either unwilling or unable to accompany the patient to the hospital, follow routine procedures en route to the hospital.

3. As soon as the patient's clinical condition permits, EMS personnel should notify Medical Control that a physician is on scene and desires to retain medical control.

4. After notifying Medical Control of the physician's desire to retain control of the patient, encourage the physician to communicate directly with the emergency physician at medical control.

5. If a physician gives orders, while on scene or en route, for procedures or treatments that the EMT/PHRN feels are unreasonable, medically inaccurate, and/or not within the scope of practice of the provider, refuse to follow such orders and establish communication immediately with on-line medical control to clarify further treatment.

6. Document all orders/treatment given by the attending physician. The on-scene physician must sign the ambulance report form.

*MD or DO is acceptable.

E. When voice communications with on-line medical control is not available, the EMS crew is instructed to follow the System SOGs.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS600
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

GENERAL SCENE SAFETY

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

A. The importance of scene safety cannot be underestimated. Many hazards await us in the pre-hospital environment. Regardless of whether the threat is infectious, environmental, or criminal in nature, EMS providers must protect themselves at all costs. We must take every reasonable measure to ensure that, at the end of the day, we all go home.

B. Safety is the responsibility of each provider. Participants of the Southwestern Illinois EMS System shall utilize basic safety measures:

1. Make certain a scene is secure. Evaluate a scene each and every time you approach. Maintain a balance between the need for immediate patient access and provider and patient safety.

2. Providers should use their best judgment to either stage at a distance from the patient, or retreat from the scene if immediate danger exists.

3. Wear seatbelts at all times, unless inhibiting patient care.

4. Drive appropriate for conditions. Use appropriate caution when driving, particularly when utilizing emergency lights and siren.

5. Wear ANSI reflective vests when necessary and/ or required by federal law to do so.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS601
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Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCENE SAFETY

FIRE, TECHNICAL RESCUE, AND HAZMAT SCENES

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

A. EMS may be requested to respond to a fire, technical rescue, or HAZMAT scene to care for victims of the incident, treat the ill or injured responder, or provide responder rehabilitation during extended incidents.

B. Ideally, on extended or large incidents, an ambulance shall be dedicated solely for the care of responding personnel and/or incident rehabilitation.

C. Do not impair the ability of apparatus to depart or access the scene or fire hydrants.

D. The principles of ICS shall be adhered to at all times.

E. Responders may not enter the “hot zone” without permission of the Incident Commander.

F. Where specialized care for patients or responders is potentially needed in the “hot zone” of a technical rescue incident, EMS personnel with training in technical rescue shall be utilized here above all others, including Field Training Officers.

G. Requisite PPE shall be worn while in and around the hot zone, including but not limited to helmets, eye protection, safety gloves, and turnout gear.

H. Consider the need for additional personnel and supplies and request EARLY.

I. A large number of fire service injuries and deaths occur during post-incident activities including salvage and overhaul. Continue to be conspicuous and provide incident support through all phases of response unless released by the Incident Commander.

J. If a patient was extracted from a HAZMAT scene, ensure that the patient is decontaminated PRIOR TO PLACING THE PATIENT IN AN AMBULANCE AND TRANSPORTING.

K. IF THIS IS NOT POSSIBLE (PATIENT WAS PLACED IN THE AMBULANCE AND TRANSPORT INITIATED PRIOR TO REALIZING A HAZMAT EXPOSURE OCCURRED), CALL THE RECEIVING FACILITY AS EARLY AS POSSIBLE TO NOTIFY OF THE NEED FOR DECONTAMINATION AT THE HOSPITAL.

L. AT ALL COSTS, DO NOT ENTER AN EMERGENCY DEPARTMENT WITH A CONTAMINATED PATIENT, EVEN IF THE PATIENT IS CRITICALLY ILL OR INJURED!

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCENE SAFETY

INFECTION CONTROL

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

A. BODY SUBSTANCE ISOLATION (which incorporates Universal Precautions as recommended by the Center for Disease Control) has been adopted by the Southwestern Illinois EMS System.

B. Each ambulance owner/administrator will provide BSI protective apparel as established by BSI and OSHA guidelines.

C. Because the potential for infectiousness of any patient's blood and body fluids cannot be known, *all patients should be handled as though they are potentially infectious.*

D. Disposable gloves must be worn with all patient contact to prevent exposure to blood, body fluids, mucous membranes, or non-intact skin. Wearing two pairs of gloves is recommended during situations where large amounts of blood may be present.

E. Most illnesses that are spread via air are transmitted through droplets. Droplet precautions consisting of a surgical mask with eye shield/coverage is sufficient to protect against most viruses and meningitis.

1. Providers shall wear a surgical mask when treating patients with

a) A temperature of 100.4 or greater with cough, dyspnea, hypoxia (flu-like symptoms).

b) Hemoptysis.

c) Unidentifiable rash or large amounts of bruised/necrotic skin tissue.

d) Stiff neck.

2. Providers shall also institute droplet precautions for patients with severe immune deficiency such as patients on chemotherapy or suffering from leukemia or patients with severe burns**.**

F. While unlikely, EMS personnel should also be aware of clues to suggest a bioterrorism event:

1. An unusual increase or clustering of patients presenting with unexplained illness and any of the following:

a) Sepsis
b) Pneumonia
c) Flaccid muscle paralysis
d) GI illness
e) Bleeding disorders
f) Severe flu-like illness
g) Rash
h) Encephalitis/meningitis

2. An unusual or impossible pathogen for our region in a patient without a travel history to an endemic area (e.g., a case of plague in a patient that does not live in, or has not traveled to the southwest region of the U.S.).

3. An unusual temporal and/or geographical clustering of illness (e.g., persons who attended the same public event or gathering).

G. Airborne precautions consisting of N95 masks shall be worn when patients are suspected of suffering from Tuberculosis (combination of night sweats, fatigue, weight loss, hemoptysis).

H. For patients on droplet or airborne isolation precautions:

1. Only a minimum number of EMS providers should take care of the patient.

2. Instruct the patient to wash his/her hands with waterless soap/alcohol gel.

3. Place a surgical mask on the patient, if possible. Do not place an N-95 mask on any patient, and do not withhold oxygen if needed.

I. Wash hands immediately with bactericidal soap or alcohol gel after all patient contact. Remove gloves immediately after patient contact.

J. Use gloves, mask, gown and face protection during intubation and all procedures during which splashes/contamination are likely to occur.

K. Dispose all contaminated medical supplies in appropriate biohazard container. All red biohazard bags shall be removed from each EMS unit upon arrival at the receiving facility. The hazardous material shall be disposed of in accordance with the receiving facility's policy.

J. Needles and Syringes

1. NO NEEDLE SHOULD EVER BE RECAPPED, BENT OR BROKEN BY HAND.

2. Needles and syringes should be disposed of in rigid impervious containers provided by the Resource Hospital. Containers may be brought back to the Resource Hospital for final disposal.

L. Decontamination Procedures

1. Clean up all blood spills with 10 parts water to 1 part household bleach solution or commercial cleaning agent.

2. Non-disposable equipment, i.e. laryngoscope blades, must be soaked in 10:1 water/bleach solution or commercial cleaning agent for 30 minutes. After soaking, wash with disinfectant detergent, rinse well, and dry.

3. Linens soiled with blood and body fluids should be double-bagged and marked "Blood/Body Fluid Precautions". Those companies using a professional laundry service should notify recipients at the time of pick-up. Those companies who do their own laundry should use a professional solution or the same 10:1 water/bleach mixture.

4. Air the ambulance after each run. Scrub and disinfect the ambulance interior once a day, or more often as necessary.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS603
Effective Date: 2/11
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Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCEME SAFETY

EXPOSURE TO BLOOD OR OTHER BODILY FLUIDS

I. Purpose:

To establish guidelines for all participantsin regards to procedures for exposure to blood or other bodily fluids.

II. Policy:

A. Percutaneous exposure ("Needle Stick"):

1. Immediately wipe off blood or fluid and apply alcohol or alcohol gel.

2. After arriving at the hospital, and as soon as patient care allows, wash your hands and the wound.

3. If the wound is such that it requires sutures, seek prompt medical attention.

4. If you have received a puncture wound, seek medical attention to evaluate your tetanus immunization status.

B. Mucocutaneous exposure:

1. Eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials.

2. Flush your eyes or rinse your mouth with saline or water.

3. After arriving at the hospital, and as soon as patient care allows, wash your face.

C. Any pre-hospital care provider exposed to blood or other bodily fluid should report the incident immediately to his/her supervisor and the Resource Hospital EMS Department.

D. The pre-hospital care provider may request to have HIV testing on the patient utilizing the following procedures:

1. Documentation of the exposures (needle stick, etc.) must be on the patient report form.

E. The HIV test request form (#C910-146) must be completed immediately upon arrival to an Illinois Hospital by the EMT.

F. If the patient is being transferred/transported to Missouri, the laws governing HIV testing and protection of allied health workers vary. If this occurs, contact the ER Director/Manager.

G. All testing will be done at the expense of the employer or the requesting individual.

H. Verbal notification should be followed by a written report utilizing the Incident Report Form submitted to the EMS Department within two days.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS604
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCENE SAFETY

NOTIFICATION OF A COMMUNICABLE/INFECTIOUS DISEASE

I. Purpose:

To establish guidelines for all participantsin regards to notification of a communicable/ infectious disease.

II. Policy:

A. Upon confirmation of a reportable communicable/infectious disease, according to IDPH, the Infection Control Department will issue a letter of notification to the provider agency.

B. The EMS Office will review the patient's chart to verify that the patient was transported by ambulance and to identify crewmembers and any first responders who assisted.

C. If the patient is being discharged per ambulance, the nursing personnel caring for the patient will provide the ambulance personnel with additional information needed to protect against exposure to any communicable/infectious disease.

D. All patient-specific health information is to be treated in a confidential manner.

SOUTHWESTERN ILLINOIS EMS SYSTEM

ORDER FOR HIV TEST BECAUSE OF ACCIDENTAL CONTACT WITH BLOOD OR BODY FLUIDS

An HIV test is ordered for this patient, pursuant to Illinois Revised Statutes, Chapter 111 ½, Section 7307, because a health care provider, hospital employee, fire fighter, First Responder or EMT/PHRN had accidental skin or mucous membrane contact with the blood or body fluids of this patient, and, as stated below, the contact was of such a nature that HIV, if it is present, may have been transmitted.

Date of Exposure: _____

Nature of Exposure:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Physician Signature Date

Patient Information

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS700
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCENE SAFETY

INTERACTION WITH LAW ENFORCEMENT/EVIDENCE

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

A. If a law enforcement agency is present at a scene prior to EMS, the senior EMS crew member should contact the officer in charge to confirm scene safety. If EMS discovers, after arrival on scene, that they have responded to a suspected crime scene, immediately notify law enforcement. Retreat from the scene as necessary to ensure safety of personnel.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS701
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrator
Signature_____

EMERGENCY MEDICAL SERVICES

SCENE SAFETY

CRIME SCENE INTERACTION

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

To establish a good working relationship with law enforcement with regards to crime scene preservation.

A. At a potential crime scene, providing medical care is the highest priority. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt treatment. Remember, your role is to provide emergency care, not law enforcement or detective work. However, providers should strive to disturb the crime scene as little as possible.

B. Also remember that most auto accidents are also crime scenes, and the debris is evidence. As with other crime scenes, providing medical care is the utmost priority. Try not to disturb the accident debris.

1. Observe any individuals or vehicles in the area.

2. Do not allow onlookers or other unauthorized personnel on the premises of the crime.

3. Observe and note anything unusual, especially if the evidence may not be present when the police arrive. This may include smoke and odors.

4. If possible, park your vehicle so that other vehicle tracks will not be destroyed.

5. When you leave, remember where you parked your vehicle for later crime scene reconstruction.

7. Watch where you walk. Do not walk over vehicle tracks, footprints, etc. Do not wander through the scene.

8. Avoid tracking dirt or snow into the scene, and do not walk through blood or other possible evidence at the scene.

9. Avoid touching, moving, or relocating any item at the scene unless absolutely necessary to provide treatment to an injured victim. If it is necessary to move any evidence or the victim in any way, note the location and position of the evidence or victim. Advise law enforcement of the actions you have taken.

10. Do not examine any potential evidence

11. Avoid moving an article unless it is absolutely necessary. If moved, do not attempt to put it back in its original position.

12. Do not use ashtrays, bathrooms, telephones, etc.

13. Do not eat, drink or smoke at the scene.

14. Do not cut through ropes, bindings, etc.; however, if it is necessary, never cut through or untie knots. Any ligature used in a suicide attempt should be left as intact as possible and should be cut rather than untied. All cuts made should be in an area well away from knots.

15. Do not tear or cut clothing through bullet holes, knife wounds, etc.

16. If you must cut or remove clothing, be careful, as the slightest movement can destroy evidence such as paint, hair, fibers, gun powder, etc.

17. If you recover clothing, do not put everything in one bag; put each item in a separate PAPER BAG. NEVER USE PLASTIC OR CELLOPHANE.

18. During treatment or patient exam, if you find a cartridge or any other evidence, leave it and notify law enforcement authorities.

19. Weapons should not be handled by a provider unless necessary to ensure a safe patient care environment. If weapons must be handled, the provider must wear gloves, clearly document the items' original/new location, and inform on-scene law enforcement.

20. In drug overdose cases, containers of any substance which may have been ingested in a suicide attempt should be left in the position found unless they need to be taken to the hospital. If you take medication bottles, remember where you obtained them. If you give them to medical personnel at the hospital, record who you gave them to and the time. Use gloved hands and limit handling to a minimum in order to preserve any fingerprints that may be present.

21. Do not rinse or clean the hands of the patient, for it may disrupt certain evidence such as gun powder, blood, and dirt. Victims of assault should be strongly discouraged against “cleaning up” prior to arrival of law enforcement or transport.

22. When you enter a potential crime scene and you determine no medical care is necessary, DO NOT disturb the scene. Exit the scene the same way you arrived.

23. When confirmation of death is required, only one properly credentialed provider should make entry to the area.

24. Once resuscitation efforts have ceased and a pronouncement has been obtained, providers should immediately vacate the area.

25. If the patient has been placed on a sheet, notify the receiving facility that the sheet and all personal effects may be considered evidence.

26. Clothing, jewelry, or other objects removed from the patient should be left on-scene. Clearly document any items left, and inform on-scene law enforcement of the items’ original and current locations.

27. If the victim is obviously dead, then he or she should remain undisturbed. Even the position of the body can provide valuable clues.

28. Any scene involving a patient that is pulseless and apneic is to be considered a crime scene and treated accordingly.

29. Once the patient is pronounced dead, the body becomes the property of the coroner’s office. It may not be touched or altered in any way without authorization from the coroner’s office.

30. It is acceptable to share patient care information with appropriate on-scene law enforcement.

31. Intravenous lines, endotracheal tubes and all other disposable equipment used, successfully or unsuccessfully, are to remain in place and/or on-scene.

32. Disposable items used during resuscitation efforts are to be left in place. Sharps used during the resuscitation should be stored in an appropriate container with the container being left in the area.

33. Keep detailed records of the incident including your observations of the victim and the scene of the crime.

34. When documenting projectile wounds, DO NOT indicate whether the wound is an entrance or exit wound. Simply document the size, shape and location of the penetrating wound(s).

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EMERGENCY MEDICAL SERVICES

SCENE SAFETY

SIGNS OF POTENTIAL ABUSE

I. Purpose:

To establish guidelines for all participants to in regards to personal, crew, and patient safety.

II. Policy:

To provide guidance during patient encounters when providers see signs of potential abuse.

A. Potential clues in the history:

1. Significant delay in seeking medical attention.
2. Major discrepancies in the history.
3. History of multiple ED visits for various injuries.
4. A story that is vague and contradictory.
5. An accusation that the patient injured himself or herself intentionally.

B. Potential clues in the physical exam:

1. Excessive passivity, compliant or fearful behavior.
2, Excessive aggression, hyperactivity, or violent tendencies.
3. Apathetic or emotionally withdraw. Does not want to be near spouse, parents, or caregiver.
4. Excessive crying, fussy behavior, or other behavioral disorders.

5. Suspicious injuries.

6. Injuries inconsistent with the reported mechanism of injury.

7. Defensive injuries (e.g. to forearms).

8. Injuries during pregnancy.

9. Injuries in different stages of healing may indicate repeated episodes of violence.

10. Fractures in pre-ambulatory children or non-ambulatory adults.

11. Widely scattered injuries.

12. Multiple bruises, burns, and abrasions especially around the trunk and buttocks.

13. Injuries in various stages of healing

14. Burns by cigarettes or scalds.

15. Injuries about the mouth.

C. Potential signs and symptoms of neglect:

1. Inappropriate level of clothing for weather.'

2. Inadequate hygiene.

3. Absence of attentive caregiver(s).

4. Physical signs of malnutrition.

5. Long standing skin infections

D. General management:

1. Treat all injuries per appropriate protocol. Medical treatment is the EMS provider's first priority.

2. Provide emotional support to the victim.

3. See policy on Crime Scene Interaction (above).

4. See policy on Mandatory Reporting of Suspected Crimes (below).

5. Make sure that the victim is transported to the hospital by the ambulance or another dependable source. Do not leave the task of transport to the alleged abuser.

5. Do not accuse or challenge the suspected abuser.

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EMERGENCY MEDICAL SERVICES

SCENE SAFETY

MANDATORY REPORTING OF SUSPECTED CRIMES

I. Purpose:

To establish resources for patients that is a victim of abuse or neglect, and resources for mandatory reporting.

II. Policy:

A. This is a legal requirement to report, not an accusation.

1. All providers within the Southwestern Illinois EMS System shall report the following to local law enforcement:

   a) Assaults, wounds from serious beatings, gunshot, knife, or other dangerous weapons.

   b) A patient with any injury sustained in the commission of or as a victim of a criminal offense.

   c) All violent or accident deaths including all suicides, homicides, and suspicious deaths.

   d) All moving vehicle accidents.

   e) Suspected child abuse or neglect.

   f) Suspected elder abuse or neglect.

2. There is no mandatory reporting requirement for victims of domestic violence in the State of Illinois. However, EMS providers are required to report to law enforcement when treating a victim of a crime, as stated above. This includes assault and battery.

3. Make the physician or charge nurse at the receiving facility aware, in private, of your concerns and intent to report. Do not make any reference to your suspicions of abuse on the radio.

4. EMS providers are *also* required to report potential cases of child abuse/neglect to the Illinois Department of Children & Family Services.

    a) HOTLINE : 1-800-25-ABUSE

5. EMS providers are also required to report potential cases of elder abuse/neglect to the Illinois Department of Aging.

    a) ELDER ABUSE/NEGLECT HOTLINE: 1-800-252-8966 or 1800 279 0400 after hours and holidays.

    b) For cases of suspected abuse/neglect of a long term care facility resident, NURSING HOME ABUSE/NEGLECT HOTLINE: 1-800-252-4343.

6. Documentation

    a) Carefully document all observations and any statements made by the patient, family members, or care-givers on the run report. Remember, the run report is a legal document and may be used in a court of law.

    b) When the appropriate authorities are notified, record the following on the run record:

        (1) Time.
        (2) Department.
        (3) Name, and if possible, badge number of the officer contacted.

B. All persons licensed under the Illinois EMS Act shall offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse.

1. Illinois Domestic Violence Help Line: 877-863-6338

    a) Illinois Coalition Against Domestic Violence: www.ilcadv.org

b) St. Clair County, Monroe County, Randolph County

(1) Program Name: Violence Prevention Center of Southwestern Illinois
(2) Location: Belleville
(3) Hotline Phone Number: 618-235-0892
(4) TTY: 618-233-0741
(5) Location: East St. Louis
(6) Hotline Phone Number: 618-875-7970
(7) TTY: 618-233-0741
(8) Website: www.vpcswi.org

2. Madison County

a) Program Name: Oasis Women's Center

(1) Location: Alton
(2) Hotline Phone Number: Alton area only 800-244-1978
(3) Hotline Phone Number: Statewide 618-465-1978

b) Program Name: Phoenix Crisis Center

(1) Location: Granite City
(2) Hotline Phone Number: 618-451-1008

3. Clinton County

a) Program Name: People Against Violent Environments (PAVE)

(1) Location: Centralia
(2) Hotline Phone Number: 800-924-8444
(3) TTY: 618-533-9003

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

APPLICABILITY OF SOG'S/WHO IS A PATIENT?

I. Purpose:

To establish guidelines for all participants to in regards to who is a patient and when to use the Southwestern Illinois EMS Systems Standard Operating Guidelines (SOG's).

II. Policy:

A. Anyone that fits the definition of a patient must be properly evaluated and/or appropriate treatment options taken (including an informed refusal if the competent patient absolutely does not wish medical care or transport despite our suggestions that they do).

B. Anyone that does not fit the definition of a patient does not require an evaluation or completion of a patient care record. If there is ever any doubt, an individual should be deemed a patient and appropriate evaluation should take place.

1. The definition of a patient is any human being that:

2. Has a complaint suggestive of potential illness or injury.

3. Requests evaluation for potential illness or injury.

4. Has obvious evidence of illness or injury.

5. Has experienced an acute event that could reasonably lead to illness or injury.

6. Is in a circumstance or situation that could reasonably lead to illness or injury.

C. These criteria are intended to be considered in the widest sense. If there are any questions or doubts, the individual should be considered a patient. EMS personnel should contact Medical Control if they have any questions as to whether someone should be considered a patient.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

PATIENT ABANDONMENT

I. Purpose:

To establish guidelines for all participants to in regards to who is a patient and when to use the Southwestern Illinois EMS Systems Standard Operating Guidelines (SOG's).

II. Policy:

A. Once a pre-hospital care provider has responded to an emergency, he/she must not leave a patient that requires continuing medical care until another competent, equally trained healthcare professional takes responsibility for that patient's care, or the patient refuses care.

B. An exception to this shall be when the policy for Non-Paramedic Transport is followed. (See Section XI.)

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

ADULT AND MINOR CONSENT

I. Purpose:

To establish guidelines for all participants to in regards to who can give consent and when to use implied consent.

II. Policy:

A. The US Supreme Court has recognized that a "person has a constitutionally protected liberty interest in refusing unwanted medical treatment" even if refusal could result in death. Although courts protect a patient's rights to refuse care, "preservation of life, prevention of suicide, maintenance of the ethical integrity of the medical profession, and protection of innocent third parties" may also be considered when evaluating a patient's wish to refuse treatment. Each case must be examined individually.

B. In providing medical care, the universal goal is to act in the best interest of the patient. This goal is based on the principle of autonomy, which allows patients to decide what is best for them. A patient's best interest may be served by providing leading-edge medical treatment, or it may be served simply by honoring a patient's refusal of care. Although complicated issues can arise when providers and patient disagree, the best policy is to provide adequate information to the patient, allow time for ample discussion, and document the medical record meticulously.

C. Consent must be obtained from every legally competent adult with present mental capacity (18 years of age and older), OR consent must be obtained from the guardian or person responsible for the patient.

D. Informed Consent

1. It is the moral responsibility on the part of the EMS provider based on the recognition of individual autonomy, dignity, and present mental capacity to obtain informed consent. The patient must be aware of and understand the risk(s) of any care provided, procedures performed, medications administered, and the consequences of refusing treatment and/or transportation. He/she must also be aware of options available to them if they choose not to accept our evaluation and/or treatment.

E. Implied Consent

1. In a potentially life-threatening emergency situation, consent for treatment is not required if the individual is:

a) Unable to communicate because of an injury, accident, illness, or unconsciousness, and suffering from what reasonably appears to be a life-threatening injury or illness,

OR

b) Suffering from impaired present mental capacity.

2. The law presumes that if the individual with a real or potential life-threatening injury or illness were conscious and able to communicate, he/she would consent to emergency treatment.

F. Substituted Consent

1. Substituted consent is obtained in a situation in which another person consents for the patient, as in minors, incapacitated patients, incarcerated patients, and those determined by the courts to be legally incompetent.

2. Substituted consent is provided by:

a) Court appointed guardians.

b) Power of Attorney for Healthcare when the patient lacks present mental capacity. (See below.)

c) Parents of minors. (See below.)

G. In order to provide consent for or refuse treatment, a patient must have:

1. Mental competency. Mental competency is a legal term. EMS providers shall presume an adult patient has mental competency unless he/she has been declared mentally incompetent by a court of law.
   a) If a patient has been declared legally incompetent, he/she will have a court-appointed guardian. This court-appointed guardian will have the same decision-making capability as a parent would for a minor child. The guardian has the right to consent to, or refuse evaluation, treatment, and/or transportation for the patient.

   b) He/she may NOT refuse life-saving therapy of the patient based on religious or other grounds.

2. Present mental capacity. Present mental capacity refers to one's present mental ability to understand and appreciate the nature and consequences of his/her condition and to make rational treatment decisions. He/she must:

   a) Be 18 or older.

   b) Be alert and fully oriented, able to communicate, and demonstrate appropriate cognitive skills for the circumstances of the situation. He/she must have the ability to engage in conversation about their condition, demonstrate understanding of the situation, and the risks associated with refusing.

   c) Show no indication of alcohol or drug use to the extent that it impairs his/her ability to make sound decisions.

   d) Show no current evidence of bizarre/psychotic thoughts and/or behavior, or display behavior that is inconsistent with the circumstances of the situation.

   e) Show no physical finding or evidence of illness or injury that may impair their ability to understand and evaluate their current situation, i.e. a patient with a head injury and abnormal GCS, a patient with significant hypoxia, hypotension, hypoglycemia, hypothermia/hyperthermia, etc.

   (f) Show no current evidence of suicidal ideations, suicide attempts, or any indication that they may be a danger to themselves or others.

g) Patients with impaired mental capacity may be treated under implied consent.

H. Minors

1. A minor is one who has not yet reached the age of consent and refusal for purposes of medical treatment. Minors can neither consent to, nor refuse, medical treatment. Exceptions to this are:

a) Emancipated minors whom a court of law has granted the ability to make legally binding decisions. Note that only a specific court order can render a minor emancipated. Prior pregnancy does NOT imply that a minor is emancipated.

b) Any minor parent may consent to treatment for his/her child. A pregnant minor may consent to the evaluation and/or treatment related to the pregnancy

c) A minor, 12 years of age or older, requesting treatment for sexual assault or abuse, a sexually transmittable disease, alcohol or drug abuse or limited out-patient mental health counseling, may give consent for treatment.

d) A minor may consent to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law to be reported to a physician by IDPH.

e) A minor on active duty with the armed services.

f) A minor 16 or older and resides separate and apart from his/her parents/guardian and manages his/her own financial affairs.

2. In all cases, the minor must have present mental capacity as dictated above.

3. The following persons may consent to or refuse the evaluation, treatment, and/or transportation for a minor:

a Parent.

b) Grandparent.

c) Adult (18 or older) brother or sister, aunt or uncle.

d) Educational institution in which the child is enrolled that has received written authorization to consent/refuse from a person having the right to consent/refuse.

e) Adult who has actual care, control, and possession of the child and/or has written authorization to consent/refuse from a person having the right to consent/refuse, i.e. daycare, camps, etc.

f) Adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court.

g) A peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.

4. In all cases, the person must have present mental capacity as dictated above.

5. Implied consent of a minor

a) Consent is not necessary for emergency treatment to sustain life of a minor who is suffering from what appears to be a life-threatening injury or illness.

b) A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

REFUSAL OF EVALUATION, TREATMENT, AND/OR TRANSPORATION

I. Purpose:

To establish guidelines for all participants in regards to refusal of evaluation, treatment and/ or transportation.

II. Policy:

Providers should attempt to obtain a history and physical, in as much detail as is permitted by the patient.

A. Who may refuse care:

1. The patient

2. Must be legally competent.

3. Must have present mental capacity.

4. Note that no friend or relative, such as an adult, of a patient 18 years of age or older may refuse evaluation, treatment, and/or transportation of an adult lacking present mental capacity unless he/she is the Healthcare Power of Attorney or court-appointed legal guardian of the patient. No one may refuse potentially life-saving care for a patient. An exception to this may be those at end of life. Contact medical control for clarification.

B. For minor patients:

1. Those individuals listed above with the ability to consent for treatment of a minor.

2. Must be legally competent and have present mental capacity.

3. A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds**.**.

C. A court-appointed Legal Guardian:

1. If a person indicates that they are a legal guardian to the patient, attempt to obtain documentation of this fact (court order, etc.) and attach to trip sheet. If no such documentation is available, you may obtain refusal signature from the guardian as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as a legal guardian.

2. A parent or guardian cannot refuse life-saving therapy for a child based on religious or other grounds.

D. Health Care Agent (Durable Power of Attorney for Healthcare)

1. A Health Care Agent is person appointed by the patient in a Durable Power of Attorney for Healthcare to consent or refuse care on behalf of the patient if the Power of Attorney contains such authorization.

2. EMS Personnel may honor the requests of a person purporting to be the patients Power of Attorney for Healthcare when:

a) The patient is unable to express his/her own wishes regarding treatment/transportation or refusal of treatment/transportation.

b) EMS personnel are presented with a written Power of Attorney for Healthcare document. The document should list the name and signature of the Power of Attorney for Healthcare, the patient's name and signature, the date the document was signed, and any restriction to the authority of the Power of Attorney for Healthcare.

c) EMS personnel must inform the medical control physician of the presence of the Power of Attorney for Healthcare, the nature of the document, the patient's condition, and the direction of the Power of Attorney for Healthcare.

d) EMS personnel may not honor the request of the Power of Attorney for Healthcare to discontinue resuscitative efforts on a patient in cardiac arrest. The medical control physician must be contacted for direction. See Section X.

3. Attempt to obtain a copy of the Durable Power of Attorney for Healthcare document to attach to the trip sheet. If no such documentation is available, you may obtain refusal signature from the Health Care Agent as

long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself as the Health Care Agent.

III. Refusal Procedure

A. Attempt to obtain a history and physical, in as much detail as is permitted by the patient.

B. Complete the patient refusal form in its entirety. Document competency assessments, results of the history and physical exam, clinical symptoms on which need for transport was based, information provided to fully inform the patient and/or other authorized individual of the consequences of their refusal of treatment/transport, patients understanding, medical control instructions, alternatives offered, and crew signatures**.**

C. Contact medical control:

1. If disagreement exists between care providers and the patient as to need for evaluation, treatment, and transportation, particularly for patients in need of ALS care.

2. For high risk patients which include, but are not limited to patients with:

a) Head Injury.
b) Any trauma with significant mechanism of injury.
c) Chest pain.
d) Dyspnea.
e) Syncope.
f) Seizures.
g) Headache (new onset).
h) TIA/resolving stroke symptoms.
i) Pediatric complaints.
j) Presence of alcohol and/or drugs.
k) <u>WHEN IN DOUBT, CONTACT MEDICAL CONTROL!</u>

3. Review the form with the patient or signer.

4. Provide a detailed explanation of the risks and dangers to patient or signer.

a) EMS providers should advise all patients that he/she has not been evaluated by an emergency department physician; therefore the EMS system does not recommend refusals of treatment and transport. Since he/she is refusing treatment and transport despite being informed of the associated risks, it is recommended he/she be evaluated by his/her primary physician or the nearest ED as soon as possible. The patient should understand that their refusal may result in complications up to and including death.

5. Inform the patient to call 911, his/her primary care physician, or go to the nearest ED if symptoms persist or get worse or any dangers signs you inform them appear.

6. Obtain signatures, and have the signer date the form. If the patient refuses to sign, document this on the refusal form.

7. Obtain a witness signature. This should preferably be someone who witnessed your explanation of risks and benefits, heard you advise the patient to receive medical evaluation and treatment, and who watched the patient sign. If no witness is available, a crew member may sign as a last resort. All should be 18 or older, have mental competency and present mental capacity. Write witnesses' address and telephone number on back of refusal form.
8. If the patient refuses transport to the closest appropriate medical facility and the refusal would create a life threatening or "high risk" situation, treat as a high risk refusal. Contact medical control, and have the patient sign a refusal form.

9. At no time will EMS professionals mention cost of transport, patient's insurance status, hospital billing or insurance practices, status of system/unit availability, ED wait times, or any other non-clinical subject in an attempt to influence a patient's decision to decline treatment or transport.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

PATIENTS UNABLE TO REFUSE EVALUATION, TREATMENT, OR TRANSPORTATION

I. Purpose:

To establish guidelines for all participants in regards to patients that are unable to refuse evaluation, treatment and/ or transportation.

II. Policy:

A. If a patient is mentally incompetent or lacks present mental capacity, he/she may be evaluated, treated, or transported accordingly to the principle of implied consent.

B. In circumstances where an acute illness or injury impairs a patient's ability to make an informed decision (lacks present mental capacity) and the patient is in need of medical treatment or evaluation to prevent further significant illness or injury, the patient shall be transported to an ED for further evaluation.

C. Determine that a potentially harmful condition exists. If the condition is immediately life-threatening, the patient should be treated and transported as soon as safely possible.

D. Take all reasonable steps to secure treatment or transportation for a patient who is mentally incompetent or lacks present mental capacity to refuse care, but do not put yourself or your crew in jeopardy.

E. Take all reasonable steps to ensure that the patient is evaluated, treated, and transported to the Emergency Department in a calm and cooperative manner.

F. When appropriate, consult family and friends, the patient's primary care physician, or medical control to speak with the patient in an effort to convince him/her to comply.

G. Whenever possible, contact medical control prior to transporting a patient against his/her will.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

PARENT/GUARDIAN REFUSAL IN THE PRESENCE OF POTENTIALLY LIFE-THREATENING MEDICAL CONDITIONS

I. Purpose:

To establish guidelines for all participants in regards to parent/guardianrefusalinthe presence of potentially life-threatening medical conditions.

II. Policy:

A. Take all reasonable steps to convince the parent or guardian to consent to evaluation, transportation, or treatment. This includes contacting the patient's primary care physician or medical control to speak with the patient's parent or guardian.

B. If the parent or guardian continues to refuse evaluation, treatment, or transportation, contact local law enforcement for assistance. Local law enforcement may place the patient in protective custody and request evaluation, treatment, and transportation.

C. **CONTACT MEDICAL CONTROL FOR DIRECTION AS SOON AS POSSIBLE!**

E. Do not delay treatment of patients suffering from immediately life-threatening conditions.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

EMOTIONALLY DISTURBED PATIENTS

I. Purpose:

To establish guidelines for all participants in regards to emotionally disturbed patients.

II. Policy:

A. Psychiatric, or behavioral emergencies, are those in which the patient's presenting problem is a disorder of mood, thought, or behavior that is dangerous or disturbing to themselves or others.

B. Note that current evidence of, or history of, mental illness does not, in itself, constitute lack of present mental capacity. EMS personnel or family must reasonably suspect that an emotionally disturbed patient at the time the determination is being made or within a reasonable time thereafter, would intentionally or unintentionally physically injure himself/herself or other persons, or is unable to care for his own physical needs.

C. Determine scene safety. If there is any doubt as to scene safety, request local law enforcement for assistance. Self-defense is of highest priority and may necessitate retreat from the scene.

D. Never leave the patient alone.

E. Never turn your back on the patient.

F. Never allow your exits to be blocked.

G. Be observant of verbal and/or nonverbal clues which may indicate the patient's aggressive or violent mood is escalating. Remove the patient from the agitating situation when possible.

H. Always assess for other medical or traumatic conditions.

I. Always assess for mental status. Psychiatric illnesses typically do NOT impair a patient's level of orientation.

J. Rule out other common medical problems such as hypoglycemia, hypoxia, hypovolemia, etc.

K Maintain a nonjudgmental attitude when assessing patients with possible behavioral emergencies.

L. Utilize open-ended questions while interviewing, and do not argue with the patient.

M. Attempt to orient the patient to reality and to persuade the patient to be transported to the hospital so that he/she can receive emergency medical care and mental health services.

N. If persuasion is unsuccessful, contact medical control. The EMS crew will then follow the direction of the medical control physician.

1. If the medical control physician determines the patient cannot understand informed consent for patient care and transportation to the hospital for emergency treatment of a non-psychiatric condition is required to preserve life or prevent serious impairment to health, the physician shall order, against patient will and based upon implied consent, the emergency care and transportation to the hospital.

2. In no way does this mean that the EMS crew is committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of treatment to a hospital against his/her will so that a physician may further evaluate the patient.

3. Notify the appropriate law enforcement agency if the patient is combative or may harm self or others.

O. If the patient is not suffering from a non-psychiatric condition but may present a danger to him/herself due to a psychiatric condition, EMS providers shall contact mental health professionals.

1. Mental health professionals have the authority to petition for involuntary admission and immediate hospitalization. Upon receipt of a petition, law enforcement shall take the patient into custody and transport him/her to a mental health facility.

2. A police officer is the only individual given the authority to restrain and transport a person against their will. Neither a physician nor the patient's family may authorize such transport. Physicians may authorize involuntary commitment, but their authority does not extend to the forcible transport of a patient against their will.

3. Should the local law enforcement or mental health professional not support the decision to transport the person against their will, the patient's condition, information conveyed to and from the patient, the assisting agencies involved, and the patient's refusal of service should be documented on the run record, patient's signature obtained, and, if possible, witnessed by an impartial observer (preferably, police, mental health professional, family, etc.). The names of mental health professionals and law enforcement officers involved shall be documented in the run report.

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EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

USE OF RESTRAINTS (CHEMICAL AND PHYSICAL)

I. Purpose:

To establish guidelines for all participants with the use of restraints both chemical and physical.

II. Policy:

A. Attempt to avoid the use of restraints by maintaining a calm, reassuring demeanor and taking all reasonable steps to urge the patient to comply.

B. Restraints shall only be implemented as a last resort by EMS personnel for patients who lack present mental capacity and demonstrate physical resistance or violent behavior that poses an immediate threat to the health and safety of them or others around them.

C. Unless the patient poses an immediate threat to self or others or is suffering from an immediately life-threatening condition, medical control must be contacted prior to the use of restraints or transport of any patient against his/her will.

D. The patient requiring restraint should be safely and humanely restrained. At no time should a patient be struck or managed in such a way as to impose pain. Restrain in a position of comfort and safety. It is very important that restraints not be applied so tightly as to compromise limb circulation. Patients shall not be restrained in the prone position.

E. Attempt voluntary application of restraints. Use of patient restraints should be held to a minimum and only as a last resort to protect the patient and others from his/her irrationality.

F. If voluntary restraint is not possible, assemble adequate personnel. One person for each of the patient's limbs is necessary.

G. Attempts to physically restrain a patient should be made (when possible) with law enforcement assistance.

H. After application of restraints, the patient must at no time be left alone.

I. In addition to soft restraints, secure the confused patient to the stretcher with at least three belts.

J. Maintain a calm, professional, reassuring demeanor.

K. Attempt to modify the patient's environment to minimize stimulation. (Avoid bright lights, loud sounds, etc.)

L. Protect the patient's privacy when in public areas.

M. Patients should be monitored every 5-10 minutes while restrained.

N. If chemical restraint is deemed necessary, refer to the appropriate SOG and contact medical control.

O. If a patient is restrained by law enforcement with handcuffs or other law enforcement restraint implements, the patient will be accompanied in the ambulance by law enforcement to the hospital to assist with further restraint of the patient or to release the restraints if patient care is impaired by the devices.

P. Documentation requirements:

1. Indication for restraints.

2. Prior attempts at less restrictive alternatives, i.e. verbal communication, removal from stressful environment, etc.

3. Method of restraint.

4. Periodic checks for proper application.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Signature_____

EMERGENCY MEDICAL SERVICES

PATIENT CONSENT

PATIENTS IN LAW ENFORCEMENT CUSTODY

I. Purpose:

To establish guidelines for all participants with the patients that are in law enforcement custody.

II. Policy:

A. When a patient in law enforcement custody requests evaluation, treatment and/or transportation and a Southwestern Illinois EMS System provider responds, the responding provider shall conduct an evaluation and institute treatment and transportation to the ED in accordance with SOGs.

B. Providers should maintain a nonjudgmental attitude when transporting patients in the custody of law enforcement.

C. If the patient requests treatment and transportation, but a law enforcement officer refuses to allow treatment and transportation, obtain the law enforcement officer's name and badge number. Document this on the refusal form, and have the officer sign the refusal. Inform the officer of the risks of refusing, benefits of evaluation and treatment, and alternatives as one would a patient refusing medical care.

D. A person in police custody has the right to sign a refusal of treatment unless the police mandate treatment for this person. The patient will then be transported to the hospital in police custody for further evaluation.

E. EMS providers within the Southwestern Illinois EMS System may NOT draw blood for law enforcement purposes. While venipuncture is well within the scope of practice of EMT-I/P/PHRN, the pre-hospital provider may only render patient care in accordance with the written SOGs.

F. A prisoner cannot be determined as being fit for confinement by EMS personnel.

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EMERGENCY MEDICAL SERVICES

DEATH ON SCENE

WITHHOLDING CPR

I. Purpose:

To establish guidelines for all participants on withholding CPR.

II. Policy:

A. EMS providers shall withhold CPR on apneic and pulseless patients with:

1. Evidence of significant time lapse since pulselessness.

   a) Dependent lividity.
   b) Rigor mortis.
   c) Decomposition.

2. Penetrating or blunt trauma with injuries obviously incompatible with life.

   a) Decapitation.
   b) Incineration.
   c) Obvious destruction of brain or intra-thoracic organs.

3. All other blunt trauma patients found apneic and pulseless without organized ECG activity.

4. All other penetrating trauma patients found apneic and pulseless without organized ECG activity or papillary reflexes.

5. Patients submersed greater than 30 minutes in warm water or greater than 90 minutes in cold water. (An exception is a person trapped with a potential air source such as diver.)

6. A patient with a completed State of Illinois DNR Form.

B. These patients do not require contact with medical control.

C. When in doubt, initiate resuscitative efforts. All other patients require contact with medical control.

D. Contact the appropriate coroner.

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EMERGENCY MEDICAL SERVICES

DEATH ON SCENE

DO NOT RESUSCITATE ORDERS

I. Purpose:

To establish guidelines for all participants on do not resuscitate orders.

II. Policy:

A. The patient must have the State of Illinois Do Not Resuscitate form which has the Seal of the State of Illinois in the lower right corner.

B. By itself, a DNR order does not affect treatment of patients NOT IN FULL CARDIAC ARREST. Southwestern Illinois EMS System providers should institute treatment according to the SOGs unless specifically instructed not to on the DNR form. Transport both the patient and the DNR form to the hospital.

C. Providers should make a reasonable effort to verify the identity of the patient named in a valid DNR order.

D. If the EMS provider has concerns regarding the validity of the DNR orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition, the provider should immediately institute CPR or BLS treatment as indicated by the patient's condition and contact medical control for further direction.

E. If the primary care physician of a patient without a valid DNR order is at the scene or on the telephone and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity and notify medical control of the request. Institute CPR or BLS treatment as indicated by the patient's condition until further direction can be obtained from medical control.

F. Note that a parent, guardian, or Power of Attorney for Healthcare can provide consent to a DNR order, but the order itself must be written by a physician.

1. Pre-hospital providers can NOT honor a verbal or written DNR request or order made directly by a surrogate decision maker or any other person, other than the patient's primary care physician. If such a situation is encountered, institute CPR or BLS treatment as indicated by the patient's condition and contact medical control for direction.

G. DNR should NOT be honored when:

1. A patient or person who executed the order destroys the form.

2. A patient or person who executed the order orders someone in their presence to destroy the form.

3. A patient tells a provider or primary care physician that it is his/her intent to revoke the order.

4. The primary care physician has voided the DNR.

5. The patient is known to be pregnant.

H. If a DNR Order is rescinded, pre-hospital care providers have a duty to act and provide care in the best interest of the patient. This requires the provision of full medical and resuscitative interventions when medically indicated and not contraindicated by the wishes of the patient.

I. A copy of the DNR Form should be retained and attached as supporting documentation to the pre-hospital care report form when possible.

J. Any other advance directives such as a "Living Will" cannot be honored, followed, or respected by pre-hospital care providers. EMS personnel must contact medical control for direction regarding any other type of advanced directive. Full resuscitation should not be withheld during the process of contacting or discussing the situation with medical control.

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EMERGENCY MEDICAL SERVICES

DEATH ON SCENE

REGION IV DO NOT RESUSCITATE POLICY*

I. Purpose:

To set forth the procedures to be followed by all EMS/Pre-hospital RNs when a physician issues an order that no resuscitative measures be initiated on behalf of a patient and to document the procedures to be followed when a patient or his agent instructs EMS personnel that death-delaying procedures shall not be utilized for the prolongation of his life.

II. Policy:

A. Persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision that no resuscitative measures be initiated on behalf of a patient and including the decision to have death-delaying procedures withheld or withdrawn

III. Basic Guidelines

A. No Code" orders apply only to certain patients in cardiopulmonary arrest. A DNR order does not mean that necessary medical treatment or hospitalization be withheld from a seriously ill patient.

B. EMTs/Pre-hospital RNs will withhold resuscitative measure when:

1. Obvious sign of death:

   a) Rigor mortis without profound hypothermia
   b) Decompositio
   c) Decapitation
   d) Profound dependent lividity

2. Patient has been declared dead by a coroner or patient's physician.

3. Patient has a valid DNR order or indicated by an agent/valid Durable Power of Attorney for Health Care. (Look quickly on refrigerator.)

C. Record on run sheet if patient declared dead by coroner or patient's physician and request coroner of physician to sign the run sheet.

D. If signs of death are confirmed, EMS personnel may then notify the coroner and police/sheriff. EMS should remain on scene until advised by the coroner or police/sheriff.

E. In all other cases of cardiopulmonary arrest, unless indicated as above, resuscitative measures should begin immediately by the first on-scene EMS personnel and carried out per region protocols. Transport as soon as possible.

F. Once resuscitative measures have been initiated by EMS personnel, resuscitative measures may be stopped only by order of the Resource Hospital physician or private physician. Document physician's name on the run report.

G. When there is no indication to the contrary, all patients receive full ACLS resuscitative measures.

H. Contact Medical Control if any other conditions to resuscitation are requested.

IV. Do Not Resuscitate Orders

A. Do Not Resuscitate (DNR) orders are orders issued by a physician, based on the patient's previous request, that no resuscitative measures be initiated on behalf of that patient.

B. DNR refers to the withholding of cardiopulmonary resuscitation (CPR); electrical therapy to include pacing, cardioversion and defibrillation; tracheal intubation and manually or mechanically assisted ventilations, unless otherwise stated on the DNR order.

C. A valid DNR order shall consist of a written document, which has not been revoked, containing at least the following information:

1. Name of patient
2. Name and signature of attending physician
3. Effective date
4. The words "Do Not Resuscitate"
5. Evidence of consent (one of the following):
6. Signature of patient
7. Signature of legal guardian
8. Signature of Durable Power of Attorney for Health Care agent
9. Signature of surrogate decision-maker
10. Attached living will or other advance directive prepared by, or on behalf of the patient.

D. *NOTE: A living will by itself cannot be recognized by pre-hospital care providers.

E. System personnel must make a reasonable attempt to verify the identity of the patient named in the valid DNR, e.g., identifying bracelet, identification by another person.

F. Revocation: A person's consent to a DNR order or instruction that death delaying procedures be withheld or withdrawn may be revoked at any time by the patient, without regard to the person's mental or physical condition.

G. In transporting a patient with a valid "No Code" (DNR) order, if the patient arrests en route, go to the designated hospital and do not start resuscitative measures, e.g., transfer to or from home, inter-hospital transfer, long-term care facility transfer, Hospice patient transfer.

V. Durable Power of Attorney for Health Care

A. A Durable Power of Attorney for Health Care (DPA) is written document allowing an individual to delegate his or her power to make health care decisions to an appointed agent in the event the individual becomes mentally disabled or incompetent.

B. The written document must:

1. Be signed and dated by the individual granting the power.
2. Name an agent.
3. Describe health care powers granted to the agent.

C. A written document does NOT have to be seen; a verbal report from the agent will suffice.

D. The DPA may grant the agent any and all powers to make health care decisions, or it may grant only limited powers.

E. A valid DPA for health care must be honored by any health care provider. A health care provider may refuse to comply with an agent's directions only if they conflict with the provider's right of conscience or medical judgment, but the provider must then arrange for another provider to assume care for the patient; which would be highly unpractical in the EMS field setting.

VI. Education

A. All Region personnel will receive a copy of the DNR policy. All Region personnel are responsible for reviewing and implementing the DNR policy.

VII. Reporting to IDPH

A. An annual report addressing DNR issues/problems will be submitted to IDPH by each EMS System Coordinator.

***Region-Wide Policy**

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EMERGENCY MEDICAL SERVICES

DEATH ON SCENE

TERMINATION OF RESUSCITATION FOR NON-TRAUMATIC CARDIAC ARREST

I. Purpose:

To establish guidelines for all participants on terminating resuscitation of non-traumatic cardiac arrest.

II. Policy:

A. Termination of resuscitative efforts for victims of non-traumatic cardiac arrest should be considered when:

1. An adult suffers non-traumatic cardiac arrest that is not witnessed by bystanders or pre-hospital care providers, AND
2. No bystander CPR is provided, AND
3. The patient has received 20-30 minutes of full resuscitative effort from the time of the arrival of the first responding personnel including:
4. Adequate CPR.
5. Airway managed with endotracheal intubation or King LT placement.
6. IV or IO access has been obtained.
7. There is no evidence of drug overdose, hypothermia, internal bleeding, or preceding trauma, AND
8. The patient remains in asystole or a wide-complex pulseless bradycardic rhythm (rate less than 60), AND
9. All personnel agree to discontinue resuscitative efforts.

B. OR

1. Resuscitation efforts were inappropriately initiated when criteria to withhold CPR were present, OR

2. A valid DNR was discovered after resuscitative efforts have been initiated.

C. Logistic factors should be considered such as patient size and location, weather, collapse in a public place, family wishes, and the safety of the crew and public.

D. Online medical control must be contacted prior to termination of resuscitation.

E. When the order to terminate resuscitative efforts is received, the coroner and law enforcement must be notified.

F. Notify the patient's primary care physician.

G. EMS providers should provide support to the patient's family. Offer to contact family members or clergy.

H. The following are not candidates for pre-hospital termination of resuscitation unless highly extenuating circumstances exist:

1. Pediatric patients.

2. The patient is hypothermic.

3. EMS providers have been unable to manage the patient's airway with endotracheal intubation or King LT placement or unable to establish IV/IO access therefore preventing full ACLS efforts.

4. The patient has return of spontaneous circulation at any point in the resuscitative efforts.

5. The patient has a rhythm of Ventricular Tachycardia or Ventricular Fibrillation at any point in the resuscitative efforts. This includes situations where the patient receives defibrillation via an AED prior to EMS arrival.

6. The family is uncomfortable with pre-hospital termination of resuscitation.

7. Any pre-hospital care provider feels uncomfortable with pre-hospital termination of resuscitation.

8. Cardiac arrest occurred in a public area or other setting where pre-hospital termination of resuscitation is undesirable, i.e. potentially violent scenes.

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EMERGENCY MEDICAL SERVICES

DEATH ON SCENE

DEATH AT THE PRE-HOSPITAL SITE, CORONER'S POLICY

I. Purpose:

To establish guidelines for all participants on terminating resuscitation of a traumatic cardiac arrest.

II. Policy:

A. Once an order to terminate or withhold resuscitation is received, the body must not be removed or altered in any way until so directed by the coroner and/or investigating law enforcement officers.

B. If it is necessary to remove the body in order to extricate a viable person, law enforcement agencies and the coroner should be notified as soon as possible.

C. Follow crime scene precautions given in Section VIII.

D. Do not remove lines or tubes from unsuccessful cardiac arrests.

E. EMS providers should take note of their location when the order to terminate or withhold efforts is given. From this point, EMS providers may NOT cross county lines.

F. Notify law enforcement and the appropriate coroner for the county in which the providers are in when they receive the order.

1. In St. Clair, Clinton, Madison, and Randolph Counties, proceed to the hospital unless doing so would involve crossing county lines. Proceed to the nearest facility within county lines or wait at the scene for the coroner to arrive.

2. In Monroe County, wait on scene for the coroner.

Important Points to Remember

A. It is appropriate to transport seemingly non-viable patients who have arrested to the hospital for pronouncement if, in the assessment of the transport providers, circumstances mandate such an action, i.e. death in a public place, potentially violent scenes, pediatric patients with obvious evidence of death, etc.

B. Always rule out a non-traumatic etiology for what may be perceived as a traumatic arrest, i.e. primary non-traumatic cardiac arrest resulting in a minor car crash.

C. Anytime a DNR is not honored, the reason must be documented.

D. A DNR order does not imply that a patient refuses aggressive, potentially life-saving treatment up to the point of cardiac arrest.

E. An advanced directive does not imply that a patient refuses palliative and/or supportive care. Care intended for the comfort of the patient should not be withheld based on POA.

F. When in doubt, always initiate resuscitative efforts. Later termination can be implemented if appropriate.

G. When in doubt, contact medical control

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

DESTINATION SELECTION

I. Purpose:

To establish a guideline for destination selection for system wide use.

II. Policy:

A. The following guidelines in Section X are intended to be just that, guidelines for destination selection. While each patient should ideally be transported to the most appropriate facility, it is understood that in the chaotic prehospital environment exceptions do exist. Prehospital providers should always contact Medical Control for any concerns.

B. Prehospital providers may choose at any time to divert to the closest facility when the patient is in *imminent* danger of death that cannot be adequately addressed by the prehospital provider. The provider should bear in mind his/her level of training (BLS, ALS), the nature of the patient's injury or illness, the possible need for a specialty center (i.e. trauma center) ultimately required for the patient's survival, if the patient's immediate needs can be adequately addressed at a closer facility, and the ETA to the specialty center vs. closest facility. Contact with Medical Control is encouraged, when time allows, to assist in making these difficult destination decisions.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

REGION IV GUIDELINES FOR PATIENT TRANSFER PATTERNS AND PATIENT CHOICE OR REFUSAL*

I. Purpose:

To establish an understanding of the IDPH Region IV guidelines for patient transfer patterns and patient choice or refusal.

II. Policy:

This policy is intended to assist Region IV personnel in determining appropriate distribution of pre-hospital patients with respect for patient choice or refusal.

A. Patient Choice or Refusal

1. Whenever possible, the wishes of the patient, family, or Power of Attorney for Health Care should be the primary consideration in determining the facility to which the patient is transported.

2. The Resource Hospital Medical Control should be contacted by EMS personnel to divert any emergency patient to a facility other than patient choice or routine transport patterns.

3. The Resource Hospital Medical Control will decide if the benefits to the patient reasonably expected from the provision of appropriate medical treatment at another or more distant facility outweigh the increased risks to the patient.

4. A competent adult and/or parent has the right to refuse medical treatment and transport for himself/herself and his/her child.

5. The Resource Hospital should be contacted for assistance for serious medical problems.

6. Documentation should be completed per System protocols.

B. Pediatric Trauma (<17 years) & Medical (<18 years) Guidelines

1. Information regarding pediatric patients or pediatric patients with special health care needs (See appendix A, B & C) must be relayed to the Resource Hospital Medical Control for transport consideration directly to a specialized pediatric hospital.

C. Adult Trauma Guidelines

1. If a patient has an altered level of consciousness and meets the field triage guidelines for trauma, the patient will be transported according to Resource Hospital Medical Control and/or Region trauma boundaries (See appendix D & E).

D. Guidelines for Bypassing & Diversion

1. Bypass should NOT occur when:

a) A patient is in full cardiopulmonary arrest or a critical life-threatening condition exists, i.e. airway compromise.

b) Three or more hospitals in a geographic area are on bypass and transport time by an ambulance to the nearest facility exceeds 15 minutes.

2. Bypass may occur when:

a) Pediatric non-trauma patients meet criteria listed in Appendix A.

b) Pediatric trauma patients meet criteria listed in Appendix B.

3. Pediatric patients have special healthcare needs (Appendix C).

4. Adult trauma patients meet field triage guidelines listed in Appendix D. Note that this appendix has been updated to include CDC Field Triage Guidelines per Region IV Trauma Advisory Council meeting December, 2009.

5. Appendix E describes the regional trauma boundaries for Region IV. It is not included in this document due to lack of relevancy. Contact the EMS Office if any questions arise.

***Region-Wide Policy**

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

SPECIAL POPULATIONS: PEDIATRICS

I. Purpose:

To establish an guideline when transporting special populations.

II. Policy:

We are fortunate to have two pediatric hospitals & trauma centers in the St. Louis Metropolitan Area, Cardinal Glennon Children's Hospital and St. Louis Children's Hospital.

A. EMS providers must first identify which pediatric patients would benefit from treatment at a pediatric hospital/trauma center. Refer to the Region IV Appendix A, B, and C below for a partial list of these patients. Providers may always contact medical control for clarification.

B. When an EMS provider encounters a patient that he/she believes would benefit from treatment at a pediatric hospital/trauma center:

1. BLS units should ask for ALS intercept/assistance, per the ALS assist guidelines.

2. If the pediatric hospital/trauma center is the closest facility, transport to that facility.

3. If the patient is located in the catchment area of Kenneth Hall or Touchette Regional Hospital and the anticipated ETA to a pediatric hospital/trauma center is less than 25 minutes, transport to the pediatric hospital/trauma center.

4. If the patient is located within the catchment area of another facility (all of which generally have ETAs to pediatric hospitals/trauma centers > 25 minutes) transport to the closest facility OR arrange for helicopter EMS transport. See HEMS policy below.

C. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice. EMS providers may always contact medical control for assistance with transport decisions.

D. Bypass of any facility should ***NOT*** occur when:

1. The patient is treated and transported by a BLS unit, without the availability of ALS assistance.

2. The patient is suffering from an immediately life-threatening condition such as airway compromise or severe hemorrhage uncontrolled with pre-hospital care including tourniquet application.

3. The patient is in cardiac or respiratory arrest.

III. APPENDIX A: GUIDELINES FOR EVALUATION OF PEDIATRIC MEDICAL (NON-TRAUMA) PATIENTS FOR TRANSPORT*

A. Physiologic Criteria:

1. Depressed or deteriorating neurologic status.

2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:

   a) Cyanosis.
   b) Retractions (moderate to severe).
   c) Apnea.
   d) Stridor (moderate to severe).
   e) Grunting or gasping respirations.
   f) Status asthmaticus.
   g) Respiratory failure.

3. Children requiring endotracheal intubation and/or ventilator support.

4. Serious cardiac rhythm disturbances.

5. Status post cardiopulmonary arrest.

6. Heart failure.

7. Shock responding inadequately to treatment.

8 Children requiring any one of the following:

   a) Arterial pressure monitoring.
   b) Central venous pressure or pulmonary artery monitoring.
   c) Intracranial pressure monitoring.
   d) Vasoactive medications.

9: Severe hypothermia or hyperthermia.

10. Hepatic failure.

11. Renal failure, acute or chronic requiring immediate dialysis.

B. Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems.

2. Status epilepticus.

3. Potentially dangerous envenomation.

4. Potentially life threatening ingestion of, or exposure to, a toxic substance.
5. Severe electrolyte imbalances.
6. Severe metabolic disturbances.
7. Severe dehydration.
8. Potentially life-threatening infections, including sepsis.
9. Children requiring intensive care.
10. Any child who may benefit from consultation with, or transfer to, a Pediatric Critical Care Center.

***Region-Wide Policy**

IV. APPENDIX B: GUIDELINES FOR EVALUATION OF PEDIATRIC TRAUMA PATIENTS FOR TRANSPORT*

A. Physiologic Criteria:

1. Depressed or deteriorating neurologic status.

2. Respiratory distress or failure.

3. Children requiring endotracheal intubation and/or ventilatory support.

4. Shock, compensated or uncompensated.

5. Injuries requiring any blood transfusion.

6. Children requiring any one of the following:

a) Arterial pressure monitoring.
b) Central venous or pulmonary artery pressure monitoring.
c) Intracranial pressure monitoring.
d) Vasoactive medications.

B. Anatomic Criteria:

1. Fractured and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury.

2. Fracture of two or more major long bones, i.e. femur, humerus.

3. Fracture of the axial skeleton.

4. Spinal cord or column injuries.

5. Traumatic amputation of an extremity with potential for replantation.

6. Head injury when accompanied by any of the following:

7. Cerebrospinal fluid leaks.

a) Open head injuries (excluding simple scalp injuries)
b) Depressed skull fractures.
c) Decreased level of consciousness.

8. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis.

9. Major pelvic fractures.

10. Significant blunt injury to the chest or abdomen.

C. Other Criteria:

1. Children requiring intensive care.

2. Any child who may benefit from consultation with, or transfer to, a Trauma Center or Pediatric Critical Care Center.

D. Burn Criteria (Thermal or Chemical) – Contact should be made with a Burn Center for children who meet any one of the following criteria:

1. Second and third degree burns of greater than 10% of the body surface area for children less than ten years of age.

2. Second and third degree burns of greater than 20% of the body surface area for children over ten years of age.

3. Third degree burns of greater than 5% of the body area for any age group.

4. Burns involving:

a) Signs or symptoms of inhalation injury.
b) Respiratory distress.
c) The face.
d) The ears (serious full-thickness burns or burns involving the ear canal or drums).
e) The mouth and throat.
f) Deep or excessive burns of the hands, feet, genitalia, major joints or perineum.

5. Electrical injury or burns (including lightning).

6. Burns associated with trauma or complicated medical conditions.

***Region-Wide Policy**

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

SPECIAL POPULATIONS: TRAUMA PATIENTS

I. Purpose:

To establish options for transporting to the closest appropriate destination.

II. Policy:

We are fortunate to have two American College of Surgeons (ACS) verified adult trauma centers, Barnes Jewish Hospital and St. Louis University Hospital, and two pediatric trauma centers, Cardinal Glennon Children's Hospital and St. Louis Children's Hospital, in the St Louis Metropolitan Area.

EMS providers must first identify which patients would benefit from treatment at a trauma center. Refer to the field triage diagram below for assistance. This field triage decision scheme, originally developed by the American College of Surgeons Committee on Trauma, was revised by an expert panel representing emergency medical services, emergency medicine, trauma surgery, and public health. The panel was convened by the Centers for Disease Control and Prevention (CDC) with support from National Highway Traffic Safety Administration (NHTSA). Its contents are those of the expert panel and do not necessarily represent the official views of CDC and NHTSA. Additions were made, as necessary, to maintain full compliance with IDPH rules. Providers may always contact medical control for clarification.

A. When an EMS provider encounters a patient that he/she believes would benefit from treatment at a trauma center:

1. BLS units should ask for ALS intercept/assistance, per the ALS assist guidelines.

2. If the trauma center is the closest facility, transport to that facility.

3. If the patient meets the field triage criteria below, transport to the trauma center, if the anticipated ETA is < 25 minutes.

4. If the anticipated ETA to a trauma center is greater than 25 minutes, transport to the closest facility OR arrange for helicopter EMS transport. See HEMS policy below.

B. If an EMS provider feels that the destination above is inappropriate, contact medical control for advice. EMS providers may always contact medical control for assistance with transport decisions.

C. Bypass of any facility should NOT occur when:

1. The patient is treated and transported by a BLS unit, without the availability of ALS assistance. The only exception shall be patients transported from accident scenes on the bridges and their approaches that may be transported directly to a St. Louis trauma center or to KHRH (the closest facility) as the crew deems appropriate at that time.

2. The patient is suffering from an immediately life-threatening condition such as airway compromise or severe hemorrhage uncontrolled with pre-hospital care including tourniquet application.

3. The patient is in cardiac or respiratory arrest.

III. FIELD TRIAGE DECISION SCHEME (REGION IV APPENDIX C)*

A. Measure vital signs and level of consciousness. If any of the following are present, strongly consider transport to a trauma center if anticipated ETA to the trauma center is < 25 minutes:

1. GCS < 14 Glasgow Coma Scale.
2. Systolic blood pressure ≤90 (Pediatrics ≤80).
3. Respiratory rate <10 or >29 (<20 in infants less than one year of age).

B. If the above are normal, assess anatomy of injury. If any of the following are present, strongly consider transport to a trauma center if anticipated ETA to the trauma center is < 25 minutes:

1. All penetrating injuries to head, neck, torso, groin, and extremities proximal to elbow and knee.
2. Flail chest.
3. Two or more proximal long-bone fractures.
4. Two or more body regions with a potential life or limb threat.
5. Combination trauma with 20% or greater TBSA burned.
6. Crush,degloved or mangled extremity.
7. Amputation proximal to wrist and ankle.
8. Pelvic fractures.
9. Open or depressed skull fracture.
10. Limb paralysis and/or sensory deficit above wrist & ankle.

C. If the above are not present, assess mechanism of injury and evidence of high-energy impact. If any of the following are present, strongly consider transport to a trauma center if anticipated ETA to the trauma center is < 25 minutes:

1. Falls
2. Adults: > 20 ft. (one story is equal to 10 ft.)
3. Children: > 10 ft. or 2-3 times the height of the child
4. High-risk auto crash
5. Intrusion: > 12 in. occupant site; > 18 in. any site
6. Ejection (partial or complete) from automobile
7. Death in same passenger compartment
8. Vehicle telemetry data consistent with high risk of injury
9. Auto v. pedestrian/ bicyclist thrown, run over, or with significant (>20 mph) impact
10. Motorcycle crash > 20 mph

D. If the above are not present, assess for special patient or system considerations. If any of the following are present, contact medical control and consider transport to a trauma center if anticipated ETA to a trauma center is < 25 minutes:

1. Age
2. Older Adults: Risk of injury & death increases after age 55
3. Children: Should be triaged preferentially to pediatric-capable trauma centers
4. Anticoagulation and bleeding disorders
5. Burns
6. Without other trauma mechanism: Triage to burn facility.
7. With trauma mechanism: Triage to trauma center.
8. Time sensitive extremity injury.
9. End-stage renal disease requiring dialysis.
10. Pregnancy > 20 weeks.**
11. EMS provider judgment.

E. For all other patients, transport to the closest facility or patient's facility of choice.

***Region-Wide Policy**

****See Special Populations: Obstetrics policy below.**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

SPECIAL POPULATIONS: STEMIs

I. Purpose:

To establish an options for transport to the closest appropriate destination.

II. Policy:

A. We are fortunate to have a number of PCI-capable facilities within close proximity to our System. These include:

1. Memorial Hospital, Belleville
2. St. Elizabeth's Hospital, Belleville
3. Anderson Hospital, Maryville Monday – Friday until 5:30pm
4. Barnes Jewish Hospital
5. Christian Hospital Northeast
6. Saint Louis University Hospital
7. St. Anthony's Hospital, South County
8. St. Mary's Hospital, Clayton

B. When a patient is identified as potentially suffering from an ST-Elevation Myocardial Infarction, System providers shall take the following actions:

1. Verify the presence of a STEMI, defined as 1mm ST elevation in two contiguous anatomical leads OR new onset left bundle branch block.

   a) Providers may contact medical control for assistance in diagnosing a STEMI (regardless of destination), including sending the 12 lead to Memorial Hospital ED for clarification. Providers may also contact St. Elizabeth's Hospital ED for assistance as well, if St. Elizabeth's would be the receiving PCI-capable facility.

2. Minimize on-scene times. On-scene time less than 15 minutes is strongly preferred.

3. It is clear, in the medical literature, that treatment of a STEMI at a PCI-capable facility is preferred. System providers shall transport STEMI patients to a PCI-capable facility, bypassing all others, if the anticipated ETA to the PCI-capable facility is < 30 minutes.

4. Send the 12 lead, if at all possible, to the receiving PCI-capable facility.

5. If the patient refuses transport to a PCI-capable facility, transport to the patient's facility of choice. Advise the receiving facility that you suspect STEMI, but the patient has refused immediate transportation to a PCI-capable facility. Follow the refusal procedure.

7. If the EMS provider suspects STEMI but is unable to establish radio contact with medical control, transport without delay to a PCI-capable facility. Establish radio contact as soon as possible to alert the receiving facility.

8. Helicopter EMS may be utilized, under appropriate circumstances for the STEMI patient. Refer to the HEMS policy below.

9. Bypass of any facility should NOT occur when:

    a) The patient is treated and transported by a BLS unit, without the availability of ALS assistance.

    b) The patient is suffering from an immediately life-threatening condition such as airway compromise, severe pulmonary edema, severe rhythm disturbances not responding to pre-hospital interventions such as symptomatic bradycardia, second degree Mobitz II or third degree AV block, ventricular tachycardia, etc.

    c) The patient is in cardiac or respiratory arrest.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

SPECIAL POPULATIONS: CVA

I. Purpose:

To establish an options for transport to the closest appropriate destination when a patient is having a cardio vascular accident (CVA).

II. Policy:

A. With the advent of thrombolytic therapy for acute ischemic CVA, pre-hospital providers have the opportunity to dramatically impact the morbidity and mortality of patients suffering from a horrible disease.

B. Stroke centers within the St. Louis Metropolitan Area include:

1. Barnes Jewish Hospital
2. Saint Louis University Hospital
3. St. Anthony's Hospital, South County

C. Hospitals within proximity to the Southwestern Illinois EMS System that are members of the MidAmerica Stroke Network, founded by Saint Louis University Hospital include:

1. Anderson Hospital, Maryville
2. Memorial Hospital, Belleville
3. Red Bud Regional Hospital, Red Bud
4. Sparta Community Hospital, Sparta
5. St. Elizabeth's Hospital, Belleville
6. St. Joseph's Hospital, Breese
7. St. Joseph's Hospital, Highland

D. When a patient is identified as potentially suffering from an acute CVA, System providers shall take the following actions:

1. Providers must first identify potential stroke patients. Consider acute CVA for patients with onset of the following within the last 12 hours:

a) Abnormal Cincinnati Stroke Scale.Sudden numbness or weakness of the face, arm or leg, especially on one side of the body.

b) Sudden confusion, trouble speaking, or understanding.

c) Sudden trouble seeing in one or both eyes.

d) Sudden trouble walking, dizziness, loss of balance, or coordination.

e) Sudden, severe headache with no known cause.

E. Providers may always contact medical control for assistance in determining if the patient is potentially suffering from an acute CVA and the ideal destination.

F. When determining if a patient is to receive thrombolytics, it is essential to document the onset of symptoms. Obtain contact information (name and cell phone number) of anyone who can describe when the onset of symptoms took place OR when the patient was last seen normal.

G. Minimize on-scene times. On-scene time less than 15 minutes is strongly preferred.

H. When an EMS provider encounters a patient that he/she believes would benefit from treatment at a stroke center:

1. If a Stroke Center is the closest facility, transport to that facility.

2. If the anticipated ETA to a stroke center is < 30 minutes, transport to the stroke center.

3. If the anticipated ETA to a stroke center is > 30 minutes, but the ETA to a member of the MidAmerica Stroke Network is < 30 minutes, transport to the member hospital.

4. If the ETA to a stroke center and a member hospital is > 30 minutes, transport to the closest facility.

I. If the patient refuses transport to the hospital determined by the above criteria, transport to the patient's facility of choice. Advise the receiving facility that you suspect an acute CVA, but the patient has refused immediate transportation to the determined hospital.

J. If the EMS provider suspects an acute CVA but is unable to establish radio contact with medical control, transport without delay to the hospital determined by the above criteria. Establish radio contact as soon as possible to alert the receiving facility.

K. Helicopter EMS may be utilized, under appropriate circumstances for the acute CVA patient. Refer to the HEMS policy below.

L. Bypass of any facility should NOT occur when:

1. The patient is treated and transported by a BLS unit, without the availability of ALS assistance.

2. The patient is suffering from an immediately life-threatening condition such as airway compromise or rapidly deteriorating mental status.

3. The patient is in cardiac or respiratory arrest.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

SPECIAL POPULATIONS: OBSTETRICS

I. Purpose:

To establish an options for transport to the closest appropriate destination when a patient is having an obstetric emergency.

II. Policy:

When a system provider encounters a pregnant patient >20 weeks EGA, he/she shall determine the appropriate destination as follows:

A. Trauma victims designated by the Field Triage Guidelines above for transport to a trauma center shall be transported to a trauma center with obstetrics capabilities if the anticipated ETA is < 25 minutes.

B. Trauma victims not designated by the Field Triage Guidelines above for transport to a trauma center shall be preferentially transported to a hospital with obstetrics capabilities. These include:

1. Anderson Hospital, Maryville
2. Belleville Memorial Hospital, Belleville
3. Gateway Regional Hospital, Granite City
4. St. Elizabeth's Hospital, Belleville
5. Touchette Regional Hospital, Centreville
6. Barnes Jewish Hospital
7. St. Anthony's Hospital, South County
8. St. Mary's Hospital, Clayton

C. For non-obstetric emergencies, transport to the closest appropriate facility or facility requested by the patient based on her chief complaint.

D. For potential obstetric emergencies such as abdominal pain/cramping, vaginal bleeding, etc., transport to the closest appropriate facility with obstetrics capabilities.

E. If the patient refuses transport to the hospital determined by the above criteria, transport to the patient's facility of choice. Advise the receiving facility that you suspect an obstetric emergency, but the patient has refused immediate transportation to the determined hospital.

F. Bypass of any facility should NOT occur when:

1. Delivery is imminent or anticipated prior to arrival at the hospital with obstetrics capabilities.

2. The mother is suffering from a severe illness to the extent that bypassing a closer facility might result in worsening of her outcome.

3. The mother is in cardiac or respiratory arrest.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DISTINATION

SPECIAL POPULATIONS: PSYCHIATRIC EMERGENCIES

I. Purpose:

To establish an options for transport to the closest appropriate destination when a patient is having a psychiatric emergency.

II. Policy:

A. Patients with behavioral/psychiatric emergencies require specialized inpatient care that is only available at:

1. Gateway Regional Medical Center, Granite City
2. St. Elizabeth's Hospital, Belleville
3. Touchette Regional Hospital, Centerville
4. St. Anthony's Hospital, South County
5. Barnes Jewish Hospital
6. Saint Louis University Hospital (voluntary admissions only)

B. When a patient is identified as potentially suffering from a behavioral/psychiatric emergency, System providers shall take the following actions:

1. Preferentially transport the patient to one of the above listed facilities, if within a reasonable distance.

C. If the patient, patient's family, or guardian (as appropriate for the situation) refuses transport to a hospital listed above, transport to the patient's facility of choice. Advise the receiving facility that you suspect a behavioral/psychiatric emergency, but the patient has refused immediate transportation to hospital with inpatient psychiatry services.

D. If the patient is found to have complicating non-psychiatric issues that would make transportation to one of the above facilities unsafe such as hypotension, hypertension, dyspnea, altered level of consciousness, etc. transport to the closest facility for stabilization and treatment.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

ST. LOUIS VA MEDICAL CENTER (John Cochran Hospital)

I. Purpose:

To establish a procedure for all transport request to St. Louis VA Medical Center.

II. Policy:

The VA hospital is very limited in its capabilities. For example, CT scan is not available on a 24 hour basis. In light of this and the fact that the entire hospital is frequently at capacity, they divert a significant number of patients, as we all know. As a general rule, they will not accept any trauma/backboarded patients due to a lack of resources. The VA hospital is NOT subject to the discontinuation of diversion the remainder of the Missouri hospitals in the St. Louis area has agreed to. They will continue to go on complete diversion at times.

When a patient is diverted from John Cochran ED, he/she will be able to apply for reimbursement from the VA for medical expenses at the outside facility. When stabilized, the outside hospital ED physician will contact the ED physician at John Cochran to arrange transfer. If no bed is available at the VA Medical Center or if the patient is too unstable for transfer, he/she can be admitted to the outside hospital and apply for reimbursement from the VA. Note that this is a source of frustration for some patients, as the VA is frequently slow to provide reimbursement. Often the outside hospitals bill the patient and request payment before the VA system processes their reimbursement claim.

A. The following procedure shall be followed for all patients requesting transfer to the ED at John Cochran. This includes residents of skilled nursing facilities. SNF staff may be asked to complete this process prior to or while calling EMS if appropriate.

1. After initial assessment of the patient, call the ED by phone at (314) 289-6410 prior to leaving the scene. Ask for a nurse to give report. The nurse will require the last name of the patient and last four digits of the patient's social security number. Occasionally, additional basic information such as date of birth may be required. This is done to verify that the patient is eligible for care at John Cochran. If he/she is not eligible for care for whatever reason, the patient may not request transport to John Cochran.

2. If, after initial assessment, the patient is determined to be too unstable for transport to the VA medical center, divert to the closest facility for stabilization. Ask your dispatch agency to contact the VA and provide the patient's last name and last four digits of his/her social security number. If this is not possible, contact the VA medical center immediately when it is feasible to do so. Do not delay or forego contact with the VA medical center. The ED nurse at John Cochran must enter this information and the name of the diverting physician into their computer system in order for the patient to receive reimbursement from the VA for outside hospital medical costs.

3. Document the name of the ED physician at John Cochran providing the order to divert in your run report.

4. If John Cochran diverts a patient, try in earnest to convince the patient to seek care elsewhere. Advise them that John Cochran has been contacted and they feel that they cannot appropriately care for the patient and/or they do not have an inpatient bed for the patient. So, he/she will be transferred elsewhere regardless. If the patient has decision-making ability and adamantly refuses transfer elsewhere, the VA is obligated to accept him/her as long as he/she is eligible for care there. If the EMS provider feels that John Cochran is an inappropriate destination for the patient, i.e. for trauma patients, unstable patients, etc. the refusal process should be followed as well. Transport the patient to John Cochran and advise them as such.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

INTER-FACILITY TRANSFERS

I. Purpose:

To establish guidance for inter-facility transfers..

II. Policy:

A. An attending physician, clinic physician, or ED physician will authorize or request inter-facility transports. It is the transferring physician's responsibility to:

1. Determine the appropriate receiving facility.

2. Receive confirmation of acceptance of the patient from the receiving facility and receiving physician.

3. Indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.

A. The attending physician may provide written medical orders prior to transport to be executed during transfer. These orders must be affixed to the run report. The EMT/PHRN may follow only those orders that fall within their scope of practice and the Southwestern Illinois EMS System SOGs.

1. S personnel are not authorized to administer any medications or monitor intravenous fluids, but may transport patients with saline locks if the patient is stable and will require no advanced treatments during transport.

2. Medical control may provide approval for transport of any additional medications not previously listed in the SOGs.

B. In the event of unexpected decompensation during an inter-facility transfer, the System provider shall:

1. Follow all System SOGs.

2. Contact medical control for direction. All care provided during the transfer by System providers falls under the authority of the EMS Medical Director, not the transferring physician.

3. The transferring unit may, at any time, divert to the closest facility for stabilization if deemed necessary.

C. Any patient requiring care at a level higher than the highest level of pre-hospital care provider available must be transported with an RN or other appropriate professional personnel as deemed necessary by the transferring physician.

1. All care provided during the transfer by System providers falls under the authority of the EMS Medical Director.

2. System providers shall maintain control of patient care at all times. Other caregivers accompanying EMS personnel during the transfer function under specific orders of the transferring physician to manage specific tasks such as the administration of unapproved IV medications or monitoring ventilated patients.

3. Contact medical control for any discrepancies in opinion concerning medical care that may arise during transport or for any other concerns.

D. Ambulance services must give consideration to maintaining adequate coverage of their 911 service area prior to accepting the patient transfer.

Appendix: **REGION IV GUIDELINES FOR INTER-SYSTEM/INTER-REGION PATIENT TRANSPORTS***

Policy: The goal of EMS personnel is to transport patients from a pre-hospital site to an appropriate emergency care facility for further assessment and treatment.

1. General Guidelines – Adult and Pediatric

a. Whenever possible, the wishes of the patient, family or Power of Attorney for Health care should be the primary consideration in determining the facility to which the patient is transported.

b. The Resource Hospital Medical Control should be contacted by EMS personnel to divert any emergency patient to a facility other than patient choice or routine transport patterns.

c. The Resource Hospital Medical Control will decide if the benefits to the patient reasonably expected from the provision of appropriate medical treatment at another or more distant facility outweigh the increased risks to the patient.

2. Pediatric Trauma (<17 years) & Medical (<18 years) Guidelines

a. Information regarding pediatric patients or pediatric patients with special health care needs (See appendix A, B & C) must be relayed to the Resource Hospital Medical Control for transport consideration directly to a specialized children's hospital.

3. Adult Trauma Guidelines

a. If a patient has an altered level of consciousness and meets the field triage guidelines for trauma, the patient will be transported according to Resource Hospital Medical Control and/or Region trauma boundaries (See appendix D & E).

4. Hospital ER Classification and Transport Guidelines

a. Pediatric patients meeting appendix A, B & C guidelines and adult patients meeting appendix D guidelines may bypass a "Standby" ER and transport to the nearest "Basic" or "Comprehensive" ER.**

b. In no case should bypass occur when a patient is in cardiopulmonary arrest.

***Region-Wide Policy**

****Note that there are no Standby Emergency Departments within St. Clair, Randolph, Monroe, or Clinton Counties.**

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

USE OF LIGHTS AND SIRENS

I. Purpose:

To establish guidance in the use of lights and sirens.

II. Policy:

A. In an effort to maximize the safety of System providers, patients, and the public at large, EMS providers within the Southwestern Illinois EMS System should restrict use of lights and sirens during patient transportation to the hospital to situations where the patient is (or potentially might be) critically ill or injured or where delayed arrival at an emergency department by even a few minutes may lead to increased morbidity or mortality. This includes, but is not limited to, suspected acute CVA, STEMI, or trauma patients meeting criteria for anatomical injuries or mechanism of action.

B. The use of lights and sirens must be evaluated on a case-by-case basis, and the responsibility for this determination resides solely with the highest level EMS provider caring for the patient or the transferring physician for inter-facility transfers.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

NON-PARAMEDIC TRANSPORT OF PATIENTS

I. Purpose:

To establish guidance in use of non-paramedic transport of patients.

II. Policy:

It is occasionally desirable for a lower level provider to treat and transport a low acuity patient after paramedic evaluation. When a single-paramedic unit responds to an emergency, select patients may be cared for by an EMT-B after evaluation by an EMT-P. In addition, to maximize the number of ALS ambulances available for emergency care, an EMT-P may transfer care of the patient to a BLS ambulance by the following procedure:

A. All personnel are encouraged to participate in patient care while on-scene, regardless of who "attends" with the patient while en route to the hospital. If non-paramedic transport is desired, the EMT-P on scene must conduct a detailed physical assessment and subjective interview with the patient to determine their chief complaint and level of distress.

B. The determination of who attends should be based upon the patient's chief complaint, findings of the history and physical exam, immediate treatment needs and any reasonably anticipated treatment needs while en route to the hospital.

C. If the paramedic determines that the patient is stable and all foreseeable patient care needs can be managed by the EMT-B, patient care can be transferred to the EMT-B for transport to a hospital.

D. Both the transporting technician and the EMT-P who transferred care must write a narrative documentation that covers all aspects of assessment, care, and disposition. This should be done on one patient care report.

E. Patients who can NOT be transferred to a lower level of certification include, but are not limited to, the following:

1. Any patient who would benefit from ALS care.

2. Any patient with abnormal vital signs.

3. Any patient with an acutely altered level of consciousness, signs of CVA, or postictal state.

4. Any patient suffering from chest pain or difficulty breathing.

5. Any patient suffering from abdominal pain.

6. Any patient meeting anatomical injury or mechanism of injury criteria for field triage to a trauma center.

7. Any patient for whom transport would be delayed significantly by waiting for a BLS unit to arrive.

8. Any patient for which ALL EMS providers on scene do not agree can be safely transported without a paramedic.

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EMERGENCY MEDICAL SERVICES

PATIENT TRANSPORT AND DESTINATION

HELICOPTER EMS (HEMS)

I. Purpose:

To establish guidance in use of Helicopter EMS.

II. Policy:

HEMS offers many critically ill or injured patients rapid transport to specialized centers. However, it is inherently more dangerous and expensive for providers and patients. HEMS must be utilized responsibly. The EMS Office encourages HEMS utilization in appropriate circumstances, though:

A. The EMS provider must first determine which patients may benefit from HEMS.

1. Trauma patients meeting anatomical injury or mechanism of injury criteria for field triage to a trauma center.

2. Patients with a time-critical diagnosis requiring specialized care, i.e. STEMI and acute CVA.

3. Other critically ill patients that either require the critical care skills offered by aeromedical personnel or rapid transport to a tertiary care center.

B. Next, the EMS provider must determine if the patient would benefit from bypassing local facilities.

1. Bypass should NOT occur for patients in cardiac arrest. HEMS is NOT appropriate for these patients.

2. If the patient is in need of immediate life-saving intervention such as airway stabilization, for example, what is the quickest way a qualified person can reach the patient… by requesting HEMS or by rapid transport to a local facility?

C. Note that, in the East St. Louis area where there is a high incidence of severe trauma and frequently only BLS service is available, a BLS unit may request HEMS to rendezvous with them at the helipad of Kenneth Hall Regional Hospital or another appropriate location. This is done in an effort to minimize the patient's time to ALS care and time to a trauma center. If the helicopter is not present on the BLS crew's arrival to Kenneth Hall Regional Hospital or on approach to the pad, the BLS crew must take the patient into the ED at Kenneth Hall Regional Hospital for evaluation.

D. Next, the EMS provider must determine if the patient would arrive at the tertiary/trauma center more quickly if transported by air or by ground.

1. HEMS should be considered for patients whom EMS providers determine that the time needed to transport the patient by ground to an appropriate facility poses a threat to the patient's recovery.

2. HEMS should be considered for patients in whom transportation will be delayed such as entrapped patients or those in isolated rural areas away from roads.

E. In an effort to expedite HEMS response, System providers may develop criteria for automatic standby based on specific caller information received and location of the call. This will ensure that a check for aircraft availability, weather check by the pilot, and preflight preparations are taking place while the initial crews are responding. EMS crews may also consider requesting an aeromedical service to be placed on standby when responding to a call.

F. In the event a helicopter is not required, the caller will cancel the standby request as soon as possible.

G. If HEMS transportation is desired, the request to respond should be made as soon as possible.

H. The transporting unit may, due to location of the call, need to rendezvous at a predetermined location with the helicopter. Transport to this location to meet a helicopter is not contra-indicated.

I. Patient transportation via ground ambulance will not be delayed to wait for helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable

distance, then transportation will be initiated by ground ambulance according to the destination criteria already provided.

J. Maintain radio contact with the responding helicopter. Advise the pilot of any hazards on the ground including trees, power lines, uneven terrain, etc. Also advise the pilot if other helicopters are responding to the scene.

K. Notify the HEMS agency of the change in destination. Advise them to respond to the receiving facility, if appropriate.

III. HELICOPTER EARLY LAUNCH PROGRAMS

A. Many services in various parts of the Country utilize early launch programs. These programs involve a helicopter automatically responding to the scene if specific caller information is obtained for calls distant from an appropriate – typically trauma – center.

B. System providers are not prohibited from developing early launch programs. However, all must be approved by the EMS Medical Director prior to institution. All must involve a quality assurance review of each use. If an early launch program is utilized in an area serviced by BLS ambulances, an ALS ambulance must be dispatched to the scene simultaneously with HEMS as a part of the early launch program.

IV. HELICOPTER SHOPPING

A. “Helicopter shopping” occurs when a service or hospital requests a helicopter to respond for patient transportation/transfer. When the first service turns down the request due to weather conditions, the requesting service or transferring hospital then requests a helicopter from a second agency without informing them of the denial by the initial service. The second agency may not have the specific knowledge of adverse weather conditions that the initial service had, and, consequently accepts an unsafe call.

B. Many HEMS accidents and deaths have been linked to “helicopter shopping”. Whether a specific HEMS agency accepts a transport/transfer or not is a decision made solely by the pilot. However, in the event that any Southwestern Illinois EMS provider contacts a second agency for transport after being denied by another agency, the provider MUST inform the second agency of the first agency’s denial and any specific knowledge of reasons why. The pilot of the second agency may then choose to accept or deny the request.

Appendix: LANDING ZONE SAFETY PRECAUTIONS

A. The landing zone (LZ) should be a minimum of 100 foot by 100 foot level area (less than 5^0 of slope) clear of trees, wires, and loose debris. For nighttime operations, the LZ should optimally be 150 foot by 150 foot.

B. The four corners may be marked with flares. If flares are used, crews must ensure they are well secured and do not pose additional risks to scene safety.

C. Vehicles may be used to make the LZ. Position the vehicles at two corners of the LZ with the headlights crossing in the center in the direction of the wind.

D. Monitor statewide MERCI or other frequency as assigned prior to landing as the pilot may select a different landing zone due to safety, wind, or other considerations.

E. Personnel shall remain at least 100 feet away from the aircraft during landing and takeoff.

F. Care should be taken to protect eyes from flying debris during landing and takeoff. Safety glasses/goggles are recommended.

G. All loose objects such as blankets shall be secured prior to takeoff and landing.

H. Vehicle strobe lights should be turned off prior to the aircraft landing.

I. Never approach a running helicopter unless accompanied by a crewmember.

J. When approaching a running aircraft with a crew member escort, you will always approach and depart from the front of the aircraft after making eye contact with the pilot and being acknowledged, maintaining a crouched position in full view of the pilot. Never approach or depart aircraft from the rear. Never extend your hands or any other equipment such as IV poles over your head.

K. Long objects shall be carried horizontally and no higher than waist high.

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EMERGENCY MEDICAL SERVICES

DOCUMENTATION

EMS SYSTEM MEDICAL RECORDS

I. Purpose:

To establish an EMS System standard for EMS medical records.

II. Policy:

A. Documentation shall be completed by each vehicle service provider for every emergency pre-hospital or inter-facility transport and every non-emergency medical transport by an IDPH-licensed vehicle.

B. All system units will utilize and complete in full, the Southwestern Illinois EMS System Patient Report Form and the Statewide Illinois Pre-hospital Care Report Form ("bubble sheet").

1. One copy shall be left with the receiving hospital emergency department, trauma center or health care facility before leaving that facility.

2. Only the need to immediately respond to another call for emergency assistance may delay leaving a copy of the run report. If this occurs, the report must be faxed or delivered to the receiving facility immediately upon completion of the pending run.

3. Copies of all ECG strips will be attached to each copy of the Patient Report Form.

C. In addition to the above, if ILS/ALS supplies were used, the Patient Charge Form must be completed in full.

D. All system copies must be submitted to the EMS Department within twenty four (24) hours of the emergency run. Self-addressed, stamped envelopes are made available for all system units to prevent trips to the hospital specifically for this purpose.

E. All Statewide Illinois Pre-hospital Care Report Forms will be mailed to IDPH quarterly by the Southwestern Illinois EMS System.

F. System first responders must complete a Southwestern Illinois EMS System Patient Report Form on every patient.

1. The original (top page) is retained by the First Responder service.

2. The remaining 2 copies are to be given to the EMT/PHRN upon their arrival.

3. The EMT/PHRN will attach the second copy (yellow) to the yellow narrative that goes to the Resource Hospital.

4. The EMT/PHRN will retain the third copy (pink) for their ambulance service provider.

G. All First Responder Patient Report Forms must be retained for a period of 7 years.

H. All System providers must notify the EMS Office of any AED utilization.

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EMERGENCY MEDICAL SERVICES

DOCUMENTATION

GENERAL RECOMMENDATIONS

I. Purpose:

To establish general recommendations for EMS System Documentation.

II Policy:

A. Be truthful, accurate, objective, pertinent, legible, and complete with appropriate spelling, abbreviations, and grammar.

B. Reflect your patient's chief complaint and a complete history or sequence of events that led to his/her current request or need for care.

C. Detail your assessment of the nature of the patient's complaints and the rationale for that assessment.

D. Reflect your initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment, and significant changes important to patient care.

E. Reflect your ongoing monitoring of abnormal findings.

F. Summarize all assessments, interventions, and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events.

G. Include an explanation for why an intuitively indicated and appropriate assessment, intervention, or action did NOT occur.

H. Clearly describe the circumstances and findings associated with any complex call or out-of-the-ordinary situations.

I. Elaborate on any extended on-scene times.

J. Utilize addendums to the standard patient care report liberally.

K. Use of electronic patient reports is highly encouraged.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1200
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

DOCUMENTATION

SOUTHWESTERN ILLINOIS EMS SYSTEM CQI REQUIREMENTS

I. Purpose:

To establish requirements for all participating agencies for continuous quality improvement.

II. Policy:

The Southwestern Illinois EMS System is committed to providing excellent prehospital care throughout a large area of Southwestern Illinois. CQI is a team effort. Thus, the System relies on each service to maintain its own CQI program and promptly report any concerns/issues to the EMS Office.

A. All agencies shall be required to submit reports (except as noted) to the Southwestern Illinois EMS System Coordinator that will include:

1. EMD agencies
2. CQI will be addressed by each 911 agency.
3. Will be subject to random audit by the EMS Medical Director.

B. All EMS agencies (including FR agencies)

1. What are the mean and 90th percentile response time intervals (urban vs. rural) per zip code?

2. For transport agencies, what are the mean and 90th percentile on scene times for trauma?

C. BLS agencies

1. Per agency:

a) AED use.
b) Random chart reviews for appropriate ALS intercept.

D. ALS Agencies, per agency:

1. Altered mental status (GCS < 9)/status epilepticus.

    a) Percent with recorded blood glucose.

2. Cardiac Arrest

    a) In cardiac arrest occurring prior to EMS arrival where defibrillation is attempted, what is the mean time and 90th percentile time from PSAP contact to the initial defibrillation?

3. Non-Traumatic Chest Pain

    a) Symptom onset to 911 call.

    b) EMS arrival to first 12 lead obtained.

    c) Time 911 call is first received by primary PSAP to EMS arrival at ED.

    d) Proportion of patients with non-traumatic chest pain > 35 years treated by EMS for whom 12-lead ECGs were obtained.

    e) Proportion of patients with non-traumatic chest pain > 35 years who received an aspirin.

    f) Proportion of patients with STEMI treated by EMS for who 12 lead ECGs were obtained.

E. ALS Agencies, per medic:

1. ETT, King LT placement (number of successful placement, success rate).

2. Record completion.

F. To be turned in on no less frequent than monthly basis, by the 10th of each month:

1. Airway interventions per Airway Intervention Form. An Airway Intervention Form shall be completed for each patient who received attempted intubation or King LT placement.

2. Each instance of Cricothyroidotomy/TLJV.

3. Each instance of Needle Decompression.

4. Each instance of Cardioversion.

5. Each use of dopamine.

G. A system incident report shall be completed for instances of equipment failure affecting patient care.

III. SOUTHWESTERN ILLINOIS EMS SYSTEM CQI PLAN

A. CQI of the Southwestern Illinois EMS System will typically consist of:

1. Review of the submitted data (policy 1200).

B. Random chart reviews:

1. Random chart audits at the discretion of EMS System Coordinator and EMS Medical Director.

2. External/internal complaints.

C. Peer Review cases by Field Training Officers:

1. Pediatric cardiac arrest.

2. Adult cardiac arrest, including all pre-hospital termination of resuscitation.

3. Major trauma.

4. Miscellaneous.

D. Mandatory EMS Medical Director review:

1. All use of advanced CCEMTP protocols

Appendix: Airway Intervention Form

Please complete this form for each patient on whom visualization, intubation, or King LT placement was attempted (regardless of success). This form should be returned to the EMS Office at Memorial Hospital on no less than a monthly basis.

EMS Run Number: _____
Date:_____
Patient Age_____ (please circle) Years or Months
Patient Condition Medical Trauma
Was this patient in cardiac arrest at time of attempt? Yes No
Route of Intubation: Oral Nasal
If intubation failed, was King LT placed?
Yes No King LT was primary airway
If intubation was unsuccessful, why?
Difficult anatomy: obese, large tongue, secretions/blood/vomitus.
Clenched jaws/inadequate relaxation.
Difficult environment.
Other_____
How many personnel made an attempt to intubate? _____
How many total visualizations were made? _____
How many total attempts were made? _____
Was etomidate or midazolam used (please circle which)? Yes No
If etomidate was administered, was it administered prior to all attempts? (Clarify briefly if not.)
Yes No

Was it necessary to reintubate the patient due to an accidental dislodgement or intentional removal of the tube? (please circle) Yes No
If an attempt to reintubate a patient was made, please complete a second form.

Was colorimetric CO2 used to confirm placement? Yes No
If waveform capnography was used, what was the initial reading_____ & reading at ED arrival_____
Was ET tube/ King LT still inserted on arrival at the ED? Yes No
Was ET tube/ King LT in trachea/properly seated on arrival at the ED? Yes No

Name and license number of person completing this form_____

*Visualization is defined as a blade insertion and a "look" without an attempt to pass a tube
**Attempt is defined as the tip of the tube passing the teeth

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1201
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

DOCUMENTATION

SOUTHWESTERN ILLINOIS EMS SYSTEM CQI PLAN

I. Purpose:

To establish requirements for all participating agencies for continuous quality improvement.

II. Policy:

A. CQI of the Southwestern Illinois EMS System will typically consist of:

1. Review of the submitted data (policy 1200).

B. Random chart reviews:

1. Random chart audits at the discretion of EMS System Coordinator and EMS Medical Director.

2. External/internal complaints.

C. Peer Review cases by Field Training Officers:

1. Pediatric cardiac arrest.

2. Adult cardiac arrest, including all pre-hospital termination of resuscitation.

3. Major trauma.

4. Miscellaneous.

D. Mandatory EMS Medical Director review:

1. All use of advanced CCEMTP protocols

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1300
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SEVICES

MISCELLANEOUS

POLICY FOR MASS GATHERING EVENTS

I. Purpose:

To establish guidelines when working at mass gathering events.

II. Policy:

A. EMS providers are frequently called upon to provide medical care at mass gathering events within our system, often with inadequate funding for ideal staffing. For that reason, the Southwestern Illinois EMS System will not impose specific requirements for medical care at events, fearing that doing so would result in NO medical care at many events. The following do apply to mass gathering events staffed by personnel of the Southwestern Illinois EMS System:

B. The EMS service staffing the event is responsible for notifying the EMS Office in advance of any events that may reasonably result in either a significant number of patients requiring transport to area EDs so as to cause a noticeable increased patient load OR if one may reasonably foresee the need to treat critically ill or injured patients.

1. Management personnel of the requested EMS agency must take into account the nature of the event, crowd size, anticipated weather conditions, etc.

2. This determination will be at the discretion of management personnel of the EMS service requested to attend.

3. Submit the required “Special Events Form” to the EMS System Coordinator when a mass gathering is planned.

C. The EMS service staffing the event may, at any time, request assistance with planning or execution of the medical action plan. The service is responsible for requesting assistance from the EMS Office, if needed. The EMS Office reserves the right to become involved in the planning or execution of the medical action plan for any mass gathering event utilizing Southwestern Illinois EMS System providers if deemed necessary.

D. The concepts of NIMS/ICS will be utilized at all events.

E. Southwestern Illinois EMS System providers will utilize the System policies and SOGs at all times.

1. All on-site treatment without transport must follow the refusal process.

2. When interacting with non-System providers to provide care at a mass gathering event, follow the on-scene physician/nurse protocol once System providers have assumed patient care.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1301
Effective Date: 2/11
Supersedes:
Reviewed: 5/15
Revised: 5/15
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

RESTOCK OF CONTROLLED SUBSTANCES & ROUTINE DRUGS AND EQUIPMENT

I. Purpose:

To establish a method of restocking of controlled substances and routine drugs and equipmentin the Southwestern Illinois EMS System in accordance with Illinois Department of Public Health (IDPH) regulations and Department of Drug Enforcement Agency (DEA).

II. Statement:

It is not just the agencies responsibility to insure the security of narcotics. Agencies will develop and maintain a written plan and or policy describing how they will insure narcotic security and integrity is maintained during high call volume during shift change where on-going and off-going paramedics are unable to reconcile narcotics at shift change. These will be inspected at least on an annual basis.

III. Policy:

A. Controlled substances may be restocked only at Memorial Hospital and only to Southwestern Illinois EMS System personnel.

B. All additional drugs and medical equipment will be restocked by all Region IV hospitals.

C. Narcotic Restock

1. Each ALS unit will have a designated controlled drug container that is secured using a tamper evident plastic lock using sequential numbering with the following contents:

    a) (2) Valium 10mg prefilled syringe
    b) (2) Midazolam 10mg/2ml vial
    c) (5) Morphine 4mg prefilled syringe

2. The pharmacy will maintain a like container for each ALS unit within its department

3. Narcotics must be locked in the vehicle. All drugs must be counted and verified DAILY with names and signatures and the number from the tamper evident lock by both the off-going and on-coming ALS personal/ or supervisor. The narcotics cannot be placed back in service until they have been verified. Company's management will ensure off duty vehicles are verified DAILY. The signature sheets will be kept 7 years by the ambulance service and are subject to inspection by EMS Office staff on a minimum of an annual basis.

D. Medication Accountability

1. It is the responsibility of the ALS personnel on the ambulance to ensure all medications are not expired during their shift.

2. To ensure proper accountability all services will perform an expiration log for each ALS unit, both transport and non-transport units, on a monthly basis. These will be subject to random inspection by the EMS Office.

IV. Procedure:

A. When a controlled drug is used, the paramedic administering the drug will complete the sign-out sheet contained in the narcotic container.

B. The paramedic will bring the following to the pharmacy when exchange is needed:

1. The container with the remaining stock

2. Sign-out sheet

C. The pharmacist will then exchange a full, complete, narcotic container for the partial container.

V. Guidelines & Points of Emphasis

A. Controlled substances may be dispensed to a paramedic/ PHRN ONLY.

B. Monthly narcotic accountability sheets will be inspected on a minimum of an annual basis, with unannounced inspections done during site visits.

C. Cases of suspected theft of unexplained loss will be reported to the EMS System Coordinator immediately, and an “Incident Occurrence Form” completed in detail.

1. Local law enforcement should also be contacted by the ambulance service.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1302
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

REQUEST FOR NEW TECHNOLOGY OR MEDICATIONS

I. Purpose:

To establish a method of requesting new technology or medications.

II. Policy:

A. Complete the request form, and submit it to the System Coordinator.

B. If approved by the System Coordinator and Medical Director, a protocol will be written and submitted to IDPH for approval.

C. The EMS Coordinator, Educator, and Medical Director will determine the necessary education prior to placing the new medication/technology into service.

1. This education may be offered by the EMS Office, or the EMS Office may request that the service complete its own IDPH-approved training.

2. It is the responsibility of the service to ensure that all personnel are trained in a timely manner (full and part time). This is subject to audit by the EMS Office at any time by random testing or review of records.

REQUEST FOR NEW TECHNOLOGY OR MEDICATIONS

When a pre-hospital care provider is interested in obtaining new technology or medications not previously approved within the Southwestern Illinois EMS System, he/she shall submit the following information to the EMS Office (serious requests with potential funding only please):

New technology or medication being requested: _____

Manufacturer: _____

Describe how acquisition of this technology or medication will impact patient care:

_____

_____

_____

_____

_____

Please reasonably estimate, based on a review of your agency's run records, the incidence with which this new technology or medication is needed:

_____

Describe how your agency will train all employees on the use of this technology or medication:

_____

_____

_____

_____

Submitted by:_____ Agency:_____

Medical Director Response:

_____

_____

_____

_____

_____

Approved: Yes/No

Signature: _____

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: **EMS 1303**
Effective Date: **2/11**
Supersedes:
Reviewed: **1/15**
Revised:
Administrator: **EMS Administrative Director**
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

REGION IV SCHOOL BUS INCIDENT POLICY*

I. Purpose:

This policy governs the handling of school bus collision/incidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with System/Regional policies including mass casualties. The goal of this policy is to eliminate the transport of uninjured children/students to the hospital and to reduce EMS scene time and utilization of resources.

II. Policy:

A. Each ambulance service provider within the System/Region is required to design and implement a procedure for discharging uninjured children/students to their parents/legal guardians or to local school officials. A statement must be included within the service policy stating that the highest level of care available will be dispatched to the scene for patient evaluation. Discharge procedures will facilitate transferring care of uninjured children/students to the parent/legal guardians or school officials consistent with System and Regional policies. It is recommended that these procedures be developed in coordination with school officials and provider's legal counsel.

III. Procedure:

A. Determine the category of the collision/incident:

1. CATEGORY 1 bus collision/incident – significant injuries present in one or more children/students or there is a documented mechanism of injury that could reasonably be expected to cause significant injuries.

2. CATEGORY 2 bus collision/incident – minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students also present.

3. CATEGORY 3 bus collision/incident – no injuries present in any children/students and no significant mechanism of injury present.

B. Determine if implementation of this policy is appropriate. Implement this policy only if the collision/incident is a Category II or III bus collision/incident. Follow multiple victim and disaster preparedness policies for all Categories I bus collisions/incidents, and transport all children/students to the hospital.

C. Children/students with disabilities, special needs or communication difficulties will be transported to the hospital for evaluation, when involved in a Category I or Category II collision/incident. For those involved in a Category III, where there is no injury and no significant mechanism of injury present, list children/students on the "School Bus Incident Log."

D. Contact medical control, advise of the existence of a Category II or III bus collision/incident and determine if a scene discharge or uninjured children/students by the emergency department physician in charge of the call is appropriate.

E. Injured children/students by exam and/or complaint are treated and transported as deemed necessary and appropriate by EMS personnel or at the request of the child/student.

F. Implement provider procedures for contacting school officials or parents/legal guardians to receive custody of the uninjured children/students consistent with System/Regional policies. Procedures may include option of ambulance service provider escorting bus, if operable, back to school of origin or other appropriate destination.

G. Medical Control, after consulting with scene personnel, will discharge the uninjured children/students to care of the ambulance service provider, who then will release the children/students, consistent with appropriate System/Regional policies and procedures, to parent/legal guardians or school officials.

H. Each uninjured child/student name must be added to the "School Bus Incident Log" and the "Notice of Emergency Medical Services Response to a Minor" form. A copy of the evaluation form must be given to the parent/legal guardian or school official.

***Region-Wide Policy**

REGION IV SCHOOL BUS INCIDENT LOG OF UNINJURED PATIENTS*

All individuals on the bus 18 and older should initial in the indicated space adjacent to their name when uninjured. Parent/legal guardian or school official should initial in the indicated space adjacent to their child's name when uninjured. Initials indicate agreement that no injury has been suffered and no transportation is required to the hospital.

==========

Date & Time _____ Location _____ School Name _____ _____

Bus Number _____ Total # of Persons _____ # Transported _____ # Not Transported _____

==========

NAME	AGE	M/F	ADDRESS	PHONE	INITIALS

***Region-Wide Policy**

REGION IV NOTICE OF EMERGENCY MEDICAL SERVICES REPONSE TO A MINOR*

A. Date: _____

From: Service _____

Address_____

_____

Phone # _____

Name of Child: _____

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 the child. Based on our assessment and statement 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 wish additional information, please contact our agency at the above phone number.

***Region-Wide Policy**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1304
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

REGION IV GUIDELINES FOR BYPASS & DIVERSION*

I. Purpose:

To assure that pre-hospital triage decisions are made in the best interest of the patient, communication procedures must be in place which inform and update the Resource Hospital regarding the patient's condition and any resource limitations at the Associate or Participating hospital.

II. Policy:

A. Hospitals shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, during the next business day following any bypass or resource limitation decision.

III. General Procedure

B. If it is decided that resource limitations affect the ability of a Region IV hospital to provide optimum care to a particular patient, the Resource Hospital Medical Control may divert the ambulance transporting that patient to another facility. Diversion may be implemented provided all monitored and emergency department beds are at capacity.

1. The Resource Hospital Medical Control will decide, based upon the EMS providers report, if the benefits to the patient reasonably expected from the provision of appropriate medical treatment at another or more distant facility outweigh the increased risks to the patient.

2. In the event of the lack of availability of a specialty component necessary for critical care (e.g. no critical or monitored beds available in hospital, hospital internal disaster, staffing resources insufficient after all attempts have been made to add staff, etc.), and all emergency department beds are at capacity, a Region IV hospital may request temporary bypass of EMS patients.

3. In the above circumstances, the Region IV hospital requesting bypass should first check the available resources at surrounding hospitals, then notify their Resource Hospital and the EMS agencies normally transporting patients to them with the following information prior to “going on bypass”:

    a) The specific patient care problems the hospital is unable to manage temporarily (e.g. closed head injury, multiple trauma, all critical patients, etc.)

    b) The length of time it is anticipated bypass of patients will be necessary.

    c) When the specialty component is again available, the Region IV hospital should again notify their Resource Hospital and the EMS agencies normally transporting patients to them.

4. Each hospital should have an in-house policy and procedure designating the appropriate individual(s) empowered to determine the need for bypass request and the mechanism of subsequent notification.

5. In the event that bypassing is implemented, the Illinois Department of Public Health shall be notified of the bypass implementation by the hospital instituting the bypass, within 24 hours.

B. Exceptions/Special Situations

1. Bypass should NOT occur when:

    a) A patient is in full cardiopulmonary arrest, or critical life-threatening condition exists, i.e. airway compromise.

    b) Three or more hospitals in a geographic area are on bypass and transport time by an ambulance to the nearest facility exceeds 15 minutes.

2. Bypass may occur when:

    a. Pediatric non-trauma patients meet criteria listed in Appendix A.

    b) Pediatric trauma patients meet criteria listed in Appendix B.

    c) Pediatric patients have special healthcare needs (See Children With Special Healthcare Needs).

d. Adult trauma patients meet field triage guidelines listed in Appendix C. Note that this appendix has been updated to include CDC Field Triage Guidelines per Region IV Trauma Advisory Council meeting December, 2009.

e) Appendix D describes the regional trauma boundaries for Region IV. It is not included in this document due to lack of relevancy. Contact the EMS Office if any questions arise.

f) Appendices A-C are provided in Section XI.

C. Bypass Status Review by IDPH (77 IL Adm. Code, Chapter I, 515.315, Subchapter b and c)

1. The (individual) hospital shall notify the Illinois Department of Public Health immediately via the Web Portal.

2. In determining whether a hospital's decision to go on bypass status was reasonable, the Department shall consider the following:

a) The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;

b) Whether an internal disaster, including but not limited to a power failure, had occurred in the hospital at the time that the decision to go on bypass status was made;

c) The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and

d) The approved Regional Protocols for bypass and diversion at the time that the decision to go on bypass status was made.

D. For Trauma Centers only, the following situations constitute a reasonable decision to go on bypass status:

1. All staffed operating suites are in use or fully implemented with on-call teams, and at least one or more of the procedures in an operative trauma case;

2. The CT scan equipment is not working; or

3. The general bypass criteria in this Section.

***Region-Wide Policy**

REGION IV DIVERSION CHECKLIST

Name of Facility<u>MemorialHospital</u>NotifiedBy _____

Name of Individual Notifying Resource Hospital _____

Name of Individual Notifying IDPH _____ **Date** _____

Date of Bypass/Limitation _____ Time of Bypass/Limitation_____

Individual Authorizing Bypass or Limitation:

A. Emergency Room Physician _____

B. Charge Nurse _____

C. Administrative Supervisor _____

Area Hospital(s) Notified: Yes _____ No _____

Area Fire/or Private Ambulances Notified: Yes _____ No _____

If Participating of Associate Hospital has Resource Hospital been notified:

Yes _____ No _____

Reason for Bypass _____

Number of Critical/Monitored Beds Available _____

Number of Staff after call in attempts _____

Internal ____ or External ____ Disaster occurred: Yes _____ No _____

Number of ER Physicians On Duty _____

Number of Registered Nurses On Duty _____

Emergency Room Director of Designee called at _____

Nursing Call List Implemented at _____

1. Reason For Diversion

Equipment Failure Type _____

Internal Disaster Plan Implemented at _____.

D. Time On Call/In-house Physicians at Maximum Patient Care Capabilities _____

Other _____

1. Additional Data Required

E. Total Monitored Beds _____**Available Monitored Beds** _____

Date Diversion Canceled _____ Time Diversion Canceled _____

Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes.

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1305
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

REGION IV PROTOCOLS FOR DISBURSEMENT OF IDPH GRANTS*

I. Purpose:

To set guidelines for annual disbursement of IDPH grants within Region IV.

II. Procedure:

A. All applicants must be submitted on the IDPH form, "EMS Assistance Fund Application." Forms may be acquired through IDPH. An original application and two copies are required for submission.

B. Applicants shall comply with all rules and regulations governing Emergency Medical Services and Highway Safety and the EMS Assistance Fund.

C. Applications must be submitted to the Regional EMS Advisory Committee by the deadline required by each regional committee. Deliver to your EMS System Coordinator for forwarding.

D. The Regional EMS Advisory Committee will vote on each application utilizing the following IDPH Grading Scale:

1. Grade 1 Immediate Funding Need

a) Alternate funding sources exhausted or unavailable. System will suffer if program postponed. Program request is of greatest impact to citizens served.

2. Grade 2 Definite Funding Need

   a) Alternative funding limited or delayed availability. Program of high priority. Need is present. Program of high impact to citizens served.

3. Grade 3 Project Needed Eventually

   a) Local funding available in future. System will benefit from improved time table. Limited available funding.

4. Grade 4 Project Can Be Delayed

   a) Local funds available. Program of low impact to citizens served. Consideration will be given as need increases.

5. Grade 5 Project Not Needed

   a) Local funds available. Limited or no impact to service area. Duplication of resources. Considerations will be given as need is evident.

E. Applications will then be forwarded to IDPH.

***Region-Wide Policy**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1306
Effective Date: 2/11
Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

EMS ASSISTANCE FUND GRANTS* REPORTING REQUIREMENTS

I. Purpose:

To set guidelines for reporting requirements of EMS assistance fund grants within Region IV.

II. Policy:

A. The grantee shall submit a report to the Division of Emergency Medical Services and Highway Safety every six months detailing the status of the grant funds. Within 60 days after the final disbursement of the grant funds, a final report shall be submitted to the division. The final report shall consist of a financial report for the project and a brief narrative describing the completed project.

B. Modification of a Grant Agreement

1. Any change in the use of grant funds from that specified in the approved application shall be permitted only by modification of the grant agreement. The grantee may request the modification of the grant agreement by writing the Chief of the Division of Emergency Medical Services and Highway Safety detailing the reasons and circumstances necessitating the request.

C. The award may be suspended and all disbursements of funds held. There shall exist reasonable cause for suspension, such as:

1. Failure to comply with the Act
2. Failure to follow the EMS Regional Plan in which the grantee participates
3. Violation of the terms of grant agreement

D. See Region IV Protocols For Disbursement of IDPH Grants.

***Region-Wide Policy**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

Policy No.: EMS 1307
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Supersedes:
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Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

MISCELLANEOUS

REGION IV PROTOCOLS FOR RESOLVING REGIONAL OR INTER-SYSTEM CONFLICT*

I. Purpose:

This policy will serve as a guideline for resolution of Regional or Inter-System conflicts for the purpose of evaluating and improving patient care, reduction of morbidity and mortality, and provide feedback information to Region IV personnel.

II. Policy:

A. Regional or inter-system problems/conflicts will be documented on the "Incident Report Form".

B. The "Incident Report Form" will be submitted to the respective EMS System Coordinator.

C. The "Form" will then be submitted to the EMS System Coordinator/Quality Improvement Committee for discussion/resolution and feedback to Region IV personnel.

D. A report will be submitted to the Region IV EMS Medical Directors Committee for review.

E. CONFLICT OF INTEREST

F. Memorial Hospital agrees to notify the Department in writing of any association that the EMS Medical Director, EMS System Coordinator or the EMS Administrative Director may have with an ambulance service provider through employment, contract, and ownership, or if they should in any way be answerable to or directed by an ambulance service provider concerning any matter falling within the scope of the Emergency Medical Service System Act.

***Region-Wide Policy**

IDPH REGION 4 EMS SOUTHWESTERN ILLINOIS EMS SYSTEM

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Supersedes:
Reviewed: 1/15
Revised:
Administrator: EMS Administrative Director
Signature_____

EMERGENCY MEDICAL SERVICES

DISASTER RESPONSE

SOUTHWESTERN ILLINOIS EMS SYSTEM DISASTER PLAN

I. Purpose:

This policy will serve as a guideline for disaster response within the Southwestern Illinois EMS System.

II. Policy:

A. This plan shall serve as the basis for medical disaster response within the Southwestern Illinois EMS System.

1. It is MANDATORY that:

a) A full copy is kept in every unit.

b) Every provider within the Southwestern Illinois EMS System is familiar with the plan.

B. What is a disaster/mass casualty?

1. Any event that will overload the Southwestern Illinois EMS System and/or receiving facilities, whether it be gradual in nature such as a pandemic influenza or sudden such as a tornado, earthquake, etc.

2. Any event that requires an EMS agency to contact more than one additional EMS agency for mutual aid.

3. Any event that requires greater than 5 ambulances.

4. A prolonged rescue where a victim will be entrapped 60 minutes or more. (Notify EMS Medical Director directly or ask Memorial Hospital to do so. Provide location, nature of event, and contact information.)

5. A hazardous materials release (a chemical that is a direct life-threat to a population) with multiple patients or that involves 1 or more contaminated patients being transported to a hospital.

6. Any Weapons of Mass Destruction (WMD) event.

7. Any natural or man-made event with multiple patients (or the potential for multiple patients) that will have a prolonged EMS scene time of greater than 2 hours.

C. Initial Actions

1. Establish command quickly. Call BMH quickly. Call for mutual aid quickly.

2. If any of the above criteria are met, Memorial Hospital MUST be contacted. If on-scene EMS personnel anticipate that activation of the RHCC plan is not necessary (in other words, if further assistance by Memorial Hospital is not necessary), advise Memorial Hospital as such.

3. When on-scene EMS determines that they are at the scene of a MCI, it is imperative that first-responding units begin to think in an ICS thought process.

4. Call early. The benefits of early communication with Memorial Hospital cannot be underestimated, even if initial information is scarce. When in doubt, call Memorial Hospital.

5. Give the location, nature of incident, and best guess (if known) number of victims.

6. All services are encouraged to provide each of their employees with two ID badges, one to be provided at check-in and one to remain on their person.

D. Identify resources that are needed.

1. Memorial Hospital and the Incident Commander will assist with obtaining these resources. This may include, but not be limited to:

a) For prolonged incidents with numerous EMS agencies responding for mutual aid, the ITEC team may be needed to assure continuity of communications between responding agencies.

b) Disaster trailers – Memorial Hospital and the RMERT team have immediate access to several caches of medical equipment including dozens of backboards, IV fluids, trauma bags, etc.

c) The RMERT Team – Our RMERT team is maintained through St. Clair Special Emergency Services (SCSES). They are a fire department that serves as the county/region's technical rescue/HAZMAT team. The RMERT Team also has access to area disaster trailers.

d) Chem-Pack – For a WMD event with possible chemical agent release, ask Memorial Hospital for release of the antidote cache. This will take additional time as it requires direct communication with the Southwestern Illinois EMS Medical Director and Memorial Hospital pharmacy director.

e) Buses for transportation of walking wounded. These can be requested by the Incident Commander from Bi-State or from Scott AFB. The buses from Scott AFB may be staffed, if requested and available, with medical personnel. Again, requesting Scott AFB assets will require direct contact with the Southwestern Illinois EMS Medical Director and command personnel at Scott AFB.

2. All EMS personnel, including the RMERT team, shall report to the Medical Branch Director or his/her designee. This does NOT include Rescue Medics tasked with direct support of St. Clair Special Emergency Services/St. Louis USAR Task Force 4. These personnel shall report to the Chief of SCSES but will coordinate all patient care with the Medical Branch Director.

3. The Medical Branch Director or his/her designee shall make all requests for above personnel and equipment from Memorial Hospital, the RHCC.

4. At any time you are requesting these additional resources, provide the type of event, exact location of staging area, number of casualties, name and contact information for the person requesting.

E. Scene Safety

1. Scene safety at an MCI scene, as at any scene, is paramount. Each provider is responsible for his/her safety, not just command personnel or an assigned safety officer. All personnel have the responsibility of reporting unsafe situations and remaining clear of hazardous scenes.

2. When you approach the scene of a potential MCI, if you feel the situation is unsafe, do not enter the scene. Advise dispatch and all incoming units

of the potential hazard. Coordinate all actions with the Incident Commander in order to avoid entering a potentially hazardous area.

3. If you suspect Hazardous Materials are involved, stay away from the hot zone as determined by the Incident Commander. Remain uphill and upwind until command staff determine it is safe for you to proceed.

4. As with any scene, EMS calls that involve technical rescue or HAZMAT are best handled by EMS providers with the appropriate training through Illinois Office of the State Fire Marshal. When available, EMS providers with appropriate training should ideally be the providers engaged in patient care for patients at a HAZMAT release or for entrapped patients at incidents involving technical rescue.

F. Incident Command System

1. All EMS calls, regardless of the size or scope of the incident, will utilize the Incident Command System, in accordance with HSPD #5.

2. EMS will have very specific roles during a disaster. Not all may be needed; some may be combined. EMS will typically NOT be in command of the scene. Typically, fire or law enforcement personnel, depending on the nature of the incident will serve as incident command.

3. It is crucial that the initial responders NOT begin patient care. Rather, they should begin to think in an ICS thought process and establish the medical chain of command.

4. Medical care at the scene of an MCI shall be established in an orderly fashion. Medical care, unless directed otherwise by command staff, will be established as a Medical Branch beneath the Operations Section. Freelancing is strictly forbidden. All personnel must conform to the ICS process.

5. The most experienced provider on the initial responding unit shall assume the position of Medical Branch Director. He/she will answer to the Operations Section Chief and/or the Incident Commander.

   a) He/she will be responsible for implementation of the Incident Action Plan within the medical branch as set forth by command staff.

   b) The Triage, Treatment, and Transport Officers will report to the Medical Branch Director. This position and its responsibilities may be transferred to a more experienced provider on another

incoming unit when they arrive. All personnel must be made aware of the transfer of command if this occurs.

c) The main goal of the Medical Branch Director will be to step back and look at the big picture, even though it is inherently difficult for all of us to do.

(1) The Medical Branch Director should make initial contact with Memorial Hospital if the position of Transportation Officer has not yet been assigned.

d) The Medical Branch Director shall request necessary resources from the Operations Section Chief and from staging as needed.

e) The Medical Branch Director shall determine triage, treatment, and transport areas in conjunction with appropriate officers (when assigned). Assist these officers as necessary.

f) The Medical Branch Director will NOT be involved in patient care.

6. The second most experienced provider will initially assume the position of Triage Officer.

a) He/she will report to the Medical Branch Director.

b) The Triage Officer is responsible for identification and triage of all victims. He/she will establish a casualty collection point if the nature of the event dictates that casualties would be best served by being brought to one concise point for triage (whether due to relatively large geographic area or for scene safety).

c) The Triage Officer will ensure that triage tags are placed on each victim.

d) He/she will NOT be involved in patient care outside of that included in the triage process.

7. A Treatment Officer may also be assigned.

a) He/she shall report to the Medical Branch Director.

b) The Treatment Officer is responsible for establishing treatment areas if not already done. He/she may delegate an individual to supervise each treatment area (RED/YELLOW/GREEN).

c) The Treatment Officer ensures that each patient is prepared for transport and communicates with the Transport Officer to ensure that the most critical patients are transported first.

d) All treatment is to be documented on triage tags.

8. A Transport Officer may also be assigned.

a) He/she shall report to the Medical Branch Director.

b) The Transport Officer coordinates transportation/dissemination of patients of various acuities to appropriate facilities.

c) After possible initial contact by the Medical Branch Director, the Transport Officer is the only person to remain in radio contact with Memorial Hospital regarding patient destination decisions. The Transport Officer should be identified to Memorial Hospital as soon as possible, as well as a reliable means of communication. He/she will be Memorial Hospital's contact person in the field. The Medical Branch Director may continue to contact the Resource Hospital for administrative needs/concerns, to request additional EMS resources, etc.

d) The Transport Officer will NOT be involved in patient care.

9. A Patient Tracking/Accountability Officer may also be assigned.

a) The function of the Accountability Officer will be to maintain accountability of all EMS personnel operating on scene and all patients, including their ultimate destination.

b) The staging officer will account for personnel staged for transporting patients.

c) If personnel are re-assigned to on-scene operations, he/she will provide one of his/her accountability tags to the Accountability Officer. The other will remain on his/her person.

d) Patient tracking shall be undertaken in either written and/or electronic form.

e) Depending on the nature of the incident, patient tracking may be accomplished in either the triage or treatment areas but MUST be completed prior to transport of any patient.

10. Miscellaneous roles:

    a) The staging officer reports directly to the Operations Section Chief and is responsible for staging of all incoming apparatus. The Incident Commander/Operations Section Chief may request that an EMS provider assist the staging officer.

    b) Incident Rehabilitation is very important on extended incidents. The Incident Commander may request EMS to establish/assist with rehabilitation of personnel.

        (1) The Medical Branch Director will coordinate which personnel are to be assigned to the rehabilitation sector.

        (2) Personnel in the rehabilitation sector will answer directly to the Logistics Section Chief, not the Medical Branch Director or the Operations Section Chief.

        (3) Refer to the Incident Rehabilitation SOG for procedures to follow in this sector.

11. All other responding personnel:

    a) Report to the designated check-in area.

    b) It is mandatory that all responding EMS personnel have some element of a uniform in order to identify them on scene.

    c) It is highly suggested that all personnel have 2 photo IDs from his/her place of employment – one to carry with them and one to leave at the check-in area.

    d) No personnel shall self-dispatch to the scene of a reported emergency/disaster.

    e) Each agency shall have methods for internal paging/all-calls of off-duty personnel. Stricken EMS agencies may utilize their own all-call at their discretion.

    f) Memorial Hospital will contact the POC at each agency to request an all-call, if needed from another agency.

12. Volunteers

    a) Often, well-intentioned volunteers with varying capabilities will self-dispatch to the scene of a disaster. However, volunteers

unknown to responding personnel may misrepresent their capabilities and/or become a safety hazard to on-scene personnel.

b) Volunteers, if utilized, MUST conform to the Incident Command System, proceed through check-in if established, and must follow appropriate safety procedures.

c) Medical personnel NOT registered with Southwestern Illinois EMS System must show proof of licensure. If utilized, these personnel must be confined to dedicated treatment areas under the direct supervision of Southwestern Illinois EMS System personnel. They may only serve to administer basic first-aid to victims.

d) Any physician that responds to the scene of a disaster must also conform to the policies set forth in the Southwestern Illinois EMS System Policy Manual.

e) Any question or concern regarding the use of volunteers should result in the expulsion of the volunteer from the scene or communication with Memorial Hospital by the Medical Branch Director.

G. Communications

1. Notify incoming units of the staging location and check-in, if established.

2. The EMS channel for communications on scene will be EMS Common 1 (800 MHz) in St. Clair Co. The stricken ALS agency in all other counties will designate a primary EMS channel and communicate this to incoming units.

3. All services should attempt to obtain and preprogram available frequencies of other EMS agencies within the Southwestern Illinois EMS System in order to alleviate obstructions to communication as much as possible.

4. All services without the capability to communicate on the designated channel will send someone to the EMS command area to ensure a cohesive communication plan with all EMS personnel on scene.

H. Dispatch

1. EMS agencies may call for mutual aid from within their agency or from neighboring EMS agencies.

2. In order to request mutual aid from more remote agencies, the Resource Hospital shall contact these agencies and request them to respond.

3. During a disaster event, PSAPs are encouraged to utilize call-stacking via the MPDS system.

4. It is suggested that agencies defer non-emergency runs or transfers.

I. Triage

1. It is imperative that triage be performed in a rapid, coordinated, systematic fashion using the START and Jump-START algorithms. If a victim appears to be an adult or young adult, use the START algorithm. If they appear to be a child, use the Jump-START algorithm.

2. The Triage Officer (and his/her designated personnel, if any) shall move through the entire scene, rapidly assess each patient, stopping only to open an airway or stop profuse bleeding.

3. A triage tag shall be affixed to each patient. OR:

4. The Triage Officer will establish a Casualty Collection Point (depending on the nature of the incident) where other personnel (firefighters, law enforcement officers, etc.) will bring patients for triage.

5. START Adult Triage (See Appendix 1.)

   a) Mobilize all ambulatory patients to the GREEN treatment area. All ambulatory patients will initially be triaged as GREEN but may be upgraded if they are found to meet YELLOW or RED criteria.

   b) Remember to keep the GREEN triaged patients supervised by dedicated EMS personnel.

6. Assess ventilations of remaining patients:

   a) If no respiratory effort is present after opening the patient's airway, tag the patient as BLACK.

   b) If the respiratory rate is > 30, tag the patient as RED.

7. If the respiratory rate is < 30, assess the patient's perfusion.

   a) If the patient has no radial pulse present, tag the patient as RED.

8. If the patient has a radial pulse, assess the neurological status.

a) If the patient is Unresponsive or cannot follow simple commands, tag the patient as RED.

b) If the patient can follow simple commands, tag the patient as YELLOW.

9. Jump-START Pediatric Triage (See Appendix 2.)

a) Again, mobilize all ambulatory patients to the GREEN treatment area. All ambulatory patients will initially be triaged as GREEN but may be upgraded if they are found to meet YELLOW or RED criteria.

10. **Children that are not yet ambulatory due to young age may be carried to the GREEN area but MUST be the first assessed by treatment personnel in that area.

11. Assess ventilations of remaining patients (note that this differs from adult patients):

a) If the patient has no respiratory effort after opening the airway AND no pulse, triage the patient as BLACK.

b) If the patient has a pulse, open the airway and give 5 breaths. If no spontaneous respirations are triggered by these rescue breaths, triage the patient as BLACK.

c) If spontaneous respirations resume, tag the patient as RED. Provide no further respiratory assistance, and move on.

d) If the patient has a respiratory rate < 15 or > 45, tag the patient as RED.

12. If the patient has a respiratory rate between 15 and 45, assess the patient's perfusion.

a) If the patient has no distal pulses present, tag the patient as RED.

b) If the patient has distal pulses present, assess neurological status.

c) If the patient is unresponsive or cannot follow simple commands (age appropriate), tag the patient as RED.

d) All other patients shall be tagged as YELLOW.

J. Crime Scene Preservation

1. All disasters and scenes involving fatalities shall be considered crime scenes until determined otherwise by law enforcement officers or the responding coroner.

2. Movement of bodies is strictly forbidden (unless necessary to access potential survivors) until authorized by law enforcement officers or the responding coroner.

3. Refer to Section VIII for further detail.

K. Transportation

1. The Transportation Officer, in coordination with the Treatment Officer, shall determine the order in which patients shall be transported from the scene.

2. Helicopter EMS (HEMS) should be preferentially utilized for transportation of patients to trauma centers in St. Louis before transportation of lesser acuity patients.

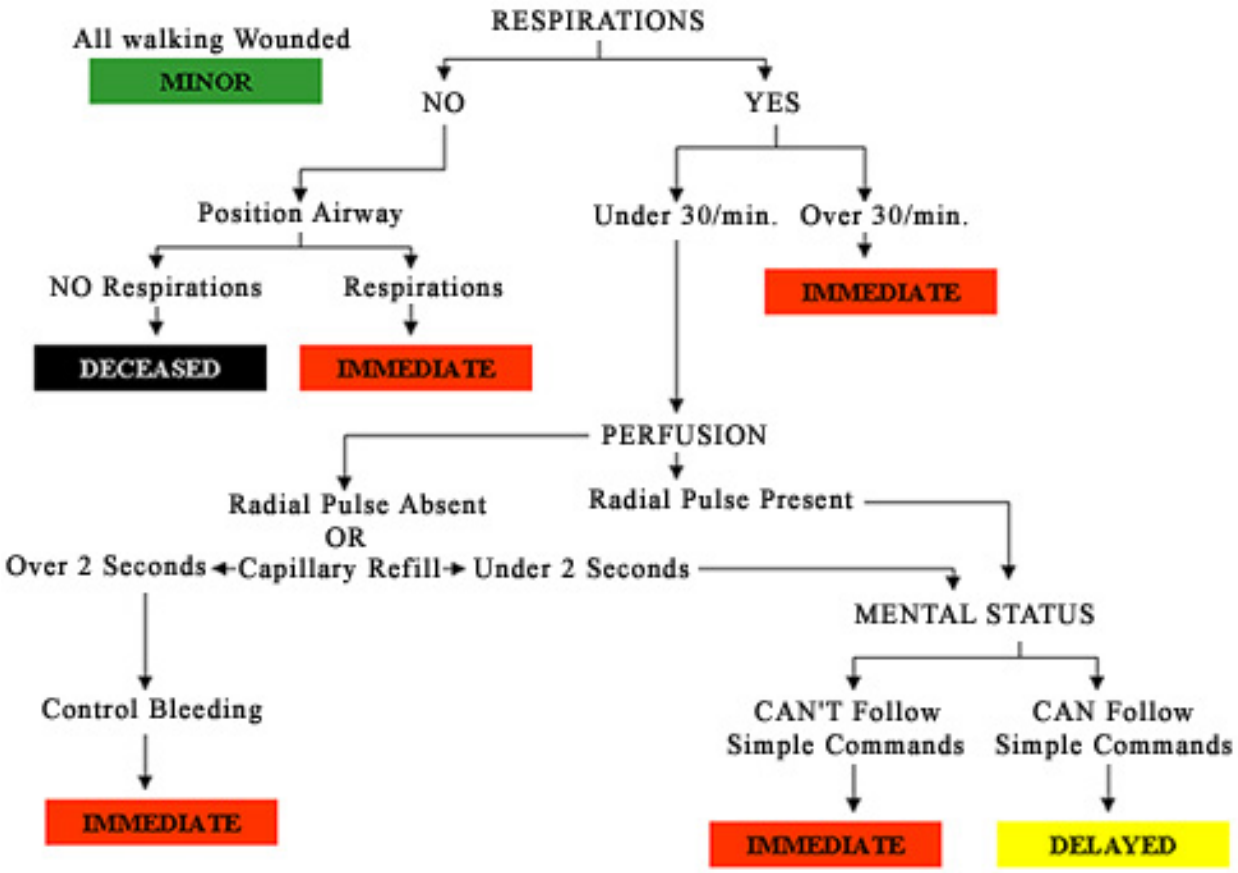
L. Documentation

1. Do not delay patient care or transportation during a disaster for documentation.

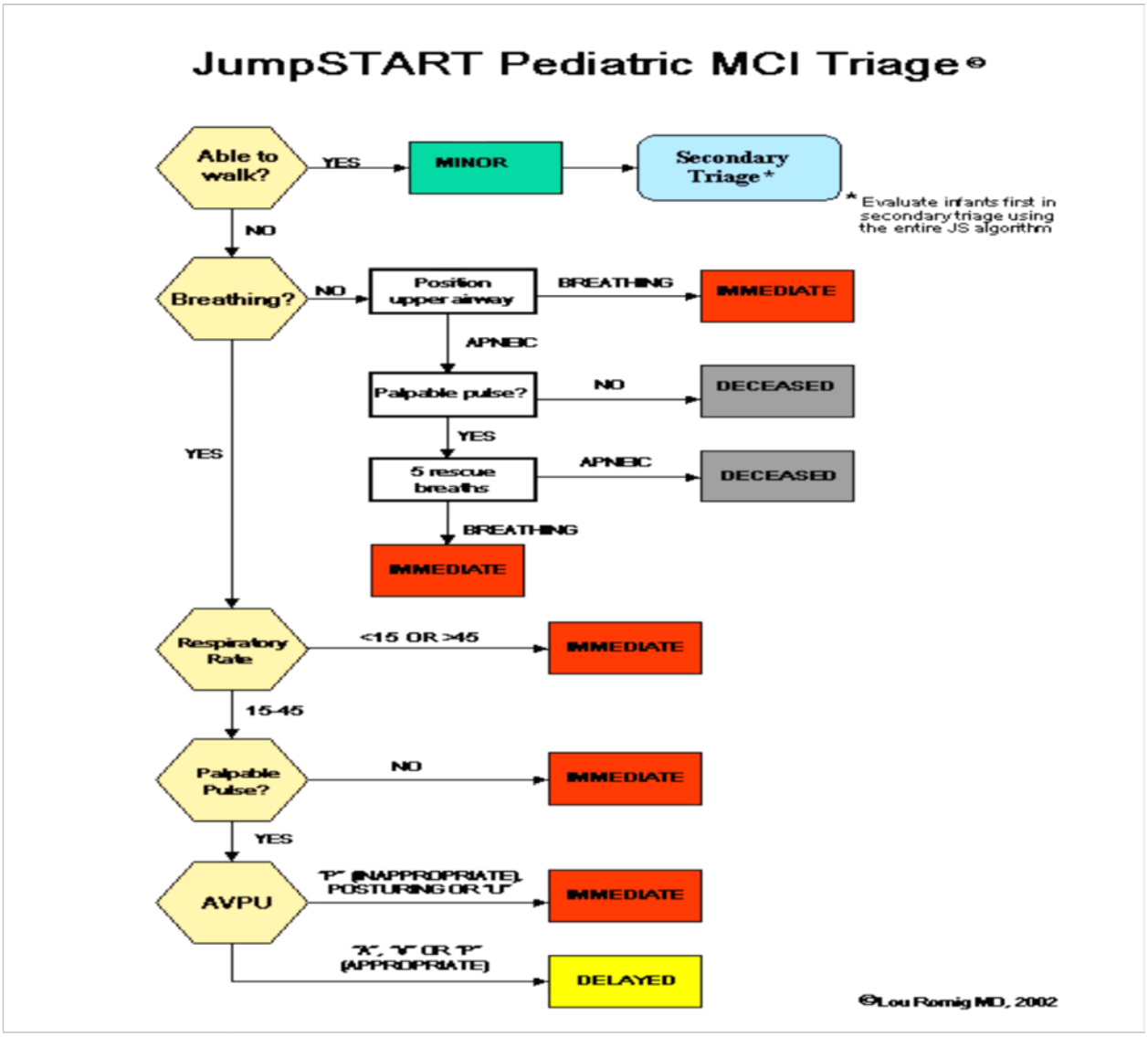
2. However, documentation is crucially important. The triage tag is considered patient documentation, as well as confidential patient information. Triage tag information should be attached to a run report for submission to Memorial Hospital.

M. For additional information concerning Regional disaster response, refer to the Region IV Disaster Manual.

Appendix 1 START Triage Algorithm



Appendix 2 Jump-START Triage Algorithm



APPENDIX A:

Airway Intervention Form

Please complete this form for each patient on whom visualization, intubation, or King LT placement was attempted (regardless of success). This form should be returned to the EMS Office at Memorial Hospital on no less than a monthly basis.

EMS Run Number: _____
Date:_____
Patient Age_____ (please circle) Years or Months
Patient Condition Medical Trauma
Was this patient in cardiac arrest at time of attempt? Yes No
Route of Intubation: Oral Nasal
If intubation failed, was King LT placed?
Yes No King LT was primary airway
If intubation was unsuccessful, why?
Difficult anatomy: obese, large tongue, secretions/blood/vomitus.
Clenched jaws/inadequate relaxation.
Difficult environment.
Other_____
How many personnel made an attempt to intubate? _____
How many total visualizations were made? _____
How many total attempts were made? _____
Was etomidate or midazolam used (please circle which)? Yes No
If etomidate was administered, was it administered prior to all attempts? (Clarify briefly if not.)
Yes No

Was it necessary to reintubate the patient due to an accidental dislodgement or intentional removal of the tube? (please circle) Yes No
If an attempt to reintubate a patient was made, please complete a second form.

Was colorimetric CO2 used to confirm placement? Yes No
If waveform capnography was used, what was the initial reading_____ & reading at ED arrival_____
Was ET tube/ King LT still inserted on arrival at the ED? Yes No
Was ET tube/ King LT in trachea/properly seated on arrival at the ED? Yes No

Name and license number of person completing this form_____

*Visualization is defined as a blade insertion and a "look" without an attempt to pass a tube
**Attempt is defined as the tip of the tube passing the teeth