GENERAL PATIENT ASSESSMENT & MANAGEMENT/

EMS OPERATIONS

Patient Destination Policy

Patients should be transported to the closest appropriate hospital. A patient (or the patient's *Power of Attorney for Healthcare*) does have the right to make an informed decision to be transported to a hospital of choice. This decision should be respected unless the risk of transporting to a more distant hospital outweighs the medical benefits of transporting to the closest hospital.
Such requests cannot be honored during the initial actions of a MCI event. Secondary transfers may be coordinated in the hours and days following. Additionally, certain patient complaints will be best served at hospitals certified or licensed for unique specialty services.

Patient Hospital Preference Guidelines

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

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

The patient's hospital preference may be honored if:

- There are no identifiable risk factors.
- The patient has a secure airway.
- The patient is hemodynamically stable.
- The patient has been advised of the closer hospital.
- Medical Control approves.
- A specialty hospital direct transfer is available and it is agreed by Medical Control (specifically or by MOU) that the specialty hospital would serve the patient's needs better.

The EMS provider will explain the benefits versus the risks of transport to a more distant hospital and involve Medical Control for approval. **No transporting service shall bypass a hospital in order to meet an ALS intercept unless approved by Medical Control**.

Patients may be transported to the hospital of choice within the limits of the same city without contacting Medical Control for approval as the differences in transport times is negligible.

Patient Destination Policy

EMS Triage Destination Plan

The purpose of this plan is assist EMS in identifying patients in need of specialty services not available at all hospitals, identify hospitals that provide specialty services, and, within geographic parameters, transport those patients to the most appropriate facility the first time, thereby reducing the need for secondary transfers. This plan must address the 24/7/365 needs of EMS and provide objective criteria for identifying the patients and facilities involved.

Patient choice should always be the first criteria considered. If patient choice is not the most appropriate hospital, the patient must be educated and make their own informed decision, unless deemed not competent for decision making.

Pt Complaint	Criteria	Distance	Facilities certified/ licensed to meet patient's complaint
Burn	• Isolated burn to hand, face or genital regions, or • Any full thickness burns, or • > 20% TBSA adults, or • > 15% TBSA pediatrics, or • Any circumferential burns	25 minute	Springfield • Springfield Memorial Hospital

Early Term OB	• > 20 and < 32 full weeks gestation, **AND**
	• Any of the following
	  ○ Abdominal \Low back pain
	  ○ Contractions
	  ○ Fluid leakage/ bleeding
	  ○ Urge to push/ Pressure
	  ○ S/S of abdominal trauma
		25 minute	Springfield
			• St. John's Hospital
			Peoria
			• OSF St. Francis

Antepartum & Postpartum HTN	• Pregnant or ≤ 6 weeks post delivery, **AND**
	• Any of the following
	  ○ Headache
	  ○ Visual Complaints
	  ○ AMS
	  ○ Stroke like symptoms
	  ○ Seizure
	  ○ SBP > 140
	  ○ DBP > 90
		25 minute	Springfield
			• St. John's Hospital
			Peoria
			• OSF St. Francis

STEMI	• Cardiac Complaint, **AND** • Elevation on 12 lead in 2 or more contiguous leads.	25 minute	Springfield • Springfield Memorial Hospital • St. John's Hospital Bloomington/ Normal • Carle BroMenn • OSF St. Joseph's Decatur • Decatur Memorial Hospital Peoria • OSF St. Francis

Patient Destination Policy

EMS Triage Destination Plan- Continued

Pt Complaint	Criteria	Distance	Facilities certified/ licensed to meet patient's complaint
Stroke (meets or exceeds IDPH Region 3 protocol)	• Positive Fast ≤ 4.5 hours ○ Closest Facility (Minimum ASRH)	Not applicable	Region 3 • Every Region 3 EMS hospital is ASRH (Acute Stroke Ready Hospital) • Every EMS hospital within 30 miles of Region 3 is ASRH
	• Positive Fast >4.5 hours **AND** ≤ 24 hours with LAMS ≥ 4	45 minute	CSC (Comprehensive Stroke Centers) Springfield • Springfield Memorial Hospital Peoria • OSF St. Francis
Pediatric Trauma	• Age ≤ 12 years, **AND** • Any of the following ○ ≤ 12 GCS ○ ≤ 6 PTS	25 minute	Springfield • St. John's Hospital Peoria • OSF St. Francis
Trauma	• CDC Field Triage Decision Scheme Criteria	25 minute	Level 1 Springfield • Springfield Memorial Hospital • St. John's Hospital Peoria • OSF St. Francis Level 2 Decatur • Decatur Memorial Hospital Bloomington/ Normal • Carle BroMenn • OSF St. Joseph's
Suspected EBOLA or other current CDC alerted highly infectious disease.	• Fever, ABD Pain, Nausea/Vomiting, Diarrhea, Body Aches **AND** who has traveled from any country with widespread virus transmission in the last 2-21 days.	Per Medical Control	Peoria OSF St. Francis
Patient seeking Mental Health Screening/ Treatment	• Patient complaint, signs and symptoms	Not applicable	• Every hospital emergency room has capacity to screen and begin treatment.

Patient Destination Policy

Assumptions

- If patient is in extremis, the closest emergency department should be destination to stabilize the patient. This includes unstable airway patients.
- Agencies need to know the capabilities of all destination hospitals.
- Transport agencies must identify all destinations that they will transport to from prehospital calls. Barring weather emergency and facilities closed to EMS, an agencies response to a specific hospital request must be the same every time.
- If within the distance to the most appropriate facility, the most appropriate facility should be recommended to the patient so that the patient makes and informed decision. Should the patient refuse the most appropriate destination, medical control should be included to document that the patient has made an informed refusal.
- STEMI declaration requires recognition by Medical Control, the provider must contact Medical Control following EKG submission. This should be done in coordination with local Medical Control before transporting to PCI Center.
- Memorial EMS does not have a protocol for the transport of prehospital patients to urgent care or intermediate care facilities. All prehospital patients will be transported to Emergency Departments or to specific definitive treatment locations within the hospitals until 24/7/365 options become available.
- Transport agencies must respect that if a facility is on bypass, no patients may be transported to that facility.

Additional Transport information

- Unless it would be a detriment to patient treatment or a risk for EMS providers, transport agencies must transport a service/ support animal as provided for in the Americans with Disabilities Act.
- So long as it does not delay needed care of other patients, transport providers may transport an ill or injured law enforcement animals to an appropriate veterinary facility. Providers should include the handler if at all possible and have restraint equipment available to protect themselves.

Transfer and Termination of Patient Care Policy

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

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

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

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

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

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

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

3. More appropriate or prudent transportation is available.

Transfer and Termination of Patient Care Policy

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

During the transport of a patient by ambulance, should the EMS crew come across a separate emergency or incident requiring ambulance assistance; the local EMS system will be activated. Crews involved in the treatment and transportation of an emergency patient (lights and sirens) are not to stop and render care. The priority is to the patient onboard the ambulance. Crews involved in the treatment of a non-emergency patient (no lights and sirens) may stop and render aid if safe to do so. The safety of the on-board patient and the crew are the priority.

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

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

Transition of Care Policy

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

Patient Care Transition Procedure

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

Intercept Policy

To improve access to Advanced Life Support in the more rural communities the EMS System Intercept Protocol should serve as a guide to pre-establish procedures and work to minimize the amount of possible variables when a Basic Life Support ambulance requires assistance from an Advanced Life Support Ambulance from another geographic area. The goal should always be to provide ALS care to the patient who need ALS care in the most expeditious manner.

Dispatch Initiated ALS Intercept

1. At the point of 911 EMD all calls prioritized as Charlie, Delta, and Echo will have ALS automatically requested from the 911 center taking the call. The ALS dispatch should come secondary to dispatching the local unit, but in the most timely manner possible.
    a. As areas needing ALS assistance are situated geographically between two or more hospitals, the 911dispatcher is to ask patient what destination city they want to be transported to (Carlinville, Jacksonville, Pittsfield or Springfield). The 911 center taking the call should then contact the 911 center in the destination location to request an intercept. The request should also include identifying the call sign of both ambulances involved in the intercept, radio frequency that will be used, and patient chief complaint. Updates may need to be provided.
    b. If patient destination is not known, the closest 911 dispatch center with ALS ambulances services should be contacted. This should be predetermined.
        i. ALS unit origin does not dictate patient destination. Transport units must be informed as to 24/7 capabilities of all area hospitals.
2. The higher level of care and lower level units must communicate via radio frequency regarding patient status and rendezvous location as soon as possible.
    a. Radio frequency should be predetermined.
3. Rendezvous location should be off main roadways and, if at all possible, a parking lot or secondary road.
    a. EMS providers functioning on roadways are required to meet the CFR655 (F) requirements by wearing high visibility, breakaway safety vests.
4. Patient transport/transfer
    a. Patient care should be of the upmost priority in making decisions about which vehicle will provide transport of the patient.
        i. The provider with the highest level of care, in cooperation with Medical Control, will have the ultimate authority regarding patient care decisions.
    b. Agencies must identify who they could intercept with and address any administrative issues with those agencies.
    c. The decision as to whether the lower level rig can return to service should be a team decision based upon each patient situation. If needed, both rigs can be taken out of service to provide enough providers for patient care.
    d. Should the lower level unit be returned to service, every reasonable attempt to resupply that unit should be made by the intercepting unit.

Intercept Policy

BLS/ILS Request for Intercept

At any time ALS can be requested based on BLS assessment or change in patient condition. In order to request that intercept

1. The requesting unit should contact their dispatching 911 center (or the center in their destination city if unable to reach their own dispatch 911 center).
    a. Reason for request
    b. Patient requested destination
    c. Route of travel
    d. 911 dispatch centers should proceed with request in the same manner as if requesting based on 911 call information.
2. Both agencies should work to achieve radio communication as soon as possible.
    a. Communication between the lower level unit and the intercepting unit should occur prior to intercept.
3. Patient intercept should follow the process outlined for EMD initiated dispatch.
4. Any time a BLS unit is transporting a patient with lights and siren it must be to intercept with a higher level unit.

Intercepting Unit Transfer of Care back to ILS/BLS

1. Should the intercepting unit arrive on scene and feel that the patient may be appropriate for the lower level unit to continue care
    a. Patient assessment must be completed and communicated to Medical Control by the senior most provider of the intercepting unit.
    b. ALS, ILS/BLS and Medical Control must agree that the lower level of care meets all of the patients needs.
    c. Situations that cannot be transported by a lower level of care include
        i. Any suspected cardiac complaint
        ii. Respiratory distress not relieved by a single nebulizer
        iii. Patients meeting trauma declaration criteria
        iv. Patients with uncontrolled pain
        v. Postictal seizure patients
        vi. Imminent childbirth
        vii. Any situation where medications were given that are not in the transporting units protocol
    d. Both agencies should complete all appropriate patient documentation.

Discrepancies
Should initial units arrive and find a situation different than that which they were dispatched for, the update should be communicated to the dispatching agency and highest level of providers so to make the best use of available resources. Unless in a situation where the patient(s) are signing refusals, once initiated, the higher level of care unit must assess the patient. At no time should units not on scene be making decisions that supersede the decisions made by Emergency Medical Dispatch priority coding. Disagreements regarding response should be handled at an administrative level. Agencies that represent specific geographic areas must identify if they will or will not provide intercept services.

Coroner Notification Policy

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

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

2. Deaths that are subject to coroner investigation include:

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

3. The coroner should via dispatch at appropriate county and be provided the following information:

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

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

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

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

Reporting and Control of Suspected Crime Scenes Policy

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

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

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

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

    a. **At no times should EMS responders move a weapon at a crime scene unless fear of the weapon being utilized by others on the scene.**
    b. **In situations of violent crime, EMS responders should only enter the scene after Law Enforcement Officers have advised to approach the scene.**

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

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

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

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

Physician/Other Medical Professional on Scene Policy

Only personnel licensed to perform care in the prehospital setting and certified in the Memorial EMS System are allowed to provide advanced patient care (*e.g.* intubation, IV access, medication administration, pacing, etc.) at the scene unless approved by Medical Control. An on-scene physician (or other medical professional) does **not** automatically supersede the EMS provider's authority. Patient care shall not be relinquished to another person or provider unless approved by the EMS Medical Director or Medical Control.

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

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

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

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

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

Emergency Medicine Residents can and will do ''ride time'' with MEMS agencies as part of their EMS Rotation and as requested. Their presence should never take the place of on-line medical control when required/ requested by the EMS Provider, nor cause deviation from the MEMS protocols at any time.

Region 3 School Bus and MCI Policy

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

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

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

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

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

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

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

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

Region 3 School Bus and MCI Policy

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

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

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

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

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

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

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

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

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

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

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

Region 3 School Bus and MCI Policy

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

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

Region 3 School Bus and MCI Policy

School Bus Incident Form/ EMS Multiple Casualty Release Form

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

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

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

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

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

_____
Name of EMS Provider

_____
Name of School Authorized Representative

_____
EMS Signature Date

_____
School Representative Signature Date

Region 3 School Bus and MCI Policy

Notice of Emergency Medical Services Response to a Minor

Date:

From:

Child's Name:

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

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

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

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

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

Region 3 Concealed Carry Weapons Policy

In order to comply with the passage of Illinois Firearm Concealed Carry Act, the following policy has been agreed to by Illinois EMS Region 3 as a Region 3 Policy. It applies to EMS providers with concealed and not concealed weapons.

General Guidelines

When EMS is called to respond to any call, they should always be alert for scene safety and potential changes as scenes should always be considered dynamic. A patient who has a Concealed Carry Weapon should, in most cases, be cared for with minimal interruptions in care. At any time that EMS encounters a situation where they do not feel their safety has been reasonably ensured, they may retreat, call for law enforcement support, and wait at a secure location until the situation is secured before returning to patient care. If EMS should encounter an uncooperative or altered mental status patient who possesses a weapon, law enforcement may be contacted to assist.

Since many hospitals have declared themselves weapon-free facilities, every reasonable effort should be made to encourage the patient to secure the weapon at the patient's home, vehicle or with appropriate family member. If the patient is a law enforcement/security officer, they should be encouraged to secure the weapon in their vehicle or with a supervisor. This should be documented in the patient care report. Should EMS encounter a situation where this is not possible, the weapon should remain holstered at all times. If transporting with a weapon, EMS should identify early in the communications report specifically, **"I have a firearm onboard and will need assistance on arrival."** The receiving facility should have a designated process for assisting with this. Most likely this will involve a security officer meeting the patient in the ambulance garage area. Never should a weapon be left where it could be obtained by others.

While the professions of law enforcement and EMS often overlap, only those EMS agencies who are functioning as a Tactical EMS Unit or when members of law enforcement are responding while on duty should EMS providers respond to a call with a weapon. EMS agencies are supported in their efforts to be weapons-free facilities and no-carry signage on transport vehicles is appropriate. Should an EMS provider, who is responding to a call, possess a weapon, it should be secured in their personal vehicle prior to approaching the scene.

Pearls

Law enforcement/ security officers (when they are the patient) that remain in possession of their weapon will not be given sedation or pain medications.

Do not ask the patient whether he/ she has the right to carry a weapon. If the person has no legal right, they may become alarmed and cause EMS personnel harm.

Unless specific procedures have been established, all EMS providers should assure a safe scene before treatment should begin. EMS should always be alert to the dynamic scene conditions.

Aero Medical Transportation Activation

Use of aero medical transport is a great tool in the care of acutely injured patients. As EMS continues to strive to provide the most appropriate care for a patient, the following guidance should be used to assist in decision making regarding use of aero medical transport.
A helicopter may be utilized when **ALL** of the following criteria are present:

- □ Patient meets 1 or more of any criteria items within step 1 or 2 Field Trauma Criteria,
- □ Patient is entrapped and extrication is expected to last greater than 20 minutes,
- □ The ground transport time will be greater than 15 minutes,
- □ The patient is NOT in traumatic cardiac arrest.

Step One

Glasgow Coma Scale	≤13
Systolic Blood Pressure (mmHg)	<90 mmHg
Respiratory rate	<10 or >29 breaths per minute* (<20 in infant aged <1 year), or need for ventilatory support

Step Two[b]

- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

A helicopter can be utilized when **ANY** of the following is present:

- □ Situation specifically approved by Medical Control
- □ Mass Casualty Situation

If a helicopter is requested, resources must be dedicated to establishing a landing zone (100 ft by 100 ft), establishing radio communications with the inbound helicopter (I-Reach or other identified channel) and assisting with access to the helicopter.
Some Critical Access Hospitals allow use of their helipad for intercept with a helicopter. This plan should be developed prior to any incident. Should this plan be enacted, the staff of the hospital cannot be requested to help with any aspect of the call or the patient must be seen in the facility.
The decision to request aero medical transport must be made early in the response so to avoid waiting for the helicopter when the patient is ready for transport.
If at any time a helicopter is deemed to be unnecessary and the patient is transported by ground or refuses transport, an incident report should be forwarded to the EMS Office. Included with the incident report should be the patient care report identifying the patient status as well as the dispatch information including all times for responding agencies and the agency/ organization making the helicopter request. All field activations of aeromedical resources qualify for continuous QI (CQI).

Continuous Quality Improvement

In order to continuously monitor the quality of care provided under the Memorial EMS System, a Continuous Quality Improvement program exists at the System level. Certain call types automatically qualify for CQI review.

- Use of physical and/or chemical restraint by EMS providers
- Medication Assisted Intubations
- Paramedic initiated refusals
- All Alert Patient Report criteria (Stroke, Sepsis, Trauma, STEMI, & Arrest/Near-Arrest)
- Aero Medical resource utilization
- Requests for Override of Medical Control Order

Additional protocols may be added to the CQI process based on

- Utilization of pain medications
- Change in treatment protocol
- Protocols where a loss in quality is perceived
- Protocols where external factors impact EMS care

Additionally, opportunities to pilot (trial) changes in protocol or process will be implemented via the Continuous Quality Improvement process. Any changes that include researching patient outcomes and the variance in outcome based on alternative treatments will require, and will have, Institutional Review Board approval prior to the beginning of said changes. Participation in such projects may be voluntary or mandatory. Participation may be agency or provider specific based on capacity and prior involvement.

MCI/ Tactical MCI Guidelines

As emergency responders, members must have the skills and training to adapt to a variety of situations. While it is impossible to plan for every event the following guidelines are designed to assist not only in the planning of likely events within an agency's own response area, but also to function within the larger response structure.

Incident Command System (ICS)

All EMS/ Fire/ Law Enforcement responders should, at minimum, be NIMS compliant by completing NIMS700 and 100 and being competent in functioning in an Incident Command System Structure.

Agency Having Jurisdiction (AHJ)

The agency whose primary response area the event occurs in, is the Agency Having Jurisdiction. That agency should initially establish command and initiate requests for additional resources. Per ICS, command can be passed to another provider with more capability or additional resources can assist the incident commander based on the situation.

Emergency Response Plan

Every county should have an Emergency Response Plan, including discussion of Mass Casualty events. This plan should be updated regularly and available to all responders in that area. This plan should include listings of available resources (people and supplies) within the county as well as general resource capabilities from neighboring counties and the mechanism with which dispatch should use to request those resources. The plan needs to include primary and secondary patient destination hospitals than can reasonably be utilized for units transporting from the scene. There must also be a mechanism where a hospital identifies when they have exceeded capacity and need additional patients diverted to other facilities.

Additional Resources

Every agency should have a mechanism to contact off shift staff to respond to an emergency. Additionally, it should be noted that not all staff may be needed initially, but may be needed in the twelve (12) and twenty-four (24) hour increments after the initial call. As information becomes available, agencies may want to start contacting staff to determine availability. **At no time should individuals or agencies self-dispatch.** Unless all communication/ dispatch mechanisms in the area impacted are lost, the established channels for dispatching agencies/ vehicles will be utilized. The Incident Commander should utilize normal channels of communication to request specific resources based on the incident as well as other community needs.

MCI/ Tactical MCI Guidelines

Scene Safety

A reasonable attempt to control scene hazards should be established based on the capabilities of the responding departments. Based on the unlimited possibility of response situations, this should be based on a continuous assessment by responders based on their capabilities with any responder able to communicate concerns via ICS chain of command.

Mass Care

Medical responders should be knowledgeable of how to triage patients based on the SMART algorithm to rapidly categorize patients while only treating reversible life threats. Treatment teams should be established as soon as responders are available to begin treating victims and organizing based on triage category for prioritizing transport. Agencies must be able to work together to cache supplies as well as responders to be most focused on patient needs. It is reasonable to expect that traditional models for patient care will be modified. Extended scene treatment time may be needed, as well as transporting more than one patient at a time, but the goal should always be utilizing non-transport providers on scene and ambulance staff to transport as quickly as patient priorities can be established.

Tactical Incidents

The response to a tactical incident (where a warm zone response may be needed) is unlike that which EMS typically responds. It requires a very different mindset, approach, and equipment (both for providers and for patients). Any incident where violence is being enacted upon others requires EMS resources to stage a safe distance from the actual incident. **Responders are not to approach the scene until told to do so by law enforcement officers**. Responders and/ or agencies not willing, not able, or not equipped to handle the needs of responding in a tactical environment should be identified prior to the incident so that alternate action plans can be established. Responders providing transport service should be the last option for filling this role as all ambulances available may be needed to transport patients.

Law Enforcement's priorities are to stop the attack, rescue victims, and then provide aid. Until the aggressor has been stopped more victims will be created. After the initial law enforcement response, additional officers will be assigned to Rescue Task Force. This is a team model that must be led by law enforcement who provide the security for EMS as well as the communication in regards to areas that are still deemed Hot Zone. Law enforcement determines hot, warm and cold zones. All responders must be aware that the zones are potentially fluid and subject to change based on the tactical situation as the event unfolds. Due to the nature of this response, only lifesaving treatment should occur at the location where victims are found. A Casualty Collection Point should be established based on EMS needs and law enforcement's opinion of a defendable location. Treatment will occur in this location until the victims can be moved to an ambulance corridor with law enforcement support. EMS will never move freely within the scene until a complete search of the building has advised no additional threats; this will take hours or even days.