ABERRANT SITUATIONS

Domestic Abuse and Elder Abuse/Neglect Protocol

Illinois law establishes requirements that any person licensed, certified or otherwise authorized to provide healthcare shall offer immediate and adequate information regarding services available to abuse and neglect victims.

Abuse is defined as physical, mental or sexual injury to (a child or) eligible adult. An eligible domestic partner is defined as a spouse or person who resides in a domestic living situation with another individual suspected of abuse. EMS personnel should not rely on another mandated reporter to file a report on the victim's behalf.

EMR Care, BLS Care, ILS Care, ALS Care

Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Patient Care Protocol*.
2. Maintain control of the scene and request law enforcement if they have not already been called.
3. Survey the scene for evidence of factors that could adversely affect the patient's welfare:
    - Environmental
    - Interaction with family members
    - Discrepancies in history of events
    - Injury patterns that do not correlate with the history of patient use and mobility
    - Signs of intentional injury or emotional harm
4. Treat injuries and/or illness according to protocol.
5. Initiate transport as soon as possible.

Reporting Methods

The following telephone numbers regarding services available to victims of abuse shall be offered to all victims of abuse whether they are treated & transported or if they refuse treatment & transport to the hospital:

Elderly Abuse Hotline	**(866) 800-1409**
Crime Victims Compensation Program	**(800) 228-3368**

Behavioral Emergencies / Chemical Restraint Protocol

Behavioral episodes may range from despondent and withdrawn behavior to aggressive and violent behavior. Behavioral changes may be a symptom of a number of medical conditions including head injury, trauma, substance abuse, metabolic disorders, stress and psychiatric disorders. Patient assessment and evaluation of the situation is crucial in differentiating medical intervention needs from psychological support needs.

Emergency Medical Responder Care

Emergency Medical Responder Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as assuring personal safety.

1. Render initial care in accordance with the *Routine Patient Care Protocol*.
2. Maintain control of the scene and request law enforcement if needed.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as assuring personal safety and preparing the patient for or providing transport.

1. BLS Care includes all components of *Emergency Medical Responder Care*.
2. Determine if the patient is a threat to self or others.
3. **Contact Medical Control** as early as possible if **restraints** have been used to ease in safe patient handoff. **All field activations of physical restraint qualify for QI (CQI). A copy of the call must be forwarded by the crew to the EMS Office within 24 hours, via HIPAA acceptable mechanism.**
4. Apply **Waveform Capnography** (if equipped).
5. Call for ALS intercept if needed and initiate transport as soon as possible.

ILS Care

ILS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring personal safety and preparing for or providing patient transport.

1. ILS Care includes all components of *BLS Care*.
2. Initiate **IV access** when safe to do so.

Behavioral Emergencies / Chemical Restraint Protocol

ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring personal safety and preparing for or providing patient transport. The goal of utilizing the Chemical Restraint Protocol is to administer the minimum amount of medication required to ensure patient and crew safety while still allowing for a thorough E.D. evaluation upon arrival or ASAP.

1. ALS Care includes all components of *ILS Care.*
2. **Midazolam (Versed)**: 0.1mg/kg IM (max single dose is 10mg) for agitated delirium ***if absolutely necessary.***
   a. **OR**
   b. **Ketamine:** 4mg/ kg IBW IM for agitated delirium ***if absolutely necessary***. Dose on ideal body weight (see formula below).

The formula for calculating IBW is: ***Men***= 50 kg + 2.3 kg for every inch over 5 foot tall. ***Women***= 45.5 kg + 2.3 kg for every inch over 5 foot tall. **Patient height must be documented in the PCR**

3. Contact **Medical Control** for repeat dosing of either medication.
4. Initiate transport as soon as possible, **Monitor VS, cardiac monitor, waveform capnography, and SPO2 closely during entire patient contact**
5. These patients are medical patients and must be transported by EMS to the E.D.
   - All physical and chemical restraints are reviewed via the MEMS CQI process. **A copy of the call must be forwarded by the crew to the EMS Office within 24 hours, via HIPAA acceptable mechanism.**
   - **Failure to document complete VS (including waveform capnography) or time-stamped attempts with reasons as to failures are an actionable event by the EMS System.**

Critical Thinking Elements

- **<u>Consider Versed over Ketamine</u> -in cases of suspected stimulant ingestion and/or true Excited Delirium (with elevated HR, BP, and RR). The downward trending of these elevated vitals following Versed administration are a desired effect.**
- **Use with extreme caution in the Alzheimers, Dementia, and Intellectually Disabled patient populations.**
- **Document the patient's behavior, statements, actions and surroundings.**
- **Verbally attempt to calm and/or re-orient the patient to reality.**
- **When IBW is calculated, the estimated height must be documented in the PCR.**
- **If restraints are used, thoroughly document the reasons for applying restraints, time of application, condition of the patient before and after application, method of restraint and any law enforcement involvement, including any use of law enforcement equipment (e.g. handcuffs) and the time Medical Control was contacted.**

Petitioning an Emotionally Disturbed Patient Policy

EMS providers should consider the mental health needs of a patient who appears emotionally or mentally incapacitated. This involves cases that the EMS provider has reasonable cause or evidence to suspect a patient may intentionally or unintentionally physically injure himself/herself or others, is unable to care for his/her own physical needs, or is in need of mental health treatment against his/her will.

This does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years and the patient is under the supervision of family or another healthcare provider, unless the family or healthcare provider has activated EMS for a specific behavioral emergency.

1. Attempt to persuade the patient that there is a need for evaluation and compel him/her to be transported to the hospital.
2. If persuasion is unsuccessful, contact Medical Control and relay the history of the event. Clearly indicate your suspicions and/or evidence and have the base station physician discuss the patient's needs with the parties involved in the situation. Suggest that the Medical Control Physician talk directly with the patient to assist in determining capacity or lack thereof.
3. The EMS crew will then follow the direction of the base station physician in determining the disposition of the patient or termination of patient contact. Another agency's or party's opinion should not influence the EMS provider's assistance to a mental health need.
4. Under no circumstances does transport of the patient, whether voluntarily or against his/her will, commit the patient to a hospital admission. It simply enables the EMS providers to transport a person suspected to be in need of mental health treatment.
5. If a patient is combative or may harm self or others, call law enforcement for assistance and follow the *Patient Restraint Policy*.

Critical Thinking Elements

- **Many of these patients fit into a syndrome known as "excited delirium" that has been associated with adverse medical outcomes, including SUDDEN DEATH, especially when restraints are utilized. Careful monitoring should be exercised when dealing with these patients.**

Patient Restraint Policy

BLS Care

Patients will only be restrained if clinically justified. The use of restraints is only utilized if the patient is violent and may cause harm to themselves or others. Physical and/or chemical restraints are a last resort in caring for the emotionally disturbed patient.

1. To safely restrain the patient, use a minimum of 4 people.
2. **Contact Medical Control** if the restraint protocol has been initiated to develop plan for continuity of care.
3. If available, may use police protective custody.
4. Explain the procedure to the patient (and family) if possible. The team leader should be the person communicating with the patient.
5. If attempts at verbally calming the patient have failed and the decision is made to use restraints, do not waste time bargaining with the patient.
6. Remember to remove any equipment from your person which can be used as a weapon against you (*e.g.* trauma shears).
7. Assess the patient and surroundings for potential weapons.
8. Approach the patient, keeping the team leader near the head to continue communications and at least one person on each side of the patient.
9. Move the patient to a backboard or the stretcher.
10. Place the patient **supine** and place **soft, disposable restraints** on 2-4 limbs and fasten to the backboard or stretcher. **Never is a patient to be transported in the prone position.**
11. Transport as soon as possible.
12. Document **circulation checks** every ***15 minutes*** (of all restrained limbs). **Monitor VS, cardiac monitor, waveform capnography (if equipped), and SPO2 continuously during entire patient contact.** Thoroughly document the reasons for applying restraints, time of application, condition of the patient before and after application, method of restraint and any law enforcement involvement, including any use of law enforcement equipment (e.g. handcuffs) and the time Medical Control was contacted. Handcuffs should be placed in front of the patient in order to assess circulation during transport. Law enforcement should accompany the patient anytime they are in custody. Attempts should be made to change the patient from handcuffs to soft restraints when safe to do so. Document reasons if unable.
13. Do not remove restraints until released by medical personnel at the receiving hospital (or if a patient safety issue is recognized).
14. The only items that should be placed over top of a patient are linens, cot straps, and masks to control spitting. Use of a posey vest is allowed so long as circulation is assessed.
15. **All field activations of physical restraint qualify for QI (CQI). A copy of the call must be forwarded by the crew to the EMS Office within 24 hours, via HIPAA acceptable mechanism.**

Less Lethal Weapons Protocol

As law enforcement agencies look for alternative means of subduing dangerous subjects and bringing individuals into custody, they have begun using a set of devices known as ***"less lethal"* weapons**. These include but are not limited to:

- Teargas / Oleoresin capsicum sprays (*i.e.* pepper spray)
- Tasers
- Pneumatic Fired Projectiles

All levels of providers in the System should do the following when encountering these patients:

1. Ensure that the scene has been secured by law enforcement personnel and that the scene is safe to enter.
2. Ensure no cross contamination occurs to providers or equipment.
3. Ensure that the patient is subdued and is no longer a threat to EMS personnel.

Teargas / Oleoresin Capsicum (Pepper Spray) Exposure

Emergency Medical Responder Care

Emergency Medical Responder Care should be focused on assessing the airway and breathing.

1. Render initial care in accordance with the *Routine Patient Care Protocol*.
2. **Oxygen**: If respiratory distress noted, 15 LPM via NRM or 6 LPM via nasal cannula.
   a. If no obvious respiratory distress, apply pulse ox. If $\geq$ 94% and no signs/ symptoms of respiratory distress, no Oxygen is required. If $\leq$89% apply nasal cannula at 2-6 LPM. If unable to increase $\geq$ 94% move to 15 LPM via NRM.
3. **Flush eyes (if affected) with sterile water** to get rid of gross contamination and to aid in recovery.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment and preparing the patient for or providing transport.

1. BLS Care includes all components of *Emergency Medical Responder Care*.
2. **Proventil (Albuterol)**: 2.5mg in 3mL of normal saline via nebulizer over 15 minutes ***if the patient is short of breath and wheezing***. May repeat Albuterol 2.5mg every ***15 minutes*** as needed.
3. Assess for secondary trauma that may be present and treat appropriately per trauma protocols.

Less Lethal Weapons Protocol

BLS Care {Continued}

4. Assess for any secondary causes of patient behavior which lead to law enforcement subduing the patient. These secondary causes include:
    - Alcohol intoxication
    - Drug abuse
    - Hypoglycemia or other medical disorder
    - Psychotic disorder
5. See "Patient Restraint Policy" if needed.
6. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. **Contact Medical Control** for ALL refusal issues.
7. Initiate ALS intercept if needed and transport as soon as possible.
8. Contact receiving hospital as soon as possible or Medical Control if necessary.

ILS Care

ILS Care should be directed at conducting a thorough patient assessment and preparing the patient for or providing transport.

1. ILS care includes all components of *BLS Care*.
2. **Ipratropium (Atrovent)**: 0.5mg (with Albuterol) via nebulizer over ***15 minutes if the patient is short of breath and wheezing***. Repeat Albuterol 2.5mg with Atrovent 0.5mg every 15 minutes as needed.
3. Initiate **IV access** if safe to do so.
4. **IV Fluid Therapy**: 500mL fluid bolus if the patient is cooperative and to maintain a systolic BP of at least 90mmHg.
5. Initiate cardiac monitoring per *Routine Cardiac Care Protocol* or if the patient appears agitated.

ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. ALS Care includes all components of *ILS Care*.

Less Lethal Weapons Protocol

Critical Thinking Elements

- **Chemical defense sprays such as oleoresin capsicum (pepper spray) leave residue that may be contacted and transferred to providers. Care must be taken to ensure cross contamination does not occur. Avoid touching your own face, eyes or any other mucous membrane.**
- **Due to the oil base of oleoresin capsicum, if exposure to responders, washing with baby shampoo may be most effective way to remove.**
- **Patients who have been subdued using *less lethal* weapons are commonly agitated and may be combative. Safety of the EMS crew is of utmost importance.**
- **Contaminated clothing should be removed and sealed in a plastic bag to prevent further irritation and to reduce cross contamination.**

Taser-Related Injuries

A taser is an electrical device that is capable of shooting out two small barbed probes that are designed to pierce a subject's skin for the purpose of delivering a subduing pulse of electricity that causes the subject to lose voluntary muscular control. Anecdotal and theoretical consequences of taser use include *cardiac arrhythmias* and *seizures* (especially if the subject is under the influence of alcohol and/or illegal drugs).

Emergency Medical Responder Care

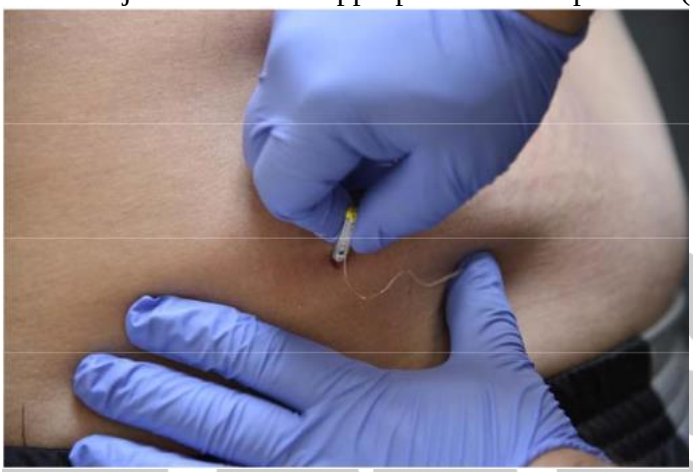
Emergency Medical Responder Care should be focused on assessing the airway, breathing and circulation.

1. Ensure that the law enforcement officer has removed the cartridge from the gun.
2. Render initial care in accordance with the *Routine Patient Care Protocol*.
3. **Oxygen**: If respiratory distress noted, 15 LPM via NRM or 6 LPM via nasal cannula.
   a. If no obvious respiratory distress, apply pulse ox. If $\geq$ 94% and no signs/ symptoms of respiratory distress, no Oxygen is required. If $\leq$89% apply nasal cannula at 2-6 LPM. If unable to increase $\geq$ 94% move to 15 LPM via NRM.
4. If the probes are in a sensitive area such as the ***face, eye, neck, genitalia*** or a ***female's breast,*** leave the probes in place and bandage.
5. Removing sooner after use causes less discomfort to the patient as sensation is reduced.

Less Lethal Weapons Protocol

Taser-Related Injuries {Continued}

6. To **remove barbs**, break the wire 5-10 inches away from the probe.
7. Place non-dominant hand approximately 5 inches away but on patient.
8. Firmly grasp barb with dominant hand thumb and fore finger.
9. Pull up at 90 degree angle to impact location. If unable to remove in quick pull, discontinue efforts and transport.
10. Ensure the perpendicular barb is removed intact.
11. Place removed barb upside down in used cartridge and return to law enforcement.
12. Assess for bleeding and clean wound with alcohol wipe. Treat identified and suspected injuries based on appropriate trauma protocol(s).



Source: Smart Probe Wound Study

BLS Care

BLS Care should be directed at conducting a thorough patient assessment and preparing the patient for or providing transport.

1. BLS Care includes all components of *Emergency Medical Responder Care*.
2. Assess for any secondary causes of patient behavior which lead to law enforcement subduing the patient. These secondary causes include:
    - Alcohol intoxication
    - Drug abuse
    - Hypoglycemia or other medical disorder
    - Psychotic disorder
3. See "**Patient Restraint** Policy" if needed.
4. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. **Contact Medical Control** for ALL refusal issues.
5. Initiate ALS intercept if needed and transport as soon as possible.
6. Contact receiving hospital as soon as possible or Medical Control if necessary.

Less Lethal Weapons Protocol

Taser-Related Injuries {Continued}

ILS Care

ILS Care should be directed at conducting a thorough patient assessment and preparing the patient for or providing transport.

ILS Care includes all components of *BLS Care*.

1. Initiate **IV access** if safe to do so.
2. Initiate **cardiac monitoring**.

ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. ALS Care includes all components of ILS Care.
2. See **Chemical Restraint** Protocol if needed.

Less Lethal Weapons Protocol

Critical Thinking Elements

- **If law enforcement has removed the probes, treat the probes as biohazards. Exercise caution to prevent accidental needlestick-like injuries.**
- **Be alert for potential for patient to fall, forcing probes in further.**
- **Patients who have been subdued using *less lethal* weapons are commonly agitated and may be combative. If the patient is not yet subdued and/or is violent, do not initiate contact. Safety of the EMS crew is of utmost importance.**

Pneumatic Fired Projectile

EMR Care, BLS Care, ILS Care, ALS Care

Care for any patient who has received impact with a pneumatic fired projectile should include care assessment and ongoing monitoring for injury to underlying organs and tissues. Treat identified and suspected injuries based on appropriate trauma protocol(s).

Do Not Resuscitate (DNR) Policy

A *Do Not Resuscitate (DNR)* policy is a tool to be used in the prehospital setting to set forth guidelines for providing CPR or for withholding resuscitative efforts. The purpose of this policy is to specify requirements for valid DNR orders and to establish a procedure for field management of these situations.

A *DNR* policy shall be implemented only after it has been reviewed and approved by the Illinois Department of Public Health in accordance with the requirements of Section 515.380 of the Illinois Administrative Code.

1. Any EMR, EMT-B, EMT-I, EMT-P or PHRN who is actively participating in a Department approved EMS system may honor, follow and respect a valid DNR.

2. *DNR* refers to the withholding of life-sustaining treatment such as CPR, electrical therapy (e.g. pacing, cardioversion & defibrillation), endotracheal intubation and/or manually/mechanically assisted ventilation, unless otherwise stated on the DNR order.

3. By itself, a DNR order does not mean that any other life-prolonging therapy, hospitalization or use of EMS is to be withheld. DNR orders **do not affect treatment of patients who are not in full arrest (pulseless and breathless)**.

4. A DNR order may be invalidated if the immediate cause of a respiratory or cardiac arrest is related to trauma or mechanical airway obstruction or in any situation where non-natural causes should reasonably be suspected.

5. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR **is not** in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist in addition to Asystole noted in 2 EKG leads:
    - Obvious signs of biological death are present:
        - Decapitation
        - Rigor mortis **without** profound hypothermia
        - Dependent lividity
        - Obvious mortal wounds with no signs of life
        - Decomposition
        - Cold to touch, not associated with environmental temperature or drowning
    - Death has been declared by the patient's physician or the coroner.

    - A valid DNR order is present and the EMS provider has made reasonable effort to verify the identity of the patient named in the order (i.e. identification by another person, ID band, photo ID or facility, home-care or hospice nursing staff).

Do Not Resuscitate (DNR) Policy

- If the above signs of death are recognized, EMS personnel should contact the appropriate law enforcement and/ or coroner's office.

- The EMS provider should immediately institute BLS measures and contact Medical Control for further direction if he or she 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.

6. When EMS personnel arrive on scene and discover that CPR **is** in progress, the EMS provider should:

   - Determine if signs of death are present or a valid DNR exists (a copy of a valid DNR is also acceptable).

   - If signs of death are present and/or the patient does not have a pulse, has no respirations, is Asystolic, and a valid DNR does exist, **contact Medical Control** for orders, including possible cease efforts order.

   - If no valid DNR exists, continue CPR (refer to cardiac resuscitation policy).

7. If the patient's primary care physician is at the scene of (or on the phone) and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity (if not known to the EMT) and notify Medical Control of the request of the on-scene physician. Follow Medical Control orders.

8. If EMS is called to transport a patient with a valid DNR to the hospital and EMS perceives the patient has lost vitals, EMS should continue transport to the ED for declaration so long as no county lines are involved.

9. EMS providers are obligated to honor, follow & respect the standardized ***State of Illinois Do Not Resuscitate (DNR) Order*** and the ***Illinois Department of Public Health Uniform Do-Not-Resuscitate (DNR) Advanced Directive Physician Orders for Life-Sustaining Treatment (POLST)*** form which have the *Seal of the State of Illinois* in the upper left and right corners, respectively. All signature lines must be completed in order for the DNR to be valid. A copy of a valid DNR/ POLST is also acceptable.

10. Any other advance directives or "living will" **cannot be honored, followed and respected by pre-hospital care providers.** EMS personnel must contact Medical Control for direction regarding any other type of advanced directive**.** Resuscitation should not be withheld during the process of contacting or discussing the situation with the on-line Medical Control physician.

Do Not Resuscitate (DNR) Policy

11. A *Durable Power of Attorney for Healthcare* is an agent who has been delegated by the patient to make any healthcare decisions (including the withholding or withdrawal of life-sustaining treatment) which the patient is unable to make. When a patient's surrogate decision-maker is present or has been contacted by prehospital personnel and they direct that resuscitative efforts not be instituted:

    - Ask the *Durable Power of Attorney for Healthcare* agent to provide positive identification (i.e. driver's license, photo ID, etc.), see the document and ask the agent to point out the language that confirms that the "power" is in effect and that it covers the situation at hand (i.e. assure the scope of authority the *Durable Power of Attorney for Healthcare* has and that the patient's medical or mental condition complies with the document designating the *Durable Power of Attorney for Healthcare*).

    - The *Durable Power of Attorney for Healthcare* agent or a surrogate decision-maker can provide consent to a DNR order, but the order itself must be written by a physician.

    - An EMS Provider cannot honor a verbal or written DNR request/order made directly by a *Durable Power of Attorney for Healthcare* agent, surrogate decision-maker or any person other than a physician. If such a situation is encountered, contact Medical Control for direction.

12. Revocation of a written DNR order is accomplished when the DNR order is physically destroyed or verbally rescinded by the physician who signed the order and/or the person who gave consent to the order.

13. Prehospital 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 appropriately documented wishes of the patient.

14. When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear unclear (i.e. upset family members, disagreement regarding DNR order, etc.), EMS personnel should provide assessment, initiate resuscitative measures and contact Medical Control for further direction.

15. If EMS personnel encounter a patient with a valid DNR from a **long-term care facility, hospice, during an inter-hospital transfer or when transporting to or from home** and the patient arrests enroute, do not initiate resuscitative measures and contact Medical Control for orders.

Do Not Resuscitate (DNR) Policy

16. If EMS personnel arrive at the scene and the family states that the patient is a hospice patient with a valid DNR order, do not initiate resuscitative measures and contact Medical Control for orders.

17. On occasion, EMS personnel may encounter an out-of-town patient with a valid DNR order visiting in the Memorial EMS System area. If the DNR order appears to be valid (signed by the patient and physician), contact Medical Control for orders.

18. The coroner will be notified of any patient or family wishes that there is to be tissue donation in cases where the patient is not transported to the hospital.

19. The Medical Control physician's responsibility is to make reasonable effort to confirm the DNR order is valid and order resuscitative measures within the directives of the DNR order.

20. Appropriate patient care reports will be completed on all patients who are not resuscitated in the prehospital setting. A copy of the DNR form should be retained and attached as supporting documentation to the prehospital care report form.

21. All Memorial EMS System personnel are to submit an incident report to the EMS Coordinator and the EMS Medical Director regarding any difficulties experienced with DNR situations. These cases will be evaluated on an individual basis.

22. Follow the System's *Coroner Notification Policy*.

Critical Thinking Elements

- **Ask the patient's family to produce an actual copy of the DNR / Advanced Directives. Family members will often identify themselves as "Power of Attorney" when in fact, they are solely "Power of Attorney for Finance".**

- **"Power of Attorney for Finance" does NOT convey authority for healthcare decisions. Only a valid "Durable Power of Attorney for Healthcare" conveys authority for healthcare decisions.**

Resuscitation vs. Cease Efforts Policy

The EMS provider is responsible to make every effort to preserve life. In the absence of an advanced directive, resuscitative measures shall be attempted if there is any chance that life exists.

When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR **is not** in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist in addition to Asystole noted in 2 EKG leads:

- Obvious signs of biological death are present:
  - Decapitation
  - Rigor mortis **without** profound hypothermia
  - Dependent lividity
  - Obvious mortal wounds with no signs of life
  - Decomposition
  - Cold to touch, not associated with environmental temperature
- Death has been declared by the patient's physician or the coroner.
- A valid DNR order is present and the EMS provider has made reasonable effort to verify the identity of the patient named in the order (*i.e.* identification by another person, ID band, photo ID or facility, home-care or hospice nursing staff.
- If the above signs of death are recognized, EMS personnel should contact the appropriate law enforcement and/ or coroner's office.
- The EMS provider should immediately institute BLS measures and contact Medical Control for further direction if he or she 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.

When EMS personnel arrive on scene and discover that CPR **is** in progress, the EMS provider should:

1. Assess circulation, airway and breathing and analyze EKG activity at the next pause in CPR cycle.
2. Determine if signs of death are present or a valid DNR exists. Continue resuscitation if signs of death are not obvious and a valid DNR is not available.

Resuscitation vs. Cease Efforts Policy

3. **Contact Medical Control** for orders, including possible cease efforts order for any of the following

    - A *cease efforts* order may be considered and the base station physician may order resuscitative efforts be discontinued (or not initiated at all) if the following conditions exist:

    - No signs of life are present (*i.e.* pulseless & apneic), patient "down time" is unknown, EKG is **asystole** or **PEA**, and on-site resuscitative efforts have been unsuccessful.

    - The patient has injuries inconsistent with life (even if the patient's body temperature is warm).

    - Triage or patient prioritization deems resuscitative resources would be more beneficial for use on other victims.

Critical Thinking Elements

- **Pediatric patients and patient with hypothermia may have no signs of life but still be viable. Prolonged resuscitative efforts are indicated in these cases. No Cease Efforts Order will be given.**

- **Traumatic arrest patients, may meet criteria for resuscitation if immediately accessible.**

- **In situations where decision to cease efforts is not believed to be a safe option for EMS, the patient should be treated based upon most appropriate treatment protocol and transported. Information about such decision should be included in the telemetry communication.**

Functional Needs/ Special Needs Population

EMR Care, BLS Care, ILS Care, ALS Care

These guidelines should be used when an EMS provider, responding to a call, is confronted with a patient using specialized medical equipment that the EMS provider has not been trained to use, and the operation of that equipment is outside of the EMS provider's scope of practice. The EMS provider may treat and transport the patient, as long as the EMS provider doesn't monitor or operate the equipment in any way while providing care.

When providing care to patients with special needs, EMS personnel should provide the level of care necessary, within their level of training and certification. When possible, the EMS provider should consider utilizing a family member or caregiver who has been using this equipment to help with monitoring and operating the special medical equipment if necessary during transport. If a caregiver is unavailable or unwilling to accompany the patient, transport as usual. Contact Medical Control should you encounter any complications.

Some examples of special medical devices include.

- Out-patient infusion pumps to include but not be limited to PCA (patient controlled analgesic), TPN, Anti-biotic infusions, Chemo-agents.
- Chest Tube
- Ventilator
- Wound Drainage Devices (i.e. Wound Vac)
- Left Ventricular Assist Device (LVAD)
- Life-vest

If a communication barrier exists between the EMS Provider and the patient, then that provider should utilize staff, caregivers, family etc. to facilitate the best possible assessment and Hx. The EMS provider should notify the E.D. staff of these communication difficulties during the call-in patient report.

This protocol is not intended for inter-facility transfers.

Relinquished Newborn

The Illinois Abandoned Newborn Infant Protection Act (325 ILCS 2/) recognizes that newborn infants have been abandoned to the environment or to other circumstances that may be unsafe to the newborn infant. This Act is intended to provide a mechanism for a newborn infant to be relinquished to a safe environment, for the parents of the infant to remain anonymous if they choose, and to avoid civil or criminal liability for the act of relinquishing the infant.
Fire stations, police stations, and emergency medical facilities: Every fire station, police station, and emergency medical facility must accept and provide all necessary emergency services and care to a relinquished newborn infant, in accordance with this Act.
The act of relinquishing a newborn infant serves as implied consent for the fire station, police station, or emergency medical facility and its emergency medical professionals to treat and provide care for the infant, to the extent that those emergency medical professionals are trained to provide those services.

After the relinquishment of a newborn infant, the fire station, police station, or emergency medical facility's personnel must arrange for the transportation of the infant to the nearest hospital as soon as transportation can be arranged.
If the parent of a newborn infant returns to reclaim the child within 72 hours after relinquishing said child, staff must inform the parent of the name and location of the hospital to which the infant was transported.

"Newborn infant" is defined as a child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished.
EMS will care for the child and transport to the closest appropriate facility regardless of suspected age.

The following link provides facility specific details such as signage, on-site packet requirements, and liability etc.
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1459&ChapterID=32

EMR Care, BLS Care, ILS Care, ALS Care

Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the Routine Patient Care Protocol.
2. Maintain control of the scene and request law enforcement if they have not already been called.
3. Assess the infant for signs of abuse.
4. Treat injuries and/or illness according to protocol.
5. Initiate transport as soon as possible.

Communicable/ Highly Infectious Diseases Protocol

Ebola Virus Process

Dispatcher Screening and EMS Guidance for possible Ebola Virus Disease patients
When a call taker receives call for a patient with any of the following:

- Fever
- Abdominal Pain
- Nausea/ Vomiting
- Diarrhea
- Body Aches

AND who has traveled from any country with widespread Ebola virus transmission in the last 2-21 days **or** has had contact with someone who has been diagnosed or presumed to have Ebola by a physician.

1. Request that the patient meet EMS at the door of the house/ apartment, when EMS rings the bell/ knocks at the door, if possible.
2. Dispatch is to notify EMS of all symptoms **PRIOR** to EMS arrival. EMS is to don protective gear prior to any patient contact. Level of gear is based on level of symptoms.
    a. Fever/body aches: gloves, mask, eye protection, and gown.
        i. Limit the number of care givers who interact with the patient.
    b. Nausea/ vomiting/ diarrhea: gloves, mask (N-95 or PAPR if available), eye protection, impervious gown or impervious jump suits.
        i. Limit the number of care givers who interact with the patient.
        ii. Limit intravenous procedures. **Contact medical control** for guidance in regard to any interventions beyond supportive care.
        iii. If patient is actively passing fluid/ bleeding, and time allows, all surfaces need to be covered with Visqueen to protect the interior of the ambulance. If no, use a layer of Visqueen under the blanket on the stretcher. Soap and water cleaning and then decontamination are needed. Decontamination of the surfaces needs to be done be using 1:10 bleach solution or a solution such a Cavacide. Any soiled items need to be left in the patient room.
3. **St. John's Hospital** (Springfield, IL) is the current Regional Ebola Assessment Center, any patient meeting the above criteria will be directed there unless unstable. St. John's Hospital may direct cases to **Carle Hospital** in Champaign as the Regional Ebola Treatment Center. EMS **must** communicate "possible Ebola Virus Disease symptoms" to ED in report. EMS may need to wait shortly in ambulance bay to deliver patient into appropriate room.
    a. This destination criteria could be applicable for a future suspected highly infectious disease yet to be determined, based upon CDC notification and guidelines.
4. If such a situation arises that meets this criteria, the information is still patient protected and only those with a need to know, should be involved in the discussions regarding. Information should be transmitted via telephone and CAD as much as possible.