Memorial EMS
Decatur Memorial EMS
Springfield Memorial EMS

Medical Operations

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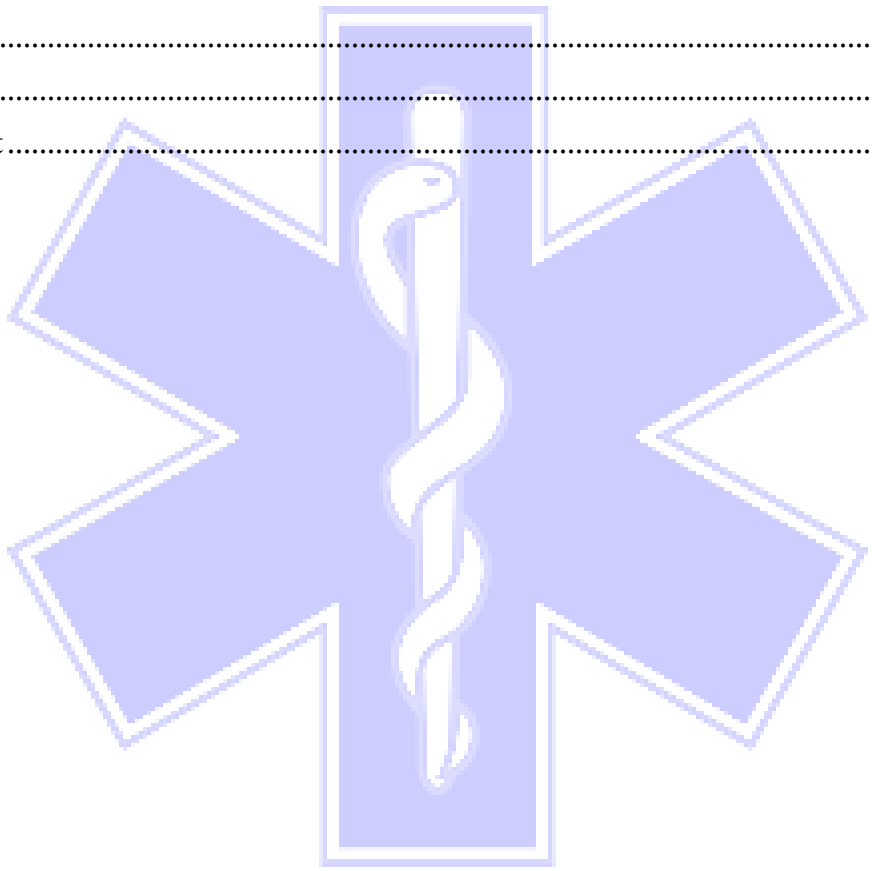

Medical Control, Standing Orders and Policies

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

1. Standing Medical Orders, Protocols, Policies & Procedures contained in this Prehospital Care Manual are the written, established standard of care to be followed by all members of the Memorial EMS System for treatment of the acutely ill or injured patient.
    - Medical Control Orders can only be obtained from Resource and Associate EMS Hospitals. Participating Hospitals cannot provide orders but can and should receive timely patient report. A list of Resource, Associate, and Participating hospitals is available here.
    - All hospitals providing or able to provide Medical Control Orders are required to have recording capabilities and the ability to maintain the recordings for 365 days. All other communication is encouraged to be recorded, but not required. EMS agencies contacting Medical Control but utilizing the Twiage voice call, have the ability to access all calls for agency QI.
    - If contacting a hospital other than the patient destination regarding the need for orders a clear decision needs to be made at the end of the communication regarding who will contact the receiving facility with patient report.

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

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

    - For conditions covered by this protocol manual.
    - In the event communication cannot be established or is disrupted between the Prehospital provider and Medical Control.
    - In the event that establishing communications would cause an inadvisable delay in care that would increase life threat to the patient.
    - In the event the Medical Control physician or ECRN is not readily available for communication.
    - In the event of a disaster situation, where an immediate action to preserve and save lives supersedes the need to communicate with hospital-based personnel, or where such communication is not required by the disaster protocol.

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

Online Medical Control

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

1. EMS communications requiring on-line contact with a base station physician shall be conducted using MICU phone communications, in at all possible.

2. *Pre-hospital personnel in need of on-line Medical Control identify the need for orders at the beginning of the report. A licensed ECRN can give orders for anything within protocol requiring Medical Control approval. An ECRN may elect to contact an Emergency Department Physician at any time. An ECRN is required to engage an Emergency Department Physician any time treatment outside of protocol is being provided or when a situation presents for which there is no direct protocol to outline treatment.*

3. ***Memorial EMS agencies and providers can only accept Medical Control orders from Associate and Resource Hospitals. If a provider feels the order is incorrect and for the safety of the patient requests override, the request will go the senior most physician the agency's Resource Hospital. Regardless of final disposition, the provider should submit all such situations for QI.***

4. Contact with Medical Control is required for patient care requiring interventions beyond the *Routine BLS, ILS or ALS* standing medical orders. Situations requiring Medical Control contact include, but are not limited to:
    - Any time an order is specifically required for BLS, ILS or ALS medications as outlined in the protocol.
    - Any time orders are needed for certain defined *procedures*.
    - Any instance an EMS provider desires *Medical Control involvement*.
    - Circumstances involving a Death on Scene (DOS) or cases involving advanced directives (DNR et al).
    - High risk refusals (*see next pages*).
    - *First Responder* low risk refusals (*see item #10 of this policy*).

5. Communication with Medical Control and Receiving facilities can take a variety of forms. In instances where direct patient consultation is required, MICU phone communication is strongly recommended. In all other cases, The TWIAGE App is the preferred method of communications with all participating area hospitals. On-line Medical Control is designed to provide immediate medical direction and consultation to the Prehospital EMS provider in accordance with established patient treatment guidelines and policies in this manual. MERCI VHF communications should be

the last option regarding choices of communication given the reduced quality of communication compared to other options.

6. **High Risk Refusals** require Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High risk refusals involve cases where the patient's condition may warrant delivery of care in accordance with implied consent of the *Emergency Doctrine* or other statutory provision. **High risk refusals** include, but are not limited to:
    - Head injury (based on mechanism or signs & symptoms)
    - Presence of alcohol/ drugs resulting in questionable loss of decisional capacity
    - Anytime medications are given and patient refuses transport (Dextrose is the only exception to this)
    - Significant mechanism of injury (e.g. rollover MVA)
    - Altered level of consciousness or impaired judgment
    - Unaccompanied minors (≤17 yrs old, when guardian cannot be contacted, and patient is not emancipated)

7. **Low Risk Refusals** do not require Medical Control consultation (for BLS, ILS & ALS levels) if the prehospital provider determines that the patient meets the *Low Risk Criteria* and there is no doubt that the patient demonstrates the capacity to understand the risk of refusal. The patient cannot be impaired and must be able to consent to the refusal. Medical Control should be contacted if there are any concerns about the patient's ability to refuse. **Low risk** refusals may include:
    - Slow speed auto accidents with no intrusion into patient compartment, low mechanism of injury, and no patient injury beyond minor scrapes and bruises.
    - Fall from standing without other medical conditions and no extreme of age.
    - Isolated injuries not related to an auto accident or other significant mechanism of injury
    - False calls or "third party" calls where no illness, injury or mechanism of injury is apparent.

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

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

10. When EMS is requested but the patient identified, from the initial request call that mobility assistance only is all that is requested, documentation at the agency administrative level is allowed. If any question exists about the patient's needs or condition an informed refusal should be completed and signed by the patient. At all times arrival at a patient or person asking for any interaction from EMS, documentation must be completed.

Communications

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

Regardless of the destination, **early** and **timely** notification of Medical Control or the receiving hospital is essential for prompt care to be delivered by all involved. All communication with Medical Control will be recorded and available for review for at least 365 days.

Components of the Patient Care Report

1. Unit identification
2. Destination & ETA
3. Age/sex
4. Chief complaint
5. Assessment (General appearance, degree of distress & level of consciousness)
6. Vital signs
7. Pertinent physical examination and negative findings, history
8. Treatment rendered and patient response to treatment

If Medical Control contact is necessary to obtain orders (where indicated by protocol), diligent attempts must be made to establish communication with local and/ or receiving facility capable of providing Medical Control.

EMS Alert Patient Report

Certain patient populations benefit from activation of specialty teams, protocols, providers and other resources that the majority of patients do not require. As such, including in the notification for such patients the specific need as soon as possible in the EMS communication can aid both the EMS provider giving report and the Emergency Department receiving the communication to obtain specific critical elements of information. Specific treatment protocols include reference to identifying a patient as an "EMS Alert Patient Report" and identifying the specific suspected complaint in the initial seconds of the radio report.

EMS Alert Patient Report categories include

- STEMI
- Stroke
- Trauma
- Cardiac/ Respiratory Arrest/ Impending Arrest
- Sepsis

Specific information for each patient type is included in the protocols. Information listed in those protocols is to aid is determining severity, as well as needs of the inbound patient with the goal of activating resources prior to patient arrival.

Communications

While all patients in the above categories are critical, the EMS provider must understand the process and needs of those patients to assist in getting the patient the most appropriate service in the timeliest fashion. While expedited transport is appropriate in most situations, assessment and early communication could improve the time to definitive treatment if care is provided in a different order for specific patient needs.

All EMS Alert Patient Report situations qualify for continuous QI (CQI).

EMS Patient Care Reports

Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. It is imperative to patient care that receiving facilities have the EMS Patient Care Report available to review. The best, most accurate documentation of patient care will be that which is completed immediately following the call.

Patient Care Reports

1. All EMS providers/agencies involved must complete a patient care report for each patient contact.
    a. If there is any question of if patient contact occurred, the crew should assess based on what the public would consider based on the patient's condition as well as any care/ assistance provided.
    b. Should a non-transport unit arrive after the transport unit and only assist with the general patient support, the agency may elect to allow documentation at the agency administrative level to be completed. Should an agency elect to allow this, it should be closely monitored to ensure appropriate decision- making.

2. Per IDPH 515.330, 515.350 and 515.310 EMS units are required to complete their patient care reports prior to leaving the destination hospital. Returning the unit to service ready condition should not be delayed for paperwork completion.
    a. Agencies who utilize Twiage can utilize their Twiage report as the System approved short form documentation which then allows for paperwork completion within 2 hours of completion of the call. In all situations the ePCR must be completed and submitted prior to the end of shift. If a crew is unable to complete and submit their report within 2 hours, an incident report should be submitted to the EMS Office also before end of shift. Memorial EMS will notify IDPH any time an ePCR is not completed within the 2-hour requirement.

    b. It is the responsibility of the crew and agency to ensure their patient care reports are submitted to all receiving facilities in accordance with this requirement.

    c. Agencies must have their own policy for what length of time patient care reports are held on file.

3. Documentation must be completed on System approved forms and/or System approved electronic reporting systems. For transporting agencies, the electronic reporting system must be NEMSIS compliant and up to date with IDPH requirements. **Any PCR software changes must be discussed with MEMS (prior to purchase).**

4. Non-transport agencies must complete patient care documentation immediately following the call. If unable to complete documentation at that time, an incident report should be submitted as outlined in 6.I.1. below.

EMS Patient Care Reports

5. Copies of all patient care reports must be provided to the EMS Office. This can be completed by bunching quarterly and can be the original hand written report or an electronic copy of all reports. This includes every transport and refusal.

6. Transport agencies are also required to ensure that their patient care reports are regularly and successfully submitted for the National Emergency Medical Services Information System.

Patient Right of Refusal

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

Refusal Process

1. Assure an accurate assessment has been conducted that includes the patient's chief complaint, history, objective findings and the patient's capacity to make **sound** decisions. All patients will be offered treatment and transport to a hospital.

2. Explain to the patient the risk associated with his/her decision to refuse treatment and transportation. Even if the patient decides to refuse, the patient should be informed and it should be documented that the patient was advised they can call 911 again at any time.

    a. Any patient wishing to refuse must have decisional competency and capacity. This requires that the patient has the legal right (is not a minor or has an appointed guardian) to make decision and has decisional capacity to understand and appreciate the nature of consequences of a medical decision to reach and communicate an informed choice (decision).

3. Secure Medical Control approval of **high risk refusals** (low risk refusals for Emergency Medical Responders) in accordance with the *Online Medical Control Policy*. If there is any question as to a patients' legal ability to refuse treatment/transport (emancipated minors, pregnant minors, etc), consider as high risk and contact medical control for guidance. Medical Control can also be a resource to assist when the patient does not want transport but EMS has ongoing concerns about not transporting.

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

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

6. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and refuses to sign the release, clearly document the patient's refusal to sign the report. Also, have the entire crew witness the statement and have an additional witness sign your statement, preferably a police officer.
7. The patient (guradian) is entilted to a copy of the refusal documentation. If not completed and a print copy provided onsene, the parties must be provided with how they will be able to obtain that refusal. Sample documents are available here.

Minor Patients

A minor cannot generally consent to or refuse treatment.

1. The consent of a parent or guardian is required for refusal of treatment for minors. If a parent or guardian is not available to consent and, without treatment, the minor's health would be adversely affected, EMS personnel should administer appropriate emergency treatment and transport. Document efforts to obtain consent. If the minor is refusing or resisting treatment, contact Medical Control and if necessary, contact law enforcement.
2. If a parent or guardian reuses to consent for treatment without which the minor's health would be endangered, EMS personnel will contact law enforcement and Medical Control. Law enforcement or a physician may take or retain temporary protective custody of the child without the consent of the person responsible for the child's welfare. A person taking protective custody of a minor must immediately make every reasonable effort to notify the person responsible for the child's welfare, and notify the Department of Children and Family Services.

When a minor may consent to or refuse treatment.

1. A person who is under the age of 18, is a minor in Illinois, but may consent to or refuse care as though an adult if the person:
   a) Has been emancipated by a court of law
   b) is married
   c) is a parent (mother or father)
   d) is pregnant
   e) is on active duty with the armed forces
2. Any minor parent may consent to the treatment for his/her child.
3. A parental or guardian's consent is not required for patients aged 12 and over seeking treatment for sexually transmitted diseases, sexual assault, alcohol or substance abuse treatment, and limited outpatient mental health treatment.

NOTE- for the purposes of patient treatment protocols a pediatric patient is under age 16. For legal purposes a patient is typically a minor when they are under age 18.

Transitions in Patient Care

A smooth transition of care between EMS providers and other Healthcare workers is essential for optimum patient care. The tiered response nature of EMS is designed to provide early responders who may have a lesser level of training and then later responders able to provide higher levels of patient care. 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 expected.

As healthcare continues to specialize, the need to transfer patient care to both higher and lower licensed providers has become more of a daily activity, regularly involving EMS.

Responsibility to Maintain Patient Care

Once a relationship has been established with a patient (person asking for or believed to be in need of Emergency Medical Services) and the patient is accepting of that treatment, the relationship should be continued. EMS personnel must not leave or terminate care unless one of the following conditions exist:

- Appropriate receiving facility personnel assume medical care and responsibility for the patient.
- The patient or legal guardian refuses EMS care and/or transportation (In this instance, follow the procedure as outlined in the *Patient Right of Refusal Policy*). Refusal can be completed by any provider at or above the level of care provided.
- EMS personnel are physically unable to continue care of the patient due to exhaustion or injury.
- Law enforcement personnel, fire officials or the EMS crew determine the scene to be unsafe and immediate threat to life or injury hazards exist.
- The patient has been determined to be dead and all policies and procedures related to death cases have been followed (including DNR situations.)
- Medical care and responsibility for the patient is transferred to licensed personnel in accordance with applicable policies. (See also Relegation below.)

The application of any of these criteria does not remove EMS from the responsibility to either return to the scene after safety has been addressed, or to maintain presence and responsibility of the scene until the responsibility has been transferred to other appropriate parties.

Failure to continue patient care, transition to a higher level/hand off to appropriate personnel or obtain a refusal, with appropriate signatures and documentation puts the EMS provider at risk for patient abandonment. Continuity of care must be assured unless patient relationship otherwise terminated.

Transitions in Patient Care

Transport Units Only

EMS personnel may leave the scene of an illness or injury incident, where initial care has been provided to a patient and the **only** responsibility remaining for the EMS crew is transportation of the patient or securing a signed refusal, if all 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. Some level of EMS (at or above the level of care provided by this crew) remains with the patient.
3. Appropriate documentation is completed by all responding units involved.

If while traveling in an emergency vehicle, the crew comes across a separate incident where a prudent person would reasonably see the need for patient care, the crew should activate the local EMS System. Crews involved in the treatment and transportation of an unstable patient are not to stop and render care. In all other situations, a crew member not required for the care of the onboard patient should assess the scene and begin treatment until able to hand off to those from the local jurisdiction. Patient care reports should be completed based on these protocols.

Patient Care Management and Handoff

1. 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. If the transport unit is of a lower license level than the non-transport unit, an early decision needs to be made regarding expected patient needs and opportunities to provide for those needs, including requesting a higher level of transport unit or utilizing an upgrade from the non-transport department.
2. 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. Call location relative to a destination hospital is not reason for reduction of care by EMS, but in some specific situations could serve as explanation for expedited scene time when the needs of the patient exceed the providers available on scene. Similarly, the time estimated to transport versus the time to obtain a higher level intercept should be a consideration. The patient care report documentation should include such decisional information.
3. **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 provider's concern. Such discussion must be respectful, brief, and based on patient safety concerns, not provider preferences.**

4. The transport provider should obtain report from the non-transport provider and conduct a thorough patient assessment. Treatment initiated by the non-transport provider should be taken into consideration in determining subsequent patient care steps.

5. Every time care transitions to a new provider, that 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. A few situations with EMS handoff are extremely challenging (e.g. transcutaneous pacing and suspected spinals injuries) and require teamwork by all members as well as a single team leader coordinating all activities in the movement and handoff.

Intercepts

Intercept by a unit with a higher level of licensure allows for the ability to provider higher level of care to patients. Every agency must know how to obtain intercepts within their service area and normal transport patterns. Agencies will intercept with the closest available unit based on dispatcher decision.

Upgrading of a Transport Unit

Given the variation in EMS level of licensure, there can be times when the non-transport unit is licensed at a higher level of care than the transport unit. In such situations, patient care needs will always guide decision making. The situation should be identified early in patient care to determine if a transport unit with a higher license level should be requested. If unavailable, or greater delay than the estimated transport time, the non-transport unit may need to maintain and lead patient care efforts to the hospital.

Transitions in Patient Care

Relegation of Patient Responsibility

In situations where transport unit(s) are less than Paramedic level, guidance is needed for continuity of care that meets the patient's expected needs. In all areas of service, dispatchers have already triaged calls based on an internationally recognized criteria to both communicate patient need as well as dispatch the most appropriate resources. The below downgrade criteria is established to address regularly expected situations where downgrade of care provider would be an appropriate use of resources.

Cancellation of Dispatched Resources

Should an on scene EMS unit cancel higher level resources that have been dispatched to the same call and the patient is not signing a refusal, the call should be submitted for QI within 24 hours. If the cancellation (or transport by a lower level unit without assessment by the additionally dispatched units) is to occur, the Downgrade Criteria should be utilized.

Downgrade Criteria

1. Should a higher licensed unit arrive on scene and feel that the patient may be appropriate for the lower licensed unit to continue care (also applicable for higher level ambulance when determining if the patient can be appropriately treated by a lower license staff member on same unit)
    a. Patient assessment must be completed by a member of the highest level of care.
        i. Use of assessment tools higher than the scope of the lower licensed staff/ crew necessitates that the patient should remain in the care of the higher level provider.
    b. A member of the unit must maintain patient care for any of the following situations
        i. Any time treatment higher than the level of the ambulance has been started.
        ii. Any time the lower level of care ambulance does not feel comfortable that they are able to appropriately manage the patient's needs.
        iii. Any of the following complaints
            1. Any suspected cardiac complaint
            2. Respiratory distress not relieved by a single nebulizer
            3. Patients meeting trauma declaration criteria
            4. Patients with uncontrolled pain
            5. Postictal seizure patients
            6. Imminent childbirth
            7. Any situation where medications were given that are not in the scope of the transporting unit.

2. All units who have patient contact are responsible for completing patient care reports based on guidelines set forth in these protocols.

Discrepancies

Disagreements regarding response should be handled at an administrative level after call completion. Agencies that represent specific geographic areas must identify if they will or will not provide intercept services.

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Patient Destination Criteria

The day-to-day functionality of the prehospital EMS System requires that we have units available at all times to assist patients and families in need. As such, it would not be reasonable to expect that a transport unit be able to take a prehospital patient to any hospital they choose but rather EMS transport agencies must have an established list of hospitals with which they are able to always transport to. All providers at the agency must refer to that same list of destinations while assisting patients in making an informed decision about their destination. Scheduled transfers do not fall into these requirements.

Patients (guardians) should be informed of when, based on their symptoms, one facility is licensed and/or certified to better meet their needs than another. This does not mean that the patient cannot be transported to the hospital of their choice, but rather that the patient make an informed decision and documentation of the informed decision be included in patient care report. Destination requests cannot be honored during an MCI or to any hospital that has requested and been approved for diversion.

The below criteria should be followed by all providers in the Memorial EMS Systems.

Pt Complaint	Criteria	Distance	Facilities certified/ licensed to meet patient's complaint
Region 3 Stroke Guidelines	• Positive Fast ≤ 4.5 hours ○ Closest Facility (Minimum ASRH)	Not applicable	• Every Region 3 and Region 6 EMS hospital is ASRH (Acute Stroke Ready Hospital) • Agencies who would regularly transport outside of Region must know the certification level of those destination hospitals.
	• Positive Fast >4.5 hours **AND** ≤ 24 hours with LAMS ≥ 4	60 minute	CSC (Comprehensive Stroke Centers) Springfield • Springfield Memorial Hospital • HSHS St. John's Hospital Peoria • OSF St. Francis Medical Center
Region 6 Stroke Guidelines	• Positive Fast **AND** negative LAMS • Positive Fast **AND** LKW > 24 hours	Not applicable	• Every Region 3 and Region 6 EMS hospital is ASRH (Acute Stroke Ready Hospital) • Agencies who would regularly transport outside of Region must know the certification level of those destination hospitals.
	• Positive Fast **AND** LAMS > 4 **AND** transport time to destination will not exceed 4.5 hours from LKW	60 minutes	CSC (Comprehensive Stroke Centers) Springfield • Springfield Memorial Hospital • HSHS St. John's Hospital Champaign • Carle Foundation Hospital

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Pt Complaint	Criteria	Distance	Facilities certified/ licensed to meet patient's complaint
Trauma	• CDC Field Triage Decision Scheme Criteria	25 minute	**Level 1** Springfield • Springfield Memorial Hospital • St. John's Hospital Champaign • Carle Foundation Hospital Peoria • OSF St. Francis Medical Center **Level 2** Decatur • Decatur Memorial Hospital Bloomington/ Normal • Carle BroMenn Medical Center • OSF St. Joseph's Medical Center
Pediatric Trauma	• Age ≤ 12 years, **AND** • Any of the following ○ ≤ 12 GCS ○ ≤ 6 PTS	25 minute	Springfield • HSHS St. John's Hospital Peoria • OSF St. Francis Medical Center
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
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 Medical Center • OSF St. Joseph's Medical Center Decatur • Decatur Memorial Hospital Peoria • OSF St. Francis Medical Center Mattoon • Sarah Bush Lincoln Champaign • Carle Foundation Hospital • OSF Heart of Mary
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 Medical Center Champaign • Carle Foundation Hospital

Pt Complaint	Criteria	Distance	Facilities certified/ licensed to meet patient's complaint
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 Champaign • Carle Foundation Hospital
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 choice and medical history should be utilized to determine destination.
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.	Only Per Medical Control	Peoria • OSF St. Francis Medical Center

Assumptions

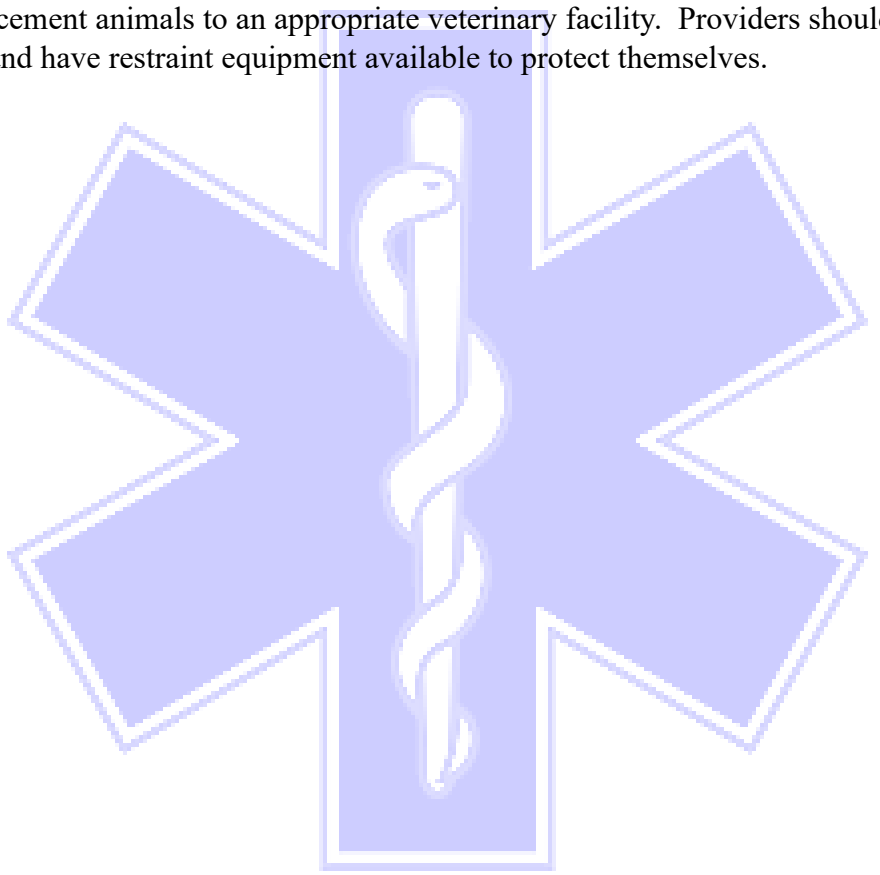
- If patient is in extremis, the closest emergency department should be destination to stabilize the patient. This includes, but is not limited to, unstable airway patients.
- Agencies need to know the capabilities of all destination hospitals.
- Transport agencies must identify all destinations that they will transport to in regard to 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.

Patient Destination Criteria

- 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.



Mass Casualty Incidents

A multiple patient incident becomes a mass casualty incident (MCI) occurs anytime there is greater patient need than responders can readily address. The threshold for declaring an MCI is considerably different in rural areas where resource limitations may exist than in suburban/urban areas with more resource availability. This protocol does not list a specific number of patients required to identify an MCI. Additionally, the severity of the patient needs are, potentially, more significant in initiating an MCI response.

Every agency must empower their providers by encouraging early identification of potential MCI situations, activation of MCI support resources, notification to potential receiving hospitals and recognition of special needs associated with the response.

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

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. This agency will also be responsible for establishing/ assigning the establishment of a patient reunification process for those not transported and coordinate with receiving hospitals and other authorities in the hours after the incident.

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 and how the hospital will notify EMS on this status.

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.

Mass Casualty Incidents

Resources assigned to an MCI response should expect to continue their assignment to the MCI response until released by Incident Command. This includes ambulances who have completed a transport.

Mass Care

Medical responders should be knowledgeable of how to rapidly address patient care needs based on the M.A.R.C.H. principles and 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.

School/ School Bus Incident/ MCI Management

Due to the potential for multiple students and the likelihood that parents are not readily available, school/school bus incidents create a unique challenge. As such the following management tools have been created.

Classification

Category 1 (Decatur EMS)/Category A (Springfield EMS)- Significant mechanism of injury (*i.e.* rollover, high-speed impact, intrusion into the bus, etc.) to at least one occupant of the bus necessitates that all occupants receive treatment as individual patients.

Category 2 (Decatur EMS)/Category B (Springfield EMS)- Suspicious mechanism of injury (*i.e.* speed of impact, some intrusion into the bus, etc.) relays that at least one occupant 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.

Category 3 (Decatur EMS)/Category C (Springfield EMS)- No obvious mechanism of injury and/ or no injuries present.

Category 4 (Decatur EMS)/Category D (Springfield EMS)- The occupant(s) have special healthcare needs and/or communication difficulties.

MCI Specific Documentation

- A single report documenting the nature of the incident can be utilized in conjunction with all patient care reports/ refusal.
- Any patient transported will have a PCR completed.

- Any patient meeting Category 1/A and 4/D who is not transported should have a full assessment and refusal completed. Any patient meeting Category 2/B and 3/C who is a refusal can be documented on the MCI patient log. Minor patients can be released to the school official in lieu of on scene parent/ guardian. Those aged 18 and older will sign for themselves.
    - The MCI patient log is available in the Appendix and should be included on every vehicle.
    - Any time a patient is released from a scene they should be provided with information regarding how to obtain copies of any completed documentation.

Tactical MCI Guidelines

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 regard 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.

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Aeromedical Resource Activation

Use of aeromedical 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 Field Trauma Criteria below,
- 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.

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure	**All Patients** • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% **Age 0-9 years** • SBP < 70mm Hg + (2 x age years) **Age 10-64 years** • SBP < 90 mmHg or • HR > SBP **Age ≥ 65 years** • SBP < 110 mmHg or • HR > SBP

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. Responder movement anywhere within the landing zone should only be with the direction of and oversight by the flight crew(s).

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.

Aeromedical Resource Activation

The decision to request aeromedical transport must be made early in the response to avoid waiting for the helicopter when the patient is ready for transport. Patient transport via ground ambulance should not be delayed waiting for aeromedical transport arrival.

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).

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Incident Reporting

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

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

Incident Report Process

1. All incident report forms should be forwarded to the Memorial EMS System Quality Assurance Coordinator. An electronic mechanism for submission is available on the EMS System website. Providers must also follow any agency reporting requirements.

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

Incident Report Indicators

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

- "Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or the System."
- Any deviation from Memorial EMS System policies, procedures or protocols.
- **Medication errors**
- **Treatment errors**
- Delays in patient care or scene response
- Operating on protocol when Medical Control contact was indicated but unavailable
- Violence toward EMS providers that results in injury or prevents the provider from delivering appropriate patient care
- Equipment failure (e.g. cardiac monitor, glucometer)
- Inappropriate Medical Control orders
- Repeated concerns/conflicts between agencies, provider/physician or provider/hospital conflicts
- Patterns of job performance that indicate skill decay or knowledge deficiencies affecting patient care
- Every time an EMS provider is not able to complete their paperwork within the two hour IDPH requirement.

Incident Reporting

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

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

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Advanced Directives

Advanced Directives such as Do Not Resuscitate requests, Physician Order for Life Sustaining Treatment and Durable Power of Attorney for Health Care are all legal documents that EMS providers can expect to encounter during their course of work.

Illinois POLST Form (Physician Orders for Life Sustaining Treatment): Updated by the IDPH to remove "DNR" from the title of the form and from around the form border; care options redefined; modified to align with the POLST standards used in other states. Since the POLST form allows patients to indicate whether they accept or refuse CPR, it is no longer possible to equate the mere existence of the form with a DNR choice.

Do Not Resuscitate: Do not resuscitate is a colloquial term typical referring to a situation, but also referencing a form that is no longer in use. The DNR form has been replaced by the POLST form, but only represents a portion of the declaration options incorporated into the POLST form.

Durable Power of Attorney for Health Care: A document that permits a person to delegate to another person the power to make any health care decision. In very rare occasions EMS may encounter situations where a patient has a Durable Power of Attorney for Health Care AND by physician order the criteria has been met to invoke this delegation. In all such instances conversation with Medical Control can be of assistance in clarification.

Patient Care

When EMS personnel arrive on scene in a situation where they are advised of a patient having an advanced directive, EMS should request a copy of the document. (Photocopies and pictures are acceptable if able to be fully viewed.) If the patient is to be transported, a copy (or photocopy) is to be added to the EMS electronic patient care report.

If patient is in arrest and CPR has been started, BLS care should be continued while EMS works to validate paperwork as well communicate the situation with Medical Control.

If patient is in arrest and CPR has not been started, but EMS is immediately provided with advanced directive documentation, contact with Medical Control prior to initiating CPR is acceptable. In a situation where EMS has a concern about validity or situations surrounding the request, CPR should be started.

Exceptions- if the cardiac arrest situation is the result of non-medical and non-natural causes, advanced directives will not be honored, and the patient should be fully resuscitated and early communication of the situation relayed to Medical Control.

Revocations- an advanced directive can be revoked at any time if it is physically destroyed or verbally rescinded by the person who gave consent for the order or the physician who wrote the order.

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
- All Alert Patient Report criteria (Stroke, Sepsis, Trauma, STEMI, & Arrest/Near-Arrest)
- Aero Medical resource utilization
- Requests for Override of Medical Control Order
- Field Termination and Field Death
- BLS/AEMT ambulance upgraded after being dispatched due to unavailability of ALS resources

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.

Quality Improvement Steps

At any time, any member of the Emergency Medical Services team can forward a call for review. Any request for QI will be reviewed in the same manner as items identified above.

Opportunities for improvement will be discussed in either in person or online meetings with the crew(s) involved.

Follow up could include case sharing, ongoing case review, and/ or performance improvement plan. Significant quality of care issues and/ or ongoing care issues can be elevated to disciplinary procedures