Operational Policies

Prehospital Transfer of Care from Higher Level of Care to Lower Level Provider

I. POLICY STATEMENT

The "hand-off" or transfer of patients, between EMS providers, particularly between Advanced Life Support (ALS) to Intermediate Life Support (ILS) or Basic Life Support (BLS) represents one of the most important elements of successful pre-hospital patient care.

II. PURPOSE

The purpose of this policy is to provide guidelines for the safe transfer of care from a non-transport on-scene paramedic to an ILS or BLS staffed transport ambulance.

III. DEFINITION – None.

IV. POLICY

A. Criteria for transfer of care from ALS to ILS or BLS must include:

a. The ILS or BLS level provider must agree to the transfer of care.
b. Prior to the transfer of care, a history and physical examination (H&P) must be performed by the ALS provider. This H&P must be documented and the higher level provider must affix their signature to the report. This H&P may be documented on the patient care record of the transporting unit, or on a separate PCR. If documented on a separate PCR, the H&P must be forwarded to the receiving medical facility.
c. With any transfer of care, the provider transferring care must interface directly with the receiving provider and ensure all pertinent information is conveyed.
d. Patent airway, maintained without assistance or adjuncts.
e. Patient appears hemodynamically stable with medical complaints or injuries that could be cared for at the ILS or BLS level.
f. GCS ≥ 14.
g. No mechanism of injury that would warrant a trauma alert or activation.
h. No cardiac, respiratory, or neurological complaints that may warrant ALS intervention.
i. No patient may be transferred to ILS or BLS once an ALS intervention has been initiated.
j. Before transferring care to the ILS or BLS transport ambulance, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition.
k. Any level of provider accepting transfer of patient care must be continuously alert for changes in patient condition and be prepared to provide immediate medical intervention and potentially call for an ALS intercept.

B. Documentation:

1. Both the transferring and receiving providers shall document the transfer of care in their Patient Care Report (PCR). The ALS Provider will complete an independent PCR which will include the completed H&P from (A-2) and will identify the receiving transport ambulance.
2. ALS transferring unit is identified on the BLS PCR.

C. The responsibility of transfer of care lies with the ALS provider. If the ILS or BLS provider is not comfortable accepting responsibility for primary care and the providers cannot agree, contact Medical Control for further direction and resolution.

V. REFERENCES – None

Ambulance Estimated Time of Arrival

I. PURPOSE

This policy is to provide the patient with an opportunity to request another agency for transport, if the initial agency's response time is deemed too excessive.

II. DEFINITION--None

III. POLICY

A. The patient calling for the EMS response and/or transport may request the estimated time of arrival once the agency dispatcher has been contacted. It is the responsibility of the agency dispatcher to estimate the time of arrival of the responding unit.

B. Emergency Medical Dispatch training includes teaching dispatchers to provide an estimated time of arrival for the responding unit when requested by the patient. Estimated times of arrival must be available for the patient for both emergent and non-emergent situations.

C. After receiving communication of the estimated time of arrival for the transporting ambulance, the patient has the opportunity to request another transport agency.

D. All EMS dispatchers in the ~~HSHS St Mary's~~ EMS System must abide by this policy.

IV. RESOURCES—None

EMS Controlled Substances

I. **PURPOSE**

The purpose of the Controlled Substance Policy is to provide guidelines for the security, storage, administration, documentation and replacement of controlled substances for the ~~HSHS St Mary's~~ EMS System.

II. **DEFINITION**

III. **POLICY**

Storage and Accountability

A. All controlled substances shall be kept in a drug box/bag or cabinet within the vehicle and secured with a numbered tamper-proof tag labeled with the earliest expiration date. Tag numbers are to be recorded on the **ALS Drug Box Daily Check Sheet.**

B. When the crew is not physically inside the unit, controlled substances will be secured on the unit by locking all exterior doors or compartments. The crew members assigned to that unit are the only personnel authorized to unlock the unit.

C. Once a drug box/bag is opened, it should remain on the advanced provider's person until it is returned to pharmacy for exchange. The opened tags should remain with the opened box if at all possible.

D. At the beginning of each shift, two (2) advanced EMS providers (Paramedic, EMT-Intermediate or PHRN) will verify that the numbered tags are secured and match the number recorded on the **ALS Drug Box Daily Check Sheet**. Upon verification, both EMS providers must sign the sheet.

1. If the numbered tag is not intact or cannot be verified, a complete inventory must be taken immediately and a supervisor notified. An ~~HSHS St Mary's~~ EMS System Risk Screen must be completed and submitted to the EMS Coordinator within twenty-four (24) hours of the findings.

2. The **ALS Drug Box Daily Check Sheets** will be turned in to the ~~HSHS St Mary's~~ EMS System office at the end of each month.

E. After each use of a drug box, it is taken to the pharmacy of the receiving hospital to be exchanged. The pharmacist will check the box for the opened tag, and will sign the box in. The Advanced level provider (EMT-P, EMT-I, PHRN) will sign the sheet in pharmacy with

the used box numbers and the new box numbers. He/she will then record the new box numbers in the unit's **ALS Drug Box Daily Check Sheet**.

F. Controlled Substances shall be available for inspection by the IDPH, ~~HSHS St Mary's~~ EMS Office or any other authorized individual announced or unannounced.

Patient Administration and Documentation

A. Advance providers (EMT-P, EMT-I or PHRN) may only administer a controlled substance in accordance with the Region 6 ~~HSHS St Mary's~~ EMS System treatment protocol(s) and/or a direct order from an on-line medical control physician.

B. When a controlled substance is administered in patient care, the Patient Care Report (PCR) will contain at a minimum in relation to the controlled substance:

1. Date of administration
2. Time of administration
3. Patient name
4. Patient Address
5. Reason for administration/Medical condition being treated
6. Physician name (if administered by on-line medical control order.)
7. Medication name
8. Medication strength
9. Dosage form
10. Quantity administered and route
11. Quantity wasted
12. Name of provider administering/wasting
13. Name of RN witnessing any wastage.

C. When returning the Controlled Substance Drug box/bag, the patient's name must be on the form.

Controlled Substance Exchange and Replacement

A. All controlled substances utilized in prehospital patient care will be replaced in the drug box after being checked by the pharmacist and a new box will be presented.

B. For portions of controlled substances not used, the unused amount will be brought into the Emergency Department and discarded in the presence of both the provider that administered it and an Emergency Department Nurse. Amount administered, along with waste amount will then is recorded on the form in the drug box, and the EMS provider and RN will sign on wastage.

C. Controlled substances will be restocked by the pharmacies of the Resource and Associate Hospitals. At participating hospitals, after hours restocking will be through the ER.

D. When the pharmacy is unavailable, the ER Staff can replace used medications through the Pyxis in the ER. The nurse is to enter under "add patient" Paramedic name and what ambulance he or she represents. Expired meds must be replaced from the pharmacy during regular business hours.

Non-Transporting Agencies

A. All controlled substances administered by non-transporting agencies should be administered as outlined under "Patient Administration and Documentation.

B. For portions of controlled substances not used by non-transport agencies the unused portion will discarded in the presence of both the non-transporting advanced provider and the transporting advanced provider once arriving on scene.

C. The transporting agency will then take the open non-transporting agency's controlled substance box and trade them for the unused box, recording numbers of the opened box in the **ALS Drug Box Daily Check Sheet.** A notation of the exchange will be recorded in the documentation.

D. The non-transporting agency will record the new drug box received from the transporting agency on the **ALS Drug Box Daily Check Sheet.**

Non Full-Time Agencies

A. Agencies that do not have full time staff and are not able to perform the daily security checks of controlled substances should perform at a minimum weekly security checks and document this on the **ALS Drug Box Daily Check Sheet**.

Responsibilities of the Resource and Associate Hospitals

A. The Resource and Associate Hospitals will accept any excess controlled substances from the EMS providers and dispose of such substances according to appropriate hospital and DEA policy. The hospitals, upon proof of use, will then replace the controlled substance used by the ALS/ILS provider.

~~HSHS St Mary's~~ EMS System Record Keeping

A. Per DEA Policy, all records related to controlled substances must be maintained and be available for inspection for a minimum of two (2) years.

IV. REFERENCES--None

EMS Medication Exchange and Replacement Policy

I. PURPOSE

This is to provide guidelines for the exchange and replacement of expired, soon-to-be expired, damaged or medications used in refusal of service.

II. DEFINITION—None

III. POLICY

Medication Exchange and Replacement

A. All medications utilized in prehospital patient care will be exchanged on a 1:1 basis.

B. All medications will be replaced by the hospital pharmacy.

C. Medication replacement form to be completed in EMS office prior to taking medications to pharmacy

Soon to be expired/Damaged Medications

A. All drugs, according to the FDA, are dated with an expiration date on the outside of the box. If dated with month and year only, the drug will expire on the last day of the indicated month (for example 10/21 will expire on 10/31/2021).

B. In order to replace the soon-to-be expired or damaged medications through the pharmacy prior to the expiration date, they must be brought to the pharmacy of the Resource hospital and exchanged with the pharmacist.

C. Medication replacement form must be completed in EMS office and taken to pharmacy, or completed in pharmacy.

Refusal of Service

A. When a patient has received care, but refuses transport following care. The opened drug box is returned to pharmacy just as if the patient had been transported.

IV. REFERENCES

--BLS Medication Replacement form Appendex page 207
--ALS Medication Replacement form Appendex page 208

High Performance CPR

I. PURPOSE

To improve the overall survival rate of sudden out-of-hospital cardiac arrest patients within the ~~HSHS St Mary's~~ EMS System. Research indicates that High Performance CPR (HP CPR) along with Code Resource Management (CRM) can save lives. In order to have effective HP CPR ALL involved must work as team. This systematic change in treatment and management of cardiac arrest patients is based on research and practices being used in many other high performance EMS systems across the county. Minimal breaks in compressions, full chest recoil, adequate compression depth, and adequate compression rate are all components of CPR that can increase survival from cardiac arrest. Together, these components combine to create high performance CPR (HP CPR).

II. DEFINITION – None.

III. POLICY

A. Effective Compressions

1. CPR should be initiated immediately upon identification of cardiac arrest as long as the scene is safe.
2. Compressors should be rotated every 2 minutes.
3. Ideally, one compressor is on each side of the patient's chest (one person compressing and the other person ready to start)
4. Maintain compression depth of at least 2 inches.
5. Compression should allow for complete chest recoil/decompression between compressions (50% Compression / 50% Decompression).
6. Compressor shall also rotate when a decrease in ETCO2 is observed.

B. Continuous Compressions

1. Compressions at a rate of 100-120 per minute for 2 minutes (use of a metronome is recommended). (Compression Fraction > 60%)
2. Do NOT interrupt chest compressions during the 2 minute cycle for ANY reason.
3. Treatments such as ventilations, IV/IO access, or intubation shall be done while CPR is ongoing.
4. After completion of a two-minute cycle, a phase to assess pulses and/or defibrillate will be limited to ≤ 10 seconds.

C. Defibrillation

1. Turn on the AED/monitor as soon as cardiac arrest is confirmed.
2. Chest compressions should NOT be interrupted to remove clothing or place defibrillation pads.
3. Compressions should continue during charging of the AED; pausing only for analysis and shock delivery.
4. Compressors will hover over the patient with hands ready during defibrillation so compressions can start IMMEDIATELY after a defibrillation.
5. NO PULSE CHECKS AFTER SHOCKS.
6. Manual Defibrillator
    a. Charge to appropriate energy level as the end of the compression cycle nears (approx. 1 minute and 45 seconds into a two-minute cycle).
    b. At the end of the two-minute cycle, the patient will be cleared, the rhythm will be interpreted rapidly and then the patient will either be defibrillated or the defibrillator energy will be cancelled.
    c. This sequence must be performed within 10 seconds.
    d. Rhythm interpretation will not occur after a shock, but only after the two-minute cycle of CPR is performed.

D. Ventilations

1. Once an advanced airway is in place, ventilations will be performed WITHOUT STOPPING chest compression.
2. Once an advanced airway is in place, ventilations will be asynchronous with compressions during the recoil phase (1 ventilation for every 10 compressions which equates to about 1 ventilations every 6 seconds).
3. Compressions should NOT be interrupted to place an advanced airway.

E. Mechanical CPR Devices **Mechanical CPR devices should be used in accordance with the devices specific instructions.

1. Per AHA 2015 manual chest compression remain the standard of care for the treatment of cardiac arrest.
2. Mechanical CPR devices may be reasonable alternative to conventional CPR in specific settings where delivery of high-quality manual compressions may be challenging or dangerous for the provider:
    a. Limited rescuers available
    b. Prolonged CPR
    c. CPR during hypothermic cardiac arrest
    d. CPR in a moving ambulance
3. Placement of mechanical CPR device should not create excessive interruptions in compressions.

4. Mechanical CPR devices should be deployed by providers who have received proper training on the device and a trained provider should accompany any patient who the device is being used on for the duration of transport.
5. Upon arrival at the hospital, the mechanical CPR device should be left in place and active until the receiving ED staff advises otherwise.
6. Impedance Threshold Devices (ITD) should only be considered when using mechanical CPR devices that are capable of doing active compression-decompression CPR.

F. Advanced Life Support

1. ALS providers will address manual defibrillation, IV/IO access medication administration and advanced airway placement, as indicated.

*** However, intubation is no longer a primary focus of cardiac arrest management and any advanced airway intervention should NOT interrupt chest compressions

2. Capnography should be utilized to optimize CPR performance and evaluation of ROSC.

    a. EtCO2 > 10 mm Hg is indicative of quality CPR.
    b. Abrupt sustained increase in EtCO2 is indicative of potential ROSC.

G. Return of Spontaneous Circulation (ROSC)

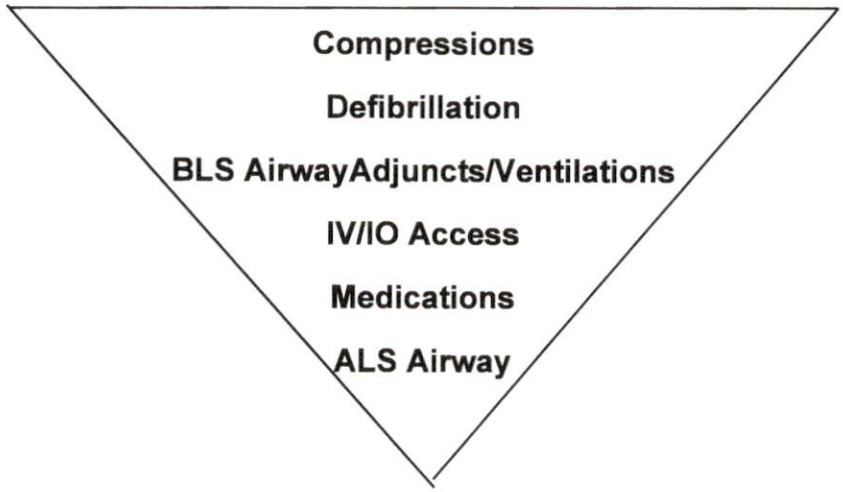
1. Refer to RETURN OF SPONTANEOUS CIRCULATION Protocol

H. Transport Considerations

1. Medical Cardiac Arrests generally do not benefit from "load-n-go" situations.
2. Patient's best chance of survival is obtaining ROSC on scene (working where found).
3. Consider "load-n-go" for traumatic and pediatric arrests.
4. Transport rapidly after obtaining ROSC, and after prolonged resuscitation for persistent Vfib/Pulseless V-Tach.

CODE RESOURCE MANAGEMENT

1) Crews should coordinate their duties keeping the call priorities in mind. Intervention priorities are (in order of highest to lowest):



2 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Ventilate, attach/operate AED/Defibrillator, assume crew leader responsibilities.
(providers rotate positions every two minutes)
**Roles remain the same even if providers are ALS equipped

3 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Crew Leader, attach/operate AED/defibrillator
Provider 3 – Ventilate (Providers 1 and 3 rotate every two minutes)
**Roles remain the same even if providers are ALS equipped

4 Provider Crew:

Provider 1 – Chest Compressions
Provider 2 – Attach/operate AED/Defibrillator

Provider 3 – Ventilate
Provider 4 – Crew Leader (Preferably ALS) (Providers 1, 2, and 3 rotate every two minutes)
**Once first two roles have begun treatment, ALS providers will establish IV/IO and administer medications

Greater Than 4 Providers:

Utilize the same initial assignments as the four provider crew. The crew leader will assign additional roles such as informing the family of patient status, gathering patient information, and documenting

the medical interventions performed on the call. If resources allow, rotate additional providers to do chest compressions to achieve optimal performance.

IV. REFERENCES—None

Infection Control

I. PURPOSE

This is to establish guidelines to prevent the transmission of communicable diseases in the prehospital environment.

II. DEFINITION--None

III. POLICY

EMS providers are responsible for providing care to patients while following precautions for exposure to communicable diseases and/or body substances. Because EMS providers have a higher than normal risk of exposure to body substances and communicable diseases the following precautions are recommended:

A. Hand washing: Regardless of the use of gloves, all EMS Providers wash their hands before and after patient contact. Each response vehicle is recommended to carry alcohol-based foam/liquid for immediate cleansing in the case of direct body substance exposure to the skin.

B. General Body Substance Isolation (BSI)

1. Gloves are to be worn then there may be contact with body substances from a patient. Any open wounds or dermatitis on the skin of EMS providers should be covered with a sealed, moisture-proof substance.

2. Safety glasses and goggles should be used whenever there may be splattering of body substances.

3. Masks should be worn then there is risk of contact with body substances on mucus membranes (i.e. intubation, suctioning, major facial trauma).

a. NIOSH-APPROVED N-95 masks (such as a HEPA mask) should be worn whenever there is direct contact with a patient who is known or suspected to have a transmissible respiratory disease (i.e. tuberculosis).

b. Only NIOSH-APPROVED N-95 masks which have been fit-tested for EMS providers prior to use are recommended.

c. Patients with a productive cough and known or suspected transmissible respiratory disease should wear a mask during transport.

C. Cardiopulmonary Resuscitation: Disposable resuscitation masks with one-way valves are carried by all EMS agencies/providers and are easily retrievable when the need arises. NO EMS PROVIDERS SHALL PERFORM UNPROTECTED MOUTH-TO-MOUTH RESUSCITATION.

D. Pregnant EMS providers: Due to the risk to the fetus, pregnant EMS providers must be especially familiar with and strictly adhere to the precautions outlined in this policy.

E. Needles, Syringes and Sharps: Contaminated needles, syringes and other medical sharps are disposed of in a rigid, puncture-resistant container. Full containers are brought to an ~~HSHS St Mary's~~ EMS System facility Emergency Department for proper disposal.

F. Body wastes: Body substances collected in the course of providing patient care (i.e. urine, emesis, suction bottle contents) are placed in a biohazard bag, sealed and left at a designated location at the receiving hospital.

G. Linens and Clothing: Linens soiled with body substances are placed in leak-proof bags. Laundering of linens is done per individual EMS agency arrangements. EMS provider uniforms soiled with body substances must be changed as soon as possible for clean clothing. Soiled clothing is cleaned according to OSHA guidelines.

H. Ambulances and Equipment:

1. Gloves should be worn throughout the cleaning process.

2. Ambulances, cots and all non-disposable equipment should be cleaned with an approved disinfectant after each patient use. Additional sanitation with a 1:10 bleach solution may be used as needed.

3. Laryngoscope blades are to be cleaned and soaked for 15-20 minutes in an approved disinfectant solution then rinsed and air-dried.

Significant Exposure to Body Substances and/or Communicable Disease

A significant exposure to a body substance and/or communicable disease is defined as:

A. Body substance contact:

1. Via a percutaneous puncture by a contaminated needle, or other sharps;
2. On a provider's mucous membranes (eyes, nose, mouth);
3. On a provider's non-intact skin.

B. Exposure to one of the diseases listed in the policy on Communicable Disease Notification.

Any EMS provider with a significant exposure will take the following steps:

A. Immediately clean the area with soap and water and/or alcohol-based foam/liquid. Irrigation is recommended for eye exposure.

B. Report to an appropriate facility (Emergency Department, Occupational Health or other approved facility) for evaluation. Register under Worker's Compensation for your provider agency. If the provider is unsure whether or not the exposure was significant, he or she may contact an ~~HSHS St Mary's~~ EMS System associated ED and talk with the physician or triage nurse on duty.

C. Complete an ~~HSHS St Mary's~~ EMS System Risk Screen, and return the form or faxes it to the EMS office within twenty-four (24) hours of the exposure.

D. The EMS provider will be contacted by the appropriate person at the treating facility (Occupational Health, Emergency Department, Infection Control office) when lab results are available, and will be given follow-up instructions.

E. The EMS provider will contact the ~~HSHS St Mary's~~ EMS office when all follow-up is completed to allow completion of the Risk Screen.

F. The ~~HSHS St Mary's~~ EMS Risk Screen forms are considered confidential are will be kept in a secure location in the EMS office.

Exposure to Communicable Disease Notification

A. If a patient is transported by an EMS agency/provider, and during the normal course of medical events is diagnosed as having a communicable disease, the treating facility is required to notify the EMS agency/provider and the EMS office in writing within seventy-two (72) hours.

B. EMS providers who are exposed to patients with any of the following diseases are required to be notified:

1. Rubella
2. Measles
3. Tuberculosis
4. Meningitis or meningococcemia
5. Mumps
6. Chicken Pox
7. Herpes simplex

8. Diphtheria
9. Human Rabies
10. Anthrax
11. Cholera
12. Plague
13. Poliomyelitis
14. Hepatitis B
15. Louse-borne Typhus
16. Smallpox
17. Hepatitis non A/non B

18. Acquired Immunodeficiency Syndrome (AIDS)
19. AIDS-related complex (ARC)
20. Human Immunodeficiency Virus (HIV) Infection

C. The written notification which is sent to the EMS agency/provider includes the following information:

1. The names of prehospital providers as listed on the prehospital care record.
2. The patient's diagnosed disease.
3. The date that the patient was transported.
4. A statement that this information is to be confidential.
5. Instructions on who the agency/provider is to follow-up with.

D. If a patient with a known Communicable Illness is to be transferred to another facility, the ambulance crew will take the appropriate measures to protect themselves and anybody who may come in contact with the patient. The ambulance will be disinfected with appropriate cleaning supplies prior to leaving the receiving facility.

IV. RESOURCES

~~HSHS St Mary's~~ EMS System Risk Screen

Intercepts

I. PURPOSE

This policy is to establish guidelines when a patient would benefit by an increased level of care during transportation.

II. DEFINITIONS--None

III. POLICY

A. All non-transport agencies that identify patients in need of emergency medical care must notify a transport agency immediately.

B. Intermediate and Basic Life Support agencies that encounter a patient who requires medical care at a higher level of care must call for an intercept as soon as the need is identified. In calling for an intercept, agencies shall abide by the following guidelines:

1. The EMS system follows the standards adopted by the Region 6 Medical Directors Council. Please refer to the Region 6 Intercept Criteria Protocol.

2. The EMS provider with the higher level of medical training takes whatever medical equipment is deemed necessary and boards the unit of the agency with the lesser medical training for the duration of the transport. Areas that might be left without EMS provider services in the response areas may alter this procedure via System Waiver.

3. The EMS provider with the highest level of medical training is responsible for the care of the patient.

4. Activation of an intercept must meet the following standards:

   a. The initial EMS providers must arrive on the scene and assess the mechanism of injury/illness. Mutual aid agreements with Advanced Live Support Providers may supersede this.

   b. The initial EMS providers must assess the patient and identify the adopted Region 6 criteria for activation of an intercept.

c. The initial EMS providers must estimate scene time. Initial EMS providers who have extended scene times with a critical patient must activate an intercept with an ALS agency. A critical patient is one whose medical treatment may be enhanced with advanced care.

d. Ambulances and intercept vehicles contact each other via MERCI or other predetermined frequency to arrange a rendezvous site.

e. Pertinent patient care information is transmitted to the intercepting EMS providers prior to the rendezvous, including chief complaint, level of consciousness and respiratory status.

C. The initial transport agency will continue to transport the patient, with the higher level of care personnel and equipment boarding the unit. The only time the patient would move from the initial unit to the intercepting unit would be if the primary unit was not able to continue on due to mechanical issues.

IV. RESOURCES--None

Interfacility Transfers (Region 6 Policy)

I. **PURPOSE**

This is to provide consistent guidelines to Region 6 EMS agencies/providers and hospital personnel for interfacility/interregional transports.

II. **DEFINITION—None**

III. **POLICY**

This policy assumes that all EMS agencies/providers that provide interfacility/interregional transports have had System-Specific education/training for such transports.

A. An attending physician, Emergency Department physician, or physician designee will authorize or request interfacility transports.

B. The transferring physician or physician designee will determine the appropriate receiving facility.

C. The transferring physician or physician designee will receive confirmation of acceptance of the patient from the receiving facility and the receiving physician or physician designee.

D. It is the responsibility of the transferring physician or physician designee to indicate what level of service and care is required for the transport based on the severity/complexity of the patient condition.

E. EMS agencies providing interfacility transports may only function to their level of licensure as defined by the National EMS Education Standards and Department regulations unless otherwise stated in this policy.

F. Any patient requiring care at a level higher than the highest level of prehospital care provider available must be transported with an RN or other appropriate professional personnel.

G. Prior to the transport, EMS providers must obtain written orders from the transferring

physician or physician designee for all fluids and/or medications being transferred with the patient. EMS providers may only administer/monitor fluids and medications listed within this policy and the Region 6 Protocols.

H. A ***Transfer Time-Out*** shall be conducted for each interfacility transfer prior to initiating transport

Online Medical Control

A. Medical Control (MC) may be defined as either the EMS Medical Director, the transferring or receiving MD and as a last resort, the ED physician of the transferring or receiving hospital.

B. In any situation that the EMS Provider needs to contact a physician for medical direction, they will first attempt to contact the transferring physician or the receiving physician. If unable to reach either one, the EMS MD may be contacted. As a last resort, use on-line medical control at the sending or receiving facility. Any orders from on-line medical control will supersede written orders.

C. If the EMS provider is unable to contact the receiving or sending facility, the EMS provider will follow Region 6 EMS Protocols until contact can be established. In a situation when medical control is unreachable and intervention is necessary, the transport team will divert to the nearest appropriate facility.

Considerations for Transport

A. Any Region 6 agency reserves the right to deny transport under the following conditions

1. If providing the interfacility transport will impede the ability for the agency to provide 911 responses within their response area due to staffing or equipment.
2. If it is deemed the patient is not stable enough for ground transport after consultation with the Medical Director or Medical Control.
3. If the safety of the patient and crew is at significant risk (i.e. weather, road conditions, violent patient, etc.).
4. Patients in active labor (when birth is imminent).
5. Active CPR in progress.

Requesting Additional Personnel

A. When the EMS provider anticipates that they will require more assistance to appropriately care for the patient during transfer, they shall request the transferring physician/health care provider to provide appropriately trained hospital staff to accompany the patient and assist. The EMS provider must contact Medical Control for medical direction in all situations where they are not comfortable with the circumstances of the transfer. **The transfer will not occur unless the EMS provider and Medical Control are confident the personnel and equipment are appropriate for transfer.**

Levels of EMS Interfacility Transports:

Basic Life Support (BLS) Interfacility transport Minimum Staffing: two (2) EMT-Basic providers.

Includes basic airway management, cardiopulmonary resuscitation including the use of AED's, basic shock management and control of bleeding, basic fracture management and medications within the Region 6 BLS Protocols:

Aspirin
Nitroglycerin (sublingual only)
Epinephrine 1:1000 (anaphylaxis only)
Naloxone
DuoNeb
Oral Glucose

Zofran

Basic Providers may also transport patients with the following:

Foley catheters
Gastric devices (i.e. NG tubes, G-tubes, ostomy equipment)
Saline locks
Wound drains
Clamped Vascular Devices (i.e. Central lines, Groshong catheters, PICC lines)*
`*** May not be accessed by Basic Providers.**

AEMT/Intermediate Life Support (ILS) interfacility transport Minimum staffing: 1 AEMT/Intermediate and 1 EMT-Basic

Includes all BLS services, cardiac monitoring, IV cannulation/fluid therapy, advanced airway management and medications within the EMS System's AEMT/ ILS protocols.

ILS providers may also transport patients with the following:

CPAP/BiPAP
IV infusion pumps **Advanced Life Support (ALS) Interfacility transport Minimum Staffing: one (1) EMT-Paramedic or Prehospital RN and one (1) EMT Basic**

Includes all BLS and ILS services, cardiac monitoring (including cardiac pacing, manual defibrillation, and cardioversion), and administration/monitoring of medications within the Region 6 ALS Protocols.

Adenosine
Amiodarone
Atropine
Aspirin
Dextrose 50%
Hypertonic Saline 3.3%
Lidocaine
Magnesium Sulfate
Methylprednisolone
Midazolam

Dextrose 10%
Diltiazem
Diphenhydramine
Dopamine
DuoNeb
Epinephrine 1:1000
Epinephrine 1:10,000
Fentanyl
Glucagon
Morphine
Naloxone
Nitroglycerin
Ondansetron
Oral Glucose
Sodium Bicarbonate
Tranexamic Acid

The following additional fluids and medications may also be transported by ALS providers:

All crystalloid and colloid solutions
Blood and blood products (already initiated)
IIb/IIIa glycoprotein inhibitors (*Aggrastat, Reopro, Integrillin*)
Antibiotics
Atenolol
Calcium Chloride
Calcium Gluconate
Cardene (drip only)
Dexamethasone sodium phosphate
Diazepam
Dobutamine
Fentanyl drip
Fosphenytoin
Heparin drip
Hydralazine
Propranolol (drip only)
Protonix
Hydrocortisone sodium succinate
Hydroxyzine
Isoproterenol
Ketorolac
Labetalol (drip only)
Levophed
Lorazepam
Mannitol
Nifedipine (tabs)
Nitroglycerin drip
Oxytocin
Octreotide
Phenobarbital (drip only)
Potassium (no faster than 10mEq/hr)
Racemic Epinephrine
Sodium Nitroprusside

****If not listed above or in the Region 6 Protocols, a Registered Nurse is required to accompany the patient during transfer/transport. If the Paramedic is "Expanded Scope, Tier I" certified, then a Registered Nurse is not needed for transport.**

One additional appropriately licensed healthcare provider in the patient compartment is required for the following:

All intubated patients*

ALS providers may also transport patients with the following:

Pain medication pumps
Femoral artery sheaths
Chest tubes; with written physician orders. If mechanical suction, the amount of

mechanical suction must be specified. Refer to "CHEST TUBE-POST INSERTION MANAGEMENT" in the Region 6 Care Guidelines.

***Does not apply to stable ventilator-dependent trach patients, unless the Paramedic is "Expanded-Scope, Tier I" certified.**

****If not listed above or in the EMS System's protocols, a Registered Nurse is required to accompany the patient during transfer/transport.**

Mutual Aid Agreements

i. PURPOSE

The purpose of this policy is to provide consistent guidelines and minimum expectations for mutual aid situations.

II. DEFINITION—None

III. POLICY

A. All EMS agencies in the ~~HSHS St Mary's~~ EMS System, both transport and non-transport must maintain current Mutual Aid Agreements to ensure adequate coverage of their service area at all times.

B. Non-transport agencies must have current Mutual Aid Agreements with transporting agencies. These must be reviewed every two (2) years.

C. When additional resources are required by an EMS agency, Mutual Aid Agencies are contacted for assistance.

D. The Mutual Aid Box Alarm System (MABAS), signed by all members of the ~~HSHS St Mary's~~ EMS System will be considered the mutual aid agreements for the ~~HSHS St Mary's~~ EMS System.

E. Copies of these signed agreements are kept by the Red Center of MABAS.

IV. REFERENCES--None

Nearest Facility By-Pass

I. **PURPOSE**

This policy is to identify circumstances in which by-passing the nearest facility would be acceptable for ~~HSHS St Mary's~~ EMS System participants.

II. **DEFINITION—None**

III. **POLICY**

Communication:

A. EMS providers at the point of patient contact will initiate communications with the EMS System hospital. The hospital initiating the bypass or EMS personnel involved will contact the receiving facility to relay the patient assessment findings.

Patient Care Practice:

A. Prehospital patient care will be provided to all adult and pediatric patients in accordance with the ~~HSHS St Mary's~~ EMS System protocols specific to the providers' level of licensure and appropriate for the patient as determined through patient assessment findings. EMS patients may only be transported to an emergency department classified as comprehensive under the Illinois Hospital Licensing Act.

Transport of Patients with Special Needs/Requests:

A. Patient care circumstances may indicate the need to bypass the nearest hospital in order to manage the needs of the patient based on the presenting assessment. Situations involving special needs may include, but are not limited to:

1. Level I trauma care
2. Specialized services
3. Patient request for transport to a specific health care facility

B. The decision to approve or deny a transport rests with the ~~HSHS St Mary's~~ EMS System Medical Director or his/her designee responsible for the on-line medical direction of the call.

1. Severity of the patient condition
2. Time and distance factors which may affect the patient outcome
3. Regional trauma guidelines
4. Mental capacity

System By-pass/Diversion:

A. Transfer patterns are considered in the notification of EMS agencies when a bypass/diversion situation exists. Neighboring hospitals which may be impacted by the situation will also be notified. There are specific instances where bypass/diversion may not be possible:

1. The patient is critical and unable to tolerate transport to a more distance comprehensive care facility.
2. The patient refuses transport to another medical facility
3. OB emergencies.

Quality Assurance/Continuous Quality Improvement

A. Patient care issues related to inter-system or inter-region transports will be directed to the ~~HSHS St Mary's~~ EMS System Coordinator for follow-up. Unresolved issues will be managed in accordance with System and Regional conflict resolution policies.

IV. REFERENCES—None

Patient Interactions

I. PURPOSE

The purpose of this policy is to define who is responsible for patient care in the prehospital setting within the East Central Illinois EMS System.

II. DEFINITION – None.

III. POLICY

A. Whoever is deemed in charge of patient care directs patient care in accordance with Region 6 Protocols, Care Guidelines, and East Central Illinois EMS System policies. Patient care responsibility shall be determined as follows:

1. The EMS provider with the highest level of licensure is in charge of patient care in the prehospital setting.
2. If two or more providers have the same level of licensure, the provider with the most experience at that licensure level is in charge of patient care.
3. If two prehospital providers have equal licensure and experience, then the first to make patient contact is in charge of patient care.
4. For the purposes of determining responsibility for patient care at the scene, the following chain of command is used:

    i. Paramedic/Prehospital RN
    ii. AEMT/Intermediate
    iii. Basic
    iv. Emergency Medical Responder

B. Access to the patient and performance of medical care shall be at the direction of the prehospital EMS provider in charge at the scene. This policy is subject to change with regard to the restrictions encountered in a Major EMS Incident.

C. The EMT in charge at the scene can only provide care at the level of licensure of the agency that the EMT represents on that call.

D. If a controversy and/or a disagreement as to protocol or policy arises and Medical Control cannot be contacted for guidance, the EMS provider in charge at the scene takes responsibility for making the final decision.

E. The EMS provider in charge at the scene delegates patient care in the field, and is responsible for the decisions made in delegation.

F. The EMS provider's duty to perform all services and all patient care decisions are to be made without unlawful discrimination (i.e. race, color, age, religion, gender, ethnic background or sexual orientation).

IV. REFERENCES – None

School Bus Incidents (Region 6 Policy)

I. PURPOSE

This policy governs the handling of school bus accidents/incidents involving the presence of minors. This policy is based on the Region 6 School Bus Incident policy. The goal of this policy is to eliminate the transport of uninjured children/students to the hospital and to reduce EMS scene time and utilization of rescue.

II. DEFINITION—None

III. POLICY

Each EMS agency/provider within the ~~HSHS St Mary's~~ EMS System shall follow this procedure in coordination with school officials.

A. Determine the category of the accident/incident:

1. Category 1 bus accident/incident: significant injuries present in one or more children/students, or there is a documented mechanism of injury and/or extent of damage to the vehicle that could reasonably be expected to cause significant injuries.

2. Category 2 bus accident/incident: Minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students are also present.

3. Category 3 bus accident/incident: no injuries present in any children/students and no significant mechanism of injury present.

B. Determine if implementation of this policy is appropriate.

1. Category 2 or 3 bus accident/incident: Implement the School Bus Incident Policy. Follow Region 6 Triage Protocol if necessary to transport children/students to the hospital.

2. Category 1 bus accident/incident: Do not implement the School Bus Incident Policy. Follow Region 6 Triage Protocol if necessary to transport children/students to hospital.

C. Contact medical control and advise of the existence of a Category 2 or 3 bus accident/incident. Determine if a scene discharge of uninjured children/students by the Emergency Department physician in charge of the call is appropriate.

D. Children/students determined to be injured by exam and/or complaint shall be treated and transported by EMS personnel. All children/students with special healthcare needs and/or communication difficulties shall be transported to the hospital.

E. Contact school officials. It will be the responsibility of the school officials to inform the parents/legal guardians of the accident/incident.

F. This procedure may include the option of the ambulance service provider escorting the bus back to the school of origin or other appropriate destination.

G. Medical Control, after consulting with scene personnel, may discharge the uninjured children/students to the care of the ambulance service provider, who then will release the children to parents/legal guardians or school officials.

H. Authorized school representatives shall utilize the School Bus Incident log and sign the log sheet. The school's representative's signature indicates acceptance of responsibility for the children/students after medical clearance by the EMS personnel. The school representatives will then follow their own policies, which shall include informing the parents/legal guardians in regard to the bus accident/incident.

I. Any child/student having reached the age of eighteen (18) years of older and any adult non-student present on the bus will initial the log sheet adjacent to their name when in agreement that they have suffered no injury and are not requesting medical care and/or transport to the hospital.

J. Complete one (1) prehospital care report form in addition to the School Bus Incident log.

This policy addresses discharge disposition of uninjured children/students only, thus no individual release/AMA signatures are necessary. An isolated abrasion or superficial wound can be regarded as uninjured should the EMS personnel and medical control concur.

This policy is also applicable for school/student incidents not involving a bus is deemed appropriate by the responding EMS agency and evaluated and executed in a like manner.

SCHOOL BUS INCIDENT LOG

DATE	LOCATION	SCHOOL DISTRICT	BUS NUMBER
INCIDENT REPORT	**TOTAL PERSONS**	**TRANSPORTED**	**NOT TRANSPORTED**

ADULT NAME (NON STUDENT)	AGE	REFUSAL INITIAL (over 18)

CHILD/STUDENT NAME	AGE	REFUSAL INITIAL (over 18)

The Children listed above have been determined to be uninjured. Medical Control has been contacted and approved release of custody to school officials or parents/legal guardians or to self if age 18 or older.

_____//_____

Responding Agency School Representative

_____ _____

Signature of Responding Agency Date Signature of School Representative Date

SCHOOL BUS INCIDENT LOG

CHILD/STUDENT NAME	AGE	REFUSAL INITIAL (over 18

The Children listed above have been determined to be uninjured. Medical Control has been contacted and approved release of custody to school officials or parents/legal guardians or to self if age 18 or older.

_____//_____

Responding Agency (print) School Representative (print)

_____//_____

Signature Date Signature Date

Use of Aeromedical Resources

I. PURPOSE

This policy is to provide guidelines for the appropriate use of aeromedical resources.

II. DEFINITION—None

III. POLICY

Aeromedical transport offers many critically ill or injured patients rapid transport to specialized centers. However, it is inherently more dangerous and expensive for providers and patients. It must be used responsibly. The EMS Office encourages aeromedical utilization in appropriate circumstances.

A. Aeromedical resources may be used in the following situations:

1. When emergency personnel determine that the time needed to transport a patient by ground to an appropriate facility poses a threat to the patient's survival and recovery.
2. When weather, road, or traffic conditions would seriously delay the patient's access to ALS care;
3. When critical care personnel and equipment are needed to adequately care for a patient during transport.

B. General Guidelines:

1. In general, when the transport of a seriously injured trauma patient will take more than thirty (30) minutes by ground ambulance to the nearest appropriate Trauma Center, aeromedical resources should be considered.
2. Patient transportation via ground ambulance should not be delayed to wait for

helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance, then the transportation should be initiated by ground ambulance.

3. Helicopter transport may NOT be appropriate for patients in cardiac arrest.
4. Personnel at the scene shall notify their dispatcher if aeromedical resources are needed (See Criteria for Field Activation of Aeromedical Transport by EMS).
5. If aeromedical resources are dispatched, and ALS ground unit shall be dispatched at the same time (if not already on scene or enroute.
6. Medical Control must be kept informed of any situation in which aeromedical resources are used.

C. Safety Precautions:

1. Never allow ground personnel to approach the helicopter unless requested to do so by the pilot or flight crew.
2. The pilot and/or flight crew will determine which personnel are absolutely necessary to assist with loading and unloading of patients.
3. Secure any loose clothing or items that could be blown about by rotor wash, such as blankets, pillows and sheets.
4. Allow no smoking
5. After the aircraft is parked, move to the front, beyond the perimeter of the main rotor blades and wait for a signal from the pilot.
6. Approach the helicopter from a crouched position, staying within view of the pilot or other crew members.
7. Never approach the rear of the aircraft.
8. Long objects should be carried horizontally and no more than waist high.
9. All IVs should be placed in pressure bags and secured to the patient.
10. Depart the helicopter from the front and within view of the pilot.

Line of Duty Death

I. PURPOSE

This Policy is to define the procedures in the event there is a Line of Duty Death of a licensed EMS provider at any level.

II. DEFINITION

III. POLICY

The profession of EMS provider, whether paid or volunteer is a dangerous one. From responding in vehicles to the scene, providing care in uncontrolled conditions to transporting to the hospital at a high-rate of speed, injuries and deaths can occur in accidents and episodes of violence.

A Line of Duty Death is any time a licensed EMS provider suffers mortal injuries while engaged in the activity of responding, providing care, or returning to duty as an EMS provider. In the case of a volunteer agency, then that would include responding to or returning from a call. If the licensed EMS provider dies within twenty-four (24) hours after a response, it will be considered a Line of Duty Death. (i.e. fatal heart attack, stroke, etc.)

In the event that a licensed EMS provider dies during, or due to injuries or illnesses sustained while providing care, the agency is to notify the ~~HSHS St Mary's~~ EMS Coordinator within twenty-four (24) hours of the event.

The agency will submit to the ~~HSHS St Mary's~~ EMS Coordinator a copy of the Patient Care Report, a copy of the agency's response report (incident report) and a written report of the incident that caused the provider's death.

The ~~HSHS St Mary's~~ EMS Coordinator will then notify the IDPH Division of EMS and Highway Safety, and the State Regional Coordinator the next business day with the information submitted to the Coordinator by the affected agency.

Concealed Carry Weapons

I. PURPOSE

This policy is to outline common expected procedures for intervening with patients and/or their families who under the law may be carrying a concealed deadly weapon. The intent is to reduce the potential risk 0f injury to emergency responders, healthcare personnel and the public. This policy aims to mutually respect the right of citizens who lawfully carry a concealed weapon as well as to provide safety for emergency responders and healthcare providers.

II. DEFINITION—None

III. POLICY

A. The ~~HSHS St Mary's~~ EMS System policy is that EMS personnel who have a Conceal Carry Weapon Permit shall not knowingly bring any firearm onto any prohibited area.

B. At no time shall open carry (OC) and/or Conceal Carry Weapon (CCW) be permitted when on official EMS business, to include meetings, emergency response, training or any other function of the ~~HSHS St Mary's~~ EMS System, or any EMS organizations' properties. The only exception to this is if the EMS provider is a sworn law enforcement officer that is on duty at that time.

C. It is also the policy of the ~~HSHS St Mary's~~ EMS System that patients and visitors shall not have weapons on their persons while on any and all EMS property which also includes transport and/or non-transport vehicles.

Applicable Scenarios

1. Conscious patients willing to relinquish a weapon
2. Conscious patients unwilling to relinquish a weapon
3. Patients with altered levels of consciousness
4. Family members and/or friends of a patient who have weapons and want to be with the patient in emergency response vehicles
5. Chain of custody transfer between emergency responders and medical facilities

General Guidelines

A. Emergency responders and healthcare personnel should always assume that all firearms are loaded.

B. Optimally, weapons should be safely secured by the patient at their residence and not be transported with the patient or family/friend in an emergency response vehicle or to a healthcare facility.

C. Optimally, a patient with a CCW away from their residence should be taken control by local law enforcement. The goal is for the EMS provider to minimally handle any weapon.

D. All ~~HSHS St Mary's~~ EMS System members who are licensed to carry a concealed weapon and doing so at the time of a call should secure their weapon either at home or in their personal vehicle prior to entering the station, entering response equipment or entering a scene.

E. For EMS personnel with a CCW arriving on scene from home, the weapon must remain secure in their personal vehicle. Privately remove the weapon and place the weapon in the lock box in their personal vehicle. Place the key in a pocket until the weapon has been retrieved after completion of the call.

F. Patients with an altered level of consciousness, severe pain, or with difficulties in motor control should not be encouraged to disarm themselves. An emergency response or healthcare worker may need to obtain control of the weapon for the safety of responding personnel, the public and the patient. Caution should be used at all times when handling a weapon. Emergency response and healthcare workers should not attempt to unload a firearm. Regardless of a person's familiarity with firearms, there is no way to know if the gun is in proper working order.

G. A public or private hospital, hospital affiliate, hospital parking lot, nursing home or mental health facility is a no carry zone. Other no carry zones include:

1. Any building, real property, and parking area under the control of a public or private elementary or secondary school.
2. Any building, real property, and parking area under the control of a preschool or child care facility, including any room or portion of a building under the control of a pre-school or child care facility.
3. Any building, parking area, or portion of a building under the control of an officer of the executive or legislative branch of government.

4. Any building designated for matters before a circuit court, appellate court, control of the Supreme Court.
5. Any building or portion of a building under the control of a unit of local government.
6. Any building, real property, and parking area under the control of an adult or juvenile detention or correctional institution, prison, or jail.
7. Any bus, train, or form of transportation paid for, in whole or in part with public funds, and any building, real property, and parking area under the control of a public transportation facility paid for in whole or in part with public funds.
8. Bars or other establishments that serve alcohol.
9. Any public gathering or special event conducted on property open to the public that requires the issuance of a permit from the unit of local government.
10. Any public playground.
11. Any public park, athletic area, or athletic facility under the control of a municipality or park district.
12. Any building, classroom, laboratory, medical clinic, hospital, artistic venue, athletic venue, entertainment venue, officially recognized university-related organization property, whether owned or leased, and any real property, including parking areas, sidewalks, and common areas under the control of a public, or private community college, college, or university.
13. Any building, real property, or parking area under the control of a gaming facility licensed under the Riverboat Gaming Act or the Illinois Horse Racing Act of 1975, including inter-track wagering location licensee.
14. Any stadium, arena, or the real property or parking area under the control of a stadium, arena, or any collegiate or professional sporting event.
15. Any building, real property, or parking area under the control of a public library.
16. Any building, real property, or parking area under the control of an airport.
17. Any building, real property, or parking area under the control of an amusement park.
18. Any building, real property, or parking area under the control of a zoo or museum.
19. Any street, driveway, parking area, property, building, or facility, owned, leased, controlled, or used by a nuclear energy, storage, weapons, or development site or facility regulated by the federal Nuclear Regulatory Commission. The licensee shall not under any circumstance store a firearm or ammunition in his or her vehicle or in a compartment or container within a vehicle located anywhere in or on the street, driveway, parking area, property, building, or facility descried in this paragraph.
20. Any area where firearms are prohibited under federal law.

H. EMS agencies are encouraged to designate themselves as a weapons-free facility. No-carry signage should be clearly posted in emergency squads and EMS facilities. Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles or in hospitals that have declared themselves as no-carry zones.

I. Under no circumstances should an emergency responder or healthcare worker compromise his/her safety in regards to these guidelines. When in doubt about a patient with a weapon or the weapon itself, emergency responders and healthcare personnel should contact local

law enforcement. Law enforcement officers will make the decisions regarding disarming the patient and the weapon.

1. **Note:** *Do not ask the patient whether he/she has the right to carry a weapon. If the person has no legal right, they may become alarmed and cause EMS personnel harm.*
2. All weapons are removed from the patient. The only exception is a conscious and alert law enforcement officer. No EMS personnel shall provide medical care to an armed person.

Conscious Patient Willing to Relinquish a Weapon

A. Patients who are alert and oriented and for whom the emergency response is occurring at their place of residence should be asked to leave their weapons in a secure location at home prior to transport. Patients should be told that EMS vehicles are no carry zones.

B. Patients for whom the emergency response is occurring away from their residence may relinquish their weapon to law enforcement officer on scene if one is available.

C. If patient is not at their residence or if a law enforcement officer is not available, emergency response personnel should do the following:

1. Place weapon into a "Lock Box."
2. Secure the Lock Box with a numbered security seal and place the Box in a locked exterior vehicle compartment for transport.
3. Complete and have the patient sign the Chain of Custody Form (Attachment A).
4. Conduct a thorough secondary survey.
5. If additional weapons are found, begin again at Step (1). If no additional weapons are found, load the patient into the vehicle and transport to an appropriate medical facility.
6. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
7. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at he medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.
8. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody form.*

Conscious Patient Unwilling to Relinquish a Weapon

A. Emergency responders should engage alert and oriented patients in calm discussion about the rationale to secure the weapon prior to transport. Simple explanations can be given including that these regional guidelines are in place.

B. If the patient continues to refuse to relinquish the weapon, emergency responders should refrain from continuing the assessment and from transporting to a medical facility.

C. EMS Providers should be suspicious of ill or injured patients unwilling to relinquish weapons.

D. Law enforcement shall be called to intervene in the situation.

E. If the situation becomes threatening, emergency responders should evacuate the scene to a secure rendezvous point a safe distance away and notify law enforcement.

Patients with Altered Levels of Consciousness

A. Emergency responders must use extreme caution when approaching patients with altered levels of consciousness.

B. If a weapon is found on an awake patient with an altered level of consciousness, emergency responders should not attempt to have the patient hand over the weapon. EMS personnel should not attempt to remove a weapon from a patient whose level of consciousness could precipitate use of that weapon against them. Law enforcement should be called to assist in disarming these patients. If a weapon is removed by a law enforcement officer, the officer will maintain possession of the weapon.

C. If the patients unconscious and requires emergent care but law enforcement is not on the scene, emergency medical services (EMS) personnel will need to carefully separate the weapon from the patient prior to transport. **Optimally a firearm should be removed from the patient while still in the holster.** If removing the holster and weapon together jeopardizes the safety of the patient or emergency response personnel, or it is physically impossible to remove the holster and firearm together, the weapon may be removed without the holster. Once removed, emergency response personnel shall:

1. Handle all weapons carefully as they will most likely be loaded and may not have an engaged safety.
2. Place the weapon or weapon-in-the-holster into the Lock Box.
3. Secure the Lock Box with a numbered security seal and place the Box in the locked exterior vehicle compartment for transport.
4. Complete the *Chain of Custody Form.*
5. Conduct a thorough secondary survey.
6. If additional weapons are found and removed, begin again at step (1). If no additional weapons are found, load the patient into the vehicle and transport to an appropriate medical facility.
7. While en route, emergency response personnel shall notify the receiving facility that a weapon is being transported with the patient.
8. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility

doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.

9. Medical facility and emergency response personnel shall document the transaction on the *Chain of Custody Form.*

Family Members and Friends Who Have Weapons and Want to be with Patients in Emergency Response Vehicles

A. The decision to transport family members and/or friends with the patient solely rests with existing policies of individual emergency response agencies.

B. Agencies that permit transport of family/friends with the patient shall;

1. Ask the family member/friend to declare if they have a concealed weapon.
2. Explain that no unsecured weapons may be transported in the emergency vehicle.

C. If a family member/friend discloses a concealed weapon AND the patient's condition is such that the emergency medical personnel deem it in the best interest of the patient to transport the family member/friend with them:

1. The family member/friend should be instructed to leave the weapon in a secure place at the home. If the family member/friend refuses, emergency response personnel have the prerogative to decline transport of the family member/friend with the patient. No family member/friend should be transported with an unsecured weapon.

D. If the scene is not at the family member's/friend's residence, or circumstances prevent the weapon from being secured in the home:

1. Have the family member/friend place the weapon into a Lock Box.
2. Secure the Lock Box with a numbered security seal and place the Box in a locked exterior vehicle compartment for transport.
3. Complete and have the family member/friend sign the *Chain of Custody Form* (Attachment A).
4. If additional weapons are discovered, begin again at Step (1). If no additional weapons are discovered, load the patient into the vehicle and transport to an appropriate medical facility.
5. While en route, emergency response personnel shall notify the receiving facility that a Lock Box weapon is being transported with the patient.
6. The medical facility security personnel or local law enforcement (if the hospital does not have security staff) shall meet the transport vehicle at the medical facility doors to take control of the weapon. Emergency response personnel shall hand over the Lock Box with numbered locks in place.

Activities Which Shall Result in Immediate Licensure Suspension

A. Attempting to engage a "safety" or undoing a "safety" on a handgun, stun gun or pepper spray.

B. Treating a gun as if it were not loaded.

C. Unloading a gun.

D. Failure to place a weapon in a Lock Box.

E. Showing off a weapon or flashing a weapon.

F. Making remarks about violence with a weapon

G. Bringing a weapon into a prohibited area while on duty.

IV RESOURCES—None

Advanced Provider Agency Sharing

I. PURPOSE

This policy is to permit on-the-scene EMS provider assistance while maintaining ~~HSHS St Mary's~~ EMS System Standards

II. DEFINITION—None

III. POLICY

A. When an EMS response agency first arrives to treat an EMS patient, the scope of the care they can provide is clearly dictated by that agency and vehicle's IDPH certification, regardless of their individual licensure. When an ALS transport vehicle is on scene, we then utilize the Illinois shared servant doctrine to allow the transport paramedic to engage the skills of other providers on scene. If so requested, these providers may then work up to their individual level of maximum state licensure, as a voluntary extension of the transport paramedic's own skills.

B. An EMT-I or Paramedic responding with a lower level agency is never "required" to perform advanced interventions with the ambulance. But if they wish to voluntarily assist the paramedic in a critical or multi-patient scene, we welcome that help for our transport medics. As a practical matter, it is often in the best interest of the patient.

C. The ultimate responsibility for the call overall and for every procedure performed falls to the transport paramedic. Therefore they are responsible for everything done to their

patient, including any intervention performed by others. For this reason, we grant complete discretion to the transport medic on scene as to whether, and for what, they accept assistance from such other personnel on scene. Any time such individuals perform any skill beyond those contained in the scope of their own response agency; they must be listed on the ambulance transport run ticket as additional crew. The interventions they performed should be delineated in the ambulance transport narrative.

D. This same doctrine applies in the circumstance where an off-duty member of the transport service or of a local first response agency is present on scene. The transport paramedic on duty may use their discretion to enlist such assistance, when it is judged to be in the medical best interest of the patient.

IV. RESOURCES--None

Transport of Law Enforcement K-9's

I. PURPOSE

It is the intention of the ~~HSHS St Mary's~~ EMS System, and its affiliate agencies to be cooperative partners within the public safety community. The EMS System authorizes, but does not require agency affiliates to transport police K-9's.

II. DEFINITIONS

In 2017 the state of Illinois amended the EMS System act with passage of Public Act 100-0108. That legislation authorizes the following:

"An EMR, EMT, EMT-I, A-EMT, or Paramedic may transport a police dog injured in the line of duty to a veterinary clinic or similar facility if there are no person requiring medical attention, or transport at that time. For the purposes of this subsection, "police dog" means a dog owned or used by a law enforcement department or agency in the course of the department or agency's work, including a search and rescue dog, service dog, accelerant detection canine, or other dog that is in use by a county, municipal, or State law enforcement agency."

III. POLICY

A. EMS agencies have the individual discretion and autonomy to decide whether or not they will transport police dogs. If an agency chooses to provide this service, they must do so in compliance with this policy.

B. All human patients must be transported or dispositioned in accordance with the systems Patient Right of Refusal Policy and/or Patient Abandonment vs Prudent use of EMS Resources Policy.

   a. The severity of injuries or lack thereof to either a human patient or the K-9 is irrelevant. The human patient will always have priority.

C. Under no circumstance shall an injured K-9 be transported with a human patient. The only acceptable exception to this would be the transport of an injured law enforcement officer and an injured police K-9.

   a. In this instance, the law enforcement officer will be transported to a hospital first. The K-9 can then be transported to a veterinary clinic or similar facility.

D. Under no circumstance shall an injured K-9 be transported to a hospital, as defined by its standard definition and connotation for emergency care.

E. Items, which EMS agencies are required to have prescription to purchase such as medications, IV fluids, IV catheters, needles, ET tubes, etc. are prescribed by the EMS System Medical Director. The intended use for these prescription supplies and medications is for use on human patients.

   a. As a result, ILS/ALS services may not perform advanced level procedures on K-9's.
   b. EMR/BLS/ILS/ALS providers are prohibited from administering medication to K-9's other than Oxygen or Naloxone.

F. If a Doctor of Veterinarian Medicine, is on the scene, then he/she may utilize supplies and medications that are available on the ambulance, with the exception of controlled substances.

G. The EMS System is not empowered or authorized by the EMS System Act, the Medical Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, or any state administrative rule to create protocols or in any way regulate the practice of veterinary medicine. Related there is no authority for an EMS System to create protocols for the provision of pre-hospital care to animals of any kind.

H. As a result of sections 5 and 6 above, the EMS provider should confine their interventions to transport, BLS bleeding control, and/or basic first aid. It is acceptable to administer oxygen therapy utilizing a pet oxygen mask system. a. As Naloxone administration has been included in the basic first aid curriculums for the public, EMS providers at any level may administer Naloxone if necessary to a police K-9. If administered the dosage recommended is 2 mg for an average sized police dog.

I. As there is no patient provider relationship established, the EMS System does not make a recommendation in regards to the permissibility of the use of lights and sirens in transporting injured police K-9.

J. Due to the protective instincts of these animals it is recommend that the animal be transported with a handler who is familiar with the commands with which the dog was trained.

K. Due to the protective instincts of these animals it is strongly recommended that the animal be transported with a muzzle if practical, to protect EMS providers from the possibility of being bitten.

a. Should an EMS provider be bit, that provider shall follow the significant exposure procedure for their agency in additions to following the procedures outlined in the system communicable disease policy.

b. n addition to the standard communicable disease policy, verification of the K-9's rabies vaccination status.

L. Agencies which have a working relationship with a law enforcement agency that regularly employs the use of K-9's are encouraged to have a conversation beforehand to identify a plan of action for these situations that is consistent not only with this policy, but also the policies and procedures of the involved law enforcement agency.

Communications