Medical-Legal Policies

Abuse

I. PURPOSE

This policy is to identify victims of abuse and provide the guidelines for prompt treatment and appropriate referral to support services for potential victims of abuse, including children, adults and the elderly.

II. DEFINITION—NONE

III. POLICY

A Child Abuse or Neglect

1. The alleged victim is a child under the age of eighteen (18).
2. All EMS personnel are required by Illinois law (Mandated Reporters) to report any suspicion of child abuse or neglect to the Department of children and Family Services (DCFS) in accordance with the Abused and Neglected Child Reporting Act.
3. Mandated reports are required to call the Child Abuse Hotline when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. The Hotline worker will determine if the in by the reporter meets the legal requirements to initiate an investigation. Only one report per ambulance, fire department, etc., needs to be filed.
    a. **DCFS Child Abuse Hotline 1-800-252-2873 (1-800-25-ABUSE)**
4. No assumption should be made that law enforcement or hospital personnel will file a report. In the event there is disagreement between mandatory reporters, the person suspecting the alleged abuse shall complete the necessary reporting requirements.
5. The law does not require certainty. It requires only that there be reasonable cause to believe that a child has been abused and/or neglected. Any person participating in good faith in the making or a report shall have immunity from any liability, civil, criminal or that otherwise may result by reason of such actions.

B. Elder Abuse and Neglect.

1. All EMS personnel are required by Illinois law (Mandated Reporters) to report any suspicion of child abuse or neglect to the Department of children and Family Services (DCFS) in accordance with the Abused and Neglected Child Reporting Act.
2. Identification of abuse, neglect, self-neglect, or interpersonal violence can occur at any time during the examination, history and physical exam or other assessments

performed by members of the prehospital team. This identification can be made in any setting.

3. If abuse or violence is suspected, it is important to safely isolate the patient (victim) from the alleged perpetrator. Safety of the EMS team must be a first priority.

4. For those suspected of elder abuse, contact the Department of Aging, Elder Abuse Hotline to make a report.

   a. **Elder Abuse Hotline 1-800-252-8966** during business hours
   b. **1-800-279-0400 after 5:00pm or on weekends**

C. Long-Term Care Facility Residents Abuse and Neglect

1. EMS personnel who have identified that a long-term care facility resident is a possible victim of abuse or neglect should report their suspicions to the receiving hospital ED personnel.

   a. **Elder Abuse Hotline for Nursing Home/Extended Care Facility Residences: 1-800-252-4343**

2. Any Mandated Reporter have reasonable cause to suspect a resident of a long-term care facility has died as a result of abuse or neglect, shall also immediately notify the appropriate medical examiner or coroner.

D. Reporting of abuse:

1. All EMS personnel are required under the Illinois EMS Act to offer to a person suspected to be the victim of abuse immediate and adequate information regarding services available to victims of abuse in accordance with the Illinois Domestic Violence Act.

   a. **Illinois Domestic Violence Help Line: 1-877-862-6338**

2. When evidence of physical injuries exists, law enforcement is notified by the EMS provider. The law enforcement agency notified should be from the residence city or county area in which the patient resides.

3. For the competent adult patient, when there is evidence of psychological/emotional abuse without physical injuries, law enforcement officials are contacted at the patient's request.

4. For minors and patients not competent to give consent, when there is evidence of psychological and/or emotional abuse without physical injury, Medical Control and law enforcement officials are contacted.

E. All pertinent information will be documented in the prehospital report.

F. All information obtained during treatment remains confidential.

IV. RESOURCES--None

Advanced Directives and Do Not Resuscitate

I. PURPOSE

This policy is to assure consistent guidelines for EMS providers regarding DNR Orders/Illinois POLST form, Durable Power of Attorney for Health Care, Surrogate Decision Maker and Living Wills.

II. DEFINITIONS

A. **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.

B. **Surrogate Decision Maker:** A person identified by the court to make decisions regarding the foregoing of life sustaining treatment on behalf of a patient who lacks decision making capacity and suffers from a qualifying condition. The surrogate expressed decisions directly to the patient's physician. There are **NO** situations in which a surrogate can directly give instructions to an EMS provider.

C. **Living Will:** A witnessed, written document voluntarily executed by a person with the proper formalities, instructs the person's physician to withhold or withdraw death-delaying procedures in the event that the person is diagnosed as having a terminal condition.

D. **Biological Death:** The cessation of vital processes, resulting in irreversible brain damage, usually following 3-10 minutes of cardiac arrest.

E. **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 for 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.

III. POLICY

A. When EMS personnel arrive and CPR is not in progress, personnel should initiate Cardiac Arrest Protocol unless:

1. Triple Zero criteria are present.
2. The patient has been pronounced dead by the coroner or the patient's physician
3. A valid DNR order/Illinois POLST Form is present.

B. A valid Illinois POLST Form should be honored unless compelling circumstances arise and an on-line medical control physician directed EMS personnel to resuscitate.

C. EMS personnel must make a reasonable attempt to verify the identity of the patient (i.e. identification by another person or identification bracelet as seen in long term care facilities) named in the valid DNR order.

D. If at any time it is unclear if this policy applies, begin BLS treatment and contact Medical Control for orders. If communication with Medical Control is impossible, begin treatment per SOPs and transport as soon as possible.

E. Components of a valid Illinois POLST Form:

1. Patient name; DOB, gender, and address

2. Section A: **Cardiopulmonary Resuscitation:** must have one of the boxes selected: *"Attempt Resuscitation/CPR"* or *"Do Not Attempt Resuscitation/DNR"*

3. Section B: **Medical Interventions:** must have one of the boxes selected: *"Full Treatment"*, *"Selective Treatment"*, or *"Comfort-Focused Treatment"*

4. Section C: **Medically Administered Nutrition:** Not applicable for EMS

5. Section D: **Documentation of Discussion:** Signature of patient or legal representative and Signature of Witness to Consent.

6. Section E: **Signature of Authorized Practitioner:** Name and signature of the authorized practitioner.

F. Revocation of a written DNR order/Illinois POLST Form can be made only if:

1 The order is physically destroyed or verbally rescinded by the physician who wrote the order.

2 The order is physically destroyed or verbally rescinded by the person who gave written consent to the order.

G. In transporting a patient during a transfer to or from home with a valid DNR order and the patient arrests en route, contact Medical Control and go the closest available hospital and do not start resuscitation measures.

H. If transporting a patient during an inter-hospital transfer with a valid DNR order and the patient arrests en route, contact Medical Control and go to the closest available hospital and do not start resuscitation measures.

I. In transporting a patient from a long-term facility with a valid DNR order and the patient arrests enroute, contact Medical Contact Medical Control and continue transport to the hospital and do not start resuscitation measures.

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

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

L. Any other advance directives such as a "Living Will" cannot be honored, followed or respected by prehospital care providers. EMS personnel must contact Medical Control for direction regarding any other type of advanced directive. Full resuscitation should not be withheld during the process of contacting or discussing the situation with medical control.

M. A Durable Power of Attorney for Health Care (DPA) is a written document allowing an individual to delegate his or her power to make health care decisions to an appointed agent in the even the individual becomes mental disabled or incompetent.

1. The written document must:

   a. Be signed and dated by the individual granting the power.

   b. Name an agent.

   c. Describe health care powers granted to the agent.

2. A written document does NOT have to be seen; a verbal report from the agent will suffice.

3. Prehospital providers CAN NOT honor a verbal or written DNR request or order made directly by a surrogate decision maker or any other person, other than the patient's primary care physician. If such a situation is encountered, institute CPR or BLS treatment as indicated by the patient's condition and contact Medical Control for direction.

N. If a patient is found in cardiopulmonary arrest and EMS providers are presented with a Living Will and/or a Durable Power of Attorney for Health Care Agent or Surrogate Decision Maker, CPR must be started and Medical Control contacted immediately for direction.

O. <u>EMS providers will not be held responsible for determining the validity of a DNR order, Durable Power of Attorney, or Surrogate Decision Maker, and/or Living Will.</u> A health care professional or healthcare provider is immune from criminal or civil liability, and cannot be found to have committed an act of unprofessional conduct, if, in good faith, and pursuant to reasonable medical standards, death-delaying procedures were withheld or withdrawn.

1. Subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65: *"A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform POLST Form, or a copy of that form or a previous version of the uniform form, is valid. A health care professional, or health care provider, or an employee of a health care professional or health care provider, who, in good faith complies with a*

cardiopulmonary resuscitation (CPR) or life-sustaining treatment order, Department of Public Health Uniform POLST form, or a previous version of the uniform form made in accordance with this Act, is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

P. Minors: Minors (unless emancipated) cannot execute advance directives. The parent or guardian "stands in place" at all times and can provide consent to written Illinois POLST orders executed by a qualified practitioner. Unless there is a valid written ILLINOIS POLST Order, all minors should be resuscitated.

Q. All paperwork regarding Living Wills and Durable Power of Attorney for Health Care and/or Surrogate Decision Maker must be brought to the receiving facility with the patient.

R. A run report will be filled out on all patients who are not resuscitated in the prehospital setting. The reason that the patient was not resuscitated should be documented. DNR patients should also have documentation of why this is a valid DNR. If possible, attach a copy of the DNR order to the run report.

S. On a yearly basis, the EMS system will report to the IDPH indicating issues or problems which have been identified and the EMS System response.

T. This policy will be distributed to all EMS System agencies and made available to all EMS providers. All EMS providers are responsible for reviewing and implementing this policy.

IV. REFERENCES

Illinois POLST form

Assistance by Non-System Personnel

I. PURPOSE

This is to clearly delineate the roles of all personnel at the scene to provide the highest quality of patient care.

II. DEFINITIONS--None

III. POLICY

A. Only personnel licensed to perform in the prehospital setting and who are members of the ~~HSHS St Mary's~~ EMS System are allowed to perform advanced patient care at the scene unless approved at the time of service by Medical Control. Advanced patient care includes, but is not limited to IV placement, intubation, medication administration, and cardiac pacing.

B. EMS providers who are confronted by individuals wanting to render assistance at the scene of an emergency should use the following guidelines:

1. If assistance is needed the Senior EMS provider and/or EMS Sector Officer contacts Medical Control to advise of the presence of providers from outside the ~~HSHS St Mary's~~ EMS System. The Senior EMS provider and/or EMS Sector Officer requests approval from Medical Control for these providers to assist with care appropriate to their licensure.

2. Non-system personnel function under the direction of the Senior EMS provider and/or the EMS Sector Officer at the scene.

3. The Senior EMS provider and/or Sector Officer directs the medical activities and assigns the responsibilities of outside providers at the scene based upon their documented and/or reported level of training and experience.

4. Registered Nurses (RNs) may perform care in the prehospital setting based on the Nurse Practice Act. RNs may be of assistance under the direction of the Senior EMS provider and/or the EMS Sector Officer at the scene. RNs cannot routinely work on an ambulance unless they are licensed as a Prehospital Registered Nurse (PHRN).

5. The Senior EMS provider and/or EMS Sector Officer shall be responsible for keeping Medical Control informed of all treatment being rendered.

6. Medical personnel at the scene function at or below the level of the highest trained EMS provider unit responding to the scene.

IV. REFERENCES--None

Confidentiality

I. PURPOSE

This policy is to ensure consistent instruction to ~~HSHS St Mary's~~ EMS System providers regarding confidentiality and release of written, verbal, radio and scene information concerning patient care, treatment and/or prognosis.

II. DEFINITIONS—None

III. POLICY

A. The Health Information Portability and Accountability Act (HIPAA) privacy rule protects the rights of individuals from the disclosure of protected health information. Inappropriate sharing of confidential information is not tolerated in the ~~HSHS St Mary's~~ EMS System. EMS providers must understand that breach of confidentiality is a serious infraction with legal implications which may result in disciplinary action up to and including system suspension. Any concerns regarding the definitions of protected health information or the application of HIPAA are referred to the HIPAA privacy rule through the Health Information Officer at ~~HSHS St Mary's~~ Hospital.

B. Reasonable steps should be taken to limit uses and disclosures of protected health information to the minimum amount required to accomplish the intended purpose. Exceptions to the minimum necessary rule include disclosures to a healthcare provider for treatment purposes, discloses to individuals of their own protected health information; uses or disclose under authorization; disclosures to the Department of Health and Human Services regarding compliance or enforcement; or uses and Disclosures required by law.

C. Every patient has the right to expect both verbal and nonverbal communications and records pertaining to his/her care to be treated as confidential. Therefore, discussion of the patient's prognosis, diagnosis, history, treatment or any portion thereof should occur only in private.

D. EMS providers may be asked to sign a confidentiality agreement.

1. Written Information

a. Confidentiality regarding written patient care documentation is governed by the "Need to Know" concept.

b. Only ~~HSHS St Mary's~~ EMS System providers and hospital staff directly involved in a patient's care or the monitoring of the quality of care are allowed access to a patient's medical records and reports.

c. Prehospital Patient Care records are kept in secure areas of Emergency Departments, EMS Agencies, and the ~~HSHS St Mary's~~ EMS System Offices following written procedures.

d. Request for release of all patient care related information, including requests from third party payers, should be directed to the Medical Records Department of the receiving hospital or the transporting agency.

e. Requests by law enforcement, coroner, fire service or other agencies for patient care reports should be directed to the Medical Records Department of the receiving hospital or the transporting agency. In cases of Triple Zero or refusals, patient care reports may be provided by the EMS agency to the requesting agency. The request for documentation must be in the form or a subpoena or a release of information obtained from the patient or patient's family.

2. Verbal Information

a. Confidential information should be discussed with other EMS providers only when it is necessary to do so in the provision of EMS care.

b. EMS providers are not to discuss patients in public areas. Conversations regarding specific patient problems and/or care are inappropriate.

c. Information regarding the care/hospitalization of a friend or relative cannot be acted upon or passed on unless that information came from an outside source or directly from the patient. An EMS provider who encounters information regarding a friend or relative while on duty as a representative of the ~~HSHS St Mary's~~ EMS System must keep that information confidential.

3. Radio/Telephone Communication

a. No patient name will be mentioned in the process of prehospital radio transmissions via MERCI or cell phone communications.

b. When necessary to refer to patient, references such as "we have a diabetic patient on North Street that we brought in last week" could be used. Patients may identified by initials.

c. Inappropriate patient information regarding diagnosis or prognosis should not be discussed during radio/telephone transmissions.

4. Scene Security

a. Every effort should be made to maintain the patient's auditory and visual privacy during the treatment at the scene and enroute.

b. EMS providers should limit bystanders at the scene of an emergency. Law enforcement may be called to assist in maintaining reasonable distance.

c. Any questions from the media are forwarded by EMS providers to the receiving Facility.

E. Any deviation from this policy is grounds for disciplinary action which may include immediate suspension from the system.

F. EMS providers should report to the EMS System Coordinator any breach or violation of confidentiality as soon as he/she becomes aware of it.

G. EMS providers and Educators should remove any identifiable information about a patient in case studies and reports used for education purposes.

IV. REFERENCES

Crime Scenes

I. PURPOSE

This is to ensure proper reporting of suspected crimes, and to establish guidelines for proper management of a crime scene by EMS personnel.

II. DEFINITION--None

III. POLICY

A. EMS providers may arrive at the scene of a violent crime before law enforcement. To avoid destroying evidence, EMS providers must understand how law enforcement agencies preserve, collect and use evidence at a crime scene. Anything at the scene may serve as evidence to law Enforcement.

B. Immediately upon identifying a suspected crime scene, EMS providers should take the following steps:

1. Immediately notify law enforcement or call dispatch to do so. Documentation on the prehospital care report the time law enforcement was notified.

2. If the victim is obviously dead, the body should remain undisturbed. In some circumstances, the victim's body may be moved to gain access for assessment, or to gain access to other living victims.

3. Access to the scene should be restricted to only the personnel required to care for the patient.

4. Do not touch, move, or relocate any item at the scene unless it is absolutely necessary to provide treatment to an injured victim. Document the location of any item that is moved, so that law enforcement can determine its original position.

5. Observe and note anything unusual, especially if the evidence may not be around when law enforcement personnel arrive (i.e. smoke or odors).

6. Give immediate care to patients. The possibility of the patient being a crime victim should not delay prompt treatment. The EMS provider's role is to provide emergency care, not to enforce the law or perform detective work.

7. Keep detailed records of the incident, including observations of the victim and the crime scene. In many felony cases, EMS providers may be called to testify since they were the first on the scene. An incomplete or inaccurate record will hurt credibility.

8. Once the patient is pronounced dead, the body becomes the property of the coroner's office. It may not be touched or altered in any way without authorization from the coroner's office.

9. It is acceptable to share patient care information with appropriate on scene law enforcement.

10. Intravenous lines, endotracheal tubes and other disposable equipment used, successfully or unsuccessfully, are to remain in place and/or on scene.

11. Disposable items used during resuscitation efforts are to left in place. Sharps used during the resuscitation should be stored in an appropriate container with the container being left in the area.

12. Once law enforcement personnel arrive, EMS providers should leave the scene as soon as possible to avoid hindering the investigation. Give police any information that might be useful.

13. When EMS arrives at the scene after the police, refer to Region 6 protocol "EMS involvement in Crime Scenes."

14. When documenting projectile wounds, DO NOT indicate whether the wound is an entrance or exit wound. Simply document the size, shape and location of the penetrating wound(s).

C. EMS providers will report required incidents to the appropriate law enforcement agencies in compliance with current state statutes. These incidents include but are not limited to:

1. Gunshot wounds
2. Injuries sustained in the commission of or as a result of a criminal event.
3. Stab wounds
4. Suspected foul play
5. Assaults
6. Sexual assault
7. Motor vehicle accidents
8. Possible suicide and/or suicide attempts
9. Child abuse
10. Elder abuse
11. Domestic violence
12. Any other violent crime

IV. RESOURCES—None

Emotionally Disturbed Patients

I. PURPOSE

The purpose of this policy is to ensure appropriate patient assessment, management and documentation of care for the emotionally ill patient and/or the patient with an altered mental state.

II. DEFINITION

III. POLICY

A. Patients requesting treatment for an emotional problem, who become emotionally disturbed after initiation of care and/or who have an altered mental state, will be provided medical care according to protocol and degree of illness.

B. Every effort is made to assess any underlying medical cause for the exhibited emotional state.

C. Utilize open-ended questions while interviewing, and do not argue with the patient.

D. Maintain a nonjudgmental attitude when assessing patients with possible behavioral emergencies.

E. All patients are treated with dignity and respect and without underlying prejudice towards their condition.

F. Protective safety devices may be required for the patient who is violent and/or threatening to harm himself/herself or others (See Patient Restraints Policy).

G. Determine scene safety. If there is any doubt as to scene safety, request local law enforcement for assistance. Self-defense is of highest priority and may necessitate retreat from the scene.

H. Never leave the patient alone.

I. Be observant of verbal and/or nonverbal clues which may indicate the patient's aggressive or violent mood is escalating. Remove the patient from the agitating situation when possible.

J. Attempt to orient the patient to reality and to persuade the patient to be transported to the hospital so that he/she can receive emergency medical care and mental health services.

K. If persuasion is unsuccessful, contact medical control. The EMS crew will then follow the direction of the medical control physician.

1. If the medical control physician determines the patient cannot understand informed consent for patient care and transportation to the hospital for emergency treatment of a non-psychiatric condition is required to preserve life or prevent serious

impairment to health, the physician shall order, against patient will and abased upon implied consent, the emergency care and transportation to the hospital.

2. In no way does this mean the EMS crew is committing the patient to a hospital admission. It simply enables the EMS personnel to transport a person in need of treatment to a hospital against his/her will so that a physician may further evaluate the patient.

IV. RESOURCES--NONE

Interaction with Law Enforcement

I. PURPOSE

The purpose of this policy is to delineate functions of law enforcement personnel and EMS providers in the prehospital setting.

II. DEFINITION--None

III. POLICY

A. The function of law enforcement is to enforce the law. The function of EMS is to provide prehospital emergency care. EMS providers must not hinder law enforcement's ability to enforce the law.

B. In cases where there is a conflict of interest between law enforcement and EMS regarding a police suspect who may be in need of medical attention, EMS providers may request sufficient time to obtain an adequate patient history and perform a physical assessment. EMS providers should convey assessment findings and any need for further medical evaluation and treatment to law enforcement personnel.

C. If a conflict should exist between EMS providers and law enforcement personnel regarding patient treatment, the following guidelines are suggested:

1. Attempt to discuss privately with law enforcement officers an approach to the conflict that satisfies both law enforcement needs and the needs of the patient.

2. Explain to law enforcement officers the patient's history, physical assessment, and need for treatment.

3. Listen with an open mind to law enforcement officers. They also have a duty to perform.

4. If a difference of opinion exists regarding the need for medical treatment, immediately establish EMS telephone or radio contact with Medical Control for further direction.

5. If an agreement cannot be reached regarding the proper handling of the patient, law enforcement requests must be respected. EMS providers should continue to perform treatment allowed by law enforcement officers, and must not leave the patient unless ordered to do so by law enforcement officers.

6. EMS providers are not required to perform services or treatment requested by law enforcement officers that may be potentially harmful to the patient (i.e. drawing of blood alcohol specimens). Law enforcement agents to not have the right to order medical evaluation or treatment of patients.

7. If law enforcement officers place limitations on prehospital evaluation and treatment, EMS providers should advise the patient of those limitations. These limitations should be documented in the prehospital patient care report.

8. Complete an EMS Risk Screen within twenty-four (24) hours of the incident and forward it to the EMS office for review by the EMS Coordinator and Medical Director. Document all the discussions with law enforcement officers. State facts, not opinions, and be as detailed as possible.

IV. RESOURCES—None

Internet Communications and Social Media

I. PURPOSE

This policy is to provide guidelines for providers in the ~~HSHS St Mary's~~ EMS System regarding Internet Communications and Social Media in the context of their functioning in the EMS System.

II. DEFINITION—None

III. POLICY

A. Professional standards of conduct apply to all agencies and personnel within the ~~HSHS St Mary's~~ EMS System, engaging in communication through blogs and social network sites, and other areas.

B. Everyone should be aware that others, including peers and other agencies both inside and outside the ~~HSHS St Mary's~~ EMS System may actively be reading what is posted in online forums. In choosing words and content, it is a good practice for everyone to consider that their supervisor, family members of patient and the general public may read their posts. Therefore, everyone needs to exercise good judgment before posting material on internet sites or email. Using a blog or social network site to make negative statements about and or embarrass the ~~HSHS St Mary's~~ EMS System, any HSHS System facility, agency or person associated with the ~~HSHS St Mary's~~ EMS System is inconsistent with our Mission, Values and standards of conduct.

C. The ~~HSHS St Mary's~~ EMS System reserves the right to monitor conduct of our members in regards to social networking, and apply corrective action should it be determined that conduct is inconsistent with our policies.

D. The following activities are ***Specifically Prohibited*** under this policy:

1. Sharing Protected Health Information (PHI). PHI includes, but is not limited to patient's name, address, age, race, extent or nature of illness or injury, hospital destination, crew member names and date, time and location of care.

2. Posting photos, videos, or images of any kind which could potentially identify patients, addresses, or any other PHI.

3. Sharing confidential or proprietary information about ~~HSHS St Mary's~~ EMS System or our agencies.

4. Postings or other online activities which are consistent with or would negatively impact the reputation of the ~~HSHS St Mary's~~ EMS System.

5. Engaging in vulgar or abusive language, personal attacks, or offensive targeting groups or individuals within the ~~HSHS St Mary's~~ EMS System.

6. Posting statements which may be perceived as derogatory, inflammatory, or disrespectful.

E. Posting online comments on third party sites:

1. Everyone should consult with the ~~HSHS St Mary's~~ EMS System prior to engaging in communication related to Hospital Sisters Health System issues or activities through blogs or comment sections of material posted on the internet.

2. If communication is done through the internet in regards to ~~HSHS~~ issues, you must disclose your connection ~~to HSHS~~. You should strive for accuracy in your communication. Errors and omissions are poorly reflected ~~upon HSHS~~ and present a liability for you or ~~HSHS.~~

3. Everyone should be respectful and professional to everyone in the ~~HSHS St Mary's~~ EMS System, community partners, co-responders, and patients and avoid using unprofessional online personas.

F. Personal Blogs and Other Social Networking Content:

1. Where a connection to ~~HSHS~~ is apparent, everyone should make it clear that they are speaking for themselves and not on behalf of ~~HSHS~~. In these circumstances, the following disclaimer is recommended:

   "The views expressed on this (blog, website) are my own and do not reflect the views of my employer, or the ~~HSHS St Mary's~~ EMS System."

2. Furthermore, employees should consider adding this language in the "about me" section of their profiles.

3. This disclaimer does not by itself exempt employees from a special responsibility when blogging; employees should remember that their online behavior should still reflect and be consistent with the ~~HSHS St Mary's~~ EMS System standards of behavior, and each member agency's standards.

G. ~~HSHS St Mary's~~ EMS System and Agency Sponsored Sites or Content

1. Posts to sites will be accurate and factual.

2. Mistakes should be corrected promptly

3. When corrections are made, the original post will be preserved for integrity showing by strikethrough what corrections have been made.

4. All spam and comments off-topic will be deleted.

5. ~~HSHS St Mary's~~ EMS System staff will respond to all emails and comments as appropriate

6. Whenever possible the ~~HSHS St Mary's~~ EMS System will link directly to online references and original source materials.

IV. RESOURCES—NONE

Notification of the Coroner

I. PURPOSE

This is to define the procedures for when and how to call for the coroner.

II. DEFINITION--None

III. POLICY

A. Illinois State Statute, Chapter 31, Section 10.6, states" "Every law enforcement official, funeral director, ambulance attendant, hospital director or administrator or persons having custody of a body of a deceased person, where the death is one subject to investigation under Chapter 31, the Coroner's Act, shall notify the Coroner or Deputy Coroner promptly."

B. "No dead body, which may be subject to the terms of the Coroner's Act shall be moved, disturbed, embalmed or removed from the place of death by any person except with the permission of the Coroner/Medical Examiner unless moving the body shall be necessary to protect life, safety or health."

C. Any person knowingly violating the provisions of this section shall be guilty of a Class A misdemeanor.

D. Any prehospital death is to be reported to Coroner immediately. Special circumstances once the coroner is notified include:

1. The body shall not be moved and the scene shall not be disturbed or altered in any way until directed by the coroner. The body may, however, be moved to verify the absence of vital signs, to perform an adequate assessment, or to gain access to a viable patient Involved in the same incident.

    a. Do not remove lines or tubes from unsuccessful cardiac arrests.

2. If EMS providers are required to go to another emergency call before the arrival of the coroner, they must do the following:

    a. Leave the body in the care of law enforcement present at the scene, or other medical personnel

    b. Contact Medical Control regarding the situation and the need to leave, and confirm that the coroner has been notified.

E. If a patient is determined to be dead during transport, note the time and location and record this information on the patient care report. Immediately contact the coroner to discuss death jurisdiction. Do not cross county lines with a patient that has been determined to be dead.

F. Refer to the following Region 6 Protocols regarding the determination of prehospital death:

1. Trauma Field Death Declaration
2. Termination of Resuscitation
3. Triple Zero

IV. REFERENCES--None

Patient Abandonment

I. PURPOSE

The purpose of this policy is to assure that patients are not abandoned by EMS providers in the ~~HSHS St Mary's~~ EMS System.

II. DEFINITION

III. POLICY

A. Abandonment is defined as termination of a provider/patient relationship without assuring a mechanism for continuation of care. This is assuming, and unless proven otherwise, there exists a need for continued medical care and the patient is accepting the treatment.

B. EMS providers may not leave a patient with whom care has been initiated unless one of more of the following situations exists:

1. The patient or legal guardian refuses treatment and/or transportation. In this instance, EMS providers are referred to the policy on *Refusal of Care.*

2. EMS providers are unable to continue care due to extreme physical exhaustion or injury.

3. Law enforcement, fire service and/or EMS providers determine the scene is not safe and the potential for injury or death to a rescuer exists.

4. The number of patients exceeds the resources immediately available, and EMS providers are involved in triage activities. In this instance, EMS providers are referred to the policy on *EMS Sector Command for Major EMS Incident.*

5. The patient is in full cardiac arrest, has a valid DNR/POLST Order physically with the patient and Medical Control concurs. In this instance, EMS providers are referred to the policy on *Do Not Resuscitate.*

6. Medical care and responsibility for the patient is assumed by individuals trained, certified and licensed at a level equal to or higher than that of the initial provider.

7. The patient meets the criteria for Triple Zero. In this instance, EMS providers are referred to the policy on *Notification of the Coroner.*

C. If EMS personnel arrive on scene, establish contact and evaluate a patient who then refuses care, the EMS crew shall conduct termination of the patient contact in accordance with the *Refusal of Care* Policy.

D. During the transport of a patient by ambulance, should the EMS crew come across a separate emergency or incident requiring ambulance assistance; the local EMS system will be

activated. Crews involved in the treatment and transportation of an emergency patient are not to stop and render care.

1. The priority is to the patient onboard the ambulance.

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

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

IV. REFERENCES—None

Patient Hospital Preference

I. **PURPOSE**

This policy is to ensure that patients treated within the ~~HSHS St Mary's~~ EMS System are transported to their facility of choice whenever possible.

II. **DEFINITION—None**

III. **POLICY**

A. In any emergency situation, patients should be transported by the ambulance to the nearest appropriate facility as defined in the Illinois EMS Act. However, each patient/legal guardian has the right to make an informed decision to be transported to the facility of his/her choice.

B. If at patient/legal guardian refuses to be transported to the nearest appropriate facility, the patient/legal guardian should be informed of the risk associated with not being transported to the nearest appropriate facility. Once all the risks have been explained, and the patient or the patient's legal guardian demonstrates complete understanding of those risks, the patient should be transported to the facility of choice.

C. If EMS providers determine that the patient/legal guardian's choice of facility would be detrimental to the well-being of the patient, or would take the provider agency out of its response area for an extended period, the EMS providers must contact Medical Control for permission to transport to the closest available facility. Whenever possible, Medical Control should talk with the patient/legal guardian.

1. If it is deemed to transport to the patient's choice of facility will be detrimental or could possibly incur harm to the patient, a refusal of service must be filled out **AGAINST MEDICAL ADVICE.**

D. If the patient continues to refuse transport to the closest appropriate facility, EMS providers must follow these guidelines:

1. Make sure the patient/legal guardian is notified of and understands the risks and benefits of their decision to be transported to a facility other than the closest appropriate facility.

2. Document the patient/legal guardian's refusal of transport to the closest appropriate facility.

3. Remain with the patient at the scene until additional EMS providers are available to cover the EMS agency's primary response area as listed in the provider's EMS System Plan.

4. The patient is cared for at the highest level of care required to meet his/her needs. The level of care is not diminished due to his/her refusal to be transported to closest appropriate facility. If the level of care required by the patient is higher than that available by the responding providers, an ALS intercept is required *(See Intercept Policy).*

E. Any patient who meets criteria for transport to a Trauma Center, as listed in the policy on Trauma Center Referral, must be transported to the nearest appropriate facility.

1. If the patient requests to go to a hospital that is not a Trauma Center, Advise the patient that due to the Signs/Symptoms/Mechanism of Injury that the EMS provider feels it is in the best interest to be transported to the Closest Trauma Center.

2. If the patient still refuses, and chooses to go to a hospital without Trauma Center designation, document in the radio report, and the written report.

F. When a patient is not taken to the nearest appropriate facility, the EMS provider must document the reason on the prehospital run report form. Acceptable reasons for not taking the patient to the closest appropriate facility include:

1. Patient/legal guardian's choice

2. Trauma Center criteria

3. Diversion to another facility by Medical Control

4. Major EMS Incident

5. Stroke Center criteria

IV. REFERENCES--None

Patient Restraints

I. PURPOSE

The purpose of this policy is to provide guidelines for the use of patient restraints in situations when the patient must be restrained due to posing a risk to himself/herself or others.

II. DEFINITION

III. POLICY

A. Attempt to avoid the use of restraints by maintaining a calm, reassuring demeanor and taking all reasonable steps to urge the patient to comply.

B, Restraints shall only be implemented as a last resort by EMS personnel for patients who lack present mental capacity and demonstrate physical resistance or violent behavior that poses an immediate threat to the health and safety of them or others around them.

C. Determine the need for restraint. Criteria for restraint include violence toward personnel or physical resistance to transport by a confused or obtunded patient who must be transported to the hospital.

D. Unless the patient poses an immediate threat to self or others, or is suffering from an immediately life-threatening condition, medical control must be contacted prior to the use of restraints or transports of any patient against their will.

E. The patient requiring restraint should be safely and humanely restrained. At no time should a patient be struck or managed in such a way as to impose pain. Restrain in a position of comfort and safety. It is very important that restraints not be applied so tightly as to compromise limb circulation. **Never is a patient to be transported in the prone position.**

F. Law enforcement must be called to manage the situation when danger exists, such as when the patient has a weapon or injury to the patient, bystanders, or personnel is anticipated.

1. If a patient is restrained by law enforcement with handcuffs on other law enforcement restraint implements, the patient will be accompanied in the ambulance by law enforcement to the hospital to assist with further restraint of the patient, or to release the restraints if the patient care is impaired by the devices.

G. It is desirable to have female personnel present when a female patient is being restrained.

H. The patient MUST NOT be left alone after application of restraints.

I. Pulses, movement and sensation of the extremities must be checked at least every fifteen (15) minutes while the patient is restrained.

J. Document the indications for applying restraints (i.e. presence of self-destructive behavior), prior attempts at less restrictive alternatives (i.e. verbal communication), method of restrain and periodic checks for proper application and patient well-being.

K. Refer to Region 6 Care Guideline, "Use of Restraints", for procedure.

IV. RESOURCES—None

Physician on Scene

I. PURPOSE

This is to clarify the EMS provider's responsibility to a patient when a physician is present at the scene of an emergency and wishes to direct or assist in patient care.

II. DEFINITION—None

III. POLICY

A. A physician (MD/DO) on the scene does not automatically supersede the EMS provider's authority. Once a provider-patient relationship is established, written System protocol and standing orders provide the legal basis for EMS providers to function. This authority is considered to be the delegated practice to the EMS Medical Directors. Patient care cannot be relinquished to another person unless identification and credentials of that individual can be verified and the EMS MD or his/her designee (the on-line Medical Control Physician) approves the request.

1. If a professed, licensed medical professional (physician) wishes to participate in and/or direct patient care at the scene of an emergency, the Senior EMS provider shall immediately contact Medical Control.

2. If the on-scene physician (including the patient's private physician) has properly identified himself/herself and wishes to direct patient care, he or she must:

   a. Obtain approval from Medical Control, as witness by the EMS provider in charge at the scene.

   b. Sign the prehospital care report.

   c. Assume total responsibility for the patient

   d. Accompany the patient to the hospital in the ambulance.

3. If the on-scene physician obstructs the efforts of the EMS providers to aid the patient, and/or insists on rendering patient care inappropriate to System standards, and/or hinders EMS provider efforts to provide good and reasonable patient care, the EMS providers shall:

   a. Contact Medical Control.

   b. Contact law enforcement for assistance.

   c. Remove the patient from the scene.

4. If a physician gives orders while on scene, or enroute, for procedures or treatments that the EMT/PHRN feels are unreasonable, medically inaccurate, and/or not within the scope of practice for the provider, refuse to follow such orders and establish communication immediately with on-line medical control to clarify further treatment. In all circumstances, the EMS provider shall avoid any order or procedure that would be harmful to the patient.

B. When voice communications with on-line Medical Control is not available, the EMS crew is instructed to follow the Regional Protocols.

IV. RESOURCES—None

Prehospital Care Reporting

I. PURPOSE

To maintain pertinent Patient Care Report (PCR) information for the purpose of medical/legal records and statistics.

II. DEFINITION—None

III. POLICY

A. A Patient Care Report is used by EMS providers to record pertinent patient information. Patient Care Reports are maintained as follows:

1. EMS providers must accurately complete and submit a patient care report for each patient contact or request for response.

2. A patient care report is not necessary if the provider is cancelled enroute to the scene however the response and cancellation should be documented in some manner i.e. dispatch center, dispatching software.

3. Receiving facility copies are left with the receiving facility immediately following the call whenever possible. This copy will become part of the patient's permanent medical record.

4. In the event that a patient care run report cannot be completed prior to leaving the facility, then a system approved 'EMS Short Form' must be left with the patient. The patient care run report must be completed and provided to the health care facility as soon as possible, but no later than the end of the provider's shift.

5. Agency copies are maintained by the agency on paper or electronically for a period of not less than seven years.

6. All other copies are forwarded to the East Central Illinois EMS office monthly, where they will be maintained for a period of not less than seven years.

7. Computer generated records must be in accordance with IDPH guidelines.

8. Prehospital Care Reports may be periodically examined by the East Central Illinois EMS System Medical Director or the EMS System Coordinator for quality assurance purposes

B. IDPH Rules Section 515.350 DATA COLLECTION AND SUBMISSION; Amended at 42 Ill. Reg. 17632, effective September 20, 2018)

1. A patient care run report shall be completed by each Illinois-licenses transport vehicle service provider for every inter-hospital transport and pre-hospital emergency call, regardless of the ultimate outcome or disposition of the call.
   a. One patient care report shall be provided (paper or electronic) to the

receiving hospital emergency department or health care facility before leaving this facility.

b. Each EMS System shall designate or approve the patient care report to be used by all of its vehicle providers. The report shall contain the minimum requirements listed in Appendix E of the EMS Rules and Regulations.

2. All non-transport vehicle providers shall document all medical care provided and shall submit the documentation to the EMS System within 24 hours. The EMS System shall review all medical care provided by non-transport vehicles and shall provide a report to the Department upon request.

C. Records of EMS radio reports to the receiving hospital are maintained as follows:

1. All radio and cell phone reports from EMS providers to the receiving hospital are recorded on a radio log at the receiving hospital.

2. All calls are recorded at the receiving hospital.

3. All radio logs and recordings are kept by Resource, Associate and Participating Hospitals for a period of not less than seven years.

IV. REFERENCES--None

Refusal of Service

I. PURPOSE

The purpose of this policy is to provide guidelines for the use of the ~~HSHS St Mary's~~ Hospital Refusal Form, in regards to refusal evaluation, treatment and/or transportation.

II. DEFINITIONS

A. **Competent patient:** Someone with the legal authority to consent to or refuse care for their own person (not an adult with a guardian or a minor who does not meet one of the exceptions set out below).

B. **Decisional patient:** One who is able to understand and appreciate the nature and consequences of a medical decision and reach and communicate an informed choice.

C. **Competent patient with decisional capacity:** A person who has both the legal authority and actual ability to consent to or refuse treatment.

D. **Minor:** A person under the age of 18 and under most circumstances may not consent to or refuse treatment.

III. POLICY

REFUSAL PROCEDURE

A. All patients will be offered treatment and transportation to a hospital after attempt to obtain a history and physical, in as much detail as is permitted by the patient.

B. Determine decisional capacity of the patient and reason for refusing care.

C. Document decisional capacity assessments, results of the history and physical exam, clinical symptoms on which need for transport was based, information provided to fully inform the patient of risks, benefits and alternatives as well as the patient's understanding.

D. Complete and review the patient refusal form in its entirety with the patient.

1. Obtain patient signature and the have the patient date the form.

2. Obtain a witness signature. This should preferably be someone who witnessed your explanation of risks and benefits, heard you advise the patient to receive medical evaluation and treatment, and who watched the patient sign. If no witness is available, a crew member may sign as a last resort. All should be eighteen (18) or older, have mental competency and present mental capacity. Write witnesses' address and telephone number on the back of refusal form.

3. If the patient refuses to sign the refusal form, document this on the refusal form as well in your patient report.

E. Inform the patient to call 911, his/her primary care physician or go to the nearest Emergency Department if symptoms persist or get worse or the patient changes their mind.

F. At no time will EMS professionals mention cost of transport, patient's insurance status, hospital billing or insurance practices, status of system/unit availability, ED wait times, or any other non-clinical subject in an attempt to influence a patient's decision to decline treatment or transport.

COMPETENT DECISIONAL PATIENT

A. When a competent patient with decisional capacity refused medical assistance or transport, EMS personnel will advise the patient of his/her medical condition, and explain why the care and or transport is indicated. Encourage the patient to consent to treatment and transport.

B. If the patient persists in the refusal of treatment, explain the risks or refusing treatment and document attempts to persuade the patient to accept treatment/transport.

C. Document the patient's ability to comprehend the information provided, including statements made by the patient and confirm that the patient had been fully informed of the risks or refusing care and/or transportation and understood the consequences of the decision.

D. Continually asses the patient's condition as the patient permits. If the patient is decisional, EMS may, but is not required, to contact the Resource or Associate Hospital for assistance. The EMS Medical Director or designee may encourage the patient to comply. If the patient continues to decline treatment/transport, document the refusal, and the call, if made.

INCOMPETENT AND NON-DECISIONAL PATIENT

A patient, who is not decisional, lacks the ability to consent to or refuse treatment.

A. Attempt to determine whether the patient's decisional capacity is impaired and consider whether the patient has a condition that might impair capacity such as hypoglycemia, trauma, stroke, dementia, or the presence of alcohol or other substances in the patient's system.

B. These conditions alone do not dictate a conclusion that the patient lacks decisional capacity. The patient must be assessed to determine whether he or she understands the condition, the nature of the medical advice given, and the consequences of refusing to consent to treatment/transport.

C. If EMS Personnel determine that the patient lacks decisional capacity, they should attempt to treat the patient and transport with the patient's cooperation.

D. If the patient persists in refusing treatment/transport, or if the patient becomes combative, EMS personnel should request backup from law enforcement and contact Medical Control.

EMS personnel should avoid putting themselves in danger, even if doing so may cause a delay in treatment or transport.

E. If law enforcement is on scene, EMS personnel should request assistance in ensuring transport of a non-decisional patient.

F. EMS personnel may employ restraints in an emergency only to protect the patient, EMS personnel, and others from imminent physical harm. *SEE RESTRAINT POLICY*

CONTACTING MEDICAL CONTROL

A. Medical Control must be contacted when the patient:

1. Is disoriented to person, time, place or event.
2. Is under the age of 18 and not accompanied by a parent or guardian.
3. Is unable to repeat understanding of the medical condition and consequences of treatment refusal.
4. Is showing obvious life threatening injuries, signs and symptoms.
5. Shows evidence of trauma related to significant mechanism of injury.
6. Has expressed suicidal or homicidal ideation or intention, or there is evidence of recent self-harm.
7. Is under the influence of alcohol or other substances to the point that decision making is impaired.
8. Refuses transport after EMS treatment has begun.

MINOR PATIENT

A. **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 (1), 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.

B. **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 (2)

   b. is married

   c. is a parent (mother or father)

   d. is pregnant

   e. is on active duty with the armed forces

C. Any minor parent may consent to the treatment for his/her child. A pregnant minor may consent to the evaluation and/or treatment related to the pregnancy.

D. A parent's or guardian's consent is not required for patient over the age of 12 seeking treatment for sexually transmitted diseases, sexual assault, alcohol or substance abuse treatment, and limited outpatient mental health treatment.

IV. REFERENCES

(1) 410 ILCS 210/3
(2) 750 ILCS 30/1 applies only to minors between 16-18 years old.
--~~HSHS St Mary's~~ EMS System Refusal Form