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Purpose

To describe the high priority of data-driven quality improvement within the EMS System and activities directed toward performance improvement.

Policy

1. The goal of EMS quality improvement (QI) is to measure and improve the effectiveness of prehospital care provided by EMS personnel through continuous and systematic monitoring to identify opportunities to improve, implement corrective actions, evaluate for attainment of sustained resolution, and improved outcomes.
2. The EMS System Resource Hospital has the authority and responsibility to demonstrate to consumers, the community, and regulatory and accrediting bodies that the quality and appropriateness of prehospital care within the EMS System is acceptable.
3. EMS System QI initiatives shall include participation in provider, system, regional, state, and national activities.
4. Quality improvement is the responsibility of all System members.
    a. The EMS System Resource Hospital will actively partner with provider agencies in the DMAIC (define, measure, analyze, improve, control) process.
    b. The EMS System will use a dashboard to share information.
    c. Continuous self and peer review and reporting of opportunities for improvement is a professional and ethical means to improve quality.
5. Quality indicators will include but not be limited to high-risk or low-frequency events, new medications, procedures, protocols, policies, and issues identified by sentinel events.
    a. Examples of metrics to be monitored include:
        i. EMD provided appropriately, dispatch assisted CPR
        ii. Hypoxia corrected
        iii. Hemorrhage controlled
        iv. Success rates/complications: airway, vascular access
        v. Level I TC appropriate destination
        vi. Scene times for time-sensitive pts
        vii. STEMI pts: 12L ECG and ASA
        viii. Cardiac arrest ROSC rates, hospital discharge rates
        ix. Pre-arrival alert/notification: sepsis, STEMI, stroke, trauma
        x. Pediatric pts assessed and treated appropriately
        xi. Geriatric pts assessed and treated appropriately
        xii. Assessed & treated appropriately: allergic reaction, altered mental status, cardiac arrest, dysrhythmias, hypoglycemia, nausea, pain, respiratory distress/failure, seizures, shock, stroke

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6. Greater results can be gained by improving processes rather than identifying/blaming individuals. Thus, processes shall be evaluated first.
    a. Emphasis is placed on closing the loop by disseminating information to appropriate interested parties.
    b. QI findings are used as a safety process for root cause analysis and drive education and protocol updates.
7. Quality improvement will include retrospective, concurrent real-time, and prospective strategies.
    c. Retrospective review of patient care reports, OLMC logs and tapes, complaints, and quality reports will be used in quality monitoring.
        i. 100% of the following dispositions are included in quality monitoring by EMS System staff:
            1. Drug Assisted Intubations (DAI)
            2. Cardiac Arrest (CARES Registry)
            3. EMS System - paramedic student capstone calls
    d. Real-time quality activity will include:
        i. EMS-MD and EMSC monitoring of OLMC communication
        ii. EMS System Resource Hospital staff will periodically:
            1. Respond to EMS scenes or schedule observational ride time to monitor EMS activities and pt care.
            2. Perform unannounced inspections (as required by IDPH EMS Rules) of EMS vehicles, equipment, medications, supplies, and documentation.
8. Quality Reporting: High-risk and near-miss incidents and issues of concern should be reported to the EMS System Resource Hospital Administrator/ Coordinator and/or EMS-MD for follow-up including root cause analysis.
    e. Examples include, but are not limited to:
        i. Commendation
        ii. Communication
        iii. Complaint
        iv. ED related
        v. EMS provider related
        vi. Injury to EMS provider or patient
        vii. Medical or patient care device/equipment malfunction
        viii. Medication/treatment error
        ix. OLMC, contrary to SOP, policy, procedure
        x. Patient-related or patient harm

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xi. Policy, Procedure, SOP related
xii. Unusual occurrence
xiii. Vehicle crash (EMS)

f. Information may be submitted electronically via email, fax, USPS mail, hand-delivered, or verbally communicated to the EMSC or EMS-MD. Information to include in the report includes:
   i. Date & time of occurrence/report made
   ii. EMS provider agency/hospital
   iii. EMS personnel name and contact information
   iv. Hospital name, if applicable
   v. Summary of occurrence, question or concern

g. The quality report form (page 4 of policy) may be used to submit information.

9. Quality improvement activities are privileged and confidential under the IL Medical Studies Act and Patient Safety Act.

References

https://one.nhtsa.gov/people/injury/ems/leaderguide/index.html
https://www.ems.gov/pdf/research/Studies-and-Reports/EMS_Performance_Measures_2009.pdf
http://emscompass.org/ems-compass-measures/
https://nemsis.org/
http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=073500050K8-2101

Attachment Quality Report Form (page 4 of 4 of policy)

Evert Gerritsen
EMS System Administrator/Coordinator

Michael I. Peters, MD
EMS Medical Director

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Quality Report Form

Privileged and Confidential under the IL Medical Studies Act and Patient Safety Act

High-risk and near-miss incidents and issues of concern should be reported to the EMS System Resource Hospital Administrator/Coordinator and/or EMS-MD for follow-up including root cause analysis.

Information may be submitted: via email (evert.gerritsen@nm.org, michael.peters@nm.org), USPS mail, hand-delivered or verbally communicated to the EMSC or EMS-MD.

Date & time of occurrence/report made

Nature of Report (check all that apply)

☐ Commendation	☐ Injury to EMS provider or patient	☐ Policy related
☐ Communication	☐ Medical or pt care device/equip. malfunction	☐ Procedure-related
☐ Complaint	☐ Medication/treatment error	☐ SOP related
☐ ED related	☐ OLMC contrary to SOP, policy, procedure	☐ Unusual occurrence
☐ EMS provider related	☐ Patient related or patient harm	☐ Vehicle crash (EMS)

EMS provider agency/hospital

EMS personnel name and contact information

Hospital name, if applicable

Summary of occurrence, question or concern

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Title	**Fitness for Duty: Felony, Controlled Substance Abuse**
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Purpose To provide an environment for safe patient care.

Policy

1) All applicants for any license permit or certification shall fully disclose any and all felony convictions in writing to the EMS System Resource Hospital at the time of initial application or renewal.
    a. All license, permit and certificate holders shall report all new felony convictions to the EMS System Resource Hospital EMS-MD/System Coordinator within seven (7) days after the conviction.
2) The use, sale, purchase, transfer, theft or possession of an illegal drug is a violation of the law. “Illegal drug” means any drug which is; not legally obtainable or, legally obtainable but was not legally obtained. The term “illegal drug” includes prescription drugs not legally obtained and prescription drugs legally obtained but not being used for prescribed purposes. Anyone in violation of illegal drug activities shall be referred to the appropriate law enforcement agency.
3) Substances are defined as, but are not limited to, alcoholic beverages, narcotics, stimulants, controlled substances, legal, illegal, and over the counter drugs.
4) Use, sale, dispensing or possession of the defined substances while on duty on behalf of the EMS system is prohibited.
5) Substance abuse by System providers while on duty will be grounds for suspension. The EMS-MD/System Coordinator reserve the right to immediately suspend from function any EMS provider who is or appears to be in violation of this policy. The EMS provider’s employer will be notified immediately. See Discipline-Suspension policy.
6) EMS System Provider Agency
    a. Shall have a policy addressing substance abuse and felony conviction by EMS personnel while on or off duty. The policy will accompany the provider's letter of participation, will be reviewed by the EMS-MD/System Coordinator and will be submitted as part of the EMS System Plan to IDPH.
    b. Upon notification by the EMS provider agency of impaired EMS personnel, the EMS-MD may subject the individual to immediate suspension of EMS privileges and notify IDPH of the suspension.
    c. Prior to returning to duty, any individual removed from duty by their employer for documented reasons of impairment, must have documentation forwarded to the EMS-MD that they are medically and psychologically capable of resuming EMS privileges. IDPH will be notified of the re-instatement.

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d. Any rule that requires drug testing as a condition for licensure which conflicts or duplicates a provision of a collective bargaining agreement should not apply to any person covered by that collective bargaining agreement.

7) EMS System Personnel

   a. Reporting for duty while under the influence of alcoholic beverages, narcotics, stimulants, controlled substances or other drugs that impair judgment/performance will not be tolerated.

   b. EMS System personnel observing signs of substance abuse by EMS providers are responsible for reporting their observations to the EMS System immediately.

   c. If hospital staff believe that any EMS providers behavior suggests that judgment or performance is compromised for any reason or is in violation of this policy, the EMS-MD/System Coordinator are to be notified immediately.

   d. The EMS-MD/System Coordinator will contact the participant's employer and request immediate removal from patient care activities and suspension of EMS privileges will be initiated.

8) With the exception of information required by a Local System Review Board, all information will be handled in strictest confidentiality.

References http://www.ilga.gov/commission/jcar/admincode/077/077005150A01900R.html

Evert Gerritsen
EMS System Administrator/Coordinator

Michael I. Peters, MD
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Purpose To define minimum personnel staffing requirements for each type of Emergency Medical Services System participant vehicle.

Policy

1) Each Basic Life Support (BLS) ambulance or vehicle shall be staffed by a minimum of one EMT Basic, Intermediate, Paramedic or PreHospital RN, and one other EMT Basic, Intermediate, Paramedic, Pre Hospital RN, or physician on all responses.
2) Each Advanced Life Support (ALS) non-transport vehicle shall be staffed by a minimum of one Paramedic or PreHospital RN, and one other EMT Basic, Intermediate, Paramedic, PreHospital RN or physician on all responses.
3) Each Advanced Life Support (ALS) ambulance responding to 911 calls shall be staffed by a minimum of one Paramedic or PreHospital RN, and one other Paramedic, PreHospital RN, or physician on all responses.
    a. When a 911 provider agency has multiple simultaneous calls, an Advanced Life Support (ALS) ambulance responding to 911 calls may be staffed by a minimum of one Paramedic or PreHospital RN, and one other EMT Basic or Intermediate, with the knowledge that additional ALS providers (Paramedic, PreHospital RN, or physician) will also respond to the scene in other vehicles.
4) Advanced Life Support (ALS) ambulances NOT responding to 911 calls shall be staffed by a minimum of one Paramedic or PreHospital RN, and one other EMT Basic, Intermediate, Paramedic, PreHospital RN or physician on all responses.
5) Deviation from this policy will be allowed with a system and IDPH approved system modification.

References http://www.ilga.gov/commission/jcar/admincode/077/077005150F08300R.html
ftp://www.ilga.gov/jcar/admincode/077/077005150F08300R.html

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Purpose To describe the grounds for suspension of EMS privileges and due process for EMS System providers.

Policy

1) The EMS medical director (EMS-MD) or designee may suspend from medical participation within the system any individual EMS personnel or individual ambulance service provider within the System considered not to be meeting the standards of the System.
2) Due process will be afforded prior to suspension, unless continued practice would cause imminent harm to patients.
3) Any suspension must be based on one or more of the following:
    a. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay;
    b. Failure to meet continuing education or relicensure requirements prescribed by IDPH EMS Act, Rules and Regulations or by the EMS-MD;
    c. Violation of the EMS Act, Rules or Regulations;
    d. Failure to maintain proficiency in skills for licensure level;
    e. Failure to maintain or has violated standards of performance and conduct as prescribed by IDPH or EMS System's Program Plan;
    f. Failure to comply with the provisions of the System standing operating procedures (SOP's) and/or policies and procedures;
    g. During the provision of medical services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public (e.g., use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status);
    h. Intoxication or personal misuse of any drugs or use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in a manner as to adversely affect delivery, performance or activities in the care of patients;
    i. Intentional falsification of any medical reports or orders, or making misrepresentations involving patient care;
    j. Abandoning or neglecting a patient requiring emergency care;
    k. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility, institution or other work place location;
    l. Performing or attempting emergency care, techniques or procedures without proper permission, licensure, training or supervision;
    m. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence, in the provision of emergency care;
    n. Violation of the system's standards of care, including conduct and behavior unbecoming or unprofessional;

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o. Physical impairment to the extent that the individual cannot physically perform the skills and functions for which licensed, as verified by a physician, unless the person is on inactive status;
p. Mental impairment to the extent that the individual cannot exercise the appropriate judgment, skill and safety for performing the functions for which licensed, as verified by a physician, unless on inactive status;
q. Conviction (or entered a plea of guilty or nolo contendere) by a court of competent jurisdiction of an IL Class X, 1, or 2 felony or an out-of-state equivalent offense;
r. Failure to report a felony conviction to the EMS System Resource Hospital within seven (7) days after the conviction;
s. License has been revoked, denied or suspended by IDPH.

4) Due Process
   a. Prior to suspending an EMS provider, the EMS-MD shall provide the EMS provider with the opportunity for a hearing before the local System Review Board.
      i. If the local System Review Board affirms or modifies the EMS-MD's suspension order, the EMS provider shall have the opportunity for a review of the local board's decision by the State EMS Disciplinary Review Board.
      ii. If the local System Review Board reverses or modifies the EMS-MD's suspension order, the EMS-MD shall have the opportunity for a review of the local board's decision by the State EMS Disciplinary Review Board.
   b. The suspension shall commence only upon the occurrence of one of the following:
      i. The EMS provider has waived the opportunity for a hearing before the local System Review Board; or
      ii. The suspension order has been affirmed or modified by the local board and the EMS provider has waived the opportunity for review by the State Board; or
      iii. The suspension order has been affirmed or modified by the local board, and the local board's decision has been affirmed or modified by the State Board.
   c. All suspensions related to failure to complete mandatory continuing education requirements shall be accompanied by written notice, hand delivered or via USPS mail to the suspended participant from the EMS-MD (all mailings will be considered delivered unless returned).
      i. A copy of suspension notice shall also be sent to employer.
      ii. Such notice shall include a statement describing the reason(s) for suspension, length and terms of suspension.
   d. An EMS-MD may immediately suspend an EMS provider if he or she finds that the information in his or her possession indicates the continuation

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in practice by an EMS provider would constitute an imminent danger to the public.

i. The suspended EMS provider shall be issued an immediate verbal notification followed by a written suspension order to the EMS provider by the EMS-MD which states the length, terms and basis for the suspension.
ii. Within 24 hours following the commencement of the suspension, the EMS-MD shall deliver to the Department, by messenger or telefax, a copy of the suspension order and copies of any written materials which relate to the EMS-MD's decision to suspend the EMS provider.
iii. Within 24 hours following the commencement of the suspension, the suspended EMS provider may deliver to IDPH, by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMS provider feels relate to that response.
iv. Within 24 hours following receipt of the EMS-MD's suspension order or the EMS provider's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the EMS provider's opportunity for hearing or review in accordance with the EMS Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS-MD, who shall immediately notify the suspended EMS provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.
v. Upon issuance of a suspension order for reasons directly related to medical care, the EMS-MD shall also provide the EMT or provider with the opportunity for a hearing before the local System Review Board.
    1. If the local System Review Board affirms or modifies the EMS-MD's suspension order, the EMS provider shall have the opportunity for a review of local board's decision by the State EMS Disciplinary Review Board.
    2. If the local System Review Board reverses or modifies the EMS-MD's suspension order, the EMS-MD shall have the opportunity for a review of local board's decision by the State EMS Disciplinary Review Board.
vi. The EMS provider may elect to bypass the local System Review Board and seek direct review of the EMS-MD's suspension order by State EMS Disciplinary Review Board.

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5) System Review Board
    a. The EMS System Resource Hospital shall designate a local System Review Board, for the purpose of providing a hearing to any individual or individual provider participating within the System who is suspended from participation by the EMS-MD.
        i. The EMS System Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an Emergency Department Physician with the knowledge of EMS, and one of whom is an EMT-B/paramedic, and one of whom is of the same professional category as the individual EMS personnel, individual ambulance service provider, or other system participant requesting the hearing.
        ii. The EMS MD shall prepare and post, in a 24-hour accessible location at the Resource Hospital, the System Review Board List.
    b. The EMS-MD shall arrange for a certified shorthand reporter to make a stenographic record of the hearing.
        i. A copy of the hearing transcription shall be made available to any involved party so requesting at the party's expense.
        ii. The transcript, all documents or materials received as evidence during such hearing and the System Review Board's written decision shall be retained in the custody of the EMS System Resource Hospital office and shall be maintained in confidence.
    c. Upon receipt of a Notice of Suspension from the EMS Medical Director, the EMS personnel or ambulance service provider, or other system participant shall have fifteen (15) days to request a hearing before the System Review Board, by submitting a written request to the EMS-MD via certified mail. Failure to request a hearing within fifteen (15) days shall constitute waiver of right to System Review Board Hearing. The decision of the EMS-MD shall be considered final and suspension shall commence.
        i. The hearing shall commence as soon as possible but within at least 21 days after receipt of a written request. The suspended participant shall be notified by certified return receipt mail or personal service of the date, time and place of the hearing and shall receive a copy of this policy. For good cause, the hearing may be changed upon advance request by one of the parties.
    d. A hearing held by the System need not be formal in legal terms, nor need it adhere to established rules of evidence. The hearing shall be conducted in a fair and objective manner under procedures outlined:
        i. The Board shall review and consider any testimony and documentation related to the suspension which is offered by either the EMS-MD or the suspended party.
        ii. The EMS-MD and the suspended party may both elect to have legal counsel representation.

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iii. Each party to the proceedings shall have the right to select a person to represent him/her and be present at the hearing at his/her own expense.
iv. Any rights of participation, review or commentary extended to the counsel for the EMS System will be similarly extended to the same degree to the representative for the suspended participant.
v. At the hearing, the EMS-MD or the counsel for the EMS System shall present such witnesses and evidence, as they deem appropriate to uphold the suspension.
vi. The suspended participant or his/her representative may present such witnesses and evidence, as the suspended participant deems appropriate.
vii. The System Review Board will direct questions to all concerned parties in order to gather all of the facts and pertinent information.
viii. The System Review Board shall review and consider any testimony and documentation related to the issue at hand which is offered by either party to the suspension issue.
ix. Only current allegation may be presented unless previous information illustrates a pattern of behavior or practice.
x. Each party shall have the right to submit evidence explaining or refuting the charges as well as the right to question the witnesses.
xi. The suspended participant, the EMS-MD and/or legal counsel(s) shall be allowed to listen to all testimony, but shall not be allowed admittance to the discussion and decision process of the System Review Board. However, they may be present after the decision is reached, and the System Review Board's recommendations are announced, if the decision can be reached immediately.
xii. Witnesses may only be present during their testimony or when making their statement, and shall be instructed not to discuss the situation with any other witness.

e. The Board shall state, in writing, its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS-MD and the EMS personnel, ambulance service provider or other system participant within 5 business days after the conclusion of the hearing.
f. The System shall implement a decision of the local System Review Board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the IDPH EMS Act and Rules.

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g. The EMS-MD shall notify the IDPH Chief of the Division of EMS, in writing, of a decision by the System Review Board to either uphold, reverse or modify the EMS-MD's suspension of an EMS personnel, ambulance service provider or other system participant from participation within the EMS System, within five (5) business days after the System Review Board's decision is received. Such notice shall include, if applicable, a statement detailing the duration of and grounds for the suspension.

h. The EMS System shall implement a decision of the System Review Board unless that decision has been appealed to the State EMS Disciplinary Review Board.

i. A request for review by the State EMS Disciplinary Review Board shall be made in writing by certified mail to the IDPH Chief of the Division of EMS, within ten (10) business days after receiving the System Review Board's decision.
    i. A copy of the System Review Board's decision shall be enclosed.
    ii. Requests for review shall only be made by an EMS System participant whose suspension order was affirmed or modified by the System Review Board.
    iii. If reversed or modified, the EMS-MD can request review.

j. Upon receipt of a valid request for review, IDPH, Division of EMS and Highway Safety shall convene a State EMS Disciplinary Review Board to review the decision of the System Review Board.

6) A recommendation to IDPH by an EMS-MD to deny, suspend or revoke the license of a participant within an EMS System is not subject to the provisions of this section, unless such recommendation forms the basis for suspension pursuant to the EMS Act.

References

http://www.ilga.gov/commission/jcar/admincode/077/077005150A01650R.html
http://www.ilga.gov/commission/jcar/admincode/077/077005150C04200R.html
http://www.ilga.gov/commission/jcar/admincode/077/077005150C04400R.html
http://www.ilga.gov/commission/jcar/admincode/077/077005150F08200R.html

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Title	**ECRN: Education, Licensure, Renewal, Inactive Status**	
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Purpose To describe the requirements and procedure for initial ECRN education, licensure, renewal, and inactive status.

Policy

1) Any nurse providing OLMC must hold an active Emergency Communications Registered Nurse (ECRN) license with current practice privileges. An ECRN is a RN, who under the authority of the EMS MD, in accordance with protocols may accept telecommunications from and give verbal orders to EMS personnel.

2) To be approved as an ECRN, an individual shall:
    a. Be a RN in accordance with the IL Nursing Act.
    b. Successfully complete, in order, the following requirements:
        i. ECRN course prerequisites: cardiac - ACLS; pediatrics - PALS/ENPC/CPEN or equivalent; trauma - TNCC/TNS/TCRN or equivalent; and minimum one year ED nursing experience.
        ii. ECRN education program with curriculum formulated by EMS System, approved by IDPH, which consists of at least 40 hours of classroom and practical training for both the adult and pediatric population, including telecommunications, system standing medical orders, procedures and protocols.
        iii. Meet with EMS Medical Director.
        iv. OLMC calls (minimum 10 ALS & 5 BLS) precepted by ECRN or ED physician.
            1. Submit copies of logs to EMS Coordinator.
            2. Recordings will be reviewed for appropriateness of assessment and intervention and acceptance toward completion of requirement.
        v. Eight (8) hours of field observation on an ALS ambulance with high call volume to optimize the experience, supervised by approved EMT/PM preceptor.
            1. EMS Coordinator will schedule with provider agency.
            2. ECRN student to submit completed form to EMS Coordinator.
        vi. ECRN application form as prescribed by the Department.

3) Renewal of ECRN license occurs every four years if the ECRN:
    a. Is a RN in accordance with the IL Nursing Act
    b. Has completed 32 hours of approved EMS continuing education.
    c. Has completed 4 yearly education sessions provided by the EMS System.
        i. 2 Mandatory sessions. Hosted in June and December at NM Lake Forest and NM Grayslake Campus'.
        ii. 2 Sessions of choice hosted at EMS System fire departments.

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iii. ECRNs may be excused from mandatory sessions in the event of medical or parental leave upon notification from department leadership/management.

d. ECRN Licensure Renewal Procedure
   i. ECRN will receive IDPH renewal form in mail before expiration.
   ii. Fill out EMS system renewal form and complete documentation.
   iii. If not received in the mail, fill out IDPH Renewal Notice/Child Support/Personal History Statement.
   iv. http://dph.illinois.gov/sites/default/files/licensecertificate/ems-renewal-notice-011717.pdf
   v. Pay fee online; will need renewal pin listed on form.
      1. https://emslic.dph.illinois.gov/GLSuiteWeb/clients/ildohems/private/Renewal/Login.aspx?ProcType=Renewal
         a. Select system Code = 1082
      2. If pin misplaced, call IDPH 217-785-2080 or contact EMS System Administrator/Coordinator.
   vi. After paying fee, forward copy of completed IDPH renewal form and EMS system renewal form to EMS Coordinator, at least 45 days before expiration, to allow for renewal authorization.
   vii. If ECRN license is not authorized for renewal before expiration date, ECRN will be also responsible for the additional late fee.
   viii. If ECRN license is not renewed within 60 days after expiration, ECRN need to retake the ECRN course, and pay the initial licensing fee.

4) Prior to license expiration, ECRN may request inactive status.
   a. The request shall be in writing and contain the following information:
      i. Name of individual
      ii. Circumstances requiring inactive status
      iii. Statement that recertification requirements have been met
      iv. EMS MD will review and grant or deny request.
      v. Date of approval
   b. For the ECRN to return to active status, the EMS MD must document that the ECRN has been examined (physically and mentally) and found capable of functioning within the EMS System, the ECRN's knowledge and clinical skills are at the active ECRN level, and that the ECRN has completed any refresher training deemed necessary by the EMS System.
      i. If the inactive status was based on a temporary disability, the EMSS shall also verify that the disability has ceased.
      ii. While inactive, individual shall not function as ECRN.
   c. IDPH will be notified in writing of the ECRN's approval, reapproval, or granting or denying inactive status within 10 days after change in an ECRN's approval status.

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5) An ECRN shall notify IDPH within 30 days after change in name or address. Notification may be in person, by mail, phone, fax, or electronic mail.
   a. https://emslic.dph.illinois.gov/GLSuiteWeb/clients/ildohems/private/AddressChange/AddressLogin.aspx

References http://www.ilga.gov/commission/jcar/admincode/077/077005150E07400R.html

Evert Gerritsen
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Written	12/2017
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North Region EMS System

Policy Section	**Administrative**
#	**AD 206** **Date 10/2021**
Title	**Continuing Education/License Renewal – Paramedic/EMT**
Page	**1 of 4**

Purpose To establish a standard for continuing education for EMT and Paramedic providers as a requirement for system participation and state license renewal.

Policy

1) The EMS system will provide live continuing education (CE) for 10 months of the calendar year.
    a. Each session will provide a minimum of 2 hours of CE credit.

2) Primary Field Provider System Requirements
    a. **Annual** minimum requirements:
        i. Completion of **all 10** months of System provided education.
            1. Attendance to **5 live**, in-station sessions.
                a) Airway/Ventilation Credentialing is a **mandatory** live session
            2. Providers allowed a maximum of 5 online make-up CE.
        ii. Completion of an additional **5 hours** of self-directed CE
            1. Self-directed CE can include any combination of the following:
                a. Approved Target Solutions education
                b. Approved IFSI education
                c. Approved department-sponsored education
                d. Relevant college-level education
                e. ACLS/PALS/PHTLS/PEEP, etc.
                f. Other education not listed upon approval
        iii. In extenuating circumstances, providers who do not meet the minimum requirements must meet with the EMS Coordinator to establish a plan of action.
    b. Requirements for State Re-licensure
        i. 4 Year cycle requirements:
            1. completion of 100 hours of CE
                a. 80 of 100 hours provided by System education
                b. 20 hours of self-directed CE
            2. current valid Airway/Ventilation Credentialing
            3. current valid AHA BLS for Healthcare Providers card

3) Primary Hospital Provider System Requirements
    a. Annual minimum requirements:
        i. Completion of **2** months of live System provided education.
            1. Airway/Ventilation Credentialing is a **mandatory** live session
        ii. Completion of an additional **23 hours** of approved CE
            1. Can include any combination of the following:
                a. other live/online System provided education
                b. approved NM Learning online education

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c. annual NM Skills Fair
    i. Any non-System education must be submitted to the EMS Field Educator for credit to be granted.
iii. In the event of extenuating circumstances, providers who do not meet the minimum requirements must meet with the EMS Coordinator to establish a plan of action.

b. Requirements for State Re-licensure
    i. 4 Year cycle requirements:
        1. completion of 100 hours of CE
            a. 16 of 100 hours provided by System education
            b. 84 hours of alternative CE
                i. Must be submitted and entered prior to renewal
        2. current valid Airway/Ventilation Credentialing
        3. current valid AHA BLS for Healthcare Providers card

4) Secondary Field Provider System Requirements
    a. Annual minimum requirements:
        i. **Mandatory** attendance to live CE session for Airway/Ventilation Credentialing
        ii. Current IDPH license on file with NMnrEMSS
        iii. In Good Standing with Primary System

5) License Renewal
    a. Providers must renew through their Primary EMS System.
    b. Before renewal, the provider should receive a renewal notice through the mail from IDPH with a PIN to allow payment online.
        i. To receive this notice, providers must have the correct address on file with IDPH.
        ii. If the notice is not received, please email the EMS coordinator to obtain the PIN.
        iii. Payment must be made before renewal.
    c. Primary Field Providers submit a License Renewal Request to the EMS Office through the Medical Officer at least 45 days before expiration.
    d. Primary Hospital Providers submit a License Renewal Request to the EMS Office at least 45 days before expiration.
    e. All providers submit the following:
        i. https://northregionems.org/systemforms
        ii. Attach the following to the Renewal Request:
            1. license payment receipt
            2. Renewal Notice/Child Support/Personal History statement

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3. current AHA BLS for Healthcare Providers card
4. current CE Report with hours total

iii. Medical Officer will verify all documents and forward the completed renewal request packet to the EMS Coordinator for license renewal.

6) Offsite Education Submission for Hours
   a. Upon completing approved department-sponsored education, instructors must complete an NM Offsite CE Roster and submit it to the EMS Offices within one month of class for credit to be awarded.
   b. Illinois Department of Public Health (IDPH) provides a list of CE recommendations. Courses listed in this document will be accepted after proof of attendance/participation/passing is provided.
      i. http://tiltonil.com/wp-content/uploads/2015/09/formsoprems-continuingeducationrelicensurerecommendations.pdf

7) Approved Leave of Absence (LOA) Requirements
   a. In circumstances where the Primary or Secondary provider will be on an Employer approved leave of absence to exceed 60 calendar days, the Medical Officer or Department Manager will notify the EMS Offices.
   b. The provider will be placed in the "Leave of Absence" category in PCR Reporting Software and CE Tracking Software.
      i. During this time, online make-up CE will continue to be assigned.
   c. Upon return to active status, the Medical Officer or Department Manager will notify the EMS Offices who will verify the provider is compliant with the following:
      1. current valid Airway/Ventilation Credential
      2. current valid Protocol Score on file
      3. current valid State License
      4. current AHA BLS for Healthcare Providers
      5. any other requested documentation to verify Good Standing

      i. Upon return, Primary Providers will not be held to the annual minimum requirement for live CE missed during LOA.
         a. Providers are still required to practice protocols with proficiency and must still meet the requirements for renewal at the end of the 4-year cycle.
         b. During LOA, providers will be maintain access to EMS1 and the ability to complete online modules for credit.

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8) Quick Reference Guide to CE Requirements

Provider Type	**Mandatory AVR**	**Minimum Mandatory Live CE**	**Maximum Online CE**	**Hours in a 4 year renewal cycle**
Primary Field Provider	annual live	5 annual (10 hours)	5 annual (10 hours)	100
Primary Hospital Provider (NM -ED Tech)	annual live	2 annual (4 hours)	none	100
Secondary Field Provider	annual live	1 annual (2 hours)	none	Primary System dependent

References

https://northregionems.org/systemforms

http://tiltonil.com/wp-content/uploads/2015/09/formsoprems-continuingeducationrelicensurerecommendations.pdf

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 207**	**Date 9/2023**
Title	**Drug Management and Exchange**	
Page	**1 of 5**	

Purpose

To establish and maintain a standard process for obtaining, securing, monitoring, and documenting the storage and use of System approved drugs in accordance with federal and state regulations and the safe administration of such medications.

Policy

1. Hospitals and EMS providers must comply with all federal, state, and local laws, rules, and guidelines regulating the provision, storage, exchange, and inventory management of drugs and medical supplies, including the laws relating to the handling of controlled substances.
2. EMS personnel must maintain their competency in the management of drugs and ensure their familiarity with and compliance with changes to therapeutic guidelines as they are adopted in the SOPs.
3. EMS personnel may only administer/handle approved drugs in dosages and routes to their level of certification as outlined in the Region X SOPs or with verbal orders from OLMC.
    a. All patients receiving administration of controlled substances, including, but not limited to, morphine, fentanyl, midazolam, or ketamine, must be placed on capnography to monitor for respiratory depression.
    b. EMS personnel must complete a witnessed waste of any remaining controlled substances and document it in the patient care report.
        i. The preferred witness to waste is a registered nurse at the receiving facility.
            1. If unable to obtain an RN witness, another ALS provider on the call for service may be witness to waste
        ii. EMS personnel shall complete a Witness to Waste form in ESO to include the amount wasted (mg or mcg), and the witness's signature.
4. Drugs stocked for EMS use shall be of suitable quality, quantity, concentration, and formulation for approved routes of administration per the SOPs and ALS Medication List. Only those drugs listed in the SOPs, the ALS Medication List, or approved by the EMS Medical Director in written format shall be carried on EMS vehicles and given by NMnrEMSS personnel.
5. Drugs shall be issued and stored in their original manufacturer's packaging or if reformulation is necessary, in packaging produced and labeled by a hospital pharmacist.
6. EMS personnel shall be responsible for checking their drugs and solutions daily to ensure that there are sufficient numbers of each in accordance with the ALS Medication List, that the packaging is System appropriate and intact, and that they are well within their expiration dates.

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a. Drug Replacement: controlled and non-controlled
    i. At least ten working days from the drug expiration date, EMS personnel shall submit a Pharmacy Restocking Form to the System for replacement directly from the Pharmacy.
    ii. The Pharmacy will complete the order and contact EMS personnel for pickup within five working days from completion.
    iii. EMS personnel are not to replace expired drugs from the ED supply or the EMS pyxis.
    iv. All drugs and solutions should be checked for compliance with EMS specifications before being placed into service, including but not limited to expiration within 30 days of receipt, differing concentrations, and approved drugs for shortages.

b. Drug Procurement: new ALS vehicle
    i. Non-controlled drugs shall be ordered from the Pharmacy before System ALS vehicle inspection. EMS personnel shall submit a Pharmacy Restocking Form to the System requesting a full complement of non-controls per the appropriate ALS Vehicle Medication List.
    ii. Controlled substances shall be issued by the System following a successful ALS inspection.
    iii. Note: If the new ALS vehicle replaces a previous ALS vehicle, drugs may be transferred from the previous vehicle to the new vehicle.

c. Drug Restocking: one-for-one exchange
    i. Both controlled and non-controlled drugs used for patient care must be restocked in a one-for-one exchange at the receiving facility. Follow each individual facility process for exchange.
    ii. If the receiving facility is unable to restock during business hours, EMS personnel may submit a Pharmacy Restocking Form and the completed patient care report to the Resource Hospital pharmacy for restocking. If medications must be restocked after hours, please contact the EMS Coordinator or restock the medications the following day.
    iii. The Resource Hospital pharmacy must restock non-controlled drugs used for a patient not transported via EMS. EMS personnel must submit a Pharmacy Restock Form and the patient care report to the System for replacement.

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d. Drug Restocking: broken vials or damaged seals

i. Non-controlled drugs that are broken or are found to have damaged seals may be removed from the EMS vehicle and disposed of. For replacement, EMS personnel must submit a Pharmacy Restock Form to the System and pickup from Pharmacy when completed.

ii. Controlled substances found to be broken or with damaged seals must be reported to the department Medical Officer immediately. Medical officers should contact the EMS Coordinator for replacement. Broken/damaged vials should be kept until after replacement.

7. Provider Chiefs/Administrators or their designees are responsible and accountable for the day-to-day safe and secure handling of drugs within the operational environment of their agency. They must ensure that staff understand and are competent to carry out the duties described in this policy.

8. Hospitals and EMS providers shall take all reasonable precautions to mitigate risks to patients and staff arising from the use of drugs, including but not limited to the safe use and security of those items.

a. Controlled substances are permitted to be stored in a drug bag, providing they are stored separately from non-controlled substances and are secured with a tamper-evident device such as a plastic seal.

b. Controlled substances stored in an EMS Vehicle must be kept in "a securely locked cabinet of substantial construction." This requirement extends to storage within the EMS Agency facility if medications are removed from vehicles for storage.

i. Vehicles must be secured if not occupied or parked in a secure building.

ii. Vehicles taken out of service for maintenance should have controlled substances removed and secured in the station. These medications shall still have a daily check performed and documented.

iii. Controlled substances can only be carried or stored in ALS-licensed vehicles.

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iv. It is strongly recommended, though not mandated, that the EMS Agency utilizes available technology for electronic monitoring of access to controlled substances. This technology allows the provider to limit access to controlled substances to a select number of authorized individuals and real-time tracking of which individuals have accessed these substances.

c. EMS personnel must maintain daily controlled substance logs and administration logs on every vehicle with controlled substances, including vehicles that are out of service or not staffed.

   i. Controlled substance logs will be signed by both incoming and outgoing ALS providers and will include the following information:
      1. Vehicle identifiers
      2. Seal number (if applicable)
      3. Drug quantities/concentrations
      4. Provider name/signature
   ii. A department officer will sign as the second provider if there is no incoming ALS provider to sign the controlled substances log.
   iii. The administration log will include, at minimum, the medication used, the provider's signature, and the run number documented on the patient care report.
   iv. Inventory and administration discrepancies must be addressed immediately and reported to the EMS Agency Administration and the EMS System Coordinator for investigation.
   v. Suspicion of controlled substance diversion must be immediately reported to the EMS Agency Administration and EMS System Coordinator.

d. Controlled substance logs will be maintained monthly and filed for at least two years.

   i. Controlled substance logs must be forwarded to the EMS offices by the end of the following month for record-keeping.
   ii. These logs must also be kept in-station and available for audit.
   iii. If a department obtains technology to monitor, track and secure controlled substances electronically and wishes to use it in place of a written controlled substances, log, a written plan for controlled substance tracking and inventory must be submitted to the EMS System for approval.

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References

https://www.congress.gov/115/plaws/publ83/PLAW-115publ83.pdf
https://legcounsel.house.gov/Comps/91-513.pdf
http://www.ilga.gov/commission/jcar/admincode/077/07703100sections.html
https://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf
https://www.deadiversion.usdoj.gov/pubs/manuals/sec/sec_req.htm

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Written	3/2020
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IDPH Approval	9/07/2023
Effective	9/07/2023

North Region EMS System

Policy Section	**Administrative**	
#	**AD 208**	**Date 02/2020**
Title	**System Entry Credentialing**	
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Purpose

To standardize the process for credentialing of prehospital EMS providers. Credentialing is the authorization to practice and establishes an oversight relationship with the EMS System.

Medical practice is built on the domains of education, certification, licensure, and credentialing. Credentialing is to confirm providers are maintaining at least minimal competency in the knowledge and skills of their licensure level, and are assimilating initial and continuing education into local standards of clinical practice. Credentialing is a safety process that helps assure the public that providers have met a minimum acceptable level of competence. Credentialing is ongoing and continues to evolve to remain aligned with current clinical standards, provider scope of practice, and community needs.

Credentialing is ongoing and continues to evolve to remain aligned with current clinical standards, provider scope of practice, and community needs.

Policy

1) All prehospital EMS personnel functioning in the System must be credentialed.
2) Before working their first shift, a provider must establish a relationship with the System. The provider must complete the Request for System Entry form and a Letter of Good Standing from the current primary EMS System.
3) EMS providers, upon hire, may function at a BLS level of care while pursuing the credentialing process.
    a. The credentialing period shall not exceed three months from the hire date unless a System waiver is approved.
4) Procedural steps:
    a. If the provider is licensed in Illinois
        i. The department Medical Officer submits the "*Request for System Entry & Credentialing*" form and the required documents.
            1. Current copy of AHA BLS for Healthcare Provider card
            2. Current copy of the provider's Driver's License
            3. Letter of Good Standing from the current primary EMS System and continuing education records (if applicable)
                a. If the provider has no previous System affiliation and has completed EMT or Paramedic initial education within the last six months, a letter of Good Standing is needed from the Program Lead Instructor.

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b. If a provider has no previous System affiliation and has not completed EMT or paramedic initial education within the last six months, the department Medical Officer should contact the EMS Coordinator.

4. Current copy of Illinois State EMS License
5. Signed department clearance to verify state conviction clearance requirements

ii. System Entry Coordinator activates the provider's online education account through EMS1 Academy.

iii. Provider completes the System Entry assignment.

b. If the provider is NREMT certified only, the provider may practice under provisional status as an EMT (BLS Care Only) until the State license is granted. The provider must have applied for licensure with IDPH and provide the System with the required documents.

i. The department Medical Officer submits the "*Request for System Entry & Credentialing*" form and the required documents.

1. Current copy of AHA BLS for Healthcare Provider card
2. Current copy of the provider's Driver's License
3. Letter of Good Standing from the current primary EMS System and continuing education records (if applicable)

a. If the provider has no previous System affiliation and has completed EMT or Paramedic initial education within the last six months, a letter of Good Standing is needed from the Program Lead Instructor.

b. If a provider has no previous System affiliation and has not completed EMT or paramedic initial education within the last six months, the department Medical Officer should contact the EMS Coordinator.

4. Current copy of NREMT Certificate
5. Signed department clearance to verify out-of-state conviction clearance requirements

North Region EMS System

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6. Proof of application to IDPH

c. To be successfully credentialed, the provider is expected to demonstrate live-in-person proficiency in airway management, as outlined in the pre-class work.

d. Providers who do not come from a Region X system will be required to complete a Region X Protocol Exam.

The EMS provider will be credentialed and receive practicing privileges upon completing the above steps.

References IDPH EMS Reciprocity Application: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/emsreciprocityapplication.pdf

Attachments
1. System Entry Request Form
2. System Entry Criminal Background Attestation

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EMS System Administrator/Coordinator

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EMS Medical Director

Written	8/2023
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North Region EMS System

North Region EMS System Entry Process Checklist

1. **Request the following documentation from previous System**
   - Have previous System EMS Coordinator send directly to System Entry Coordinator
     - ☐ Letter of Good Standing
     - ☐ Continuing Education Report
     - ☐ Region X Protocol Score (if previous System was not Region X, omit)
   - If provider has no previous System affiliation and has completed EMT or Paramedic initial education within the last six months:
     - ☐ Letter of Good Standing from Program Lead Instructor
   - If provider has no previous System affiliation, please have Medical Officer contact System Entry Coordinator for options in fulfilling this requirement

2. **Assemble Proper Documentation**
   - ☐ Completed System Entry Request Form – MUST have department email address
   - ☐ Legible copy of current Illinois EMS License
     - If currently Nationally Registered – copy of NREMT Certificate
   - ☐ Legible copy of current AHA BLS for Healthcare Providers Card
   - ☐ Legible copy of current Driver's License

3. **Submit All Paperwork to System Entry Coordinator**
   - ☐ Submit paperwork to Medical Officer
   - ☐ Medical Officer will scan all paperwork into one PDF and email to the following:

     Rita.Rice@nm.org

     - Processing of paperwork may take up to five business days

4. **System Entry online education assigned via EMS1 Academy**
   - ☐ Once completed, have Medical Officer verify completion and submit
   - ☐ Medical Officer notifies System Entry Coordinator via email

5. **Schedules System Entry Testing**
   - ☐ Email sent to Medical Officer from System Entry Coordinator with testing registration link
   - ☐ Schedule testing
     - New to Region X: Protocol test, Airway Credentialing
     - New to North Region from another Region X System: Airway Credentialing

North Region EMS System

System Entry Form

Completed by Provider

Last Name:	First Name:	MI:
Home Address:		Apt.
City:	State:	Zip Code:
Phone Number:	Last 4 SSN:	DOB:
Department Email Address:		
Personal Email Address:		

Previous Affiliation

☐ I am previously affiliated with another EMS System: _____

☐ I am not previously affiliated with another EMS System but have completed my initial education within the last 6 months

Program Hospital Affiliation: _____ Graduation Date: _____

☐ I am not previously affiliated with another EMS System

NMnrEMSS Affiliation Request

☐ I am requesting Primary affiliation with NMnrEMSS

☐ I am requesting Secondary affiliation with NMnrEMSS

- My Primary affiliation is with _____

Licensure Level

☐ EMT-B IDPH Number: _____ NREMT Number: _____

☐ Paramedic Expiration: _____ Expiration: _____

Program Hospital Affiliation: _____ Graduation Year: _____

Completed by Medical Officer

Medical Officer Signature:_____ Date: _____ ESO User Name:_____

Completed by System Entry Coordinator

Protocol Test Score: _____

- ☐ Completed EMS1 Assignment
- ☐ Completed in-person Testing
- ☐ Physical File Completed
- ☐ Welcome Email Sent

EMS1 Activation:

- ☐ Member added
- ☐ Group assigned
- ☐ Credential added
- ☐ System Entry assigned
- ☐ Learning Plan assigned
- ☐ Annual CE block assigned
- ☐ Previous CE entered

ESO Activation:

- ☐ User name added
- ☐ Roles added
- ☐ License number added
- ☐ Force password reset

Completed by EMS System Coordinator

☐ IDPH Number Updated Coordinator Signature:_____ Date: _____

North Region EMS System

Policy Section	**Administrative**	
#	**AD 209**	**Date 8/2023`**
Title	**Animal Transport: Service/Support /Law Enforcement Animals**	
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Purpose To provide treatment and transport guidelines for law enforcement and service animals.

Policy

1) Law Enforcement Animals
   a. North Region EMS System Providers may transport a police dog injured in the line of duty to a veterinary clinic or similar facility if no persons require medical attention or transport at that time.
   b. A "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.
   c. EMS personnel will require the assistance of the police dog's police handler to approach the dog and ensure it is safe for EMS personnel to attend to the police dog.
   d. EMS personnel may provide BLS-level first aid, cardiopulmonary resuscitation, and life-saving interventions. Providers are NOT authorized to provide ALS-level care to a police dog.
2) Service Animals
   a. A service animal is a dog individually trained to perform tasks for an individual with a disability. The functions performed by the service animal must be directly related to the person's disability.
   b. EMS personnel may ask the following two questions to determine if an animal is a service animal:
      i. Is the animal required due to a disability?
      ii. What work or task has the animal been trained to perform?
   c. EMS personnel shall make reasonable accommodations to allow service animals to accompany individuals with disabilities during patient transports.
   d. The presence of a service animal should not hinder the provision of necessary medical care. The safety and well-being of both the patient and the service animal should be considered.
   e. EMS personnel should not separate the patient from their service animal unless it poses a direct threat to the safety of others or if the presence of the animal interferes with the provision of medical care.
   f. If the service animal needs to be temporarily relocated during medical procedures, efforts should be made to reunite the patient and their service animal as soon as possible.
   g. Before leaving the scene, EMS personnel shall communicate with the receiving hospital staff to determine if the hospital can receive the patient with the service animal.
      i. If the receiving hospital cannot accommodate the service animal due to exceptional circumstances (e.g., infection control, safety risks, specific medical procedures), alternative arrangements should be made to

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ensure the patient's continuity of care and the well-being of the service animal.

h. EMS personnel should document the presence of a service animal in the patient care report, including any pertinent details such as the animal's behavior and interactions.

References

https://ag.state.il.us/rights/servanimals.html

https://idhhc.illinois.gov/resources/service-animals-resources.html

Attachment

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 210**	**Date 6/2023**
Title	**Securing a Weapon**	
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Purpose

To establish a framework and guidelines to ensure the safe and effective handling, storage, and control of weapons to minimize the risk of unauthorized access, loss, theft, or misuse of weapons, thereby promoting the safety of EMS personnel and patients.

Policy

1. EMS should make every attempt to screen all patients for concealed weapons prior to leaving the scene to transport to a medical facility.
2. When the emergency response is occurring away from their home, the patient may relinquish their weapon to a law enforcement officer on scene if one is available or to another responsible party at the scene.
3. Patients with concealed arms should secure the weapon at their residence whenever possible.
4. It is preferred that the local law enforcement agency meets the EMS transport vehicle at the scene to secure the weapon.
5. If the weapon is discovered while already enroute to a medical facility, the weapon may be secured by EMS personnel in a locked compartment within the vehicle. The medical facility shall assume control of the locked weapon when the patient is delivered, regardless of the patient's concealed carry status.
    a. While enroute, emergency response personnel shall notify the receiving facility that a weapon is being transported in a locked compartment with the patient. Advise the receiving facility if the patient is or was uncooperative regarding their weapon.
    b. Facility security personnel shall meet the transport vehicle at the doors to take control of the weapon.
    c. Medical facility and emergency response personnel shall document the transaction in the ePCR and obtain a signature from the security personnel.

References

Northwestern Medicine Patient Rights and Responsibilities
Lake County Concealed Carry Act: 430 ILCS 66/65 Sec. 65. Prohibited areas

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 211**	**Date 8/2023**
Title	**EMS Crew Member – Line-of-Duty Death**	
Page	**1 of 1**	

Purpose

To establish a procedure for EMS agencies to notify the North Region EMS System in the event of an EMS crew member's death in the line of duty. The policy aims to ensure timely and accurate reporting of such incidents to the Illinois Department of Public Health (IDPH), facilitate appropriate response and support from the EMS System, and maintain the confidentiality and privacy of the affected individuals and their families.

Policy

1) Upon learning about the death of a North Region EMS System crew member in the line of duty, the EMS agency shall notify the EMS System.
    a. Upon learning about the death of an EMS crew member in the line of duty, the EMS agency shall immediately notify the North Region EMS System before the end of the next business day.
    b. The EMS agency shall provide accurate and detailed information regarding the incident, including the date, time, location, and circumstances surrounding the crew member's death.
2) Upon receiving notification of an EMS crew member fatality, the North Region EMS System shall acknowledge the report and initiate the appropriate response and support mechanisms.
    a. Upon receiving notification of an EMS crew member fatality, the North Region EMS System shall fulfill its responsibility to promptly notify the IDPH or any other relevant governing body before the end of the next business day.
    b. The North Region EMS System shall provide accurate and timely information to IDPH, including the details of the incident, the identity of the deceased crew member, and any additional documentation or reports as required by regulatory guidelines.
    c. The North Region EMS System shall collaborate with IDPH and cooperate fully with any investigation or review processes initiated by the regulatory agency.
3) All information related to the EMS crew member fatality shall be treated with the utmost confidentiality and privacy, following applicable laws and regulations.

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 212**	**Date 6/2023**
Title	**EMS Provider Deployment**	
Page	**1 of 1**	

Purpose To define the procedure for notification to the North Region EMS System of a provider leaving the state for deployment to regional or national incidents.

Policy Agencies who are willing to send their providers to an Emergency Management Assistance Compact (EMAC) or are requested via FEMA or MABAS (outside Illinois) shall complete the following PRIOR to deployment:

1. Submit proof of request for deployment
2. Submit the following information to Orth Region EMS System (NMnrEMSS):
    a. Provider name and credentials that is planning on deployment
    b. Agency planning on deploying with
    c. License plate number of the vehicle planning on deployment
    d. Date of Departure
    e. Date of Return
    f. Service Level
    g. EMAC / NAC request
    h. Location deployed to
3. Once the above information is submitted to NMnrEMSS, NMnrEMSS will notify via email the Regional EMS Coordinator for IDPH, the Ambulance Section Chief for IDPH and the Division Chief of EMS for IDPH.
4. Upon return from deployment, NMnrEMSS must be notified prior to the provider operating as minimum staffing on an ambulance to assess the need for updated training. If an IDPH licensed vehicle is returning from a deployment, a NMnrEMSS inspection (as well as possible IDPH inspection) will need to be performed prior to return to normal service.
5. If the deployment would increase or alter the standard response times of the agency, NMnrEMSS and or IDPH may reject the request.

References North Region EMS System Policy Manual AD 206.7
Section 515.810 EMS Vehicle System Participation

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 213**	**Date 8/2023**
Title	**Equipment Management**	
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Purpose To establish and maintain a standard process for supplying, maintaining, and new implementation of required disposable and non-disposable equipment as approved by the System for EMS personnel use.

Policy

1. Each NMnrEMSS agency agrees to purchase and maintain its own non-disposable equipment as specified in the System Equipment and Medication List with sufficient back up to meet usual and customary needs.
2. New non-disposable equipment purchase shall be a collaborative process between the hospital and prehospital System members unless the EMS MD believes there are unusual and compelling medical reasons for requiring a product based on their prerogative alone.
3. New products being considered for use in the NMnrEMS System will go through the following process before being added to the System Equipment and Medication List:
    a. Members of the Quality Team, department leadership, or department-approved individuals will submit a request for new non-disposable item inclusion into the approved System Equipment and Medication List to the EMS MD with supporting research and product information from the manufacturer.
    b. Review by the EMS MD to determine if further evaluation or consideration is warranted or approved. If the EMS MD rejects the product for prehospital use in this System, the investigation process stops at this point.
    c. If the EMS MD approves the product for further review, the manufacturer/distributor shall be directed to the Quality Team to discuss the item's merits with potential users.
    d. The Quality Team will provide feedback on a product's strengths and perceived limitations and may decide to conduct field testing with the prior authorization of the EMS MD.
    e. The System is committed to responsible stewardship and agrees that any product purchase that would impact the capital budgets of providers or hospitals shall be brought to the Chiefs/Administrators before making a decision for approval or developing a timeline for compliance.
    f. The EMS Coordinator will file a System plan amendment with IDPH if needed.
    g. The EMS MD or designee will ensure the creation of educational materials, mandatory implementation of the education, and documented competency of all users before implementing the new non-disposable equipment.

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4. If it becomes necessary to leave a non-disposable item at a receiving hospital due to ongoing patient requirements, the hospital assumes responsibility for ensuring its safe and expeditious return to the Provider within the guidelines below.
    a. All non-disposable equipment must be appropriately labeled by the EMS Provider using engraving tools or indelible ink/paint indicating the owner's name and identifying ambulance number, if appropriate. Unmarked equipment is exempt from this policy.
    b. EMS personnel should check the availability of their non-disposable equipment before leaving the ED. If the equipment has been removed from the patient, it is the responsibility of EMS personnel to clean/disinfect (per OSHA guidelines) their equipment before placing it back into the ambulance.
    c. If equipment is removed after EMS departure from the ED, it is the responsibility of the receiving hospital to ensure that it is cleaned/disinfected per OSHA guidelines before being placed into the EMS equipment room/locker. If provider non-disposable equipment is soiled with blood/body fluids in such a way that makes cleaning/disinfecting impossible, it should be placed into a red biohazard bag labeled with the Provider Agency name. The Provider Agency is to be notified regarding a decision on the disposition of the contaminated equipment (i.e., returned or discarded). Contaminated equipment should NEVER be placed in the EMS equipment room/locker.
    d. Hospitals shall store EMS equipment in a secure environment and are responsible for its safekeeping for up to 48 hours. Responsibility for the equipment returns to the EMS Provider if the item is not claimed within 48 hours after leaving it at the hospital unless the agency has made special arrangements for storage until pick up is possible.
5. Linens exchange, i.e., sheets, blankets, pillowcases, towels: System hospitals will not be expected to provide linen for ambulance bunk rooms or for the private use of System personnel unless the nature of the call necessitates immediate showering or cleaning of uniforms upon arrival at the ED. System hospitals may fulfill requests to provide EMS personnel with scrubs or other suitable attire that may be worn in the interim and shall be returned to the hospital the same or the next shift day.
6. Disposable equipment is to be exchanged one-to-one at a Region X receiving facility.
    a.

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b. If a Region X receiving facility does not have the required disposable equipment, EMS personnel may obtain a one-for-one replacement at the Resource Hospital by submitting a Central Supply Request Form and the associated PCR to the EMS Coordinator.
c. Disposable equipment used in a non-transport may be replaced at the Resource Hospital by submitting a Central Supply Request Form and the associated PCR to the EMS Coordinator.
d. Note: It is the responsibility of the department to resupply specialty disposable equipment not otherwise provided by the Resource Hospital

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North Region EMS System

Policy Section	**Administrative**	
#	**AD 214**	**Date 8/2023**
Title	**Ambulance Licensing Requirements**	
Page	**1 of 1**	

Purpose

To define the Northwestern Medicine North Region Emergency Medical Services System (NMnrEMSS) requirements for vehicle design for NMnrEMSS operations and Illinois Department of Public Health (IDPH) licensing.

Policy

1) Vehicle Design
    a. Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as:
        i. National Fire Protection Association
        ii. Ground Vehicle Standards for Ambulances
        iii. Federal Specifications for the Star of Life Ambulance
        iv. Commission on Accreditation of Ambulance Services (CAAS)
        v. Ground Vehicle Standard for Ambulances.
    b. *A licensed vehicle* shall be exempt *from subsequent vehicle design standards or specifications required by the Department* in this part *as long as* the *vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until* the *vehicle's title of ownership is transferred*.
2) Equipment
    a. Vehicles shall have all required equipment that is unexpired and in good working order, as determined by the IDPH and NMnrEMSS based on vehicle licensure level.
        i. Equipment lists can be found on the IDPH website and the NMnrEMSS website.

References

https://www.ilga.gov/commission/jcar/admincode/077/077005150F08300R.html

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 101**	**Date 3/2020**
Title	**Abandonment - Patient**	
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Purpose To provide for continuity of appropriate medical care and identify when EMS providers may discontinue patient care.

Policy

1) Abandonment may occur when a provider-patient relationship, once established, is intentionally reduced or ended by EMS personnel without consent of the patient. This patient relationship can only end when:
    a. The patient ends the relationship.
    b. Patient care is transferred to another qualified medical professional.
2) EMS providers may not leave a patient if a needs exists for continuing medical care. Exceptions:
    a. Presence and availability of individual with comparable or higher licensure assume responsibility for patient care.
    b. EMS personnel are physically unable to continue care due to exhaustion or injury.
    c. Law enforcement, fire officials, or EMS crew determine the scene is not safe and immediate life or injury hazards exist.
    d. Patient has been determined to be deceased or to have a valid DNR.
    e. Specifically requested to leave the scene due to an emergent specific need (e.g., triage, mass casualty disaster).
    f. Decisional patient refuses care.

References

http://www.jems.com/articles/2007/09/patient-abandonment-what-it-an-0.html
http://www.jems.com/articles/2008/02/patient-abandonment-part-two.html

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North Region EMS System

Policy Section	**Patient Care**
#	**PC 102** **Date 8/2023**
Title	**Human Trafficking, Abuse/Neglect Victims: Child, Domestic, Elder**
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Purpose Offering immediate and adequate information regarding services available to victims of human trafficking, abuse or neglect, or for any person suspected to be a victim of domestic abuse.

Policy

1) Human Trafficking

   a. North Region EMS Providers shall report suspected cases of human trafficking to the appropriate authorities promptly. EMS personnel are required to be vigilant in recognizing potential signs of human trafficking and are expected to report such cases following the guidelines outlined in this policy.

   b. Recognizing Signs of Human Trafficking:

      i. Potential signs of human trafficking, which may include but are not limited to:
         1. Unexplained injuries or physical abuse
         2. Visible signs of malnutrition or neglect
         3. Evidence of control or domination by others
         4. Fear, anxiety, or reluctance to speak
         5. Inability to provide identification or travel documents
         6. Inconsistencies in the victim's story

   c. Reporting Procedure:
      i. If EMS personnel suspect that a patient is a victim of human trafficking, they should ensure the immediate safety and medical needs of the patient are addressed.
      ii. Once the patient's condition is stable and appropriate medical care has been provided, EMS personnel should document any relevant information related to the suspected human trafficking case, such as observations, statements made by the patient, or any other pertinent details in the patient's care report.
      iii. EMS personnel should promptly notify the following to inform of the suspected human trafficking case:
         1. If transported: The receiving facilities Emergency Department Charge Nurse
         2. Local Law Enforcement
         3. The National Human Trafficking Hotline (1-888-373-7888)
         4. North Region EMS System Coordinator or Medical Director
         5. The EMS Providers immediate supervisor

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2) Child Abuse & Neglect
    a. The following should raise the suspicion of child abuse and indicate need for more investigation:
        i. Discrepancy between history and physical exam
        ii. Prolonged interval between injury and seeking medical care
        iii. History/suspicion of repeated trauma
        iv. Parent/guardian respond inappropriately or do not comply with or refuse assessment, treatment or transport of child
        v. Apathetic child, e.g., does not seek comfort from parent/guardian
        vi. Poor nutritional status
        vii. Environment that puts the child in potential risk
        viii. Perioral and perianal injuries
        ix. Long bone fracture under three (3) years of age
        x. Multiple soft tissue injuries
        xi. Frequent injuries - old scars, multiple bruises and abrasions in varying stages of healing
        xii. Injuries such as bites, cigarette burns, rope marks
        xiii. Trauma to genital or perianal areas
        xiv. Sharply demarcated burns in unusual areas

    b. Illinois law (Abused and Neglected Child Reporting Act 325 ILCS 5/4) designates EMS personnel as mandated reporters of suspected child abuse or neglect. “Mandated reporters are required to report suspected child abuse or neglect immediately 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.”
        i. Emergent reports should be made immediately by telephone to the DCFS Hotline (800-25-ABUSE, 800-252-2873). Telephone reports must be confirmed in writing using the DCFS CANTS 4 form via the U.S. Mail, postage prepaid, within 48 hours of the initial report.
        ii. Non-emergent reports can be reported using the Online Reporting System available at https://www2.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx.
        iii. EMS personnel shall also report their observations and suspicion to the emergency department physician and/or charge nurse and document findings on patient care report.
    c. Treat patient per SOP.

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d. If parent/guardian refuses to let you treat and/or transport the child, remain at the scene. Contact OLMC/Resource Hospital and request law enforcement assistance.
e. A law enforcement officer, physician or a designated Department of Children and Family Services (DCFS) employee may take or retain temporary protective custody of the child.
f. Any person acting in good faith in the removal of a child shall be granted immunity from any liability as a result of such removal.

3) Domestic

a. EMS personnel who suspect a patient is the victim of domestic abuse are required by law to provide immediate and adequate information regarding services available to victims of abuse.

b. All licensed EMS vehicles will carry information to provide domestic abuse victims information regarding services available.

c. EMS personnel shall make every reasonable effort to transport the patient. If transport is refused, request law enforcement assistance if indicated.

d. Report your suspicions to the emergency department physician and/or charge nurse.

4) Elder/Disabled Persons

a. EMS personnel who suspect an elderly or disabled adult patient may be abused or neglected shall report the circumstances to the appropriate authority upon completion of patient care in compliance with the Adult Protective Services Act.

i. Who/what must be reported: According to the Adult Protective Services Act, any abuse, neglect or financial exploitation of a person 60 years of age or older, or 18-59 living with a disability, must be reported when it is determined, or unable to be determine, that the individual is unable to self-report. Self neglect is included, however is not listed for mandatory reporting.

ii. If a provider is in doubt to the ability of the person to self-report, suspected abuse, neglect or financial exploitation must be reported.

b. Elder/Disabled Persons Abuse/Neglect Notification:

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i. 1-866-800-1409 for 24-hour Adult Protective Services Hotline (For elders/disabled persons not in a nursing home/long term care center: IL Dept of Aging, Adult Protective Services)

ii. In Lake County, Catholic Charities of the Archdiocese of Chicago manages Adult Protective Services cases and can be contacted directly at 1-847-546-5733.

iii. 1-800-252-4343 (For elders/disabled persons residing in nursing homes/long term care centers: IDPH Nursing Home Hotline)

c. Report your suspicions to the emergency department physician and/or charge nurse upon arrival.

d. Carefully document history and physical exam findings as well as environmental and circumstantial data on the patient care report.

5) If there is reason to believe the elderly/disabled patient has been abused/neglected/financially exploited, EMS personnel shall make every reasonable effort to transport the patient. If transport is refused, request law enforcement assistance if indicated.

6) Providers fulfilling their mandated reporter requirements in good faith are protected from any civil or criminal liability by Illinois law.

References

http://www.ilga.gov/legislation/ilcs/documents/075000600K401.htm
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North Region EMS System

Policy Section	**Patient Care**
#	**PC 103** **Date 3/2020**
Title	**Advanced Directives: DNR, POLST, Power of Attorney, Living Will**
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Purpose To provide guidance regarding applicability of advanced directives in the prehospital setting.

Policy

1) The U.S. Patient Self-Determination Act recognizes patients have the right to make healthcare decisions. An advance directive is a document that expresses those choices. Illinois has 4 advance directives: health care power of attorney; living will; mental health treatment, and Do-Not-Resuscitate (DNR)/ Practitioner Orders For Life-Sustaining Treatment (POLST).
    a. EMS personnel shall make a reasonable attempt to verify the identity of the patient (e.g., identification by another person or identifying bracelet) named in a valid DNR Advance Directive.
    b. Revocation of a written DNR Advance Directive shall be made only in one or more of the following ways:
        i. Advance Directive is physically destroyed by the physician who signed it or the person who gave written consent; or
        ii. Advance Directive is verbally rescinded by physician who signed it or person who gave written consent and word "VOID" is written in large letters across the front of Advance Directive, and Advance Directive is signed and dated by physician who signed it or the person who gave written consent to the Advance Directive.
2) Power of Attorney (POA) for Healthcare:
    a. Illinois law allows persons to appoint someone (“agent”) to act on their behalf in making healthcare decisions.
    b. Durable POA for Healthcare supersedes a Living Will.
    c. Appointed via a "Durable POA for Health Care" form.
    d. Can be anyone other than the patient's physician.
    e. An attorney is not needed to execute the form.
    f. The POA's ability to make decisions are usually designated to begin when the patient is unable to make decisions. If the patient is alert and consents to treatment, treat the patient.
        i. The POA may make choices regarding acceptance or refusal of treatment, transport, and hospital preference.
        ii. The POA can consent to a DNR order, but the DNR order must be written by an authorized provider.
    g. If someone claims to have a POA for healthcare:
        i. Begin treatment per SOPs.
        ii. Immediately inform OLMC Resource Hospital that a POA for the patient is present. Follow orders of OLMC physician.
        iii. Ask for the Illinois POA for Health Care form.

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iv. Document name of POA on the PCR. Bring the POA form to the hospital, if the patient is transported.
v. If doubt about identity, validity, authority, or OLMC cannot be established, treat per SOP and transport ASAP.

3) Do Not Resuscitate (DNR)/Practitioner Orders for Life-Sustaining Treatment (POLST)

a. In Illinois, DNR/POLST orders should be documented on the IDPH Uniform POLST Advance Directive, however previous version of this document may be honored. Providers must also honor photocopies of DNR/POLST. In the event a provider is given a DNR/POLST form from a facility or out of state, contact OLMC for guidance.
b. To be considered a valid document, the following are required:
    i. Name of the patient
    ii. Name and signature of authorized practitioner
    iii. Effective date
    iv. The phrase "Do Not Resuscitate" or "Practitioner Orders for Life-Sustaining Treatment" or both
    v. Evidence of consent
        1. Signature of patient
        2. Signature of legal guardian
        3. Signature of durable power of attorney for health care agent; or
        4. Signature of surrogate decision-maker
        5. Signature of witness
c. A POLST form is used to document choices for medical interventions (full, selective, comfort focused treatment), nutrition, and cardiopulmonary resuscitation (attempt CPR, DNR).
    i. DNR refers to the withholding of cardiopulmonary resuscitation (CPR) in pulseless and apneic patients, including electrical therapy such as cardioversion, defibrillation, and pacing, manually/mechanically assisted ventilation and invasive airway management.
    ii. A DNR order does <u>not</u> authorize withholding of treatment if the patient is not in cardiopulmonary arrest; treat per Region X SOP and in conjunction with specific instructions documented on POLST form.
    iii. All EMS personnel may honor valid DNR orders.
d. This policy includes, but is not limited to, cardiac arrest in long term care facilities, hospice and home care patients, and patients who arrest during inter-hospital transfer or transportation to/from home.
e. Online Medical Control must be contacted when a DNR is honored.

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4) Withholding Resuscitative Efforts
    a. Cardiopulmonary resuscitation (CPR) should be withheld if:
        i. The patient is declared dead by coroner/medical examiner or the patient's physician
        ii. The patient has a valid DNR and OLMC has been contacted.
        iii. Any of the following signs of biological death are present:
            1. Decapitation
            2. Decomposition/incineration/mummification/ putrefaction
            3. Profound dependent lividity
            4. Rigor mortis without profound hypothermia/frozen state
            5. Thoracic/abdominal transection
    b. Provider must document reason for withholding resuscitation in patient care report.
5) Refer to Coroner Notification policy.
6) A Living Will cannot be recognized by EMS personnel on its own.
7) Contact OLMC Resource Hospital if any questions/concerns.
8) System personnel will receive education on this policy when joining the system, when changes to the policy are made, and when annual quality assurance measures performed by the provider agency and EMS System Resource Hospital, or sentinel events, indicate a need for focused re-education, that will be provided via written materials and/or during scheduled continuing education classes.

References

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http://www.dph.illinois.gov/sites/default/files/forms/forms-legal-power-attorney-040716.pdf
ftp://www.ilga.gov/jcar/admincode/077/077005150C03800R.html

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 104**	**Date 5/2024**
Title	**Behavioral Emergencies/ Emotionally Disturbed Patients**	
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Purpose To provide guidelines for the care of a patient experiencing a behavioral emergency.

Policy

1) Definitions

   a. **Behavioral emergencies** are those in which the patient's problem is that of mood, thought, or behavior that is dangerous or disturbing to himself/herself or to others.

   b. **Decisional capacity** is determined by evaluating the patient's affect, behavior, and cognitive (intellectual) ability. Psychiatric signs and symptoms are grouped into the systems that they affect: consciousness; motor activity; speech; thought; affect; memory; orientation; and perception. The determination of decisional capacity generally depends on the person's ability to:

      i. communicate a choice

      ii. understand relevant information

      iii. appreciate the situation and its consequences

      iv. weigh the risk and benefits of options and rationally process this information before making a decision

      See PC 117 Patient Choice Policy

   c. **Life-threatening psychiatric conditions**

      i. **Suicide risk**: Any willful act or planned act designed to end one's own life.

      ii. **Homicidal risk**: Any willful act designed to end another's life.

      iii. **Grave mental disability**: A state of impaired judgment such that the patient is unable to provide for his basic needs of food, clothing, and shelter.

   d. A **petition** is a legal psychiatric form from the Illinois Department of Mental Health that, when completed, represents the first step in the process to admit a person against his or her will. It provides first-hand information to the physician for his/her consideration of a certificate. It does not, by itself, admit the patient.

2) On-scene Procedure

   a. Evaluate scene safety. Utilize information from observation, and reports from dispatch, law enforcement and bystanders to assess potential risks of violence or escalation.

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i. EMS personnel should avoid placing themselves in danger; this may result in a delay in initiation or pause in patient care until the safety of EMS personnel is assured.

ii. Ensure law enforcement is present for all potentially dangerous situations.

b. Identify yourself and attempt to gain the patient's confidence in a non-threatening manner

c. Consider and attempt to evaluate for possible physiological causes of behavioral problems and initiate treatment as required. Examples hypoxia, hypotension, hypoglycemia, head injury, alcohol/drug intoxication or reaction, stroke, postictal states, electrolyte imbalance, thyroid disorders, infections and dementia.

d. Assess decisional capacity and potential danger to self or others by observation, direct exam and reports from family, bystanders, or law enforcement.

e. Attempt to orient the patient to reality, gain cooperation and persuade him or her to be transported to the hospital voluntarily so they can be examined by a physician.

f. If the patient is unwilling to be transported to the hospital voluntarily: With the support and participation of on-scene law enforcement, if the patient is judged to be experiencing a behavioral emergency and poses an immediate danger to self or others, EMS personnel should initiate treatment and transport in the interest of the patient's welfare, despite patient's refusal of such. Contact EMS Resource Hospital to discuss options. See Region X SOPs and PC 118 Restraint Use.

3) Involuntary Admission Petition

a. Assure EMS personnel safety at all times.

b. If the patient is judged to have a psychiatric cause for their illness that meets one of the eligibility requirements on the petition form, any witness to behavior that qualifies the patient for involuntary admission may initiate The Petition for Involuntary/Judicial Admission Form (IL 462-2005 R-01-10).

i. If EMS personnel on-scene are the witnessing party, they may initiate a petition form with the support and participation of law enforcement on scene. The participation and support of law enforcement is to ensure safety of EMS personnel and patient during treatment and transport of any involuntary admission.

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I. If law enforcement is unable or unwilling to participate, contact OLMC (See Policy PC 105 Communication: On-Line Medical Control)

ii. EMS personnel may transport a patient whose family member has completed an Involuntary Admission Petition with the support and participation of on-scene law enforcement.

I. If law enforcement is unable or unwilling to participate, contact OLMC (See Policy PC 105 Communication: On-Line Medical Control)

iii. EMS personnel who witnessed the behavior that qualifies the patient for involuntary admission may provide witness statements to the receiving facility that initiates an Involuntary Admission Petition.

c. Per the Region X Standard Operating Procedures Patient Restraint Protocol, no forcible or involuntary restraint of a patient may be used without the assistance and participation of on-scene law enforcement.

4) EMS Completion of Involuntary Admission Petition Instructions

a. EMS personnel on scene may initiate an Involuntary Admission Petition with the assistance and participation of on-scene law enforcement.

b. EMS personnel must have been the ones to observe the behavior that qualifies.

c. Page 1:

i. Statutory reason for initiation of petition: Fill out patient's name and leave the rest of page 1 blank

d. Page 2:

i. Assertions: The EMS responder must insert the patient's name and check the assertion that applies

ii. Insert a detailed description of any acts or significant threats supporting the assertion and the time and place of their occurrence. Quote any statements made by the patient that substantiate the determination of risk.

e. Page 3:

i. Leave first statement area blank. Hospital will fill in.

ii. Insert information regarding police officer involvement

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iii. Notification statements: If another adult or the EMS personnel is signing the petition form, they have the option of requesting or declining notifications as listed.

iv. The person who signs the petition (petitioner) must be 18 years or older and be an eyewitness to the patient's behavior. It is not appropriate for a petition to set forth facts which are true "according to family members". A family member/ advocate/guardian should sign the petition if they are the only witnesses. If the family is not available or refuses to sign the form, the next most appropriate person would be a police officer who witnessed or was informed about the behavior.

v. List the petitioner's relationship to the patient and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the patient as known to you at the time of the call.

vi. The petition must indicate the date it is filled out.

f. Page 4: leave blank

g. Petition forms completed by EMS Personnel should be uploaded as an attachment to the Electronic Patient Care Report.

References (405 ILCS 5/) Mental Health and Developmental Disabilities Code
Region X Standard Operating Procedures

Attachment

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 105**	**Date 8/2023**
Title	**Communication: On-Line Medical Control (OLMC)**	
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Purpose To establish patient care-related communication guidelines for the EMS System Resource Hospital and Provider Agencies.

Policy

1) EMS System Resource Hospital
    a. Will maintain two-way ambulance to the hospital, and hospital-to-hospital communication, including but not limited to telephone lines, UHF/med channels, and VHF/MERCI radio.
    b. Hospital telecommunications equipment will be maintained, with maintenance and repair agreements, to minimize breakdown.
        i. In the case of equipment breakdown at:
            1. Calls will be directed to the other site by NM Lake Forest Hospital (NMLFH) or NM Grayslake Freestanding Emergency Center (FEC).
            2. Both NM Lake Forest and NM Grayslake FEC, calls will be directed to other Region X hospitals.
    c. On-line medical control (OLMC) communication will be audio recorded using the General Devices CAREpoint workstation and retained on the NMLFH server for retrospective review for a minimum of 365 days. The ECRN or Emergency Department Physician will complete a digital CAREpoint ECRN log form for each call.
    d. On-line medical control (OLMC) communication from the EMS System Resource Hospital to prehospital EMS personnel must be given by the EMS-MD or designee, who must be either a licensed physician (ECP) authorized by the EMS-MD or qualified emergency communications registered nurse (ECRN).
        i. The EMS System Resource Hospital will at all times have qualified ECRN and ECP staff available for communication with prehospital EMS personnel.
    e. An ECRN will request ECP consultation in the following:
        i. Situations requiring deviation from SOP/protocols.
        ii. Complex issues and/or policy interpretation. Examples:
            1. High risk refusal of care/transport
            2. Crime scene
            3. DNR question
            4. Patient/family request more distant hospital
            5. Hospital on bypass: risk/benefit determination
            6. Diversion to specialty center (e.g., trauma, stroke)
            7. Concern regarding invasive procedure (e.g., cardioversion, cricothyrotomy, decompression)
            8. EMS personnel, patient or family members request consultation with a physician
            9. Physician at the scene involved in providing care

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10. Termination of resuscitation

f. If OLMC staff need to re-contact an EMS provider agency, after termination of radio contact, the provider agencies dispatch center can be called, to request the provider re-contact OLMC.
g. It is the responsibility of the senior ECP in the emergency department to assure that there is immediate ECP response whenever medical consultation and assistance is requested.
h. The EMS System Resource Hospital will not provide OLMC direction to EMS providers not in EMS Region X; those providers should contact the appropriate hospital.

2) EMS Provider Agencies
   a. All providers must maintain at least two means of communication including MERCI channel and cellular phone or telemetry radio.
      i. Cellular phones will be used as the primary method of communication with the MERCI radio as back-up.
      ii. Prehospital telecommunications equipment will be maintained to minimize breakdown.
   b. EMS provider agencies will have the capability of transmitting 12 lead electrocardiograms (ECG) to EMS System Resource Hospital.
   c. EMS personnel will initiate contact with OLMC in the following:
      i. All transports
         1. If transporting to a Resource or Associate Hospital, or Freestanding Emergency Center - within Region X, may contact the desired destination directly.
         2. If transporting to a hospital <u>not</u> in Region X, contact OLMC/EMS System Resource Hospital.
         3. EMS personnel should not contact a non-Region X hospital for OLMC direction.
      ii. Medical-legal issues, e.g., DOA, DNR, crime scene, physician on scene, etc.
      iii. Refusal of transport - prior to leaving the scene - for the all of following types of high-risk patients:
         1. ALS: Received ALS assessment/treatment or would have met criteria for ALS transport, including L1-2 trauma
         2. Age: Minors under age 18, regardless of presence of parents/guardian on scene; and elderly, age 65 and older
         3. AMS: Altered mental status, under the influence of drugs/alcohol, or behavioral/psychological complaints
         4. Obstetric patients
         5. Any complex call where EMS personnel wish to seek additional consultation

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6. EMS personnel will be given a log number by the ECRN or ECP who takes the call. This number must be documented in the patient care report.

d. EMS personnel shall provide the following information to OLMC:
   i. EMS provider agency information
   ii. Patient gender & approximate age
   iii. Chief complaint/mechanism of injury
   iv. Past medical history
   v. Physical exam
   vi. Impression (alerts; cardiac/STEMI, sepsis, stroke, trauma)
   vii. Treatment initiated
   viii. Destination & estimated time of arrival

e. If prehospital EMS personnel have a question about treatment ordered by an ECRN, the prehospital EMS personnel may ask to speak directly with the ECP.
   i. Following this communication, the Resource Hospital EMS Coordinator is to be immediately notified by the ECRN.
   ii. The EMS System Resource Hospital Coordinator and EMS-MD will review the circumstances with all involved individuals in a timely manner.

f. Written standing orders may be utilized when OLMC is impossible or when a delay in care could cause further harm to the patient.
   i. EMS personnel will document unsuccessful attempt at reaching OLMC on patient care report. Notification of communication problems should be made to the EMS System Resource Hospital Coordinator/Medical Director.

References

http://www.ilga.gov/commission/jcar/admincode/077/077005150C04000R.html
http://www.ilga.gov/commission/jcar/admincode/077/077005150C04100R.html

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 106**	**Date 3/2020**
Title	**Confidentiality Release of Information**	
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Purpose To comply with Federal and State regulations regarding protection of patient privacy and release of confidential medical information.

Policy

1) Patient information is protected under the Department of Health and Human Services standards for privacy of individually identifiable health information, Health Insurance Portability and Accountability Act (HIPAA).
    a. Patient's right of privacy is the right to be free from intrusion upon the physical solitude or seclusion; and the right to keep secret some or all details of personal life and health status.
    b. Confidentiality is the right of the patient to expect information they reveal will not be inappropriately shared with others.
    c. Patients have a right not to have sensitive, private information made public despite the fact that it may be true information.
    d. Breach of confidentiality occurs with redisclosure of previously revealed private matters, usually to others who have no legitimate need to know the information.
2) To protect the patient's right to privacy, medical records must be kept confidential. The EMS Patient Care Report (PCR) is a medical-legal document and is considered protected health information (PHI).
    a. PHI includes, but is not limited to, patient name, demographic, medical information, and treatment, with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
    b. Access to these records shall be in accordance with the laws and regulations that govern the right to either examine or copy and release confidential medical information.
    c. The patient and legal subpoena may request a copy of the PCR through the EMS provider agency.
    d. Patient information will be maintained and handled in a manner to assure that unauthorized individuals do not have access.
    e. All EMS communication via cell phone, telemetry, MERCI radio, and recordings by hospital CAREpoint workstation are considered PHI.
    f. Patient name should not be used over the MERCI radio; a cell phone should be used if transmission of patients name is necessary to facilitate treatment of a time sensitive condition.
3) Scene Privacy
    a. Make every effort to maintain patient’s auditory/visual privacy.

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   b. Law enforcement may be requested to help keep bystanders at a reasonable distance.

   c. EMS providers who encounter someone filming should create a barrier around the patient using providers, vehicles, or blankets.

4) During a multi-victim incident confidentiality must be maintained when collecting individual patient information.

5) All necessary information relevant to the patient's care must be disclosed to those providing care; for business purposes; for quality assurance activities; and when reporting is required under other statutes.

   a. Information about the patient can be revealed to other health care providers who are involved in the care of the patient.

   b. Copies of PCR's, audio recordings, log sheets, must be provided by system participants to the EMS System Resource Hospital.

6) Mandated reporting: Information can be released without consent for purposes of compliance with mandated reporting of abuse/neglect, death, certain injuries (e.g., GSW), communicable diseases, other circumstances.

7) Media requests to review patient care reports are specifically exempted from the Freedom of Information Act (section 207(b)(i)).

8) Law enforcement, Other Agencies: Guidance about releasing information should be obtained from the provider's legal counsel or risk manager.

References

http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=073500050K8-802
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

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Written	6/2017
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North Region EMS System

Policy Section	**Patient Care**
#	**PC 107** **Date 9/2018**
Title	**Hospital Destination: Bypass, Diversion**
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Purpose To provide guidelines for EMS field decisions regarding hospital destination.

Policy

1) Nearest hospital is the hospital closest to the scene as determined by transportation travel time, not actual mileage.
2) Patients shall be transported to the nearest hospital with a comprehensive ED, unless one of the following:
    a. Medical benefits to the patient, reasonably expected from the provision of appropriate medical treatment at a more distant facility, outweigh the increased risks to the patient from transport to the more distant facility (e.g., patients who meet SOP predefined field triage criteria for Level-I trauma center).
    b. The decisional patient requests transport to a more distant facility (see Refusal regarding Treatment, Transport, Destination Policy).
    c. The patient meets pre-established criteria for, and consents to, transport to a free-standing emergency center (FEC).
    d. The nearest hospital is on bypass, and the OLMC physician has done a medical risk/benefit analysis, and has approved patient transport to a more distant facility.
        i. When the nearest hospital is on bypass, EMS personnel should still contact the nearest hospital as soon as possible - while on the scene, for a destination determination.
        ii. In most cases, unstable patients or those experiencing a time sensitive emergency will be transported to the nearest hospital - despite being on bypass.
        iii. Bypass may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes.

References http://www.ilga.gov/commission/jcar/admincode/077/077005150C03150R.html

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North Region EMS System

Policy Section	**Patient Care**
#	**PC 108** **Date 3/2020**
Title	**Infectious Disease: Disinfection, Exposure, Follow-up**
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Purpose To provide guidelines for preventing occupational disease transmission.

Policy

1) EMS personnel and patient protection
    a. EMS personnel shall take reasonable precautions to prevent exposure to pathogens and acquiring infectious diseases from patients.
    b. Patients shall be reasonably protected from acquiring infections from equipment used in EMS care.
    c. Personal protective equipment (PPE) shall be available on all EMS response vehicles. The size, quantity, and type of equipment provided by the employer shall be sufficient to supply all employees expected to respond to an incident.
    d. Universal precautions are standard of care and should be used with all patients.
        i. Wash hands after patient contact, regardless of glove use.
        ii. Alcohol based waterless hand sanitizers should be available for use in the field, and hands should be washed with soap and water when facilities are available.
        iii. Use appropriate PPE during patient care when touching non-intact skin/blood/body fluids, invasive procedures, and handling materials contaminated with blood/body fluids.
        iv. Masks and protective eyewear/face shield shall be worn when working within six feet of a patient suspected of having a disease transmitted by droplets, and during procedures that may generate droplets or a spray of blood/ body fluids to prevent exposure of mucous membranes of the eyes, nose, and mouth.
        v. Fluid repellent gowns/apron shall be worn during procedures that may generate blood/body fluid splash.
        vi. Gloves must be changed after contact with each patient and when moving from patient compartment to passenger compartment of vehicles.
    e. When transporting a patient suspected of having an infectious disease transmissible via air (measles, SARS, tuberculosis, varicella), personnel within six feet of patient should at minimum wear a properly sized N-95 mask and eye protection. The patient should wear a surgical mask.
    f. Extra care should be used to prevent exposures from needles and sharp objects, including ampules and lancets.
        i. After use, immediately place needle or other sharp instrument in puncture resistant container. Avoid recapping needle; if absolutely necessary, use one hand technique. Sharps containers shall be readily available at point of care and in ambulance. Never pass a needle from one person to another.

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g. EMS providers with any area of open skin, shall cover the area with moisture proof covering prior to patient contact.
h. EMS personnel are advised to have immunity, via vaccination or prior illness, to: influenza, hepatitis B, measles, mumps, rubella, pertussis, varicella, tetanus, diphtheria, and polio, in addition to annual TB screening.
i. Appropriate barrier precautions should be used when cleaning, disinfecting, or disposing of contaminated materials.

2) Ambulance and EMS equipment

a. Each EMS provider agency shall have a policy addressing infection control, cleaning and disinfecting of vehicles and EMS equipment. The policy will accompany provider's letter of participation, will be reviewed by the EMS-MD or designee and submitted as part of the EMS System Plan to the Illinois Department of Public Health. The EMS System Resource Hospital staff will be available to assist in the development/revision of policies.

3) Exposures

a. Each EMS provider agency shall have a policy addressing infection control prevention and exposures. This policy will include the names and contact information for the provider agencies designated infection control officer (DICO). The policy will accompany provider's letter of participation, will be reviewed by the EMS-MD or designee and submitted as part of the EMS System Plan to the Illinois Department of Public Health. The EMS System Resource Hospital staff will be available to assist in the development/revision of policies.
b. All parenteral (e.g., needlestick, cut), mucous membrane (e.g., eyes or mouth), or non-intact skin exposure to blood/body fluids from any patient should be reported to the EMS personnel's DICO as soon as possible.
    i. Upon request, the EMS System Resource Hospital will perform source patient testing on patients brought to NMLFH or NMGL-FEC in accordance with Ryan White Act.
c. EMS personnel exposed to measles, mumps, rubella, varicella, herpes zoster, tuberculosis, meningitis, herpes simplex, diphtheria, rabies, anthrax, cholera, plague, polio, hepatitis B or C, typhus, smallpox, AIDS/HIV infection should report the exposure to their employers designated infection control officer (DICO) as soon as possible.

4) Post exposure notification

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a. In accordance with IDPH Hospital Licensing Requirements Section 250.725, the EMS System Resource Hospital will notify police officers and EMS personnel who have provided, or are about to provide, care to a patient diagnosed as having the following diseases: rubella (including congenital rubella syndrome), measles, tuberculosis, invasive meningococcal infections (meningitis or meningococcemia), mumps, chickenpox, herpes simplex, diphtheria, rabies (human rabies), anthrax, cholera, plague, polio (poliomyelitis), hepatitis B, typhus (louse-borne), smallpox, hepatitis non-A, non-B, acquired immunodeficiency syndrome, AIDS-related complex, human immunodeficiency virus infection.
b. Letter notification will be sent to the provider agency within 72 hours after the hospital receives actual knowledge of a confirmed diagnosis of any of the diseases listed above, other than AIDS, ARC or HIC infection, of any patient who has been transported to the hospital by police officers or EMS personnel.
c. In the case of a confirmed diagnosis of AIDS, ARC, or HIV infection, the hospital shall send a letter of notification to the emergency services provider agency within 72 hours only if one or both of the following conditions exist: police officers or EMS personnel have indicated on the ambulance run sheet that a reasonable possibility exists they had blood/body fluid contact with the patient, or the hospital has reason to know of a possible exposure of the police officers or EMS personnel to the blood/body fluids of the patient.
d. Letters of notification shall be sent to the designated contact at the emergency services provider agency listed on the ambulance run sheet and shall include at least the following information: names of police officers, EMS personnel, and other crew members listed on ambulance run sheet; patient's diagnosed disease; date patient was transported; statement information shall be maintained as a confidential medical record; and statement that upon receipt of the notification letter, the provider agency shall contact all personnel involved in the prehospital or interhospital care and transport of the patient. Such notification letters shall not include the name of the patient or any patient-identifying information.
e. Upon discharge of a patient with a communicable disease listed above, or below, to ambulance personnel, the hospital shall notify the personnel of appropriate precautions against the disease, but shall not identify the name of the disease: typhoid fever, amebiasis, shigellosis, salmonellosis, giardiasis, hepatitis A.

References

https://www.cdc.gov/niosh/topics/ryanwhite/default.html
https://www.cdc.gov/niosh/topics/ryanwhite/pdfs/RyanWhiteActof2009.pdf

North Region EMS System

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https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=directives&p_id=2570
ftp://www.ilga.gov/JCAR/AdminCode/056/056003500E07000R.html
https://www.ems.gov/pdf/workforce/Guide_Infection_Prevention_EMS.pdf
http://www.dgprofessionals.com/seavival/infection%20control%20guidance%20for%20ems%20providers%20chicago%20ems%202012.pdf
ftp://www.ilga.gov/JCAR/AdminCode/077/077002500G07250R.html
https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 109**	**Date 3/2020**
Title	**Law Enforcement Interaction and Coroner Notification**	
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Purpose To describe appropriate on-scene interaction of EMS providers with law enforcement at a crime scene and indications and procedure for coroner notification.

Policy

1) Assess scene safety: If indicated, treatment and transport should be delayed pending arrival of law enforcement to secure the scene.
2) Law enforcement has authority of any crime scene. They may refuse admittance to a scene, for safety reasons and to preserve physical evidence.
    a. EMS personnel should follow the direction of law enforcement regarding scene safety and evidence preservation.
        i. If following law enforcement direction prevents patient access or compromises patient care, immediately notify Supervisor and Resource Hospital.
3) Document scene observations, name, department, and badge number of law enforcement officer on patient care report.
4) Avoid contamination of scene and damage to, or loss of, evidence. If alteration of scene occurs due to patient care, notify law enforcement.
    a. Avoid contact with, and do not remove, objects from the scene.
    b. All equipment and supplies (e.g., dressings, packages) brought to the scene by EMS personnel should be removed by EMS personnel when they leave the scene.
    c. If clothing must be cut, avoid cutting through any tears, holes, or damaged or stained areas.
    d. Gunshot wounds:
        i. Do not wash/clean patient's hands or area with gunshot wounds.
        ii. Use caution to avoid loss of evidence when handling clothing, as expended bullets may be in clothing. Check ambulance, linens, and stretcher for evidence. Retain sheet from under patient for possible evidence. All evidence should be given to law enforcement and documented on patient care report.
    e. Hanging or asphyxiation: Avoid untying or cutting into any knots in the material unless needed to open the patient's airway.
    f. Stab wounds: When treating patients, impaled objects should be stabilized in place.
5) If crime, suicide, accidental or suspicious death, and law enforcement is not already on-scene, request law enforcement response.
    a. The following are Lake County Coroner reportable deaths:

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i. sudden or violent, whether apparently suicide, homicide or accidental,
ii. firearm related deaths
iii. blunt trauma (blows),
iv. cutting or stabbing,
v. falls,
vi. electric shock,
vii. asphyxia,
viii. drowning,
ix. hanging,
x. suffocation,
xi. strangulation,
xii. vehicular collisions
xiii. weather-related (exposure),
xiv. burns,
xv. drug overdose,
xvi. poison ingestion,
xvii. fractures of bones,
xviii. carbon monoxide poisoning,
xix. anesthetic accident (O.R.),
xx. work related deaths,
xxi. maternal or fetal death due to abortion,
xxii. sex crime or a crime against nature,
xxiii. suspicious, obscure or mysterious death,
xxiv. death where addiction to alcohol or drugs may have been a contributing cause,
xxv. natural death where the decedent was not attended by a licensed physician or occurring within 24 hours of admission to hospital,
xxvi. death occurring in any jail or other correctional institution.

6) Notify Coroner or confirm notification by law enforcement. The Lake County Coroner can be contacted at 847.377.2200.

References

https://www.lakecountyil.gov/716/Coroners-Case
http://ilga.gov/legislation/ilcs/documents/005500050K3-3020.htm

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North Region EMS System

Policy Section	**Patient Care**
#	**PC 110** **Date 3/2020**
Title	**Minors: Consent/Refusal for Treatment**
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Purpose To provide guidance regarding treatment of minors.

Policy

1) In Illinois, persons under the age of 18 are considered to be a minor and not eligible to consent to, nor refuse, medical treatment.
    a. Exception: In Illinois, a minor under age of 18 is legally recognized as an adult and may refuse care and/or transport if the person is:
        i. married
        ii. pregnant
        iii. a parent (minor parents may consent to treatment for themselves and for minor child)
        iv. a sworn member of the U.S. armed services
        v. has a court order of emancipation (individual at least 16-years of age, that the court has determined is capable of managing their affairs and lives independent of parent/guardian).
    b. Exception: Parental/guardian consent is not required for patients over age 12, seeking treatment for alcohol/drug abuse, mental health, sexual abuse/assault, or sexually transmitted infection/disease.
2) When treating minors, the consent of a parent/legal guardian is required.
    a. If, in the opinion of the OLMC physician, a delay in obtaining consent would adversely affect the minor's condition, emergency treatment may be provided without first obtaining consent.
    b. If a parent/guardian is not available to consent or refuse service, complete and document the following:
        i. Advise the patient of their illness/injury and explain the need for further evaluation by a physician.
        ii. Contact OLMC and inform them of the situation.
        iii. Administer care and request police assistance, if needed.
    c. If a parent/legal guardian refuses consent when medical care is indicated, or if the parent/legal guardian refuses consent stating religious or other non-medical objections, or in cases of suspected child abuse or neglect:
        i. Contact OLMC as soon as possible.
        ii. Protective Custody may be taken by police, DCFS, or physician if leaving the child in the home or in the care and custody of the child's caregiver presents an imminent danger to the child's life or health

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iii. See policy Reporting Abuse and/or Neglect.

iv. A parent/legal guardian may refuse treatment of a minor after OLMC/Resource Hospital approval EXCEPT under the following conditions:
   1. Suspicion of abuse and/or neglect.
   2. Life or limb threatening illness or injury.
   3. Non-decisional parent/legal guardian.

3) Guardianship is a legally determined role. Official court documents are issued to identify the legal guardian(s).

4) Babysitters and day care providers are not legally empowered to provide consent, unless written parental consent is provided. In all cases, contact OLMC.

References

http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1539&ChapAct=410%26nbsp%3BILCS%26nbsp%3B210%2F&ChapterID=35&ChapterName=PUBLIC+HEALTH&ActName=Consent+by+Minors+to+Medical+Procedures+Act%2E
ftp://www.ilga.gov/JCAR/AdminCode/089/089003000001200R.html
http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=032500050K5

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 111**	**Date 3/2020**
Title	**Patient Interaction Guidelines: EMS Personnel Requirements**	
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Purpose To define guidelines for EMS personnel initiation of patient care.

Policy

1) Appropriate initial care, per SOP's, should be started at the point of patient contact prior to movement to the ambulance, unless the patient refuses or scene safety cannot be secured. This includes care provided by BLS or ALS EMS personnel prior to the arrival of an ambulance.
2) EMS personnel shall perform all services without unlawful discrimination.
3) Additional personnel should be requested as needed for patient care and conveyance.
4) Equipment: When responding to all requests for prehospital care, EMS personnel (EMT, Paramedic) will take the following to the initial contact with the patient:
    a. Conveyance device (ex. Stretcher, backboard, stair chair)
    b. Monitor/Defibrillator with defibrillation pads, pulse oximetry, capnography, ECG rhythm and 12L ECG capability for ALS licensed vehicles or AED for BLS licensed vehicles.
    c. Oxygen
    d. Bag(s) containing at minimum
        i. BLS and ALS licensed vehicle: personal protective/body substance isolation equipment, suction, oral and nasal airways, oxygen, oxygen delivery devices including bag-valve mask, stethoscope, BP cuff, glucose meter, hemorrhage control supplies including a tourniquet, and c-collar.
        ii. ALS licensed vehicle: advanced airway equipment including laryngoscope with blades, ET tubes, alternate airway device and cricothyrotomy equipment; vascular access supplies including IV fluid, tubing, IO and IV catheters; and first line medications including: adenosine, albuterol, amiodarone, ASA, atropine, diphenhydramine, dopamine, etomidate, epinephrine 1mg/1mL and 1mg/10mL, dextrose, ipratropium, lidocaine, midazolam, naloxone, NTG, and verapamil.
5) Indications for ALS include, but are not limited to:
    a. Abnormal vital signs (regardless of complaint)
        i. Pulse <60 or >110 or irregularity; (pediatric VS, see SOP)
        ii. Respiration <10 or >22, shallow or labored; (pediatric VS, see SOP)
        iii. Systolic BP <100 or >180; (pediatric VS, see SOP)
        iv. Oxygen saturation <95%

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b. Potential life threatening complaint/condition. Examples include:

i. CNS: altered mental status, seizure, postictal, suspected stroke/TIA, dizziness, syncope or near syncope

ii. Cardiac: chest/epigastric discomfort, suspected ACS, dysrhythmia/palpitations, heart failure, anginal equivalents

iii. Respiratory: dyspnea, shortness of breath

iv. Medical: GI bleeding, overdose/poisoning

v. Obstetrics: pregnancy complications or childbirth

vi. Trauma: Level 1-2; multiple system; penetrating injury to head, neck, torso, or proximal extremity; burns >10%

6) Advanced Life Support (ALS) care includes, at minimum:

a. ECG monitoring - must continue during transportation into the hospital emergency department until patient care is transferred to the physician/nurse

b. Oxygen, if indicated based on oxygen saturation

c. Vascular access, if IV fluid or IV medications are indicated

7) If scene is unsafe or the patient is uncooperative: The requirement to initiate care at point of patient contact or during transport may be waived in favor of assuring the patient is transported to an appropriate facility. Contact OLMC and document situation.

8) Do not discontinue care once initiated unless approval is granted by OLMC, care has been transferred to higher level personnel (e.g., ED physician/nurse, BLS transfer to ALS crew), or scene becomes unsafe. If any doubt, consult with OLMC.

9) In-field service level upgrades: All transfer of care shall be made under the direction of OLMC who shall determine the risk/benefit.

10) BLS personnel shall allow ALS personnel access to patients to determine if ALS care is needed. If ALS personnel determine the patient requires ALS care, BLS personnel shall transfer patient care to ALS personnel.

11) If BLS personnel identify that ALS is indicated: The BLS crew shall call 911/radio dispatch to request an ALS ambulance from the local municipal EMS agency, unless the initial responders are a private provider and can provide an ALS ambulance on-scene within six (6) minutes. If the BLS crew are able to transport to the nearest hospital faster than ALS can arrive, the BLS crew should contact OLMC, seeking authorization to transport providing BLS care.

12) Transferring patient care to another crew: Initial crew shall:

North Region EMS System

Policy Section	**Patient Care**	
#	**PC 111**	**Date 3/2020**
Title	**Patient Interaction Guidelines: EMS Personnel Requirements**	
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a. Continue to assess and provide care until the patient is transferred to the transporting crew;

b. Provide verbal report to transporting crew that includes assessment and treatment information;

c. Complete a PCR with patient assessment and treatment information, until the point of transfer;

d. Provide written report to receiving hospital within 90 minutes.

13) Cardiac arrest: If ambulance personnel from a single vehicle response (private or municipal) identify cardiac arrest, begin BLS CPR/defibrillation and call 911/radio dispatch to request ALS from the nearest municipal EMS agency to provide an adequate number of rescuers. Do not attempt ALS interventions (e.g., advanced airway, vascular access) until adequate rescuers are available.

References http://www.ilga.gov/commission/jcar/admincode/077/077005150C03300R.html

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Written	6/2017
Reviewed/Revised	3/17/2020
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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 112**	**Date 9/2018**
Title	**Physician/Nurse on Scene**	

Purpose To optimize patient care and provide guidelines for interacting with a physician/nurse on-scene who requests to participate in patient care.

Policy

1) When a patient's personal physician is physically present on-scene, EMS personnel should respect the established doctor/patient relationship.
2) EMS personnel at the scene of an emergency may allow a physician/nurse to assist with patient care, after the licensed professional has identified themselves and volunteered to assist with patient care. EMS personnel may request identification and/or proof of licensure.
3) EMS personnel may inform physician/nurse they will need to accompany the patient in ambulance to the hospital.
4) If there is disagreement between EMS personnel and on-scene physician/nurse, contact OLMC Resource Hospital as soon as possible. On-scene physician/nurse may be asked to communicate directly with OLMC physician.
5) If on-scene physician/nurse requests/orders treatment that EMS personnel feel is not appropriate or not within EMS personnel scope of practice, refuse to follow such orders and immediately contact OLMC.
6) Document identifying information (name, license #) and any orders or treatment given by on-scene physician/nurse on patient care report.

References https://www.acep.org/Clinical---Practice-Management/Out-of-Hospital-Medical-Direction-and-the-Intervener-Physician/#sm.000mn3kdc1e1td7210s6xknhvcjur

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Original Written	6/2017
Reviewed/Revised	
IDPH Approval	4/5/2018
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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 113**	**Date 8/2023**
Title	**Abandon Newborn / Infant**	
Page	**1 of 2**	

Purpose

To comply with the Illinois Legislature Public Act 92-0408. The act is intended to provide a mechanism for a newborn infant to be relinquished to a safe environment and for the parents of the infant to remain anonymous if they choose and to avoid civil or criminal liability for the act of relinquishing the infant.

Policy

1) Definitions
   a. Newborn infant**:** means a child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished to a hospital, police station, fire station, or emergency medical facility and who is not an abused or a neglected child.
   b. Relinquish: means to bring a newborn infant, who a licensed physician reasonably believes is 30 days old or less, to a hospital, police station, fire station, or emergency medical facility and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that they will not return for the infant.
   c. Department or DCFS: means the Illinois Department of Children and Family Services.
2) The act of relinquishing a newborn infant serves as implied consent for the fire station or emergency medical facility and its emergency medical professionals to treat and provide care for the infant.
   a. Initiate necessary emergency treatment per SOP under implied consent and contact online medical control.
   b. Ensure that the infant is kept warm and transported to the nearest System hospital, secured appropriately in an infant car seat or pediatric restraining device.
   c. Complete a patient care report on the infant. List the infant's name as "Baby Girl or Baby Boy " if it is unknown.
3) After relinquishing a newborn infant to a fire station or emergency medical facility, the fire station emergency medical facility's personnel must arrange for the transportation of the infant to the nearest hospital.
4) If the parent of a newborn infant returns to reclaim the child within 72 hours after relinquishing the child to a fire station or emergency medical facility, the fire station or emergency medical facility must inform the parent of the name and location of the hospital to which the infant was transported.
5) If there is suspected child abuse or neglect that is not based solely on the newborn infant's relinquishment to a police station, fire station, or emergency medical facility, the personnel of the police station, fire station, or emergency medical facility who are mandated reporters under the Abused and Neglected

North Region EMS System

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Child Reporting Act must report the abuse or neglect. See North Region EMS System policy PC 102 Abuse/Neglect Victims: Child, Domestic, Elder.

6) A fire station or emergency medical facility that receives a newborn infant relinquished must offer an information packet to the relinquishing person and, if possible, must inform the relinquishing person that their acceptance of the information is entirely voluntary. The information packet must include all of the following:

   a. Written notice of the following:

      i. No sooner than 60 days after the initial relinquishment of the infant to a hospital, police station, fire station, or emergency medical facility, the child-placing agency or the Department will commence proceedings for the termination of parental rights and placement of the infant for adoption.
      ii. Failure of a parent of the infant to contact the Department and petition for the return of custody of the infant before termination of parental rights bars any future action asserting legal rights with respect to the infant.
      ii. A resource list of providers of counseling services, including grief counseling, pregnancy counseling, and counseling regarding adoption and other available options for placement of the infant.
      iii. A brochure (with a self-mailer attached) that describes this Act and the rights of birth parents, including an optional section for the parent to complete and mail to the Department of Children and Family Services, that shall ask for basic anonymous background information about the relinquished child.
      iv. A brochure that describes the Illinois Adoption Registry, including a toll-free number and website information.
      v. A brochure describing postpartum health information for the mother.

References

(325 ILCS 2/) Abandoned Newborn Infant Protection Act.
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1459&ChapterID=32

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Written	8/2023
Reviewed/Revised	
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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 114**	**Date 8/2023**
Title	**Data Collection and Submission: Patient Care Report Requirements**	
Page	**1 of 2**	

Purpose To define patient care run reports and data collection requirements.

Policy

1) Each Illinois-licensed transport and non-transport vehicle service provider shall complete a patient care run report 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 the facility.
    b. The Electronic Health Record (EHR) shall be completed using the North Region EMS System-provided EHR software.
2) All non-transport vehicle providers shall document all medical care provided. The validated EHR shall be completed within 2 hours of concluding the call.
3) North Region EMS providers may provide an ESO "Quick Summary Report" (paper or electronic) to the receiving hospital emergency department or health care facility before leaving the facility. If a "Quick Summary Report" is left with the receiving facility, a validated patient care run report shall be completed and either faxed or dropped off within 2 hours of clearing the receiving health care facility.
    a. Pursuant to Sec. 515.310(k), EMS Systems utilizing an approved EMS provider short patient care report (ESO-Quick Summary Report) form will require, at a minimum, the following data elements to be left at the receiving hospital:
        i. Name of the patient;
        ii. Age;
        iii. Vital Signs;
        iv. Chief complaint;
        v. List of current medications;
        vi. List of allergies;
        vii. All treatment rendered;
        viii. Date; and
        ix. Time.

North Region EMS System

Policy Section	**Patient Care**	
#	**PC 114**	**Date 8/2023**
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Page	**2 of 2**	

References https://www.ilga.gov/commission/jcar/admincode/077/077005150C03500R.html

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Written	8/2023
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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 115**	**Date 8/2023**
Title	**Transport Destination: Mental Health Care Facility**	
Page	**1 of 1**	

Purpose

To ensure appropriate utilization of Mental Health Care Facilities within the North Region EMS system.

Policy

1) North Regin EMS System Providers may transport to the following Mental Health Care Facilities**:**
   a. N/A – No Mental Health Care Facilities are currently EMS System approved.
2) North Region EMS System Providers may transport patients to a system-approved Mental Health Care facility when the patient's condition meets the following criteria:
   a. The patient does not present with an immediate life-threatening condition.
   b. The patient desires to be transported to a non-Emergency Department destination.
      i. The patient signs a refusal for transportation to a comprehensive Emergency Department.
   c. Patient presentation does not meet the initiation of Advanced Life Support (ALS) care as specified within the Region X Standard Operating Procedures or North Region EMS System Policy: PC-111, Patient Interaction Guidelines.
   d. Transport to a Mental Health Care Facility is within a reasonable transport distance considering patient safety and available resources.
3) EMS providers shall contact Lake Forest Hospital Online Medical Control (OLMC) to determine if transport to a Mental Health Care Facility is approved for a given patient.
   a. If transport to a Mental Health Care Facility is deemed appropriate and approved by OLMC/Lake Forest Hospital, OLMC will notify the receiving facility of the patient's impending arrival and provide pertinent patient information for continuity of care.
4) EMS providers shall accurately document all patient encounters and transport decisions.

References

System Policy PC 111: Patient Interaction Guidelines
Region X Standard Operating Procedures

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Written	8/2023
Reviewed/Revised	
IDPH Approval	9/07/2023
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North Region EMS System

Policy Section	**Patient**	
#	**Care PC 116**	**Date 8/2023**
Title	**Transport Destination: Urgent Care/ Immediate Care Facility**	
Page	**1 of 1**	

Purpose

To ensure appropriate utilization of Urgent or Immediate Care Facilities within the North Region EMS System.

Policy

1) North Regin EMS System Providers may transport to the following Urgent or Immediate Care Facilities**:**
    a. N/A – No facilities are currently EMS System approved.
2) North Region EMS System Providers may transport patients to a system-approved Urgent or Immediate Care facility when the patient's condition meets the following criteria:
    a. The patient does not present with an immediate life-threatening condition.
    b. The patient desires to be transported to a non-Emergency Department destination.
        i. The patient signs a refusal for transportation to a comprehensive Emergency Department.
    c. Illness and/or injury does not meet the initiation of Advanced Life Support (ALS) care as specified within the Region X Standard Operating Procedures or North Region EMS System Policy: PC-111, Patient Interaction Guidelines.
    d. Transport to an urgent care facility is within a reasonable transport distance considering patient safety and available resources.
3) EMS providers shall contact Lake Forest Hospital Online Medical Control (OLMC) to determine if transport to an urgent care facility is approved for a given patient.
    a. If transport to an urgent care facility is deemed appropriate and approved by OLMC/Lake Forest Hospital, OLMC will notify the receiving facility of the patient's impending arrival and provide pertinent patient information for continuity of care.
4) EMS providers shall accurately document all patient encounters and transport decisions, including the rationale for choosing transport to an urgent care facility.

References

System Policy PC 111: Patient Interaction Guidelines
Region X Standard Operating Procedures

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Reviewed/Revised	
IDPH Approval	9/07/2023
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North Region EMS System

Policy Section	**Patient Care**
#	**PC 117** **Date 3/2020**
Title	**Refusal - Patient Choice: Treatment, Transport, Destination**
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Purpose To provide guidelines when EMS has been called, and established patient contact and the patient is refusing treatment, transport, or destination.

Policy

1) Determine decisional capacity of the patient. Components of evaluation:
    a. Understanding: States meaning of information (e.g., diagnosis, risks/benefits, options).
    b. Appreciation: Explains how information applies to self.
    c. Reasoning: Compares information and consequences.
    d. Expressing choice: States a decision.

2) Patient with Decisional Capacity

    a. Patients with decisional capacity have the right to consent to, or refuse, some or all assessment, treatment, and/or transport.

    b. In all situations when a decisional patient refuses assessment, treatment, or transportation:

        i. Attempt to medically assess patient, including obtaining VS.

        ii. Advise the patient of their medical condition.

        iii. Explain why assessment, treatment and/or transport is recommended.

        iv. Explain to the patient the risks of refusal.

        v. Verify the patient understands the situation and risks.

        vi. Encourage cooperation.

        vii. Use refusal form only as a procedure for documenting persistent refusal of transport by a decisional adult.

            1. Request the patient sign the written refusal form.

            2. Document two (2) witnesses to the refusal; one witness the EMS provider, the other preferably a family member or police officer.

            3. If a patient refuses to sign the form, the refusal should be witnessed and signed by a family member or police officer, if possible.

            4. Encourage the patient to seek medical care from provider of choice, and to re-contact EMS if they change their mind.

        viii. EMS personnel must initiate contact with online medical control (OLMC) for approval of refusal for the following types of high-risk patients:

North Region EMS System

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#	**PC 117** **Date 3/2020**
Title	**Refusal - Patient Choice: Treatment, Transport, Destination**
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1. ALS: Received ALS assessment/treatment or would have met criteria for ALS transport, including L1-2 trauma
2. Age: Patients under age 18, regardless of presence of parents/guardian on scene; and elderly, age 65 and older
3. AMS: Altered mental status, under the influence of drugs/alcohol, or behavioral/psychological complaints
4. Obstetric Patients
5. Any complex call where EMS personnel wish to seek additional consultation

ix. EMS personnel will be given a log number by the ECRN or ECP who takes the call. This number must be documented in the patient care report.

c. For refusal of assessment, treatment, or destination, document the refusal in comments of patient care report.

d. Destination request: If requested destination is not within service area determined by responding EMS provider agency:

i. Attempt to convince the patient to consent to be transported to the closest, appropriate hospital for initial evaluation and treatment.

ii. If patient continues to refuse closest, appropriate hospital: Offer option of transport to desired destination by private ambulance provider.

iii. If patient agrees to transport by a private provider, determine ETA of private provider.

iv. When an ALS crew determines the patient requires BLS care and transport, the patient may be transferred to the BLS unit after approval by OLMC/Resource Hospital.

v. Contact OLMC/Resource Hospital to document situation.

vi. Transferring care from FD to private provider: FD EMS personnel are to remain on scene and administer care until transferred to private ambulance personnel.

e. In the interest of encouraging the patient be transported rather than receive no care at all, deviations from policies, procedures, or SOP's may be necessary; consult with OLMC Resource Hospital, as soon as possible.

f. EMS provider may request patient to speak directly with OLMC physician/ECRN, or OLMC physician/ECRN may request to speak directly with patient.

North Region EMS System

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#	**PC 117** **Date 3/2020**
Title	**Refusal - Patient Choice: Treatment, Transport, Destination**
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3) Patient without Decisional Capacity
    a. Patient demonstrating behavior and/or a medical condition that indicates non-decisional capacity have neither the right to consent to, or refuse, assessment, treatment, and/or transport.
    b. Family/friends may not refuse assessment, treatment, and/or transportation of a patient lacking decisional capacity, unless they have Durable Power of Attorney for Healthcare or are the court-appointed legal guardian for the patient.
    c. Assess for, and treat per SOP as indicated, possible causes of non-decisional capacity including:
        i. Hypoxia, hypercarbia
        ii. Shock, hypotension
        iii. Hypoglycemia, electrolyte imbalance
        iv. Neuro: brain injury, stroke, seizure/postictal, dementia
        v. Toxicological (alcohol, drug)
        vi. Infection, sepsis
        vii. Psychiatric (e.g., suicidal, homicidal, inability care for self)
    d. Once determined to be non-decisional, EMS personnel should assess, treat, and transport in the best interests of the patient.
        i. Non-decisional patients may not refuse transportation to the closest appropriate hospital.
    e. EMS personnel should avoid placing themselves in a dangerous situation; this may delay initiation of treatment until the safety of EMS personnel can be assured. Contact OLMC/Resource Hospital, police and/or fire department for additional backup personnel as needed.
    f. Try to obtain the patients cooperation.
    g. If patient resists care and/or transport:
        i. Request police and/or fire department backup as needed.
        ii. Contact OLMC/Resource Hospital.
        iii. Reasonable force may be used to restrain the patient if the patient is a risk to self or others (see Restraint Use policy).
        iv. The requirement to complete assessment and treatment may be waived in favor of assuring patient is transported to the closest appropriate emergency department.

4) Minor Patient – see Minors: Consent/Refusal for Treatment policy

North Region EMS System

Policy Section	**Patient Care**
#	**PC 117** **Date 3/2020**
Title	**Refusal - Patient Choice: Treatment, Transport, Destination**
Page	**4 of 4**

References https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults

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Reviewed/Revised	
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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 118**	**Date 3/2020**
Title	**Restraint Use**	
Page	**1 of 2**	

Purpose To provide guidelines for use of restraints.

Policy

1) Restraints may only be used as a therapeutic measure to prevent a patient from causing physical harm to self or others.
    a. Physical Restraint: Any manual method, physical, or mechanical device, material or equipment that reduces the ability of a patient to freely move their arms, legs, body or head.
    b. Chemical Restraint: A drug or medication used to manage the patient's behavior or restrict freedom of movement and is not a standard treatment or dosage for the patient's condition.
    c. Use of restraints for behavioral health reasons is used as a last resort, and limited to emergency situations in which a patient's behavior is aggressive or violent, and there is imminent risk of an individual physically harming self or others, and non-physical interventions are ineffective.
    d. Unless the patient poses an immediate threat to self or others, or is suffering from an immediately life-threatening condition, OLMC/Resource Hospital should be contacted prior to the use of restraints or transport of any patient against their will.
2) Restraint use has potential hazards. Care must be taken to ensure that the restraints are applied correctly and the patient is continuously monitored.
    a. Refer to manufacturers guidelines for correct application.
    b. All EMS providers who might restrain a patient must be educated and their competency maintained by provider's employer.
3) Select the most appropriate restraint based on the need. Sedation can be considered for combative, uncooperative patients who may harm themselves or others. Refer to Standard Operating Procedures.
4) Restraint Application
    a. Assure the scene is safe for the EMS personnel. Ensure adequate number of personnel (minimum 4-6) are available to restrain the patient. At least one person for each of the patient's limbs is necessary. Additional personnel or police assistance should be requested, as needed.
    b. Attempt to avoid the use of restraints by maintaining a calm, professional, reassuring manner, urging the patient to cooperate. Assist the patient to manage their emotions and regain control of their behavior. Attempt to minimize stimulation (e.g., bright lights, loud sounds).
    c. Explain to the patient what actions will lead to application of restraints and encourage the patient to stop those behaviors.
    d. Patients should be treated with dignity and respect. The patient requiring restraint should be safely and humanely restrained. Protect the patient's privacy when in public areas.
    e. Attempt voluntary application of restraints.

North Region EMS System

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#	**PC 118**	**Date 3/2020**
Title	**Restraint Use**	
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f. If necessary, the minimum required force may be applied to neutralize the amount of force exerted by the patient. All attempts should be made to avoid injury to the patient and other personnel.
g. Full restraint requires the application of a restraint to each limb.
    i. In addition to extremity restraints, secure the patient to the stretcher with stretcher straps.
h. Restraints should be positioned so the airway is always accessible and there is no respiratory or circulatory impairment.
    i. Patient should not be restrained in prone, face down position.
    ii. Restrain in a position of comfort and safety.
i. Patient must be continuously observed by EMS personnel while restrained. At no time may the patient be left alone.
    i. Assess vital signs immediately following restraint application and every 5 minutes thereafter.
    ii. Assess distal extremity neurovascular status (pulse, movement, sensation), immediately after restraint application and every fifteen (15) minutes thereafter.

5) Handcuffs are only to be applied and removed by and at the discretion of law enforcement officers.

6) When transportation is required of a patient who is handcuffed, the EMS provider should request that the law enforcement officer, in possession of the handcuff key, accompany and remain with the patient in the ambulance to the hospital to assist with further restraint or to release the restraints if patient care is impaired by the devices.

References

http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=040500050K2-108
http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=040500050K2-109
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf

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North Region EMS System

Policy Section	**Patient Care**	
#	**PC 119**	**Date 2/2021**
Title	**School Bus Accidents**	
Page	**1 of 1**	

Purpose To provide guidelines for response and documentation of School Bus Accidents.

Policy

1) NM North Region EMS System providers will follow guidelines set forth in the Region X System Policy Manual (see attached).
2) The Provider must utilize the NM North Region EMS System School Bus Log and Release Form for incidents that meet the definitions of Category B and C incidents.
    a. This policy must not be utilized for Category A incidents.
    b. Only uninjured children may be documented on the School Bus Log and Release Form.
3) Individual EMS Providers must implement a policy/plan for the disposition of uninjured children to either school district staff or to the child's legal guardian/parent.
    a. The custody and responsibility of uninjured children remain with the EMS provider until children are transferred to the child's legal guardian/parent or school district staff.

References EMS Trauma Region X Policy and Procedure Manual, pg. 16-17

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IDPH Approval	
Effective	02/2021

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: **February 2000**
REVIEWED: **February 2017**

POLICY TITLE: **SCHOOL BUS ACCIDENTS**

POLICY: **7**

This policy governs the handling of school bus accidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with the System's policies governing mass casualties. The goal of this policy is to reduce the number of uninjured children transported to hospitals and to reduce the EMS scene time and utilization of resources.

Each EMS provider within the System is required to design and implement a procedure for discharging uninjured children to their parents/legal guardians or to local school officials who are ***willing*** to take custody of the children. The provider may adopt whatever policy it chooses that will best accomplish the goal of transferring custody of uninjured children to the parents/legal guardians or school officials. It is recommended that these policies be developed with the joint input of local school officials and provider legal counsel.

Once it is determined that minor children are not injured, the custody and responsibility for these children will remain with the EMS provider agency until the children are transferred to parents or school officials.

PROCEDURE:

1. Upon arrival at the scene;

    a. Determine the category of the accident:

    CATEGORY A BUS ACCIDENT - significant injuries present in one or more children or there is documented mechanism of injury that can reasonably be expected to cause significant injuries.

    CATEGORY B BUS ACCIDENT - minor injuries present in one or more children and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children may also be present.

    CATEGORY C BUS ACCIDENT - no injuries present in any children and no obvious mechanism of injury present.

    b. Determine if implementation of this policy is appropriate. Implement this policy only if the accident is a Category B or C bus accident.

    All children involved in a Category A accident will be transported to the hospital(s). Do not implement this policy if the accident/incident is a Category A bus accident/incident -

follow multiple victim and disaster preparedness policies for all Category A bus accidents/incidents, and transport all children/students to the hospital(s).

c. Other injured patients are treated and transported as required.
For adults, follow your EMS System's policy.

d. Contact Medical Control, advise of the existence of a Category B or C bus accident, and determine if a scene discharge of uninjured children by the emergency department physician in charge of the call is appropriate.

e. Implement provider procedures for contacting parents/legal guardians or school officials to receive custody of the uninjured children.

f. The provider agency then transfers the custody of the minor children, consistent with its own policies and procedures, to parents/legal guardians or school officials.

g. The school representative will then follow their own policies to include informing the parent(s)/legal guardians as regards the accident/incident.

2. **DISPOSITION OF UNINJURED CHILDREN**: This policy only governs the disposition of uninjured children. A list of children who have been determined to be uninjured by medical personnel will be completed at the scene of the accident. All uninjured students will be discharged to the custody of school officials upon approval of Medical Control as per procedure in 1) F. Use your EMS System's approved form for such documentation.

3. **PROVIDER RESPONSIBILITY**: Once the decision is made by the emergency department physician to discharge the children at the scene, it is the responsibility of the local responding EMS agency in charge of the scene to make certain that these children are returned to their parents/legal guardians or appropriate school officials.

CAVEAT

If EMS personnel on the scene feel that any child should be offered medical care or evaluated by the hospital, the child should be transported to the hospital.

North Region EMS System

School Bus Accident Student Log and Release Form

School Bus #: _____ Page: _____of _____

Route #: _____

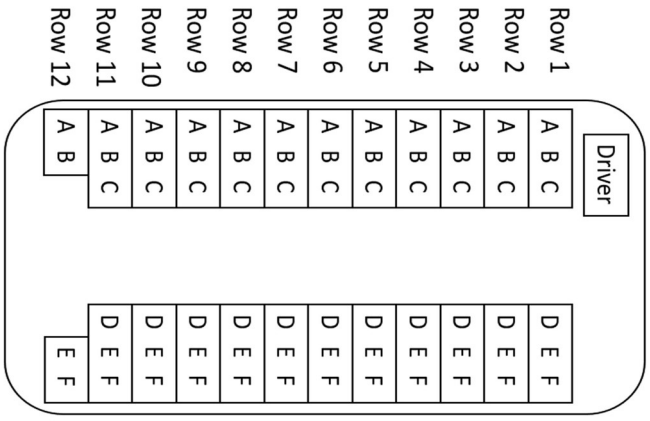
Driver: _____

Department: _____ Date:_____ Incident #: _____

Location: _____

System Policy PC 115 - The associated incident has met the criteria of a Category B or Category C incident as defined in the Policy. These children have been determined to be uninjured and therefore Medical control has approved discharge to the custody of school officials or child's legal guardian/parents.

NAME	ADDRESS	PHONE	SEAT #



Signature/Title of Fire Department Officer:

_____

Signature/Title of School - Authorized Representative:

_____

School District #: _____

Hospital Contacted: _____

RN: _____

MD: _____

North Region EMS System

Policy Section	**Patient Care**	
#	**PC 120**	**Date 2/2021**
Title	**Multiple Patient Management Plan**	
Page	**1 of 1**	

Purpose To provide guidelines for response and documentation of multiple patient incidents.

Policy

1) NM North Region EMS System providers will follow guidelines outlined in the Region X Multiple Patient Management Plan (see attached).
    a. Contact information for North Region EMS Resource Hospital:
        i. Northwestern Lake Forest Hospital
        1000 N. Westmoreland Rd
        Lake Forest, IL 60045
        OLMC Telemetry: 847-535-7375

References Region X Multiple Patient Management Plan (September 1, 2012)

Evert Gerritsen
EMS System Administrator/Coordinator

Michael I. Peters, MD
EMS Medical Director

Written	01/2021
Reviewed/Revised	
IDPH Approval	
Effective	02/2021

North Region EMS System

Patient Care Re

Department Name: **Incident Number:** **Date:**

Patient Information				Clinical Impression	
Last		Address		Primary Impression	
First		Address 2		Secondary Impression	
Middle		City		Protocol Used	
Gender		State		Anatomic Position	
				Chief Complaint	
DOB		Zip		Duration	
Age		Country		Secondary Complaint	
Weight		Tel		Duration	
Pedi Color		Physician		Patient's Level of Distress	
SSN		Ethnicity		Signs & Symptoms	
Race					
Advance Directive				Injury	
Resident Status				Medical/Trauma	

Medication/Allergies/History
Medications
Allergies
History

Vital Signs												
Time	AVPU	Side	Pos	BP	Pulse	RR	SpO2	EtCO2	GCS	BGL	Temp	Pain

ECG			
Time	Type	Rhythm	Notes

Flowchart			
Time	Treatment	Description	Provider

Initial Assessment			
Category	Comments	Abnormalities	Notes
Mental Status			
Skin			
HEENT			
Chest			
Abdomen			
Back			
Pelvis/GU/GI			
Extremities			
Neurological			

Narrative

Incident Details		Destination Details		Incident Times	
Location Type		Disposition		PSAP Call	
Location Type		Transport Due To		Dispatch Notified	
Address		Transported To		Call Received	
Address 2		Requested By		Dispatched	
Mile Marker		Destination Details		Enroute	
City		Department		Staged	
County		Address		On Scene	
State		Address 2		At Patient	
Zip		City		Care Transferred	
Medic Unit		County		Depart Scene	
Run Type		State		At Destination	
Response Mode		Zip		Pt. Transferred	
Shift		Condition at Destination		Call Closed	
Zone				In District	
Level of Service					

Crew Members		
Personnel	**Role**	**Certification Level**

Billing Authorization

Authorization

Section I - Patient / Parent of Minor Authorization Signature

Signature

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

Signed On	
Notice of Privacy Practices Provided	
Printed Name	
Reason unable to sign	

Facility Signatures

Signed On	
Print Name	

Provider Signatures

Lead Provider		**Certification Level**	

Provider		**Certification Level**	

******This form is to be used in the event of ePCR/technology failure. Please leave a copy of the completed form at the receiving facility. An ePCR MUST be completed, once available, and a copy of this form uploaded in lieu of electronic signatures.**

Region X

MULTIPLE PATIENT MANAGEMENT PLAN

Effective January 1, 2023

Current Version 07122023

Region X Multiple Patient Management Plan
Effective January 1, 2023

The Region X Multiple Patient Management Plan (MPMP) was developed and approved through a collaborative process involving the five Emergency Medical Service (EMS) Systems located within EMS/Trauma Region X of the Illinois Department of Public Health (IDPH) listed below:

- Condell Medical Center EMS System, Libertyville, IL
- NorthShore Highland Park Hospital EMS System, Highland Park, IL
- Northwestern Medicine North Region EMS System, Lake Forest, IL
- Saint Francis Hospital EMS System, Evanston, IL
- Vista Health/North Lake County EMS System, Waukegan, IL

The Region X MPMP is intended to serve as a guideline for the management and transport of patients from incidents involving greater than five patients, not limited to disaster situations. The assumption is that in certain multiple patient incidents, the usual and customary forms of communication identified in the Region X EMS Standard Operating Procedures may be contraindicated as specified in the Region X MPMP. Furthermore, incidents involving mass violence or truncal trauma may result in providers initiating rapid EMS transport over formal on-scene triage/sorting activities.

Field providers, including command staff, as well as the Emergency Communication Registered Nurses (ECRN's) for the participating EMS agencies, resource hospitals and receiving hospitals within Region X will receive initial and ongoing training from their EMS System on the use of the Region X MPMP.

The signatures of the EMS System Medical Directors listed below officially approve the guidelines set forth by the Region X MPMP dated January 1, 2023 for the provision of emergency medical care and transport during multiple patient incidents by Region X EMS personnel and hospital based ECRN's. This Region X MPMP has been approved by the Illinois Department of Public Health based on the approval of the EMS System Medical Directors.

Jarrod Barker, MD
North Lake County EMSS
Vista Health System

Michael Peters, MD, FAEMS
Northwestern Medicine North Region EMSS
Northwestern Lake Forest Hospital

Scott French, MD, FACEP
Condell Medical Center EMSS
Advocate Condell Medical Center

Jeremy Lott, DO
Saint Francis EMSS
Ascension Saint Francis Hospital

Ben Feinzimer, DO, FACEP
NorthShore Highland Park Hospital EMSS
NorthShore University Health System

LOG OF REVISIONS

Date of Change	Page Number	Summary of Revisions
10.12.2021	6	Revised endorsements to reflect current DMSC Committee members
	9	Redefined incident types from number of ambulances needed to number of patients transported and removed "Business as Usual"
	10	Reformatted "*Region X MPMP*" chart to reflect change in definition of incident types and removed Business as Usual
	12	Added language under Medium/Large Scale incident to indicate the need to maintain communication with the Resource Hospital until the scene has been cleared of patients.
	15	Changed LifeSource to Vitalant for blood needs
	16	Added flowchart for incident communications from deleted *Tactical Communications Plan* page
	-	Deleted *Tactical Communications Plan* page
	17	Updated *Hospital/Field Provider Affiliations and Resource Hospital Alt*. to reflect current affiliations
	18	Added Dispatch Center names and updated phone numbers in *Appendix I, Participating MABAS Divisions*
	19	Added *Appendix II* to show Area Wide Fire Depart. Dispatch Centers
	20	Added column for CarePoint Fax to *Appendix III: Are Wide Hospitals*
	29	Updated *O'Hare Incident Participating Calls* contact numbers for ER and Med Control
	31	Added *Appendix VII, Region X School Bus Accident Policy*
	38	Added Illinois Firefighter Peer Support as an agency under *Appendix XI, Post-Incident Recovery Services*
	40	Reformatted Field Provider Log Form
	41	Reformatted Emergency Department Log Form
	43	Added to *Appendix VII, School Bus Accident Log Form*
	-	Removed ICS 214 form from *Appendix VII: Forms*
	44	Removed "RMERT" from *Abbreviations/Acronyms*
7.11.2022	10	Added "Consider MABAS assistance" to medium/large scale incident
	11	Deleted medical categories on *Region X Criteria for Transportation Destination on Small Scale* and listed all medical patients to be transported to closest appropriate hospital.
	11	Added language to Region X MPMP chart to allow for use of electronic reports for large scale/healthcare evacuation if no delay in patient care or returning to service
	40	Added language to identify which hospital to call based on event size. Added patient tracking method on Field Provider Log Form and ED Log Form for hospital capability and patients transported.
	42	Added Healthcare Evacuation checkbox to *After-Action Report* and revised information on form
8.24.2022	7	Added language to assumptions to allow plan use for multiple patient incident consisting of trauma and/or medical patients. Also added assumption language that in the event of scene safety or other unique challenges, patients may be transported prior to hospital notification
	33	Added language to *Training Guidelines* identifying the need for all groups to regularly review the MPMP at all levels of users

10.25.2022	7	Added bullet point under Assumptions allowing the use of alternative triage tags/methods by agencies based on accepted current research on triage and rapid transport of patients
	20	Sorted table of Area Wide Hospital by status: Level I or Level II Trauma Center, Comprehensive ER, Standby ER and Free Standing ER
	21	Addition of Hatzalah Ambulance-Chicago to the Participating Private Ambulance Provider Chart
	28	On the O'Hare Incident/Disaster Plan, changed Our Lady of Resurrection to Community First Medical Center
	34	Added verbiage on Appendix IX: Medical Personnel Requested to The Scene to identify IMERT must be requested through IEMA
10.29.2022	6	Added bullet points "During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition" and "EMS command should determine if on-scene patient collection/treatment activities are useful based on the nature and size of the incident, number of trained EMS providers, available ambulances and other transport vehicles, scene safety concerns, capacity of nearby hospitals, environmental conditions, and the number of remaining injured patients."
	9	Added verbiage under Triage Tags and Triage Method for Medium/Large Scale Incident "During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities."
	9	Added note for Patient Care Report for Large Scale Incident stating "During an incident involving a mass shooting or truncal penetrating trauma, an abbreviated report should be completed in the absence of a triage tag".
11.10.2022	6	Updated e-mail address for Sara Van Dusseldorp
	9	Added a note with verbiage addressing potential for walk-in to overwhelm ER's
	12	Added verbiage under Medium/Large Scale incidents to notify hospital when all patients are transported and scene is "all clear"
	12	Under Hospitals on Bypass, changed "Closest Appropriate" to "Resource Hospital"
	13	Added "EMS Transport" to first bullet point under Small Scale Incident
	13	Under Hospitals on Bypass, changed contact "Closest Appropriate" hospital to "Resource Hospital"
	18	Changed Abbott Park dispatch number and dispatch center. Added a note on their response abilities.
	27	Revised item #2 to read "Governor's office or designee"
	27	Revised item #4 from "REMERT" to "RMERT"
	28	Under 2nd bullet for Implementation, removed contact of "4-4-11" and left as CFD Officer in Charge
	28	Revised to indicate CFD contacting IEMA to request IMRT
12.7.2022	6	Changed Brianna Kuechle to EMS System Coordinator
12.22.2022	21	Deleted Paratech; Added MedEx and Lifeline; Added note that Midwest and Advance are under Elite who coordinates dispatch; place providers in alphabetical order.
6.26.2023	6	Removed Chief Carlson and added Deputy Chief Joel Eaton as new Highland Park Ems System Provider representative. Replaced Martha Pettineo as the Highland Park EMS System Coordinator.

7.12.2023	Cover Page	Revised to show only current version number
	5	Added Appendix VIII Mass Violence Response to Table of Contents and revised Table of Contents to match new corresponding page numbers
	46	Added Appendix VIII Mass Violence Response to MPMP

TABLE OF CONTENTS

ENDORSEMENTS

This plan has the endorsement of each of the MABAS Divisions covered within the plan, the Medical Directors of each of the EMS Systems located within the boundaries of this plan and the Disaster Management Services Committee of Region X. The plan has been approved by the Region X Trauma/EMS Advisory Committee as well as the Illinois Department of Public Health.

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INTRODUCTION

The purpose of this plan is to enable Fire/EMS agencies and Region X hospitals to respond effectively and efficiently to multiple patient incidents so as not to tax the resources of any single pre-hospital provider or healthcare facility and to provide optimal patient care. This plan is intended to supplement each participant's individual mass casualty or disaster plan.

ASSUMPTIONS:

- The fundamental principles of risk assessment and risk management are essential to responder safety.
- Multiple patient incidents will occur in Region X.
- Given the population of Region X, responders and receivers should expect patient diversity in an incident, to include (at a minimum) age, gender, and special needs.
- This goal of this plan is to promote proper patient destination in the best interest of patient outcome.
- This plan is motivated by the essential priorities of Fire/EMS service response to a multiple patient incident consisting of trauma and/or medical patients.
- The most probable multiple patient incidents will involve less than five patients.
- The influx of multiple patients from the same incident or the inability to determine scene safety may create unique challenges for both hospitals and field providers including the ability to make proper notification of plan use before transport or arrival of patients.
- Given the challenges of simultaneously caring for multiple patients, altered standards of care may be temporarily required.
- Communication challenges will occur during multiple patient incidents.
- Patient conditions may change en route to the hospital and following initial communications with hospital(s).
- Alterations to modes of transportation or traditional transportation practices may be required, such as more than one patient per ambulance and/or the use of buses or vans to transport patients to regional healthcare facilities.
- Typical transportation routes may be affected by adverse weather conditions, debris or road closures which may impact hospital destinations.
- EMS personnel and hospital-based Emergency Communications Radio Nurses (ECRNs) are well versed in the trauma classification system as outlined by the Illinois Department of Public Health and inherent to the Region X Standing Operating Procedures.
- Region X has adopted the SMART® tag system as the standard process in Region X for identifying the urgency of patient transport. Agencies may choose to use alternate triage tag methods such as wristbands, which identify patients by the same color system. Alternate triage tag methods should be based on accepted current mass casualty research for triage and rapid transport of patients.
- During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition.
- EMS command should determine if on-scene patient collection/treatment activities are useful based on the nature and size of the incident, number of trained EMS providers, available ambulances and other transport vehicles, scene safety concerns, capacity of nearby hospitals, environmental conditions, and the number of remaining injured patients.

This plan assigns specific responsibilities to EMS providers and hospitals to coordinate resources and activities when an incident involves multiple patients. The plan outlines:

1. An approach that is scalable to the size, nature, geographic specifics, and speed of the event.

2. A classification system which promotes an orderly disbursement of patients to local/ regional hospitals.

3. A uniform operational guideline for handling multiple victim incidents within the structure of the Incident Command System.

4. A communications network linking responding Fire/EMS agencies to receiving hospitals and Region X Resource Hospitals.

5. Responsibilities of responding EMS providers.

6. Responsibilities of hospitals closest to a small scale multiple patient incident.

7. Responsibilities of the Resource Hospitals who shall serve as Hospital Command to assist with transportation management, including, but not limited to, managing logistics, obtaining hospital resource availability, and communicating such information to scene personnel when the number of ill or injured persons exceeds the routine disbursement of patients in Medium and Large Scale incidents.

8. Basic guidelines for the management of an emergent evacuation of a healthcare facility.

Hospitals and Fire/EMS providers in Region X are responsible for functioning as a unified entity in the event of a multiple patient incident. This plan enables all participants to collectively serve their communities and patients with efficiency and competence.

Every agency participating in this plan shall routinely conduct post-action reviews of all training exercises and plan activations to identify areas of improvement and to amend procedures, as necessary. A form to facilitate such review is contained within the plan.

Local government is recognized as the first line of official public response for emergency management activity. In addition to local resources used during a multiple patient incident, county, state, and federal emergency management agencies may be relied upon for support when damage, illness or injury is unusually widespread or severe. Private ambulance providers affiliated with Region X are considered valuable members of the EMS community and as such may be called upon as needed. The Private Provider Emergency Response System (PPERS) has been established in Illinois and may be activated to assist Illinois' Mutual Aid Box Alarm System (MABAS) during incidents involving large numbers of victims. Protocols for activating these agencies reside in the emergency operations plans of local governments, MABAS, and Resource Hospitals.

For additional information regarding this plan, please contact a member of the DMSC Committee listed on the Endorsements page.

DEFINITIONS OF MULTIPLE PATIENT INCIDENT TYPES

SMALL SCALE INCIDENT:

- A **Small Scale Incident** may require more than routine resources to mitigate the incident.
- The incident usually involves the transport of more than 5 but less than 10 patients.
- Command and General Staff functions are activated only if required.
- The incident is generally limited to one operational period in the control phase.
- A written Incident Action Plan (IAP) is not required but other documentation methods may be employed.

MEDIUM SCALE INCIDENT:

- A **Medium Scale Incident** exists when capabilities exceed the typical initial emergency response. The appropriate ICS positions should be added to match the complexity of the incident.
- The incident usually involves the transport of 10 or more but less than 20 patients.
- Some or all of the Command and General Staff positions may be activated, as well as Division/Group Supervisors and/or Unit Leader level positions.
- The incident may extend into multiple operational periods.
- A written Incident Action Plan (IAP) may be required.

LARGE SCALE INCIDENT:

- A **Large Scale Incident** generally extends beyond the capabilities of local control and may require multiple operational periods.
- The incident involves the transport of 20 or more patients.
- Most or all the Command and General Staff positions are filled.
- Many of the functional units may be required and staffed.
- A written Incident Action Plan (IAP) may be required for each operational period.

NOTE:
The definitions of multiple incident types shown above revolve around the transport of patients by EMS providers from the field. It should be understood that some incidents classified as Medium or Large Scale may create an overwhelming increase in the number of “walk-in” patients to area hospital emergency rooms. This influx of multiple patients, both transported and “walk-in”, may create unique challenges for both hospital and field providers, including the ability to assign transport destinations according to this plan. In these instances, communications between the Resource Hospital, Receiving Hospitals and Field Command is imperative to the appropriate distribution of patients based on injuries or illness.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN

Definition	Small Scale Incident At least 5 but less than 10 patients	Medium Scale Incident At least 10 but less than 20 patients Consider MABAS assistance	Large Scale Incident 20 or greater patients Consider MABAS assistance	Evacuation of a Healthcare Facility
Initial Communication	If the number of transported patients is between 5 and 9, contact closest appropriate Hospital to advise of incident and determine their maximum patient availability. State: "We are on scene of a small scale multiple patient incident"	Contact Resource Hospital State: "We are on scene of a (medium) or (large) scale multiple patient incident"		Contact Resource Hospital State: "We are on scene of an emergency evacuation of a healthcare facility"
Initial Information	• Event Description • Estimated number of patients to be transported • Briefly describe pt. condition	• Event Description • Estimate number of patients to be transported • Estimate pt. acuities (R, Y, G) • Closest hospitals		• Event Description • Estimated number of patients to be transported • Closest hospitals • Alternative receiving facilities
Patient Disbursement	Field Command, or designee, coordinates transportation management and destination of patients. Patients should be disbursed to appropriate facilities based on trauma categories and guidelines. Maximum of 2 patients to each hospital unless advised otherwise.	Resource Hospital coordinates transportation management and destination of patients On a large scale incident, the RHCC may be employed for assistance with communications and additional resources		Resource Hospital works in conjunction with field command and administration of affected facility to determine transportation management and patient destination. RHCC may be employed for assistance with communications and additional resources Consider activation of PPERS and/or CHUG
Triage Tags	Triage tags not used	Triage tags MUST be used ***with the exception*** of incidents involving mass shootings or truncal penetrating trauma where rapid transport should be favored over formal triage activities		Triage tags MUST be used
Triage Method	Use rapid assessment to identify patient Category and appropriate hospital determination	START Triage ***with the exception*** of incidents involving mass shootings or truncal penetrating trauma where rapid transport should be favored over formal triage activities		Within facility use Reverse Triage Prior to transport use START Triage
Ambulance to Hospital Communication	Every transporting ambulance contacts their receiving hospital with an abbreviated report State: "We are transporting from a small scale multiple patient incident"	NO contact between transporting ambulance and receiving hospital		NO contact between transporting ambulance/patient transportation vehicle and receiving facilities
Patient Care Report	Complete written patient care reports as usual	Complete written patient care reports as usual	No written patient care reports since Triage Tags serve as written report unless able to complete with electronic means with **no delay** in patient care or returning to service (See note below)	No written patient care reports since Triage Tags serve as written report unless able to complete with electronic means with **no delay** in patient care or returning to service

Note: During an incident involving a mass shooting or truncal penetrating trauma, an abbreviated report should be completed in the absence of a triage tag.

REGION X CRITERIA FOR DETERMINING PATIENT TRANSPORT DESTINATION FOR SI NCIDENT

TRAUMA	
CRITERIA	**DESTINATION**
Traumatic Arrest	Closest Trauma Center
No Airway	Closest comprehensive ER
Systolic Blood Pressure • Adult ≤ 90 (2 consecutive measurements) • Peds ≤ 90 (2 consecutive measurements)	**Highest** level Trauma Center within 25 minute transport time
Category I Unstable Vital Signs • Glascow Coma Scale ≤ 13 with associated head trauma • Respiratory rate < 10 or > 29 (< 20 infant) or need for ventilatory support Anatomic Criteria • Penetrating injury to head, neck, torso and extremities proximal to elbow or knee • Two or more proximal long bone fractures • Unstable pelvis • Chest wall instability or deformity (e.g., flail chest) • Crushed, degloved, mangled or pulseless extremity • Open or depressed skull fractures • Amputation proximal to wrist or ankle • Paralysis	**Highest** level Trauma Center within 25 minute transport time
Category II (Mechanism of Injury) High Risk Auto Crash • Ejection from automobile (partial or complete) • Death in same passenger compartment • Intrusion, including roof, > 12 inches occupant site or > 18 inches any site • Vehicle telemetry data consistent with a high risk for injury • Motorcycle crash > 20 mph • Rollover (unrestrained) Falls • Adult Falls ≥ than 20 feet (1 story = 10 feet) • Peds Falls ≥ than 10 feet or 2X height of child Other • Auto vs. Pedestrian thrown, run over or with > 20 mph impact • Auto vs. Bicyclist thrown, or run over or with > 20 mph impact	**Closest** Trauma Center
Special Considerations Age • Adults ≥ 55 years: risk of injury and death increases • SBP < 110: consider shock if age > 65 years • Low impact mechanisms/standing falls may lead to injury • Children should be preferentially transported to a pediatric capable trauma center Anticoagulation and bleeding disorders: Pts. with head injury at high risk for rapid deterioration Burns: MOI with or without trauma: transfer to closest trauma center Pregnancy > 20 weeks preferentially transported to a facility with emergency obstetrics capabilities EMS Provider judgement	**Closest** Trauma Center If no trauma center, contact Medical Control
If none of the above, Simple Trauma	Closest comprehensive ER

MEDICAL
All medical patients, regardless of stability, are to be transported to the closest comprehensive emergency room.

FIRE DEPARTMENT RESPONSIBILITIES

SMALL SCALE INCIDENT:

- Contact the closest appropriate hospital, may be Resource Hospital in some areas, using normal modes of communication. State, *"We are on the scene of a Small Scale multiple patient incident."* Utilize the **Field Provider Log Form** (Appendix XII) for assistance with field to hospital communication.
- Report event description, estimated number of patients to be transported, general patient descriptions and the closest appropriate hospitals.
- After conferring with the closest appropriate hospital, transport the agreed upon number of patients to that hospital.
- If the closest hospital cannot take all the patients from the incident, Incident Command or their designee will assign each transporting ambulance a destination hospital. ***Transport no more than two patients to each remaining hospital.***
- If EMS desires more than two patients be transported to a hospital, the ECRN at the closest hospital should contact the desired hospital to confirm ***prior to transport.***
- When the number of ill or injured patients exceeds the routine transport of patients to the nearest hospitals, contact the Resource Hospital to coordinate remaining patient distribution.
- Communicate remaining patients' destinations to the closest hospital.
- All transporting ambulances should contact their destination hospitals with patient care reports (abbreviated reports are acceptable). All radio reports must begin with, *"We are transporting a patient from a Small Scale multiple patient incident"*.

MEDIUM or LARGE SCALE INCIDENTS:

- Contact the Resource Hospital IMMEDIATELY using normal modes of communication. State, *"We are on the scene of a Medium/Large Scale multiple patient incident".* Utilize the **Field Provider Log Form** (Appendix XII) for assistance with field to hospital communication.
- Requesting transportation management, report event description, estimated numbers of patients to be transported, estimated patient acuities and closest hospitals. Provide the Resource Hospital with a call-back number.
- After the Resource Hospital reports hospital capabilities, record information and assign patients and destination hospitals to ambulances.
- Maintain communication with the Resource Hospital until the scene has been cleared of patients. For each transporting ambulance, report ambulance number, acuities of patients being transported and destination hospital to the Resource Hospital.
- Once all patients have been transported on a medium or large scale incident (All Clear), notify the Resource Hospital of the number transported to each hospital so that appropriate notification of patient expectations can be made.
- Complete an After-Action Report (Appendix XII) following every multiple patient incident. Fax the report to the EMS Office at the Resource Hospital within 7 days of the event.

HOSPITALS ON BYPASS:

- Contact the Resource hospital regardless of the bypass status to discuss patient disbursement during a Small Scale incident.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

EARLY COMMUNICATION WITH THE HOSPITAL IS INDICATED EVEN IF PATIENT COUNTS AND CONDITIONS HAVE NOT BEEN REFINED!

RECEIVING HOSPITAL RESPONSIBILITIES

SMALL SCALE:

Each medical control hospital within Region X must be prepared to manage initial calls from local emergency responders during a Small Scale incident. The closest appropriate, may be the Resource Hospital in some areas, will be contacted by a field provider representative for an initial discussion of patient disbursement. ***During some incidents, it may be possible for the closest hospital to accept all or most patients.***

- Following the initial disbursement of patients by EMS transport to the closest hospital, each area-wide hospital will receive NO MORE THAN TWO patients by EMS transport from a multiple patient incident (according to appropriate trauma triage criteria) without giving specific approval prior to transport.
- In the event that EMS would like to transport more than two patients to a hospital (most often victims from the same family), the ECRN at the closest Hospital will contact the desired hospital to confirm the receipt of additional patients ***prior to transport***.
- Receiving hospitals will be notified of their arriving patients via normal modes of field to hospital communication. Providers will announce, "*We are transporting a patient from a Small Scale multiple patient incident"* at the beginning of their radio report. Most often, this will be the first notification for a receiving hospital that a multiple patient incident has occurred.
- **Receiving hospitals MAY NOT divert ambulances transporting from a multiple patient incident.**

MEDIUM or LARGE SCALE:

- If patient numbers or acuity prevents the even disbursement of patients to local hospitals, or if field providers need immediate assistance for any reason, field providers will contact their Resource Hospital for assistance with transportation management.
- Upon receiving notification from the Resource Hospital, receiving hospitals should immediately report their ability to accept specific numbers of red, yellow and green patients.
- ***Note: Ambulances transporting patients from the scene will NOT contact the receiving hospital prior to their arrival.***
    - Consider activation of internal hospital mass casualty/disaster plan in order to accommodate a larger number of patients.
    - Be prepared to report availability of medical personnel to send to the scene.
    - Maintain a log sheet of communication with the Resource Hospital.
    - Report increases or limitations in treatment capability to the Resource Hospital.
    - Be prepared to send pre-assembled bags of medical supplies to the scene (per state and regional guidelines).

HOSPITALS ON BYPASS:

- Pre-hospital providers will contact the Resource Hospital to discuss patient disbursement during a Small Scale incident when the closest appropriate hospital is on bypass status.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

DO NOT ATTEMPT TO STOP PATIENT FLOW FROM INDIVIDUAL AMBULANCES ***NOT*** ASSOCIATED WITH THE DISASTER SCENE.

(Continued on next page)

Receiving Hospital Responsibilities, continued

Once the Resource Hospital has been contacted by field personnel for assistance with transportation management

ALL COMMUNICATION MUST GO THROUGH THE RESOURCE HOSPITAL!

- Do not attempt to contact the scene.
- Do not attempt to contact dispatch.
- Do not divert individual ambulances.

*Complete an After-Action Report (Appendix XII) following every medium or large scale multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital EMS Coordinator within 7 days of the event.

RESOURCE HOSPITAL RESPONSIBILITIES

The Resource Hospital is contacted by scene personnel when the number of ill or injured patients exceeds the routine transport of patients to the nearest appropriate hospitals in order to coordinate the remaining patient distribution.

NOTE: *The Resource Hospital may be contacted at any time to assist field personnel.*

Upon notification by scene personnel that a Medium or Large Scale multiple patient incident has occurred, the Resource Hospital will assume the duties of Hospital Command, providing transportation management and serving as Medical Control throughout the incident.

The Resource Hospital shall:

- Initiate a **Hospital Communications Flow Sheet: ICS 214.**
- Collaborate with scene personnel to identify receiving hospitals based upon incident location, transport routes remaining open (consider natural disaster disruptions), volume and acuity of patients, and number of patients already transported.
    - Establish inter-hospital communications with possible receiving hospitals via telemetry, radio intercom, landline phone or MERCI 155.280.
    - Inform the hospitals about the nature of the incident, including approximate number, acuity and type of patients that will be transported.
    - Assess receiving hospitals' resources *(may be incident specific)*:
        - Ability to receive patients, including numbers of red, yellow and green
        - Blood inventory
        - Ability to decontaminate patients
        - Ability to send medical personnel and supplies to the scene
- Continue to monitor, log and communicate receiving hospitals' capacity throughout incident.
- Identify and alert additional receiving hospitals as casualty load exceeds the initial receiving hospitals' patient capacity.
- Maintain communication with the scene Incident Commander or their designee, relaying receiving hospital availability and providing on-going transportation management.
- Consider contacting the alternate Resource Hospital for assistance with communication.
- Consider contacting the RHCC if regional coordination or assistance with communication as required. (Highland Park Hospital: (847) 432-2294 or (847) 432-2295)
- Obtain status of specialized facilities as needed (burn units, pediatrics, etc.)
- Consider notifying Vitalant Blood Services at (847) 260-2701 or the emergency hotline at (800) 821-6277 if a multiple patient incident has occurred (if nature of casualties implies need for transfusions).
- Coordinate medical personnel to respond to the site as needed.
- Serve as Hospital Command liaison with disaster and public agencies.
- An After-Action Report (Appendix XII) should be completed following every medium or large scale multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital's EMS Coordinator within 7 days of the event.

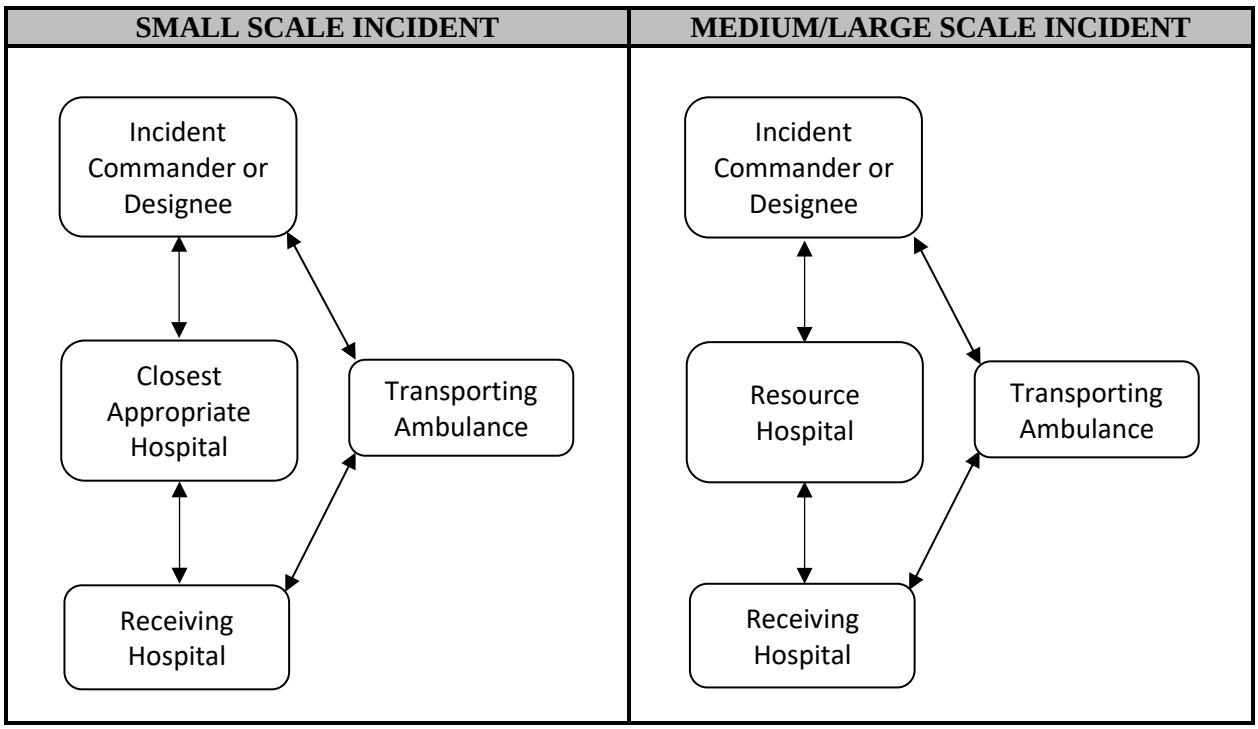
REGIONAL HOSPITAL COORDINATING CENTER (RHCC) RESPONSIBILITIES

The Regional Hospital Coordinating Center (RHCC) is contacted by Regional Resource Hospitals for assistance with communications and obtaining additional resources.

The RHCC shall:

- Initiate a Hospital Communications Flow Sheet: ICS 214
- Collaborate with requesting hospital to determine and attempt to meet logistical needs, including:
    - On-scene medical personnel/teams
    - Medical equipment/resources
- Communicate with other regions for assistance, as needed.
- Contact the Illinois Department of Public Health for assistance and/or notification, as needed.

FLOWCHART FOR ALL COMMUNICATIONS



HOSPITAL/FIELD PROVIDER AFFILIATIONS and RESOURCE HOSPITAL ALTERNATES

During a Medium Scale or Large Scale incident, *Hospital Command will be assumed by the Resource Hospital affiliated with the fire department that has jurisdiction over the incident location*. However, the Resource Hospital may be directly affected by the disaster or overwhelmed by patients and unable to function in that role. In such a case, Hospital Command will be assumed by the first or second alternate hospital, as designated below.

Condell Medical Center serves as Medical Control and Hospital Command for:	
Antioch Fire Department	Round Lake Fire Protection District
Countryside Fire Protection District	Wauconda Fire Department
Libertyville Fire Department	
Mundelein Fire Department	
First alternate: Vista Medical Center East	Second alternate: Highland Park Hospital

Highland Park Hospital serves as Medical Control and Hospital Command for:	
Deerfield-Bannockburn Fire Protection Dist.	Highland Park Fire Department
Glencoe Public Safety	Northbrook Fire Department
Gurnee Fire Department	
First alternate: St. Francis Hospital	Second alternate: Vista Medical Center East

Lake Forest Hospital serves as Medical Control and Hospital Command for:	
Grayslake Fire Protection District	Lake Villa Fire Department
Great Lakes Fire Department	Newport Township Fire Protection District
Lake Bluff Fire Department	North Chicago Fire Department
Lake Forest Fire Department	Waukegan Fire Department
First alternate: Condell Medical Center	Second alternate: Highland Park Hospital

St. Francis Hospital serves as Medical Control and Hospital Command for:	
Evanston Fire Department	Wilmette Fire Department
Lincolnwood Fire Department	Winnetka Fire Department
Northfield Fire Department	Wheeling Fire Department
Skokie Fire Department	
First alternate: Highland Park Hospital	Second alternate: Condell Medical Center

Vista Medical Center East serves as Medical Control and Hospital Command for:	
Beach Park Fire Protection District	Zion Fire and Rescue Department
Winthrop Harbor Fire Department	
First alternate: Condell Medical Center	Second alternate: Highland Park Hospital

APPENDIX I: PARTICIPATING MABAS DIVISIONS

REGION X MABAS DIVISION DISPATCH CENTERS

MABAS Division	Primary Dispatch Center		Back-Up Dispatch Center	
Division 1	Northwest Central	(847) 590-3300	RED Center	(847) 724-5700
Division 3	RED Center	(847) 724-5700	Northwest Central	(847) 590-3300
Division 4	CENCOM	(847) 270-9111	Countryside FPD	(847) 566-4621

MABAS DIVISION 1 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Wheeling	St. Francis	(847) 724-5700	Red Center

MABAS DIVISION 3 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Deerfield-Bannockburn	Highland Park	(847) 724-5700	Red Center
Evanston	St. Francis	(847) 866-5095	Evanston
Glencoe	Highland Park	(847) 724-2121	Glenview
Glenview	Lutheran General	(847) 724-2121	Glenview
Highland Park	Highland Park	(847) 861-9611	Glenview North
Lincolnwood	St. Francis	(847) 982-5300	Skokie
Morton Grove	Lutheran General	(847) 724-5700	Red Center
Niles	Lutheran General	(847) 724-5700	Red Center
Northbrook	Highland Park	(847) 724-5700	Red Center
Northfield	St. Francis	(847) 724-5700	Red Center
North Maine	Lutheran General	(847) 724-5700	Red Center
Park Ridge	Lutheran General	(847) 724-5700	Red Center
Skokie	St. Francis	(847) 982-5300	Skokie
Wilmette	St. Francis	(847) 724-5700	Red Center
Winnetka	St. Francis	(847) 724-5700	Red Center

MABAS DIVISION 4 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Abbott Park[1]	Condell	(224) 667-7970	Global Comms.
Antioch	Condell	(847) 270-9111	CenCom
Beach Park	North Lake County	(847) 599-7000, ext. 0	Gurnee
Countryside	Condell	(847) 362-5244	Countryside
Deerfield (Also Division 3)	Highland Park	(847) 724-5700	Red Center
Grayslake	Lake Forest	(847) 587-3100	FoxCom
Great Lakes	Lake Forest	(847) 688-6902	Norfolk, VA
Gurnee	Highland Park	(847) 599-7000, ext. 0	Gurnee
Lake Bluff	Lake Forest	(847) 861-9611	Glenview North
Lake Forest	Lake Forest	(847) 861-9611	Glenview North
Lake Villa	Lake Forest	(847) 587-3100	FoxCom
Libertyville	Condell	(847) 362-5224	Countryside
Mundelein	Condell	(847) 566-6051	Mundelein
Newport	Lake Forest	(847) 599-7000, ext. 0	Gurnee
North Chicago	Lake Forest	(847) 566-6051	Mundelein
Round Lake	Condell	(847) 270-9111	CenCom
Wauconda	Condell	(847) 438-2349	Lake Zurich
Waukegan	Lake Forest	(847) 599-2608	Waukegan
Winthrop Harbor	North Lake County	(847) 566-6051	Mundelein
Zion	North Lake County	(847) 599-7000, ext. 0	Gurnee

1. Abbott personal do not respond off of Abbott property for EMS calls or Mass Casualty Incidents but will respond to mutual aid requests for Haz Mat incidents.

APPENDIX II: AREA-WIDE FIRE DEPARTMENT DISPATCH CENTERS

Dispatch Center	Primary Dispatch Number	Back-Up Dispatch Center
CenCom	(847) 270-9111	Fox Com
Countryside FPD	(847) 362-5224	Lake Zurich
Evanston	(847) 866-5095	Red Center
FoxCom	(847) 587-3100	CenCom
Glenview South	(847) 724-2121	Glenview North
Glenview North	(847) 861-9611	Glenview South
Gurnee	(847) 599-7000, Dial 0	Waukegan
Lake Zurich	(847) 438-2349	Countryside FPD
Mundelein	(847) 566-6051	Countryside FPD
Norfolk (Great Lakes)	(847-688-6902	N/A
Northwest Central	(847) 590-3300	Red Center
Red Center	(847) 724-5700	Northwest Central
Skokie	(847) 982-5300	Red Center
Waukegan	(847) 599-2608	Gurnee

APPENDIX III: AREA-WIDE HOSPITALS

REGION X RHCC

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	(847) 926-5325

REGION X RESOURCE HOSPITALS

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Condell Medical Center	(847) 362-2963	(847) 573-4258	(847) 990-5300	(847) 990-2992
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	
Lake Forest Hospital	(847) 535-7375		(847) 535-6150	(847) 535-7376
St. Francis Hospital	(847) 864-6564	(847) 864-8550	(847) 316-4000	
Vista Medical Center East	(847) 360-4234		(847) 360-4181	

LEVEL I TRAUMA CENTERS / COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Condell Medical Center	(847) 362-2963	(847) 573-4258	(847) 990-5300	
Evanston Hospital	(847) 492-9453	(847) 492-1457	(847) 570-2111	(847) 570-2932
Lutheran General Hospital	(847) 696-0743	(847) 696-9073	(847) 723-7722	
Saint Francis Hospital	(847) 864-6564	(847) 864-8550	(847) 316-4000	

LEVEL II TRAUMA CENTERS / COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Alexian Brothers Medical Ctr.	(847) 437-8118	(847) 952-7454	(847) 981-3599	
Glenbrook Hospital	(847) 729-9260	(847) 657-6010	(847) 657-5632	(847) 657-5960
Good Shepherd Hospital	(847) 385-9525		(847) 842-4444	
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	(847) 926-5325
Lake Forest Hospital	(847) 295-1440		(847) 535-6150	
Northwest Community Hospital	(847) 259-8720		(847) 618-3913	
Saint Alexius Medical Center	(847) 843-5308		(847) 843-5309	(847) 490-6930
Vista Medical Center East	(847) 360-4234			(847) 360-4181
Froedtert Pleasant Prairie (WI)	(262) 697-5563			(262) 577- 8202

COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Aurora Medical Center (WI)	(262) 694-1968	(262) 694-1973	(262) 948-5640	
Captain James A. Lovell FHCC	(224) 610-1442	(224) 610-1076	(224) 610-5505	(224) 610-5306
Resurrection Medical Center	(773) 774-8455		(773) 990-5255	
Skokie Hospital	(847) 674-2665	(847) 674-2694	(847) 933-6950	

STANDBY EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Midwestern Regional Med Ctr.			(847) 872-6220	.

REGION X FREESTANDING EMERGENCY CENTERS

Hospital	Medical Control Phone Number	ER Phone Number	CarePoint Fax
Northwestern Grayslake	(847) 535-8736	(847) 535-8950	
Vista Lindenhurst	(847) 356-4782	(847) 356-4705	

REGION 9 RHCC HOSPITAL (Information Only)

Hospital	Medical Control Phone Number	ER Phone Number	CarePoint Fax
Sherman Hospital		(847) 429-2950	

APPENDIX IV: PARTICIPATING PRIVATE AMBULANCE PROVIDERS

Private Provider	Dispatch Phone Number	Contact Information
Advance Ambulance[2]	Chicago: (773) 774-8999 Suburbs: (847) 963-8700	Advise dispatcher of need(s) and request that Shift Manager be paged
Ambulnz	Chicago: (773) 429-8880 Suburbs: (708) 478-8880	Advise dispatch of need(s) and request that 'management' be paged
A-TEC Ambulance	(800) 729-2780	Advise dispatcher of need(s) and request that Chief Officer be paged
Elite Ambulance	Chicago: (773) 429-8880 Suburbs: (708) 478-8880	Advise dispatch of need(s)
Hatzalah Chicago[1]	(847) 504-1500	Advise dispatch of need(s)
Lifeline Ambulance	(312) 949-9500	Advise dispatch of need(s)
MedEx Ambulance	(847) 674-9111	Advise dispatch of need(s)
Midwest Ambulance[2]	(847) 745-0050	Advise dispatch of need(s)
Murphy Ambulance	(847) 816-4600	Advise dispatch of need(s)
Superior Ambulance	(630) 832-2000	Advise dispatch of need(s) and request Regional Manager be paged

1. Hatzalah Chicago enhances pre-hospital care and support in the Chicagoland Jewish Community by augmenting the existing services provided by the municipalities by providing emergency medical response 24 hours a day, 7 days a week within defined geographical boundaries in Lincolnwood, Peterson Park, Skokie, and West Rogers Park.
2. Advance Ambulance and Midwest Ambulance are one company with Elite. Dispatch number redirects to Elite.

Private Providers Emergency Response System (PPERS)

Primary Dispatch Number: (800) 558-6050

PPERS was developed to assist fire departments, local health departments, hospitals and healthcare facilities during large-scale disaster events. All major ambulance providers in the Northern Illinois region are members of this disaster response network. Membership to PPERS is selective to ensure that the best resources are deployed for such large scale, disaster events. The ATI dispatch center serves as the communication center for PPERS and coordinates all activities of its members as it is received requests from any government agency and/or healthcare centers.

Collaborative Healthcare Urgency Group (CHUG)

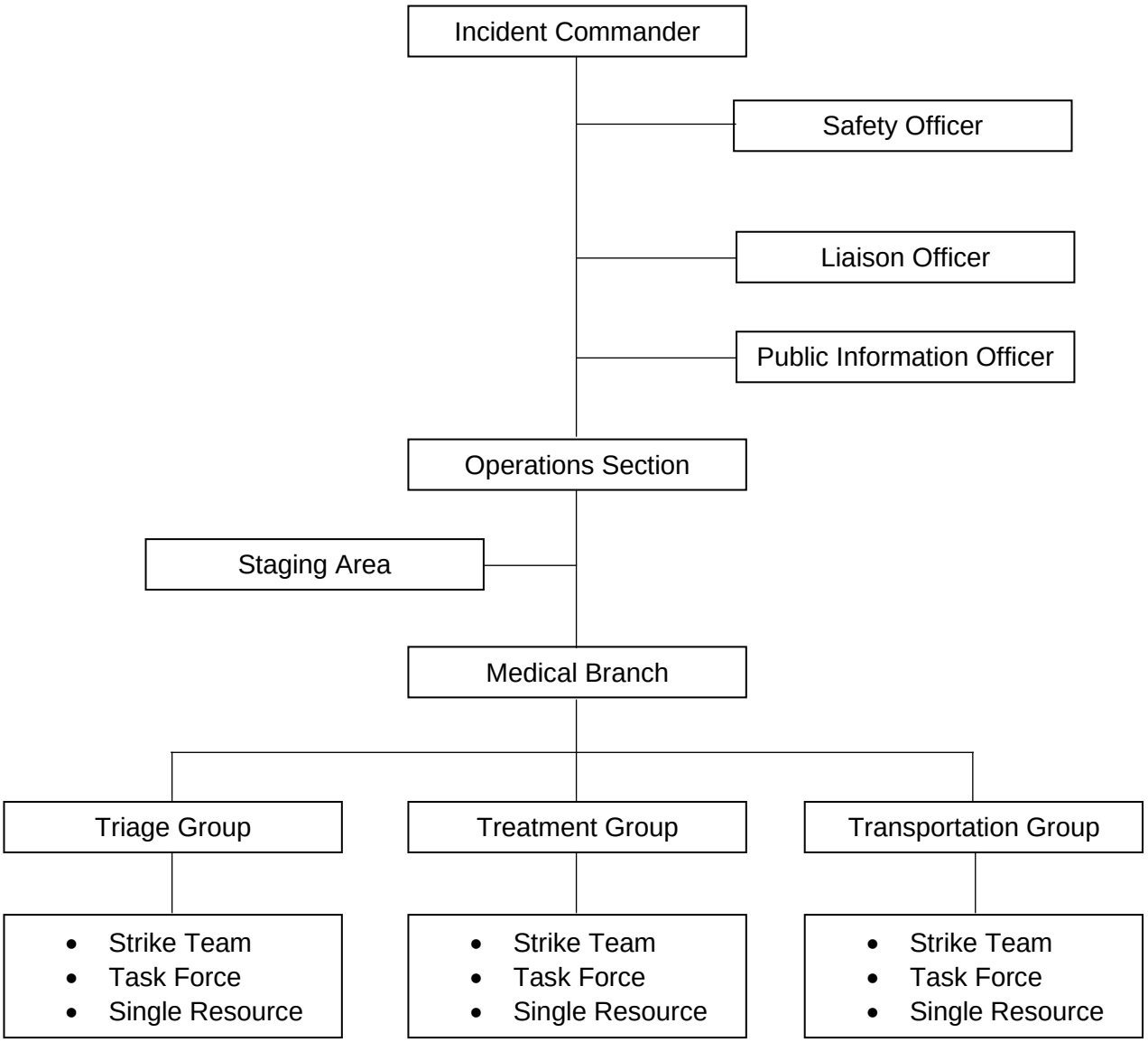
Primary Dispatch Number: (866) 794-2210

At their core, CHUG is a unique mutual aid system for nearly 1,000 healthcare members across the country providing their members with expert coordination of evacuation, transportation, relocation and shelter-in-place services. CHUG also offers expertise with response and restoration services, including fire and water damage, mold remediation, infectious disease clean-up and catastrophic loss.

APPENDIX V: INCIDENT COMMAND POSITION DESCRIPTIONS

The position descriptions contained herein are dictated by experience as necessary for the successful management and resolution of a multiple patient incident. The performance outlines are simply suggestions and are not intended to be viewed as a requirement for activation of the plan.

INCIDENT MANAGEMENT SYSTEM ORGANIZATION



MEDICAL BRANCH

The Medical Branch may be organized as either a separate group or section under the Incident Management System, depending on the scope of the incident. Functions of the medical branch include triage, patient treatment and transportation. A single Medical Group Supervisor at a multiple patient incident may coordinate all these functions. However, such duties may be delegated as appropriate to a separate Triage Unit Leader, Treatment Unit Leader and/or Transportation Unit Leader in a multiple patient incident, overseen by a single Medical Group Supervisor who reports directly to Incident Command.

MEDICAL GROUP SUPERVISOR

Assigned By: Incident Command

Duties: Oversees the medical section of a multiple patient incident. May appoint and supervise triage, treatment and transportation units.

Responsibilities may include:

- Determining the approximate number of patients and extent/type of injuries
- Immediately advising either the closest hospital or the Resource Hospital (depending on the size/scale of the incident) that an incident has occurred, utilizing normal modes of communication.
- Communicating patient numbers and acuity to the hospital.
- Advising the hospital of those hospitals closest to the incident scene.
- Determining the patient destination hospitals for each patient not transported to the closest hospital (during a Small Scale incident) and assigning patients to a transporting ambulance crew.
- Advising transporting ambulances of their assigned destination hospital according to communication received from the Resource Hospital in a Medium Scale or Large Scale incident.
- Maintaining communication with the hospital throughout the incident or appointing a group or branch supervisor to assume communication with the hospital.
- Continually assessing the need for additional ambulances, personnel and equipment, making such requests through Incident Command.
- Assessing the need for medical teams and aero-medical transportation (according to local system policy) in consultation with the Resource Hospital and Incident Command. (If aero-medical transportation is required, staging must be notified by the Medical Group Supervisor to set up an appropriate landing zone.)
- Determining the extent of documentation (in the form of a patient care report) required per incident, relaying information to the Transportation Unit Leader who will pass the information to transporting ambulance crews.
- Ensuring that an After-Action Report (Appendix XI) is generated within 7 days of the incident and that a copy of the report has been faxed to the EMS Office at the Resource Hospital of the host department.

MEDICAL SUPPLY UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Secures and organizes medical supplies and equipment

Responsibilities include:

- Coordination of needed supplies and equipment including, but not limited to, backboards, oxygen supplies, dressings and bandages, medications, volumes of sterile water, IV fluids and equipment.
- This logistical function may be necessitated in Medium Scale or Large Scale incidents or when specialized equipment and/or supplies are required.
- Additional supplies and equipment may be obtained via mass casualty bags located on each ambulance or by requesting the mass casualty trailer be brought to the scene.

TRIAGE UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Provides coordination necessary for effective categorization and transportation of patients from the incident to the treatment area.

Responsibilities include:

- Supervision of triage personnel during the initial phase of a multiple patient incident.
- Determining and relaying number of patients and general acuity to the Medical Group Supervisor, updating information, as necessary.
- Reporting any needs regarding equipment and manpower to the Medical Group Supervisor.
- Confirming that ALL patients have a triage tag present and that the appropriate area of the tag has been retained by triage personnel.
- Reporting to the Medical Group Supervisor for reassignment upon completion of triage and transfer of patients to the Treatment Unit Leader.

TREATMENT UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: The designation of the Treatment Unit Leader is intended for use in larger incidents where the Medical Group Supervisor would be unable to coordinate activities in the patient treatment area. Establishes and manages the patient treatment area.

Responsibilities include:

- Overseeing EMS personnel in the treatment and frequent reassessment of patients in the treatment area.
- Prioritization of patients for transport to hospitals.

TRANSPORTATION UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Establishes loading of ambulances and records patient destination.

Responsibilities include:

- Communication with the Resource Hospital (initial communication may have been established by Medical Group Supervisor or their designee).
    - The Transportation Unit Leader will:
        - give patient numbers and triage categories to the Resource Hospital.
        - receive and record hospital capabilities as reported by the Resource Hospital.
        - give specific hospital destination for each ambulance to the Resource Hospital, including number of patients and triage categories.
        - Advise Resource Hospital when last patient has been transported.
- Establishment of patient loading area allowing for safe and coordinated access and egress of ambulances.
- Communication with Staging Area Unit Leader, requesting specific number and capabilities (ALS, BLS) of available ambulances.
- Notation of each patient's triage tag number on a log sheet.
- Assignment of a destination hospital to each transporting ambulance.

STAGING AREA UNIT LEADER

Assigned By: Operations Chief or Incident Command

Duties: Management of all incoming Fire/Rescue apparatus, ambulances and other resources.

The first unit to arrive at the staging location will typically assume the role of Staging Unit Leader until such time as they are relieved by an officer designated by Operations Chief or Incident Command.

Responsibilities include:

- Maintaining communication with (either Transportation or Treatment Unit Leader) to supply required vehicles.
- Maintaining communication with Incident Command to advise on available resources.
- Sending requested resources to the scene.
- Management of the staging area, assuring orderly parking, maintaining clear access to the incident site.
- Maintaining accountability of available equipment, apparatus and manpower.
- Collection of mass casualty bags located on each ambulance in staging upon request from the Medical Group Supervisor.
- In a large-scale incident, the Staging Unit Leader may need to request additional personnel from Incident Command to assist in these functions.

APPENDIX VI: DISASTER PLAN LEVELS

FEDERAL PLAN

The National Disaster Medical System (NDMS) is a cooperative effort between the Department of Homeland Security (DHS), Department of Health and Human Services (HHS), Department of Defense (DOD), Department of Justice (DOJ), Department of Veterans Affairs (VA), Federal Emergency Management Agency (FEMA), state and local governments and the private sector. NDMS includes Disaster Medical Assistance Teams (DMATs) and Clearing-Staging Units (CSUs) at the disaster site or receiving location, a medical evacuation system and more than 100,000 pre-committed non-federal acute care hospital beds in more than 1,500 hospitals throughout the United States. NDMS does not replace, but rather supplements, state, regional and local disaster planning efforts. The program provides for "mutual aid" among all parts of the nation and is able to handle large numbers of patients that might result from a domestic disaster situation or an overseas conflict.

In the event of a major disaster, the Governor of an affected state may request federal assistance and the President may make a declaration of a major disaster or an emergency either before or after the incident occurs. The presidential declaration triggers a series of federal responses coordinated by FEMA. These operations may include activation of NDMS when appropriate. Upon system activation, the NDMS operations support center is activated to coordinate federal health and medical responses to the disaster.

NDMS Plan Activation Sequence

1. A mass casualty incident has occurred requiring NDMS activation.
2. After initial stabilization, patients are transported to a hospital in the area of the mass casualty.
3. Once stabilized, patients are prepared to be transported via the best available means.
4. The Federal Coordinating Center for the areas covered by this plan (Hines VA Hospital) will contact the Governor of Illinois and the Illinois Department of Public Health (IDPH) to notify them that a national disaster has occurred and that the NDMS plan has been activated.
5. Illinois Masonic Medical Center (IMMC) is notified by the IDPH that the NDMS has been activated.
6. IMMC notifies the area wide RHCC hospitals (Highland Park Hospital (HPH) and Sherman Hospital) of the disaster and activation.
7. IMMC, HPH and Sherman Hospital will contact the Chicago and suburban hospitals within their regions to obtain status reports.
8. Once NDMS has been activated, bed status reports will be generated at least every 12 hours until directed to discontinue.
9. IMMC is responsible for assigning receiving hospitals for all patients who arrive via O'Hare International Airport or another designated receiving facility/area.
10. Prior to landing at O'Hare or another designated receiving facility/area, IMMC and the RHCC hospitals will receive manifests giving details of all patients.
11. If medical assistance is required for arriving patients, once hospital assignments have been made, IMMC and HPH will plan for transportation to medical facilities via Chicago Fire Department and other EMS providers for those patients arriving in the area.

STATE PLAN

The State of Illinois Emergency Medical Disaster Plan is not meant to take the place of the NDMS plan, but exists to address the preparedness, response and recovery to an emergency medical situation within the State of Illinois. The goal of the plan is to aid and allow emergency medical services personnel and health care facilities to work together in a collaborative manner in situations where local resources are overwhelmed.

State Disaster Plan Activation Sequence

1. The Governor of Illinois is notified by a local government official (mayor, county commissioner, etc.) that a disaster has occurred. The Governor makes the determination to 'declare' a disaster thereby initiating the state disaster response plan.

2. The Deputy Director of the Office of Preparedness and Response is notified by the Governor's office or designee and activates the appropriate phase of the Disaster Plan (Phase I or Phase II), determines required resources and requests assistance from the appropriate RHCC Hospitals.

    - The RHCC Hospitals covered by this plan include:
        - Region X: Highland Park Hospital
        - Region IX: Sherman Hospital

3. Each RHCC directs the Resource Hospitals within their region to immediately contact each of their Associate and Participating Hospitals. All hospitals in each region will provide accurate information on EMResource.

4. The RHCC hospital shall consider the activation of the Regional Medical Emergency Response Team (RMERT).

5. Every hospital will report on some or all of the following information, based on the level of activation (Phase I or Phase II) via EMResource:

    - ED availability
    - Adult and Pediatric monitored beds
    - Total other beds
    - Total units of blood
    - Number of ventilators – adult, peds, both
    - Number of field bags
    - Number of walking and littered decontamination patients per hour
    - Special needs

6. **All hospitals must continually update required information via EMResource until notified by their Resource Hospitals that the disaster has officially ended.**

O'HARE INCIDENT/DISASTER PLAN
Region XI / City of Chicago EMS System

Implementation:

- This plan is to be implemented if any incident/disaster occurs within the confines of O'Hare Airport/field.
- Advocate Illinois Masonic Medical Center (AIMMC) will be contacted by the Chicago Office of Emergency Communications or Chicago Fire Department (CFD) Officer in Charge.
- Utilize the "O'Hare Disaster Log Sheet" for record keeping.

Upon notification, AIMMC will:

1. Page EMS System Coordinator on their cell at (773) 447-2065
2. Notify the following facilities (see phone sheet):
    - Highland Park Hospital (who will activate their notification list)
    - Resurrection Medical Center
    - Community First Medical Center
    - Swedish Covenant Hospital
    - Additional hospitals may be needed; CFD will advise AIMMC if this need occurs.
    - Highland Park Hospital, ED (847) 480-3751, will call the following facilities (see phone list on page 26)
        - Lutheran General
        - Northwest Community
        - Alexian Brothers (Elk Grove Village)
        - Gottlieb Memorial
        - Westlake Hospital
        - Elmhurst Hospital
        - St Alexius Medical Center (Hoffman Estates)
        - Loyola Medical Center
        - Good Samaritan
3. Notify American Red Cross as a "Heads Up" at (877) 597-0747 (Dispatch 24/7)
4. AIMMC most likely will not receive patients although this depends on the incident occurring.
5. Illinois Medical Emergency Response Teams (IMERT) may be requested by CFD through IEMA to be dispatched to the scene-contact the EMS System Coordinator to arrange teams.
6. ***Maintain communications*** with the ***field*** and ***hospitals*** until "scene cleared" by CFD Incident Command at the scene.
7. ***NOTIFY ALL HOSPITALS*** *once scene is cleared*.
8. Submit paperwork to EMS Coordinator or EMS Office.

Updated January 2017

O'HARE INCIDENT PARTICIPATING CALLS
Region XI / Chicago EMS System

The following is a list of hospitals that have agreed to support O'Hare Airport in the event of an incident/disaster:

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER notifies:			
HOSPITAL	**ADDRESS**	**ED NUMBER**	**MED CONTROL**
Highland Park Hospital	777 Park Avenue West Highland Park, IL 60035	(847) 480-3751	(847) 432-2294 (847) 432-2295
Resurrection Medical Center	7435 West Talcott Avenue Chicago, IL 60631	(773) 990-5255	(773) 774-8455
Community First Medical Center	5645 West Addison Street Chicago, IL 60634	(773) 794-7601	(773) 794-7605 (773) 794-7606
Swedish Covenant	5145 North California Avenue Chicago, IL 60625	(773) 989-3800	(773) 561-1595

HIGHLAND PARK HOSPITAL notifies:			
HOSPITAL	**ADDRESS**	**ED NUMBER**	**MED CONTROL**
Lutheran General	1775 Dempster Street Park Ridge, IL 60068	(847) 696-0743	(847) 696-0743
Northwest Community	800 West Central Avenue Arlington Heights, 60005	(847) 618-3913	(847) 259-8720
Alexian Brothers	800 Biesterfield Road Elk Grove Village, IL 60007	(847) 981-3599	(847) 437-8118 (847) 952-7454 (847) 437-8241
Gottlieb Memorial	8700 West North Avenue Melrose Park, IL 60160	(708) 450-4975	(708) 538-5378
Westlake Hospital	1225 Lake Street Melrose Park, IL 60160	(708) 343-8375	(708) 343-8375
Elmhurst Hospital	155 E Brushhill Road Elmhurst, IL 60126	(331) 221-0202	(331) 221-0202 Same as ED
St Alexius Medical Center	1555 Barrington Road Hoffman Estates, IL 60169	(847) 490-6930	(847) 843-5308 (847) 843-5309
Loyola Medical Center	2160 South First Avenue Maywood, IL 60153	(708) 216-9080	(708) 343-5828 (708) 343-4844 (708) 343-5803 (708) 681-4418
Good Samaritan	3815 Highland Avenue Downers Grove, IL 60215	(630) 275-1160	(630) 968-2150

DATE: _____ **TELE LOG #** _____

TIME: _____ **Page** _____ **of** _____

O'HARE VICTIM INCIDENT LOG

CFD EMS Chief/OFFICER: _____ **PHONE #:** _____

INCIDENT TYPE: _____

APPROXIMATE # of VICTIMS: _____

SPECIAL CIRCUMSTANCES:

Hospital	Person Notif & Time	# Pts CAN Accept	# Pts SENT	Ambulance Transporting	Comments
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		

All Clear At:_____

ECRN/ECP Signature:_____

Updated: April 2012

APPENDIX VII: Region X School Bus Accident Policy

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: February 2000
REVIEWED: February 2017

POLICY TITLE: SCHOOL BUS ACCIDENTS
POLICY: 7

This policy governs the handling of school bus accidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with their System's policies governing mass casualties. The goal of this policy is to reduce the number of uninjured children transported to hospitals and to reduce EMS scene time and utilization of resources.

Each EMS provider agency within an EMS System is required to design and implement a procedure for discharging uninjured children to their parents/legal guardians or to local school officials who are willing to take custody of the children. The provider may adopt whatever policy it chooses that will best accomplish the goal of transferring custody of uninjured children to the parents/legal guardians or school officials. It is recommended that these policies be developed with the joint input of local school officials and provider legal counsel.

Once it is determined that minor children are not injured, the custody and responsibility for these children will remain with the EMS provider agency until the children are transferred to parents or school officials.

PROCEDURE:

1. Upon arrival at the scene

    a. Determine the category of the accident

    CATEGORY A BUS ACCIDENT - significant injuries present in one or more children or there is a documented mechanism of injury that can reasonably be expected to cause significant injuries.

    CATEGORY B BUS ACCIDENT - minor injuries present in one or more children and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children may also be present.

    CATEGORY C BUS ACCIDENT - no injuries present in any children and no obvious mechanism of injury present.

    b. Determine if implementation of this policy is appropriate. Implement this policy only if the accident is a Category B or Category C bus accident.

    All children involved in a Category A accident will be transported to the hospital(s). Do not implement this policy if the accident/incident is a Category A bus accident/incident-follow multiple victim and disaster preparedness policies for all Category A bus accidents/incidents and transport all children/students to the hospital(s).

    c. Other injured patients are treated and transported as required. For adults. Follow your EMS System's policy.

    d. Contact Medical Control, advise of the existence of a Category B or C bus accident, and determine if a scene discharge of uninjured children by the emergency department physician in charge of the call is appropriate.

e. Implement provider procedures for contacting parents/legal guardians or school officials to receive custody of the uninjured children.

f. The provider agency then transfers the custody of the minor children, consistent with its own policies and procedures, to parents/legal guardians or school officials.

g. The school representative will then follow their own policies to include informing the parent(s)/legal guardians as regards the accident/incident

2. **DISPOSITION OF UNINJURED CHILDREN:** This policy only governs the disposition of uninjured children. A list of children who have been determined to be uninjured by medical personnel will be completed at the scene of the accident. All uninjured students will be discharged to the custody of school officials upon approval of Medical Control as per procedure in 1) f. Use your EMS System's approved form for such documentation.

3. **PROVIDER RESPONSIBILITY:** Once the decision is made by the emergency department physician to discharge the children at the scene, it is the responsibility of the local responding EMS agency in charge of the scene to make certain that these children are returned to their parents/legal guardians or appropriate school officials.

CAVEAT

If EMS personnel on the scene feel that any child should be offered medical care or evaluated by the hospital, the child should be transported to the hospital.

NOTE: See Appendix XII for a School Bus Accident Log Form template

APPENDIX VIII: Training Guidelines

In an effort to improve the effectiveness of this multiple patient management plan, all participating hospitals and pre-hospital providers have agreed to adhere to the following guidelines when planning training activities:

FIRE DEPARTMENTS

- Fire Departments will regularly review the Multiple Patient Management Plan and the use during small, medium and large scale incidents.
- Field training exercises may include the transportation of patients to receiving hospitals via ambulances upon mutual agreement prior to the exercise.
- Training for all personnel shall be carried out at the local and division level and include both field providers and command staff. Special emphasis should be given to the job functions associated with the incident management system of organization.
- A variety of training options may be utilized to facilitate this purpose, including lecture/discussion, tabletop exercises and small-scale field exercises.
- Local fire departments are encouraged to continue working with hospitals in their own community that participate in this plan for the purpose of assisting one another in meeting training and hospital accreditation requirements.
- In an effort to maintain proficiency, fire departments may choose to utilize SMART tags with START triage principles during small scale incidents. This is a voluntary endeavor that does not require communication to the receiving hospital.
- Training exercises within the geographic boundaries of this plan shall be communicated to the Resource Hospital for communication back to the Regional DMSC Committee. Knowledge of impending exercises and critiques of said exercises following these drills are essential to a continual assessment of this plan.

HOSPITALS

- ECRN and ER staff will regularly review the Multiple Patient Management Plan and the use during small, medium and large Scale incidents.
- EMS continuing education training with respect to multiple patient incidents will focus on the areas of plan implementation, communication, field triage and treatment.
- ER Staff and ECRN continuing education training with respect to multiple patient incidents will focus on the areas of plan implementation, communication, field triage and treatment.
- Hospitals are encouraged to partner with their local fire department in this in-house training to enhance local preparedness.

PRIVATE AMBULANCE PROVIDERS

- Private ambulance providers will regularly review the Multiple Patient Management Plan and the use during small, medium and large scale incidents.
- Private ambulance companies will work with their Resource Hospital to assure appropriate participation and compliance with the plan.

NOTE: An After-Action Report (Appendix XI) should be completed following all training activities involving the regional Multiple Patient Management Plan within 7 days of the event.

APPENDIX IX: MEDICAL PERSONNEL REQUESTED TO THE SCENE

Incident Command may request hospital-based medical personnel to respond to the scene of an incident for specific needs. This request shall be communicated through the Resource Hospital. Personnel shall be assembled based on the specific need (e.g., surgical, toxicological, psychiatric, etc.).

The medical personnel shall:

- Respond with supplies to meet the needs of the specific incident.
- Respond with a police escort or via other official means of transportation. The escort
- will provide security, ensure a rapid response, and assist with access into restricted areas.
- Report directly to the Command Post.
- Be identified by a green helmet and/or reflective vest indicating “Medical Team”, or other official uniform.

Additional medical personnel may be asked to respond to the scene based upon regional and state protocols, including the Illinois Emergency Medical Response Team (IMERT). A request for such teams must be made by the Resource Hospital to the RHCC Hospital. IMERT must be requested through the Illinois Emergency Management Agency (IEMA).

Self-dispatching of personnel to a disaster scene is STRICTLY PROHIBITED!

APPENDIX X: TRIAGE TAG INSTRUCTIONS

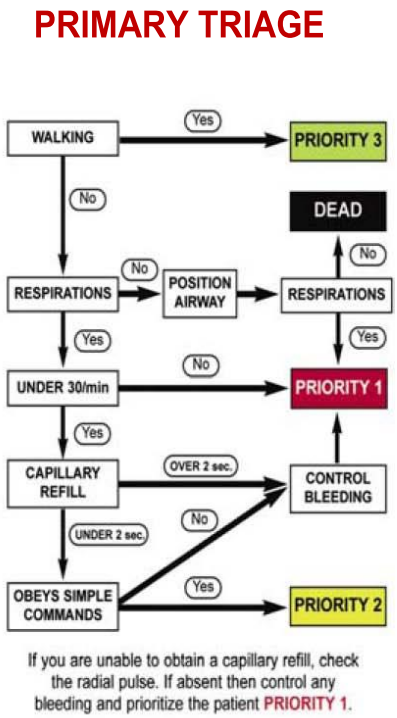
Region X has adopted the SMART Incident Command System® as a standard for the process of START triage which includes the use of specific triage tags. The SMART® tag is designed to show just one color at a time but can be refolded to reflect any change in status. The triage process should be repeated at each link of the incident management chain. The primary (first) triage method will be used to sort victims into groups and is based upon vital signs and level of consciousness. The secondary triage method is utilized to prioritize treatment and transport goals and is based upon anatomic and physiologic criteria. The information included herein applies only to the SMART® System.

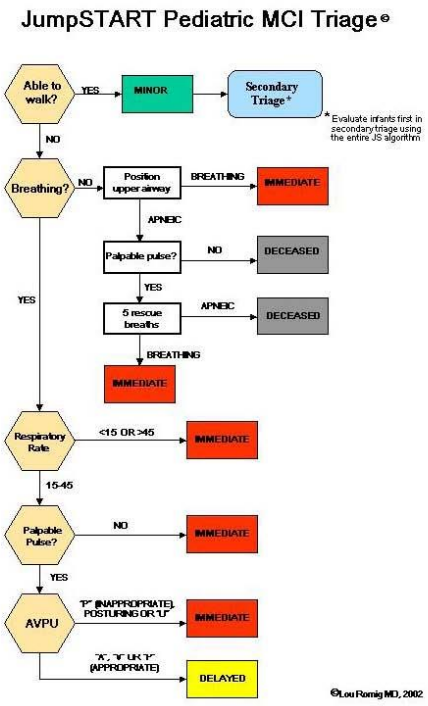
Components of the Triage Pack:

- Folding SMART® triage tags
- Mini-light sticks to identify RED patients at night
- Dead tags
- START Triage prompt cards
- Jump START Triage prompt cards
- Dynamic record of casualties already triaged
- Pencil

Primary Triage Procedure:

1. Triage personnel shall obtain a Triage Pack (designed to be carried on a belt to leave the hands free).
2. Ensure appropriate PPE.
3. The START triage process generally begins with a request for all ambulatory victims to move to an area of refuge (generally tagged Green or Priority 3).
4. Approach each remaining victim and assess triage priority by using the START Triage Prompt Card for adult victims and the Jump START Prompt Card for child victims.
5. Assign triage priority by removing the SMART® Tag from the plastic sleeve and folding the tag so the appropriate color priority is visible.
6. Attach the elastic band to the victim's upper extremity.
7. If light is inadequate at the triage site, use a mini-light stick in addition to Red triage tag to designate most serious victims.
8. Life support interventions should be limited to opening the airway and hemorrhage control. This step may depend upon readily available resources.
9. Upon completion of the primary triage process, victims may be moved to a designated (color-coded) collection area.





Secondary Triage Procedure:

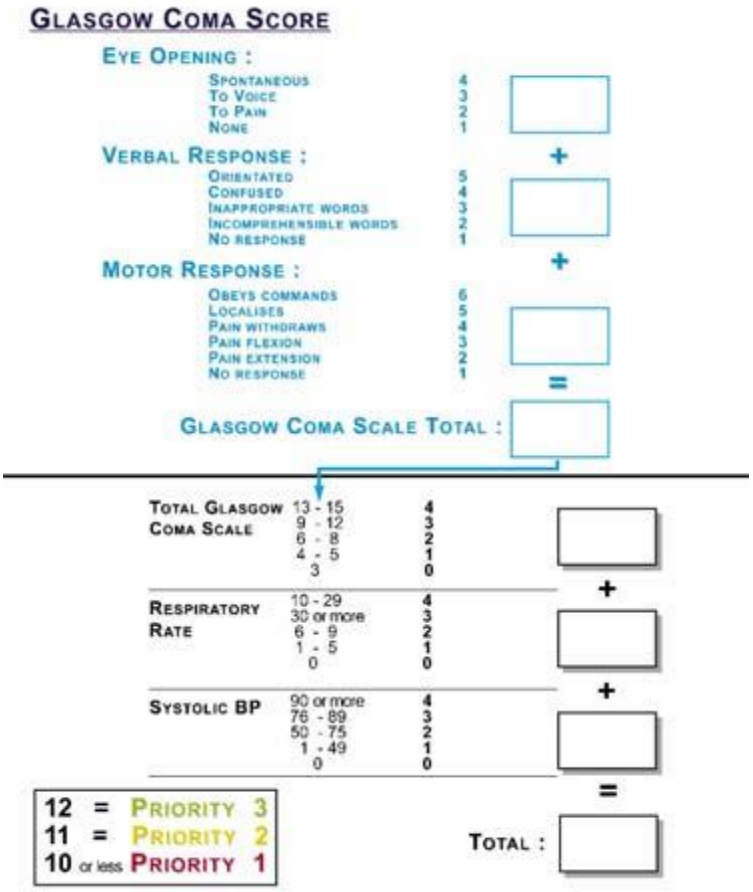
1. Upon arrival in a collection area, each victim should be (re)assessed by using the Glasgow Coma Scale, respiratory rate and systolic blood pressure.

2. The results of the secondary triage will determine treatment and transport priorities.

3. Secondary triage may also result in a change of original assigned priority code. This may be accomplished by refolding, but not removing or replacing, the original tag. Movement of the victim to another collection site is not necessary pending #2, above.

4. Prior to transport from the scene, the tag transport strip will be removed and retained by the transportation officer.

SECONDARY TRIAGE



APPENDIX XI: POST-INCIDENT RECOVERY SERVICES

Multiple agencies provide critical incident stress management. Local emergency services providers are encouraged to have a plan in place for the implementation of post-incident recovery services, including critical incident stress management. Listed below is a selection of groups able to provide such services to emergency personnel.

AGENCY	TELEPHONE NUMBER
Northern Illinois Critical Incident Stress Management Team	(800) 225-2473
Illinois Firefighter Peer Support	(855) 907-8776

APPENDIX XII: FORMS AND LOGS

- Field Provider Log Form
- Emergency Department Log Form
- After-Action Report
- School Bus Accident Log Form
- Abbreviations/Acronyms

REGION X MULTIPLE PATIENT MANAGEMENT PLAN
FIELD PROVIDER LOG FORM

Date: _____ Time: _____ Fire Department: _____

Hospital you are contacting: _____ ED Phone Number: _____

Multiple Patient Incident
(Small Scale: Call closest appropriate hospital) (Medium/Large Scale: Call Resource Hospital)

Hello, this is the "STATE FIRE DEPARTMENT NAME". We are on scene of a Small / Medium / Large scale / Healthcare Evacuation multiple patient incident. The incident is a _____

PROVIDE DESCRIPTION OF INCIDENT TO ECRN.

Our estimated total number of patients to be transported is: _____

We estimate the following types of patients (For small scale, ask how many patients hospital can take):

Red: _____ Yellow: _____ Green: _____ Deceased: _____

If Trauma and known…*We estimate the following number of categorized trauma patients:*

Category I: _____ Category II: _____ Special: _____

Our closest hospitals are (List in order of proximity to incident):

	Hospital Name	Patient Capability			Patient's Transported		
		Red	*Yellow*	*Green*	*Red*	*Yellow*	*Green*
1.							
2.							
3.							
4.							
5.							

If patients have already been transported to a hospital, report those destinations to the ECRN using the chart above. No more than two patients may be sent to hospitals without prior approval from the receiving hospital.

"MY NAME AND CALL BACK TELEPHONE NUMBER IS" _____

POINTS TO REMEMBER:

Maintain communication with the Resource Hospital until the scene has been cleared of patients. For each transporting ambulance, report acuities of patients being transported and destination hospital to the Resource Hospital

Once all patients have been transported on a medium or large scale incident, notify the Resource Hospital of the number transported to each hospital so that appropriate notification of patient expectations can be made.

Use SMART ® Command Board to record hospital availability and patient destinations.

Complete After Action Report and FAX with this form to the EMS Coordinator within 7 days of the incident.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN
EMERGENCY DEPARTMENT LOG FORM

Date: Time: Fire Department:

Type of Incident: Callback Number:

ECRN: ER Physician:

Small Scale Incident: Field Personnel call closest appropriate hospital
Medium or Large Scale Incident: Field Personnel only call Resource Hospital. ECRN responsible to call area hospitals for capabilities.

Small Scale: Medium Scale: Large Scale: Healthcare Evacuation:

Estimated total number of patients to be transported is:

Estimated triage categories: Red: *Yellow:* *Green:* *Black:*

Estimated categorized trauma, if known: Category I: Category II: Special:

Closest hospitals in order of proximity to incident and ability to receive patients:

	Hospital Name	Patient Capability			Patient's Transported		
		Red	*Yellow*	*Green*	*Red*	*Yellow*	*Green*
1.							
2.							
3.							
4.							
5.							

- During a Small Scale Incident, the closest appropriate hospital may assist with patient disbursement as requested by the caller.
- During a Medium or Large Scale Incident, the Resource Hospital will be given the names of the closest hospitals by the caller. **CALL THOSE HOSPITALS FIRST** asking for their ability to receive specific numbers of triage category patients. Use additional forms if it is necessary to contact more than 5 hospitals to distribute transported patients.
- Remind receiving hospitals they will not receive a radio report from transporting ambulances.
- Relay hospital capability information to the fire department caller.
- Contact the RHCC if assistance is required
  - Medical Control: (847) 432-2294 or (847) 432- 2295 or ER Direct: (847) 480-3751
- Upon notification that all patients have been transported on a medium or large scale incident, notify each of the receiving hospitals of the number transported to their facility.
- Complete After Action Report and FAX with this form to the EMS Coordinator within 7 days of the incident.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN
AFTER-ACTION REPORT

Incident Date: _____ Incident Time: _____ Primary Fire Dept: _____

Incident Description: _____

☐ Small*
☐ Medium
☐ Large
☐ Healthcare Evacuation

Total Pts.: _____ Red: _____ Yellow: _____ Green: _____ Deceased: _____

* Only upon request from the EMS System

Please answer the following questions. Use the reverse side for additional comments (take note when faxing form). The success of the plan depends on your detailed comments.

Which hospital was first contacted by field personnel?
What mode of communication was used between field and hospital?
Describe any difficulties with initial communication:
Was it difficult to determine the scale of the incident? If so, why?
Describe any difficulties with triage?
What hospitals received patients and how many:
Describe any difficulties with patient disbursement:
(Small Scale only) Were there any difficulties with ambulance to hospital communication:
Was the two-sided Multiple Patient Management Plan **REFERENCE CARD** used?
Was a Region X Multiple Patient Management Plan **LOG FORM** used?
How effective was the Multiple Patient Management Plan in helping disburse patients from the scene to area hospitals?
Please provide us with any additional information that may be helpful:

Hospital Personnel: Submit this form and Emergency Department Log form to your hospital EMS Coordinator.
Field Personnel: Fax this form and Field Provider Log Form to the Resource Hospital EMS Office.

Region X Emergency Medical Service System
Bus Accident Student Log

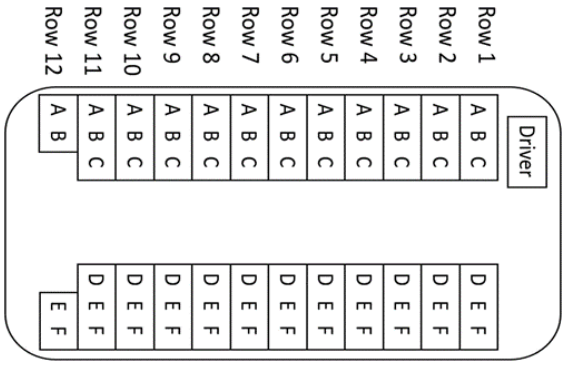
Date of Incident: _____ Incident Number: _____ Page: _____ of _____

Host Department: _____ Location: _____

School Name/District: _____ Bus Number: _____

Per the Region X EMS Policy, the children listed below have been determined to be in a Category B or C accident. These children have been determined to be uninjured and therefore Medical Control has approved discharge to the custody of school officials:

Name	Seat Location (Optional)	Address	Telephone



Signature/Title of School Authorized Representative

Signature/Title of Fire Department Officer

Hospital Contacted and RN/MD Name

White Copy to EMS Agency; Yellow Copy to EMS System; Pink Copy to School Representative; Goldenrod Copy to Local Police

ABBREVIATIONS / ACRONYMS

Altered Standards of Care: When victims' needs outweigh immediately available resources, the usual standard of care may be altered to provide for allocation of scarce resources in order to save as many lives as possible.

CHUG	Collaborative Healthcare Urgency Group, website: http://www.chughurt.com/
DMSC	Disaster Management Services Committee
ECRN	Emergency Communications Registered Nurse
EMResource	Software utilized by IDPH for daily hospital resource availability tracking and event notification.
EMS	Emergency Medical Services
Healthcare Facility	A hospital, nursing home or other fixed location at which medical and health care services are performed.
IAP	Incident Action Plan
IMERT	Illinois Medical Emergency Response Team, website: http://www.imert.org/
MABAS	Mutual Aid Box Alarm System
Multiple Patient Incident	An incident in which there is more than one patient and healthcare needs exceed immediately available resources.
Post-Action Review	Evaluation of actions taken during an incident in order to improve future performance through education or process/policy change.
PPERS	Private Provider Emergency Response System
Region X	EMS/Trauma Region as defined in the IDPH EMS Act: northern boundary of Illinois/Wisconsin state line to Route 83, southern boundary of Chicago/Evanston border to Park Ridge city limits, eastern boundary of Lake Michigan and western boundary of Route 83 to Route 173 west to Route 59 south to Route 60, east to Route 83 to the Lake/Cook county line, east to Milwaukee Avenue then south to Des Plaines River Road, south to Central Road, east to I294, south to Dempster Street, east to the Niles city limits south to the Chicago city limits.
RHCC	Regional Hospital Coordinating Center

APPENDIX XIII: MASS VIOLENCE RESPONSE

When responding to mass casualty incidents, Fire/EMS providers fall back on their training and most often use the traditional approach of triage to prioritize the transport and treatment of patients. When dealing with incidents involving patients from mass violence incidents, research has shown that the typical triage process used in day-to-day operations have less value during mass violence incidents due to time critical injuries and ongoing threats to responders and patients and may result in patients being incorrectly triaged leading to outcome-altering delays in care. Fire/EMS agencies and hospital staff must be aware of the possibility of responding to or receiving patients from multiple patient incidents resulting from mass violence such as:

- Active shooter event
- Blast / Explosive event
- Biological/epidemic/pandemic event
- Chemical event
- Radiological event

During a mass violence incident where, when, and how triage will be done may vary depending on the specifics of the incident, the location, and the resources available. Both pre-hospital providers and hospital providers should understand the concept that triage can be dynamic and reflects patient condition and resources available at the time of the appropriate provider's assessment. During incidents of mass violence, both Fire/EMS agencies and hospital staff will require flexibility in the treatment and transport of patients from mass violence incidents. This flexibility may include:

- Not following the triage protocols outlined in the Region X Multiple Patient Management Plan.
- Not being able to establish structured triage, casualty collection points, or treatment areas due to the large number of patients, the scope/size of the scene, and scene safety issues.
- Understanding that commonly used triage criteria do not include a rapid assessment for presence of truncal penetrating trauma.
- Understanding that bystanders or self-care may be the primary means of initial medical care and/or transport and that there may be a need for extra supplies to effectively control bleeding.
- Fire/EMS agencies may not realize that the hospitals are becoming overwhelmed.

GENERAL CONSIDERATIONS

- In a mass casualty event, a single triage process may not be appropriate for all incidents. Fire/EMS providers should be looking at the principles of triage which include:
  - Doing the greatest good for the greatest number of patients with the resources available.
  - Gaining rapid access to surviving casualties and evacuating them from the hazard area.
  - Providing basic life-saving interventions as soon as it is safe to do so.
  - Transporting the injured to an **appropriate** hospital as rapidly as possible.
  - Prioritize resources to those who are most in need and are salvageable with current resources.
  - Re-triaging patients as the resource situation changes over time.
- Assessment during triage should including the following considerations:
  - How much time is needed to start interventions and how quickly can they be done to be effective?
  - How much healthcare provider expertise is required for successful patient outcome?
  - How many resources, including personnel, are required and available for successful patient lifesaving interventions and outcomes?

- As the number of patients becomes overwhelming, providers may need to consider shifting their focus to prioritize assessment of victims with potential life threats rather than focusing on definitive care for the most critically injured.

- In incidents involving penetrating truncal trauma, categorizing patients as red and yellow based on typical field triage may not be efficient or effective depending on the number of casualties and the safety of the scene. Under- triage and over-triage of patients can be both dangerous and can affect patient outcome.
  - **Under-triage**: Defined as triaging a patient in a lower category than their actual injuries require and means critical injuries may not have been recognized. This can be a risk when a patient is stable with an isolated, externally unimpressive penetrating torso injury that masks major internal injuries.
  - **Over-triage:** Defined as triaging a patient in a higher category than their actual injuries require, thus diverting assessment and treatment resources from those who needed it more. Over-triage is a distinct possibility in mass violence incidents and can rapidly result in trauma center saturation. It may also occur when dealing with pediatric patients due both to child and provider reaction to the situation and injuries.

- All providers must be aware of the need to recognize early shock and potential deterioration in patients triaged as “yellow” with penetrating injuries to the torso. This awareness includes ambulatory patients, normally triaged as “green”, that quickly move to safety, even after suffering life-threatening wounds.

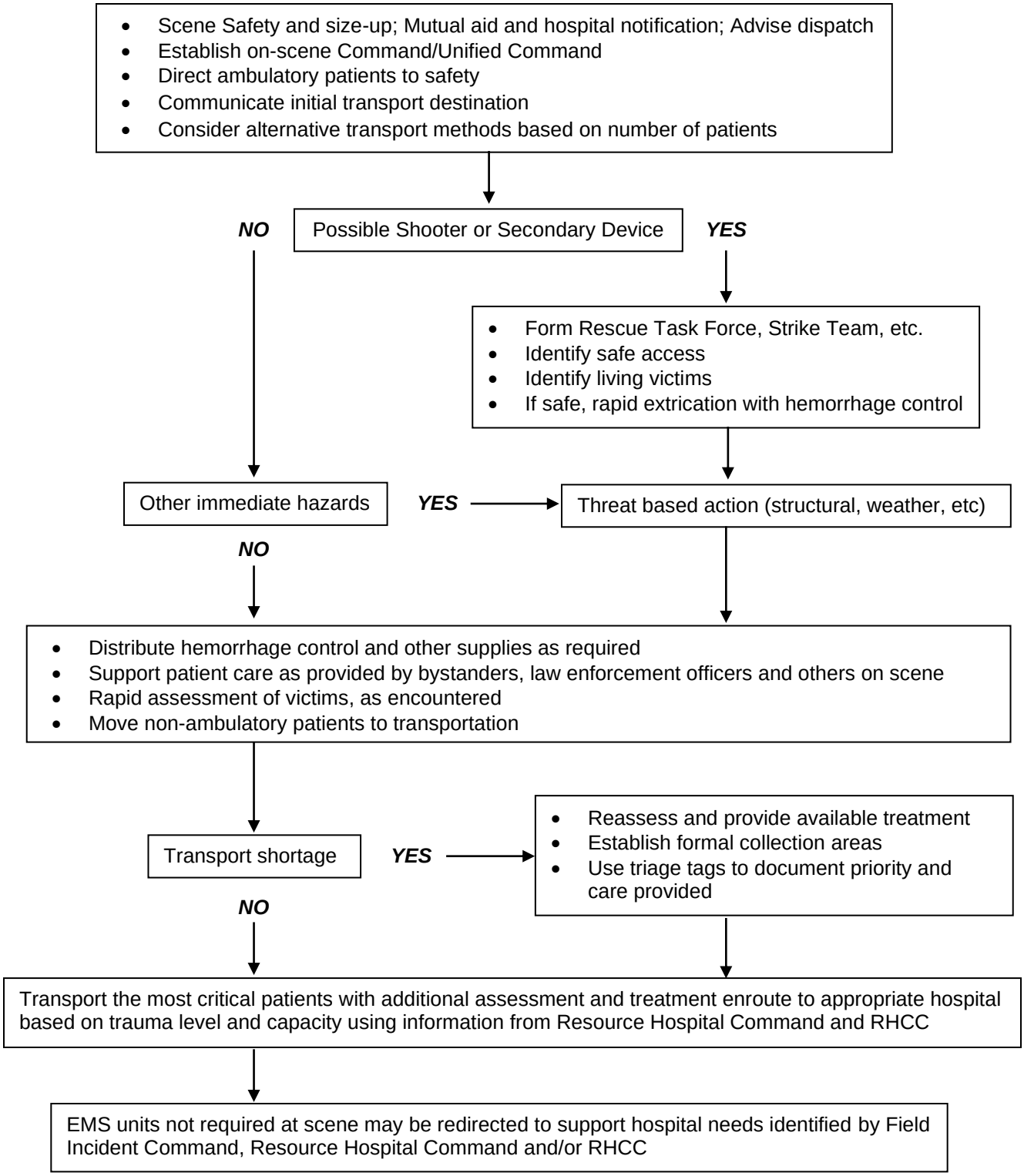
- Incidents involving mass violence are typically dynamic in nature and represent several obstacles to arriving first responders:
  - May be spread across multiple locations.
  - Involve a large number of casualties who cannot be managed by first arriving resources.
  - The geography or safety of the incident may not allow for the setup of a formal staging/collection area as well as making it may be difficult to quickly access and assess the non-ambulatory patients limiting an awareness of the actual number of patients.
  - Have a high potential to require cover or concealment during rescue operations for safety.
  - Have a high potential for victims and bystanders to flee and seek medical care on their own resulting in a disorganized evacuation.
  - Likely to involve immediate or secondary safety threats to the public and providers.
  - The scope and source of the incident may not be apparent on arrival.

- General response strategies to mass violence incidents, as well as any mass casualty incident includes:
  - Scene safety, scene size up and resource request.
  - Establishing Incident Command or Unified Command as soon as practical.
  - Patient access (use Rescue Task Force, Strike Teams, etc. if required).
  - Stop the bleed and other emergency interventions.
  - Triage/Treatment/Transport of patients as necessary.
  - In cooperation with Resource Hospital Command, evaluate appropriate destination for patients and hospital capabilities.
  - Re-evaluate resources and patients throughout incident.
  - Consider releasing extra resources to support community and hospital needs.

- EMS personnel responding to dynamic scenes, such as incidents of mass violence, should be prepared to:
  - Ensure their own immediate safety and establish Unified Command with law enforcement.
  - Maintain situational awareness to provide appropriate information to dispatch to request additional units and resources through mutual aid as well as to update area hospitals about the location and scope of the incident.

- If appropriate and possible, support “buddy” or bystander care by providing treatment materials and just-in-time instruction to immediate responder (bystanders).
- Integrate with law enforcement to create Rescue Task Forces, Strike Teams, etc., casualty collection points and ambulance exchange points.
- Anticipate secondary attacks and direct patients to safety as appropriate.
- When EMS transport is unavailable, direct patients to an appropriate hospital when they cannot or will not wait for EMS transport.
- Plan to transport patients to both trauma centers and non-trauma hospitals, using all appropriate facilities in relation to the scope of the incident.
- Determine the nearest safe ambulance loading area, known as ambulance exchange point, and direct EMS resources to that location.
    - Law enforcement cover should be provided for each ambulance exchange point on active shooter incidents.
    - Ambulances should not be staged at the exchange point to prevent multiple non-designated patient contact.
- Focus on rapid transport of the casualties tagged as “red” or “yellow” to trauma centers rather than areas where collection or categorization of patients is occurring.
- Determine the role, if any, for ongoing casualty collection/treatment points at or near the scene.
- Determine the ability for EMS to support hospitals as on-scene operations conclude if nearby hospitals or trauma centers are overwhelmed.

PRE-HOSPITAL FLOWCHART FOR MASS VIOLENCE RESPONSE



Note: Patient care tasks should be complemented by information received from the Resource Hospital Command and the RHCC, establishing liaison with law enforcement and other agencies in Unified Command to obtain threat and situation information as well as supporting on-scene operations with staging and resources.

EMS TRIAGE
• Responding units should have an abundant supply of SMART® triage tags and/or alternate triage tag methods. Alternate triage tag methods should be based on accepted current mass casualty research for triage and rapid transport of patients. • During incidents involving mass violence, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition. Additionally, if transport is immediately available, there is likely no benefit to a tape or tag. • EMS Command should determine if on-scene patient collection/treatment activities are useful based on the nature/size of the incident, number of EMS providers, available ambulances and other transport vehicles, scene safety, capacity of hospitals, environmental conditions, and number of remaining injured patients. • First responders should be aware that the use of tape or tags may prove to be useless if a Rescue Task Force, Strike Team, etc. simply moves non-ambulatory patients whenever they encounter them. • Triage tags may have their greatest benefit in situations where transportation is delayed, in which case the ability to record vital signs, medications, interventions, and assessments may be valuable. • EMS personnel should be able to provide pertinent patient information to receiving hospital personnel regardless of whether tags or tapes were used.

EMS TREATMENT
• It may be possible that EMS may need to provide just-in-time training and provide supplies for hemorrhage control or other interventions to bystanders in some extreme mass casualty incidents involving mass violence. • Law enforcement officers may perform life-saving interventions prior to or in the absence of adequate numbers of EMS personnel and may move victims to safety prior to the assembly of Rescue Task Force, Strike Team, etc. • Appropriate teams (Rescue Task Force, Strike Team, etc.) should be developed as quickly as possible to rapidly access and evacuate patients through secured areas once the threat has been neutralized or contained.

EMS TRANSPORT
• Transport to an appropriate trauma center for critically injured patients can be lifesaving and is a key triage component. For critical patients, the focus should be on getting to a trauma center as quickly as possible. • Patients with extremity penetrating injury, non-torso shrapnel injury, orthopedic injuries, and amputations may be good candidates for diversion to more distant or non-trauma hospitals even if, based on standard protocols, they would normally go to the closest trauma center. • Transport and destination decisions should revolve around the following questions: – What is the patient's condition? – What is the treatment capacity of the closest trauma center? – What transport resources are available? • If possible, children and parents should generally be kept together. The family member with the most critical injuries should generally guide determination of the destination hospital. This may result in a children's hospital taking care of parents and a non-pediatric center taking care of children. • If EMS Command cannot communicate directly with Resource Hospital Command, an EMS/hospital liaison should be at the Resource Hospital to relay incoming patient information and communicate hospital bed capacity, needs, or other issues.

REFERENCE

Exchange, United States. Technical Resources, Assistance Center and Information. *Mass Casualty Trauma Triage Paradigms and Pitfalls*. Assistant Secretary for Preparedness and Response,2019.