

QUINCY AREA EMS



Policy and Procedure Manual

REVISED

9:45am, July 2015

Revised Date	Number	Name of Policy
	Additional	Additional Index
9/09	A-1	Additional Meds-Equip
9/09	A-1F	Conditional Drugs-Equipment Form
9/09	A-2	Transfer patients with Art Lines
9/09	A-3	Transfer patients with IV Heparin
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9/09	A-7	Emergency Use CVAD
	A-8	Interfacility Transfer of Patients Receiving Standard Crystalloid Solutions & IV Solutions Containing Potassium
6/06	A-9	Transfer of Patients Receiving IV Cardizem
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9/08	AP-2	Spinal Immobilization
9/08	AP-3	Pneumatic Antishock Garment (MAST)
5/11	AP-4	Defibrillation (ALS)
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9/08	AP-6	Endotracheal Intubation-Adult (ALS)
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8/12 Reviewed	C-2	Dispatch for incoming ambulance needing ALS assistance

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3/06	CET-4-F	Instructor Evaluation Form-DELETED 1/11
7/15	<i>CET-5</i>	<i>Requirements for EMS Clinicals at Blessing Hospital</i>
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Reviewed 2/13	CET-6cF	Letter of Sponsorship
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5/07	M-1.7	Diazepam (Valium)
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10/06	MP-3	Amputated Parts
2/12	<i>MP-4</i>	COPD/SOB
1/15	MP-5	<i>Burns</i>
4/07	MP-6.1	Suspected Acute Coronary Syndrome (ACS) Deleted
1/15	<i>MP-6</i>	<i>EMS Chest Pain/Suspected Cardiac Event</i>
3/10	MP-6-1	Thrombolytic Checklist for Evaluation of Patient with STEMI
2/12	<i>MP-6.2</i>	Acute Pulmonary Edema-Cardiogenic Shock
1/15	<i>MP-6.3</i>	Bradycardia
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2/15	O13 B	Controlled Substance Policy
7/15	<i>O-13-F2a</i>	<i>Adams County: EMS Drug Boxes Restock List/Charge Sheet</i>
7/15	<i>O-13-F2b</i>	<i>Brown County: EMS Drug Boxes Restock List/Charge Sheet</i>
7/15	<i>O-13-F2c</i>	<i>Hancock County: EMS Drug Boxes Restock List/Charge Sheet</i>
7/15	<i>O-13-F2d</i>	<i>Quincy Fire Department: EMS Drug Boxes Restock List/Charge Sheet</i>
7/15	<i>O-13-F2e</i>	<i>Quincy Fire Department for Adams Co: EMS Drug Boxes Restock List/Charge Sheet</i>
7/15	<i>O-14</i>	<i>EMS Drug Box Supply List</i>
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1/15	O-14-F2	Controlled Substance Log
8/11	O-14-F3	Paramedic Contract for Controlled Substances
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8/01	O-17	Infection Control
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2/04	O-21	Canceled Ambulances
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12/11	O-24	Distribution of the EMS System Manual
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8/01	O-26	Duty to Perform Services Without Discrimination
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3/05	O-33	System Bypass
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3/05	O-33-F2	System Wide Crisis Form
2/04	O-34	Emergency Vehicle Response Operations
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4/12	O-36	Nerve Gas Auto-Injectors
1/08	O-37	School Bus Incident
2/15	<i>O-38</i>	<i>Conceal Carry (NEW POLICY)</i>
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6/14	OS-1	QAEMS System Log
10/12Reviewed	OS-2	Definition of Organizations reviewed

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5/11	PED-2.1	Cardiac Arrest BLS
5/11	PED-2.2	Cardiac Arrest ALS
5/11	PED-3.1	Bradycardia BLS
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5/11	PED-4.1	Tachycardia BLS
5/11	PED-4.2	Tachycardia ALS
5/11	PED-6.1	Respiratory Arrest BLS
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7/08	PED-7.1	Respiratory Distress BLS
9/09	PED-7.2	Respiratory Distress ALS
7/08	PED-8.1	Tracheostomy/Respiratory Distress BLS
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7/08	PED-10.1	Allergic Reaction/Anaphylaxis BLS
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7/08	PED-12.1	Altered LOC BLS
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7/08	PED-17.3	Burn Chart
7/08	PED-18.1	Management of Trauma Patient ALS-BLS
7/08	PED-18.2	Trauma Patient Normal Standards ALS-BLS
7/08	PED-19	ALS Head Trauma Addendum
7/08	PED-20.s	Suspected Child Abuse/Neglect ALS-BLS
7/08	PED-20.2	Special Considerations
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3/15	P-2	EMTP Duties
3/15	P-3	EMTB Duties
3/15	P-4	EMTD Skills (DELETED)
3/15	P-5	Field Evaluator Description
4/01	P-5 F.1	Field Evaluator Form DELETED 11/10
3/15	P-5 F2	Field Evaluator Qualifications Checklist & Agreement (NEW)
3/15	P-5 F3	Field Evaluator Application (NEW)

	Personnel	
6/14	P-6	System Candidate Requirements
3/15	P-6-Fa	System Candidate Emergency Department Clinical Form
3/15	P-6-Fb	System Candidate Clinical Form EMTP-PHRN level
3/15	P-6-Fc	ALS Ambulance Clinical Call Management Form
3/15	P-6-Fd	ALS Ambulance Clinical Evaluation (Candidate Completes)
3/15	P-7F	Change of Address Form
3/15	P-7-Fa	QAEMS Entrance Application
3/15	P-7-Fb	Candidate Requirements (EMTP or PHRN)
3/15	P-7-Fc	Candidate Requirements (FR, FRD, EMTB, EMD)
3/15	P-8	EMTP Relicensure Requirements
8/01	P-9	EMS Medical Director Job Description
8/01	P-10	EMS System Coordinator Job Description
1/02	P-11	EMS Physician Duties
8/01	P-12	EMS Physician Education
2/10	P-13	ECRN Duties
8/01	P-14	ECRN Prerequisites DELETED 2/10 use CET 9-1
1/02	P-15	ECRN Training Requirements DELETED 2/10 use CET 9-1
5/11	P-16	ECRN Recertification
7/10	P-17	Inactive Status
1/02	P-18	EMS Administrative Director
6/12	P-19	EMTBD Prerequisites/Training DELETED 6/12
8/02	P-20	Annual AED Skill Validation DELETED 2/11/11
1/02	P-21	Prehospital RN Prerequisites/Training DELETED 2/10 use CET 8
1/02	P-22	Prehospital RN Recertification DELETED 2/10 use CET 8.1
6/12	P-23	EMTB Recertification
7/10	P-24	Extensions
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1/02	P-26	State Written Exam Testing Fees
1/11	P-27	Relicensure through IDPH Website
2/13	P-28	Non renewal EMS Lead Instructor
7/10	P-29	Voluntary Reduction of Certification/Reinstatement
7/10	P-30	First Responder
6/14	P-31	First Responder AED
7/10	P-32	Emergency Medical Dispatcher
5/08	P-33	TNS Recertification (NEW POLICY)
2/12	P-34	Reinstatement of Expired License
	Problem Solving	Problem Solving Index
8/12	PS-1	Local System Review Board
8/12	PS-2	Suspension
8/12	PS-3	Problem Solving
8/12	PS-3-F	Event Report Form
8/12	PS-4	Suspected Chemical Abuse on Duty
8/12 Reviewed	PS-5	Appeal of the Local System Review Board Decision
8/12	PS-6	Disciplinary Action Form
3/07 Reviewed	PS-6-F	Notice of Corrective Action "Record of Disciplinary Action" form
8/12 Reviewed	PS-7	Filing a Complaint with the IDPH Central Complaint Registry

	Quality Assurance	Quality Assurance Index
2/10	QA-1	Data Collection and Evaluation
2/02	QA-1-F	IL PCR Form
11/10	QA-2	Quality Assurance Guidelines and Standards
11/10	QA-2-F	Case Audit Form
2/06	QA-3	Blood Glucometer
2/06	QA-4	Manual Defibrillator and Battery System Tests

QUINCY AREA EMS SYSTEM ADDITIONAL PROCEDURES

Additional Approved Medications/Equipment-----	A-1
Conditional Drugs and Equipment Form -----	A-1-F
Transfer of Patients with Arterial Lines-----	A-2
Transfer of Patients Receiving IV Heparin-----	A-3
Transfer of Patients Receiving IV Nitro -----	A-4
Transfer of Patients Receiving Glycoprotein IIb/IIIa Receptor Inhibitors ----- (Aggrastat, Integrilin, Reopro)	A-5
Transfer of Patients Receiving Amiodarone -----	A-6
Emergency Use of Central Venous Access Device (CVAD) -----	A-7
Interfacility Transfer of Patients Receiving Standard Crystalloid Solutions----- And IV Solutions Containing Potassium	A-8
Transfer of Patients Receiving Cardizem (Diltizem) -----	A-9

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ADDITIONAL APPROVED MEDICATIONS/EQUIPMENT

- I. Purpose: To identify medications/equipment utilized in the Quincy Area EMS System that are not standard equipment and have received conditional approval.
 - A. Must be approved by IDPH
 - B. Require additional inservice training
- II. Additional medications:
 - A. Amiodarone (ALS transfer only – see A-6)
 - B. Heparin drip (ALS transfer only – See A-3)
 - C. Glycoprotein IIb/IIIa receptor inhibitors (Aggrastat, Integrilin and Reopro) (ALS transfer only – See A-5)
 - D. Nitroglycerin drip (ALS transfer only – See A-4)
 - E. Nitroglycerin topical ointment (addition to EMS drug box M-1.23)
 - F. *IVs containing potassium (ALS transport only. (See A-8)*
 - G. *Diltiazem (Cardizem) ALS transport only (See A-9)*
- III. Additional equipment:
 - A. Arterial line sheath (ALS transfer only (see A-2)
 - B. Emergency use of central venous access devices (see A-7)
- IV. Documentation
 - A. Documentation on the Illinois PCR form *the same as any other medication*
 - B. Conditional drugs – equipment form *should be completed if any issues arise during the transport.*

**CONDITIONAL DRUGS AND EQUIPMENT FORM
QA & I**

Date: _____ PCR Form #: _____

Patient Name: _____ Diagnosis: _____

Conditional drug/equipment administered/used:

- ☐ Amiodarone drip
- ☐ Arterial line sheath
- ☐ Central Venous Access Devices
- ☐ Glycoprotein receptor inhibitors (Aggrastat, Integrilin, Reopro)
- ☐ Heparin drip
- ☐ Nitroglycerin drip
- ☐ Nitroglycerin paste
- ☐ Potassium
- ☐ Diltiazem

Complications

- ☐ None
- ☐ **Bleeding
- ☐ **Hypotension
- ☐ **Change in level of consciousness
- ☐ **Other

Details regarding the complication:

Outcome:

- ☐ No problems during transport
- ☐ **Patient stabilized
- ☐ **Other

Details regarding the outcome:

Person completing the report: _____

**Forward all reports to Randy Faxon, Blessing EMS Department ---
Fax 217-223-208**

RE: 9/09
Reviewed: 2/06

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS WITH ARTERIAL LINES

- I. Paramedics who have completed additional instruction in the management of patients with arterial lines may transfer patients receiving this therapy.
- II. Prior to moving a patient to the ambulance stretcher, the following must be completed:
 - A. The paramedic will have a R.N. check all connections and confirm that they are tight.
 - B. The paramedic will assess circulation in the extremity and document the color, pulse intensity, capillary refill, and sensation.
 - C. The paramedic will inspect the puncture site, noting any swelling or bruising.
 - D. The paramedic will examine the pressure bag to assure it is working properly.
- III. During the transfer, the paramedic will:
 - A. Check all connections every 30 minutes and document the findings
 - B. Check circulation in the extremity as in II.B. every 30 minutes and document the findings
 - C. Check the puncture site every 30 minutes and document.
 - D. Maintain 300 mmHg of pressure at all times in the pressure bag for adults. (For pediatrics, request pressure limit from RN or physician.)
- IV. If blood backs up into the line:
 - A. Check the position of all stopcocks.
 - B. Check all connections.
 - C. Check the bag pressure to assure 300 mmHg of pressure (adults).
 - D. Flush the catheter using the fast flush valve (valve with white plastic hand) until the line is cleared.
 - E. Do not allow the valve to remain open causing the patient to receive too much fluid.
 - F. Do not flush with a syringe.
 - G. Do not allow blood to back up to transducer dome. If it does, notify the receiving hospital upon arrival.
- V. Should an assessment reveal a loss or weakening of pulse distal to the site or a loss of warmth, sensation or mobility below the site, notify the receiving hospital immediately.
- VI. Apply direct pressure to the site should the catheter become dislodged or if you note a hematoma forming.
- VII. Should an air embolism be suspected due to an empty IV container, air in the tubing or loose connections as evidenced by a decrease in blood pressure, weakness, rapid pulse, or cyanosis of the affected extremity:
 - A. Check the line for leaks.
 - B. Notify the receiving hospital or medical control immediately.
 - C. Check vital signs.
 - D. Administer O2 as ordered.
 - E. Provide care as ordered.

TRANSFER OF PATIENTS WITH ARTERIAL LINES (CONTINUED)

- VIII. If air bubbles appear in the line:
 - A. Check for leaks and loose connections in the line
 - B. Flush air through an open stopcock
- IX. Notify the receiving hospital of any complications encountered during transport

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS RECEIVING IV HEPARIN

- I. Inservice
 - A. Paramedics and Prehospital RN's may transfer patients with heparin maintenance infusions after completing additional inservice training consisting of:
 - 1. *Review PowerPoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Complete quiz with minimum score of 90%.
- II. Drug action/Use
 - A. Anticoagulant used to help prevent clots from forming by inactivating the enzyme thrombin
 - B. Used in the prevention and treatment of emboli and thrombi
- III. Potential adverse effects
 - A. The chief complication is hemorrhage, which can occur at virtually any site in patients receiving heparin.
 - B. Any unexplained change, symptom or hypotension in your patient should be a clue to assess further for a possible bleed.
 - C. Other effects include local irritation at the IV site and hypersensitivity.
- IV. Procedure
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs currently being infused – know rate of infusion for each
 - 3. Transfer orders
 - B. The Heparin drip MUST BE maintained on an IV pump at all times during transport.
 - C. Check the infusion frequently to ensure it is infusing at the correct rate.
 - D. Observe the IV site for signs of infiltration – if this occurs, discontinue the site and apply a pressure dressing. Restart the line as soon as possible and continue with the same rate of infusion. Make note of the length of time the infusion was stopped and report to staff at the receiving facility.
 - E. Contact Medical Control or the receiving facility if any problems or questions regarding the heparin infusion while enroute.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS RECEIVING IV NITRO

- I. Inservice
 - A. Paramedics and prehospital RN's may transfer patients with nitroglycerin infusions after completing additional inservice training consisting of:
 - 1. *Review Powerpoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Complete quiz with minimum score of 90%
- II. Drug action/Use.
 - A. Drug Action: relaxation of vascular smooth muscle with dilation of peripheral arteries and veins.
 - B. Use: unstable angina, acute myocardial infarction, congestive heart failure, to decrease blood pressure/workload on the heart.
- III. Adverse effect
 - A. Adverse effects with this drug are usually dose related and almost all reactions are a result of vasodilator properties:
 - 1. Headache
 - 2. Lightheadedness related to drop in blood pressure
 - 3. Hypotension
- IV. Procedure:
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs currently being infused – know rate of infusion for each
 - 3. Transfer orders – the order should specifically indicate whether the nitroglycerin infusion is to be titrated according to pain and the blood pressure parameters to be maintained.
 - B. The nitroglycerin drip must be maintained on an IV pump at all times during transport.
 - C. Check the infusion frequently to ensure that it is infusion at the correct rate. If titrating the infusion, the nitroglycerin rate table should be used to increase or decrease dosage.
 - D. Monitor the patient's vital signs every 15 minutes if stable and every 5 minutes if unstable.

- E. If the patient experiences a drop in blood pressure you should:
 - 1. Lower the head of the stretcher and administer a 200 ml fluid bolus if not contraindicated (i.e. pulmonary edema).
 - 2. If the blood pressure does not return to the minimum systolic parameter listed in the transfer orders (or 90 systolic if no minimum indicated), stop the infusion and contact Medical Control or the receiving facility.
- V. Other
 - A. Special tubing may or may not be utilized depending upon the transferring facilities policies. (Note: Blessing Hospital does not require special tubing for nitroglycerin administration.)
 - B. Do not administer other medications through the nitroglycerin line.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS RECEIVING IV NITRO

- I. Inservice
 - A. Paramedics and prehospital RN's may transfer patients with nitroglycerin infusions after completing additional inservice training consisting of:
 - 1. *Review Powerpoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Complete quiz with minimum score of 90%
- II. Drug action/Use.
 - A. Drug Action: relaxation of vascular smooth muscle with dilation of peripheral arteries and veins.
 - B. Use: unstable angina, acute myocardial infarction, congestive heart failure, to decrease blood pressure/workload on the heart.
- III. Adverse effect
 - A. Adverse effects with this drug are usually dose related and almost all reactions are a result of vasodilator properties:
 - 1. Headache
 - 2. Lightheadedness related to drop in blood pressure
 - 3. Hypotension
- IV. Procedure:
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs currently being infused – know rate of infusion for each
 - 3. Transfer orders – the order should specifically indicate whether the nitroglycerin infusion is to be titrated according to pain and the blood pressure parameters to be maintained.
 - B. The nitroglycerin drip must be maintained on an IV pump at all times during transport.
 - C. Check the infusion frequently to ensure that it is infusion at the correct rate. If titrating the infusion, the nitroglycerin rate table should be used to increase or decrease dosage.
 - D. Monitor the patient's vital signs every 15 minutes if stable and every 5 minutes if unstable.

- E. If the patient experiences a drop in blood pressure you should:
 - 1. Lower the head of the stretcher and administer a 200 ml fluid bolus if not contraindicated (i.e. pulmonary edema).
 - 2. If the blood pressure does not return to the minimum systolic parameter listed in the transfer orders (or 90 systolic if no minimum indicated), stop the infusion and contact Medical Control or the receiving facility.
- V. Other
 - A. Special tubing may or may not be utilized depending upon the transferring facilities policies. (Note: Blessing Hospital does not require special tubing for nitroglycerin administration.)
 - B. Do not administer other medications through the nitroglycerin line.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**TRANSFER OF PATIENTS RECEIVING GLYCOPROTEIN IIb/IIIa RECEPTOR
INHIBITORS
(AGGRASTAT, INTEGRILIN, REOPRO)**

I. Inservice

- A. Paramedics and Prehospital RN's may transfer patients with approved glycoprotein receptor inhibitor maintenance infusions after completing additional inservice training consisting of:
 - 1. *Review PowerPoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Demonstrate proficiency in assessment for complications
 - 3. Complete quiz with minimum score of 90%

II. Drug Action/Use

- A. Used in the treatment of cardiac patients with signs/symptoms of ischemia or AMI. Also used in cardiac catheterization labs to reduce complications.
- B. These drugs are reversible antagonists of fibrinogen binding to prevent platelet aggregation.
- C. They coat platelets causing "slickness" and prevent platelet aggregation.

III. Procedure for transfer

- A. Obtain patient report from the RN caring for the patient in the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs being infused – know rate of infusion for each
 - 3. Transfer orders – including measures to be taken if bleeding occurs which cannot be controlled with direct pressure.
- B. Assess the patient for any signs of bleeding
- C. The glycoprotein inhibitor infusion **MUST BE** maintained on an IV pump at the ordered rate of infusion.
- D. Check the infusion frequently to ensure it is infusing at the correct rate.
- E. Observe the IV site for any signs of infiltration – if this occurs, discontinue the site and apply a pressure dressing. Restart the line as soon as possible and continue with the same rate of infusion. Make note of the length of time the infusion was stopped and report to staff at the receiving facility.

- F. Monitor the patient for any potential hemorrhage especially at infusion sites, other needle stick sites and mucous membranes. If bleeding or suspected bleeding is noted which cannot be controlled with direct pressure, follow transfer orders or contact Medical Control for instructions.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS RECEIVING AMIODARONE

- I. Inservice
 - A. Paramedics and Prehospital RN's may transfer patients with amiodarone maintenance infusions after completion of amiodarone inservice training.
 - 1. *Review PowerPoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Complete quiz with a minimum of 90% accuracy
- II. Drug Action/Use
 - A. Drug action: Antiarrhythmic with effects on sodium, calcium and potassium channels. Possesses both alpha and beta adrenergic blocking properties.
 - B. Use: A maintenance drip is utilized after conversion from dysrhythmia.
- III. Dose/Administration
 - A. Maintenance drip: Usual dose is 0.5-1.0 mg/minute (Maximum dose 2.2 grams/24 hours).
 - B. Due to the potential for drug incompatibilities, other drugs should NOT be administered through the same IV line.
- IV. Potential adverse effects/side effects:
 - A. Hypotension is the most common side effect.
 - B. Bradycardia and AV blocks.
 - C. CHF
 - D. Arrhythmia/cardiac arrest
- V. Procedure
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs currently infusing, infusion rates for each
 - 3. Transfer orders
 - B. The amiodarone infusion must be maintained on an IV pump during the transport.
 - C. Check the infusion frequently to ensure it is infusing at the correct rate.

- D. Observe the IV site for signs of infiltration. If infiltration occurs, restart the IV line as soon as possible. Continue the drug at the ordered infusion rate.
- E. Contact Medical Control or the receiving facility if any problems or questions regarding the amiodarone infusion while enroute.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMERGENCY USE OF CENTRAL VENOUS ACCESS DEVICES (CVADs)

- I. Purpose: Previously established central lines and other access ports may be utilized during an emergency in the event that a peripheral IV line cannot be established.

Emergency situations include:

1. Cardiac arrest
2. Major trauma
3. Life-threatening situation requiring immediate need for medication or fluid therapy

- II. Level of provider to perform this advanced skill:

A Paramedic

B. Prehospital RN

- III. Important information

A. Heparinized lines

1. Some CVADs utilize a heparin flush to maintain line patency.
2. Heparin is not compatible with many drugs, therefore it is important to flush the line with normal saline before and after medication administration.
3. Dialysis catheters or other access devices that have been heparinized should be aspirated to remove the 3 cc of Heparin prior to flushing the line. In a dire emergency, if you cannot aspirate, you may proceed with flushing the line.
4. In the prehospital setting we will not “re-lock” the line with Heparin after access. Therefore, a continuous Normal Saline IV will be established using the CVAD to maintain patency.

B. Risks

1. There is a risk of air embolism when a central IV system is open to the air. To help eliminate this risk:
 - a. Use a needle to access through the injection port cap (or utilize needless access system if available) for medication administration.
 - b. Clamp the line whenever you remove the injection port cap to attach or disconnect a syringe or IV fluids.
2. Risk of Infection:
 - a. Good aseptic technique must be utilized to help prevent risk of infection.
 - b. Preferred method would be to utilize sterile technique when possible.

- C. Use a 5 - 12 cc syringe when aspirating from or flushing the line. Smaller syringes have greater pressure and could force a clot through the line or even rupture the line.

- D. Following is a table outlining the various types of access devices and related information:

CENTRAL VENOUS CATHETER – QUICK REFERENCE CHART

CATHETER	DESCRIPTION	MED ADM. - LINE FLUSHING	MISCELLANEOUS
<u>Percutaneous CVC</u> Multiple lumen catheter	<ul style="list-style-type: none"> A silicone catheter inserted percutaneously into the subclavian or internal jugular vein. 	<ul style="list-style-type: none"> Flush with 3 cc NS before and after infusing medications OR resume continuous fluids. 	<ul style="list-style-type: none"> All lumens can be used to deliver medications or IV fluids.
Single lumen catheter	<ul style="list-style-type: none"> 2-5 inches in length, inserted into the subclavian or internal jugular vein. 	<ul style="list-style-type: none"> Flush with 3 cc NS before and after infusing medications OR resume continuous fluids. 	
<u>Tunneled CVAD</u> Hickman catheter	<ul style="list-style-type: none"> A surgically inserted catheter which is tunneled under subcutaneous tissue into the central venous system. Can be single or double lumen. Has dacron cuff. 	<ul style="list-style-type: none"> Flush with 3cc NS before and after medications OR resume continuous fluids. 	
Broviac catheter	<ul style="list-style-type: none"> Similar to Hickman Frequently used in children 	<ul style="list-style-type: none"> Flush with 3cc NS before and after medications OR resume continuous fluids. 	
Groshong catheter	<ul style="list-style-type: none"> Similar to Hickman Tip of catheter has a pressure sensitive valve. 	<ul style="list-style-type: none"> Flush with 10cc NS before and after medications OR resume continuous fluids. 	<ul style="list-style-type: none"> Flush briskly to maintain valve integrity

<u>Implanted Ports</u> Port A Cath or Infus A Port	<ul style="list-style-type: none"> ▪ The device is placed surgically under subcutaneous tissue with a tunneled catheter that extends into the central venous system. 	<ul style="list-style-type: none"> ▪ Flush with 10cc NS before medications. ▪ Check for blood return before instilling fluids/medications. ▪ Flush with 20ccNS after medications ▪ Or resume continuous fluids. 	<ul style="list-style-type: none"> ▪ Must use a “Gripper” needle and extension set or another type of “non-coring” needle specified for the port.
<u>Peripheral Central Catheter</u> P.I.C.C. catheters	<ul style="list-style-type: none"> ▪ Small silicone catheter inserted percutaneously into the basilic or cephalic vein in the antecubital space ▪ Advanced until it rests in the central venous system. 	<ul style="list-style-type: none"> ▪ Flush with 10cc NS before and after medications ▪ Or resume continuous fluids. 	<ul style="list-style-type: none"> ▪ Use 10-12 cc syringes ▪ Do not use vacutainers
<u>Dialysis Catheter</u> Ash Catheter tunneled Quinton catheter temporary	<ul style="list-style-type: none"> ▪ The Ash catheter – same as Broviac; 2 tailed straight. ▪ Quinton is a non-tunneled, non-cuffed 2 tailed curved catheter inserted into the central venous system. Always sutured in place. 	<ul style="list-style-type: none"> ▪ Aspirate 3 cc blood to remove heparin ▪ Flush with 10cc NS before and after medications ▪ Or resume continuous fluids. ▪ Maintain the fluids at a KVO rate so as not to overload the dialysis patient with fluid. 	<ul style="list-style-type: none"> ▪ In an emergency, if you cannot aspirate the 3 cc of heparin, it is OK to go ahead and flush.

IV. Documentation

- A. Document procedure on PCR form as with any other procedure. Include type of CVAD, authorization for access, time and what you administered through the line.
- B. Conditional drug / equipment use
 1. Field personnel: complete the conditional drug/equipment use form and submit to the EMS System Coordinator.
 2. EMS Office: Complete quarterly reports for conditional drugs/equipment and submit to IDPH.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**Interfacility Transfer of Patients Receiving Standard Crystalloid Solutions and IV Solutions
Containing Potassium**

- I. Inservice: Paramedics and Prehospital RNs may transfer patients with crystalloid solution infusions and potassium-containing IV solutions after completing inservice training consisting of:
 - A. *Review PowerPoint (transfer, medication, arterial line sheath and CVAD)*
 - B. Complete quiz with a minimum of 90% accuracy.
- II. Solutions:
 - A. The paramedic or PreHospital RN may monitor and adjust the following IV crystalloid solutions:
 - 1. Dextrose 5% in Water (D5W)
 - 2. Ringer's Lactate solution (LR)
 - 3. ½ Normal Saline (1/2NS)
 - 4. Dextrose 5% in Water and ½ Normal Saline (D51/2NS)
 - 5. Dextrose 5% in Water and ¼ Normal Saline (D51/4 NS)
 - 6. Normosol R, Normosol M

NOTE: All of the solutions mentioned above can contain up to 20 mEq of potassium. Use caution.
 - B. The paramedic or Prehospital RN may monitor solutions containing 20 mEq of potassium or less.
- III. Potential adverse effects
 - A. Fluid overload if fluids are allowed to infuse too quickly
 - B. Hyperkalemia if potassium containing fluids are allowed to infuse off the pump.
 - 1. Signs of hyperkalemia: Numbness and tingling, weakness, bradycardia, hypotension, ECH changes such as tall peaked T waves and widened QRS complex.
- IV. Procedure:
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent set of vital signs
 - 2. All drugs and IV solutions currently being infused – know rate of infusion for each.
 - 3. Transfer orders
 - B. Solutions containing potassium **MUST** be maintained on an IV pump at all times during the transport.
 - C. Check the infusion frequently to ensure that it is infusing at the correct rate.

- D. Observe the IV site for signs of infiltration – if this occurs, discontinue the site and apply a dressing. Restart the line as soon as possible and continue with the same rate of infusion. Do not try to “catch up” on the infusion. Make note of the time the infusion was stopped and restarted. Report this to staff at the receiving facility. Document appropriately.
- E. IV solutions containing potassium are not compatible with many drugs including epinephrine, atropine sulfate and diazepam. Do not administer drugs through the IV line that contains potassium.
- F. Contact Medical Control or the receiving facility if any problems or questions regarding the IV infusion while enroute.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSFER OF PATIENTS RECEIVING IV CARDIZEM

- I. Inservice
 - A. Paramedics and Prehospital RN's may transfer patients with heparin maintenance infusions after completing additional inservice training consisting of:
 - 1. *Review PowerPoint (transfer, medication, arterial line sheath and CVAD)*
 - 2. Complete quiz with minimum score of 90%.
- II. Drug action/Use
 - A. Used in the prevention and treatment of rapid atrial fibrillation
- III. Potential adverse effects
 - A. The chief complication are hypotension, acute MI, pulmonary congestions, lactation
 - B. Other effects include local irritation at the IV site and hypersensitivity.
- IV. Procedure
 - A. Obtain patient report from the RN caring for the patient at the transferring facility with special attention to the following:
 - 1. Patient condition including recent vital signs
 - 2. All drugs currently being infused – know rate of infusion for each
 - 3. Transfer orders
 - B. The Diltizem drip MUST BE maintained on an IV pump at all times during transport.
 - C. Check the infusion frequently to ensure it is infusing at the correct rate.
 - D. Observe the IV site for signs of infiltration – if this occurs, discontinue the site and apply a pressure dressing. Restart the line as soon as possible and continue with the same rate of infusion. Make note of the length of time the infusion was stopped and report to staff at the receiving facility.
 - E. Contact Medical Control or the receiving facility if any problems or questions regarding the heparin infusion while enroute.

DILTIAZEM (CARDIZEM)

CLASS:	Antiarrhythmic
ACTION	Decreases SA and AV conduction and prolongs AV node effective and functional refractory periods. Also decreases myocardial contractility and peripheral vascular resistance.
INDICATIONS:	Rapid atrial fibrillation
SIDE EFFECTS/ADVERSE REACTIONS:	Hypotension, Acute MI, pulmonary congestions, lactation.
CONTRAINDICATIONS:	Hypotension, acute MI, pulmonary congestion, lactation
CAUTION:	Safety and effectiveness in children have not been determined. The half-life may be increased in geriatric patients. Use with caution in hepatic disease and in CHF.
DOSAGE:	20mg IV bolus over 2 min. If converted start drip at 10mg/hr NOTE: Not approved in children

QUINCY AREA EMS SYSTEM APPROVED PROCEDURES

Needle Chest Decompression (ALS)-----	AP-1
Spinal Immobilization-----	AP-2
Pneumatic Anti Shock Garment (MAST) -----	AP-3
Defibrillation (ALS) -----	AP-4
Cricothyrotomy (ALS) -----	AP-5
Endotracheal Intubation - Adult (ALS) -----	AP-6
Combitube Airway (ALS) -----	AP-7
Subcutaneous Injection (ALS) -----	AP-8
Intramuscular Injection (ALS) -----	AP-9
Intravenous Cannulation (ALS)-----	AP-10
External Pacing (ALS) -----	AP-11
Automated Defibrillation -----	AP-12
Nebulizer Treatment (ALS) -----	AP-13
Intravenous Medication Administration (ALS)-----	AP-14
Endotracheal Medication Administration (ALS) -----	AP-15
Transtracheal Needle Ventilation (ALS)-----	AP-16
Synchronized Cardioversion (ALS) -----	AP-17
Endotracheal Intubation - Pediatric (ALS) -----	AP-18
Intraosseous Infusion (ALS)-----	AP-19
Pulse Oximetry -----	AP-20
Finger Stick Glucose (ALS) -----	AP-21
Twelve Lead EKG (ALS)-----	AP-22
Nasotracheal Intubation (ALS)-----	AP-23
Administration of Epi-pen for anaphylactic Reaction (BLS transport and non transport) -----	AP-24
Epi-pen Auto Injector Quality Improvement Form -----	AP-24F
EZ IO™ Intraosseous Infusion-----	AP-25
CPAP -----	AP-26

QUINCY AREA EMS SYSTEM APPROVED PROCEDURES

Needle Chest Decompression (ALS)-----	AP-1
Spinal Immobilization-----	AP-2
Pneumatic Anti Shock Garment (MAST) -----	AP-3
Defibrillation (ALS) -----	AP-4
Cricothyrotomy (ALS) -----	AP-5
Endotracheal Intubation - Adult (ALS) -----	AP-6
<i>Endotracheal Intubation– Adult (ALS) Using S.A.L.T. -----</i>	<i>AP-6A</i>
Combitube Airway (ALS) -----	AP-7
Subcutaneous Injection (ALS) -----	AP-8
Intramuscular Injection (ALS) -----	AP-9
Intravenous Cannulation (ALS)-----	AP-10
External Pacing (ALS) -----	AP-11
Automated Defibrillation -----	AP-12
Nebulizer Treatment (ALS) -----	AP-13
Intravenous Medication Administration (ALS)-----	AP-14
Endotracheal Medication Administration (ALS) -----	AP-15
Transtracheal Needle Ventilation (ALS)-----	AP-16
Synchronized Cardioversion (ALS) -----	AP-17
Endotracheal Intubation - Pediatric (ALS) -----	AP-18
Intraosseous Infusion (ALS)-----	AP-19
Pulse Oximetry -----	AP-20
Finger Stick Glucose (ALS) -----	AP-21
Twelve Lead EKG (ALS)-----	AP-22
Nasotracheal Intubation (ALS)-----	AP-23
Administration of Epi-pen for anaphylactic Reaction (BLS transport and non transport) -----	AP-24
Epi-pen Auto Injector Quality Improvement Form -----	AP-24F
EZ IO™ Intraosseous Infusion-----	AP-25
CPAP -----	AP-26
Tourniquet Application-----	AP-27
<i>Less than Lethal Weapons -----</i>	<i>AP-28</i>

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

NEEDLE CHEST DECOMPRESSION (ALS)

- I. Indications: Signs of a tension pneumothorax which may include any or all of the following:
 - A. Absent or diminished lung sounds on the affected side
 - B. Progressive respiratory distress and/or increased resistance to bagging
 - C. Tracheal deviation
 - D. Jugular vein distention
 - E. Signs of shock with chest trauma present
- II. Potential complications:
 - A. Creation of a pneumothorax if not already present
 - B. Laceration of blood vessels and nerves
 - C. Laceration of the lung
 - D. Infection from poor aseptic technique
- III. Precautions:
 - A. A tension pneumothorax can be precipitated by sealing an open chest wound with an occlusive dressing. This should be checked first to relieve the tension pneumothorax.
 - B. Nerves and blood vessels exist just below each rib. To avoid these you should always insert the needle just over the top of the 3rd rib.
- IV. Equipment:
 - A. 14 gauge or larger IV catheter, at least 3.25 inches long
 - B. Alcohol or Betadine prep pads
 - C. 10 cc syringe
 - D. Tape
- V. Procedure:
 - A. Attach the 10 cc syringe to the IV catheter
 - B. Locate the 2nd intercostal space mid-clavicular line
 - C. Cleanse the site with alcohol or Betadine
 - D. Insert the IV catheter at the superior border of the 3rd rib
 - E. Push the needle until you feel a pop as you enter the pleural space
 - F. The plunger of the syringe will be pushed outward by pressurized air exiting the chest
 - G. Advance the catheter over the needle until it is flush with the skin
 - H. Discard the needle
 - I. Secure the catheter in place with tape
 - J. *Reassess ventilatory rate status, jugular veins, tracheal position, pulse, blood pressure*

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

SPINAL IMMOBILIZATION

I. INDICATIONS

- A. All trauma patients with a neurological deficit.
- B. All trauma victims complaining of head, neck, or back pain.
- C. All unconscious trauma victims.
- D. All trauma victims who may have spinal injury, who also exhibit altered mental states, (e.g., drugs, alcohol).
- E. All trauma victims with facial or head injuries.
- F. All trauma patients with “mechanism of injury” that may have resulted in spinal injury.

II. CONTRAINDICATIONS

- A. none

III. PRECAUTIONS

- A. When in doubt, immobilize.
- B. Scoop stretchers do not adequately support the spine.

IV. EQUIPMENT

- A. Rigid Cervical Collar
- B. Head immobilization devices, (e.g., C.I.D., Bashaw)
- C. Blanket roll
- D. Proper immobilization device, (e.g., short spine board (KED))
- E. Long spine board
- F. Straps or Spider Straps

V. PROCEDURE UTILIZING SHORT SPINE BOARD

- A. First rescuer stations himself behind victim and applies manual immobilization to head and neck.
- B. Neck is held in a neutral position.
- C. Second rescuer applies properly sized rigid C-collar
- D. Position a proper immobilization device behind victim.
- E. Secure victim to device.
- F. Transfer victim to a long spine board.
- G. Secure victim to long spine board.

VI. NOTES:

- A. There are several different devices of this type, you must become familiar with the equipment and strapping procedures of your device.
- B. Short spine board or equivalent to be used when the patient is in a position that does not allow for the use of the long spine board.

VII. PROCEDURE FOR LONG SPINE BOARD

- A. Maintain manual immobilization on the head and spine (in a neutral position).
- B. Apply properly sized rigid C-collar.
- C. Log roll patient and place spine board behind him.
- D. Roll the patient back onto the board and secure him with straps.
- E. Secure head with appropriate immobilization device.

VIII. SPECIAL CONSIDERATIONS (INTERFACILITY TRANSFERS)

- A. Any patient with Mechanism of Injury that could result in spinal injury will be transported in full spinal immobilization. This includes all patients that have been cleared by the transferring facility unless cleared by a Trauma Surgeon.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PNEUMATIC ANTISHOCK GARMENT (MAST)

I. INDICATIONS (BLS personnel will request an order)

- A. Systolic blood pressure less than 80
- B. Shock like symptoms with systolic of 100 or less
- C. Pelvic fracture
- D. Fracture of lower extremity
- E. Spinal shock
- F. Massive abdominal bleeding
- G. Cardiac arrest secondary to trauma

II. CONTRAINDICATIONS

- A. Pulmonary Edema
- B. Evisceration (may use leg compartments)
- C. Pregnancy (may use leg compartments)

III. PRECAUTIONS

- A. Should only be removed in a hospital under a physician's direction, unless pulmonary edema develops
- B. NEVER allow deflation of the PASG by personnel inexperienced in its use
- C. Remove clothing and fully assess the portions of the body that will be covered by the PASG.
- D. If not able to remove clothing, remove belts and sharp objects from pockets that may damage the PASG or the patient.
- E. Cold weather may cause the suit to lose air. Check pressure frequently to maintain BP at 100-100 systolic

IV. EQUIPMENT

- A. Pneumatic Antishock Garment (MAST)
- B. Blood Pressure Cuff
- C. Stethoscope

V. PROCEDURE

- A. Evaluate need for PASG (including vitals and lung sounds) and leave B/P cuff on the arm
- B. Unfold PASG and lay it flat on a long spine board on the stretcher
- C. Maintaining immobility of the spine, place the patient on the PASG so that the top of the garment is just below the lowest rib
- D. Wrap the PASG around legs and fasten
- E. Wrap abdomen and fasten, (unless contraindicated), being sure the garment does not ride up on ribs
- F. Connect foot pump
- G. Recheck and record vitals
- H. Inflate leg compartments while monitoring blood pressure
- I. If blood pressure not in 100-110 systolic range, inflate abdominal compartment, (unless contraindicated)
- J. When blood pressure is adequate, (100-110 systolic), close stopcocks Do not attempt to increase the blood pressure beyond 110 systolic.
- K. Continue monitoring patient's blood pressure, adding pressure to the trousers as needed

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DEFIBRILLATION (ALS)

- I. Indications:
 - A. V-Fib
 - B. V-Tach (pulseless)
- II. Contraindications:
 - A. Conscious patients
- III. Precautions:
 - A. All rescuers/bystanders must be ordered clear of patient and stretcher prior to delivery of shock
 - B. A conductive medium must be used (gel or pads)
 - C. Monitor/defibrillator must be taken to the patient immediately under the following conditions
 - 1. unknown problem
 - 2. man/woman down
 - 3. chest pain
 - 4. possible D.O.A.
 - D. Assure no flammable gasses in area (*including oxygen*)
 - E. Assure no bridge of conduction medium
 - F. Assure patient being defibrillated is actually pulseless
- IV. Complications:
 - A. Spark jumping to another rescuer causing a minor burn or V-Fib
 - B. Damage to myocardial muscle mass
 - C. Skin bridging causing chest wall arc
 - D. Poor skin contact causing a burn
 - E. Tetanic contraction causing loss of IV or other attached equipment
 - F. Explosion in presence of flammable gas

V. Procedure (CPR in Progress):

- A. Turn on monitor defibrillator
- B. Place conductive medium on paddles or utilize electrode pads (Fast Patch, Quick Combo)
- C. Stop CPR
- D. Determine rhythm
- E. Recognize V-Fib or pulseless V-tach
- F. Charge defibrillator to appropriate joule setting
 - *Biphasic 200 joule*
 - *Monophasic 300 joule*
- G. Place paddles on chest if not using electrode pads
- H. Recheck rhythm
- I. Order "stand clear", check to ensure all clear
- J. Defibrillate
- K. Continue CPR for 2 minutes
- L. Check rhythm
- M. Check pulse

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

CRICOTHYROTOMY (ALS)

I. INDICATIONS

- A. Complete obstructed airway that cannot be relieved by Heimlich maneuvers or direct laryngoscopy
- B. Destructive facial injury precluding the use of advanced airway tubes
- C. Cyanosis
- D. Patient "in extremis"

II. CONTRAINDICATIONS

- A. When other techniques have not been attempted
- B. Patient under the age of 10

III. COMPLICATIONS

- A. Creation of a false passage
- B. Bleeding
- C. Laryngeal and vocal cord damage
- D. Subcutaneous emphysema
- E. Mediastinal emphysema
- F. Perforation of the esophagus

IV. Equipment

- A. Scalpel handle/blade
- B. 6.0-7.0 ET tube
- C. Povidone-iodine solution
- D. 10 cc syringe

OR

- E. Cricothyrotomy kit

V. PROCEDURE (may vary according to equipment used)

- A. Take universal precautions
- B. Place patient supine
- C. Hyperextend the neck (unless cervical injury is suspected).
- D. Identify the thyroid cartilage (Adam's apple), and the cricoid cartilage with the non-dominant hand.
- E. Locate the cricothyroid membrane.
- F. Prep the site with Povidine-iodine solution or alcohol.
- G. Make a vertical incision through the skin and subcutaneous tissue approximately 2 cm long over the identified cricothyroid membrane.
- H. Make a horizontal incision through the cricothyroid membrane itself approximately 1 cm long
- I. Dilate the opening with scalpel handle or a Trousseau dilator
- J. Insert the endotracheal tube through the opening
- K. Inflate the cuff
- L. Ventilate the patient and watch for chest rise
- M. Auscultate over the lungs and stomach to verify tube placement. Use end tidal CO₂ detector device if available.
- N. Secure the tube with tape or commercial device.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ENDOTRACHEAL INTUBATION - ADULT (ALS)

I. Indications:

- A. Comatose patients with inadequate airway
- B. Respiratory arrest

II. Contraindications:

- A. Patients with a gag reflex
- B. Comatose patients ventilating adequately

III. Complications:

- A. Teeth or dentures may be broken
- B. Esophageal Intubation
- C. Right mainstem bronchial intubation
- D. Laryngeal injury (soft tissue)

IV. Precautions:

- A. Should not take longer than 20 seconds
- B. Do not use teeth as a fulcrum
- C. If not successful after 3 attempts, maintain airway and ventilate with 100% oxygen using bag-valve-mask or positive pressure; attempt combitube if not contraindicated.

V. Equipment:

- A. Cuffed ET tube (uncuffed for children age 8 and under)
- B. Laryngoscope
- C. Straight or curved blade of appropriate size
- D. 10 ml. syringe
- E. Stylette (optional)
- F. Approved commercial device designed to secure an E.T. tube
- G. Suction devices
- H. Bag valve mask
- I. O2 supply
- J. Esophageal intubation detector (EID)
- K. Appropriate size oral airway
- L. Tape
- M. Stethoscope
- N. End Tidal CO2 monitoring device (optional)

VI. Procedure:

- A. Stabilize the neck in a neutral position (trauma patient)
- B. Hyperventilate patient approximately 30 seconds prior to intubation attempt
- C. Select correct size ET tube
- D. Assemble all equipment and check for proper functioning
- E. Grasp laryngoscope in left hand
- F. Insert laryngoscope blade in right side of mouth and sweep the tongue to the left
- G. Visualize the vocal cords
- H. Insert the ET tube until cuff or depth marker is past vocal cords
- I. Inflate cuff
- J. Check placement of ET tube via auscultation of bilateral breath sounds auscultation over epigastrium and EID
- K. Secure tube with commercial device (or other secure method)
- L. Insert oral airway if needed to prevent biting on the tube

VII. Field Extubation: to be utilized in the rare case when an intubated patient awakens and is intolerant of the endotracheal tube.

- A. Assess to determine:
 - 1. If the patient is able to maintain his own airway with adequate spontaneous respirations.
 - 2. If the patient is under the influence of any sedating agents.
 - 3. That the problem which initially required intubation is fully resolved.
- B. Contact Medical Control with the assessment information. The decision to extubate should be made by an EMS physician.
- C. Be aware that there is a risk of laryngospasms upon extubation of the awake patient that may prohibit successful reintubation.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**ENDOTRACHEAL INTUBATION - ADULT (ALS)
Using Supraglottic Airway Laryngopharyngeal Tube (SALT)**

I. Indications:

- A. Comatose patients with inadequate airway
- B. Respiratory arrest

II. Contraindications:

- A. Patients with a gag reflex
- B. Comatose patients ventilating adequately

III. Complications:

- A. Teeth or dentures may be broken
- B. Esophageal Intubation
- C. Right mainstem bronchial intubation
- D. Laryngeal injury (soft tissue)

IV. Precautions:

- A. Should not take longer than 20 seconds
- B. Do not use teeth as a fulcrum
- C. If not successful after 3 attempts, maintain airway and ventilate with 100% oxygen using bag-valve-mask or positive pressure; attempt combitube if not contraindicated.

V. Equipment:


- A. Cuffed ET tube (uncuffed for children age 8 and under)
- B. 10 ml. syringe
- C. Suction devices
- D. Bag valve mask
- E. O2 supply
- F. Esophageal intubation detector (EID)
- G. Stethoscope
- H. End Tidal CO2 monitoring device (optional)
- I. S.A.L.T.


VI. Procedure Using Supraglottic Airway Laryngopharyngeal Tube (SALT)

- A. Stabilize the neck in a neutral position (trauma patient)
- B. Hyperventilate patient approximately 30 seconds prior to intubation attempt
- C. Select correct size ET tube
- D. Assemble all equipment and check for proper functioning
- E. S.A.L.T. can be used as an OPA.
- F. Use the epiglottic tongue blade (provided in the kit) to control the epiglottis.
- G. Insert S.A.L.T. over the tongue blade (similar to inserting oropharyngeal airway over a tongue blade in a pediatric patient)
- H. Attach provided strap to maintain the airway. The patient can be ventilated with bag-mask at this time if needed.
- I. Pass the appropriate-sized ET tube (not provided in kit) through the S.A.L.T. into the trachea
- J. Verify placement. If using an esophageal detector device to confirm endotracheal tube placement, this MUST be done prior to positive pressure ventilations.
- K. Attempt to ventilate with bag-mask. Check for bilateral chest rise and auscultate for breath sounds over BOTH lung fields and for absence of sounds over epigastrium.
- L. When placement confirmed, inflate cuff (for patients > 8 years of age).
- M. Place provided securement clamp on ET tube. Move strap from S.A.L.T. to the clamp.
- N. Secondary tube placement confirmation is required and must be documented. This may be accomplished with an esophageal detector device, end-tidal CO2 detector or capnography (preferred method)

VII. Field Extubation: to be utilized in the rare case when an intubated patient awakens and is intolerant of the endotracheal tube.

- A. Access to determine:
 - 1. If the patient is able to maintain his own airway with adequate spontaneous respirations.
 - 2. If the patient is under the influence of any sedating agents
 - 3. That the problem which initially required intubation is fully resolved.
- B. Contact Medical Control with the assessment information. The decision to extubate should be made by an EMS physician.
- C. Be aware that there is a risk of laryngospasms upon extubation of the awake patient that may prohibit successful reintubation.


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**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

COMBITUBE AIRWAY (ALS)

I. Indications:

- A. Cardiac/respiratory arrest
- B. Respiratory arrest – comatose with no gag reflex

II. Contraindications:

- A. Patient with an intact gag reflex
- B. Patient under age 16 and/or under 5 feet tall
- C. Patient with known esophageal disease
- D. Patient with a history of esophageal trauma/or ingestion of caustic substance
- E. Patient with a tracheostomy or laryngectomy
- F. Patient with a foreign body obstruction in the trachea

III. Potential Complications:

- A. Damage to the proximal cuff from broken teeth or dentures

IV. Precautions:

- A. DO NOT remove the Combitube in the field unless the patient's gag reflex returns or the patient has been endotracheally intubated. Remove only upon the order of Medical Control.

V. Equipment:

- A. Combitube airway
- B. 100 ml syringe
- C. 15 ml syringe
- D. Water based lubricant
- E. Suction equipment

VI. Procedure:

- A. Hyperventilate with 100% oxygen
- B. Assemble equipment, check cuffs for leaks
- C. Place head in neutral position
- D. Insert device in midline using jaw lift

PROCEDURE CONTINUED

- E. Insert until black rings are at the teeth
- F. Inflate the pharyngeal cuff with 100 ml air (blue pilot balloon)
- G. Inflate the distal cuff with 15 ml air (white pilot balloon)
- H. Ventilate through the blue tube
- I. Auscultate lung sounds and over the epigastrium
- J. If bilateral breath sounds are auscultated,, continue ventilation through blue tube
- K. If there is absent chest rise, no lung sounds and gurgling heard over the epigastrium, begin ventilating through the clear tube labeled #2.
- L. Confirm placement. Auscultate lung sounds and over the epigastrium. Observe for chest rise.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

SUBCUTANEOUS INJECTION (ALS)

I. Indications:

- A. When a relatively slow rate of medication absorption is desired

II. Contraindications:

- A. Patient in shock
- B. Peripheral vasoconstriction

III. Precautions:

- A. Patient must not have allergy to administered medication
- B. Avoid arteries, veins, and nerves

IV. Complications:

- A. Infection
- B. Hematoma
- C. Local tissue irritation
- D. Accidental IV administration

V. Equipment:

- A. 1 ml syringe
- B. Alcohol prep
- C. Medication
- D. 5/8", 25 gauge needle
- E. 4X4 gauze pad
- F. Band-Aid

VI. Procedure:

- A. Receive the order
- B. Confirm the order
- C. Prepare equipment
- D. Explain procedure to the patient
- E. Confirm patient is not allergic to medication
- F. Select medication
- G. Inspect medication for discoloration, particles, and expired date
- H. Draw medication from source/vial/ampule, etc.
- I. Expel any air from syringe
- J. Recap needle
- K. Expose injection site
- L. Prep injection site with alcohol swab
- M. Insert needle at 45° angle to skin

PROCEDURE (CONTINUED)

- N. Aspirate for blood
- O. Inject medication slowly and withdraw needle
- P. Apply pressure to the site
- Q. Apply Band-Aid
- R. Confirm medication administration to medical control
- S. Monitor the patient for the desired therapeutic effect and any possible side effect
- T. Document administration of medication and any changes in patient condition.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

INTRAMUSCULAR INJECTION (ALS)

I. INDICATIONS:

- A. Non-cardiac emergencies where a relatively slow rate of absorption is desired

II. CONTRAINDICATIONS:

- A. patients in shock
- B. patients with suspected AMI

III. PRECAUTIONS:

- A. patient is not allergic to medication
- B. avoid arteries, veins, and nerves

IV. COMPLICATIONS:

- A. local pain and burning
- B. local infection
- C. hematoma
- D. inadvertent IV injection

V. EQUIPMENT:

- A. syringe
- B. 1 1/2", 21-23 gauge needle for adults, 1" 21-23 gauge needle for pediatrics
- C. alcohol prep
- D. 4X4 gauze
- E. medication
- F. Band-Aid

VI. PROCEDURE:

- A. receive order
- B. confirm order
- C. prepare equipment
- D. explain procedure to patient
- E. confirm patient not allergic to medication
- F. select medication
- G. inspect medication for discoloration, particles, and expiration date
- H. withdraw medication from source
- I. expel air from syringe
- J. recap the needle
- K. expose the appropriate site
- L. prep the site with an alcohol swab
- M. insert the needle at a 90o angle
- N. aspirate to assure that a blood vessel has not been entered

PROCEDURE (CONTINUED)

- O. inject the medication in a slow deliberate fashion
- P. apply pressure to the site
- Q. if necessary, apply a Band-Aid
- R. properly dispose of the syringe and needle
- S. confirm the medication administration
- T. monitor the patient for any possible side effects
- U. Document medication administration and any change in patient condition.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

INTRAVENOUS CANNULATION (ALS)

I. INDICATIONS

- A. When an IV lifeline is needed or there is potential need to administer fluids or IV medications.

II. COMPLICATIONS

- A. Infection
- B. Nerve or artery damage
- C. Tissue sloughing
- D. Intra-arterial injection
- E. Air embolism
- F. Anaphylaxis
- G. Pulmonary edema
- H. Catheter embolization

III. PRECAUTIONS

- A. Check all equipment and supplies for expiration dates and sterility
- B. Check all IV solutions for cloudiness
- C. Assure all lines do not contain air bubbles

IV. EQUIPMENT

- A. IV solution (Normal Saline)
- B. Tubing (microdrip, macrodrip)
- C. Over the needle catheter or butterfly
- D. Tourniquet
- E. Iodine swab or alcohol swab
- F. Tape
- G. Arm board (optional)
- H. Personal protective equipment

V. PROCEDURE FOR EXTREMITY CANNULATION

- A. Take BSI precautions
- B. Assemble and prepare equipment
- C. Apply tourniquet proximally
- D. Locate vein and cleanse site with alcohol or Povidine - iodine
- E. Hold vein in place by applying pressure on vein distal to point of entry
- F. Cannulate vein
- G. Advance catheter and remove needle
- H. Remove tourniquet
- I. Attach IV tubing or primed saline lock male adapter
- J. Tape in place
- K. Dispose of IV needle in appropriate Sharps container

VI. PROCEDURE FOR EXTERNAL JUGULAR

- A. Place patient supine, at least 15° head down position
- B. Turn patient head to opposite side unless contraindicated (head/spine injury)
- C. Cleanse site
- D. BSI precautions
- E. Make venipuncture midway between angle of jaw and midclavicular line, tourniqueting vein lightly with one finger above clavicle
- F. Advance catheter, remove needle and attach IV tubing
- G. Secure catheter in place

VII. SALINE LOCK NEEDLE

- A. Indication: when an IV lifeline is needed but the patient does not require IV fluid administration.
- B. Additional Equipment
 - 1. Male adapter
 - 2. Saline for injection
 - 3. 3 cc syringe/needle or prefilled syringe
 - 4. Alcohol preps
- C. Procedure
 - 1. Prime the male adapter by filling with saline for injection.
 - 2. After the IV is established, attach the primed male adapter to the hub of the IV catheter.
 - 3. Tape in place.
 - 4. Cleanse the adapter injection port.
 - 5. Flush with 3 cc saline for injection.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EXTERNAL PACING (ALS)

I. INDICATIONS:

- A. Symptomatic and hemodynamically unstable bradycardias:
 - 1. sinus or junctional
 - 2. 2^o block, type II
 - 3. 3^o block
- B. Pulseless electrical activity (PEA) with a ventricular rate < 60.
- C. Consider in asystole

II. CONTRAINDICATIONS:

- A. non-symptomatic patient

III. PRECAUTIONS:

- A. Placement of electrodes will effect current threshold
- B. Consider sedation for the conscious patient. The patient's level of consciousness may improve during pacing

IV. PROCEDURE:

- A. Apply standard EKG electrodes
- B. Apply pacing electrodes or Quick Combo pads
- C. Select desired pacing rate (70-80)
- D. *Turn pacer on*
- E. Confirm "sensing" by pacer (usually indicated by a marker on EKG)
- F. When "sensing" is confirmed, begin pacing at lowest energy setting
- G. Increase current slowly until capture occurs
 - 1. electrically indicated by a wide QRS and a tall broad T-wave
 - 2. mechanically indicated by improving cardiac output
 - a) Palpate for a *radial* or femoral pulse and check skin color and temperature. *NOTE: avoid using carotid pulse to confirm mechanical capture. Electrical stimulation causes muscular jerking that may mimic a carotid pulse.*
 - b) Check for improving blood pressure and level of consciousness
 - c) Improved level of consciousness
 - d) Improved skin color, temperature, moisture

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

AUTOMATED DEFIBRILLATION

I. Indications

- A. Unresponsive patients, no pulse, no respirations
- B. Defibrillators must be taken to the patient immediately under the following conditions:
 - 1. unknown problem
 - 2. man/woman down
 - 3. chest pains
 - 4. possible D.O.A.

II. Contraindications

- A. Conscious patients
- B. Patients with a pulse
- C. Patient less than 90 lb

III. Precautions

- A. All rescuers/bystanders must be ordered clear of the patient and stretcher prior to delivery of shock
- B. Assure no flammable gasses in area
- C. Assure patient being defibrillated is actually pulseless
- D. The ambulance must be stopped in order to analyze on the defibrillator

IV. Complications

- A. Spark jumping to another rescuer causing a minor burn or V-Fib
- B. Damage to myocardial muscle mass
- C. Skin bridging causing chest wall arc
- D. Poor skin contact causing a burn
- E. Tetanic contractions causing loss of IV or other attached equipment
- F. Explosion in presence of flammable gas
- G. Inappropriate shocks

V. Procedure

- A. Initiate and maintain CPR until automated external defibrillator (AED) is attached
NOTE: Complete 2 minutes of CPR if not a witnessed arrest.
- B. Turn on power
- C. Initiate analysis of rhythm
- D. Deliver shock, if indicated and follow policy MP-6.8.1

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

NEBULIZER TREATMENT USING ALBUTEROL (PROVENTIL, VENTOLIN) (ALS)

I. Indications:

- A. Acute attacks of bronchospasm
- B. Reversible obstructive airway disease

II. Possible Hazards and Complications:

- A. Albuterol can produce paradoxical life-threatening bronchospasm
- B. Significant cardiac effects may occur
- C. Hypersensitivity reactions
- D. Use with caution in patients with diabetes, cardiovascular, and convulsive disorders
- E. Use with caution in patients taking tricyclic antidepressants
- F. Other aerosol bronchodilators and epinephrine should not be used with Proventil, or extreme caution should be used

III. Equipment:

- A. Albuterol solution 2.5 mg in 3 ml unit dose
- B. Delivery system - disposable
 - 1. Aerosol elongated mask or mouthpiece if available
 - 2. Nebulizer medication container
 - 3. Oxygen supply tubing

IV. Procedure Sequence:

- A. Obtain patient information and communicate with treating facility - history and physical
- B. Set up delivery equipment
- C. Explain procedure to patient
- D. Position patient in sitting position
- E. Monitor vitals before, during, and after treatment
- F. ECG monitor applied
- G. Oxygen flow rate 6-10 LPM
- H. Add 2.5 mg of Albuterol to delivery set
- I. Place aerosol mask on patient or use hand held nebulizer, and instruct to inhale slowly and deeply through their mouth
- J. Have patient cough post treatment
- K. Re-evaluate breath sound and communicate findings to treating facility
- L. Nebulizer treatments last approximately 6-10 minutes

NOTE: Albuterol can be used for patients 6 years old and over in the above dose and treatment method (may be used for patients less than six years of age if ordered by the EMS Physician).

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

INTRAVENOUS MEDICATION ADMINISTRATION (ALS)

- I. Indications: Emergency situations where a fast rate of absorption is desired.
- II. Contraindications: None in emergency situation.
- III. Precautions:
 - A. Ensure the IV line is patent
 - B. Review the 5 R's
 - 1. right patient
 - 2. right medication
 - 3. right dosage
 - 4. right route
 - 5. right time - includes how fast the drug should be given
- IV. Complications
 - A. Local pain and burning
 - B. Allergic reaction
 - C. Infiltration if IV line not patent
- V. Equipment:
 - A. Medication
 - B. Appropriate size syringe and 19 gauge needle/prefilled syringe
 - C. Alcohol prep
- VI. Procedure Sequence:
 - A. Receives/requests order or operates under standing medical orders
 - B. Takes universal precautions.
 - C. Elicits patient allergies
 - D. Selects the correct medication and administration equipment.
 - E. Checks medication label for correct name, concentration, expiration date.
 - F. Inspects medication for discoloration, particles.

- G. Prepares correct dose.
 - 1. Assembles prefilled syringe, expels air.
 - 2. Draws up correct amount from ampule or vial.
- H. Cleanses injection port.
- I. Stops IV flow above injection port.
- J. Reaffirms correct medication, dose.
- K. Inserts needle into injection port, injects correct dose at appropriate rate.
- L. Opens and flushes IV line, readjusts IV flow rate.
- M. Disposes of needle in appropriate container. (Do not recap needle)
- N. Observes patient for medication effects and documents appropriately.
- O. Maintains aseptic technique throughout procedure.
- P. Document medication administration and changes in patient condition.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ENDOTRACHEAL MEDICATION ADMINISTRATION (ALS)

- I. Indications:
 - A. Fast rate of absorption is desired.
 - B. Unable to establish IV access.
 - C. Most often used in cardiac arrest.
 - D. Patient with endotracheal tube in place.
- II. Contraindications: None in emergency situation.
- III. Precautions:
 - A. Only specific drugs may be given this route
 - 1. Lidocaine
 - 2. Epinephrine
 - 3. Atropine
 - 4. Narcan
 - B. Usual dose via endotracheal tube is 2-2.5 times the usual dose diluted in 10 cc of saline.
- IV. Complications
 - A. Allergic reaction
 - B. Fluid overload
- V. Equipment:
 - A. Medication
 - B. Appropriate size syringe and 19 gauge needle to draw up the medication/saline
 - C. Saline for injection
- VI. Procedure Sequence:
 - A. Medication Order
 - 1. receives/requests order or operates under standing medical orders.
 - 2. confirms order
 - B. Takes universal precautions.

- C. Selects correct medication
- D. Checks label for correct name, concentration, expiration date.
- E. Inspects medication for discoloration, particles.
- F. Prepares correct amount of medication.
- G. Hyperventilates patient.
- H. Removes the ventilation device.
- I. Administers the medication down the endotracheal tube.
- J. Replaces the ventilation device and hyperventilates patient.
- K. Monitors the patient for desired effects.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PERCUTANEOUS TRANSTRACHEAL CATHETER VENTILATION (ALS)

- I. Indications:
 - A. A fully obstructed airway that cannot be cleared by mechanical measures.
 - B. Extensive maxillofacial or upper airway injury that makes ventilation with a bag valve mask or endotracheal intubation unfeasible.
- II. Contraindications:
 - A. Possibility of establishing a less invasive airway.
- III. Precautions:
 - A. Allow time for exhalation through the small lumen catheter.
- IV. Complications
 - A. Inadequate ventilation
 - B. Inadequate exhalation could result in hypercarbia and increased pressure in the lungs causing rupture of alveoli.
 - C. False passage
 - D. Bleeding
 - E. Laryngeal/vocal cord damage
 - F. Subcutaneous emphysema
- V. Equipment
 - A. 14 gauge 2-inch angiocath or larger
 - B. 10cc syringe
 - C. Alcohol or povidone-iodine pads
 - D. Dressing supplies
 - E. Device to deliver ventilations via the angiocath
- VI. Procedure Sequence:
 - A. Takes universal precautions.
 - B. Places the victim supine and hyperextends the head and neck; if spinal injuries are suspected, maintains the neck in a neutral position.
 - C. Locates the cricothyroid membrane and cleanses the site.

- D. Attaches a 14 gauge or larger with the needle catheter to the 10 cc syringe.
- E. Carefully inserts the needle and catheter in the midline through the skin and membrane and directs it downward and caudally at a 45° angle to the trachea.
- F. Maintains a negative pressure on the syringe as the needle and catheter are advanced.
- G. Once in the trachea, advances the catheter over the needle until the catheter hub rests on the skin.
- H. Holds the hub in place to prevent accidental displacement and removes the syringe and needle.
- I. Reconfirms the position of the catheter by aspirating freely with the syringe.
- J. Connects ventilatory equipment to the catheter hub and to the oxygen source.
- K. Ventilate.
- L. Watches the chest rise carefully.
- M. Allows exhalation to happen passively and as fully as possible.
- N. Ventilates the patient at a rate of 20 breaths per minute with an inflation time ratio of 1:2.
- O. Checks for adequacy of ventilation and fastens the hub securely to the skin.
- P. Continues ventilatory support.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

SYNCHRONIZED CARDIOVERSION (ALS)

- I. Indications:
 - A. Supraventricular or ventricular tachycardias resulting in decompensation of the patient.
 - 1. Heart rate greater than 150
 - 2. Symptomatic: cold, clammy, dyspnea, chest pain, hypotension
- II. Contraindications:
 - A. Pulseless rhythms
- III. Precautions:
 - A. Consider sedation for the conscious patient.
 - B. All rescuers/bystanders must be clear of the patient and stretcher prior to delivery of the shock.
 - C. Assure no flammable gases are in the area (*including oxygen*)
 - D. Assure sync button is engaged. *Note: reactivation of sync mode is required after each attempted cardioversion.*
- IV. Complications
 - A. Shock of rescuer or bystander
 - B. Burns
 - C. Explosion if flammable gases are present.
 - D. Conversion to undesirable cardiac rhythm
- V. Equipment
 - A. Cardiac monitor/defibrillator with sync capability
 - B. *Fast Patches*
 - C. Sedative and/or analgesic medication for conscious patient

VI. Procedure Sequence:

- A. Takes universal precautions
- B. Confirms physician order, if applicable
- C. Confirms dysrhythmia indicating synchronized cardioversion
- D. Sedates patient, if necessary
- E. Turns on monitor/defibrillator
- F. Assures synchronizer switch is in the “on” position
- G. *Apply Fast Patches*
- H. *Some defibrillators cannot deliver synchronized cardioversion unless the patient is also connected to monitor leads; in other defibrillators, ECG leads are incorporated into the defibrillation pads. Lead select switch may need to be on lead I, II, or III and not on paddles.*
- I. *Charge to appropriate setting*
 - Joullle Setting*
 - *For regular narrow-complex tachycardias, such as reentry SVT and atrial flutter, start with 50 J to 100 J. If initial dose fails, increase in stepwise fashion.*
 - *For irregular narrow-complex tachycardia consistent with atrial fibrillation, use 200 J initial monophasic shock, or 120 to 200 J initial biphasic shock, and then increase in stepwise fashion.*
- J. *Press charge button, clear the patient, and press both shock buttons simultaneously. Be prepared to perform CPR or defibrillation.*
- K. Assures the synchronizer is marking the “R” wave
- L. Instructs personnel to “clear” and clears self
- M. Assures no one is touching patient
- N. Re-verifies rhythm
- O. Presses and holds discharge button until shock is delivered
- P. Rechecks rhythm and patient for changes

If no changes noted, repeats procedure at appropriate joule setting

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PEDIATRIC INTUBATION (ALS)

- I. Indications:
 - A. Comatose patient with inadequate airway.
 - B. Respiratory or cardiopulmonary arrest
- II. Contraindications:
 - A. Patient with gag reflex
 - B. Patient with adequate ventilations
- III. Precautions:
 - A. Do not use the teeth as a fulcrum.
 - B. Do not delay ventilation for longer than 20 seconds.
 - C. If not successful after 3 attempts, maintain the airway and ventilate with 100% oxygen per pediatric bag valve mask.
 - D. Use uncuffed tube for children age 8 and under.
- IV. Complications
 - A. Damage to teeth, vocal cords, soft tissue
 - B. Esophageal intubation
 - C. Right mainstem bronchial intubation.
- V. Equipment
 - A. Appropriate size endotracheal tube
 - B. Laryngoscope
 - C. Laryngoscope blade - straight
 - D. Stylette
 - E. Tape or device to secure an E.T. tube.
 - F. Suction equipment
 - G. Bag valve mask

- H. Oxygen source
- I. Esophageal intubation detector
- J. Stethoscope
- K. Syringe for cuffed tube (over age 8)

VI. Procedure Sequence:

- A. Takes universal precautions
- B. Hyperventilates the patient with 100% oxygen.
- C. Assembles and checks the equipment.
- D. Pulls back on the plunger of the 10 cc syringe and attaches it to the one-way inflation valve (uses noncuffed tube inpatient younger than 8 years)
- E. If spinal injuries are not suspected, places the head in the sniffing position.
- F. Holds laryngoscope in the left hand, inserts it into the right side of the mouth
- G. Displaces the tongue to the left with a sweeping motion and brings the laryngoscope to the midline.
- H. advances the blade until it reaches the base of the tongue.
- I. Lifts the laryngoscope forward to displace the jaw without putting pressure on the front teeth.
- J. Suctions the hypopharynx as necessary.
- K. Looks for the tip of the epiglottis and places the blade into the proper position (curved blade into the vallecula, straight blade behind the epiglottis)
- L. Lifts the jaw at a 45° angle to the ground until the glottis is exposed.
- M. Has an assistant apply the Sellick maneuver to visualize the glottis.
- N. Grasps the tube with the right hand and advances it through the right corner of the patient's mouth.
- O. Advances the tube through the glottis opening until the distal cuff disappears past the vocal cords (if cuffed tube used).
- P. Removes the stylet, inflates the distal cuff with 10 cc of air and removes the syringe (if used).
- Q. Verifies proper placement by watching for chest rise, auscultating for breath sounds, watching for condensation in the tube on exhalation, and monitoring for color changes in an end-tidal CO₂ detector.

- R. Hyperventilates the patient with 100% oxygen.
- S. Secures the tube with tape or commercial device.
- T. Periodically rechecks tube placement.
- U. Do not withhold oxygen for > 30 seconds.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

INTRAOSSIOUS INFUSION

- I. Indications for the pediatric patient age 6 or less
 - A. Cardiac arrest
 - B. Multisystem trauma with associated shock
 - C. Unresponsive and in need of immediate drug or fluid resuscitation
 - D. IV access unable to be initiated in 3 attempts or 90 seconds
- II. Contraindications
 - A. Presence of a fracture in the pelvis or extremity proximal to the IO site chosen
- III. Potential Complications
 - A. Tibial fracture
 - B. Compartment syndrome
 - C. Skin necrosis
 - D. Osteomyelitis
- IV. Equipment
 - A. IV solution/tubing
 - B. Intraosseous needle
 - C. Alcohol or Povidine preps
 - D. Tape
 - E. 10 cc syringe filled with saline
- V. Procedure
 - A. Take universal precautions
 - B. Assemble and prepare all equipment
 - C. Grasp the thigh and knee above and lateral to the site to stabilize the tibia. DO NOT allow any portion of your hand to rest behind the site.
 - D. Locate the puncture site 1-3 cm distal to the tibial tuberosity and slightly medial.
 - E. Prep the site with alcohol or Povidine.

- F. Angle the needle slightly toward the foot.
- G. Insert the needle firmly through the skin, subcutaneous tissue , and periosteum of the bone with a twisting motion.
- H. Stop advancing the needle when a sudden decrease in resistance is felt.
- I. Withdraw the stylet (may need to unscrew cap).
- J. Slowly inject 10 cc of normal saline and observe for patency:
 - 1. free flow without signs of infiltration
 - 2. the needle can stand upright without support
- K. Attach IV tubing and set to desired rate.
- L. Secure the needle with tape.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM**PULSE OXIMETRY**

- I. Indications:
 - A. To evaluate oxygenation of patients
 - B. To alert the prehospital crew of deterioration of oxygen levels and hypoxia
- II. Precautions
 - A. May not give an accurate reading in the presence of carbon monoxide inhalation, shock, hypothermia, excessive movement, nail polish or artificial nails
 - B. To ensure a more accurate reading, correlate the heart rate on the oximeter to the patient's heart rate
 - C. Pulse oximetry should be used in conjunction with proper patient assessment
 - D. Nail polish should be removed prior to obtaining a reading
- III. Equipment
 - A. Pulse oximeter
 - B. Nail polish remover pads
- IV. Procedure
 - A. Remove nail polish if applicable
 - B. Ensure extremity to normal temperature
 - C. Apply pulse oximeter
 - D. Correlate heart rate on oximeter to patient
 - E. Note reading

NOTE: Do not make a decision to administer oxygen based on the pulse OX reading. Administer oxygen based on assessment, MOI, etc.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

FINGER STICK GLUCOSE

I. INDICATIONS

- A. Known diabetic with medical complaints
- B. Unconscious patient

II. CONTRAINDICATIONS

- A. None

III. PRECAUTIONS

- A. A finger stick glucose may not be accurate for readings of less than 40 or greater than 400.

IV. COMPLICATIONS

- A. Infection at finger stick site.

V. EQUIPMENT

- A. Blood glucose monitoring device
- B. Test strips which correlate to your device
- C. Alcohol preps
- D. 2X2 or 4X4 gauze pad
- E. Band-Aid

VI. PROCEDURE

- A. Will vary according to specific type of equipment used by each ambulance agency. (See Policy MP-7.2.1)

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

TWELVE LEAD EKG (ALS)

OBJECTIVE: The twelve lead EKG allows prehospital personnel to proceed beyond simple dysrhythmia recognition. It is designed to assist in the diagnosis of acute myocardial infarction, conduction abnormalities and other electrophysiological problems. It should be utilized for possible cardiac related complaints if the technology exists.

I. INDICATIONS

- A. Chest pain
- B. Syncope
- C. Dysrhythmia

II. POTENTIAL COMPLICATIONS

- A. Potential delay in treatment/transport if a good tracing is hard to obtain.

III. PRECAUTIONS/CONTRAINDICATIONS

- A. Cardiac Arrest
- B. Severely unstable patient unless advised by Medical Control

IV. EQUIPMENT

- A. Physio Control Lifepak 11 or 12 or other equipment capable of performing a 12 Lead EKG
- B. Electrodes
- C. Skin prep razor

V. PROCEDURE

- A. Explain the procedure to the patient
- B. Prep the skin
 - 1. Dirt, oil, and sweat can interfere with the tracing
 - 2. Wipe the skin dry, cleanse if needed
 - 3. You may abrade the skin slightly by rubbing briskly with a 4X4 gauze pad to help ensure adherence
 - 4. If the patient is very hairy, shave the area immediately over the electrode site. Use extreme caution to avoid nicks.
- C. Place the 4 limb leads on the limbs.
- D. Place the precordial leads
 - 1. V1 Right of the sternum, 4th intercostal space
 - 2. V2 Left of the sternum, 4th intercostal space
 - 3. V4 Left midclavicular line, 5th intercostal space

4. V3 Midway between V2 and V4
 5. V5 Anterior axillary line same level as V4
 6. V6 Mid axillary line same level as V4
-
- E. Turn on the machine
 - F. Enter data as appropriate to machine type
 - G. Observe for a clear tracing
 - H. Record the tracing
 - I. Provide the tracing to the treating hospital prior to patient's arrival at the ED if possible.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

NASOTRACHEAL INTUBATION

I. INDICATIONS

- A. Breathing patients requiring intubation due to airway compromise.
- B. Examples:
 - 1. Trauma with possible spinal cord injury
 - 2. Pulmonary edema/COPD
 - 3. Clenched jaw
 - 4. Fractured mandible

II. Contraindications

- A. Signs of basilar skull fracture
- B. Facial/nasal fractures/facial trauma
- C. Use caution in patients with deviated septum

III. Complications

- A. Trauma to the nasal mucosa and/or other airway structures with potential for bleeding.
- B. Esophageal intubation
- C. Intracranial tube placement in the patient with basilar skull fracture.

IV. Precautions

- A. This is a “blind” technique – the tube can be more easily misplaced.
- B. This technique is more time consuming than orotracheal intubation.
- C. This technique can be used only in patients that are breathing.
- D. A stylet should not be used due to increased risk of injury.
- E. When advancing the tube it may become hung up in the pyriform sinuses noted by a tenting of skin on either side of the trachea. Slightly withdraw the tube, rotate it to midline and again attempt gentle advancement.

V. Equipment

- A. Endotracheal tube
 1. Use an Endotrol tube or bend the tube into a circle while preparing the patient and equipment.
 2. Use a tube 1 mm smaller than the correct orotracheal size for the patient.
- B. 10 cc syringe
- C. Water soluble lubricant
- D. Tape/gauze to secure the tube

VI. Procedure

- A. Prepare equipment and patient
 1. Explain the procedure to the patient.
 2. Check all equipment, lubricate the tube.
 3. Oxygenate/hyperventilate for two minutes if possible.
- B. Select larger/clearer nostril for insertion.
- C. Stand or kneel to the side of the patient with the tube in one hand. Palpate the anterior neck in the area of the larynx with the other hand.
- D. Insert the tube into the nostril with the bevel toward the septum.
- E. Advance the tube gently.
- F. When maximal airflow is heard through the tube, gently and quickly advance it during the next inspiration.
- G. You should observe misting/condensation in the tube. The patient may cough or buck the tube.
- H. Inflate the cuff.
- I. Check the tube placement via auscultation of lung fields, auscultation over the epigastrium and EID.
- J. Secure the tube.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**ADMINISTRATION OF EPI-PEN FOR ANAPHYLACTIC REACTION
BLS TRANSPORT AND NON-TRANSPORT**

PURPOSE: To establish guidelines for the management of patients with an anaphylactic reaction. This policy should be used for BLS transport and BLS non-transport agencies that have been approved to carry adult and pediatric epi-pens.

I. Indications:

- A. The patient has a history of an allergic reaction or is now having an acute allergic reaction with some of the following symptoms:
 - 1. Flushing, itching or burning of the skin
 - 2. Urticaria (hives)
 - 3. Tightness in the chest
 - 4. Dry cough, wheezing
 - 5. Swelling of the face, neck, hands, feet, and/or tongue
 - 6. Dyspnea (difficulty breathing)

II. Contraindications

- A. Chest pain consistent with angina
- B. Blood pressure greater than 200 systolic

III. Side Effects:

- A. Tachycardia
- B. Dizziness, nausea, and vomiting
- C. Headache

IV. Procedure: NOTE: Assessment of the patient, high flow O₂, and monitoring the patient to achieve the desired effect should not be overlooked.

- A. Take body substance isolation precautions.
- B. Confirm the Epi-pen is required for patient (hypoperfusion, respiratory distress, stridor, wheezing, etc.)
- C. Call Medical Control with a patient report and receive authorization for use of the epi-pen.
- D. Check the medication for cloudiness, discoloration and expiration date.
- E. Remove safety cap and select the appropriate injection site (thigh)

- F. Push injector firmly against site in accordance with the guidelines of the manufacturer instructions.
- G. Properly discard auto injector.
- H. Document time, medication and dosage, site and patient's response.
- I. Begin transport.
NOTE: There should be an ALS intercept anytime the BLS unit uses the epi-pen.
- V. Dosage:
 - A. Adult Epi-pen dosage is 0.3 mg
 - B. Pediatric Epi-pen dosage is 0.15 mg. (Pediatric patient is 60 pounds or less)
- VI. An Epi-pen Auto Injector Quality Improvement Form (AP-24-F) must be completed and sent to EMS Office each time Epi-pen is used.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

EZ IO™ Intraosseous Infusion

PURPOSE: Provides an alternative means to gain rapid vascular access in the cardiac arrest patient.

- I. Indications: Adult 40 kg or greater (over 88 lbs) in cardiac arrest
 - A. EZ IO™ may be considered PRIOR to peripheral IV attempts for cardiac arrest (medical or trauma)
- II. Contraindications
 - A. Fracture of the tibia or femur (consider alternate tibia)
 - B. Previous orthopedic procedures (IO within 24 hours, knee replacement)
 - C. Pre-existing medical condition (tumor near site, peripheral vascular disease)
 - D. Infection at insertion site (consider alternate site)
 - E. Inability to locate landmarks (significant edema)
 - F. Excessive tissue at insertion sites (obesity)
- III. Considerations:
 - A. Flow rates: Due to the anatomy of the IO space you will note flow rates to be slower than those achieved with IV catheters:
 - 1. Flush with 10 ml rapid bolus by syringe prior to connecting IV tubing
 - 2. Use a pressure bag for continuous infusions
- IV. Equipment
 - A. EZ IO™ Driver
 - B. EZ IO™ Needle set
 - C. EZ IO™ connect extension set primed
 - D. Alcohol or Betadine Swab
 - E. IV fluid and primed IV tubing
 - F. 10 ml syringe
 - G. Tape or Gauze
 - H. Pressure Bag

V. Procedure:

- A. Wear approved PPE (gloves; consider eye protection)
- B. Rule out contraindications
- C. Locate the insertion site (Proximal tibia) & cleanse site with alcohol or Betadine
- D. Stabilize the leg with opposite hand near the insertion site
- E. Position the driver at the insertion site with the needle at a 90 degree angle to the bone surface
- F. Insert the needle through the skin at the insertion site until the needle tip encounters the bone
- G. Verify the 5mm marking on the catheter itself. If this mark is not visible, abandon the procedure.
- H. Continue to insert the EZ IO™ applying light and steady pressure on the driver and powering through the cortex of the bone ensuring the driver remains at a 90 degree angle at all times
- I. Stop when the needle flange touches the skin or a sudden decrease in resistance is felt
- J. Stabilize the needle set by holding it in position. Gently and slowly remove the driver by pulling it directly up & off. Do **NOT** rock, twist or turn the driver
- K. Unscrew the stylet counter-clockwise from the catheter. Remove the stylet while stabilizing hub and place in Sharps container
- L. Attach primed extension set with 10 mL syringe attached & flush with 10 mL sterile water or saline. Do **NOT** directly attach the syringe to the EZ IO™ catheter
- M. Verify placement by any or all of the following:
 - 1. The catheter is firmly seated and does not move
 - 2. Blood is noted at the catheter hub when stylet is removed or able to aspirate a small amount of blood or bone marrow from the catheter
 - 3. Drugs or fluids flow without difficulty
- N. Connect IV tubing to extension set, apply a pressure bag and adjust to desired flow rate
- O. Apply dressing
- P. Monitor EZ IO™ site and patient condition and document procedure
- Q. Ensure the hospital is aware of EZ IO™ placement through verbal report and patient ID bracelet.

VI. Specialized Training:

- A. All staff must complete a training program which includes:
 - 1. PowerPoint presentation or video
 - 2. Demonstration by trainer
 - 3. Demonstrate knowledge and skill through skill validation
 - 4. Complete quiz with score of 85% or greater.

VII. References:

- A. EZ IO™ by Vidacare training program
- B. www.vidacare.com
- C. Paramedic Care Principles and Practice, Volume I, 3rd Edition. Bledsoe, Porter and Cherry 2009.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

Ventilator Management: CPAP (Continuous Positive Airway Pressure)

PURPOSE: Continuous Positive Airway Pressure (CPAP) and Continuous Positive Airway Pressure (CPAP) has been shown to rapidly improve vital signs, gas exchange, reduce the work of breathing, decrease the sense of dyspnea, and decrease the need for endotracheal intubation in patients who suffer from shortness of breath from asthma, COPD, pulmonary edema, CO poisoning, near drowning, CHF, and pneumonia. In patients with CHF, CPAP improves hemodynamics by reducing left ventricular preload and afterload.

- I. Indications: Any patient who is in respiratory distress with signs and symptoms consistent with asthma, COPD, pulmonary edema, CHF, or pneumonia **and** who is:
 - A. Awake and able to follow commands
 - B. Is over 12 years old and is able to fit the CPAP mask
 - C. Has the ability to maintain an open airway
 - D. **AND** exhibits two or more of the following:
 1. A respiratory rate greater than 25 breaths per minute
 2. SPO2 of less than 94% at any time
 3. Use of accessory muscles during respirations
- II. Contraindications
 - A. Patient is in respiratory arrest/apneic
 - B. Patient is suspected of having a pneumothorax or has suffered trauma to the chest
 - C. Patient has a tracheostomy
 - D. Patient is actively vomiting or has upper GI bleeding
 - E. Patient has decreased cardiac output, obtundation and questionable ability to protect airway, (e.g., stroke, obtundation, etc.) penetrating chest trauma, gastric distention, severe facial injury, uncontrolled vomiting and hypotension , (90 systolic minimum) secondary to hypovolemia.
- III. Precautions:

Use care if patient:

 - A. Has impaired mental status and is not able to cooperate with the procedure
 - B. Had failed at past attempts at noninvasive ventilation
 - C. Has active upper GI bleeding or history of recent gastric surgery
 - D. Complains of nausea or vomiting
 - F. Has excessive secretions
 - G. Has a facial deformity that would prevent an adequate mask seal

IV. Procedure

A. Steps of the Procedure:

1. Ensure adequate oxygen supply to ventilation device
2. Continuous pulse oximetry (ETC02 can and should be used with CPAP)
3. Ensure the patient is maintained on the cardiac monitor and record rhythm strips with vital signs
4. Place the delivery device over the mouth and nose
5. Secure the mask with provided straps or other provided devices. Be sure to select a sealing face mask and ensure that the mask fits comfortably, seals the bridge of the nose, and fully covers the nose and mouth.
6. Explaining the procedure to patient:
 - a) Patient requires “verbal sedation” to be used effectively. Example: “you are going to feel some pressure from the mask, but this will help you breathe easier.”
 - b) Place delivery device over the mouth and nose, and set oxygen flow at maximum. Ask the patient to hold the mask in place.
 - c) Instruct patient to breathe through his/her nose slowly, and exhale through their mouth as long as possible. It is better not to strap the mask in place but to continue to have the patient hold the mask in place (with your help). This makes it easier to recognize if the patient is tiring, or if the patient’s level of consciousness is decreasing. Secure straps once patient is comfortable with the CPAP.
7. Start at 5cmH20 pressure and progressively increase pressure by 2-3cmH20 every 5 minutes to a max of 10cmH20 pressure. Typically there is better tolerance with gradual progression of pressure.
8. Check for air leaks.
9. Monitor and document the patient’s response to treatment
10. Check and document vital signs every 5 minutes
11. Administer appropriate medications per protocol as necessary
12. Continue to coach patient to keep mask in place and readjust as needed
13. If respiratory status deteriorates, remove device and consider intermittent positive pressure ventilation via BVM and/or definitive airway management.
14. Notify receiving hospital that patient has been placed on CPAP.

V. Removal Procedure

- A. CPAP therapy needs to be continuous and should not be removed unless the patient cannot tolerate the mask, experiences respiratory arrest or begins to vomit.
- B. Intermittent positive pressure ventilation with a Bag-Valve-Mask, placement of a non-visualized airway and/or endotracheal intubation would be considered if the patient is removed from CPAP therapy.

VI. Special Notes:

- A. Do not remove CPAP until hospital therapy is ready to be placed on patient.
- B. Watch patient for gastric distention that can result in vomiting.
- C. Due to changes in preload and afterload of the heart during CPAP therapy, a complete set of vitals must be obtained every 5 minutes.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

TOURNIQUET APPLICATION

Use of tourniquets does not require on-line medical direction; however, there may be situations in which medical direction consultation is advised. The goal of tourniquet application is to control hemorrhage. Overall morbidity and mortality, however, is affected by multiple factors related to type of device, application technique, and duration of application. Fortunately, civilian extremity exsanguination is exceedingly rare.

I. Indications:


- A. To control potentially fatal hemorrhage from wounds or traumatic amputations when significant extremity bleeding cannot be stopped using simpler methods.
- B. Tourniquet may also be indicated in tactical or safety situations, those involving prolonged extrication, remote locations, and multiple casualties.
- C. Tourniquets may be considered when treating patients who have had prolonged compression of an entrapped extremity in order to decrease the life-threatening release of potassium and acids from the ischemic limb.


II. Contraindications

- A. Venous, bony and small vessel bleeding
- B. Tourniquet application is generally unnecessary when wound bleeding is adequately controlled using direct pressure, pressure dressings, elevation, or any other simpler method.
- C. Non-extremity hemorrhage

III. Procedure

- A. Various sizes of blood pressure cuffs are preferred over improvised or manufactured devices
- B. Apply device approximately 3 inches proximal to wound. If the wound is on a joint, or just distal to the joint, apply the tourniquet above the joint
- C. Tighten until bleeding stops (venous oozing is acceptable) and/or distal pulse is absent.
- D. If one tourniquet is not sufficient a second should be applied just proximal to the first.
- E. Do not cover the tourniquet with a dressing.
- F. Once a tourniquet has been applied, do not remove or loosen it unless ordered by medical direction.
- G. Note time of tourniquet application and communicate this to the receiving care providers.
- H. Dress wounds per general wound care procedure
- I. Document application time, location, and patient response on the Patient Care report Form (PCR)


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QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

LESS THAN LETHAL WEAPONS PROTOCOL

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

- Bean Bag guns
- Teargas / Oleoresin Capsicum (Pepper-spray) Exposure
- Tasers

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

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

I. Teargas / Oleoresin Capsicum (Pepper-spray) Exposure

BLS CARE

- A. EMS Providers care should be focused on assessing the airway and breathing
- B. Render initial care in accordance with the Routine Patient Care
- C. Oxygen: for agitation, shortness of breath or chest pain: 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask.
- D. Flush eyes (if affected) with sterile water to get rid of gross contamination and to aid in recovery.
- E. Access for any secondary causes of patient behavior which lead to law enforcement subduing the patient. These secondary causes include:
 - 1. Alcohol intoxication
 - 2. Drug abuse
 - 3. Hypoglycemia or other medical disorder
 - 4. Psychotic disorder
- F. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. Contact Medical Control for ALL refusal issues.
- G. Initiate ALS intercept if needed and transport as soon as possible.
- H. Contact receiving hospital as soon as possible or Medical Control if necessary.

II. Teargas / Oleoresin Capsicum (Pepper-spray) Exposure

ALS CARE

- A. ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.
- B. ALS Care includes all components of BLS Care
- C. Restrain the patient if needed and contact Medical Control.
- D. Proventil (Albuterol): 2.5 mg in 3mL normal saline 0.5 mg via nebulizer over 15 minutes if the patient is short of breath and wheezing. Repeat Albuterol 2.5mg every 15 minutes as needed.
- E. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. Contact Medical Control for ALL refusal issues.
- F. Initiate transport as soon as possible and contact Medical control if needed.

III. Taser-Related Injuries

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

BLS Care

- A. EMS Providers care should be focused on assessing the airway, breathing and circulation
- B. Oxygen: for agitation, shortness of breath or chest pain: 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask.
- C. Ask law enforcement to remove taser probes. EMS personnel are not to remove the probes. NOTE: If the probes are in a sensitive area such as the face, eye, neck, genitalia, or a female's breast, leave the probes in place and bandage. Transport to the appropriate facility.
- D. Conduct thorough patient assessment and prepare the patient for or provide transport.
- E. Assess for any secondary causes of patient behavior which lead to law enforcement subduing the patient. These secondary causes include.
 - 1. Alcohol intoxication
 - 2. Drug abuse
 - 3. Hypoglycemia or other medical disorder
 - 4. Psychotic disorder
- F. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. Contact Medical Control for ALL refusal issues
- G. Initiate ALS intercept if needed and transport as soon as possible.
- H. Contact receiving hospital as soon as possible or Medical Control if necessary.

ALS Care

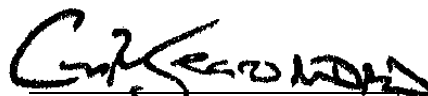
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- B. ALS Care includes all components of BLS Care
- C. Restrain the patient if needed and contact Medical Control.
- D. Proventil (Albuterol): 2.5 mg in 3mL normal saline 0.5 mg via nebulizer over 15 minutes if the patient is short of breath and wheezing. Repeat Albuterol 2.5mg every 15 minutes as needed.
- E. If the patient has an altered mental status, then the patient must be assumed incompetent to refuse care. Contact Medical Control for ALL refusal issues.
- F. Initiate transport as soon as possible and contact Medical control if needed.

Critical Thinking Elements

- If law enforcement has removed the probes, treat the probes as biohazards. Exercise caution to prevent accidental needlestick-like injuries.
- Ask law enforcement to eject the cartridge from the taser prior to patient contact.
- Patients who have been subdued using “less than lethal” weapons are commonly agitated and may be combative. If the patient is not yet subdued and/or is violent, do not initiate contact. Safety of the EMS crew is of utmost importance.
- Many of these patients fit into a syndrome known as “excited delirium” that has been associated with adverse medical outcomes, including SUDDEN DEATH, especially when restraints are utilized. Careful monitoring should be exercised when dealing with these patients.



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QUINCY AREA EMS SYSTEM

COMMUNICATIONS

Central Medical Dispatching Pattern	C-1
EMD Dispatch Cards for Dual Response	Appendix C(a)
EMD Dispatch Cards for Automatic Helicopter Launch	Appendix C(b)
Dispatch Protocol for Incoming Ambulances Needing ALS Assistance	C-2
Recorded Phone Line	C-3
Radio Protocol	C-4
Radio Transmission	C-5
Routine Transfer Radio Protocol	C-6
Radio and Time Checks	C-7
Emergency Communications Tapes and Record Keeping	C-8
Emergency Department Radio Log	C-9
Emergency Department Radio Log Form	C-9-F
Estimated Time of Arrival	C-10
Emergency Medical Dispatch	C-11

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

CENTRAL MEDICAL DISPATCHING PATTERN

I. General Information

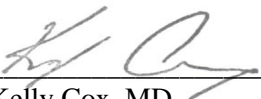
- A. All responding units and First Responders will be dispatched according to patient need so as to provide the most appropriate level of care in the most efficient manner.
- B. Ambulances will be dispatched to all calls within their response area.
- C. If a unit is out of service, dispatch should be notified at the time that the unit goes out of service so that in the event of a call, the closest appropriate unit will be dispatched. When unit is back in service. Dispatch should be notified.

II. Dual Response

- A. Goal: The overall goal of dual response is to provide advanced life support to those patients needing advanced level care in a timely, efficient manner. Both ALS and BLS providers share the common goal of improving the quality of care.
- B. ALS should be dispatched simultaneously with the closest BLS ambulance, if utilized, for emergencies meeting the following criteria for dual response:
 - 1. The call has been identified as appropriate for dual response on the EMS dispatch cards as determined by the EMS Medical Director. (See Appendix C(a))
 - 2. If an ALS ambulance (ground or air) is not in Dispatch's normal dispatch criteria and an ambulance is requested from outside their normal dispatch area, the dispatch agency will make every effort to contact that service for Dispatch.
- C. Cancellation of Dual Response
 - 1. The *FR/BLS* unit may cancel responding dual response by calling in a full patient report to Medical Control, including ETA to receiving facility and requesting that ALS be canceled.
- D. ALS Assist
 - 1. The BLS crew may request ALS be dispatched to their location or to intercept with them on calls not included in the above criteria if in their judgment the patient/situation would benefit from ALS support *by contacting the local dispatch agency.*

III. Helicopter Dispatch Criteria

- A. Goal: To reduce by as much time as possible that period required for a helicopter to arrive at the scene of a patient when that patient would benefit by the decreased out-of-hospital time that a helicopter would provide.
- B. Automatic Launch Criteria: the helicopter will be dispatched simultaneously with the appropriate ambulance(s) when the call meets both of the following criteria:
 - 1. The call is identified as appropriate for helicopter response on the EMD dispatch cards as determined by the EMS Medical Director. (See Appendix C(b))
 - 2. The call location is outside the circled Quincy area on the map. (Adams County dispatch agency will be provided with a map indicating this area.)
- C. Ground Crew Launch Request: The responding ground crew may contact dispatch to request launch of the helicopter on calls not included in the above criteria, but that in their judgment might benefit from the shorter out-of-hospital time provided by the helicopter.
- D. *The FR/BLS/ALS unit may cancel the aircraft by calling in a full patient report to Medical Control, including ETA to receiving facility and requesting that the helicopter be cancelled.*



Kelly Cox, MD
EMS Medical Director

re: 6/87, 8/89, 6/91, 8/91, 2/95, 11/97, 4/98, 1/01, 10/02, 01/06, 9/08, 1/09
reviewed 8/12

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE****EMD DISPATCH CARDS FOR DUAL RESPONSE**

1. Allergic Reaction/Hives/Medication Reaction/Stings
 - Difficulty breathing/respiratory distress/not alert
2. Back pain
 - Not alert
3. Breathing Problems
 - Difficulty breathing/respiratory distress/not alert/changing color
4. Burns/Explosion
 - Multiple victims/difficulty breathing/not alert
5. Carbon monoxide/Inhalation/Hazardous Materials
 - Multiple victims/Difficulty breathing/Not alert/Hazardous materials
6. Cardiac/Respiratory Arrest
 - Suspected or obvious
7. Chest pain
 - Abnormal breathing/Not alert/Changing color
8. Choking
 - Abnormal breathing/Not alert
9. Convulsions/Seizures
 - Continuous/Not breathing/Associated with pregnancy, trauma, diabetic or cardiac
10. Diabetic
 - Not alert/Abnormal breathing
11. Drowning
 - Abnormal breathing/Not alert/Neck injury/Diving or scuba
12. Electrocution
 - Not alert/Associated with long fall/abnormal breathing
13. Falls/Back injury
 - Not alert/Dangerous injury/Long fall/Abnormal breathing
14. Headache
 - Not alert/Speech problems/Paralysis or numbness/Abnormal breathing
15. Heart problem
 - Not alert/Cardiac history/Firing of implanted defibrillator
16. Hemorrhage/Laceration
 - Dangerous bleeding/Not alert/Respiratory distress
17. Industrial/Machinery
 - Multiple victims/Entrapped
18. Overdose/Ingestion/Poisoning
 - Not alert/Abnormal breathing/Ingested antidepressants/cocaine/lye or alkali substances
19. Psychiatric/Suicide attempt
 - Not alert/Hanging/Strangulation/Suffocation
20. Sick person
 - Not alert
21. Stab/Gunshot wound
 - Multiple victims/Not alert/Central wounds/Multiple wounds

- 22. Stroke
 - Not alert/Abnormal breathing
- 23. Traffic accidents
 - Multiple victims/Entrapped/Ejected/Severe respiratory distress/Not alert
- 24. Traumatic injuries
 - Dangerous injury/Severe hemorrhage/Not alert
- 25. Unconscious/fainting
 - Not alert/Severe respiratory distress
- 26. Unknown Problem (Man down)
 - Life status questionable
- 27. *Any additional situations as determined by the EMS Dispatch Cards/Program as determined by the EMS Medical Director.*



Kelly Cox, MD
EMS Medical Director


1/01
Reviewed: 1/06; 9/08
Revised 8/12

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMD DISPATCH CARDS FOR AUTOMATIC HELICOPTER LAUNCH

NOTE: Dispatch agency will contact closest available aircraft.

1. Burns/Explosions
 - Difficulty breathing/respiratory distress/large burn/Multiple victims
2. Drowning/Diving
 - Unconscious/Not breathing/Underwater/Abnormal breathing/Not alert/Suspected neck injury/Diving or scuba accident
3. Electrocution
 - Abnormal breathing/Not breathing/Not alert/Long fall/Life status questionable
4. Falls/Back Injuries
 - Abnormal breathing/Not alert/Serious hemorrhage/Long fall
5. Hemorrhage/Lacerations
 - Dangerous hemorrhage/Not alert/Severe respiratory distress
6. Industrial/Machinery
 - Multiple victims/Entrapped/Life status questionable
7. Stab/Gunshot wound
 - Not alert/Multiple wounds/Central wound/Multiple victims
8. Traffic Accidents
 - Multiple victims/Trapped/Ejected/Not alert/Severe respiratory distress
9. Traumatic Injuries
 - Dangerous injuries/Not alert/Severe respiratory distress
10. *Any additional situations as determined by the EMS Dispatch Cards/Program as determined by the EMS Medical Director.*



Kelly Cox, MD
EMS Medical Director

1/01; re: 1/09; 8/12
Reviewed: 1/06; 9/08

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DISPATCH PROTOCOL FOR INCOMING AMBULANCES NEEDING ALS ASSISTANCE

- I. At times, ambulances enroute to Quincy Area EMS System hospitals are in need of advanced life support assistance (*Ground or Air*).
 - A. ALS unit should be dispatched by the receiving hospital when:
 - 1. the transporting ambulance requests assistance
 - OR
 - 2. after receiving the patient assessment from the BLS unit, the receiving hospital determines it to be in the best interests of the patient to send ALS assistance.
 - B. Prior to dispatching ALS *or Air* assistance, the receiving hospital should weigh the benefits of the ALS assistance to the patient against the ETA to the hospital and subsequent delay in transport that would occur.
 - C. The ETA should be greater than 15 minutes.
 - D. Blessing Hospital will notify the local dispatch agency to arrange for dispatch. If out of Adams County, Adams County 911 Center will contact the appropriate dispatch agency.
 - 1. It is the policy of the Adams County Ambulance Service to limit their response into Missouri to the 24/61 interchange at Taylor, Missouri. This limit may be exceeded upon order of the EMS physician at Medical Control



Kelly Cox, M.D. EMS Medical Director

6/84
(reviewed 8/01, 1/06)
re: 7/86, 7/88, 5/91, 8/91, 8/95, 11/97. 9/99, 9/08, 8/12

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS RECORDED PHONE LINE

- I. When EMS phone rings and EMS providers are going to give patient report, the ECRN should:
 - A. Pick up receiver to answer.
 - B. Complete green radio log as report is given.
 - C. Document any orders from medical control on the radio log and time order given.
- II. In order for the physician to monitor the report, the speaker function can be used.
- III. All inbound radio reports will be recorded.



Kelly Cox, M.D., EMS Medical Director

6/84
revised: 8/95, 11/97, 8/01, 1/06, 9/08
(reviewed 8/12)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RADIO PROTOCOL

OBJECTIVE: * To comply with the Federal Communication Commission
 * To eliminate radio traffic on MERCI radio

I. All radio communications should be as brief and concise as possible. Eliminate unnecessary words.

II. There are only five 10 signals that shall be used for medical communications to the hospital:

10-33	Run Emergent (HOT)
10-40	Run Non-Emergent (COLD)
10-56	Intoxicated
10-79	Dead body
10-96	Psychiatric patient

These were included for use when the patient's family is in close proximity and a verbal description would not be appropriate. With the exception of these five, all other communications should be verbal messages that are clearly understood by everyone.

III. The following patient information shall be relayed to the contact hospital on all patients:

- A. patient assessment
- B. patient history
- C. vital signs
- D. treatment provided prior to contact
- E. ETA

From the above information, it will be the hospital's responsibility to determine the treatment and disposition of the patient.

IV. The name of the patient will not be transmitted via radio or during cell phone reports.



Kelly Cox, M.D., EMS Medical Director

6/84
re: 7/86, 11/97, 4/98, 8/01, 4/04, 11/06, 9/08
(reviewed: 8/95, 1/06, 8/12)

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

RADIO TRANSMISSION

POLICY:

All EMS physicians, ECRN's, EMT's at all levels, *First Responders*, RN's, and Prehospital RN's shall be capable of properly operating their respective communications equipment.

PROCEDURE:

- I. All voice radio transmissions will be limited to pertinent medical information only.
- II. All units will identify themselves at initiation and termination of the communication.
- III. The following are approved methods of establishing contact
 - A. VHF 155.340 (MERCİ)
 - B. Dedicated telephone line: Blessing Hospital (217) 224-7743
Illini Hospital (217) 285-6038
- IV. Transmission of EKG

Rhythm strip or 12 Lead EKG may be transmitted to the dedicated fax machine *or via internet*.
Blessing Hospital (217) 223-9780
Illini Hospital (217) 285-6035
Lifenet
ZOLL Rescue-Net
- V. Before terminating communications with Medical Control, prehospital personnel must notify Medical Control of a method by which they can be re-contacted.
 - A. MERCİ
 - B. Cell phone number (a current list of cell phone numbers will be kept near the radios at each hospital in the System)
- VI. In the event of communication failure, the crew will operate under system standing medical orders.

A copy of the system SMO shall be kept in each response vehicle.



Kelly Cox, M.D., EMS Medical Director

6/84
re: 7/86, 8/95, 11/97, 5/98, 8/01, 4/04, 1/06, 8/12
Reviewed 9/08

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ROUTINE TRANSFER RADIO PROTOCOL

On patients who are routine transfers (direct admits and/or "coach calls") into the hospital, the emergency department MUST be notified on the radio prior to arrival.

At the time of communication with the emergency department personnel, the following information MUST be relayed:

- I. Routine Transfer - Direct Admit - and/or "Invalid Coach Call"
 - A. Why patient being transferred - (example: illness if known, lab work, nuclear medicine, return from Blessing at 14th).
 - B. Patient's physician
 - C. Room number if in-hospital patient
 - D. ETA

After the above information is transmitted, it is the emergency department personnel's responsibility to acknowledge the communication

II. Direct Admit Warranting ALS Procedures:

If a patient is a direct admit and upon the paramedic arrival the paramedic feels the patient is in need of ALS, the procedure is as follows:

- A. Treat appropriately
- B. Transmit patient assessment.
- C. Request orders as needed.

NOTE: Any time the crew transporting the patient believes the patient should be evaluated by the emergency department physician, crew member will notify ED and the ED will notify the original receiving department if required.



Kelly Cox, M.D., EMS Medical Director

6/84; re 7/86, 8/95, 11/97, 4/98, 9/08, 8/12
(reviewed 8/01, 1/06)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RADIO AND TIME CHECKS

I. Purpose: to ensure that communications equipment is functional and that redundant measures are in place should one aspect of the communications system be non-functional.

- I. EMS provider agency daily communications equipment checks
 - A. Each agency will conduct daily communications equipment checks of existing communications equipment. For EMS purposes, this should at a minimum include a test of MERCI radio.
 - B. Each agency will maintain a daily log of the test and keep the log on file at the agency and be available upon request.
 - C. Any equipment malfunctions should be reported to agency supervisory personnel and an event report sent to Blessing EMS Dept. for follow-up
- II. Hospital radio / time checks
 - A. Each hospital in the Quincy Area EMS System will conduct daily checks of MERCI radio by contacting the dispatch agency in their area. For hospitals providing Medical Control, the clock used for Medical Control times should also be synchronized with dispatch.
 - B. Each hospital will maintain a daily log of the test and keep the log on file at the hospital.
 - C. Any equipment malfunctions should be reported to the appropriate department at the hospital for repair and an event report sent to Blessing EMS Dept. for follow-up.



Kelly Cox, M.D., EMS Medical Director

6/84, re: 7/86, 1/91, 4/91, 11/97, 8/01, 4/05, 1/06
(reviewed 8/95, 9/08, 8/12)

**QUINCY AREA EMS SYSTEM
EMERGENCY DEPARTMENT**

DAILY MERCI RADIO CHECK LOG

Month/Year: _____

DAY	Mark with "X" if Performed:					Charge Nurse/ ECRN Signature
	Radio Check?	Radio Clock set with Dispatch?	Computer Clock match Radio Clock?	Computer Clock match ECG Machine?	Reports completed on IDPH website?	
1.						
2.						
3.						
4.						
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30.						
31.						

Blessing Hospital: At the end of each month forward to Blessing EMS Department through interdepartmental mail.

Other QAEMS System Hospitals: Maintain this or other record used for daily MERCI radio/time checks in your own files. Must be able to produce the record for IDPH EMS site surveys.

04/05, Revised: 08/08
Reviewed: 01/06, 8/12

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMERGENCY COMMUNICATIONS TAPES AND RECORD KEEPING

- I. Ambulance calls to the Resource Hospital or Associate Hospital via Merci, or the dedicated EMS phone line are recorded utilizing the digital voice logger recording system.
- II. Special Considerations:
 - A. The ER Radio Log will be completed for each ambulance run.
 - B. The digital recording will be retained by the Resource Hospital or Associate Hospital for a minimum of three (3) years.



Kelly Cox, M.D., EMS Medical Director

6/84 re: 10/86, 11/90, 11/97, 5/98, 8/01, 1/06
(reviewed: 8/95, 9/08, 8/12)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMERGENCY DEPARTMENT RADIO LOG

The Emergency Department Radio Log is to be used for all radio calls coming into the Emergency Department and should be completed by the ECRN or EMS Physician answering the radio.

I. Ambulance:

Write the call numbers of the ambulance responding.

II. Date:

The date when the call was received.

III. Time Called In:

Using the 24-hour clock, designate the time the call was received.

IV. Form #

The number comes from the Prehospital Care Report. *(May not be available if service is using electronic PCR form).*

V. MERCI/PHONE

Indicate is report received via MERCI radio or dedicated phone line (circle).

VI. Age:

Known age or estimated age of patient.

VII. Sex:

Circle M (male) or F (female)

VIII. Pvt. MD:

Patient's personal physician.

IX. ETA:

The estimated time of arrival to the receiving hospital should be noted here.

X. Complaint:

MOI, nature of illness including patient's chief complaint or if the patient is unconscious, a brief statement by the paramedic relaying the main problem.

NOTE: Mark the appropriate box if an Alert/Activation was advised (STEMI, Stroke, Hypothermia, trauma)

XI. Medical History:

Pertinent past medical history.

XII. Medications:

Medications the patient is currently taking.

XIII. Allergies:

Any known allergies of the patient.

XIV. Initial Patient Assessment:

This area is used for the initial patient assessment relayed to the hospital by the prehospital personnel to assist the contact hospital in treatment rendered to the patient. Further patient assessment should be recorded in the area designated below, under PATIENT'S SIGNS AND SYMPTOMS.

Using a check system, record:

- A. Skin Condition: WNL, dry, cool, moist, pale, cyanotic or other specification.
- B. Pain: Record pain on 1-10 scale. (If patient unable, may use mild, moderate or severe.)
- C. Bleeding: None, minor, moderate or severe bleeding noted.
- D. Abdomen: Soft, distended, tender or rigid (firm).
- E. AVPU Scale: Alert, opens eyes to voice, opens eyes to pain or unresponsive to stimuli.
- F. Mentation: Oriented to person/place/time, disoriented, combative or slow to respond.
- G. Chest Sounds: Left/Right fields are clear, diminished, rales, rhonchi, wheezes or absent.
- H. Pulses: Pulses are present, quality, regular, irregular, weak, bounding.
- I. Pupils: The initial condition of the patient's pupils, (equality, reaction to light).

XV. Vital Signs:

- A. When vital signs are radioed in, they should be recorded along with the time.
- B. Blood pressure, pulse, respiration.
- C. SpO2: reading should be recorded. If patient is not on O2, circle RA for room air. If patient is currently on oxygen, circle O2.

XVI. Interventions

Using a check system, indicate which interventions were performed including successful and unsuccessful interventions (i.e. airway, intravenous access).

XVII. EKG Rhythm:

- A. Initial EKG rhythm of the patient.
NSR, Sinus Tach, Sinus Brady, Paced, A. Fib, PVCs, 1, 2 or 3rd degree block.
- B. 12 lead EKG
 - 1. Check if 12 lead received in ER.
 - 2. Record name of physician who reviewed 12 lead.
 - 3. Attach 12-lead/EKG strip to back of radio log.
- C. Code Blue: Initial heart rhythm of V.Fib, V. Tach, Asystole, PEA or other (list).

XVIII. Time - Patient's Signs and Symptoms - Time Ordered - Treatments Ordered - Time Administered:

- A. Any changes in the patient's status should be recorded along with the time.
- B. Treatments, medications, and IV's ordered should be noted along with the times that they were ordered.
- C. When a treatment, medication, or an IV has been administered by the paramedic, they are to radio back that the order was carried out. The time should be noted on the radio log.
 - If morphine given by pre-hospital personnel according to system protocol, enter amount and time administered on the line provided. (No time for ordered should be entered.)
 - If morphine is ordered per Emergency Department physician, enter time ordered and amount ordered on line provided.
- D. On all orders given over the radio, the order must be repeated back to the ECRN or EMS physician by the paramedic before being carried out. The time should be noted on the radio log.
- E. When Basic Life Support measures have been administered by either EMT's or paramedics (i.e. oxygen, splints, dressings, etc.) this information should be relayed via radio to the ECRN or EMS physician and noted on the radio log.

XIX. Refusal Accepted Per ERP

If an oriented adult (or emancipated minor) states they do not wish to be treated or transported to the hospital, the pre-hospital crew should call in a patient report, including vitals, and advise medical control of the patient's wishes not to be treated. This information must be given to the emergency department physician, who will either accept the patient's request to refuse treatment or advise crew of the patient's need to be seen by a physician.

XX. Destination:

The hospital where the patient is being taken should be indicated.

XXI. Disposition

Mark if patient was declared a trauma in field and time, refusal was accepted by ERP and/or patient was diverted to another facility (record facility name in blank).

XXII. ECRN Signature:

The ECRN who recorded the patient report should sign the radio log.

XXIII. ED Physician Name/Signature:

Record the name of the Emergency Department Physician who was given the patient report and/or issued orders for medications/interventions (*including refusals*) or change in patient destination.

The physician signs the RADIO LOG on the line provided.

XXIV. Ambulance Diverted to:

List the name of facility if patient was diverted from original destination.

XXV. Review Requested:

If a pre-hospital chart audit is requested for any reason, mark this box and follow the instructions listed on the back of the radio report for REVIEW REQUESTED.

XXVI. Trend Reporting:

Any ambulance calls indicating a trend of illness or similar complaints shall be reported to medical control and EMS. (Instructions for reporting are listed on back of radio report log.)

XXVII. Attachment of EKG/12 LEAD

The EKG or 12 Lead performed in the field should be attached to the back of the form.

XXVIII. NARCOTIC ADMINISTRATION & WASTE LOG

If narcotics were administered in the field and some amount remains in the vial/carpujet, the remainder should be disposed of and documented on the back of the RADIO LOG documenting the pre-hospital report.

Document: date, time, name of medication, ordering physician – if applicable- amount given, amount wasted, signature of paramedic or PHRN who administered the med and signature of person of the witnessed the remainder of the medication being wasted in an acceptable manner (i.e. rinsed down sink).

XXIX. Placement of Log

The Radio Log will be kept in a binder until it is forwarded to the EMS Office.



Kelly Cox, M.D., EMS Medical Director

6/84
re: 10/86, 8/95, 11/97, 5/98, 8/01, 1/06, 10/06, 07/08, 8/12

QUINCY AREA EMS SYSTEM EMERGENCY DEPARTMENT RADIO LOG

C-9-F-1a

AMBULANCE: _____ DATE: _____ TIME CALLED IN: _____ FORM # _____

MERCI / PHONE AGE: _____ SEX: M F PVT. MD: _____ ETA: _____ MIN.

COMPLAINT: _____ ☐ STEMI ALERT

MEDICAL HISTORY: _____ ☐ STROKE Activation

MEDICATIONS: _____ ☐ Hypothermia Activation

ALLERGIES: _____ ☐ Trauma Activation

SKIN CONDITION <input type="checkbox"/> WNL <input type="checkbox"/> pale <input type="checkbox"/> cool <input type="checkbox"/> cyanotic <input type="checkbox"/> hot <input type="checkbox"/> flushed <input type="checkbox"/> mottled <input type="checkbox"/> dry <input type="checkbox"/> moist	BLEEDING <input type="checkbox"/> none noted <input type="checkbox"/> minor <input type="checkbox"/> moderate <input type="checkbox"/> severe	AVPU SCALE <input type="checkbox"/> alert <input type="checkbox"/> verbal <input type="checkbox"/> pain <input type="checkbox"/> unresponsive	CHEST SOUNDS <table style="width: 100%;"> <tr> <th style="width: 50%;">LT</th> <th style="width: 50%;">RT</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	LT	RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PUPILS <table style="width: 100%;"> <tr> <th style="width: 50%;">LT</th> <th style="width: 50%;">RT</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	LT	RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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PAIN 1-10 Scale: _____ (or Mild,/Mod./Severe)	ABDOMEN <input type="checkbox"/> soft/WNL <input type="checkbox"/> distended <input type="checkbox"/> tender <input type="checkbox"/> rigid	MENTATION <input type="checkbox"/> oriented <input type="checkbox"/> disoriented <input type="checkbox"/> combative <input type="checkbox"/> slow to respond	PULSES <input type="checkbox"/> radial pulse <input type="checkbox"/> pedal pulse	PULSES cont. <input type="checkbox"/> strong <input type="checkbox"/> weak <input type="checkbox"/> regular <input type="checkbox"/> irregular																														

VITAL SIGNS					INTERVENTIONS		
TIME	B/P	P	R	SpO2			
				RA O2	_____ O2 via NC/NRB	_____ IV attempt	_____ c-collar
				RA O2	_____ oral airway	_____ IV success	_____ long board
				RA O2	_____ nasal airway	_____ ET attempt	_____ short board
				RA O2	_____ assist BVM	_____ ET success	_____ scoop
					_____ suction	_____ combitube	_____ splint
					_____ CPR	_____ cric airway	_____ dressing

EKG RHYTHM*			TIME ORDERED	TREATMENT ORDERS/PROTOCOLS	TIME ADM.
<input type="checkbox"/> NSR <input type="checkbox"/> Sinus Tach <input type="checkbox"/> Sinus Brady	<input type="checkbox"/> Paced <input type="checkbox"/> A. Fib <input type="checkbox"/> PVCs	<input type="checkbox"/> 1 st degree block <input type="checkbox"/> 2 nd degree block <input type="checkbox"/> 3 rd degree block		Morphine per ERP orders: _____ 1 st dose _____ 2 nd dose at _____ Additional doses per ERP _____ mgIV every _____ minutes for a total _____ mg	
12 Lead EKG: <input type="checkbox"/> Rec'd Reviewed by: _____ *Show to ERP, then attach strip/EKG on reverse side.				Fentanyl per ERP orders::: _____ 1 st dose _____ 2 nd dose Additional doses per ERP _____ mcgIV every _____ minutes for a total _____ mcg	
CODE BLUE <input type="checkbox"/> V. Fib <input type="checkbox"/> V. Tach <input type="checkbox"/> Asystole <input type="checkbox"/> PEA <input type="checkbox"/> other _____					
TIME	PATIENT'S SIGNS AND SYMPTOMS				

DESTINATION:	DISPOSITION:
<input type="checkbox"/> BLESSING HOSPITAL <input type="checkbox"/> ILLINI COMM. HOSPITAL <input type="checkbox"/> OTHER _____ <input type="checkbox"/> CARTHAGE MEMORIAL	<input type="checkbox"/> TRAUMA DECLARED @ _____ <input type="checkbox"/> REFUSAL ACCEPTED PER ED PHYSICIAN <input type="checkbox"/> DIVERTED TO: _____

ECRN SIGNATURE: _____ ED PHYSICIAN SIGNATURE: _____

ED PHYSICIAN (CHECK): ☐ Cliatt ☐ Eckersley ☐ Hough ☐ Pyatt ☐ Saalborn ☐ Solaro
☐ Stoops ☐ Tirado ☐ Wollaston ☐ Other _____

☐ Review Requested (See back of form)

☐ Trend Reported (See back of form)

**QUINCY AREA EMS SYSTEM
EMERGENCY DEPARTMENT RADIO LOG**

C-9-F-1a

ATTACH EKG STRIP/12 LEAD

NARCOTIC ADMINISTRATION & WASTE LOG							
DATE	TIME	MED NAME	ORDERING PHYSICIAN	AMOUNT GIVEN	AMOUNT WASTED	PARAMEDIC / PHRN SIGNATURE	WITNESS SIGNATURE

EVOLVING TREND/POTENTIAL CRISIS

The Resource Hospital shall document any notification received by providers regarding a potential or evolving trend or crisis:

1. Contact the EMS System Coordinator
2. Forward this notification to the EMS Department by Fax: 223-2087
3. If more than 1 notification of same trend, contact the EMS Medical Director
(See OPERATIONS: EMS PROVIDER/ASSOCIATE HOSPITAL & PARTICIPATING HOSPITAL WORKSHEET-SYSTEM WIDE CRISIS.)

Comments: _____

IF PRE-HOSPITAL REVIEW REQUESTED:

1. Copy the Radio Log
2. Send to EMS Department, ATTN: EMS System Coordinator.

Please provide reason a review is requested or issue to be reviewed. _____

Re: 6/04, 6/06, 9/06, 7/08, 11/10, 7/11, 5/12, 8/12, 2/13, 6/13, 10/13, 3/15, 7/15

QUINCY AREA EMS SYSTEM EMERGENCY DEPARTMENT RADIO LOG

C-9-F-1b

AMBULANCE: _____ DATE: _____ TIME CALLED IN: _____ FORM # _____

MERCI / PHONE AGE: _____ SEX: M F PVT. MD: _____ ETA: _____ MIN.

COMPLAINT: _____ ☐ STEMI ALERT

MEDICAL HISTORY: _____ ☐ STROKE Activation

MEDICATIONS: _____ ☐ Hypothermia Activation

ALLERGIES: _____ ☐ Trauma Activation

SKIN CONDITION <input type="checkbox"/> WNL <input type="checkbox"/> pale <input type="checkbox"/> cool <input type="checkbox"/> cyanotic <input type="checkbox"/> hot <input type="checkbox"/> flushed <input type="checkbox"/> mottled <input type="checkbox"/> dry <input type="checkbox"/> moist PAIN 1-10 Scale: _____ (or Mild./Mod./Severe)		BLEEDING <input type="checkbox"/> none noted <input type="checkbox"/> minor <input type="checkbox"/> moderate <input type="checkbox"/> severe ABDOMEN <input type="checkbox"/> soft/WNL <input type="checkbox"/> distended <input type="checkbox"/> tender <input type="checkbox"/> rigid		AVPU SCALE <input type="checkbox"/> alert <input type="checkbox"/> verbal <input type="checkbox"/> pain <input type="checkbox"/> unresponsive MENTATION <input type="checkbox"/> oriented <input type="checkbox"/> disoriented <input type="checkbox"/> combative <input type="checkbox"/> slow to respond		CHEST SOUNDS <table style="width: 100%;"> <tr> <th style="text-align: left;">LT</th> <th style="text-align: left;">RT</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> PULSES <input type="checkbox"/> <input type="checkbox"/> radial pulse <input type="checkbox"/> <input type="checkbox"/> pedal pulse		LT	RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PUPILS <table style="width: 100%;"> <tr> <th style="text-align: left;">LT</th> <th style="text-align: left;">RT</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> PULSES cont. <input type="checkbox"/> strong <input type="checkbox"/> weak <input type="checkbox"/> regular <input type="checkbox"/> irregular		LT	RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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VITAL SIGNS					INTERVENTIONS																																		
TIME	B/P	P	R	SpO2																																			
				RA O2	_____ O2 via NC/NRB _____ IV attempt _____ c-collar																																		
				RA O2	_____ oral airway _____ IV success _____ long board																																		
				RA O2	_____ nasal airway _____ ET attempt _____ short board																																		
				RA O2	_____ assist BVM _____ ET success _____ scoop																																		
					_____ suction _____ combitube _____ splint																																		
					_____ CPR _____ cric airway _____ dressing																																		
EKG RHYTHM*					TIME ORDERED	TREATMENT ORDERS/PROTOCOLS			TIME ADM.																														
<input type="checkbox"/> NSR <input type="checkbox"/> Paced <input type="checkbox"/> 1 st degree block <input type="checkbox"/> Sinus Tach <input type="checkbox"/> A. Fib <input type="checkbox"/> 2 nd degree block <input type="checkbox"/> Sinus Brady <input type="checkbox"/> PVCs <input type="checkbox"/> 3 rd degree block 12 Lead EKG: <input type="checkbox"/> Rec'd Reviewed by: _____ *Show to ERP, then attach strip/EKG on reverse side.						Morphine per ERP orders: _____ 1 st dose _____ 2 nd dose																																	
						Additional doses per ERP _____mgIV every _____minutes for a total _____ mg																																	
						Fentanyl per ERP orders: _____ 1 st dose _____ 2 nd dose																																	
						Additional doses per ERP _____mcgIV every _____minutes for a total _____ mcg																																	
CODE BLUE <input type="checkbox"/> V. Fib <input type="checkbox"/> V. Tach <input type="checkbox"/> Asystole <input type="checkbox"/> PEA <input type="checkbox"/> other _____																																							
TIME PATIENT'S SIGNS AND SYMPTOMS																																							
DESTINATION:					DISPOSITION:																																		
<input type="checkbox"/> BLESSING HOSPITAL <input type="checkbox"/> ILLINI COMM. HOSPITAL <input type="checkbox"/> OTHER _____ <input type="checkbox"/> CARTHAGE MEMORIAL					<input type="checkbox"/> TRAUMA DECLARED @ _____ <input type="checkbox"/> REFUSAL ACCEPTED PER ED PHYSICIAN <input type="checkbox"/> DIVERTED TO: _____																																		

ECRN SIGNATURE: _____ ED PHYSICIAN SIGNATURE: _____

ED PHYSICIAN (CHECK): ☐ Alfrhan ☐ Alzein ☐ Glasgow ☐ Holden ☐ Kuhananthan
 ☐ Raso ☐ Semenza ☐ Solaro ☐ Other _____

☐ Review Requested (See Back of form))

☐ Trend Reported (See Back of form)

**QUINCY AREA EMS SYSTEM
EMERGENCY DEPARTMENT RADIO LOG**

ATTACH EKG STRIP/12 LEAD

NARCOTIC ADMINISTRATION & WASTE LOG

DATE	TIME	MED NAME	ORDERING PHYSICIAN	AMOUNT GIVEN	AMOUNT WASTED	PARAMEDIC / PHRN SIGNATURE	WITNESS SIGNATURE

EVOLVING TREND/POTENTIAL CRISIS

The Resource Hospital shall document any notification received by providers regarding a potential or evolving trend or crisis:

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(See OPERATIONS: EMS PROVIDER/ASSOCIATE HOSPITAL & PARTICIPATING HOSPITAL WORKSHEET-SYSTEM WIDE CRISIS.)

Comments: _____

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Please provide reason a review is requested or issue to be reviewed. _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ESTIMATED TIME OF ARRIVAL

- I. Each ambulance service will make arrangements with its dispatching agency to notify a caller of the estimated time of arrival for an emergency vehicle when this information is requested by the caller.



Kelly Cox, M.D., EMS Medical Director

9/95, 5/98
(reviewed 8/01, 1/06, 9/08, 8/12)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
EMERGENCY MEDICAL DISPATCH**

- I. Purpose:
 - Provide quality patient care and emergency medical service to the citizens of the Quincy Area EMS System
 - Develop a uniform level of response for the EMS System
 - Provide a means for continuous quality improvement and feedback
 - Provide for the safest and most appropriate level of response to the patient.
- II. Policy:
 - A. Persons calling for emergency assistance shall never be required to speak with more than two persons to request emergency medical assistance.
 - B. Emergency Medical Units shall be dispatched by Illinois Licensed Emergency Medical Dispatchers in accordance to the standards developed by the Medical Director utilizing Emergency Medical Dispatch Protocols
 - C. Emergency medical units shall be dispatched hot (10-33) or cold (10-40) as determined by the Dispatch Center utilizing the EMD protocols.
 - D. A call may be upgraded to a hot response (10-33) at the medical crew's discretion. An event report shall be completed and sent to the EMS Office if the medical crew upgrades the call.
 - E. All fully staffed ALS ambulance enroute time shall be less than 02:59 minutes after dispatch, 90% of the time. The medical crew shall acknowledge the call within 30 seconds.
 - F. All "alpha" and "bravo" level calls determined not emergent shall be dispatched as cold (10-40) response. Examples: back pain, minor hemorrhage, earache, constipation, etc.
 - G. Ambulance crews may, at their discretion, request additional assistance on non-first responder calls. Examples: manpower, extreme response time, forcible entry, etc.
 - H. If contacted by a telematics service provider, such as OnStar, that utilizes a system for Automatic Crash Notification (CAN), Dispatch shall use the appropriate EMD cardset protocols dictated by the situation, most likely Card 29 "Traffic/Transportation Accidents." If ProQA is available to the EMD, Dispatch will use the CAN protocol available within the EMD software as the situation warrants.
 - I. *Any level of responders may request additional assistance/resource by contacting the local dispatch agency.*
- III. Procedures:
 - A. Emergency medical units dispatched as a cold (10-40) response, shall not upgrade to a hot response (10-33) unless:
 - 1. Dispatch Center determines that the patient's condition has changed, and requests you to upgrade to a hot (10-33) response.
 - 2. Medical crew's discretion

- B. Emergency medical units dispatched as a hot (10-33) response, shall not downgrade to a cold (10-40) response unless:
 - 1. Dispatch Center receives information from medical crews or original caller (First Responder, EMT, EMT-P) on scene that downgrade is appropriate.
 - 2. Medical Crew's discretion after receiving additional information.
- C. An ambulance may divert from a cold (10-40) call to a higher (10-33) priority ONLY IF:
 - 1. The ambulance is the closest available unit to the call. Examples of High Priority calls: chest pain, respiratory distress, CVA, etc.
 - 2. The diverting ambulance shall notify the Dispatch Center that they are diverting to the higher priority call.
 - 3. The diverting ambulance shall ensure that the Dispatch Center dispatches an ambulance or First Responder to the original call.
- D. Units must call swap between hot responses (10-33) calls so that the closer ambulance handles the closer call. If a call swap occurs, the Dispatch Center must be notified of the call swap.
- E. The EMS Medical Director shall review the following types of calls for compliance:
 - 1. Any cold (10-40) response that went to the hospital hot (10-33)
 - 2. Any cold (10-40) call in which an emergency unit diverted to a higher priority call.
 - 3. Any call in which an event report is completed and returned.
- F. An ambulance dispatched to the scene of an emergency may honor a request to cancel only under the following circumstances
 - 1. A request to cancel is received from an ambulance at the scene that is licensed and staffed at the same or higher level
 - 2. A request to cancel is received from an ambulance at the scene that is licensed or staffed at a lower level after that ambulance has given a patient report to the resource or associate hospital.
 - 3. A request to cancel is received from an individual EMT or First Responder at the scene who has identified his/her name, after making a patient report to the resource or associate hospital, and if they acquire a signed refusal of services.
 - 4. A request to cancel is received from the patient, patient's family, or original caller through the dispatcher.
 - 5. In all instances in which an ambulance honors a request to cancel, a Patient Care Report must be completed including documentation of who and under what circumstances the request for cancellation was made.
 - 6. This policy does not apply to air ambulance utilization. (See Policy O-28 for the procedure to cancel the helicopter)



Kelly Cox, M.D., EMS Medical Director

12/03; re: 2/04, 5/08, 2/10
(Reviewed: 1/06, 9/08, 8/12)

QUINCY AREA EMS SYSTEM CONTINUING EDUCATION AND TRAINING

EMT-P/PHRN Continuing Medical Education -----	CET-1
EMT-B, First Responder Continuing Medical Education -----	CET-2
Continuing Education Report Form -----	CET-3a F
Training Program Evaluation DELETED (1/11) -----	CET-3b F
Instructor Evaluation DELETED (1/11) -----	CET-4 F
Requirements for EMS Clinicals at Blessing Hospital-----	CET-5
Checklist for Requirements-----	CET-5a
Travel for Clinical Assignments -----	CET-5a-F
Dress and Grooming Guide for Clinicals -----	CET-5b
Educational Record Release Waiver -----	CET-5c-F
Contract of Personal Accountability-----	CET-5d-F
Waiver of Liability by Student/Observer -----	CET-5e-F
Release of Information to Clinical Area form (Non-Blessing Employee) -----	CET-5-F1
Release of Information to Clinical Area form (Blessing Hospital Employee)-----	CET-5-F2
Illinois EMT-P Course -----	CET-6
Physical Examination Requirements (EMTP)-----	CET-6a
Student Health Assessment & Physical Examination Form-----	CET-6a-F
Student Application -----	CET-6b-F
Letter of Sponsorship Form-----	CET-6c-F
Illinois EMT-B Course -----	CET-7
EMTB Student Application-----	CET-7a-F
EMTB Student – Patient Assessment Form -----	CET-7-F
Prehospital RN Training Course -----	CET-8
Emergency Communications Registered Nurse Course -----	CET-9
AED Course DELETED 2/11/11 -----	CET-10
AED Review Form DELETED 2/11/11-----	CET-10a-F
AED Practical Skills Assessment Form DELETED 2/11/11-----	CET-10b-F
First Responder Course -----	CET-11
EMS Lead Instructor -----	CET-12
EMS Leas Instructor Application -----	CET-12a-F

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
EMT-P/PHRN CONTINUING MEDICAL EDUCATION**

I. General Information

- A. No more than twenty-five percent (25%) of the total hours required for relicensure may be obtained in the same subject. Repetition of a specific class session within a 12 month period will not be accepted for credit.
- B. At least fifty percent (50%) of the total hours required for relicensure should be earned through System taught/approved courses.
- C. 16 hours/4 years must be in pediatric topics.
- D. Topics should be license appropriate.
 - 1. *75% of hours must be at ALS level.*
 - 1. *25% of hours may be BLS level, i.e. CPR, landing zones, etc.*

II. The following are accepted for EMT-P, Prehospital RN and ECRN continuing education hours. (must be ALS level classes)

- A. Programs assigned a paramedic level site code by the Illinois Department of Public Health or approved for paramedic credit by the National Registry of EMT's.
 - 1. Enrollment: as indicated in brochure or by the lead instructor/program director
 - 2. To obtain credit you must submit a certificate if applicable or complete a System Continuing Education form
 - 3. Credit assigned: 100% (hour for hour)
- B. Programs assigned an EMT-B level site code by the Illinois Department of Public Health or approved for EMT-B level credit by the National Registry of EMT's.
 - 1. Enrollment: as indicated in brochure or by the lead instructor/course director
 - 2. To obtain credit you must submit a certificate if applicable or complete a System Continuing Education form.
- C. Out of State conferences/seminars
 - 1. Enrollment: as indicated for the conference
 - 2. To obtain credit you must submit a certificate or proof of attendance for the session/conference/copy of agenda or brochure
 - 3. Credit assigned: 100% (hour for hour)
- D. ACLS Provider or ACLS Instructor Course
 - 1. Enrollment: per brochure or through the course director/sponsor
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: ACLS Provider Course = 16 hours; ACLS Instructor Course = hour/hour, maximum 16 hours.
- E. ACLS Preparation Course (hospital sponsored)
 - 1. Enrollment: through the sponsoring hospital
 - 2. To receive credit you must provide documentation of attendance to include dates, hours, and signature of the instructor. If taken within the System you should submit this information on a System Continuing Education form.
 - 3. Credit assigned: 100% (hour for hour)

- F. BTLS or PHTLS Provider or Instructor Course
 - 1. Enrollment: per brochure or through the course director/sponsor
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: 100% (hour for hour)

- G. PALS Provider Course; PALS Instructor Course; PEPP Provider Course; PEPP Coordinator Orientation
 - 1. Enrollment: per brochure or through the course director/sponsor
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: PALS Provider = 16 hours; PALS Instructor = hour /hour maximum 16 hours; PEPP ALS Provider = 13 hours or per certificate; PEPP Coordinator hour/hour

- H. CPR Certification; CPR Instructor Course; CPR Instructor-Trainer Course
 - 1. Enrollment: per brochure or through the course director/sponsor
 - 2. To obtain credit: CPR certification submit copy of card or certificate; for CPR Instructor Courses submit proof of satisfactory completion.
 - 3. Credit assigned: CPR certification = 3 hours every 2 years. Maximum of 6 hours in a four year period. CPR Instructor Courses: hour/hour, maximum 16 hours in a four year period.

- I. EMS Lead Instructor Course
 - 1. Enrollment: through the System EMS Office
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: 100% (hour for hour)

- J. Blessing Hospital EMT-P Course
 - 1. Enrollment: Contact the course instructor prior to the start of the class you wish to attend
 - 2. To obtain credit you must submit a completed System Continuing Education form (blue) with instructor's signature.
 - 3. Credit assigned: 100% (hour for hour)

- K. Prepared Childbirth Course (hospital sponsored) plus birth of baby
 - 1. Enrollment: through the sponsoring agency
 - 2. To obtain credit you must submit proof documentation of attendance to include dates, hours, and instructor's signature
 - 3. Credit assigned: up to 3 hours
 - 4. Maximum: once per license period

- L. Preceptorship of EMT-P/Prehospital RN students in the field
 - 1. Enrollment: must be approved as field evaluator in the System
 - 2. To obtain credit you must submit a completed System Continuing Education form (blue) with course instructor's signature. For equipment training you must provide documentation of date, hours and course instructor's signature.
 - 3. Credit assigned: 1 hour for each call. Hour for hour for specific equipment training. Maximum of 25% total hours.

- M. Article Review (JEMS, Emergency Medical Services, Rescue, Rescue EMS News etc.)
Topic must be EMS related.
1. Enrollment: through the journal registration form for CEU articles
 2. To obtain credit you must submit a copy of completion certificate
 3. Credit assigned: 100% (hour for hour)
- N. Blessing EMS Inservice Video Review
1. Enrollment: through the EMS Office, must receive prior approval.
 2. To obtain credit you must satisfactorily complete (80%) a written exam after viewing the video. You will then complete a System Continuing Education form (orange) and obtain a signature from the EMS Department Staff member.
 3. Credit assigned: 2 hour per video up to a maximum of 16 hrs/4 years.
- O. Clinical (Must be completed off duty)
1. Ambulance from another *service*
 2. Air Medical Service from another *service*
 3. Surgery rotation to obtain intubation practice
 4. Emergency Department rotation for skills
 5. Other areas will be considered on a case by case basis by the EMS Medical Director
 - a) Enrollment: Receive prior approval from the EMS System Coordinator or EMS Medical Director. For hospital clinical within the System you will schedule through the EMS Office. For areas outside the System you will schedule through the agency. (Blessing Hospital may require a criminal background check and drug testing at your expense prior to clinical rotations.)
 - b) To obtain credit you will submit a clinical observation form signed by an EMT-P, RN, or physician from the clinical area
 - c) Credit assigned: 100% (hour for hour). Maximum of 25% of total hours to be obtained from clinical
- P. Teaching (Must be EMS or health related subject)
1. Enrollment: N/A
 2. To obtain credit: submit a copy of the signed/approved training application and schedule or submit a letter from the EMS Medical Director.
 3. Credit assigned: 2 teaching hours = 1 hour credit. One hour preparatory time per class. Maximum of 50% total hours. No more than 25% taught in same subject.
- Q. Disaster Drills
1. Enrollment: Participate in drill
 2. To obtain credit: submit a letter from your agency director outlining drill and hours of participation.
 3. Credit assigned: hour for hour. Maximum of 25% of total required hours.
- R. Firefighter II Course (EMS/medical portion)
1. Enrollment: through agency sponsoring the course
 2. To obtain credit: Submit a completion certificate or instructor letter.
 3. Credit assigned: hour for hour, maximum 28 hours.

- S. College level health related courses
 - 1. Enrollment: through the college
 - 2. To obtain credit: Show evidence of course completion such as a grade sheet with number of credit hours for the course listed.
 - 3. Credit assigned: 1 hour for each college credit hour.

 - T Prevention programs (Such as SafeKids, health fairs, handguns safety, bicycle safety, etc.)
 - 1. Enrollment: Participate in the program
 - 2. To obtain credit: submit a letter from the program coordinator indicating number of hours of participation.
 - 3. Credit assigned: hour for hour. Maximum of 25% of total hours.

 - U. Internet Education (Must be EMS related topics)
 - 1. Enrollment: Per web site instructions. Approved sites include:

www.EMInet.com	www.emedicine.com
www.ems-ce.com	www.freecme.com
www.MedicEd.com	www.traumaed.com
www.EmCert.com	www.paems.org
 - 2. For sites not listed, contact the EMS Dept. Staff for approval.
 - 3. To obtain credit: Submit copy of completion certificate.
 - 4. Credit assigned: hour for hour. Maximum of 25% total hours.

 - V. Other programs may be accepted for credit on a case by case basis at the discretion of the EMS Medical Director.
- III. All participants in the Quincy Area EMS System are responsible for maintaining copies of all documentation regarding continuing education activities which they have completed. This documentation will be submitted to the EMS Office at the time of relicensure or as indicated for the specific course.
- IV. Quincy Area EMS will accept CECBEMS (Continuing Education Coordinating Board for Emergency Medical Services) continuing education on an hour/hour basis.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMT-B, FIRST RESPONDER CONTINUING MEDICAL EDUCATION

I. General Information:

- A. No more than twenty-five percent (25%) of the total hours required for relicensure may be obtained in the same subject. Repetition of a specific class session within a 12 month period will not be accepted for credit.
- B. At least fifty percent (50%) of the total hours required for relicensure should be earned through System taught/approved courses.
- C. 8 hours/4 years must be in pediatric topics (EMTB)
- D. *Topics should be license appropriate, at the same level of training or higher.*

II. The following are accepted for EMT-B continuing education credit:

- A. Programs assigned an EMT-B level site code by the Illinois Department of Public Health or approved for EMT-B credit by the National Registry of EMT's
 - 1. Enrollment: as indicated in brochure or by the lead instructor/program director
 - 2. To obtain credit you must submit a certificate of completion or complete a System Continuing Education form (blue)
 - 3. credit assigned: 100% (hour for hour)
- B. Out of State conferences/seminars
 - 1. Enrollment: as indicated for the conference
 - 2. To obtain credit you must submit a certificate or proof of attendance for the session/conference/copy of agenda or brochure
 - 3. Credit assigned: 100% (hour for hour)
- C. Attendance at EMT-B courses or assistance with clinical skills during a course
 - 1. Enrollment: Contact the course instructor prior to the start of the class you wish to attend
 - 2. To obtain credit you must submit a completed System Continuing Education form (blue) with instructor's signature.
 - 3. Credit assigned: 100% (hour for hour)
- D. BTLS or PHTLS Provider Course for Basics
 - 1. Enrollment: through brochure, course director/sponsor
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: 100% (hour for hour)

- E. CPR Certification; CPR Instructor Course; CPR Instructor-Trainer Course
 - 1. Enrollment: per brochure or through the course director/sponsor
 - 2. To obtain credit: CPR certification submit copy of card or certificate; for CPR Instructor Courses submit proof of satisfactory completion.
 - 3. Credit assigned: CPR certification = 3 hours every 2 years. Maximum of 6 hours in a four year period. CPR Instructor Courses: hour/hour, maximum 16 hours in a four year period.
- F. Prepared Childbirth Course (hospital sponsored) plus birth of baby
 - 1. Enrollment: through the agency
 - 2. To obtain credit submit proof of attendance
 - 3. Credit assigned: up to 3 hours
 - 4. Maximum: once per license period.
- G. EMS Lead Instructor Course
 - 1. Enrollment: through the sponsoring agency
 - 2. To obtain credit you must submit proof of satisfactory completion of the course
 - 3. Credit assigned: 100% (hour for hour)
- H. Article Review (JEMS, Emergency Medical Services, Rescue, Rescue EMS News)
 - 1. Enrollment: through the journal's registration form for CEU articles/Internet site
 - 2. To obtain credit you must submit a copy of completion certificate
 - 3. Credit assigned: 100% (hour for hour) Maximum 25% of total hours.
- I. Clinical (Must be completed off duty)
 - 1. Ambulance from another *service*
 - 2. Emergency Department rotation for skills
 - 3. Autopsy (max 3 hours)
 - 4. Observe childbirth (max 3 hours)
 - 5. Other areas will be considered on a case by case basis by the EMS Medical Director
 - a) Enrollment: Receive prior approval from the EMS System Coordinator or EMS Medical Director. For hospital clinical within the System you will schedule through the EMS Office. For areas outside the System you will schedule through the agency. (Blessing Hospital may require a criminal background check and drug testing at your expense prior to clinical rotations.)
 - b)
 - c) To obtain credit submit a clinical observation form signed by an EMT-P, RN, or physician from the clinical area
 - d) Credit assigned: 100% (hour for hour). Maximum of 25% of total hours to be obtained from clinical

- J. Teaching (Must be EMS or health related subject)
1. Enrollment: N/A
 1. To obtain credit: submit a copy of the signed/approved training application and schedule or submit a letter from the EMS Medical Director.
 2. Credit assigned: 2 teaching hours = 1 hour credit. One hour preparatory time per class. Maximum of 50% total hours. No more than 25% taught in same subject.
- K. Disaster Drills
1. Enrollment: Participate in drill
 2. To obtain credit: submit a letter from your agency director outlining drill and hours of participation.
 3. Credit assigned: hour for hour. Limit of 25% of total required hours.
- L. Firefighter II Course (EMS/medical portion)
1. Enrollment: through agency sponsoring the course
 2. To obtain credit: Submit a completion certificate or instructor letter.
 3. Credit assigned: hour for hour, maximum 28 hours.
- M. College level health related courses
1. Enrollment: through the college
 2. To obtain credit: Show evidence of course completion such as a grade sheet with number of credit hours for the course listed.
 3. Credit assigned: 1 hour for each college credit hour.
- N. Prevention programs (Such as SafeKids, health fairs, handguns safety, bicycle safety, etc.)
1. Enrollment: Participate in the program
 2. To obtain credit: submit a letter from the program coordinator indicating number of hours of participation.
 3. Credit assigned: hour for hour. Maximum of 25% of total hours.
- O. Internet Education (Must be EMS related topics)
1. Enrollment: Per web site instructions. Approved sites include:

www.EMInet.com	www.emedicine.com
www.ems-ce.com	www.freecme.com
www.MedicEd.com	www.traumaed.com
www.EmCert.com	www.paems.org
 2. For sites not listed, contact the EMS Dept. Staff for approval.
 3. To obtain credit: Submit copy of completion certificate
 4. Credit assigned: hour for hour. Maximum of 25% total hours.
- P. PEPP Provider/Coordinator Course
1. Enrollment: per brochure or through the course director/sponsor
 2. To obtain credit you must submit proof of satisfactory completion of the course
 3. Credit assigned: PEPP ALS Provider = 13 hours or per certificate; PEPP Coordinator hour/hour
- Q. Other programs may be accepted for credit on a case by case basis at the discretion of the EMS Medical Director.

- III. The following will be accepted for EMT-B and FR-D continuing education credit in addition to those listed in II.
 - A. Documentation of successful completion of a written and practical exam regarding defibrillation and use of the AED which will be administered through the EMS Office annually.
- IV. All participants in the Quincy Area EMS System shall be responsible for maintaining copies of all documentation concerning continuing medical education or activities that he or she completes. This documentation will be submitted to the EMS Office at the time of relicensure.
- V. Quincy Area EMS will accept CECBEMS (Continuing Education Coordinating Board for Emergency Medical Services) continuing education on an hour/hour basis.

QAEMS PROGRAM EVALUATION FORM

CET-3a-F

DATE: _____
AGENCY: _____

TIME: _____

PROGRAM _____

#HOURS _____
SITE CODE: _____

RATE THE FOLLOWING AREAS

PROGRAM COMMENTS:

	Excellent	Good	Fair	Poor		
PROGRAM RATING						
Overall Rating						
Audio/Visual Presentations						
SPEAKER NAME:					Speaker Comments:	
TOPIC:						
Knowledge						
Rapport						
Delivery						
Was material relevant to your education/position						
To what extent did presentation meet your expectations						
SPEAKER NAME:						Speaker Comments:
TOPIC:						
Knowledge						
Rapport						
Delivery						
Was material relevant to your education/position						
To what extent did presentation meet your expectations						

See reverse side for additional program/speaker evaluations

Please retain this section for your upcoming renewal

CET-3a-F

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM CONTINUING EDUCATION REPORT

NAME: _____ CERTIFICATION # _____

AGENCY: _____

PROVIDER LEVEL: ☐ FR/FRD ☐ EMT/B ☐ EMT/P ☐ ECRN ☐ PHRN ☐ RN ☐ OTHER

DATE: _____ HOURS: ☐ ALS ☐ BLS

LOCATION: _____ IDPH SITE CODE NUMBER: _____

SPEAKER: _____

TOPIC/SUBJECT MATTER: _____

INSTRUCTOR/SPONSOR SIGNATURE _____

Richard A. Saalborn, D.O., EMS Medical Director re: 11/97, 4/00, 11/02, 1/03 (reviewed: 8/95, 8/01, 3/06, 11/10; 10/13)

STATEMENT OF CONFIDENTIALITY

I understand and agree to keep all patient information used for quality improvement and teaching purposes in the strictest confidence and will not share this information, either written or verbal, with others. Unauthorized release of confidential information may have personal, civil and/or criminal liability and legal penalties attached.

	Excellent	Good	Fair	Poor	
PROGRAM RATING					
Overall Rating					
Audio/Visual Presentations					
SPEAKER NAME:					Speaker Comments:
TOPIC:					
Knowledge					
Rapport					
Delivery					
Was material relevant to your education/position					
To what extent did presentation meet your expectations					
SPEAKER NAME:					Speaker Comments:
TOPIC:					
Knowledge					
Rapport					
Delivery					
Was material relevant to your education/position					
To what extent did presentation meet your expectations					

QAEMS

appreciates your participation in the
programs that you attend.

Any new ideas or suggestions should be noted on the evaluation form.

QUINCY AREA EMS TRAINING PROGRAM EVALUATION

DATE: _____ INSTRUCTOR: _____ COURSE: _____

Rate the following areas:

I. COURSE	<u>EXCELLENT</u>	<u>GOOD</u>	<u>FAIR</u>	<u>POOR</u>	<u>SUGGESTIONS</u>
Management of Course	_____	_____	_____	_____	_____
Overall Rating of Course	_____	_____	_____	_____	_____
Teaching Aids	_____	_____	_____	_____	_____
Breaks	_____	_____	_____	_____	_____

II. INSTRUCTOR'S RATING	<u>EXCELLENT</u>	<u>GOOD</u>	<u>FAIR</u>	<u>POOR</u>	<u>SUGGESTIONS</u>
Appearance	_____	_____	_____	_____	_____
Rapport	_____	_____	_____	_____	_____
Promptness	_____	_____	_____	_____	_____
Voice	_____	_____	_____	_____	_____
Knowledge	_____	_____	_____	_____	_____
Relevance of Content	_____	_____	_____	_____	_____
Overall Rating of Course	_____	_____	_____	_____	_____

III. What area would you like to see improved?

IV. Comments:

Kelly Cox, M.D., EMS Medical Director

re: 5/98, 3/06
(reviewed: 8/95, 8/01)

**QUINCY AREA EMS SYSTEM
INSTRUCTOR EVALUATION**

INSTRUCTOR NAME: _____ DATE: _____

TOPIC TITLE: _____

	Superior	Very Good	Good	Fair	Poor
1. Appearance	_____	_____	_____	_____	_____
2. Support	_____	_____	_____	_____	_____
3. Delivery	_____	_____	_____	_____	_____
4. Knowledge	_____	_____	_____	_____	_____
5. Information Presented	_____	_____	_____	_____	_____
6. Overall Rating	_____	_____	_____	_____	_____

INSTRUCTOR NAME: _____

TOPIC TITLE: _____

	Superior	Very Good	Good	Fair	Poor
1. Appearance	_____	_____	_____	_____	_____
2. Support	_____	_____	_____	_____	_____
3. Delivery	_____	_____	_____	_____	_____
4. Knowledge	_____	_____	_____	_____	_____
5. Information Presented	_____	_____	_____	_____	_____
6. Overall Rating	_____	_____	_____	_____	_____

SIGNATURE OF APPLICANT FOR CREDIT _____

**QUINCY AREA EMS SYSTEM
REQUIREMENTS FOR EMS CLINICAL AT BLESSING HOSPITAL**

- I. **PURPOSE:** To ensure the safety and well being of patients who receive care from students or other licensed individuals who are fulfilling their clinical requirements at Blessing Hospital and/or other clinical sites associated with Blessing EMS programs.

- II. **SCOPE:** Applies to all students of Blessing Hospital EMS programs, students from other EMS programs who wish to have a clinical experience at Blessing Hospital and licensed individuals who come to Blessing Hospital for a clinical experience to meet continuing education needs or requirements. **NOTE:** Individual wanting to complete clinicals at Blessing Hospital may have to be 18-years old to complete the requirement below.

- III. **POLICIES/PROCEDURES:**
 - A. **OFFICE OF INSPECTOR GENERAL (OIG) CHECK:** All persons wishing to perform clinical at Blessing Hospital must provide full name and date of birth so that an OIG check can be done. There is no charge associated with this check conducted on-line by Blessing EMS Department. Non-clear checks could result in the individual being denied permission to perform clinical at Blessing Hospital.

 - B. **STATE BACKGROUND CHECK(S):**
 1. EMS Students
 - a. *State background check since the age of 18 to be completed through Blessing Hospital Human Resource Department. (At student's expense)*
 - a. Non-clear background checks will be taken to a review board to determine if the student will be allowed to continue in the program at Blessing Hospital. Students will be informed that their ability to obtain a professional license may be in jeopardy due to the non-clear background check.

 - C. **DRUG TESTING:** EMS students and licensed EMS providers wishing to perform clinical at Blessing Hospital are required to report for their clinical experience free from the effects of illegal drugs, alcohol or any other drugs that may impair their performance or cause them to fail to comply with the "Drug-Free Workplace Act of 1988".
 1. Blessing EMS Students
 - a. Provide Blessing EMS Department with a negative five panel drug screen (at student's expense. *The drug screen must be completed at Blessing Physician Services Occupational Health and Sports Medicine Department* prior to the start of clinical. It is the student's responsibility to schedule the appointment for the test. The drug screen cannot be performed greater than 30 days prior to the start of clinical.
 - b. The hospital's Medical Review Officer (MRO) will review all non-negative drug results with the student.
 - c. The student will have five days after notification of a non-negative result to explain or contest the results.
 - d. If the explanation or challenge is not satisfactory as defined by the MRO, the director of the educational program will be notified and the student will be dismissed from the program or clinical rotation.
 - e. Random drug testing may be conducted during the course of the school year (at the hospital's expense). The students selected for random testing will be instructed by the Blessing Hospital EMS Manager to report to Blessing Physician Services (Office of Sports & Occupational Medicine) for a drug screen

2. Students from EMS programs outside of Blessing Hospital or licensed EMS providers planning a clinical rotation at Blessing:
 - a. Must provide Blessing EMS Department with a negative five panel drug screen (at their own expense) prior to the start of clinical.
 - b. The drug screen cannot be performed greater than 30 days prior to the start of clinical.
 - c. Blessing Hospital will accept verified drug test results for students from a non-Blessing Hospital EMS program or from licensed individuals that have drug testing done at their place of employment.

D. IMMUNIZATIONS / TESTS:

1. Proof of negative TB test within 1 year of scheduled clinical.
2. Proof of MMR X 1 dose if born before 1957 and 2 doses if born after 1957.
3. Proof of Tetanus/diphtheria (td) within past ten years.
4. Proof of Hepatitis B series.

E. HIPAA / CONFIDENTIALITY / SAFETY:

1. Review HIPAA / confidentiality packet and return quiz with minimum of 90% accuracy plus signed confidentiality statement.
2. Review safety procedures packet and return quiz with minimum of 90% accuracy.
 - a. NOTE: Paramedic students will be enrolled in Computer Based Learning modules for safety and other topics and will not complete #2 above.

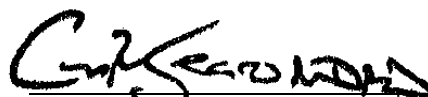
F. RELEASE OF INFORMATION: Paramedic students must have an ALS ambulance sponsor in order to be accepted in the Blessing Paramedic program. Our primary sponsor is Adams County Ambulance & EMS and all Blessing paramedic students must at a minimum be accepted by that entity for sponsorship. The student will sign a release of information form that allows Blessing EMS Department to release the information obtained in the previous sections of this policy to the ALS agency in order to obtain sponsorship.

G. Additional forms as requested including

- ☐ CET 5a-f Travel
- ☐ CET 5c-f Educational Release Waiver
- ☐ CET 5d-f Personal Accountability
- ☐ CET 5e-f Waivers of Liability
- ☐ CET 6b-F1 Application
- ☐ CET 6c-F Letter of Sponsorship (paramedic only)



Richard A. Saalborn, D.O., FACEP, FACOEP
EMS Medical Director
Quincy Area EMS System



Christopher R Solaro, MD, PHD
Associate Medical Director
Quincy Area EMS System

QUINCY AREA EMS SYSTEM

REQUIREMENTS FOR EMS CLINICAL AT BLESSING HOSPITAL

- ☐ **OIG Check** (Done by Blessing EMS Department – no cost)
- ☐ **State background check** *since the age of 18 to be completed through Blessing Hospital Human Resource Department. (At student's expense)*
- ☐ **Drug testing:** A clear five panel urine drug screen must be done within 30 days of the start of clinical to be completed at Blessing Physician Services Occupational Health and Sports Medicine Department. (At student's expense)
- ☐ **Immunizations / Testing (At own expense)**
 - TB test within past year
 - MMR X 1 dose if born before 1957 and 2 doses if born after 1957
 - Tetanus/diphtheria (td) within past 10 years
 - Hepatitis B series
- ☐ **HIPAA / Confidentiality/Safety**
 - Review HIPAA packet – submit quiz to Blessing EMS Department
 - Submit signed confidentiality statement
 - Review safety packet – submit quiz to Blessing EMS Department
 - CET 5F-1 & CET 5.F-2(Requirements for EMS Clinical at Blessing Hospital)
- ☐ **Release of Information form:** If requesting to perform clinical at a site that has an affiliation with Blessing EMS programs such as an ALS ambulance agency, fire department or dispatch agency, you must agree to release the information about background checks, drug testing, OIG checks and immunizations to that agency. Note that the affiliated agency has the right to accept or deny the clinical experience and may also have other requirements that must be met prior to beginning a clinical rotation.
- ☐ **Additional Requirements**
 - CET 5a-f Travel
 - CET 5c-f Educational Release Waiver
 - CET 5d-f Personal Accountability
 - CET 5e-f Waivers of Liability
 - CET 6b-F1 Application
 - CET 6c-F Letter of Sponsorship (paramedic only)
 - ICARE/AIDET expectations

Reviewed 11/30/07
Revised 2/13, 7/15

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL / JWCC EMS TRAINING PROGRAM**

TRAVEL FOR CLINICAL ASSIGNMENTS RELEASE

Purpose: To verify understanding of the student regarding issues that may arise related to travel to clinical.

I, _____, affirm that I am currently enrolled as a student in a QAEMS System EMS training course and that in the course of my education, I will be traveling to various clinical assignments.

I understand that in driving my own vehicle to clinical assignments, I am responsible for its safety and operating condition and for my own safety. I further understand and agree that, if I choose to drive my vehicle to clinical assignments as part of my education, neither Blessing Hospital / JWCC nor its employees will be liable in any way for any occurrence which may result in my injury, death, or damages to me or my family, heirs, or assigns.

In consideration of being allowed to participate in clinical assignments as part of my education by Blessing Hospital and its employees, I hereby personally assume all risks in connection with any clinical assignments, and I further release Blessing Hospital / JWCC and its employees and agents for any injury or damage that may befall me while I am participating in those clinical assignments, whether foreseen or unforeseen; and further agree to save and hold harmless Blessing Hospital and its employees and agents from any claim by me or my family, estate, heirs or assigns arising out of my participation in clinical assignments.

I further state that the vehicle I will be driving is insured with the amount of insurance coverage required by the laws of the State of Illinois.

I further state that I am of lawful age and I am legally competent to sign this Release; that I have fully informed myself of the contents of this Release by reading it before I signed it; that I understand the terms in the Release are contractual and not a mere recital; and that I have signed this document as my own free act and deed.

IN WITNESS WHEREOF, I have executed this Release on _____
(Date)

(Student)

WITNESS: _____
(Representative of Academic Program)

QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL EMS STUDENT DRESS AND GROOMING CODE

POLICY AND/OR PROCEDURE:

EMS Students attending clinical at Blessing or affiliated clinical sites will adhere to the following general dress code policy:

- I. In order to project a professional image and to abide by infection control and safety standards, students will be expected to be in compliance with the dress code at all times. Non-compliant individuals will be requested to leave the clinical area and reschedule at a later date.
- II. Good body hygiene is expected.
- III. Hair will be clean and neat.
 - A. Hair will be of a length and styled in a manner that is neat, clean and professional. Hair must be appropriate color. No blue, pink, purple, green, etc. No Mohawks or other styles that could be considered unprofessional. Long hair must be pulled back.
 - B. Beards and mustaches must be neatly trimmed.
- IV. Dress:
 - A. **EMT-P:** Only the approved uniform pant and shirt are acceptable. Uniforms must be clean, in good repair, wrinkle-free and of proper fit. Pants will touch the top of the shoe. A turtleneck may be worn under the short sleeved shirt
 - B. **EMT-B/FR:** Dark colored slacks, shirt with a collar. No jeans, t-shirts or shorts. Shirt must be of a length that doesn't expose mid-section.
- V. Jewelry will be limited to the following:
 - A. Watch
 - B. A ring or wedding band set
 - C. Earrings - two pair of pierced earrings no larger than 1/4 inch in diameter.
 - D. Neck chains are not encouraged, but if worn are limited to:
 1. simple silver or gold color choker without charms or pendants
 2. religious medals
 3. medical alert tags
 - E. All religious medals, medical alert tags and chains must be worn inside the clothing.
 - F. Other than earrings, no visible body piercing will be allowed; includes tongue or any other piercings that can be seen.
- VI. Undergarments will be worn.
- VII. Tattoos of an inappropriate nature must be covered with clothing.
- VIII. Shoes will be skid resistant. They will be cleaned and polished, in good repair, and appropriate for the outfit. Shoes or boots that give additional protection from the environment are recommended for the safety of the personnel involved in the prehospital care setting. Athletic style black or white shoes are acceptable for hospital clinicals. No open toe shoes or clogs.
- IX. Excessive makeup, perfume or cologne is inappropriate.

- X. Nails must be clean and short to medium length. No artificial nails. Nail polish limited to pink, reds, corals or taupes. Clear polish is preferred.
- XI. White lab coats may be worn over the uniform.



Kelly Cox, M.D., EMS Medical Director

re: 8/95, 8/97, 11/97, 8/01, 3/06, 8/06, 7/08
reviewed: 2/13

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL / JWCC EMS TRAINING PROGRAM**

EMS TRAINING PROGRAM EDUCATION RECORD RELEASE WAIVER

Purpose: To provide the student with the opportunity to verify their wishes regarding release of educational records.

I, _____, have been informed of Blessing Hospital's policy concerning the student's right to privacy of and access to their education records.

☐ I (do / do not) wish to waive my rights to privacy of "education records."

☐ I (do / do not) wish to extend access of my "education records" to third parties.

If a waiver is indicated, the following are the name(s) and address(es) of those third parties to whom I wish granted access to my "education records".

1. _____

2. _____

3. _____

I ask that my transcript of grades be sent to the following person:

NAME: _____

ADDRESS: _____

I agree that Blessing Hospital / JWCC cannot be held legally responsible for releasing my "education records" to those third parties that I have indicated above or to QAEMS System Field Evaluators, EMS System Coordinator or EMS Medical Director.

DATE

Signature of Student

Signature of Instructor

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL / JWCC EMS TRAINING PROGRAM**

CONTRACT OF PERSONAL ACCOUNTABILITY

Purpose: To verify that the student has received information regarding items listed below and understands they are accountable for compliance.

- I. I have read or been advised of program policies regarding attendance, tardiness, scheduling, and conduct in clinical areas, written testing and dress code.
- II. I am aware that clinical activities will require access to confidential patient information and situations of a sensitive or confidential nature. My instructor has advised me that breach of confidentiality can result in my dismissal from the program.
- III. I have received the student safety orientation to Blessing Hospital and the student handbook and my instructor has reviewed this with me.
- IV. I am aware that failure to comply with these policies may result in my dismissal from the program.

- ☐ Original to student file
- ☐ Copy to clinical site (upon request)
- ☐ Copy to student

DATE

Signature of Student

DATE

Signature of Instructor

8/97; 8/02, 2/04, 6/08
(Reviewed 8/01, 3/06, 2/13)

**BLESSING HOSPITAL / JWCC EMS TRAINING PROGRAM
AMBULANCE SERVICE
WAIVER OF LIABILITY BY STUDENT/OBSERVER**

I, _____, a student or observer, in consideration of being allowed
(Student/Observer name)

to participate in _____ Ambulance Service Activities, waives any and
(Ambulance Agency)

all claims for damages for personal injury, medical expenses, property damage and losses of any nature or kind which may be suffered as a result of such participation in or about an ambulance, accident scene or any Service activity, and agrees to hold Blessing Hospital / JWCC, Ambulance Service and its affiliates, the Health Department, and the County, harmless from any and all liability for any such damages which may arise from incidents occurring during the course of such participation.

I further acknowledge that as a non-employee of the Service and Department during clinical, I am ineligible for workman's compensation or other employee benefits.

Dated: _____

Signature-Student/Observer

Ambulance Service Representative

Reviewed 8/01, 2/13
Revised: 3/06, 6/08

BLESSING HOSPITAL EMS PROGRAMS
RELEASE OF INFORMATION TO CLINICAL SITES
(Non-Blessing Employees)

I, _____, am aware of and have complied with the Quincy Area EMS System policy Requirements For EMS Clinical At Blessing Hospital concerning background checks, drug testing, immunizations and confidentiality/safety *and policies regarding the class and clinicals..*

This release gives Blessing Hospital EMS Department permission to share the information obtained related to the policy CET 5, with the following agencies in which students / licensed EMS providers will have physical contact with patients and / or will have knowledge and availability to confidential information during a clinical rotation.

ALS AMBULANCE AGENCIES (Mark all agencies with which you agree to share this information):

- ☐ Adams County Ambulance and EMS
- ☐ Brown County Ambulance
- ☐ Hancock County Ambulance
- ☐ Pike County Ambulance

Other clinical sites outside of Blessing Hospital affiliated with the Blessing / JWCC Paramedic program (Mark all agencies with which you agree to share this information):

- ☐ Quincy Fire Department
- ☐ Quincy – Adams County 911
- ☐ Other _____

DATE: _____

STUDENT/LICENSED EMS PROVIDER (PRINT): _____

STUDENT /LICENSED EMS PROVIDER SIGNATURE: _____

COURSE INSTRUCTOR OR OTHER WITNESS: _____

BLESSING HOSPITAL EMS PROGRAMS
RELEASE/CONFIRMATION OF INFORMATION TO CLINICAL SITES
(Blessing Employees)

I, _____, am aware of and have complied with the Quincy Area EMS System policy Requirements For EMS Clinical At Blessing Hospital concerning background checks, drug testing, immunizations and confidentiality/safety *and policies regarding the class and clinicals*.

This release gives Blessing Hospital EMS Department permission to share the information obtained related to the policy CET-5 with the following agencies in which students / licensed EMS providers will have physical contact with patients and / or will have knowledge and availability to confidential information during a clinical rotation.

ALS AMBULANCE AGENCIES (Mark all agencies with which you agree to share this information):

- ☐ Adams County Ambulance and EMS
- ☐ Brown County Ambulance
- ☐ Hancock County Ambulance
- ☐ Pike County Ambulance

Other clinical sites outside of Blessing Hospital affiliated with the Blessing / JWCC Paramedic program (Mark all agencies with which you agree to share this information):

- ☐ Quincy Fire Department
- ☐ Quincy – Adams County 911
- ☐ Other _____

Completed by Personnel and Employee Health Departments for Blessing Corporate Services Employees Only

As an employee of *Blessing Corporate Services*, I give the **Employee Health Department** and **Personnel Services Department** authorization to confirm the following test, procedures or requirements of employment have been completed satisfactorily and documentation has been placed in employee file:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> OIG <input type="checkbox"/> Initial Drug Testing <input type="checkbox"/> Subject to Random Drug Testing <input type="checkbox"/> HIPPA/Confidentiality/Safety <input type="checkbox"/> Licensed Patient Care Provider, Background Check per Licensure Agency
i.e., Department of Professional Regulation <input type="checkbox"/> Licensed Pt Care Provider with no Background Check if licensed by IDPH <input type="checkbox"/> Non-licensed Patient Care Provider | <ul style="list-style-type: none"> <input type="checkbox"/> TB Test within past year <input type="checkbox"/> MMR (2 Doses if DOB after 1957) <input type="checkbox"/> Tetanus/diphtheria within past 10 years <input type="checkbox"/> Hepatitis B Series |
|---|--|

 Signature*
Director, Personnel Services (Or Designee)

 Signature*
Employee Health Nurse (Or Designee)

*Personnel and Employee Health Representatives are to indicate which have been completed, sign and return to EMS Department @ 14th

Student/Licensed EMS Provider (Print): _____

Student /Licensed EMS Provider Signature: _____

Course Instructor or Other Witness: _____

Date: _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

BLESSING HOSPITAL / JWCC PARAMEDIC PROGRAM

- I. *Program goal:*
 - A. *To prepare competent entry-level paramedics in the cognitive (knowledge), psychomotor (skills), and affective (behavioral) learning domains.*
- II. *Prerequisites:*
 - A. 18 years of age before beginning the program.
 - B. High school diploma or equivalency.
 - C. *A complete application which includes copies of*
 - 1. *Current Illinois EMT-B license.*
 - 2. *Current American Heart Association healthcare provider CPR certification or equivalent.*
 - 3. *Two letters of reference (at least one should be EMS related.)*
 - D. Six months experience as an EMT-B preferred (if less than 6 months experience, additional ambulance clinical *of forty hours and ten runs* will be required prior to the start of the program.)
 - E. Successful completion of the paramedic pre-entrance exam with a score *of 77% or greater (maximum of 2 events.)*
 - F. *Individual interview with program faculty and approval of application by EMS System Coordinator and the EMS Medical Director.*
 - G. Note: All students must complete a criminal background check, drug testing and immunizations in order to complete clinical at Blessing Hospital. This component should only be undertaken upon direction of *program faculty* as some components must be within a certain time frame. If the student has completed the EMT-B class in the Quincy Area EMS System within the past year, these requirements may have already been met.
- III. *Class size*
 - A. Class size is limited to *15* students due to extensive practical skills and clinical availability.
 - B. A final decision regarding admission or re-admission to the program will be determined by program faculty in conjunction with the EMS System Coordinator and the EMS Medical Director.
 - C. The Blessing Hospital/JWCC paramedic program does not discriminate in enrollment on the basis of color, sex, age, religion, national origin, ancestry or sexual preference.

IV. Curriculum

- A. *Paramedic Program Core Courses will take approximately thirteen months to complete. All courses are based on the National EMS Education Standards.*

EMS 160 Paramedic I : This combined didactic/lab course provides a strong foundation for the student beginning with roles and responsibilities of the paramedic, wellness, legal and ethical topics and a wide range of other preparatory lessons. As the semester progresses, the student will learn more about human anatomy and physiology as well as basic pathophysiology. Pharmacology principles are introduced with a focus on drug classifications, pharmacokinetics and pharmacodynamics as well as medical mathematics, medication administration and venous access. The student will also concentrate on basic and advanced level skills to manage an airway. 6 credit hours (5 credit hours lecture and 1 credit hour of lab.) Prerequisite: Admission to the paramedic program.

EMS 165 Paramedic Clinical Practice I: This clinical course introduces the student to the hospital clinical environment and provides the student with opportunities to apply learned theory, assessment and foundational ALS skills while under the direct supervision and guidance of clinical department staff. The course is planned so that the assigned clinical and clinical objectives are closely aligned with theory and skills being taught in the co-requisite course EMS 160. 3 credit hours. Prerequisite: Concurrent registration with EMS 160.

EMS 170 Paramedic II: In this combined didactic/lab course the student will develop a complex depth and comprehensive breadth of understanding of medical emergencies including respiratory, neurologic, cardiovascular, endocrine, hematologic, gastrological and urological. The focus this semester is on anatomy, physiology, pathophysiology, assessment and management in order to integrate assessment and scene findings with knowledge to form a field impression and formulate a treatment plan for common medical emergencies. The Advanced Cardiac Life Support course is built into this semester. 6 credit hours (5 credit hours lecture and 1 credit hour lab.) Prerequisite: EMS 160, 165.

EMS 175 Paramedic Clinical Practice II: This clinical course provides the student with continued opportunities to apply learned theory, assessment and foundational ALS skills while under the direct supervision and guidance of clinical department staff in the hospital setting and begins the Field Internship. The course is planned so that the assigned clinical and clinical objectives are closely aligned with theory and skills being taught in the co-requisite course EMS 170 with a focus on the medical patient. 3 credit hours. Prerequisite: Concurrent registration with EMS 170.

EMS 260 – Paramedic III: The focus of this combined didactic/lab course is integration of assessment findings with principles of epidemiology and pathophysiology to formulate field impressions and learn to develop comprehensive treatment/ disposition plans for trauma patients and the development of paramedic operations skills in the areas of ambulance operations, mass casualty, rescue operations, introduction to ICS & NIMS and hazardous

materials. Either International Trauma Life Support or Prehospital Trauma Life Support must be successfully completed this semester.

6 credit hours (4.5 credit hours lecture 1.5 credit hours lab.) Prerequisites: EMS 160, 165, 170, 175.

EMS 265 – Paramedic Clinical Practice III: This clinical course provides the student with continued opportunities to apply learned theory, assessment and foundational ALS skills while under the direct supervision and guidance of clinical department staff in the hospital setting. The course is planned so that the assigned clinical and clinical objectives are closely aligned with theory that was taught in the didactic course from the previous semester EMS 170 with a focus on the cardiac and respiratory patient. The student will complete the Instructional Phase of the Field Internship during this semester and enter the Evaluation Phase.

3 credit hours. Prerequisite: Concurrent registration with EMS 260.

EMS 270 – Paramedic IV: In this combined didactic/lab course the student will develop a comprehensive understanding of anatomical and physiological variations found in pregnancy, the pediatric and geriatric populations as well as a working understanding of the pathophysiology of illnesses and injuries affecting these populations and the chronically ill or specially challenged patients. The student will also develop a comprehensive understanding of the pathophysiology, assessment and management of a variety of medical conditions including anaphylaxis, toxicology, environmental emergencies, infectious diseases and psychiatric emergencies. Successful completion of Pediatric Education for Prehospital Providers (PEPP) is required for this semester.

7 credit hours (6 credit hours lecture, 1 credit hour lab.) Prerequisite: EMS 160, 165, 170, 175, 260, 265)

EMS 275 – Paramedic Clinical Practice IV: This clinical course provides the student with continued opportunities to apply learned theory, assessment and foundational ALS skills while under the direct supervision and guidance of clinical department staff in the hospital setting. The course is planned so that the assigned clinical and clinical objectives are closely aligned with theory and skills being taught in the co-requisite course EMS 270 with a focus on the pediatric patient, obstetrical/labor and delivery and the patient with psychiatric or behavioral disorders. The student will also continue with a minimum of forty hours in the ALS Field Internship which will create the necessary experiences for the student to meet the established goals for the last phase of the Field Internship.

3 credit hours. Prerequisites: EMS concurrent registration with EMS 270.

EMS 199 – Work Based Education – Paramedic: This clinical course provides the student with continued opportunities to apply learned theory, assessment and foundational ALS skills while under the direct supervision and guidance of paramedic field evaluators. The student continues the ALS Ambulance field internship which will create the necessary experiences for the student to meet the established goals for the Evaluation phase of ALS Ambulance Field Internship.

2 credit hours. Prerequisite: EMS 160, 165, 170, 175, 260, 265, 270, 275.

- B. The Paramedic Certificate and Paramedic AAS degree require additional general education courses. See the John Wood Community College course syllabus or JWCC counselor for details.*

- V. Course completion requirements: Each core paramedic course has specified terminal competencies that are required in order for the student to move on to the next course. The terminal competencies can be found in each of the program syllabi.
- A. Classroom attendance:
1. Due to the rapid pace of this program and the need to be knowledgeable in all aspects of the chosen field of paramedic, the student may have no more than two absences per core didactic course. The student is responsible for all material missed when absent. Greater than two absences or excessive tardiness per core didactic course will result in disciplinary action *and could result in dismissal from the program*.
 2. If a skill validation, quiz or written examination is missed due to an absence, the student is required to contact the instructor to make arrangements to make up the missed work within one week. Failure to make up a quiz or exam within one week will result in the grade of zero for that item.
 3. Professional behavior is an expectation and excessive tardiness will not be tolerated.
- B. Clinical attendance:
1. Students are required to complete ALL clinical *objectives* satisfactorily and are expected to be on time, in clinical uniform and prepared.
 2. ALL clinical sessions are to be scheduled through the Blessing EMS Department – extension 6590.
 3. Cancellation and rescheduling of clinical
 - a) Acceptable reasons to cancel clinical are illness of the student or an immediate family member, death in the family or other major event. A student found to be canceling clinical for reasons other than listed here is not following professional behavior standards and will enter the disciplinary process.
 - b) To cancel – contact the clinical area at least 15 minutes prior to the scheduled start time AND call the Blessing EMS Department at extension 6590 to advise of the cancellation.
 - c) To reschedule – contact Blessing EMS Department at extension 6590. NO EXCEPTIONS!
 - d) A “no call-no show” at clinical is unacceptable. A first offense will result in a written warning being issued to any student failing to notify the clinical area and Blessing EMS Department of a cancellation. Any subsequent offenses *will* result in disciplinary action, including dismissal from the program.
- C. Skills completion
1. A variety of basic and advanced level skills will be taught, practiced and validated for each core course.
 2. The student will be required to complete minimum numbers of designated skills during the program in order to be considered proficient.
 3. All advanced level skills must be successfully validated with demonstrated proficiency prior to the student being allowed to sit for the Illinois or National Registry Exam.
- D. Grades
1. The student must have a course average of 77% (C) or greater in each core paramedic course in order to progress to the next level course or to sit for the State or National Registry Exam.
 2. Clinical courses will receive a Pass / Fail grade. The student must receive a grade of Pass to progress to the next level course or to sit for the State or National Registry Exam.

3. *Failure to achieve a final grade of 77% (C) or greater in a didactic/skill course or a final grade of Pass in a clinical course will result in dismissal from the program.*

E *Incomplete*

1. *It is understood that circumstances could occur which would not allow the student to complete all requirements of a course on time.*
2. *Any student who is unable to complete all terminal objectives for a course must request an extension by notifying the paramedic Program Director of the request in writing which includes the reason the extension is necessary. The Program Director will add comments and forward to the EMS Medical Director for approval.*
3. *Approval of an extension is at the discretion of the EMS Medical Director and will be based on any previous extensions, reason given for the extension, current grade in the course, past disciplinary actions in the program and any behavioral issues.*
4. *If requirements are not met by the date indicated on the JWCC extension form, the student will receive a grade of F for the course.*
5. *All terminal objectives including didactic, clinical and skill requirements for the program must be completed within 90 days of the end of EMS 199.*

F. *Leave of Absence*

1. *A leave of absence may be taken from the paramedic program when certain circumstances occur that prevent the student from meeting program requirements. This could include instances such as a major illness, high risk pregnancy or pregnancy with complications, family obligation, military deployment, etc.*
 - a) *In order for a student to request a leave of absence, they must be in good standing in the program, have a passing grade of C or better, up to date on clinical and cannot be on probation or suspension.*
 - b) *If approved, the student must reenter the program the next year at the beginning of the semester following the last successfully completed semester. (student must still be considered in good standing to return to class.)*
2. **Procedure to Request a Leave of Absence:**
 - a) *Discuss the situation that is requiring the request for leave of absence with the paramedic Program Director to determine eligibility for a leave of absence.*
 - b) *Submit a formal written request to the paramedic Program Director that specifically states the circumstances of the leave of absence.*
 - c) *The paramedic Program Director will add comments and forward the request to the EMS Medical Director.*
 - d) *Approval of the Leave of Absence is at the discretion of the EMS Medical Director. Considerations when determining approval will include the reason given for the extension, current grade in the course, past disciplinary actions in the program and any behavioral issues.*
 - d) *The student will be notified in writing of the decision by the paramedic Program Director.*
 - f) *Note: All skill books, clinical forms and loaned items must be turned in before the request will be considered.*

3. *Procedure for Re-entry into the Paramedic Program After Leave of Absence:*
 - a) *Prior to August 1st of the next year – the student notifies the paramedic Program Director in writing of their intent to return to the paramedic program.*
 - b) *The paramedic Program Director will confirm decision and supply the student with a paramedic program syllabus with dates marked for required attendance.*
 - c) *The student is required to attend and pass all skill validations for semesters previously completed.*
 - d) *The EMS Medical Director may require the student to attend other portions of the class or clinical based upon review of previous exam scores/consult with the paramedic Program Director.*
 - e) *A student who successfully completes all requirements will re-enter the program.*
 - f) *Note: Re-entry will require a review of all original entry requirements to ensure they are still valid including Illinois EMT-B license and CPR certification. A new criminal background check may be required if the original background check is greater than one year old. A urine drug screen will be required within 30 days of the start of clinical.*

VI. Dismissal from the program:

- A. A paramedic student may be dismissed from the program for the following reasons:
 1. *Inability to achieve a grade of 77% (C) or greater in each paramedic core didactic/skill course.*
 2. *Inability to achieve a grade of Pass in each of the paramedic core clinical courses.*
 3. *Excessive absences of greater than two per core paramedic course.*
 4. *Violations of professional conduct / behavioral standards*
 5. *Inability to achieve a score of 3 or greater on final behavioral evaluation for each semester.*
 6. *Breach of patient confidentiality / HIPAA violation*
 7. *Falsification of any document related to the program.*
 8. *Failure to adhere to QAEMS System policies and procedures.*
 9. *Progressive disciplinary action.*
- B. The final decision for student dismissal will be made by the EMS Medical Director.
- C. *Application to the program after dismissal or failure to leave in good standing.*
 1. *The candidate's past records including exam scores, midterm and final evaluations, behavioral evaluations, disciplinary actions and other items will be reviewed by the paramedic Program Director prior to setting up an individual meeting with the candidate.*
 2. *The candidate must attend an individual meeting with paramedic Program Director, EMS System Coordinator and EMS Medical Director if available and be able to discuss the issues related to their previous dismissal or failure to complete the program including how circumstances have changed that would allow for a successful outcome.*
 3. *The final decision regarding whether a candidate will be allowed to apply for entry into the program will be made by the EMS Medical Director.*
 5. *Once the EMS Medical Director has given approval, the candidate will join the pool of candidates being considered for enrollment and will follow the application process from the beginning.*

VII. Record Keeping

- A. Student records will be maintained for a period of seven years and shall be made available to the EMS system or IDPH upon request.
- B. College transcripts are available through John Wood Community College.

Kelly Cox, M.D., EMS Medical Director

4/02 re: 1/03, 6/03, 6/04, 8/04
re: 3/06, 11/07, 6/08, 4/09, 7/10, 4/12

**QUINCY AREA EMS SYSTEM
BLESSING / JWCC PARAMEDIC PROGRAM**

PHYSICAL EXAMINATION REQUIREMENTS

POLICY AND/OR PROCEDURE:

- I. Due to the interaction between EMT/P students with patients and the strenuous nature of clinical, a medical examination will be required upon entry into the program.
 - A. The student will be required to demonstrate proof of:
 - 1. Hepatitis B series
 - 2. Negative TB test within one year
 - 3. Tetanus/diphtheria (td) within past ten years
 - 4. Proof of MMR X 1 dose if born before 1957 and 2 doses if born in or after 1957
 - B. The EMT/P trainee will supply to the Blessing EMS Department the results of the above tests and the completed physical examination report that was completed by his/her private physician no later than the first day of *class*. The EMS Medical Director or designee will review all physical and immunization reports for final disposition.

**BLESSING HOSPITAL PARAMEDIC PROGRAM
STUDENT HEALTH ASSESSMENT AND PHYSICAL EXAM**

Student Name: _____

Date of Birth: _____

Address: _____

Phone: _____

City, State, Zip: _____

To be completed by student: Have you had, or do you now have, the following? Please answer “yes” or “no” by placing a check mark in the appropriate box.

	YES	NO		YES	NO
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bone	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Infection	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness (Respiratory Disease)	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Headache, Fainting, Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions, Epilepsy, Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>
Stomach, Liver, Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Childhood Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Three Day Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>

If your answer to any of the following questions is “yes”, please give date and explanation

	Yes	No
Have you ever had a serious injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have infections?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>

Date/Explanation:

Have any of your family members (mother, father, grandparents, brothers, sisters) had or do they now have any of the following?

	Yes	No
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Mental or Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Illness	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____
(Student)

Date: _____

PHYSICAL EXAM

This section to be completed by the physician or other health professional conducting this exam.

Height: _____ Blood Pressure: _____ Respirations: _____
Weight _____ Pulse rate/rhythm _____ Temperature _____

HEAD/SCALP

Vision: R _____ L _____ Both _____

Corrective lenses: _____

Ears: _____

Nose: _____

Mouth/Teeth/Throat: _____

NECK/CHEST

Lymph Nodes/Trachea: _____

Heart: _____

Lungs: _____

ABDOMEN/PELVIS

Abdomen (masses, hernia, tenderness) _____

Pelvis _____

EXTREMITIES/BACK

Joints/R.O.M. _____

Deformities _____

Back/Spine _____

Previous Injury _____

- ## RECOMMENDATIONS

Reviewed 8/01, 3/06; Re: 4/02, 6/08, 4/09

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL / JWCC EMT-PARAMEDIC PROGRAM
STUDENT APPLICATION**

PERSONAL DATA

Name (Last)	(First)	Initial	Date of Birth
Address (Street)	(City)	(Zip Code)	Social Security Number
Telephone Number (Home)	<i>Email</i>		

EMERGENCY NOTIFICATION

Name (Last)	(First)	(Relationship)
Address (Street)	(City)	(Zip Code)
Telephone Number (Home)	Telephone Number (Work)	

CURRENT EMPLOYMENT/OCCUPATION

Employer	Job Title
Business Address (City)	Telephone Number
Immediate Supervisor (Name)	Job Title

EMT-B TRAINING

EMT Training Location	Instructor
Date Training Completed	IL EMT-B Certification Number Expires

OTHER EDUCATION

☐ High School Diploma ☐ GED

College (Name)	Location
Years Completed	Degree or Certificate

EMERGENCY MEDICAL SERVICES EXPERIENCE

Agency	Location
Your position at the agency	
EMS System (Name)	Location
EMS Medical Director	EMS System Coordinator
Agency	Location
Your position at the agency	
EMS System (Name)	Location
EMS Medical Director	EMS System Coordinator

OTHER RELATED EXPERIENCE

Examples: nursing assistant, volunteer, explorer group
Please List

PROFESSIONAL/PERSONAL REFERENCES

1. Name _____			Telephone Number _____
Address (Street) _____	(City) _____	(State) _____	(Zip Code) _____

2. Name _____			Telephone Number _____
Address (Street) _____	(City) _____	(State) _____	(Zip Code) _____

BACKGROUND INFORMATION EMT

Have your privileges in Emergency Medical Services ever been revoked or suspended? ☐ Yes ☐ No

Have you been placed into a disciplinary process related to your EMT certification? ☐ Yes ☐ No

Have you ever been terminated from employment at Blessing Hospital ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

If any of the above answers are yes, please explain on a separate sheet and attach.

ADDITIONAL REQUIRED INFORMATION

1. Submit a copy of your current *Illinois* EMT-B certification
2. Submit a copy of your current CPR card (*Healthcare Provider or Equivalent*)

EQUAL OPPORTUNITY CLAUSE

This program will make no discrimination because of race, sex, creed, national origin, ancestry or political affiliation.

Applicants for this program must also take a pretest based on general EMT knowledge and basic mathematics. You may also be required to interview with the EMS Medical Director or designees.

Please note: Falsification of any information on this application will result in automatic denial of entry into the EMT-paramedic program.

I further understand that Blessing Hospital assumes no liability for possible injuries to me during the course of or as a result of my enrollment in this program. I authorize and direct the release of information from my personal and professional references indicated above.

Signature of Applicant _____

_____ Date:

FOR OFFICE USE ONLY

Date Application Received: _____

☐ Two Reference Letters

☐ Sponsorship Letter: ☐ Illinois EMT License Expires: _____ ☐ CPR Card (*Healthcare Provider or Equivalent*) Expires: _____

Reviewed 8/01, 3/06

Revised 12/07, 6/08, 4/09

LETTER OF SPONSORSHIP FOR PARAMEDIC TRAINING

_____ agrees to provide clinical opportunities to

_____ in order that the students clinical and provisional

requirements may be completed. We also agree to allow the student to observe and perform authorized treatments on all runs as may be appropriate and in compliance with the rules, regulations, and laws of the State of Illinois, as well as the policies of the Quincy Area EMS System under direct supervision of agency staff. We reserve the right to restrict and prohibit the student from continued participation on our vehicles for just cause including, but not limited to the violation of this agency's rules by the student. It is understood that the revocation of these privileges will result in the student being suspended from the Blessing Hospital / JWCC Paramedic program.

Authorized Agent

Date _____

I agree to the sponsoring agency performing a criminal background check or Blessing Hospital providing criminal background check results with the agency and realize that information obtained in this check could result in failure of the agency to provide sponsorship for clinical opportunities.

Print Name: _____

Date of Birth: _____ Gender: _____

Quincy Area EMS System ALS Ambulance: _____
(Adams County, Brown County, Hancock County, Pike County)

Signature

Date _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ILLINOIS EMT-BASIC COURSE

I. PURPOSE

- A. This course is intended to prepare the student to function as a medically competent entry level EMT-Basic in the prehospital setting.

II. COURSE OBJECTIVES: *Are based on Illinois EMS Rules and Regulations and National EMS Education Standards.*

- A. *Students will understand the roles and responsibilities of the EMT.*
- B. To instruct the student to recognize the nature and seriousness of the patient's condition or extent of injuries and to assess requirements for emergency medical care.
- C. To instruct the student to administer appropriate emergency care based on the patient assessment and prevent further injury to the patient.
- D. To instruct the student in designated skills with the result that each student should be able to demonstrate competency in the skills as listed in each section of the curriculum.

III. PRE-REQUISITES

- A. Eighteen (18) years of age at time of State or National Registry test date.
- B. *High school diploma or its equivalent or be enrolled in the Quincy Area Vocational Technical Center's Health Occupations program at the time of State or national registry exam date.*
- C. Current AHA CPR Healthcare Provider completion card or its equivalent.
- D. Note: All students must complete a criminal background check, drug testing and immunizations in order to complete clinical at Blessing Hospital. This should only be undertaken upon direction of the course instructor as some components must be within a certain time frame.

IV. DIDACTIC/CLINICAL REQUIREMENTS

- A. *This course will be taught in accordance with Illinois Department of Public Health EMS Rules & Regulations and National EMS Education Standards. It will consist of a minimum of 110 hours of classroom/skill lab instruction. The course includes skills required for the EMT. It does not include specialized instruction in driving skills or rescue operations. Additions to the course for enrichment may be added with the approval of the EMS Medical Director and IDPH.*

DIDACTIC.CLINICAL REQUIREMENTS (CONTINUED)

- B. *Maximum amount of classroom time will be 8 hours per week. Exception would be for PEPP or PHTLS on a weekend unless approved by EMS Medical Director.*
- C. Clinical rotations include:
 - 1. Twenty-four (24) hours observation in an emergency department under direct supervision of an emergency physician, registered nurse, licensed practical nurse or emergency department technician (EMT-P). The department must have enough patient visits to provide the student with a quality learning experience.
 - 2. Twenty-four (24) hours observation on an ambulance service under the direct supervision of a Prehospital RN, EMT-P, or EMT-B. The service must have an adequate volume of calls to provide the student with pre-hospital experience.
 - 3. Site approval for the clinical rotations will be made by the EMS System Coordinator and the Lead Instructor.
 - 4. The student will complete a total of ten patient assessments. These are to be completed during clinical either on the ambulance or in the emergency department (See CET-7-f)

V. COMPLETION REQUIREMENTS


- A. *Successful completion of the course will allow the participant to take the Illinois EMT licensing examination or the National Registry EMT certification examination.*
- B. *Successful completion requirements:*
 - 1. *Complete all skill validations satisfactorily.*
 - 2. *Achieve a score on the final comprehensive examination of 70% or greater.*
 - 3. *Maintain an overall course average of 77% or greater.*
 - 4. *Complete the required Emergency Department clinical of 24 hours, Ambulance clinical 24 hours and ten patient assessments.*
 - 5. *All course requirements must be completed within 90 days of scheduled course completion.*

DISMISSAL FROM THE PROGRAM

- A. *The EMT student may be dismissed from the course for the following:*
 - 1. *Violations of professional behavior expectations and standards.*
 - 2. *Breach of patient confidentiality.*
 - 3. *Falsification of any paperwork related to the course.*
 - 4. *Sexual or other forms of harassment.*
 - 5. *Destruction of hospital or college property.*
 - 6. *Excessive absences. Note: excessive absenteeism will be a total of 8 hours of didactic class. Two tardies will equal 4 hours of absenteeism.*
 - 7. *Other reasons as identified by the lead instructing EMS System Coordination EMS Medical Director or JWCC.*

VI. RECORD KEEPING

- A. Lead instructor for each approved program shall maintain class and student records for seven years and shall be made available to the system or IDPH upon request


 Richard A Saalborn, D.O., FACEP, FACOEP
 EMS Medical Director


 Christopher R Solaro, M.D.
 EMS Assistant Medical Director

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL EMT-BASIC STUDENT APPLICATION**

PERSONAL DATA

Name (Last)	(First)	Initial	Date of Birth
Address (Street)	(City)	(Zip Code)	Social Security Number
Telephone Number (Home)			

EMERGENCY NOTIFICATION

Name (Last)	(First)	(Relationship)
Address (Street)	(City)	(Zip Code)
Telephone Number (Home)	Telephone Number (Work)	

CURRENT EMPLOYMENT/OCCUPATION

Employer	Job Title
Business Address (City)	Telephone Number
Immediate Supervisor (Name)	Job Title

EDUCATION

☐ High School Diploma ☐ GED

College (Name)	Location
Years Completed	Degree or Certificate

BACKGROUND INFORMATION

Have your privileges in Emergency Medical Services ever been revoked or suspended? ☐ Yes ☐ No

Have you been placed into a disciplinary process related to your EMS certification? ☐ Yes ☐ No

Have you ever been terminated from employment at Blessing Hospital ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

If any of the above answers are yes, please explain on a separate sheet and attach.

ADDITIONAL REQUIRED INFORMATION

1. Submit a copy of your current CPR card

IMMUNIZATIONS REQUIRED

Must show proof of the following prior to beginning clinical if required

1. MMR (measles, mumps, rubella) or proof of immunity
2. TB skin test (chest X-ray if positive result)
3. Tetanus within last 10 years
4. Hepatitis B series

EQUAL OPPORTUNITY CLAUSE

This program will make no discrimination because of race, sex, creed, national origin, ancestry or political affiliation.

Please note: Falsification of any information on this application will result in automatic denial of entry into the EMT-Basic program or continuance in the program.

I further understand that Blessing Hospital assumes no liability for possible injuries to me during the course of or as a result of my enrollment in this program.

Signature of Applicant

Date:

8/05, 12/07

QUINCY AREA EMERGENCY MEDICAL SERVICES
EMT-B STUDENT - Patient Assessment Form

Patient Assessed: ER Room: # _____ Age: _____ Sex: M ☐ F ☐ Date: _____ Time: _____

Location of Incident: _____

Type of Incident: ☐ Medical ☐ Trauma Other: _____

Mechanism of Injury/Nature of Illness: _____

Chief Complaint: _____

Signs and Symptoms: _____

Allergies: _____

Meds: _____

Past Medical History: _____

Last Meal: _____

Events: _____

Assessment	Time:			
LOC (AVPU)			PROCEDURES OR TREATMENT	
B/P, Pulse, Resp.			(Under Supervision of EMT-P/RN only.)	
Lung Sounds		LEFT	RIGHT	
	Clear	<input type="checkbox"/>	<input type="checkbox"/>	Performed
	Diminished	<input type="checkbox"/>	<input type="checkbox"/>	Observed
	Wheezes	<input type="checkbox"/>	<input type="checkbox"/>	Airway insertion
	Crackles	<input type="checkbox"/>	<input type="checkbox"/>	Assist Ventilation
	Absent	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Control
Skin Color/Temp	Warm <input type="checkbox"/>	Cool <input type="checkbox"/>	Pale <input type="checkbox"/>	Obstructed Airway
	Dry <input type="checkbox"/>	Clammy <input type="checkbox"/>	Cyanotic <input type="checkbox"/>	Maneuvers
	Normal <input type="checkbox"/>			CPR
				Spinal Immobilization
Pupils		LEFT	RIGHT	Splint Extremities
	Equal	<input type="checkbox"/>	<input type="checkbox"/>	Suction
	Reactive	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Therapy
	Irregular	<input type="checkbox"/>	<input type="checkbox"/>	Pulse Ox _____
	Dilated	<input type="checkbox"/>	<input type="checkbox"/>	
	Constricted	<input type="checkbox"/>	<input type="checkbox"/>	
Motor Response		Strong	Weak	Absent
	LUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	RUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	RLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glasgow Coma Scale A. EYES	Glasgow Coma Scale B. VERBAL	Glasgow Coma Scale C. MOTOR	Glasgow Coma Scale Total Score	
			<div style="display: flex; justify-content: space-around; align-items: center;"> <u> </u> A + <u> </u> B + <u> </u> C = <u> </u> Total </div>	

Narrative: _____

EMT-P/RN Signature _____

Student Signature: _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PREHOSPITAL RN TRAINING COURSE

I. Prerequisites:

- A. Registered Nurse, licensed in Illinois.
- B. Completion of the Trauma Nurse Specialist Course or the Trauma Nurse Core Curriculum
- C. ACLS certification
- D. BTLS certification or PHTLS certification
- E. CPR certification
- F. Criminal background check and drug testing per Blessing Hospital policy.

II. Training

- A. To include Division 1, Section 1 through 7, and Division 2, Section 3, of the United States Department of Transportation, National Standard Curriculum for EMT-Paramedics.
- B. Subject Areas/Didactic Requirements
 - 1. Roles and Responsibilities
 - 2. EMS Systems
 - 3. Medical/Legal Considerations
 - 4. EMS Communications
 - 5. Rescue
 - 6. Major Incident Response/*Start Triage/SMART Tag*
 - 7. Stress Management
 - 8. Airway and Ventilation
 - 9. Quincy Area EMS Protocols (self study)
 - 10. Extrication (Carbuster video series)
- C. Clinical Requirements
 - 1. Surgery rotation - 40 hrs/10 intubations
 - 2. Minimum of 100 hours field internship on a system approved ALS ambulance/complete a minimum of 10 ALS calls to include call management and skills.
 - 3. Extrication rotation with an approved rescue squad/Fire Department.

III. Course Completion Requirements

- A. Quincy Area EMS System written examination with minimum score of 80%.
- B. Practical exam to include:
 - 1. Airway management - basic/advanced
 - 2. PASG
 - 3. 12 Lead EKG
 - 4. Defibrillation
 - 5. Synchronized Cardioversion
 - 6. Transcutaneous Pacing

- C. Demonstrate proficiency in all EMT-P skills.
 - D. All didactic and clinical requirements must be completed within 90 days of scheduled course completion date.
 - E. *Start Triage – 80% pass rate.*
- IV. The EMS Medical Director will submit the names of approved Prehospital RN's to the Illinois Department of Public Health and will inform IDPH of any changes in the status of approved Prehospital RN's.
- V. RECORD KEEPING
- A. Lead instructor for each approved program shall maintain class and student records for seven years and shall be made available to the system or IDPH upon request.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMERGENCY COMMUNICATIONS REGISTERED NURSE COURSE

I. PURPOSE

To prepare the emergency centers registered professional nurse to function as an Emergency Communications Registered Nurse (ECRN) in the Quincy Area Emergency Medical Services System. As an ECRN, the nurse will be expected to relay appropriate treatment and medical orders to prehospital personnel via the telemetry (UHF), Merci (VHF) radios, and cell phone utilizing standing medical orders and EMS physician direction.

II. COURSE OBJECTIVES

- A. To educate and familiarize registered professional nurses with prehospital personnel.
- B. To introduce the nurse to the EMS System policies, procedures, and standing medical orders.
- C. To present nurses with the most current principals in accepted medical practice as related to prehospital care.

III. EDUCATOR/STAFF RESPONSIBILITIES

- A. ECRN course will be offered by the Resource Hospital and may be offered by the Associate Hospital in coordination with the Resource Hospital.
- B. Each course will be coordinated by an EMS lead instructor. The course may be taught by a registered professional nurse approved by the EMS Medical Director.
- C. The lead instructor shall perform duties which will include but not limited to the following:
 - 1. Schedule the course and accept nurses who meet the pre-requisite requirements.
 - 2. Obtain and confirm qualified faculty.
 - 3. Prepare and have duplicated all written materials for registrants.
 - 4. Facilitate lectures not personally conducted.
 - 5. Tabulate results of faculty and course evaluations and assist in planning program modifications based on student feedback.
- D. The EMS System Coordinator shall perform duties which will include but may not be limited to the following:
 - 1. Ensuring that the ECRN course is conducted in accordance with state-wide ECRN rules and regulations.
 - 2. Maintain ECRN records including student transcripts, certification justification, continuing education hours, and recertification data.
 - 3. Disseminate all test results in a timely manner.
- E. Each course shall be approved by the EMS Medical Director and shall work in coordination with the Lead Instructor and EMS Coordinator to verify that all established goals and objectives are achieved by the completion of the course.

IV. PRE-REQUISITE FOR COURSE

- A. Current licensure as registered nurse in Illinois.
- B. Have completed
 - 1. Emergency Department's Employee Orientation Program, or
 - 2. Minimum of 12 weeks of Nurse Residency Program, or
 - 3. Have written approval from the Emergency Department Director and EMS Medical Director which recognizes past work-related experience and demonstrates readiness to take the ECRN class.
- C. Current CPR Certification
- D. Sponsorship by a hospital participating in the Quincy Area EMS System.
- E. Criminal background check and drug testing per Blessing Hospital policy

V. COMPLETION REQUIREMENTS

- A. Successful completion of the forty (40) hour ECRN Course which includes:
 - 1. Successful completion of twenty four (24) hour didactic and skills instruction
 - 2. Successful completion of eight (8) hour AHA ACLS class.
 - 3. Successful completion of eight (8) hours radio experience under the direct supervision of ECRN.
 - 4. Completion of eight (8) hours field observation on an ALS unit.
 - 5. Completion of the Quincy Area EMS System written exam with a score of 80% or higher.
 - 6. Successful completion of the practical exam.
 - 7. *Start Triage – pass with 80%*
- B. All requirements must be met within 90 days of schedule course completion.
- C. When all criteria are met, the EMS Medical Director will be contacted and is responsible for ECRN certification authorization.

VI. RECORD KEEPING

- A. Lead instructor for each approved program shall maintain class and student records for seven years and shall be made available to the system or IDPH upon request.

**BLESSING HOSPITAL
EMERGENCY COMMUNICATIONS REGISTERED NURSE COURSE**

COURSE CONTENT

8 Hours AHA ACLS COURSE

4 Hours MODULE I

- Overview and History of the Emergency Medical Services
- Orientation to the Quincy Area Emergency Medical Services System
- Roles and Responsibilities
- Medical-legal Considerations

4 Hours MODULE II

- Early Recognition and Field Management of
 - * Respiratory Emergencies
 Skills: Ventilation Techniques and Airway Adjuncts
 - * Cardiac Emergencies
 - * Neurological Emergencies

4 Hours MODULE III

- Early Recognition and Field Management of:
 - * Shock
 - * Other Medical Emergencies
 - Renal Dialysis Patients
 - Environmental
 - Communicable Diseases
 - Geriatrics
 - Pediatrics

4 Hours MODULE IV

- Early Recognition and Field Management of the Trauma Patient
 - * Head and Neck Trauma
 Skills: Spinal Immobilization
 - * Body Cavity Trauma
 - * Burns/Soft Tissue Trauma
 - * Musculoskeletal Injuries
 Skills: Splinting and Traction Splinting
 Use of Pneumatic Counter Pressure Device (PCPD)

4 Hours MODULE V

- Early Recognition and Field Management of:
 - * OB/Gyn Emergencies
 - * Behavioral Emergencies
 - * Minor and Major Disasters
- Communications/Radio Protocol
- Quality Improvement/Evaluations

4 Hours

MODULE VI

- Skills Evaluation/Simulated Call Situations
 - * Cardiac
 - * Medical
 - * Trauma
- Written Evaluation

8 Hours

MODULE VII

- Communications Preceptorship at Blessing Hospital or Illini Community Hospital

8 Hours

MODULE VIII

- Ambulance Preceptorship with Adams County Ambulance Service or Pike County Ambulance Service

**BLESSING HOSPITAL
EMERGENCY COMMUNICATIONS REGISTERED NURSE COURSE**

COURSE CONTENT

8 Hours AHA ACLS COURSE

4 Hours MODULE I

- Overview and History of the Emergency Medical Services
- Orientation to the Quincy Area Emergency Medical Services System
- Roles and Responsibilities
- Medical-legal Considerations

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 - * Respiratory Emergencies
 Skills: Ventilation Techniques and Airway Adjuncts
 - * Cardiac Emergencies
 - * Neurological Emergencies

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 - * Shock
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 - Environmental
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- Communications/Radio Protocol
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4 Hours

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- Skills Evaluation/Simulated Call Situations
 - * Cardiac
 - * Medical
 - * Trauma
- Written Evaluation

8 Hours

MODULE VII

- Communications Preceptorship at Blessing Hospital or Illini Community Hospital

8 Hours

MODULE VIII

- Ambulance Preceptorship with Adams County Ambulance Service or Pike County Ambulance Service

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

FIRST RESPONDER AED COURSE

I. PURPOSE

- A. To provide the First Responder with training in early defibrillation and use of the automated external defibrillator in the hope that patients suffering unexpected cardiac arrest may not die needlessly. The course is based on Section 9 of the United States Department of Transportation, Emergency Medical Technician-Intermediate: National Standard Curriculum.

II. COURSE OBJECTIVES

- A. To provide general information regarding basic anatomy of the chest and heart, including the physiology of the heart, acute myocardial infarction, and cardiac arrest.
- B. To describe the electrocardiogram, basic rhythms and dysrhythmias in simple terms to provide the necessary information for using automated defibrillators.
- C. To present the fundamental principles and use of defibrillatory shock in the management of prehospital cardiac arrest.
- D. To demonstrate the correct use of the AED on a manikin following the Quincy Area EMS Systems policies and procedures.

III. REQUIREMENTS

- A. Have a current First Responder licensure
OR
- B. The course may be included as part of an initial FR-D license training program.

IV. COMPLETION REQUIREMENTS

- A. Attend all of the classes (100%)
- B. Pass a practical exam.
- C. Pass a written exam with 80%.

V. RECORD KEEPING

- A. Lead instructor for each approved program shall maintain class and student records for seven years and shall be made available to the system or IDPH upon request.

**QUINCY AREA EMS SYSTEM
AUTOMATED EXTERNAL DEFIBRILLATION COURSE**

DATE	CONTENT	HOURS	INSTRUCTOR
	Anatomy and Physiology of the Heart	0.5	
	Basic Life Support Review Policies and Procedures for use of the AED Safety factors Demonstrations/Practicals	2.5	
	Written Evaluation Practical Evaluation	1	

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AUTOMATED EXTERNAL DEFIBRILLATOR COURSE OUTLINE

Curriculum	Knowledge Objectives	Skills Objectives
Introduction	The student will be able to: <ol style="list-style-type: none"> 1. Describe the 4 links in the Chain of Survival . 2. Describe the critical importance of calling 911, getting the AED, starting CPR, and performing defibrillation. 3. Recognize a heart attack, cardiac arrest, and FBAO. 	The skill objectives are to: <ol style="list-style-type: none"> 1. Perform adult CPR. 2. Provide rescue breathing using a pocket facemask. 3. Relieve FBAO. 4. Operate an AED safely and effectively.
Overhead based lecture	At the end of the lecture the student will be able to: <ol style="list-style-type: none"> 1. Describe the structure and function of the cardiovascular system. 2. List the links in the Chain of Survival. 3. Explain the importance of reducing the time from collapse to the start of CPR and delivery of the first shock. 4. Describe the proper location of the AED electrode pads. 5. Discuss the importance of clearing the victim before AED analysis or defibrillation. 6. Describe the special situations where corrective actions must be taken before defibrillation. 7. Describe the special situations where corrective actions must be taken before defibrillation. 	
Instructor demonstrates major AED Components	At the end of the demonstration the student should be able to identify the following AED features: <ol style="list-style-type: none"> 1. Defibrillation adhesive electrode pads 2. Cable connections 3. On button (if present) 4. Analyze button (if present) 5. Shock button 6. Screen messages 	Hands –on practice will occur later in the course.
Instructor demonstrates: <ul style="list-style-type: none"> * AED maintenance • Troubleshooting • Use of an AED with CPR • Use of an AED in special situations 	The student should be able to describe the following aspects of AED maintenance and troubleshooting: <p>AED maintenance</p> <ol style="list-style-type: none"> 1. Inspection and maintenance schedule 2. Pad expiration date 3. Battery monitoring and replacement 4. Medical direction event documentation 5. Unit self test <p>Troubleshooting</p> <ol style="list-style-type: none"> 1. Error messages 2. Weak battery message 3. Poor electrode contact 4. Hairy or sweaty skin 5. Medication patches or paste 6. Water around the victim 7. Metal surfaces 8. Implanted cardioverter-defibrillator or pacer 9. Children less than 8 years or less than 90 pounds 	At the end of the instructor's demonstration the student should have an early understanding of these steps: <p>AED operation</p> <ol style="list-style-type: none"> 1. Check for responsiveness: A-B-C. 2. Rescuer operates the AED and Assumes control of the scene. 3. Rescuer performs ABCs and starts CPR if AED not yet on the scene. 4. Other rescuer calls 911 and gets AED. 5. AED rescuer performs defibrillation in less than 90 seconds of AED arrival.

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Instructor demonstrates AED and pad placement	<p>The student should be able to describe the device placement and pad placement:</p> <ol style="list-style-type: none"> 1. Place the AED close to the victim's left ear. 2. Perform defibrillation from the left side of the victim. This position may not be possible in all situations. 	<p>The student should have an understanding of these steps:</p> <p>Power on and Pad Placement</p> <ol style="list-style-type: none"> 1. Power on the AED. 2. Open pads; attach to AED cables if necessary. 3. Peel and place pads on victim's chest <ul style="list-style-type: none"> • Sternum: right border of the sternum, above the right nipple and just below the clavicle • Apex: to the outside of the left nipple, with the top margin of the pad several inches below the left armpit. 4. As electrodes pads are about to be placed: stop chest compression's and attach the pads as quickly as possible with minimal interruption of CPR 5. Respond to "check electrode" signal from improper application of pads.
Instructor demonstrates rhythm analysis and "clearing"	<p>The student should be able to describe rhythm analysis and rationale for "clearing" before analysis:</p> <ol style="list-style-type: none"> 1. Rhythm analysis and shock delivery will vary by AED brand. Clear before analyze. 2. State loudly, "I'm clear. You're clear. Everyone clear". 3. Visually check to ensure that no one is touching the victim during analysis. 4. Shock if indicated. 	<p>During practice sessions the student should be able to demonstrate:</p> <ol style="list-style-type: none"> 1. Opening the adhesive pad package. 2. Correcting problems that may occur with pad placement or attachment. 3. Responding to tones, voice-synthesized messages, or light indicators.
Instructor demonstrates "shock indicated" and pressing shock button	<p>The student should be able to describe response to "shock indicated" message.</p> <ol style="list-style-type: none"> 1. If AED detects VF, it presents a message-e.g., "shock advised", "shock now", or "shock indicated" 2. AED advises consecutive shocks if rhythm is persistent VF 	<p>In practice sessions the student should be able to:</p> <ol style="list-style-type: none"> 1. attach the AED and deliver shocks in less than 90 seconds of AED arriving at the victim's side.
Instructor demonstrates repeat rhythm assessment and shock delivery.	<p>The student should be able to describe responding to AED messages after the first shock.</p> <ol style="list-style-type: none"> 1. Follow AED voice prompts for repeat analysis and shocks and rhythm assessment periods. 2. Continue to give shocks in sets of 3 shocks then 1 minute of CPR until "no shock indicated" message is heard. 3. Continue analysis, defibrillation, and CPR until arrival of EMS. 	<p>During practice scenarios the student should be able to :</p> <ol style="list-style-type: none"> 1. follow AED voice prompts. 2. Continue to give shocks as indicated. 3. Continue to perform CPR as indicated with and without second rescuer. <p>Four steps of CPR:</p> <ol style="list-style-type: none"> 1. Unresponsive-911-AED 2. Airway 3. Breathing 4. Circulation <p>The four steps of AED use:</p> <ol style="list-style-type: none"> 1. Power on 2. Attach the AED 3. Analyze the rhythm 4. Shock

Reviewed 8/01, 8/02, 3/06

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**QUINCY AREA EMS SYSTEM
AUTOMATED EXTERNAL DEFIBRILLATION COURSE**

DATE	CONTENT	HOURS	INSTRUCTOR
	Anatomy and Physiology of the Heart	0.5	
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	Written Evaluation Practical Evaluation	1	

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AUTOMATED EXTERNAL DEFIBRILLATION REVIEW FORM

SERVICE: _____ DATE: _____
 SEX: _____ AGE: _____ PCR FORM NUMBER: _____

APPARENT CAUSE OF DEATH:

_____ CARDIAC/DEFINITE OR PRESUMED _____ TRAUMA
 _____ DROWNING _____ DRUGS/OVERDOSE
 _____ TERMINAL ILLNESS _____ OTHER: _____

TIMES

Time Call Received _____
 Time Dispatched _____
 Time Arrived _____
 Time Unit on Patient _____
 Time Depart Scene _____
 Time Arrived Hospital _____
 Time defibrillator to
 patient in minutes: _____

**ARREST
WITNESSED BY**

**CPR STARTED
BY**

_____ None
 _____ Family/Friend
 _____ Bystander-trained
 _____ Bystander-untrained
 _____ First Responder/EMT
 _____ Paramedic
 _____ Other

FIELD RHYTHMS

TIME					
RHYTHM					
JOULES					

RECEIVING HOSPITAL: _____ INITIAL RHYTHM IN ED: _____

FOLLOW UP

	YES	NO	UNK		YES	NO
Pronounced dead in ED	_____	_____	_____	Defibrillator Used Correctly	_____	_____
Died in Hospital	_____	_____	_____	Machine Failure/Difficulty	_____	_____
Spontaneous Pulse	_____	_____	_____	Extenuating Circumstances	_____	_____
Transferred	_____	_____	_____	Describe on Other Side of Form		
Date of Discharge	_____					

Neuro Deficit: _____

EMT's: _____

First Responders: _____

EMS Instructor: _____ DATE: _____

EMS Medical Director: _____ DATE: _____

VOID 2-17-2011

AUTOMATED EXTERNAL DEFIBRILLATOR PRACTICAL SKILLS ASSESSMENT FORM

STUDENT _____ CERTIFICATION NO: _____

EVALUATOR _____ DATE: _____

Communication and Command of Scene

- ☐ Verifies arrest and directs CPR to begin
- ☐ Positions semi-automatic external defibrillator
- ☐ Attaches pads while communicating identifying information

Defibrillation

- ☐ If a witnessed arrest, AED should be initiated and patient analyzed when AED is available
- ☐ Stops CPR, calls clear and looks clear
- ☐ Presses "analyze" to assess patient rhythm
- ☐ If "shock indicated", calls clear, looks clear and presses "shock"
- ☐ Calls clear and looks clear while machine analyzes patient rhythm
- ☐ If "shock indicated", calls clear, looks clear and presses "shock"
- ☐ If an unwitnessed arrest, CPR should be initiated for 2 minutes
- ☐ Instructs CPR to be resumed for 2 minutes
- ☐ If patient is in persistent ventricular fibrillation, repeats proper sequence to deliver additional shocks with 2 minutes of CPR between each shock.

Patient Assessment

- ☐ Checks pulse if no shock indicated
- ☐ Instructs CPR to be continued on pulseless patients
- ☐ If pulse is present, takes blood pressure
- ☐ Monitors pulse, respirations and ventilations

Safety (MUST PASS)*

- ☐ Always clears patient before "analyze" and "shock"

COMMENTS:

PERFORMANCE LEVEL:

- ☐ Unsatisfactory: Completes Less Than 15 Of 18 Steps
- ☐ Satisfactory: Completes 15 of 18 steps
- ☐ Excellent: Completes 17 of 18 steps

* EMT must not omit Safety step. Step required for satisfactory level.

 Kelly Cox, M.D., EMS Medical Director

revised: 5/98, 9/08
(reviewed: 8/95, 8/01, 3/06)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

FIRST RESPONDER-D COURSE

I. PURPOSE

- A. This curriculum is intended to prepare the student to function as a medically competent first responder in the prehospital setting. Enrichment programs and continuing education will fulfill other specific needs for individual systems.

II. COURSE OBJECTIVES

- A. The overall objective of the course is to improve the quality of emergency medical care rendered to victims of accidents and illness.
- B. To instruct the student to be proficient in providing basic life support.
- C. To instruct the student in taking actions to minimize the patient's discomfort and prevent further complications.

III. PRE-REQUISITES

- A. 18 years of age at time of State or National Registry test date.
- B. Possesses a high school diploma or GED at time of State or National Registry test date..
- C. Criminal background check and drug testing per Blessing Hospital policy

IV. COMPLETION REQUIREMENTS

- A. D.O.T. Emergency Medical Services First Responder Training Course (44 hour course).
- B. Pass final medical and trauma patient assessment practical.
- C. Pass final multiple choice written exam with a 70%.
- D. Maintain a 70% course average.
- E. Complete a minimum of 10 hours observation in the emergency department. (See Policy CET-5)
- F. All requirements must be met within 90 days of schedule course completion.

V. DISMISSAL FROM THE PROGRAM

- A. First Responder trainee may be dismissed from the training course if:
 - 1. More than two (2) absences or consistent tardiness are reflected in the attendance.
 - 2. There are violations of professional conduct standards.
 - 3. There is a breach of a patient's confidentiality.
 - 4. Inability to maintain a 70% course average.

VI. RECORD KEEPING

- A. Lead instructor for each approved program shall maintain class and student records for seven years, and shall be made available to the system or IDPH upon request.

NOTE: *First Responder classes will no longer be offered. Please consider First Responder-D class.*

FIRST RESPONDER COURSE

YEAR

MODULE I : PREPARATORY

CLASS	DATE	TOPIC	HOURS	INSTRUCTOR
1		Chap 1: Introduction to the EMS System The Emergency Medical Services System Roles and Responsibilities of the First responder Chap 2: Well-Being of the First Responder Chap 3: Legal and Ethical Issues	4	
2		Chap 4: Human Body Chap 5: Lifting and Moving Chap 19: Supplemental Skills	4	

MODULE 2: AIRWAY

3		Chap 6: Airway Care and Rescue Breathing	4	
4		Chap 6: Airway Assessments, Practical Lab, Evaluation of Airway Module	4	

MODULE 3: PATIENT ASSESSMENT

5		Chap 7: Patient Assessment Chap 19: Supplemental Skills	4	
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MODULE 4: CPR AND CIRCULATION

6		Chap 8: CPR and Circulation Evaluation of Patient Assessment and CPR	4	
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MODULE 5: ILLNESS AND INJURY

7		Chap 9: Medical Emergencies Chap 10: Poisoning Chap 11: Behavioral Emergencies and Crisis Intervention	4	
8		Chap 12: Shock, Bleeding, and Soft Tissue Injuries Chap 13: Injuries to Muscle and Bone	4	

MODULE 6: CHILDREN AND CHILDBIRTH

9		Chap 14: Childbirth Chap 15: Infants and Children and Pediatric Emergencies	4	
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MODULE 7: EMS OPERATIONS MODULE 8: SUPPLEMENTAL SKILLS

10		Chap 16: EMS Operations Chap 17: Special Patients and Considerations Chap 18: Special Rescue Situations	4	
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MODULE 9:

11		Written and Practical Exam	4	
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FIRST RESPONDER COURSE

YEAR

MODULE I : PREPARATORY

CLASS	DATE	TOPIC	HOURS	INSTRUCTOR
1		Chap 1: Introduction to the EMS System The Emergency Medical Services System Roles and Responsibilities of the First responder Chap 2: Well-Being of the First Responder Chap 3: Legal and Ethical Issues	4	
2		Chap 4: Human Body Chap 5: Lifting and Moving Chap 19: Supplemental Skills	4	

MODULE 2: AIRWAY

3		Chap 6: Airway Care and Rescue Breathing	4	
4		Chap 6: Airway Assessments, Practical Lab, Evaluation of Airway Module	4	

MODULE 3: PATIENT ASSESSMENT

5		Chap 7: Patient Assessment Chap 19: Supplemental Skills	4	
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MODULE 4: CPR AND CIRCULATION

6		Chap 8: CPR and Circulation Evaluation of Patient Assessment and CPR	4	
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MODULE 5: ILLNESS AND INJURY

7		Chap 9: Medical Emergencies Chap 10: Poisoning Chap 11: Behavioral Emergencies and Crisis Intervention	4	
8		Chap 12: Shock, Bleeding, and Soft Tissue Injuries Chap 13: Injuries to Muscle and Bone	4	

MODULE 6: CHILDREN AND CHILDBIRTH

9		Chap 14: Childbirth Chap 15: Infants and Children and Pediatric Emergencies	4	
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MODULE 7: EMS OPERATIONS MODULE 8: SUPPLEMENTAL SKILLS

10		Chap 16: EMS Operations Chap 17: Special Patients and Considerations Chap 18: Special Rescue Situations	4	
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MODULE 9:

11		Written and Practical Exam	4	
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**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS LEAD INSTRUCTOR COURSE

I. PURPOSE

- A. To prepare the student to function as an instructor in an EMS system and meet the requirements to take the EMS Lead Instructors state examination for certification.

II. COURSE OBJECTIVES

- A. To instruct the student in the sound principles of learning including current educational concepts, strategies, and techniques.
- B. To understand learning principles and adapt teaching strategies to increase the effectiveness of the classes they instruct.
- C. To orient the student to DOT/IDPH format and materials necessary to set up, instruct, and complete approved classes and continuing education programs for the EMT-B and first responder.

III. PRE-REQUISITES

- A. A current license as an EMT-B, EMT-I, EMT-P, RN, or physician.
- B. A minimum of four (4) years experience in prehospital emergency care.
- C. At least two (2) years of documented teaching experience in the classroom setting, i.e., BTLS, PHTLS, CPR, PALS, etc.
- D. Submission of a letter of recommendation from the EMS Medical Director or ambulance service administrator (president, director, or chairman).
- E. Submission of resume listing prehospital experience and teaching experience.

IV. COMPLETION REQUIREMENTS

- A. Attendance at all classes (100%).
- B. Satisfactorily present three mini lectures.
- C. Pass a written examination with a 80%.
- D. Receive a certificate of completion from the EMS Medical Director.
- E. All requirements must be completed within 90 days of end of the course.

V. RECORD KEEPING

- A. Lead instructor for each approved program shall maintain class and student records for seven years and shall be made available to the system or IDPH upon request.

VI. NAESME Lead Instructor Class

- A. If a member of the system completes the NAESME Lead Instructor class, they must complete the following before being approved to *function as a lead instructor* in the Quincy Area EMS System.
1. Supply and complete paperwork and send to EMS Office to receive an Illinois Lead Instructor license.
 - a) Complete child support statement
 - b) Copy of NAEMSE course completions certificate
 - c) Copy of NAEMSE letter stating the grade for the class.
 - d) A letter from the individual requesting a Lead Instructor reciprocity.
 - e) A copy of a current EMTB, EMTI, EMTP, RN, or physician's license.
 - f) A copy of a current CPR (Healthcare provider) or equivalent certificate/card
 - g) *A letter of support from EMS Medical Director or EMS System Coordinator*
 - h) *Maintain a current curriculum vitae or similar educational resume on file with Quincy Area EMS Office.*
 - i) Documentation of prehospital emergency care experience
 2. A four hour inservice with members of the Quincy Area EMS staff to review the following:
 - a) Review paperwork required by Quincy Area EMS and Illinois Department Public Health
 - b) Review continuing education policies
 - c) Review specific requirements to allow students to complete clinicals at Blessing Hospital
 - d) Review your responsibilities as a lead instructor within the system and IDPH.
 3. Be monitored for four hours by a member of the Quincy Area EMS staff (or designee) during a class presentation. Number of hours will be determined by evaluator.

- VII. Continuing Education for Teaching (must be EMS/Health related subject). Complete a con-ed form (CET 3a-F) each date that you taught and forward to EMS Office.



Kelly Cox, M.D., EMS Medical Director

12/97, 8/01, 3/06, 11/07. 9/08, 7/10, 2/13

LEAD INSTRUCTOR COURSE

CLASS	LESSON	OBJECTIVES	REFERENCES
Day One	Introduction to the Learning Process	<p>Introduction</p> <ol style="list-style-type: none"> 1. Welcome, Introductions 2. Opening Activities 3. Course schedule 4. Administrative Details 5. Course Objectives 6. Course Expectations 	
Day One	Instructor Roles and Responsibilities	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Define five instructor roles. 2. Demonstrate the ability to use three types of feed back appropriately. 3. List two guidelines for effective team teaching. 4. List four attributes of an effective instructor. 	<p>DOT National Standard Curriculum, EMS Instructor Program</p> <p>Cherry, Richard A., EMT Teaching, Brady, Prentice Hall, New Jersey, 1998</p>
Day One	Legal Implication in Instructing	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Define harassment and explain how the law applies to instructors. 2. List the elements of an equal opportunity statement 3. Describe informal and formal grievance procedures. 4. State two responsibilities instructors must fulfill toward students. 5. State the four essential elements in a claim of negligence and explain each element. 6. State three duties of the instructor that, if breached, could result in a negligence claim. 	<p>DOT National Standard Curriculum, EMS Instructor Program</p> <p>Pravensky, Catherine A. Teaching EMS, Mosby, St. Louis, Mo. 1995</p>
Day One	Principles of Adult Learning	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Define learning and identify the three domains of learning. 2. Describe the three major learning theories. 3. List the six levels of cognitive domain, five levels of the affective domain. 4. Describe four characteristics of adult learners. 5. Create auditory, visual, and kinesthetic learning activities. 6. List five study skills and factors that affect student learning styles. 7. List five test-taking skills and methods to increase the learning rate. 	<p>DOT National Standard Curriculum, EMS Instructor Program</p>
Day Two	Objectives and Domains Preparing to Teach the Existing Curriculum	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. List five basic phases of training design and development. 2. Explain how to apply your knowledge of the training design and development process .to the existing curriculum 3. List the components of a measurable objective. 4. Explain the purpose of objectives, for participants and instructors. 5. Identify objectives as affective, cognitive or psychomotor. 6. Write objectives for a class you will be instructing. 	<p>DOT National Standard Curriculum EMS Instructor Program</p>

2001 LEAD INSTRUCTOR COURSE

CET 12.3

CLASS	LESSON	OBJECTIVES	REFERENCES
Day Two	Lesson Plan Development	<p>Upon completion of this part of the lesson the student will have sufficient information to:</p> <ol style="list-style-type: none"> 1. State the purpose of lesson plans 2. Identify the seven major components of a lesson plan 3. Describe the importance of each lesson plan component 4. Incorporate the seven major components of a lesson plan when adapting or creating an individual lesson plan from the EMT-Basic curriculum. 5. Write a lesson plan and present it. 	DOT National Standard Curriculum EMS Instructor Program
Day Two	Teacher/Student Expectations	<p>Upon completion of this part of the lesson the student will have sufficient information to:</p> <ol style="list-style-type: none"> 1. Describe the expectations of the teacher. 2. Describe the expectations of the student. 3. Explain why they are important. 	Handouts and Lecture
Day Two	Mini-lecture # 1	<p>The student will prepare and present a mini-lecture with evaluation by instructors</p> <ol style="list-style-type: none"> 1. The lecture will have written objectives and lesson plan. 	Practical
Day Three	Creating an Effective Learning Environment	<p>Through group discussion and question and answer sessions, the student should be able to:</p> <ol style="list-style-type: none"> 1. Describe three information-gathering techniques used to assess an audience. 2. Specify three individual or group attributes that affect learning 3. Describe an adaptive strategy for dealing effectively with three individual or group attributes 4. Identify two potential obstacles to learning 5. Cite methods to overcome two potential obstacles to learning. 6. List five characteristics of an ideal learning environment. 7. Describe seating arrangements that promote interaction 8. Name three factors that contribute to a stimulating atmosphere. 	DOT National Standard Curriculum EMS Instructor Program
Day Three	<p>Instructional Strategies, Methods and Alternative Teaching Methods</p> <p>Principals of Practical Skills Instruction</p>	<p>Through group discussion, question and answer sessions, and individual and group activities, the student should be able to:</p> <ol style="list-style-type: none"> 1. Define instructional strategies. 2. List the four parts of instruction. 3. List six teaching methods. 4. Describe two advantages and two disadvantages for each method listed. 5. Determine an appropriate teaching method given an objective. 6. Describe the purpose of role-playing, simulation, games, brainstorming and case studies as instructional strategies. 7. Apply the principles of active listening in a role-play exercise 8. List five guidelines for effective presentations. 9. Discuss the application of concepts, procedures and principals in skills learning. 	DOT Standard Curriculum EMS Instructor Program

2001 LEAD INSTRUCTOR COURSE

CLASS	LESSON	OBJECTIVES	REFERENCES
Day Three	Preparation and Use of Media and Instructional Aids	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. List four steps in the media selection process. 2. List three purposes of media decisions. 3. Select appropriate media to achieve instructional objectives. 4. List five components of a lecture box or AV tool kit. 5. Use an overhead projector, chalk board and flip chart. 	DOT National Standard Curriculum EMS Instructor Program
Day Three	Preparation and Presentation of Mini Lecture #2	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Develop a written lesson plan for a mini-lecture on an assigned subject. 2. Present a three-minute lecture from the prepared lesson plan. 3. Have the lecture critiqued by students and instructors. 	Practical
Day Four	Using Scenarios and Moulage	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Discuss scenarios and their components. 2. Apply the three domains of learning to a scenario. 3. Develop a moulage kit. 4. Describe the advantages and disadvantages in using moulage. 	Handouts Demonstrations of moulaging
Day Four	Orientation to DOT/IDPH Format and Forms (usually presented by state EMS Education Coordinator)	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Understand the state requirements to implement a training or continuing education program. 2. Identify key elements of documentation for training programs. 3. List class records that must be retained. 4. Be cognizant of time elements when sending information to the state. 	Handouts and Lecture
Day Four	Purposes and Types of Evaluation/Feedback Evaluation Instrument Development Principles	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. State two purposes for evaluation. 2. Define the concepts of validity and reliability. 3. List five types of test item types for measuring cognitive objectives. 	DOT Standard Curriculum EMS Instructor Program
Day Four	Mini Presentation # 3	<p>The student will:</p> <ol style="list-style-type: none"> 1. Develop a written lesson plan for a mini-lecture on an assigned subject. 2. Present a 3 minute lecture from the prepared lesson plan 3. Have the lecture critiqued by students and instructors. 	Practical

2001 LEAD INSTRUCTOR COURSE

CLASS	LESSON	OBJECTIVES	REFERENCES
Day Five	Putting It All Together	<p>Upon completion of this part of the lesson the student should have sufficient information to:</p> <ol style="list-style-type: none"> 1. Organize and prepare materials for presentation. 2. Effectively be able to deliver each lesson contained in the curriculum. 3. Prepare instructional aids, which will increase the effectiveness of the training. 4. Ensure that all-necessary equipment and materials necessary for student learning are present and operational. 5. Evaluate student performance and provide corrective feedback. 6. Provide a mechanism for evaluating the training programs effectiveness 	Handouts and Lecture
Day Five	Written State Examination	<p>The student will complete the state written exam.</p> <ol style="list-style-type: none"> 1. Pass the exam with an 80% or above. 	Written State Examination
Day Five	Mini Lecture # 4	<p>The student will :</p> <ol style="list-style-type: none"> 1. Prepare a 7-10 minute lecture incorporating a lesson plan, and use of media. 2. Follow the principles of presenting a lecture learned in the course. 3. Be critiqued and evaluated by the instructors and receive a satisfactory rating 	Practical
Day Five	Course Evaluation Wrap-up Graduation	Awarding of certificates.	

Re: 06/30/01;
(reviewed 8/01, 2/06, 7/10)

EMS LEAD INSTRUCTOR APPLICATION

NAME: _____

ADDRESS _____ D.O.B: _____

CITY: _____ STATE: _____ ZIP _____

ORGANIZATION: _____

HOME PHONE: _____ WORK PHONE: _____

☐ EMT-B ☐ EMT-BD ☐ EMT-I ☐ EMT-P ☐ RN ☐ MD

RETURN THE APPLICATION WITH DOCUMENTATION OF PRE-REQUISITES TO:

BLESSING HOSPITAL
EMS OFFICE
PO 7005
QUINCY, IL 62305-7005

PRE-REQUISITES

1. A current license as an EMT-B, EMT-BD, EMT-I, EMT-P, RN, or PHYSICIAN
2. A minimum of four (4) years experience in pre-hospital emergency care.
3. At least two (2) years of documented teaching experience in the classroom setting, BTLS, PHTLS, CPR, PALS, etc.
4. Submission of a letter of recommendation from the EMS Medical Director or ambulance service administrator (president, director, or chairman).
5. Submission of an informal resume listing pre-hospital experience and teaching experience.

COMPLETION REQUIREMENTS

1. Attendance at all classes (100%).
2. Satisfactorily present three mini lectures.
3. Pass the state written examination with a 80%.
4. Receive a certificate of completion from the EMS Medical Director

(reviewed 8/01, 3/06)

QUINCY AREA EMS SYSTEM

EQUIPMENT

Current Equipment Listings	E-1
BLS Ambulance Supplies	E-2
ALS Ambulance Supplies	E-3
Non-transport Agency BLS Equipment	E-4
First Responder Equipment List.....	E-5
Alternate Response Vehicle ALS Supplies	E-6
<i>Reserve Ambulance</i>	<i>E-7</i>

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

CURRENT EQUIPMENT LISTINGS

- I. Advanced life support transport vehicles will carry all equipment that basic life support personnel currently carry with addition of the approved drug list, approved advanced airway management equipment, defibrillation equipment, and telemetry transmission equipment as approved by the Illinois Department of Public Health Office of Preparedness and Response. (Refer to Policy E-2 and E-3.)
- II. Basic life support transport vehicles will carry equipment according to the listing approved by the Quincy Area Emergency Medical Services System and the Illinois Department of Public Health Office of Preparedness and Response. (Refer to Policy E-2.)
- III. Non-transport vehicles (BLS) will carry equipment as listed and approved by the Illinois Department of Public Health Office of Preparedness and Response and by the Quincy Area Emergency Medical Services System. (Refer to Policy E-4.)
- IV. Non-transport (ALS) will carry equipment as listed and approved by the Illinois Department of Public Health Office of Preparedness and Response and by the Quincy Area Emergency Medical Services System. (Refer to Policy E2 and E-3.)
- V. ALS Alternate Response Vehicles (non-transport) will carry equipment as listed and approved by the Illinois Department of Public Health Office of Preparedness and Response and by the Quincy Area Emergency Medical Services System. (Refer to Policy E-6 ARV.)
- VI. BLS alternative response vehicle (non-transport) will carry equipment as listed and approved by Illinois Department of Public Health and QAEMS (refer to Policy E-4)
- VII. First Responders will have equipment immediately available to them as listed and approved by Illinois Department of Public Health and QAEMS System. (Refer to Policy E-5.)
- VIII. Reserve ambulance will meet same requirements as all other ambulance with the exception of medical supplies and durable medical equipment.
- IX. *EMS agencies shall make every effort to protect EMS vehicle contents (supplies, equipment, and medications) from climate extremes.*

NOTE: The U.S. Pharmacopeial convention issues standards for the safe storage of human medications and the range of 50° to 86° is established as the parameter for EMS medication storage.



Kelly Cox, M.D., EMS Medical Director

6/84;
re: 7/86, 6/87, 11/97, 4/98, 8/01, 5/06, 4/10,
8/11, 10/12
(reviewed 8/95)

QUINCY AREA EMS SYSTEM
BLS AMBULANCE –INSPECTION FORM

Provider _____ License#: _____
 Garage Address: _____
 VIN: _____ Level of Care: _____ Local ID: _____ EMS Sys # _____
 Inspection Type: _____ Inspected By: _____
 Inspection Date: _____ Inspection Status: _____ Action: _____

Patient Transport Equipment

- ☐ Wheeled multi-level cot with 3 sets of straps+ over shoulder straps
- ☐ 3-Point fastener for cot
- ☐ Cot fits securely in fastener
- ☐ Secondary stretcher with 3 sets of straps

Main On-Board oxygen Equipment

- ☐ (Main (on-board) oxygen cylinder not empty ---volume (psi) _____)
- ☐ Adult size non-rebreather oxygen mask (minimum 2) and total of 4.
- ☐ Child size oxygen mask (minimum 1) and total of 2.
- ☐ Infant size oxygen mask (minimum 1) and total of 2.
- ☐ Adult size nasal cannulas (minimum 3) and total of 4.
- ☐ Child size nasal cannulas (minimum 3) and total of 4

Portable Oxygen Equipment

- ☐ Portable oxygen cylinder: (minimum size 'D') ---volume (psi) _____
- ☐ Dial flow meter/regulator for 15 lpm
- ☐ Full spare portable oxygen cylinder (minimum size 'D')
- ☐ Quick-release, crash-stable mounting racket for portable oxygen cylinders
- ☐ Adult size non-rebreather oxygen mask (minimum 2)
- ☐ Child size oxygen mask (minimum 1)
- ☐ Infant size oxygen mask (minimum 1)
- ☐ Adult size nasal cannulas (minimum 2)
- ☐ Child size nasal cannulas (minimum 1)

Suction and Airway Equipment

- ☐ Onboard suction capable of obtaining 300 mmHg suction within 4 seconds of clamping tube
- ☐ --- Vacuum level can be adjusted
- ☐ --- Collection bottle holds 1000 ml
- ☐ Two packages suction tubing capable of reaching second patient being transported on squad bench
- ☐ Portable battery operated suction capable of obtaining 300 mmHg suction within 4 seconds of clamping tubing
- ☐ --- Capable of charging from vehicle 12-volt DC/115-volt AC
- OR
- ☐ ---Operated from internal rechargeable battery
- ☐ ---Operates for 20 continuous minutes (perform if battery sounds weak)
- OR
- ☐ Manually operated suction device (IDPH approved)

Suction and Airway Equipment (Continued)

- ☐ Sterile, single-use suction catheters, two each size: 6, 8, 10, 12, 14, 16, 18-french with thumb suction control port (one set with on-board suction; one set with portable suction)
- ☐ Semi-rigid pharyngeal suction tips, with thumb suction control port, three (3)
- ☐ Airway, oropharyngeal – adult, child and infant sizes 00-5
- ☐ Airway, nasopharyngeal, sizes 12-34 French
- ☐ Lubricant for nasopharyngeal airways

Resuscitation Equipment

- ☐ Adult size squeeze bag-valve-mask ventilation unit with transparent adult mask (minimum one)
- ☐ Child size squeeze bag-valve-mask ventilation unit with child, infant and newborn transparent masks (minimum one)
- ☐ CPR mask with safety valve to prevent backflow of expired air and secretions (minimum one)
- ☐ Automated External Defibrillator (AED) with Adult and Pediatric Capability
 - Adult AED Pads
 - Pediatric AED Pads

Extrication/Immobilization/Splinting Equipment)

- ☐ Long spine board (72"X16" minimum) with 3 sets of torso straps
- ☐ Short spine board (32"X16" minimum) with two (9 foot) torso straps, one child strap and one head strap
- OR
- ☐ Vest type wrap around extrication device (KED, ZED)
- ☐ Infant size rigid cervical collar (minimum one)
- ☐ Child size rigid cervical collar (minimum one)
- ☐ Small adult size rigid cervical collar (minimum one)
- ☐ Medium adult size rigid cervical collar (minimum one)
- ☐ Large adult size rigid cervical collar (minimum one)
- OR
- ☐ Rigid cervical collar adjustable to adult sizes (minimum one)
- ☐ Rigid cervical collar adjustable to pediatric sizes (minimum one)
- ☐ Traction splint, adult
- ☐ Traction splint, pediatric
- ☐ Extremity splints, adult, 2 long
- ☐ Extremity splints, adult, 2 short
- ☐ Extremity splints, pediatric, 2 long
- ☐ Extremity splints, pediatric, 2 short
- ☐ Restraints, 2 pair (arm and leg) for 4-point restraint
- ☐ Wrecking bar (24" minimum)
- ☐ Goggles

Assessment Equipment

- ☐ Pulse oximeter with adult and pediatric capability/probes
- ☐ Blood pressure cuff, large adult
- ☐ Blood pressure cuff, adult
- ☐ Blood pressure cuff, child
- ☐ Blood pressure cuff, infant

Assessment Equipment (Continued)

- ☐ Gauge(s) for blood pressure cuffs appropriately calibrated
- ☐ Stethoscopes, two (2)
- ☐ Flashlight, for patient assessment, minimum one (1)
- ☐ Adequate lighting to allow patient assessment
- ☐ Electric clock with sweep second hand

Medical Supplies

- ☐ Trauma dressings (12"X30"), Six (6)
 - ☐ Gauze pads (4"X4"), sterile, Twenty (20)
 - ☐ Gauze, soft, self-adjusting (4"X5 yards), ten (10) rolls
 - ☐ Vaseline gauze (3"X8"), Two (2)
 - ☐ Adhesive tape, two (2) rolls
 - ☐ Triangle bandages or slings, five (5)
 - ☐ Bandage shears (minimum 1)
 - ☐ Burn sheets (clean, individually wrapped), Two (2)
 - ☐ Cold packs (3)
 - ☐ Obstetrical kit, sterile (minimum 1) pre-packaged with instruments and bulb syringe)
 - ☐ Thermal absorbent blanket and head cover OR aluminum foil OR appropriate heat reflective material (one per OB kit)
 - ☐ Sterile solution (normal saline) in plastic bottles or bags, 2000cc
 - ☐ Drinking water, 1 quart (may substitute 1000cc sterile water)
 - ☐ Epinephrine, adult (EPIPEN)
 - ☐ Epinephrine, pediatric (EPIPEN)
 - ☐ Pediatric equipment/drug dosage sizing tape, current (Broselow 2011 edition A or newest version).
- OR**
- ☐ Pediatric equipment/drug age/weight chart
 - ☐ Pediatric trauma score reference
 - ☐ Emesis basin or bag (minimum 1)
 - ☐ Bedpan (One)
 - ☐ Urinal (One)
 - ☐ Child and infant car seats OR convertible car seat

Personal Protective Equipment (PPE)

- ☐ Impermeable biohazard-labeled isolation bag, minimum 1
- ☐ Nonporous disposable gloves
- ☐ Face masks, minimum 1 per crew member
- ☐ Eye protection (face shields or safety glasses/protective eyewear), minimum 1 per crew member
- ☐ Gowns 1 per crew member

Linens

- ☐ Pillows, minimum 2
- ☐ Sheets, minimum 2
- ☐ Blankets, minimum 2
- ☐ Pillowcases, minimum 2

Communication

- ☐ Ambulance emergency run reports with data required by IDPH (minimum 10)
OR
☐ Electronic documentation with paper backup
☐ Illinois Poison Center Number
☐ IDPH Center Complaint hotline number (must be posted where visible to patient)
☐ Ambulance-to-hospital radio tested and working

Additional

- ☐ Glucometer with strips
☐ 10 Smart Tags
☐ Oral glucose
☐ Scoop stretcher (optional)
☐ Mast Trouser (adult and pediatric) optional

Safety/General Vehicle

- ☐ Patient area is clean
☐ Equipment in patient area is secured/crash-stable
☐ (1) Flashlight minimum 1
☐ Fire extinguishers (5 pound ABD, two (2), with current service tag
☐ Emergency warning lights operational
☐ Siren operational
☐ Flood lights operational
☐ Current IDOT – issued Safety Inspection sticker on windshield
☐ No visually apparent issues which would compromise the safety of the patient, the ambulance personnel or the public
☐ Vehicle contents should be protected from climate extremes



 Kelly Cox, M.D., EMS Medical Director

6/84; re: 10/86, 9/90, 11/97, 3/01, 4/04, 8/04
 re: 5/06, 8/07, 1/08, 11/09, 8/11, 4/12, 10/12
 (reviewed: 8/95)

QUINCY AREA EMS SYSTEM
AMBULANCE SUPPLIES - ALS

(Transport and Non-Transport)

Airway

- ☐ (1) Adult and pediatric laryngoscope handle with spare batteries/bulbs
- ☐ (Assorted) Laryngoscope blades (Straight/Miller: #0,1,2; Curved: #3)
- ☐ (2 Each) Cuffed endotracheal tubes sizes 6.0, 6.5, 7.0, 7.5
- ☐ (2 Each) Uncuffed endotracheal tubes sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
- ☐ (2 Each) Adult and pediatric stylets
- ☐ (1) Magill forceps
- ☐ (2) 10 cc syringes – no needle
- ☐ (1) Esophageal intubation detector (EID) OR End tidal CO2 monitor
- ☐ (1) Cricothyroidotomy kit (such as Kwik-Cric, Nu-Trach)
- ☐ (1) Combitube airway adult
- ☐ (1) Meconium aspirator
- ☐ (1) Spare batteries/bulbs for laryngoscope
- ☐ (1) *S.A.L.T*

CPAP (ALS transport only)

Suggest all CPAP equipment be placed in a bag to assure quick accessibility

- ☐ Full portable O2 tank
- ☐ Flow meter with Diss Port
- ☐ Med Mask with flow generator (313-7056 ea)
- ☐ Neb adapter (313-2730 ea)
- ☐ Large mask (313-7030 ea)

IV/Venipuncture/Medication Administration


- ☐ (1 Box) Alcohol swabs
- ☐ (1) Blood glucometer with test strips
- ☐ (6000 ml) 0.9% Sodium Chloride IV solution (500 or 1000 ml bags)
- ☐ (3) IV primary tubing
- ☐ (2) IV Microdrip tubing (Available in drug boxes)
- ☐ (4) Tourniquets
- ☐ (2) Saline lock kits (optional)
- ☐ (4 Each) IV Cannula – over the needle catheters (16, 18, 20, 22, 24 gauges)
- ☐ (2) Intraosseous Needles
- ☐ (Assortment) Syringes (3cml, 5-6ml, 10-12ml, 20ml)
- ☐ (Assortment) Needles (19 gauge-1", 22-23 gauge 1", 22-23 gauge 1 ½", 25 gauge 5/8"
- ☐ (1) Arm Board
- ☐ EZIO with adult needles


Cardiac Equipment

- ☐ (1) Cardiac monitor capable of monitoring in at least three leads, defibrillation, synchronized cardioversion and transcutaneous pacing. 12 lead ECG optional. (Effective 1/1/12, all cardiac monitors must have 12 Lead capability and be able to transmit 12-Leads to Blessing Hospital and all ALS ambulances must have ETCO monitoring capabilities for intubated and non-intubated patient.
- ☐ (2) Monitoring electrode cables (may substitute one set for Quick Combo)
- ☐ (1) Defib gel, defib pads, Fastpatch pads, Quick Combo pads (*adult and peds*)
- ☐ (2) Monitor paper
- ☐ (3 Sets Each) Monitoring electrodes (pediatric, adult)
- ☐ (2) Spare batteries
- ☐ (1) Razor

Other


- ☐ (1) Doppler
- ☐ (2) 14 gauge over the needle catheters, 3.25" length for needle chest decompression
- ☐ (I) System approved drug box (See Policy O-13-F)
(ALS non-transport will carry medications as listed in Policy O-14 ARV)


 Richard A. Saalborn, D.O., FACEP, FACOEP
 EMS Medical Director
 Quincy Area EMS System


 Christopher R Solaro, MD, PHD
 Associate Medical Director
 Quincy Area EMS System

QUINCY AREA EMS SYSTEM
NON-TRANSPORT AGENCY BLS EQUIPMENT

- ☐ Full portable oxygen cylinder
- ☐ Dial flowmeter/regulator for 15 lpm
- ☐ A, C, I Non-rebreather Masks
- ☐ Adult squeeze bag and valve, with adult and child masks
- ☐ Child squeeze bag and valve, with child and infant masks
- ☐ Airways, oropharyngeal, A, C, I
- ☐ Airways, Nasopharyngeal with lubrication (sizes 12-30F)
- ☐ Manually operated suction device (IDPH approved)
- ☐ Triangular bandages or slings
- ☐ Roller bandages, self-adhering (4"X5 yd)
- ☐ Trauma dressings/universal dressings
- ☐ Sterile gauze pads (4"X4")
- ☐ Vaseline gauze (3"X8")
- ☐ Bandage shears
- ☐ Adhesive tape rolls
- ☐ Blanket
- ☐ Long backboard
- ☐ Cervical collars, A, C, I, Ped
- ☐ Extremity splints, adult/child, long/short
- ☐ Adult/child/infant blood pressure cuffs and gauge
- ☐ Stethoscope
- ☐ Burn sheet, individually wrapped
- ☐ Sterile solution, (1,000 cc) plastic bottles or bags
- ☐ Aluminum foil or silver swaddler
- ☐ Obstetrical kit, sterile w/head cover
- ☐ Cold packs
- ☐ EMS run reports (System Approved Forms)
- ☐ Nonporous, disposable gloves
- ☐ Eye/nose/mouth protection or face shields
- ☐ Flashlight
- ☐ Equipment to allow communication with hospital
- ☐ Glucometer with strips
- ☐ Gowns
- ☐ AED with 2 sets of adult *and pediatric* pads
- ☐ Razor to be kept with AED
- ☐ Oral Glucose (optional)



 Kelly Cox, M.D., EMS Medical Director

8/01;
 re: 4/04, 5/06, 8/07, 1/08, 8/11, 10/12

**QUINCY AREA EMS SYSTEM
FIRST RESPONDER EQUIPMENT LIST**

I. At a minimum, First Responder-D will have the following equipment immediately available to them:

A. Equipment List

1. Triangular bandage
2. Roller type bandage
3. Universal trauma dressings
4. Gauze pad
5. Occlusive Dressing (Vaseline gauze)
6. Bandage Scissors
7. Adhesive tape
8. Stick (for impaled object/tourniquet)
9. Blanket
10. Upper; extremity splint
11. Lower extremity splint
12. Oxygen equipment: adult, child, infant mask (cylinder is to be full)
13. Adult BVM and Child BVM with child and Infant mask
14. Oropharyngeal airways (adult, child and infant)
15. OSHA personal protection items (face/eye mask, gowns, etc.)
16. Blood pressure cuffs and gauge (adult, child, and infant)
17. Stethoscope
18. EMS Patient Care Report Forms (System approved forms)
19. Non-porous disposable gloves
20. AED (If service is licensed as FRD or B level) with 2 sets of adult pads
21. Equipment to contact Dispatch and/or hospital.
22. Isolation Bag
23. SMART Triage Tags (ACERS must have a system in place to assure tags are available)
24. Razor (to be kept with AED)

B. Optional Equipment

1. Nasopharyngeal airways (sizes 12-30f with lubricant)
2. Mechanical or manually operated suction device
3. Flashlight
4. Long backboard
5. C-collars (adult, child, infant)
6. Burn sheet (individually wrapped)
7. Sterile solution (1000cc) in plastic bottles or bags
8. Obstetrical Kit, sterile with head cover
9. Cold packs
10. Glucometer with strips (Optional)
11. Glucose (oral)



Kelly Cox, M.D., EMS Medical Director

4/98

re: 12/03, 3/06, 8/07, 12/07, 4/08, 11/09, 8/11
(reviewed 8/01, 10/12)

QUINCY AREA EMS SYSTEM
ALTERNATE RESPONSE VEHICLE SUPPLIES - ALS

E-6.1 ARV

General Equipment

- ☐ (1) Ambulance to hospital radio (Merci – tests functional)
- ☐ (10) Illinois PCR run sheets
- ☐ (1 Each) Blood pressure cuff with gauge (infant, child, adult, obese)
- ☐ (2) Stethoscope
- ☐ (1) Bandage shears
- ☐ (1) Pediatric sizing/dosing chart or tape
- ☐ (1) Poison control number (posted)
- ☐ (1) Pediatric trauma score reference (On Illinois PCR run sheets)
- ☐ (1) OB kit, sterile
- ☐ (2) Sheets
- ☐ (2) Blankets
- ☐ (3) Cold packs
- ☐ (2) Penlights
- ☐ (1) Glucometer with strips (optional)
- ☐ (10) SMART Triage Tag
- ☐ (1) Cardiac monitor capable of monitoring in at least three leads, defibrillation, synchronize cardioversion and transcutaneous pacing. 12 Lead optional

Personal Safety/Biohazard Equipment

- ☐ (Appropriate Sizes) Nonporous disposable gloves
- ☐ (1) Red biohazard bag – impermeable
- ☐ (2) Goggles or face shields
- ☐ (2) Face masks to cover nose and mouth
- ☐ (2) N-95 masks
- ☐ (2) Gowns

Dressing/Bandaging Supplies

- ☐ (6) Trauma dressing
- ☐ (20) 4" X 4" gauze pads
- ☐ (10) Roller style self adhering bandages (4" X 5yd)
- ☐ (2) Vaseline gauze 3" X 8"
- ☐ (2) Burn sheet (clean, individually wrapped)
- ☐ (2) Adhesive tape rolls

Oxygenation/Airway Equipment


- ☐ (1) Portable O₂ tank with 15 LPM regulator – at least “D” size/not empty
- ☐ (1) Spare portable tank full (secured)
- ☐ (2) Oxygen connection tubing
- ☐ (3 Each) Nasal cannulas (adult, child and infant)
- ☐ (2 Each) Non-rebreather masks (adult, child and infant)
- ☐ (1) CPR mask with one way valve
- ☐ (1) Adult bag-valve-mask (adult and child size masks)
- ☐ (1) Pediatric bag-valve-mask (child and infant size masks)
- ☐ (1 Set) Oral airways (infant through adult)
- ☐ (1 Each) Nasopharyngeal airways (infant, child, adult – sizes 12-30F)
- ☐ (1) Lubricant for airway equipment (Subgilube, K-Y, etc.)
- ☐ Manually operated suction device (IDPH approved)

ALTERNATE RESPONSE VEHICLE SUPPLIES – ALS (continued)**Immobilization/Splinting**

- ☐ (1) Long spine board with 3 sets of straps and cervical immobilization device
- ☐ (1) Pediatric spine board with 3 sets of straps (optional)
- ☐ (1) Short spine board or vest type device (KED, ZED)
- ☐ (1 Each) Rigid cervical collars (pediatric, small, medium, large)
- ☐ (1 Set) Extremity splints – adult (two each, long and short) (Sam Splints)
- ☐ (1 Set) Extremity splints – pediatric (two each, long and short) (Sam Splints)
- ☐ (5) Triangular bandages with safety pins)

Extrication Equipment

- ☐ (1) Wrecking bar – at least 24 inches
- ☐ (1) Fire extinguishers – at least 5 lb. ABC each
- ☐ (1) Flashlight (battery operated)
- ☐ Agreement with local fire department/rescue agency for extrication
- ☐ Agreement with local garage to replace/repair tires


 Kelly Cox, M.D., EMS Medical Director

4/2010; re 8/11
 (reviewed 10/12)

QUINCY AREA EMS SYSTEM
RESERVE AMBULANCE

- I. Each ambulance service may license “Reserve Ambulances” to assist with unforeseen mechanical or accident related issues with the primary ambulances.
- II. Reserve ambulances must meet all requirements of a licensed ambulance except the required inventory of medical supplies and durable medical equipment, which may be rapidly transferred from a fully functional ambulance to a reserve ambulance without the use of tools or special mechanical expertise.
- III. Prior to a Reserve ambulance being placed into duty, it must be inspected by the EMS Coordinator or designee using the appropriate policy for equipment and supplies (E-2 and/or E-3).



Kelly Cox, MD, EMS Medical Director

8/2011
(reviewed 10/12)

QUINCY AREA EMS SYSTEM

PREHOSPITAL PROTOCOLS

Richard A Saalborn, DO, EMS Medical Director
Christopher Solaro, MD, Associate EMS Medical director
Randy Faxon., EMS System Coordinator

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Amputated Parts.....	MP-3
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IV Drip Conversion Chart.....	Appendix A

FIELD OPERATIONSI. STANDARD OPERATING PROCEDURES FOR BLS/ALS PROVIDERS

A. Prehospital Protocols

1. Prehospital Protocols are to be followed by all ALS and BLS personnel in the prehospital treatment and care of the acutely ill or injured patient.
 - a) Both crew members are equally responsible for ensuring that protocol is followed and that appropriate care is given to patient.
 - b) For a crew with 1 EMT-B and 1 EMT-P, the paramedic has ultimate responsibility for patient care.
 - c) A crew member cannot be held responsible for a specific act performed by his/her partner while not present.
 - d) The appropriate equipment necessary to assess and initiate treatment will be taken to the patient's location. (This should be based upon the complaint).
2. To activate Advanced Life Support in the field, there must be at least one certified paramedic and one EMT-B present.
3. An ALS vehicle will be dispatched to meet a BLS provider when:
 - a) the BLS provider requests one.
 - b) the ECRN or emergency physician at Medical Control deems it necessary based upon patient condition.
 - c) dispatch has determined the call to be a dual response.
4. Treatment, procedures, and standing orders may be initiated prior to establishing contact with the treating when radio/cell phone/telephone contact cannot be established and/or a delay in immediate lifesaving treatment would be detrimental to the patient. The following medications/procedures no longer require contact with Medical Control:
 - a) Morphine Sulfate, 2mg IVP then contact Medical Control for additional orders
 - b) Nitroglycerin ointment 1 inch of nitropaste on the ruled applicator to a hairless area prior to contacting Medical Control
 - c) Pneumatic antishock garment (BLS)
 - d) Use of a central venous access device may be used without contacting Medical Control during emergency situations: cardiac arrest, major trauma and life-threatening situation requiring immediate need for medication or fluid therapy
5. The EMS Medical Director is medically-legally responsible for the operations of the EMS System. All physicians, nurses and paramedics will function in the EMS System under his direction. Any person performing negligent acts will be accountable to the EMS Medical Director. All EMS personnel should be familiar with field operations, EMS drugs and equipment, and the EMS Protocol.
6. According to the State Law, a physician must be present at the base station to give orders for ALS. In the event that the physician is busy attending a patient in the Emergency Department, an ECRN may order according to established protocols.
7. Delay at the scene should not result from the completion of any protocol in its entirety. Transportation with stabilization enroute is to be accomplished at the earliest possible time.
8. Non-transport providers shall ensure that the dispatched ambulance personnel and/or Medical Control is informed of patient condition including changes.
9. For all medical protocols in this section, the treatment applies to both ALS and BLS providers unless marked ALS, in which case it applies only to ALS providers.

PREHOSPITAL PROTOCOL FOR ALCOHOLISM

I. Treatment

A. Airway Management

1. Suction as needed
2. Oropharyngeal/nasopharyngeal airway if unconscious or decreased level of consciousness
3. Endotracheal intubation as needed (ALS)

B. Oxygenation/Ventilation

1. Apply oxygen as indicated
2. Assist ventilations as needed

C. Perform a rapid physical examination.

1. Keep in mind conditions such as diabetes, pneumonia, head injuries, and drug ingestion symptoms may be masked.
2. Obtain as much history and physical information as possible.

D. Other Treatments

1. Continuous observation of patient's condition and vital signs checked as frequently as necessary.
2. Treat the patient in a calm, firm manner to prevent fear, panic, and other complications.
3. If patient exhibits assaultive behavior, physical restraints should be used only as a last resort.
4. If patient comatose, refer to protocol for unconscious patient. (Refer to protocol MP-16)

II. Transport

PREHOSPITAL PROTOCOL FOR AMPUTATED PARTS

- I. Prehospital protocol for handling amputated parts intended for reanastomosis.
 - A. Any gross contaminants on the part should be removed by rinsing the part in sterile saline solution.
 - B. No attempt should be made to debride or otherwise clean up the amputated part.
 - C. The part should be rinsed, wrapped in a moist but not wet sterile dressing, placed in a plastic bag and tightly sealed to prevent direct contact with liquid substances. The sealed bag should then be placed in iced saline or sterile water.
 - D. Cover stump with sterile dressing.
 - E. Patient transport should not be delayed by the search for the amputated part. Search can be continued by other personnel (i.e. 2nd ambulance, fire, law enforcement) while patient is transported.

Kelly Cox, M.D., EMS Medical Director

12/97, 4/98 Re: 10/06
(reviewed: 8/95, 8/01)

PREHOSPITAL PROTOCOL FOR COPD/SOB

I. Chronic Bronchitis and Emphysema

- A. Airway Management
 - 1. Establish a patent airway
 - 2. Suction as needed
- B. Oxygenation/Ventilation
 - 1. Oxygen. Do not withhold high flow oxygen due to the COPD if the patient is in distress
 - 2. Monitor respiratory rate and depth; be prepared to assist ventilations if necessary
 - 3. Monitor O₂ saturation if pulse oximetry is available
- C. Circulatory
 - 1. Start IV of Normal Saline TKO or saline lock needle (ALS)
 - 2. Monitor cardiac rhythm (ALS)
- D. Medication (ALS)
 - 1. Administer 2.5 mg of albuterol via nebulizer for wheezing if needed
- E. Other
 - 1. Place patient in position of comfort
 - 2. Reassess respiratory status and vital signs frequently
 - 3. Transport

II. Asthma

- A. Airway Management
 - 1. Establish a patent airway.
 - 2. Suction as needed
- B. Oxygenation/ventilation
 - 1. Administer O₂ 12-15 LPM non-rebreather mask
 - 2. Assist ventilations if necessary
 - 3. Monitor O₂ saturation if pulse oximetry is available
- C. Circulatory
 - 1. Initiate IV Normal Saline TKO or saline lock needle (ALS)
 - 2. Monitor cardiac rhythm (ALS)
- D. Medications (ALS)
 - 1. Administer epinephrine 1:1,000 solution, 0.3 ml subcutaneously and/or administer 2.5 mg of albuterol via nebulizer

(continued)

- E. Other
 - 1. Place patient in position of comfort
 - 2. Reassess respiratory status and vital signs frequently
 - 3. Maintain a calm, reassuring manner
 - 4. *Consider CPAP on any respiratory patients (AP-26)*
 - 5. Transport

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

BURNS

I. Treatment

- A. Airway Management - be alert to the possibility of associated pulmonary injuries if the burn occurred in an enclosed space or during an explosion. Note any toxic fumes.
 - 1. Ensure patent airway
 - 2. Suction if necessary
 - 3. Utilize oral or nasal airway as needed
 - 4. Perform endotracheal intubation if necessary (ALS)
- B. Oxygenation/Ventilation
 - 1. Administer oxygen
 - 2. Assist ventilations if necessary
 - 3. Monitor O2 saturation if pulse oximetry is available
 - 4. Monitor ETCO saturation if airway was affected
- C. Circulatory
 - 1. Initiate at least 1 large bore IV line (minimum 16 gauge) as is appropriate depending upon extent of burns/site available (ALS). Administer fluids at rate dependent on blood pressure/Medical Control (See "F" below)
 - 2. Cardiac monitoring (ALS)
- D. Pain Management
 - 1. *2 initial doses of 2 mg of morphine OR 2 doses Fentanyl 25mcg may be given prior to contacting Medical Control. Contact Medical Control for additional doses.*
- E. Other
 - 1. Dry sterile sheets – Do not allow patient to become hypothermic.
 - 2. Ensure smoldering clothing has been extinguished
 - 3. Cut off clothing
 - 4. Remove metal jewelry/leather articles
 - 5. Do not apply topical ointments at the scene
 - 6. Do not remove tar or asphalt unless it affects the airway
 - 7. The usual rules of splinting apply
 - a) Air splints may be applied over the burn if necessary
 - b) Traction splints may be applied to lower extremities if necessary
 - c) Attempt to protect burned areas from pressure
 - d) Transport on clean sheets
 - 8. Monitor vital signs and respiratory status closely
 - 9. Transport as soon as possible

F. Fluid Replacement

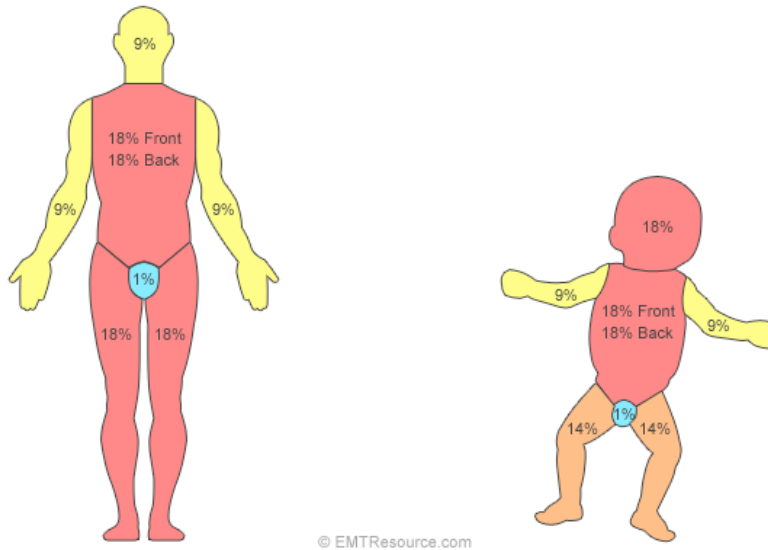
Parkland formula when determining fluid bolus.

The UParklandU Formula is as follows

$4\text{cc} \times \text{Kg (patient's weight)} \times \text{BSA}$

1/2 over 1st 8 hours

1/2 over last 16 hours



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5/93, re: 12/97, 4/98, 8/01, 6/06, 6/12, 1/15
(reviewed: 8/95)

EMS CHEST PAIN/SUSPECTED CARDIAC EVENT

History: <ul style="list-style-type: none"> • Age • Viagra, Levitra, Cialis • Past Medical History (MI, Angina, Diabetes, post Menopausal • Recent Physical Exertion • Onset • Palliation/Provocation • Quality (crampy, sharp, consistent, dull, etc) • Region/Radiation/Referred • Severity (1-10) • Time (duration, repetition) 	Signs & Symptoms: <ul style="list-style-type: none"> • CP (pain, pressure, aching, vice-like tightness) • Location (substernal, epigastric, arm, jaw, neck, shoulder) • Radiation of pain • Pallor, diaphoresis • Shortness of breath • Nausea, vomiting, dizziness 	Differential: <ul style="list-style-type: none"> • Trauma vs. Medical • Angina vs. Myocardial Infarct • Pericarditis • Pulmonary Embolism • Asthma/COPD • Pneumothorax • Aortic Dissection or aneurysm • GI reflux or hiatal hernia • Esophageal spasm • Chest wall injury or pain • Pleural pain • Overdose (Cocaine)
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Assessment/History

Maintain patent airway, assist breathing as needed
 Administer oxygen – goal is to maintain at least 95% O₂ sat.
 Monitor
 IV access

Aspirin 324 mg PO chewed (unless documented allergy)

12 Lead EKG

Acute MI with ST segment elevation

Nitro 0.4 mg SL q 5 min X3 PRN if SPB>90 mm/hg

Apply 1" NTG paste to chest wall if SBP>90 mm/hg (if time permits)

Continued pain?

Morphine 2 mg slow IV.
 Contact Medical Control for additional doses up to 10 mg

NTG 0.4 mg SL q 5 min X 3 PRN if SPG>90 mm/hg
 Morphine 2 mg slow IV, may give 2nd dose of morphine prior to contacting Medical Control or may give 2 doses of 25mcg of Fentanyl prior to contacting Medical Control. -(Contact Medical Control for additional doses up to 10mg)
 OR Metoprolol 25 mg PO X1 if no signs or symptoms of shock, heart block, or bradycardia

Transport to PCI center if within 30 minutes transport time to that center or if thrombolytic ineligible. Otherwise, transport to closest hospital for thrombolytics; notify receiving hospital of active STEMI. Give 300 mg of Plavix PO X1. If patient is over 75 years old or patient will be getting thrombolytics, give 75 mg of Plavix.

Consider fluid bolus for Inferior MIs

Universal Patient Care

- For hypotension/dysrhythmias: Treat per protocol
- For severe nausea/vomiting: Treat per protocol
- For sudden cardiac arrest/unresponsive patient: INDUCE HYPOTHERMIA (when policy is available) Begin cooling utilizing unit specific resources

Pearls: Exam: mental status, skin, neck, lung, heart, abdomen, back, extremities, neuro

- Avoid NTG in any patient who has used Viagra or Levitra in the past 24 hours or Cialis in the past 36 hours, has suspected right ventricular infarction, or severe Bradycardia (heart rate <50 BPM) due to potential severe hypotension.
- If patient has taken nitroglycerin without relief, consider potency of medication
- If positive EKG changes, establish second IV while enroute to hospital
- Monitor for hypotension after administration of NTG and morphine
- Patients with chest pain but without ST-segment elevation should be transported to the hospital of their choice. Patients with STEMI, cardiogenic shock or high degree HB should be encouraged to go to Cath Lab capable facility
- Diabetics and geriatric patients often have atypical pain, or only generalized complaints
- Document 12 lead and transmits to receiving hospital and Medical Control.

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EMS Medical Director

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Thrombolytic Checklist for Evaluation of a Patient with STEMI

Are there contraindications to thrombolytics?
If any of the following are checked "YES", thrombolytics MAY be contraindicated



Systolic BP greater than 180 mm/Hg	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diastolic BP greater than 110 mm/Hg	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Right vs. left arm systolic BP difference greater than 15 mm/Hg	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Severe tearing pain, radiating to back (suspect aortic dissection)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Known malignant intracranial neoplasm/brain tumor	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Significant closed head/facial trauma within previous 3 months	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Recent (w/in 6 weeks) major trauma, GI/GU bleed, surgery (including laser eye surgery)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding or clotting problem or on blood thinners	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CPR greater than 10 minutes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pregnant female	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Serious systemic disease (advanced terminal cancer, severe liver or kidney disease)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Current use of Coumadin	<input type="checkbox"/> YES	<input type="checkbox"/> NO



If "NO" to all of the above

Does the patient have severe heart failure or cardiogenic shock such that PCI is preferable?



Pulmonary edema (rales greater than halfway up)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Systemic hypoperfusion (cool, clammy)	<input type="checkbox"/> YES	<input type="checkbox"/> NO



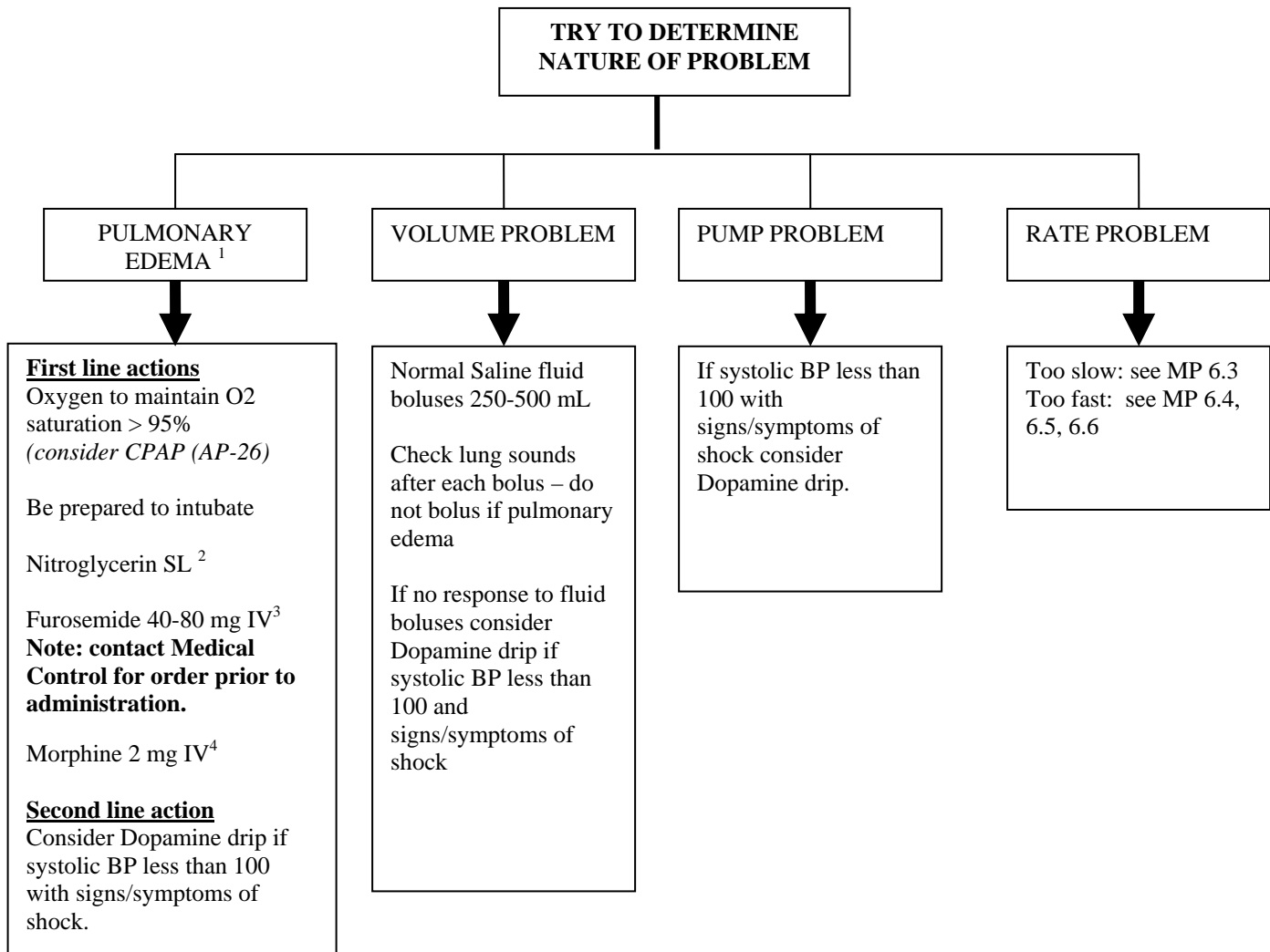
If "NO" to all of the above, continue to Thrombolytic Therapy
If "YES" to any of the above, transfer to the nearest PCI facility

EMS Signature

Date/Time

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT
ACUTE PULMONARY EDEMA / CARDIOGENIC SHOCK

- I. Routine cardiac care
 - A. Airway management
 - B. Oxygen
 - C. Cardiac monitor (ALS)
 - D. 12 lead ECG (ALS)
 - E. Obtain history & physical exam
 - F. IV line (ALS)
 - G. Consider CPAP (AP-26)
- II. Follow algorithm



¹ **Acute pulmonary edema:** Signs & symptoms include severe dyspnea, tachypnea, labored breathing, rales/crackles, cyanosis, frothy white or pink-tinged sputum

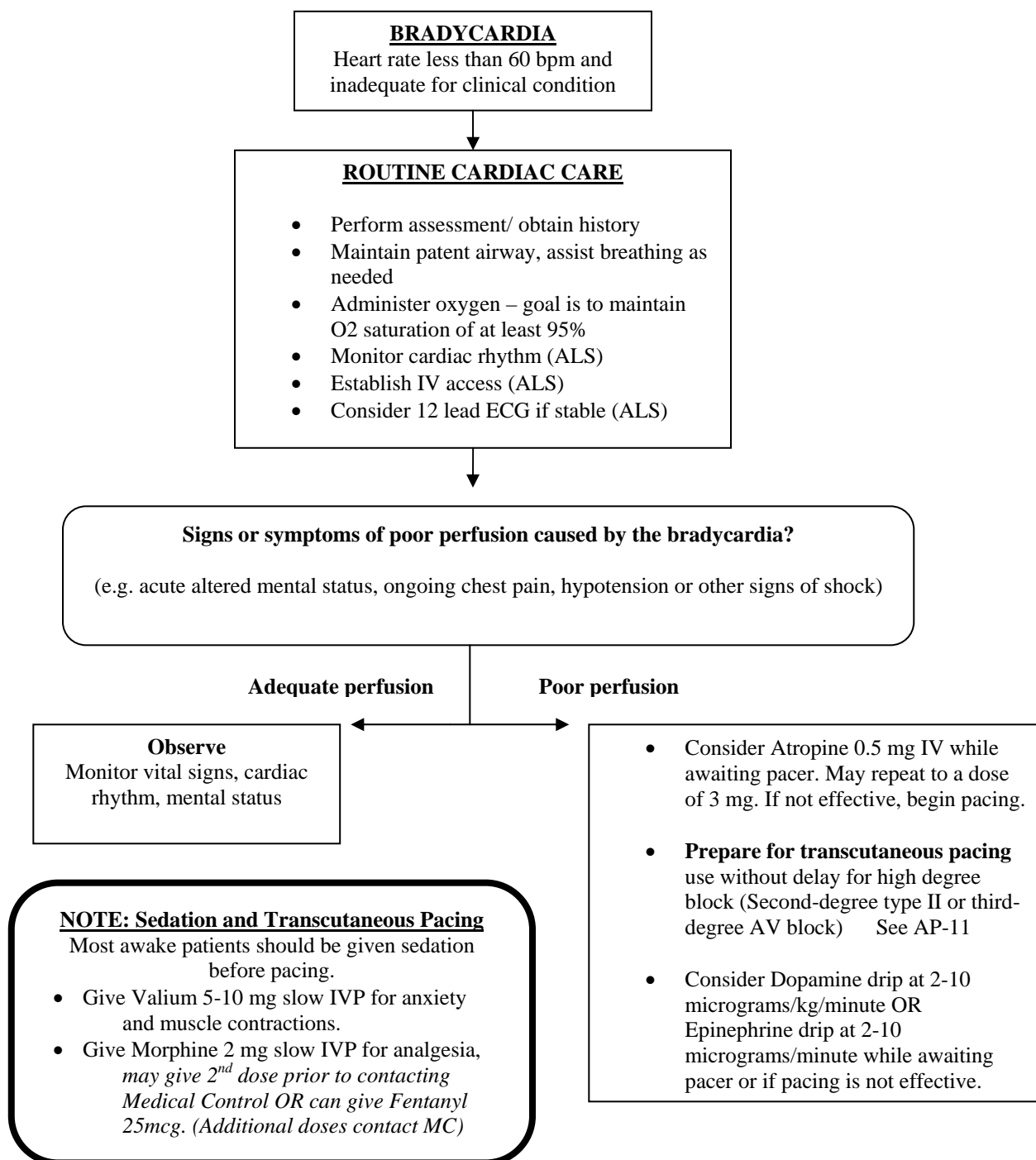
² **Nitroglycerin SL:** Nitroglycerin reduces pulmonary congestion by dilating the venous capacitance vessels thus reducing preload. It also reduces afterload by dilating systemic arteries. Administer only if systolic BP > 90. May be given 1 every 5 minutes to a maximum of three tablets.

³ **Furosemide:** Decreases preload within 5 minutes of administration by dilating veins and increasing venous capacitance. Produces diuresis within 5-10 minutes of IV administration.

⁴ **Morphine:** Dilates veins to increase venous capacitance thus reducing preload. Produces mild arterial dilation to reduce afterload. Administer initial 2 mg dose only if systolic BP > 100. Contact Medical Control for orders for additional doses.

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

BRADYCARDIA



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3/93, re: 12/97, 5/98, 8/01, 1/07, 5/11, 1/2015
(reviewed 8/95)

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

UNSTABLE TACHYCARDIA

UNSTABLE TACHYCARDIA

- Exists when the heart rate is too fast for the patient's clinical condition and the excessive heart rate causes serious signs/symptoms or an unstable condition.
- Serious signs and symptoms include altered mental status, ongoing chest discomfort or shortness of breath, near-syncopal or syncopal episode (fainting). Rate related signs/symptoms are uncommon with heart rates less than 150.
- Unstable condition includes those patients with hypotension and signs of shock



ROUTINE CARDIAC CARE

- Perform assessment / obtain history
- Maintain patent airway, assist breathing as needed
- Administer oxygen – goal is to maintain O₂ saturation of at least 95%
- Monitor cardiac rhythm (ALS)
- Establish IV access (ALS)
- Consider 12 lead ECG (ALS)



SYNCHRONIZED CARDIOVERSION

- Ensure that the synchronizer is on and that the QRS complexes are being marked.
- Synchronization avoids the delivery of a shock during cardiac repolarization, a period of vulnerability in which a shock can precipitate V-Fib.
- Most defibrillators default back to unsynchronized mode after delivery of a synchronized shock.
- See energy settings as below

RHYTHM	SYNCHRONIZED SHOCK SEQUENCE*
Atrial fibrillation	100 J – 200 J – 300 J – 360 J
SVT / PSVT Atrial flutter	50 J – 100 J – 200 J – 300 J – 360 J
Monomorphic ventricular tachycardia with pulse	100 J – 200 J – 300 J – 360 J
Polymorphic ventricular tachycardia (irregular form and rate)	Treat as V-fib with defibrillation doses
<ul style="list-style-type: none"> • Sequence above is using monophasic energy dose. Or use clinically equivalent biphasic energy dose. Consult the device manufacturer for specific recommendations. 	

(continued on next page)

NOTE: SEDATION FOR SYNCHRONIZED CARDIOVERSION

Most awake patients should be given sedation before cardioversion.

- Give Valium 5-10 mg slow IVP for anxiety and muscle contractions.
- *Give Morphine 2 mg slow IVP for analgesia, may give 2nd dose of Morphine prior to contacting Medical Control OR may give Fentanyl 25 mcg. For additional doses call Medical Control*

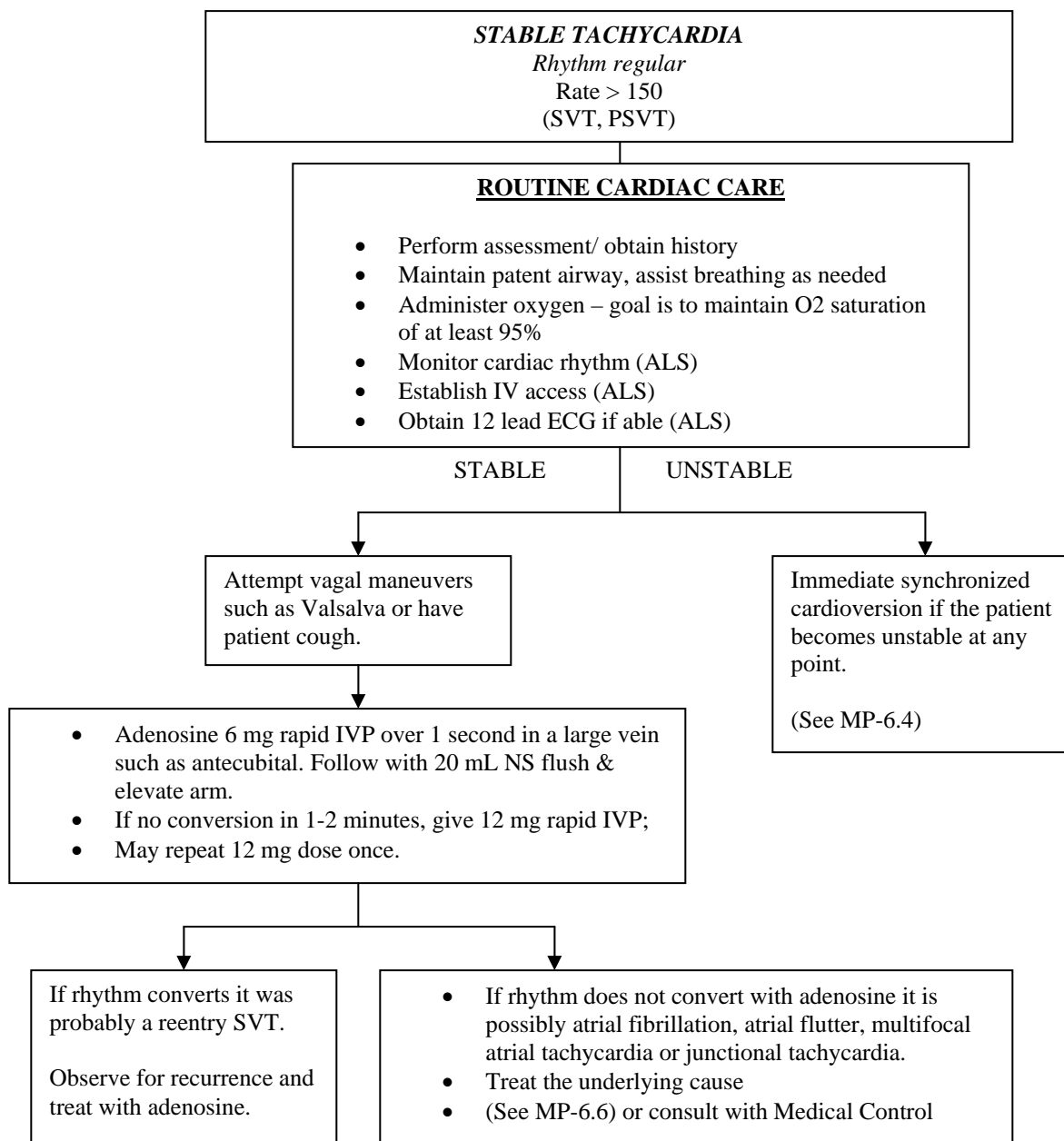
Richard A Saalborn, DO, FACEP, FACOEP
EMS Medical Director
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EMS Associate Medical

8/01; re 1/07, 1/15
reviewed 5/11

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

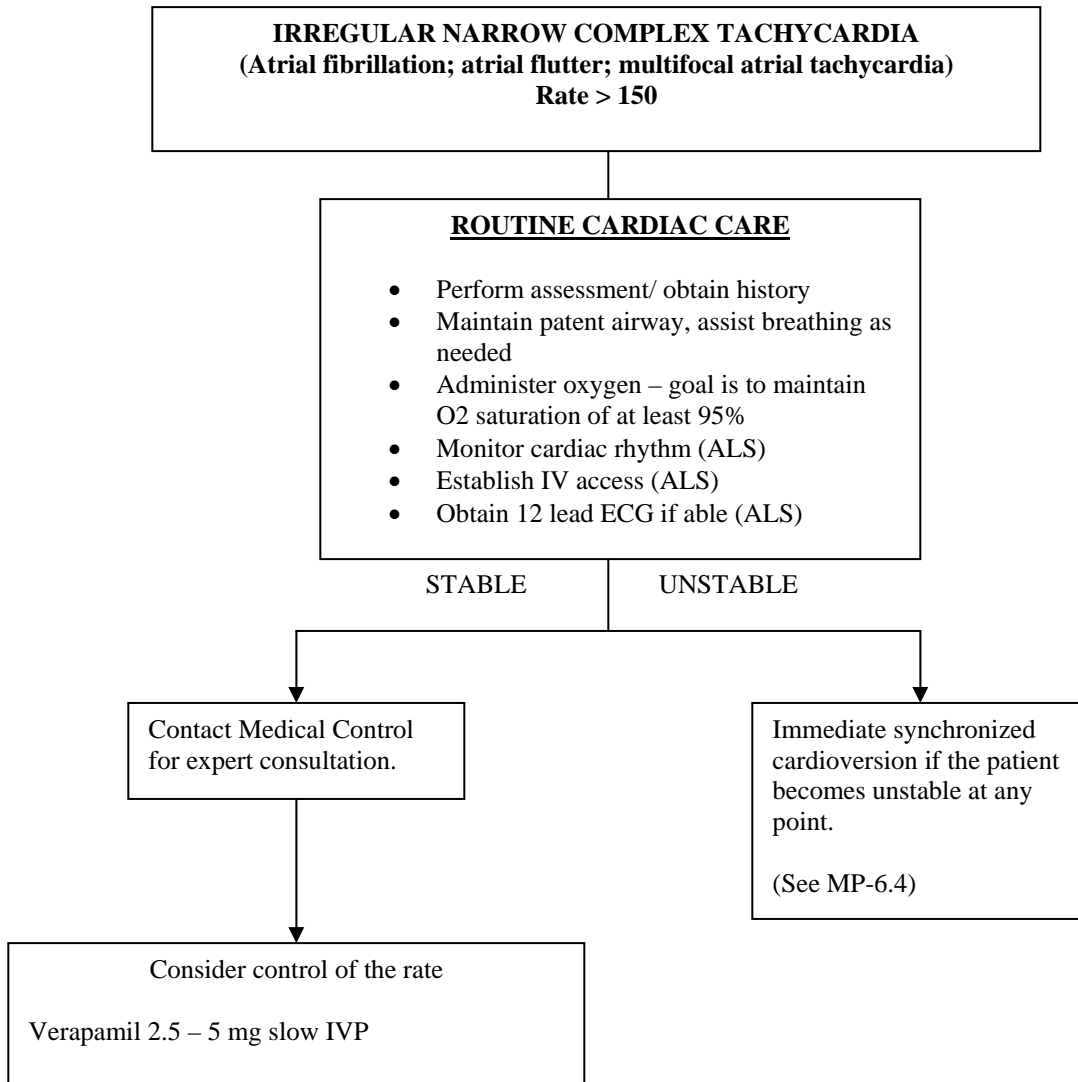
STABLE TACHYCARDIA



NOTE: Special Considerations - Consult Medical Control regarding the following:

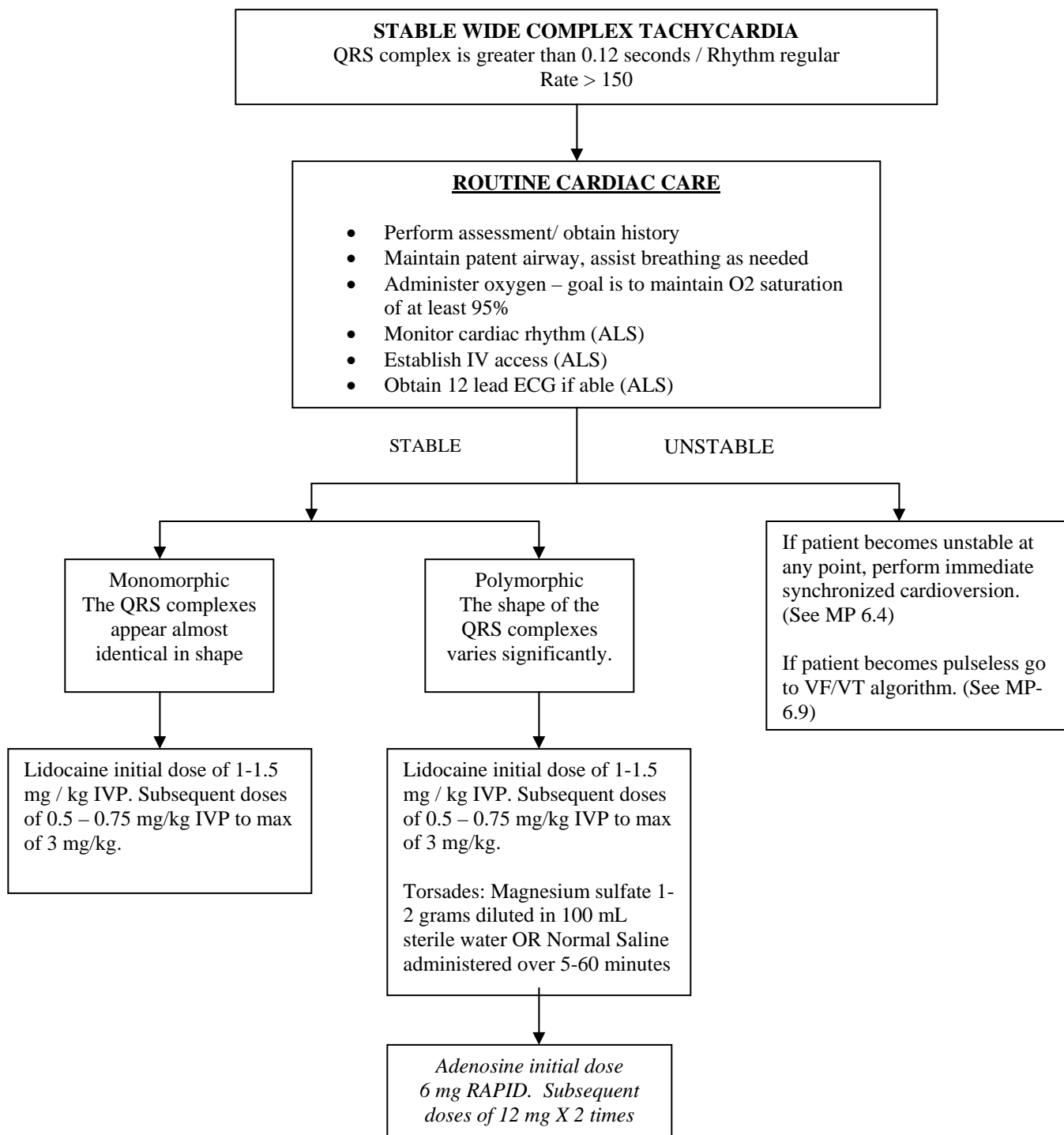
Reducing the initial dose of adenosine to 3 mg in patients taking dipyridamole (Persantine) or carbamazepine (Tegretol), patient with a transplanted heart or if administering through a CVAD.

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT
RAPID ATRIAL FIBRILLATION / ATRIAL FLUTTER



PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

STABLE WIDE COMPLEX TACHYCARDIA



PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

CARDIAC ARREST

- I. Preparation
 - A. Anticipate cardiac arrest based upon the dispatch information. Calls with a high potential for cardiac arrest include possible heart attack, patient unresponsive, patient down with unknown problem or any cardiac related complaints (chest pain, syncope, palpitations etc.)
 - B. Appropriate equipment such as airway and oxygenation equipment, AED or manual cardiac monitor/defibrillator, suction, drug box etc. should be taken to the patient location and care initiated immediately. The only exception to this is when scene safety issues prohibit providers from immediately accessing the patient and starting care.
- II. Assessment
 - A. BLS Primary (Initial) Survey (B-A-C):
 1. Ensure scene safety
 2. Assess level of consciousness
 3. Open the airway using the head tilt/chin lift or the modified jaw thrust if trauma is suspected.
 4. Assess for presence and adequacy of breathing and presence of a pulse.
 5. If no pulse, start CPR and assess for the presence of a shockable rhythm using an AED or a manual cardiac monitor/defibrillator when it becomes available.
- III. Management
 - A. Respiratory Arrest
 1. Perform rescue breaths at the rate of 1 breath every 5-6 seconds (10-12 per minute) Each breath should be delivered over 1 second and the volume of each breath should be sufficient to achieve visible chest rise.
 - Hyperventilation (ventilating too fast or with too much volume) can be harmful because it increases intrathoracic pressure, decreases venous return to the heart and diminishes cardiac output.
 - Hyperventilation can also increase gastric distention and predispose the patient to vomiting and possible aspiration of gastric contents.
 - During CPR, if an advanced airway is in place, ventilations at a rate of 8-10/minute are adequate to maintain oxygenation and carbon dioxide elimination because blood flow to the lungs is much lower than normal.
 2. Utilize basic and/or advanced mechanical airways to assist with management of the airway
 3. Utilize 100% supplemental oxygen.

B. Cardiac arrest

1. CPR

- Compressions should be initiated in the adult who is pulseless and in the child or infant with a pulse of less than 60 with signs of poor perfusion.
- Effective chest compressions are essential to provide blood flow during CPR. All rescuers should “push hard and push fast” allowing the chest to come back to normal position after each compression because blood refills the heart during chest recoil. *At least 100 compressions per minute (30:2)*
- Limit interruptions in CPR. Every time that CPR is interrupted, blood flow stops and coronary artery perfusion pressure quickly falls. This lowers the victim’s chance of survival.
- Once an advanced airway is in place (Endotracheal tube, Combitube or LMA) chest compressions should not be interrupted for ventilations.

2. AED

- If AED is available, assess for a shockable rhythm. (See MP-6.10)
- The most common initial rhythms in witnessed sudden cardiac arrest are ventricular fibrillation or pulseless ventricular tachycardia.
- Defibrillation stuns the heart and briefly terminates electrical activity. If the heart is still viable a spontaneous rhythm may then resume.
- The earlier defibrillation occurs, the higher the survival rate.
- 5 cycles of CPR (about 2 minutes) may be provided before defibrillation when the EMS response time is > 4-5 minutes and the arrest was not witnessed.
- New AHA guidelines indicate a single shock followed by 5 cycles or approximately 2 minutes of CPR before checking for a pulse.
- Many AEDs will not immediately be programmed to follow the new American Heart Association AED guidelines. It is acceptable to follow the sequence that the AED has programmed until your agency can have it re-programmed.

3. ACLS – Go to the appropriate cardiac arrest protocol.

SUMMARY OF BLS PROCEDURES FOR HEALTHCARE PROVIDERS			
MANEUVER	ADULT (ADOLESCENT OR OLDER)	CHILD (1 YEAR TO ADOLESCENCE)	INFANT (LESS THAN 1 YEAR)
ACTIVATION OF 9-1-1 FOR A SINGLE RESCUER	<ul style="list-style-type: none">• Activate when victim is found unresponsive.• If asphyxial arrest is likely call after 5 cycles of CPR.	<ul style="list-style-type: none">• If unwitnessed: Activate after performing 5 cycles of CPR.• If witnessed sudden collapse activate after verifying unresponsive.	
AIRWAY	Head tilt / chin lift. If trauma is suspected use the modified jaw thrust.		
INITIAL BREATHS	2 breaths at 1 second/breath		
RESCUE BREATHING	10-12 breaths/minute (1 breath every 5-6 seconds)	12-20 breaths/minute (1 breath every 3-5 seconds)	
VENTILATIONS W/ ADVANCED AIRWAY	8-10 breaths per minute (1 breath every 6-8 seconds)		
FBAO (Blind finger sweeps should no longer be performed – look in the mouth each time the airway is opened and remove an object if seen)	Abdominal thrusts		Back slaps and chest thrusts
PULSE CHECK	Carotid		Brachial or femoral
COMPRESSION LANDMARK	Center of chest between nipples		Just below the nipple line
COMPRESSION METHOD	Use 2 hands	Heel of 1 hand with second on top or heel of 1 hand only	1 rescuer = 2 fingers 2 rescuers = 2 thumbs with hands encircling chest
COMPRESSION DEPTH	At least 2 inches	1/3 – ½ the depth of the chest	
COMPRESSION RATE	100 per minute		
COMPRESSION TO VENTILATION RATIO	30:2 (1 or 2 rescuers) <i>Note: No pause for breaths once an advanced airway is in place.</i>	1 Rescuer = 30:2 2 Rescuers = 15:2 <i>Note: No pause for breaths once an advanced airway is in place.</i>	
DEFIBRILLATION			
AED	Use adult pads. May provide 5 cycles of CPR (2 minutes) before shock if response time > 4-5 minutes and arrest not witnessed.	Use AED as soon as it is available for sudden witnessed collapse. Use child pads for <i>infant less than 1 years. If child pads/system not available use adult AED and pads.</i>	If child pads/system not available use adult AED and pads.
For ACLS procedures see the appropriate cardiac arrest algorithm			

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

VENTRICULAR FIBRILLATION / PULSELESS VENTRICULAR TACHYCARDIA ACLS ALGORITHM

PULSELESS ARREST

- Check responsiveness
- Open the airway using the head tilt / chin lift – if trauma use modified jaw thrust
- Begin CPR – emphasis is on good chest compressions at a *minimum* rate of 100/minute with minimal interruptions and providing ventilations with BVM/supplemental oxygen at a rate of 1 breath every 5-6 seconds with enough volume for visible chest rise.
- Attach monitor/defibrillator as soon as available and determine if shockable rhythm.



V-FIB/PULSELESS V-TACH

- Give 1 shock (monophasic shock at 360 joules; biphasic shock at 120-200 joules; if unknown shock at 200 joules)
- Resume CPR immediately



Continue CPR for approximately 2 minutes / 5 cycles
Check Rhythm



V-FIB / PULSELESS V-TACH

- Give 1 shock (monophasic 360 joules; biphasic same as first shock or higher; if unknown use 200 joules)
- Resume CPR immediately after the shock
- Establish IV/ IO
- Intubate *using ET tube or combitube*
- Epinephrine 1 mg IV/IO – repeat every 3-5 minutes



Continue CPR for approximately 2 minutes / 5 cycles
Check rhythm



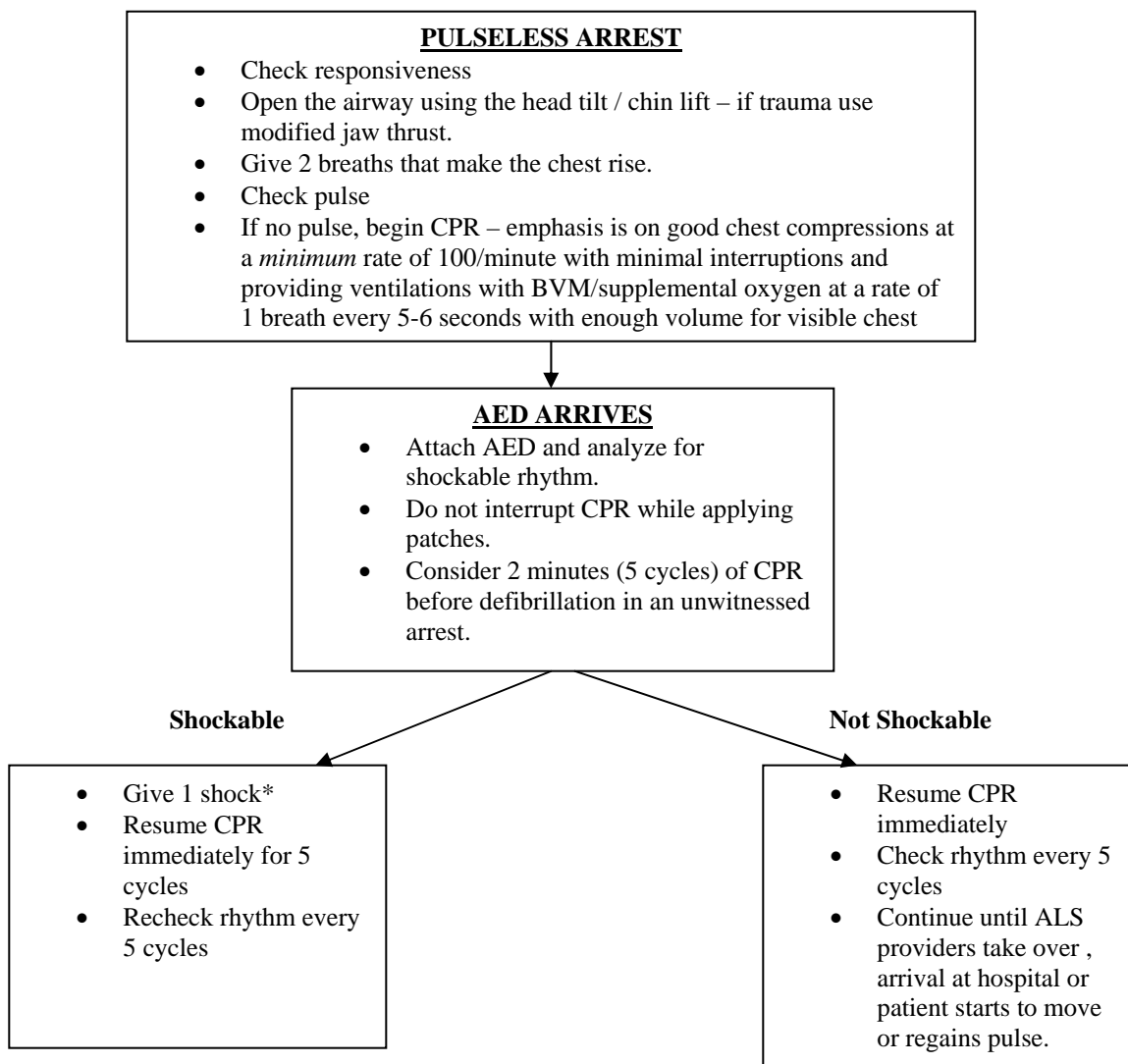
V-FIB / PULSELESS V-TACH

- Give 1 shock (same as above)
- Resume CPR immediately after the shock
- Consider antiarrhythmics (give during CPR before or after the shock)
 - Lidocaine 1-1.5 mg/kg IV/IO first dose then 0.5-0.75 mg/kg every 3-5 minutes up to max of 3 mg/kg
 - Magnesium sulfate for torsades de pointes 1-2 grams IV/IO loading dose

IMPORTANT INFORMATION!

- Compressions: Push hard and push fast at a *minimum* rate of 100/minute.
- Ensure full chest recoil.
- Minimize interruptions in chest compressions while other procedures are performed.
- One cycle of CPR = 30 compressions to 2 breaths. 5 cycles = 2 minutes.
- Avoid hyperventilation.
- Secure the airway with an advanced adjunct and confirm placement using multiple means. CPR interruption **MUST** be minimal!
- After the advanced airway adjunct is placed, rescuers no longer deliver “cycles” of CPR. Give continuous chest compressions without pause for breaths at a rate of 8-10 breaths/minute.
- Recheck the rhythm every 2 minutes.
- If V-fib/pulseless V-tach continues, repeat shocks/drugs as above
- If return of spontaneous circulation occurs, refer to *Hypothermia* Policy MP-30

**PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT
CARDIAC ARREST
BLS/AED USE**



*** IMPORTANT NOTE!**

- Many AEDs will not be programmed to follow the new American Heart Association AED guidelines.
- It is acceptable to follow the sequence that the AED has programmed until your agency can have it re-programmed.
- *If return of spontaneous circulation occurs, notify ALS/Hospital so that Hypothermia Policy MP-30 is activated*

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT

ACLS ASYSTOLE ALGORITHM (ADULT)

PULSELESS ARREST

- Check responsiveness
- Open the airway using the head tilt / chin lift – if trauma use modified jaw thrust
- Begin CPR – emphasis is on good chest compressions at a *minimum* rate of 100/minute with minimal interruptions and providing ventilations with BVM/supplemental oxygen at a rate of 1 breath every 5-6 seconds with enough volume for visible chest rise.
- Attach monitor/defibrillator when available and confirm the asystole in two leads.



ASYSTOLE CONFIRMED

- Continue CPR for 5 cycles (approximately 2 minutes). Interruptions in CPR should be minimal while other procedure are done.
- Establish an IV or IO line
- Maintain airway / intubate
- Epinephrine 1:10,000 solution 1 mg IV/IO every 3-5 minutes
- Continue CPR and check rhythm about every 2 minutes.

IMPORTANT!

- Compressions: Push hard and push fast at a rate of 100/minute.
- Ensure full chest recoil.
- Minimize interruptions in chest compressions while other procedures are performed.
- One cycle of CPR = 30 compressions to 2 breaths. 5 cycles = 2 minutes.
- Avoid hyperventilation.
- Secure the airway with an advanced adjunct and confirm placement using multiple means.
- After the advanced airway adjunct is places, rescuers no longer deliver “cycles” of CPR. Give continuous chest compressions without pause for breaths at a rate of 8-10/minute.
- Recheck the rhythm every 2 minutes.

SEARCH FOR AND TREAT POSSIBLE CONTRIBUTING FACTORS

- Hypovolemia
- Hypoxia
- Hypoglycemia
- Hydrogen ion (acidosis)
- Hypothermia
- Hypo/hyperkalemia
- Toxins
- Tension pneumothorax
- Trauma
- Tamponade, cardiac
- Thrombosis (coronary or pulmonary)

PREHOSPITAL PROTOCOL FOR THE CARDIAC PATIENT
ACLS PULSELESS ELECTRICAL ACTIVITY (PEA) ALGORITHM (ADULT)

PULSELESS ELECTRICAL ACTIVITY
 Rhythm on cardiac monitor – no detectable pulse.

PULSELESS ARREST

- Check responsiveness
- Open the airway using the head tilt / chin lift – if trauma use modified jaw thrust
- Begin CPR – emphasis is on good chest compressions at a rate of 100/minute with minimal interruptions and providing ventilations with BVM/supplemental oxygen at a rate of 1 breath every 5-6 seconds with enough volume for visible chest rise.
- Attach monitor/defibrillator as soon as available.

PEA

- Continue CPR for 5 cycles (approximately 2 minutes). Interruptions in CPR should be minimal while other procedures are done.
- Establish an IV or IO line
- Maintain airway / intubate
- Epinephrine 1:10,000 solution 1 mg IV/IO every 3-5 minutes
- Continue CPR and check rhythm about every 2 minutes.

IMPORTANT!

- Compressions: Push hard and push fast at a rate of 100/minute.
- Ensure full chest recoil.
- Minimize interruptions in chest compressions while other procedures are performed.
- One cycle of CPR = 30 compressions to 2 breaths. 5 cycles = 2 minutes.
- Avoid hyperventilation.
- Secure the airway with an advanced adjunct and confirm placement using multiple means.
- After the advanced airway adjunct is placed, rescuers no longer deliver “cycles” of CPR. Give continuous chest compressions without pause for breaths at a rate of 8-10/minute.
- Recheck the rhythm every 2 minutes.

**SEARCH FOR AND TREAT POSSIBLE
CONTRIBUTING FACTORS**

- Hypovolemia
- Hypoxia
- Hypoglycemia
- Hydrogen ion (acidosis)
- Hypothermia
- Hypo/hyperkalemia
- Toxins
- Tension pneumothorax
- Trauma
- Tamponade, cardiac
- Thrombosis (coronary or pulmonary)

PREHOSPITAL PROTOCOL FOR THE DIABETIC (ALS)

- I. Treatment
 - A. Airway management
 - 1. Assure an airway
 - 2. Smell for acetone breath odor
 - 3. Suction as necessary
 - 4. Insert oropharyngeal/nasopharyngeal airway as necessary
 - 5. Perform endotracheal intubation as necessary (ALS)
 - B. Oxygenation/Ventilation
 - 1. Administer oxygen
 - 2. Assist ventilations as necessary
 - 3. Monitor O₂ saturation if pulse oximetry is available
 - C. Obtain medical history if possible
 - D. Determine blood glucose level with a Glucometer (ALS)
 - 1. If blood glucose level is less than 60 mg/dl:
 - a) Establish IV of Normal Saline, TKO rate (ALS)
 - b) Administer 50 ml. of 50% Dextrose IV push (ALS)
 - c) Administer 1 mg Glucagon IM, if IV is not obtainable and patient is unresponsive or unable to swallow (ALS)
 - d) If IV is not obtainable but patient is responsive and able to swallow, administer glucose paste or sugar
 - 2. If blood glucose level is greater than 120 mg/dl:
 - a) Establish an IV of Normal Saline and run at 100-300 ml/hr (ALS)
 - E. If patient is unconscious, a known diabetic, and blood glucose level is not available:
 - 1. Establish an IV of Normal Saline (ALS)
 - 2. Administer 50 ml of 50% Dextrose IV push (ALS)
 - F. If the patient exhibits signs and symptoms of hypoglycemia or hyperglycemia contrary to the Glucometer reading, contact Medical Control for orders

PREHOSPITAL PROTOCOL FOR THE DIABETIC (FR, FRD, EMTB)**I. Treatment**

- A. Airway management
 - 1. Assure an airway
 - 2. Smell for acetone breath odor
 - 3. Suction as necessary
 - 4. Insert oropharyngeal/nasopharyngeal airway as necessary
 - 5.
- B. Oxygenation/Ventilation
 - 1. Administer oxygen
 - 2. Assist ventilations as necessary
 - 3. Monitor O₂ saturation if pulse oximetry is available
- C. Obtain medical history if possible
- D. Determine blood glucose level with a Glucometer (BLS) Note: The purpose of taking a blood sugar reading by a FR, FRD, and EMTB is mostly for rule-out purposes
 - 1. Personnel are to be familiar with and view the operation procedures of the particular blood glucose-monitoring device they are using.
 - 2. The manufacturer's recommendations for calibration, operation, decontamination, as well as, compliance with operating regulations are the responsibility of the agency. These should be reviewed with the agency personnel.
 - 3. Blood Glucose evaluation from a fingerstick
 - a) Choose an appropriate site for the stick. The fleshy fingertip of an adult and child over tow, or the heel of an infant are the most commonly selected locations. Check that the expiration date on the strips has not expired. Cleanse the area with an alcohol prep swab, circling from the inside outward and allow the area to dry.
 - b) After confirming that the appropriate body substance isolation precautions have been taken, remove the protective cap from the tip of the lancet and hold it directly over the selected site.
 - c) Lower the tip of the lancet until it is just touching the skin's surface and in a quick firm stab-like movement, puncture the skin with the lance so that blood flows from the site. Wipe off the initial show of blood with the gauze pad.
 - d) Squeeze the site to encourage further bleeding and use this blood for testing. The specific method for obtaining the sample and its evaluation with the device will vary depending upon the design and brand being used. The FR, FRD, or EMTB must be familiar with the specific directions and use of the particular brand of machine being used.
- E. Notify the inbound ambulance of the blood sugar reading you have received on the patient.
- F. If the patient is conscious, able to swallow, and has a blood sugar reading of less than 60 mg/dl:
 - 1. Call Medical Control with a patient report and history.
 - 2. Squeeze a small amount of glucose gel (if available) on a tongue depressor, place under the tongue and/or hold tongue depressor between the tongue and cheek with the gel side toward the cheek. Allow gel to dissolve.
 - 3. Document time, medication, approximate amount and patient's response.

- G. Document the reading on your PCR form and on the Blood Glucose test sheet per QA-3.
- H. If the patient exhibits signs and symptoms of hypoglycemia or hyperglycemia contrary to the Glucometer reading, contact Medical Control for orders

Kelly Cox, M.D., EMS Medical Director

re: 5/93, 12/94, 4/95, 12/97, 5/98, 1/99, 8/01, 10/06, 8/07

PREHOSPITAL PROTOCOL FOR DRUG OVERDOSE (ADULT) POISONING

- I. Treatment
 - A. Airway Management
 - 1. Maintain a patent airway
 - 2. Suction as necessary
 - 3. Insert oropharyngeal/nasopharyngeal airway as necessary
 - 4. Perform endotracheal intubation as necessary (ALS)
 - B. Breathing/Ventilation
 - 1. Oxygen as tolerated by the patient
 - 2. Assist ventilations as necessary
 - 3. Monitor O₂ saturation if pulse oximetry is available
 - C. Circulatory
 - 1. Monitor cardiac rhythm - transmit rhythm strip and/or perform and transmit 12 Lead EKG (ALS)
 - 2. Initiate IV normal saline TKO rate (ALS)
 - D. Obtain history; check for medic alert tags, empty medication bottles, etc.
 - E. Medications (ALS)
 - 1. Naloxone if suspected or known narcotic abuse/overdose.
 - a) Adult: 1-2 mg IV, ET, IM. May repeat in 2-3 minute intervals for 2-3 doses if no response.
 - b) Dextrose 50% if finger stick glucose (ALS) or history indicates hypoglycemia
 - F. Save all vomitus, urine, feces, bottles, containers, etc.
 - G. If patient refuses treatment and hospital evaluation and treatment appear advisable, request assistance from law enforcement officers and Medical Control.
- II. Transport

Kelly Cox, M.D., EMS Medical Director

re: 5/93, 8/95, 12/97, 5/98, 10/99, 8/01
reviewed: 10/06

LIST OF COMMON ANTIDOTES

- I. Atropine 2-5 mg every 10-15 minutes
 - A. Organophosphate poisoning – insecticides
 - 1. Parathion
 - 2. Malathion
 - 3. Diazinon
 - 4. TEEP
- II. Naloxone (Narcan) 1-2 mg every 2-3 minutes for 2-3 doses
 - A. Opiate overdose
 - 1. Codeine 4. Morphine 7. Fentanyl
 - 2. Demerol 5. Dilaudid 8. Methadone
 - 3. Heroin 6. Paregoric 9. Percodan
 - B. Synthetic narcotics
 - 1. Nubain 3. Talwin
 - 2. Stadol 5. Darvon
 - C. Dextromethorphan overdose (found in most cough syrups)
 - D. Alcoholic coma
- III. Sodium Bicarbonate per Medical Control order
 - A. Tricyclic antidepressant overdose with ventricular tachycardia or other dysrhythmias
 - 1. Elavil
 - 2. Triavil
 - 3. Tofranil

PREHOSPITAL HEAD AND SPINAL CORD/NEUROLOGICAL INJURY PROTOCOL**I. Treatment****A. Airway Management**

1. Ensure an open airway while maintaining cervical spine immobilization
2. Suction as needed
3. Insert oropharyngeal or nasopharyngeal airway as needed
4. Endotracheal intubation as needed (ALS)*

*Note: tube should be placed using neutral alignment to prevent further spinal cord injury.

B. Oxygenation/Ventilation

1. Administer oxygen
2. Assist ventilations as needed

C. Circulation

1. Control hemorrhage
2. Initiate IV of normal saline -TKO (ALS)
3. Apply pneumatic antishock garment if hypotensive with signs and symptoms of shock. Inflate after contact with medical control (BLS)
4. Cardiac monitor - transmit rhythm strip or 12 Lead EKG (ALS)

D. Other treatment

1. Check vital signs at least every 5 minutes
2. Record and note any changes in the neurologic evaluation: level of consciousness, pupils, and sensory and motor functions of hands and feet

II. Transport**A. Use caution during transport to prevent further spinal cord injury****B. Head injury Load and Go situations**

1. Head injury with rapidly deteriorating condition
2. Head injury with altered LOC

PREHOSPITAL PROTOCOL FOR OBSTETRICS/GYNECOLOGY**I. Supine-Hypotensive Syndrome**

- A. May occur in pregnant patients over 20 weeks gestation due to the gravid uterus compressing the inferior vena cava when the patient is supine.
- B. Treatment
 1. Administer oxygen
 2. Place the patient on her left side
 3. Initiate an IV line and administer a fluid bolus if needed to maintain blood pressure at a minimum of 100 systolic. (ALS)
 4. Consider use of PASG (MAST) leg sections only*
*(Note: BLS to contact Medical Control before inflating.)
 5. Monitor vital signs and fetal heart tones
- C. Rapid Transport

II. Severe Third-trimester Vaginal Bleeding

- A. Treatment
 1. Administer oxygen at 12-15 LPM per non-rebreather mask
 2. Initiate an IV line and administer a fluid bolus to maintain blood pressure of 100 systolic. (ALS)
 3. Position patient on her left side.
 4. Consider use of PASG (MAST)*
*(Note: BLS to contact Medical Control before inflating.)
 5. Monitor vital signs and fetal heart tones frequently
- B. Rapid transport

III. Normal Spontaneous Emergency Delivery

- A. Check fetal heart tones, maternal vital signs, delivery status (visual examination of the perineal area for bulging/crowning), evidence of ruptured membranes.
- B. Allow the delivery to progress spontaneously
 1. After the head delivers, check around the neck for the cord which could impede delivery or produce fetal hypoxia. Gently slip the cord over the infant's head if possible. If the cord is too tight, apply two umbilical clamps and carefully cut the cord between the clamps.
 2. After the head delivers suction the mouth then the nose.
 3. After complete delivery dry and warm the infant, holding the infant at the level of the vagina. Remove wet towel or blanket and wrap in a dry blanket.
 4. Clamp the umbilical cord approximately 7 inches and 10 inches from the infant. Carefully cut the cord between the clamps.
 5. Place the infant on the mother's abdomen or to breast.
 6. Delivery of the placenta should occur within approximately twenty minutes. Do not pull on the cord. There is no need to await delivery of the placenta prior to transporting.
 7. After birth, the mother's vagina will continue to ooze blood. Place a vaginal pad over the vagina. Massage the fundus gently to keep it contracted.
 8. Note APGAR score at 1 minute and 5 minutes post delivery.

IV. Emergency Delivery with Cord Prolapse

- A. A prolapsed cord occurs when the umbilical cord is compressed between the fetus and the pelvis.
- B. If the umbilical cord is noted to be protruding from the vagina:
 - 1. Administer oxygen at 15 LPM per non-rebreather mask to the mother
 - 2. Place the mother in knee-chest or Trendelenberg position
 - 3. Insert two fingers of a gloved hand into the vagina to raise the presenting part off the cord. This position will need to be maintained until instructed otherwise at the hospital. At the same time check the cord for pulsations.
 - 4. Cover the exposed cord with a moist sterile dressing. Do not compress, palpate or handle the cord more than necessary

V. Severe Post-Partum Hemorrhage

- A. Administer oxygen at 12-15 LPM per non-rebreather mask.
- B. Initiate an IV of Normal Saline and administer a fluid bolus to maintain systolic blood pressure at a minimum of 100 systolic. (ALS).
- C. Oxytocin 10 units – add to 500 or 1000 ml of Normal Saline and infuse slowly at the rate indicated by Medical Control. You must be certain that the placenta has delivered and there are no other fetuses present.
- D. Consider the use of PASG (MAST) leg sections only*
*(Note: BLS to contact Medical Control before inflating.)

VI. Sexual Assault

- A. Limit treatment to assessment, vital signs and care of life threatening injuries.
- B. Emotional/psychological support
 - 1. Explain all procedures prior to touching the patient
 - 2. Do not attempt to obtain a detailed history of the alleged assault
 - 3. Do not examine the genitalia unless uncontrolled bleeding is present
 - 4. Maintain a non-judgmental attitude
 - 5. If the patient is female:
 - a) Have a female EMT provide care if possible
 - b) Allow a female support person to accompany the patient to the hospital if possible
- C. Evidence preservation
 - 1. Instruct the patient not to change clothing, bathe, comb hair or use the bathroom in order to preserve evidence
 - 2. Handle clothing as little as possible
- D. Transport

PREHOSPITAL PROTOCOL FOR OBSTRUCTED AIRWAY

- I. Open Airway.
 - A. Attempt to open the airway using manual maneuvers.
 - B. If indication of spinal injury, use the modified jaw thrust.
- II. Clear Airway
 - A. Finger sweep or suction
 - B. Abdominal thrusts or chest thrusts (Heimlich maneuver)
 - C. If unsuccessful:
 - 1. Direct laryngoscopy/Magill forceps removal (ALS)
 - 2. Cricothyrotomy (ALS) if all other attempts have failed
- III. Oxygenation/ventilation
 - A. As soon as the obstruction is relieved, assess for breathing and provide oxygen/ventilatory assistance as necessary.
- IV. Airway obstruction that cannot be quickly relieved is a Load and Go Situation.

PREHOSPITAL PROTOCOL FOR RESPIRATORY ARREST

- I. Treatment
 - A. Maintain a patent airway
 - 1. Suction as necessary
 - 2. Insert oropharyngeal or nasopharyngeal airway as needed
 - 3. Perform endotracheal intubation as needed (ALS)
 - B. Oxygenation/Ventilation
 - 1. Initiate 2 ventilations, observe for rise in chest, listen for breath sounds bilaterally
 - 2. Assist ventilations as necessary
 - C. Circulatory
 - 1. Initiate an IV Normal Saline TKO (ALS)
 - 2. Monitor cardiac rhythm
 - 3. Monitor oxygen saturation via pulse oximetry if available
- II. Transport

PREHOSPITAL PROTOCOL FOR ANAPHYLACTIC SHOCK**I. Treatment**

- A. Assure an open airway
 - 1. Suction as needed
 - 2. Insert oropharyngeal/nasopharyngeal airway as needed
 - 3. Endotracheal intubation as needed (ALS)
 - 4. Perform cricothyrotomy if unable to intubate or ventilate (ALS)
- B. Oxygenation/Ventilation
 - 1. Provide O₂ 15 L/minute per non-rebreather mask
 - 2. Assist ventilations if necessary
 - 3. Monitor oxygen saturation via pulse oximetry if available
- C. Circulation
 - 1. Initiate IV normal saline wide open to maintain B/P of at least 100 systolic (ALS)
 - 2. Apply pneumatic antishock garment if severe hypotension. BLS only inflate after contact with medical control.
 - 3. Cardiac monitor - transmit a rhythm strip and/or 12 Lead EKG (ALS)
- D. Medications (ALS)
 - 1. Administer epinephrine 1:1,000 solution
 - a) Adults: 0.3 ml subcutaneously for a mild reaction
 - b) Peds: 10 kg 0.1ml SQ
20 kg 0.2ml SQ
30 kg 0.3ml SQ*
*Maximum dose: 0.3 ml SQ. May be repeated in 15 min.
 - 2. Administer epinephrine 1:10,000 solution, 5.0 ml at 1 ml/min IVP for a severe reaction
 - 3. Administer Benadryl:
 - a) Adults - 50 mg slow IV push
 - b) Peds - 1 mg/kg slow IV push*
*Maximum dose: 50mg
 - 4. If patient is conscious, Albuterol 2.5 mg via nebulizer may be considered but must be used with extreme caution if epinephrine has been administered
- E. Epi-Pen (BLS)
 - 1. BLS transport and BLS non-transport agencies: (Per protocol AP-24)
 - a) Epi pen 0.3 mg IM
 - b) Epi pen (Pediatric) 0.15 mg IM
 - 2. EMT-B's working for First Responder agencies can assist the patient with Epi-pen injection (Per protocol MP-24)

II. Transport

- A. Reassess airway status, vital signs and level of consciousness every 5-10 minutes.

re: 8/95, 9/95, 12/97, 5/98, 8/01, 8/04, 10/06

Kelly Cox, M.D., EMS Medical Director

**PREHOSPITAL PROTOCOL FOR SHOCK DUE TO TRAUMA AND/OR BLOOD LOSS
(ADULT)**

I. Treatment

- A. Ensure patent airway while maintaining cervical spine immobilization.
 - 1. Suction as needed.
 - 2. Insert oropharyngeal or nasopharyngeal airway as needed.
 - 3. Endotracheal intubation as needed (ALS)
- B. Oxygenation/Ventilation
 - 1. Administer oxygen at 15 LPM per non-rebreather mask
 - 2. Assist ventilations as necessary.
 - 3. Monitor oxygen saturation via pulse oximetry if available.
- C. Circulation
 - 1. Control active bleeding
 - 2. Apply pneumatic antishock garment. (BLS inflate after contact with Medical Control)
 - 3. Initiate 1 or more large bore IV's (16 gauge or larger) of normal saline, infuse to maintain blood pressure of 90 systolic (ALS).
 - 4. Cardiac monitoring (ALS).
- D. Other treatment
 - 1. Spine board and cervical immobilization on all suspected or potential spinal injuries
 - 2. Check vital signs and level of consciousness every 5 minutes
 - 3. Keep the patient warm
 - 4. Reassure patient
 - 5. Splinting of extremities as required (enroute).

II. Transport

- A. Transport as soon as possible and continue to monitor and report any significant changes
- B. Non-transport agencies should ensure that the dispatched ambulance personnel are kept informed of patient(s) condition.
- C. A patient demonstrating signs and symptoms of shock should be considered a "load and go"

PREHOSPITAL PROTOCOL FOR SEIZURES/STATUS EPILEPTICUS**I. Treatment**

- A. Airway management
 - 1. Assure a patent airway
 - 2. Suction as needed
 - 3. Airway adjuncts as needed
- B. Oxygenation/Ventilation
 - 1. Administer oxygen
 - 2. Assist ventilations as needed
 - 3. Monitor oxygen saturation if pulse oximetry is available
- C. Circulatory
 - 1. Initiate an IV of normal saline TKO (ALS)
 - 2. Attempt cardiac monitoring (ALS)
- D. History/Physical exam
 - 1. Obtain as much history as possible from witnesses.
 - 2. Determine if true "status epilepticus" exists (a series of rapidly repeated seizures without any period of consciousness between them).
 - 3. Determine the approximate age, height, and weight of the patient.
 - 4. Check for medic alert tags or wallet cards.
 - 5. Determine if patient is pregnant with a history of pre-eclampsia, if possible.
- E. Medications (ALS)
 - 1. Consider the administration of 50 ml./50% Dextrose IV if history/finger stick glucose indicates hypoglycemia.
 - 2. Diazepam (Valium) IV may be indicated to control seizures based on the following:
 - a) Pertinent history of prior prolonged seizure activity
 - b) Extended ETA to the hospital
 - c) Age of the patient (usually not given by paramedics in patients under age 3 and in the very elderly patient, especially those with known lung or heart disease)
 - d) Uncontrolled seizures where clinical evidence of hypoxia is noted.
 - e) Adult dose is 5-10 mg IV slowly, administered at 1 mg/min. until seizure activity stops.
 - 3. Blood pressure should be monitored very closely, checking at least each minute during injection. If blood pressure begins to drop, discontinue injection of the drug, flush the tubing, place the patient into Trendelenberg position and administer a 200ml Normal Saline fluid bolus.
 - 4. If the BP remains low after, contact Medical Control for further orders.

II. Transport

**PREHOSPITAL PROTOCOL FOR UNCONSCIOUS PATIENT OF UNDETERMINED
CAUSE**

I. Treatment

A. Airway management

1. Ensure a patent airway while maintaining cervical spine immobilization
2. Suction as needed
3. Oropharyngeal/Nasopharyngeal airway as needed
4. Endotracheal intubation as needed (ALS)

B. Oxygenation/Ventilation

1. Administer oxygen
2. Assist ventilations as needed
3. Monitor oxygen saturation if pulse oximetry is available

C. Circulatory

1. Initiate an IV normal saline TKO (ALS)
2. Monitor cardiac rhythm and/or perform 12 Lead EKG and transmit (ALS)

D. Obtain history, check for Medic Alert Tags, etc.

E. Other

1. Finger stick glucose to rule out hypoglycemia. (ALS)
 - a) If hypoglycemic, treat per protocol MP-7
2. Administer Naloxone in the patient suspected of having a narcotic overdose (ALS)
 - a) Adult: 1-2 mg IV, ET, IM – may repeat in 2-3 minute intervals for 2-3 doses if no response.
3. Monitor vital signs, level of consciousness and cardiac rhythm (ALS).

II. Transport

Kelly Cox, M.D., EMS Medical Director

re: 5/93, 4/95, 12/97, 9/99, 8/01
reviewed: 10/06

PREHOSPITAL PROTOCOL FOR HYPERTENSIVE CRISIS

- I. Treatment
 - A. Airway management
 - 1. Ensure a patent airway
 - B. Oxygenation/Ventilation
 - 1. Administer oxygen
 - C. Circulatory
 - 1. Monitor cardiac rhythm (ALS)
 - 2. Initiate IV normal saline KVO or saline lock needle (ALS)
 - D. Other
 - 1. Monitor vital signs every 5 minutes
 - 2. Monitor level of consciousness
 - 3. If diastolic pressure is above 120 or the patient has a severe headache, vomiting, blurred vision, hemiparesis, deteriorating mental status or seizures, contact Medical Control for orders.
- II. Transport

Kelly Cox, M.D., EMS Medical Director

1/91, 9/91, 5/93, 1/94, 12/97, 5/98, 11/98, 8/01
(reviewed: 8/95, 2/06)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

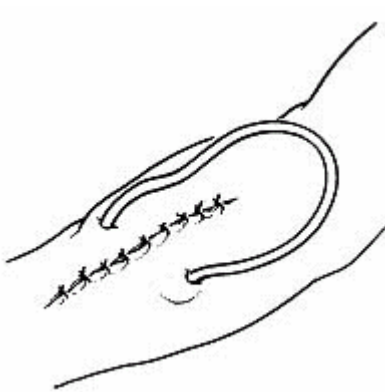
PREHOSPITAL PROTOCOL FOR RENAL PATIENTS WITH AV SHUNTS AND FISTULAS

- I. DO NOT TAKE blood pressure on arm with shunt or fistula.
- II. No venipunctures are to be done on arm with shunt or fistula. Only during life-saving measures may a venipuncture be performed on the involved arm. Hand vessels at this time are the best. (ALS)
- III. In the event a shunt is accidentally pulled out of the entrance site, the following must be done:
 - A. Apply direct pressure to site of bleeding
 - B. Elevate affected arm
 - C. Apply tourniquet above the site of bleeding as a final effort to control bleeding
- IV. If the shunt tubing accidentally becomes disconnected, apply clamps to end of tubing.
- V. Transport immediately to the hospital.
- VI. Use of shunt, fistula, or graft in an emergency: (ALS)
 - A. If the patient has cardiac standstill or ventricular fibrillation or the patient's blood pressure is very low and venipuncture is not possible, the shunt, fistula or AV graft can then be used to administer life saving drugs or IV fluids.
 - B. If the patient has a shunt -- disconnect the two small tubes, apply copper clip or any clamp on the arterial line; (arterial line is mostly on the radial side of the wrist). Attach IV line or syringe directly to the venous line.
 - C. In patients with fistulas a regular butterfly needle or IV needle can be inserted in any of the prominent veins.
 - D. In patients with AV grafts -- IV needle can be inserted to the venous side of the graft (ulnar side).
- VII. Cardiac arrest in dialysis patients: (ALS)
 - A. Initiate ACLS protocol immediately
 - B. DO NOT GIVE EXCESSIVE IV FLUIDS
 - C. Once B/P is established keep the IV rate very slow (50-100 ml/hr.)
 - D. Give Calcium Chloride IV slowly over 2-3 minutes to combat the effect of hyperkalemia on the heart
 - E. Give 50-100 mEq of Sodium Bicarbonate IV slowly over 5 minutes

F. Pulmonary edema in dialysis patients:

1. Give oxygen – 15 liters/minute via non-rebreather mask.
2. Morphine IV 2-10 mg slowly upon order of Medical Control.
3. Transport in High-Fowler's position as needed

VIII. Transport

PATIENTS WITH AV SHUNTS, FISTULAS, AND GRAFTS**CLOTTED SHUNT****NORMAL SHUNT**

- I. A shunt is made up of two small tubes, one in an artery and one in a vein of the forearm or lower leg. When closed, the tubing forms a loop on the outside of the arm, near the wrist. When used for hemodialysis, the loop is open. Shunt clotting is a serious problem, and it should be handled with prompt attention, but it is not an emergency. Frantic activity and worry will not help the situation. When the shunt clots, the blood flow is interrupted in the shunt tubing only. It does not interfere with circulation in any other part of the body. Other than the need to declot the shunt before the next dialysis, there is no physical danger to the patient. Even if it becomes necessary to miss one treatment, the patient should feel no ill effects. In many instances, shunts can be declotted successfully and continue to function well for some time. Even when declotting is not successful, the most serious consequences is that the shunt needs to be relocated.

SHUNT EMERGENCIES

Bleeding from Incision Sites



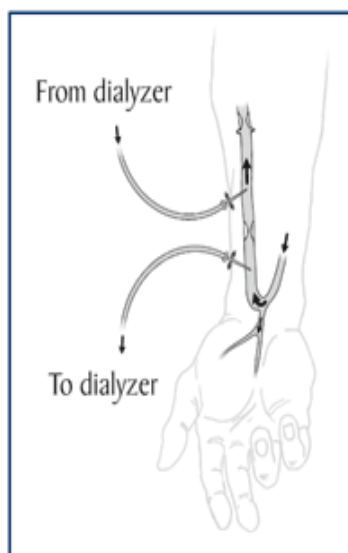
Shunt clips must be carried with the patient at all times in order to manage any accidental separation of the tubing. Reconnection of the arterial and venous tubes will restore normal shunt blood flow. Accidental injury to the arm or leg could possibly cut the tubing. Shunt clips applied to the appropriate areas will stop the bleeding. If bleeding is from the incision sites where the tubing enters the skin, a tight pressure tourniquet should be placed around the limb above the shunt site, and Medical Control should be notified immediately.

Instead of a shunt, some patients will have a fistula. A small opening is made in the side of an artery and in the side of a vein, and two vessels are joined together at these openings under the skin. This connection is called an arteriovenous fistula. Because pressure in the artery is much higher than pressure in the vein, there is a rapid flow of blood from the artery into the vein.

The usual location for a fistula is near the wrist, and as a result of the high blood flow, some of the veins in the forearm will become large, easily seen and felt. The flow through the dilated veins may be so forceful that it can be felt as a “buzz” when you gently touch this site. With this high blood flow, it is possible to insert needles into the vein and obtain sufficient blood flow for dialysis.

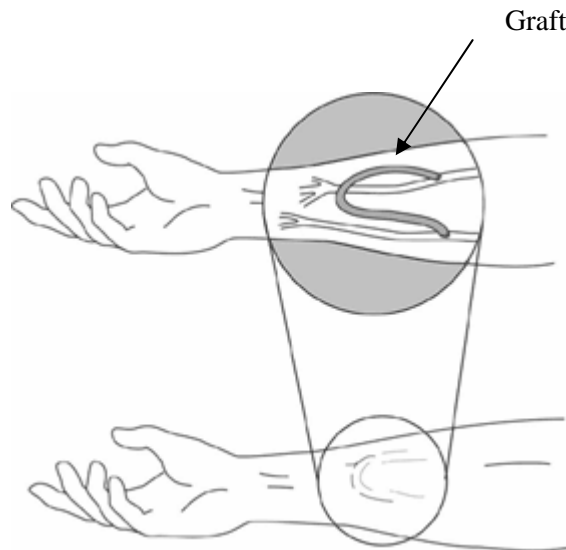
Following the end of dialysis, firm pressure needs to be applied over the needle puncture area for 10 to 15 minutes after the needles are withdrawn to prevent persistent bleeding. One complication is bleeding after discharge from the dialysis unit. (Apply direct pressure with a sterile dressing.)

FISTULA



GRAFT

Many dialysis patients now have an artificial graft made of Dacron connecting an artery and a vein in the arm. The graft is buried under the skin in the forearm. Prolonged pressure over the graft or above the graft may lead to clotting of the graft.



HEAT EMERGENCIES**I. Isolated Heat Cramps****A. Treatment**

1. Move the patient to a cool environment.
2. Consider an IV of normal saline if cramps are severe (ALS).

B. Transport**II. Heat Exhaustion/Heat Stroke****A. Treatment**

1. Move the patient to a cool environment
2. Remove excessive clothing.
3. If hypotensive or unconscious:
 - a) maintain an open airway
 - b) oxygen per nasal cannula or mask as needed.
 - c) initiate an IV of normal saline and administer an initial fluid bolus of 200 cc. (ALS).
 - d) monitor cardiac rhythm (ALS).
 - e) perform and transmit 12 lead EKG if possible (ALS).
 - f) initiate cooling of the heat stroke victim with cold packs or cool soaks to the neck, axilla, and groin.

B. Transport

COLD EMERGENCIES**I. Isolated Frostbite****A. Treatment:**

1. Move the patient to a warm environment.
2. Remove wet, restrictive clothing.
3. Cover affected areas with dry, sterile dressings.
4. Prevent thawing/re-freezing of the affected areas.
5. Rewarming of frostbitten tissue is best performed in the controlled setting of the emergency department.

B. Transport**II. Hypothermia****A. Treatment**

1. Move the patient to a warm environment, maintaining a horizontal position. Handle gently.
2. Airway management:
 - a) maintain an open airway using manual or mechanical measures as needed.
 - b) intubate as needed (ALS).
3. Oxygenation/ventilation
 - a) Administer oxygen.
 - b) assist ventilations as needed.
4. Circulatory
 - a) start CPR if pulseless and not breathing.
 - b) initiate an IV of normal saline - warmed if possible (ALS).
 - c) monitor cardiac rhythm. (ALS)
 - d) perform 12 lead EKG and transmit if possible. (ALS)
5. Other
 - a) remove all wet clothing
 - b) keep the patient as warm as possible

B. Special Considerations

1. Patients who appear dead in the setting of hypothermia should not be pronounced as such until rewarmed.
2. In severe hypothermia, electrical therapy and ACLS drugs may not be effective. Contact Medical Control for instructions if the initial three defibrillations are ineffective.

C. Transport

NEAR-DROWNING**I. Treatment**

- A. Remove the victim from the water while maintaining C-spine alignment as possible. Personal safety should be of primary consideration in this effort.
- B. Airway management
 - 1. Maintain an open airway while immobilizing the cervical spine.
 - 2. Suction as needed.
 - 3. Insert a nasal or oral airway as needed.
 - 4. endotracheal intubation as needed (ALS).
- C. Oxygenation/Ventilation
 - 1. Oxygen 15 L/minute by non-rebreather mask.
 - 2. Assist ventilations with 100% oxygen as needed.
- D. Circulatory Maintenance
 - 1. Perform CPR if apneic and pulseless
 - 2. Initiate an IV of normal saline (ALS)
 - 3. Monitor cardiac rhythm (ALS)
 - 4. Perform 12 lead EKG and transmit if possible (ALS).
 - 5. Monitor oxygen saturation.
- E. Spinal Immobilization
 - 1. Fully immobilize the spine if suspected diving injury or unknown.
- F. Special Consideration
 - 1. If the patient is hypothermic, see protocol for Cold Emergencies.

II. Transport

RADIATION EXPOSURE

I. Scene Safety

- A. Ensure that persons knowledgeable in radiation techniques are responding to the scene, primarily a hazmat team or local fire department.
- B. Professionals in appropriate protective gear should isolate the source, contain it and test the site for safety.
- C. Radiation damages the reproductive system. Protect yourself through time, distance, and shielding as instructed by trained radiation experts.

II. Treatment

- A. Limit all exposure and procedures to treatment of life-threatening problems.
- B. Decontamination will usually be carried out at the scene by trained professionals with appropriate suits. Once decontaminated, the patient no longer poses a threat as a source of contamination.
- C. If decontamination is not available, cocoon the patient in sheets/blankets and limit contact with patient to necessary procedures.

III. Vehicle/equipment decontamination

Contact local hazmat team or hospital radiation officer for information regarding the process to decontaminate equipment or vehicle and allow it to be returned to service.

SUSPECTED ABUSE OR NEGLECT

- I. Required Reporting
EMS providers are required to report any child or elderly person whom you have reasonable cause to suspect has been abused or neglected.
- II. Possible Indicators of Abuse and/or Neglect:
 - A. Obvious or suspected fractures in a child under age two.
 - B. Injuries in various stages of healing, especially burns or bruises.
 - C. Injuries scattered over many body parts.
 - D. Bruises or burns in a pattern which suggests intentional infliction.
 - E. Injuries which do not match the history.
 - F. Vague, inconsistent or changing history.
 - G. Delay in seeking treatment.
 - H. Inappropriate clothing, signs of poor nutrition or poor care.
 - I. Abandonment of an elderly person or child unable to care for themselves.
- III. Treatment
 - A. Keep suspicions to yourself - do not accuse the caretaker.
 - B. Protect the child/elder. Call for police assist if necessary.
 - C. Treat injuries according to protocol.
 - D. Convey your suspicions to hospital staff. (This does not relieve you of your duty to contact appropriate officials in III.F)
 - E. Write a detailed report describing your findings. Do not write opinions or accusations.
 - F. Make a report to officials.
 - 1. Child abuse hotline: 1-800-25A-BUSE (Illinois DCFS hotline) 24 hours
 - 2. Elder abuse hotline: 1-800-252-8966 (Illinois Department on Aging) normal business hours. 1-800-279-0400 if after hours, weekends and holidays.
 - 3. You are protected by law from civil liability for making this report.

IV. Domestic Abuse

- A. EMS providers should be aware of services available in the community for suspected victims of abuse and be able provide a list of these for the suspected victim.
1. Quanada: 222-2873 or 222-0069
 2. Family Service of Adams County: 222-8254
 3. Lutheran Child and Family Services: 222-0106
 4. Other: there are many other agencies available - a good resource is hospital social services or yellow pages

EMT-B'S ASSISTING PATIENT WITH CERTAIN MEDICATIONS

The EMT-B may assist the patient with certain medications. They are: Nitroglycerin (SL), Auto-injector/Epi-pen (Sub-q), a prescribed inhaler. The EMT-B may assist the patient only after all of the following conditions have been met:

- There are specific chief complaints
- The medication is prescribed for the patient
- The medication is not expired
- Medical control has been contacted with a patient report
- Medical control authorizes the dosage route, times, and administration

I. Nitroglycerin (tablets or spray)

A. Indications:

1. The patient is responsive
2. The patient has a known cardiac history and has chest pain
3. The blood pressure is greater than 100 mmHg systolic

B. Contraindications:

1. Hypotension or a systolic blood pressure of less than 100 mmHg
2. Head injury
3. Infants and children
4. The patient has already taken three tablets before you arrive

C. Potential Complications

1. Hypotension due to vasodilatation
2. Syncope

D. Side Effects

1. Headache
2. Burning sensation under the tongue

E. Precautions

1. Wear gloves to prevent skin absorption when handling the medication

F. Procedure

1. Take body substance isolation
2. Obtain the patient's prescribed nitroglycerin
3. Check the medication for expiration date
4. Contact medical control, give a patient report and receive authorization
5. Place one tablet or one spray under the tongue
6. Recheck blood pressure in 2-3 minutes
7. A second and third dose may be ordered every 3-5 minutes if chest pain persists and blood pressure remains greater than 100 mmHg systolic
8. Document time, dosage, medication, blood pressure and patient's response
9. Contact Medical Control and report patient's response

II. Auto-Injector/Epi-Pen (epinephrine 1:1000)

-Pediatric Dosage: 0.15 mg 1:1000 (60 lbs or less)

-Adult Dosage: 0.3 mg 1:1000

- A. Indications: The patient has a history of an allergic reaction, has an auto-injector/epi-pen prescribed, and is now having an acute allergic reaction with some of the following symptoms:
 - 1. Flushing, itching or burning of the skin
 - 2. Urticaria (hives)
 - 3. Tightness in the chest
 - 4. Dry cough, wheezing
 - 5. Swelling of the face, neck, hands, feet, and/or tongue
 - 6. Difficulty breathing (Dyspnea)
- B. Contraindications
 - 1. Chest pain consistent with angina
 - 2. B/P greater than 200 systolic
- C. Side Effects;
 - 1. Tachycardia
 - 2. Dizziness, nausea, and vomiting
 - 3. Headache
- D. Procedure
 - 1. Take body substance isolation precautions
 - 2. Obtain the patient's prescribed auto-injector
 - 3. Check the medication for cloudiness, discoloration and expiration date
 - 4. Call medical control with a patient report and receive authorization to assist with medication
 - 5. Remove safety cap and select the appropriate injection site (thigh or shoulder)
 - 6. Push injector firmly against site for a minimum of ten (10) seconds
 - 7. Properly discard auto-injector
 - 8. Document time, medication, and dosage, site and patient's response
 - 9. Contact Medical Control and report patient's response

III. Respiratory Meter-dose Inhaler

- A. Indications: Acute respiratory difficulty not relieved with oxygen therapy
- B. Precautions
 - 1. Patient is responsive and able to cooperate
- C. Procedure
 - 1. Take body substance isolation precautions
 - 2. Obtain the patient's prescribed inhaler
 - 3. Ensure that the inhaler is at room temperature and it is not expired
 - 4. Check if patient has already taken any doses, noting times and number
 - 5. Contact medical control with patient report and receive authorization to assist patient with the inhaler
 - 6. Shake the inhaler several times

7. Remove O₂, have patient inhale and exhale and put mouthpiece in his/her mouth and make a seal
8. Have patient depress the inhaler as he/she inhales deeply
9. Instruct the patient to hold his/her breath as long as he/she can comfortably do so
10. Replace O₂ and allow patient to breathe a few times
11. Chart medication, time, route, and patient's response
12. Contact Medical Control and report patient's response

QUINCY AREA EMS SYSTEM FIRST RESPONDER PROTOCOLS

- I. Response to medical call: the responder should keep scene and personal safety in mind at all times and take body substance isolation (BSI) precautions.
 - E. Airway
 1. Position the head to ensure an open airway
 2. Use oral or nasal airways to maintain an open airway as needed.
 - E. Breathing
 1. Assess for breathing. If the patient is not breathing, begin ventilations with pocket mask or bag valve mask.
 2. Apply oxygen if breathing. If no severe distress, place on 4-6 LPM/nasal cannula. If severe distress, apply 15 LPM by non-rebreather mask.
 - E. Circulation
 1. Check pulses – begin CPR if no pulse.
 2. Check for bleeding.
 3. If unresponsive/no pulse and the First Responder is AED certified, begin the AED protocol.
 - E. Disability
 1. Check level of consciousness (AVPU).
 2. Check pupillary response.
 - E. Expose
 1. Focus on the chief complaint.
 2. Assess vital signs: blood pressure, pulse and respirations.
 3. Obtain SAMPLE history.
 4. Give verbal report to the responding ambulance/helicopter crew when they arrive on the scene.
- II. Response to Trauma Call: the responder should keep scene and personal safety in mind at all times and take body substance isolation (BSI) precautions.
 - A. Airway
 1. Take manual control of the C-spine.
 2. Open the airway using the modified jaw thrust.
 3. Use oral or nasal airways to maintain an open airway as needed.
 - B. Breathing
 1. Assess for breathing. If the patient is not breathing, begin ventilations using a pocket mask or bag valve mask.
 2. Apply oxygen. If no distress: apply 4-6 LPM using a nasal cannula. If severe distress, apply 15 LPM using a non-rebreather mask.

- C. Circulation
 - 1. Check pulses – begin CPR if no pulse.
 - 2. If the patient is unresponsive with no pulse and the responder is AED certified, begin using the AED protocol
 - 3. Check for bleeding.
 - 4. Control bleeding with direct pressure/pressure dressing and elevation. If bleeding continues, use pressure points. As a last resort, utilize a tourniquet.
- D. Disability
 - 1. Check level of consciousness (AVPU).
 - 2. Check pupillary response.
- E. Expose/evaluate
 - 1. Expose areas of injury.
 - 2. Assess vital signs: blood pressure, pulse and respirations.
 - 3. Obtain SAMPLE history.
 - 4. Give verbal report to the responding ambulance/helicopter crew when they arrive on the scene.

QUINCY AREA EMS SYSTEM STROKE

- I. A stroke should be considered an emergent situation. Depending upon the type of stroke, patients may be candidates for thrombolytic (clot buster) therapy in the emergency department. Time is critical and on scene time should be kept to a minimum for all patients with signs and symptoms of stroke.
- II. Assessment: All possible stroke patients should have the following assessed, in addition to your usual assessment:
 - A. Level of consciousness
 - 1. AVPU
 - 2. Glasgow Coma Scale
 - B. Cincinnati stroke scale – 3 components.
 - 1. Facial droop (Ask the patient to smile)
 - a. Normal: Both sides of face move equally
 - b. Abnormal: One side of face does not move
 - 2. Speech (Ask the patient to repeat a simple sentence.)
 - a. Normal: Patient uses correct words with no slurring
 - b. Abnormal: Slurred or inappropriate words or unable to speak
 - 3. Arm drift (Ask patient to close eyes and hold arms straight out in front of them.)
 - a. Normal: Both arms move equally or not at all
 - b. Abnormal: One arm drifts compared to the other
 - C. Finger stick glucose
 - D. Determine time of "*last known well*" (This will be a critical determinant in the decision to give thrombolytic agents to the patient in the Emergency Department.)
 - E. Obtain SAMPLE history (It is especially important to determine what medications the patient is taking.)
- III. Treatment
 - A. Airway management
 - 1. Monitor and ensure a patent airway
 - 2. Suction if necessary
 - 3. Oral or nasal airway to maintain airway patency as needed
 - 4. Endotracheal intubation to maintain airway patency as needed (ALS)
 - B. Oxygenation
 - 1. Administer oxygen to maintain oxygen saturation of at least 95% if possible
 - 2. Assist ventilation if necessary
 - 3. Monitor oxygen saturation if pulse oximetry is available

C. Circulatory

1. Initiate IV of normal saline at KVO rate (ALS)
2. Cardiac monitoring (ALS)

D. Other

1. Contact Medical Control *and/or receiving facility* as soon as possible to indicate possible stroke and to relay assessment information (This will allow the Emergency Department to identify patients who are possibly candidates for thrombolytics.)
2. Monitor vital signs every 15 minutes for stable patients, every 5 minutes for critical patients.
3. Place patient's head flat with pillow

IV. Transport: the goal should be to keep on scene time as short as possible.

V. Documentation

- A. Besides usual documentation, your narrative should include the time of "*last known well*" and Cincinnati Stroke Scale results, *blood sugar results, loss of conscience, and sample history.*

QUINCY AREA EMS SYSTEM LATEX ALLERGIC PATIENTS

- I. Purpose:
 - A. To establish guidelines for the management of patients with suspected or known latex allergy.
 - B. To assure proper care of the patient and EMS provider who has a suspected or known latex allergy.
- II. Latex allergies
 - A. Two main types
 - 1. Delayed: Delayed reactions may produce signs/symptoms within 6-48 hours. Symptoms include:
 - a. Contact dermatitis such as local itching, edema, erythema (redness), blisters (vesicles), drying patches, crusting and thickening of the skin.
 - b. Dermatitis that spreads beyond the skin initially exposed to the latex.
 - 2. Systemic: Immediate reaction (within 15 minutes). Symptoms include
 - a. Generalized rash
 - b. Urticaria (hives)
 - c. Dyspnea
 - d. Wheezing, bronchospasms, laryngospasms, laryngeal edema
 - e. Tachycardia
 - f. Feeling faint, lightheaded
 - g. Abdominal cramps, nausea, vomiting, diarrhea
 - h. Hypotension
 - i. Cardiac arrest due to anaphylaxis
 - B. Persons at risk for latex allergy
 - 1. Workers with industrial exposure to latex / rubber industry
 - 2. Healthcare workers
 - 3. Persons with multiple surgeries
 - 4. Spina bifida (genetic predisposition for latex sensitization)
 - 5. Urogenital abnormalities and/or persons with frequent urinary procedures
 - 6. Persons with a predisposition to allergies
 - C. Common sources of latex exposure (Note that since 1998, medical supply items are required to be marked with a warning if they contain latex.)
 - 1. Gloves
 - 2. Tourniquets
 - 3. Blood pressure cuffs
 - 4. Stethoscopes
 - 5. Band-aids
 - 6. Airway equipment (ET tubes, stylets, BVM, CombiTube airway)
 - 7. IV tubing ports
 - 8. Multidose vial tops
 - 9. Electrode pads
 - 10. Catheters

III. Preparation to care for and transport the latex sensitive patient

- A. EMS providers should be educated about latex sensitivities and the prevention of an allergic reaction.
- B. EMS providers should know what equipment they carry that contains latex.
- C. Latex-free supplies must be carried on the response vehicle and readily available. Equipment can be stocked as completely latex free or in a latex-free kit.
 - 1. Exam gloves
 - 2. Airway / oxygenation equipment: bag-valve-mask, nasal cannula, non-rebreather mask, oral airways
 - 3. Suction catheters
 - 4. Tape
 - 5. EKG electrodes
- D. Steps should be taken to modify the ambulance environment by keeping loose latex items in closed compartments.
- E. Notify Medical Control or the receiving facility as soon as possible as arrangements will need to be made in the hospital to make the environment latex-free.

IV. Procedure

- A. Screen for latex allergy
 - 1. Ask if the patient has a known or suspected allergy to latex.
 - 2. If no known latex allergy, screen for suspected latex sensitivity by asking the following questions:
 - a. “Do you react to rubber bands?” – Ask them to describe the reaction.
 - b. “Do you react to balloons?” – Ask them to describe the reaction.
- B. For suspected latex sensitivity (Patient’s responses to the above questions indicated possible latex allergy)
 - 1. Monitor for signs and symptoms listed below in IV)C)
 - 2. Follow interventions listed below in IV) C)
- C. For known latex sensitivity
 - 1. Obtain history and ask patient to describe symptoms of latex sensitivity
 - 2. Monitor for the following signs/symptoms:
 - a. Itching eyes, generalized itching
 - b. Urticaria (hives)
 - c. Facial edema
 - d. Feeling of faintness
 - e. Wheezing, shortness of breath, bronchospasm
 - f. Tachycardia
 - g. Nausea, vomiting, abdominal cramping
 - h. Hypotension
 - i. Feeling of impending doom

3. Interventions

- a. Utilize latex-free supplies in the care of the patient
- b. If you are wearing gloves containing latex when you identify the patient as allergic, do NOT take the gloves off. Removal will put the powder/dust into the air where it can linger for up to five hours. Place latex free gloves on over the top of the other gloves.
- c. Do not administer medications through latex ports on IV tubing
- d. Wrap all tubing that contains latex with kling or stockinette that might come into contact with the patient. (BP cuff tubing, stethoscope tubing)
- e. Notify Medical Control of known latex sensitivity
- f. Initiate Anaphylactic Shock protocol (MP-13) if needed

D. Documentation

1. Document notification of Medical Control of suspected or known latex allergy.
2. Document notification of receiving staff upon arrival of suspected or known latex allergy.
3. Any interventions done to protect the patient from latex exposure
4. Any abnormal findings, signs/symptoms related to latex exposure.

NAUSEA & VOMITING

I. Historical Findings:

- A. Patient complains of nausea/vomiting

II. Physical Findings:

- A. *Patient complaining of nausea or vomiting.*
- B. Patient is vomiting.

III. Protocol:

A. *If the patient has a complaint of nausea or vomiting (See II A)*


1. Administer:
 - a) Adults: Zofran 4 mg slow IVP. Repeat dose X (1) if necessary in 15 minutes
 - b) Pediatrics: Must contact Medical Control prior to administration
2. Notify emergency department that Zofran was administered so they can be prepared to insert NG tube if necessary.


B. *If the patient is vomiting (See II B) you may:*

1. Administer: **Preferred medication Zofran**
 - a) Adults: Zofran 4 mg slow IVP. Repeat dose X (1) if necessary in 15 minutes
 - b) Pediatrics: Must contact Medical Control prior to administration
OR
 - c) Adults: Phenergan 12.5 mg (diluted in 10cc NS) slow IVP. Repeat dose X (1) if necessary to a max dose of 25mg IV.
 - d) Pediatrics: Must contact medical control prior to administration
Phenergan 0.25mg/kg (diluted in 10 cc NS) slow IVP, **No Repeat Dosage.** Max dose 12.5mg – **not to be used in patient under 2 years of age.**
2. Notify emergency department that Phenergan was administered so they can be prepared to insert NG tube if necessary

IV. Notes

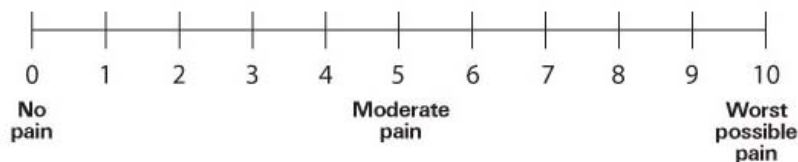
- A. Akathisia (inability to remain still or increased urge to move around) or dystonia (muscle spasms, rigidity, or rolling of eyes) may occur. If noted, administer Benadryl 25 mg IVP. Peds: Contact Medical Control
- B. Do not mix antiemetics. If you have administered one of your options of medication and it was not effective, contact medical control for guidance


 Richard A Saalborn, DO, FACEP, FACOEP
 EMS Medical Director

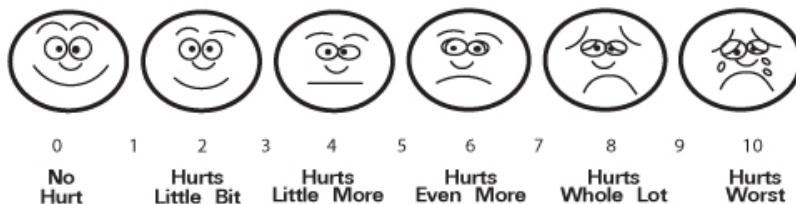

 Christopher R Solaro, MD
 EMS Assistant Medical Director
 6/06; re: 2/14

PAIN MANAGEMENT

- I. Purpose: To outline the procedures for assessment and management of severe pain in the prehospital and interhospital setting.
- II. Rationale: To provide pain management using techniques and medications that are effective and safe without leading to physiological compromise or delays in transport to definitive care.
- III. Pain assessment: Pain is subjective and is defined by the person experiencing the pain. Pain severity should be assessed before pain management interventions to obtain a baseline and after pain management interventions to determine effectiveness of the intervention. There are many assessment tools that can be utilized to assess pain.
 - A. Utilize the mnemonic OPQRST to fully evaluate the patient's pain.
 1. Onset- Ask what was the patient doing when the pain began.
 2. Provoke / Palliate - Ask whether anything makes the pain worse (provoke) such as deep breath or movement. Does anything make the pain better (palliate) such as lying still.
 3. Quality - Ask the patient to describe the pain (sharp, dull, ache, cramping, heaviness or pressure, constant or intermittent)
 4. Radiate – does the pain stay in one location or move
 5. Severity – use a pain scale
 6. Time – how long has it been going on
 - B. Numerical pain scale: allows the patient to describe the intensity of their discomfort in numbers ranging from 0-10, with zero being no pain and ten the worst possible (excruciating) pain. This scale can be utilized for most adults and for older children.



- C. Wong-Baker Faces pain rating scale: is designed for children age three and older. It can also be helpful for adults who may be cognitively impaired or have difficulty understanding the numerical pain scale. It offers a visual description for those who don't have the verbal skills to explain how their symptoms make them feel.



- D. FLACC Scale: Is used for infants and young children or adults who may be cognitively impaired. The FLACC scale evaluates five categories and assigns a score of 0-2 for each category with a total score between 0 and 10. The patient care team and family are usually involved in this evaluation.

FLACC SCALE SCORING			
Categories	0	1	2
FACE	No particular expression or smile	Occasional grimace, frown, disinterested	Frequent or constant frown, quivering chin, clenched jaw
LEGS	Normal position, relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quietly, moves easily	Squirming, tense, shifts back & forth	Arched, rigid, jerking
CRY	No cry awake or asleep	Moans, whimpers	Cries, screams, sobs
CONSOLABILITY	Content, relaxed	Reassured by touch, hug or being talked to, distractible	Difficult to console or comfort
Each of the 5 categories is scored from 0-2, which results in a total score of 0-10. Zero is no pain and 10 is severe pain.			

- E. For children or adults with cognitive impairment, the provider can also solicit the assistance of a knowledgeable caregiver, family member, or friend to help identify pain behaviors.

IV. Protocol

A. Non-pharmacologic pain management techniques (BLS and ALS)

1. Reassurance
2. Distraction: techniques to focus attention away from the pain such as talking to the patient, offering a toy or other distraction.
3. Patient positioning and padding for comfort
4. Splint extremity injuries
5. Elevation and cold packs for extremity injuries (Never apply a cold pack or ice pack directly to the patient's skin.)

B. Pharmacologic pain management (ALS)

1. Preparation before administering pain medications includes neurologic assessment, vital signs, pulse oximetry and cardiac monitor. Have equipment available to support oxygenation, ventilation and if necessary intubation.

2. Medications

a. Morphine sulfate (See policy M-1.17)

- i. Adults: An initial dose of 2 mg IVP may be administered prior to contact with Medical Control. 2nd dose of 2mg may be given after vitals and pain scale reassessment. Contact Medical Control for additional doses.
- ii. Pediatric: Requires contact with Medical Control first. Dose 0.1 mg/kg IVP. Contact Medical Control for repeat doses.

OR

b. Fentanyl (Sublimaze) (See policy M- 1.30)

- i. Adult: 25 mcg slow IVP. 2nd dose of 25mcg may be given after vitals and pain scale reassessment. Contact Medical Control for additional doses.
- ii. Pediatric: Requires contact with Medical Control first. Dose 1 mcg/kg slow IVP.

c. Opioid reversal agent naloxone (Narcan) may need to be utilized if respiratory depression ensues. (See policy M-1.18)

- i. Adult: 2 mg IVP initial dose and may repeat 2-3 doses in 2-3 minute intervals if no response.
- ii. Pediatric under 20 kg: 0.1 mg/kg up to maximum of 2 mg; pediatric over 20 kg: 2 mg IVP

C. Reassessment and documentation

1. Reassess neurologic status, vital signs, oxygen saturation every 5-15 minutes.
2. Reassess patient's response to pain measures using the pain assessment scale after 10 minutes.
3. Consider the need for additional pain management interventions.
4. Document assessment findings, interventions and the patient's response to pain management measures.

D. Additional Information:

1. Either medication can be used for pain management (including cardiac chest pain)
2. Do not mix pain medications. Contact Medical Control if 2nd dose does not control pain.

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EMS Medical Director

Christopher R Solaro, MD
EMS Associate Medical Director

**QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM
POLICY AND PROCEDURE**

HYPOTHERMIA – POST RESUSCITATION

- I. Historical Findings:
 - A. Patient ≥ 18 years of age for invasive cooling procedure
- II. Inclusion Criteria:
 - A. Patient is intubated with ETT or combitube
 - B. Return of spontaneous circulation after cardiac arrest
 - C. Cardiac arrest is NOT due to multi-system trauma or non-compressible hemorrhage.
 - D. Patient's initial temp is $> 34^{\circ}\text{C}/93^{\circ}\text{F}$
 - E. Adult patient SBP ≥ 100 mmHg
 - F. *Impaired neurologic status prior to sudden cardiac arrest (coma, dementia, active stroke)*
- III. Exclusion Criteria
 - A. Obviously pregnant patients (gravid uterus)
 - B. *Active DNR/POLST*
- IV. Protocol:
 - A. Assure airway is patent and secured by ETT or combitube
 - B. Maintain continuous cardiac, oxygen saturation and ET CO_2 (if available) monitoring at all times
 - C. Ensure vascular access with a minimum of two large bore IV's or IO
 - D. Maintain ice/cold packs into patient's axilla and groin and along the patient's neck against the carotid arteries (do not compress). Place ice packs directly on the skin for maximum cooling. Ensure patient privacy.
 - E. Medicate patient with Versed 2.5 mg every 5 minutes for sedation and shivering (titrate for BP ≥ 100 mmHg)
 - F. Medicate patient with Vecuronium 0.1 mg/kg (10mg max per dose) for continued chemical paralysis
 - G. If time permits *and available*, obtain a tympanic temperature of patient before and during cooling process

V. Invasive Cooling Procedure

- A. Administer Versed 2.5 mg IV/IO. Maintain SBP \geq 100 mmHg
- B. Administer Vecuronium 0.1 mg/kg (10 mg max per dose) IV/IO as needed
- C. Ensure that ice packs/cold packs are in place
- D. Rapidly infuse 30 ml/kg IV/IO cold saline to a max of two liters
- E. If the patient begins to shiver, move or awaken
 - 1. Repeat Versed as needed
 - 2. Repeat Vecuronium every 15 minutes as needed
- F. Target mean blood pressure (MAP) greater than 70 mmHg
 - 1. Dopamine 10-20 mcg/kg/min

VI. Key Considerations

- A. Do not delay transport for the purpose of cooling (integrate into other transport preparation/actions)
- B. Notify the receiving hospital that the patient is being cooled
- C. Do not hyperventilate!! Hyperventilation is a significant cause of hypotension and recurrence of cardiac arrest in the post resuscitation period
- D. If patient becomes pulseless again, discontinue cold saline infusion and treat per protocol. Ice packs may remain in place.
- E. Cold saline is defined as saline maintained at a near consistent temperature of approximately 4⁰ C or 39⁰F
- F. Cold saline infusion is preferred (if possible) in an IV/IO line separate from your medication line
- G. Cold saline infusion is preferred (if possible) in an IV/IO (Adult) \geq 18 gauge catheter and infused at a “wide open” rate
- H. All medications infused through normal temperature IV lines. Cold fluids may effect action of medication.

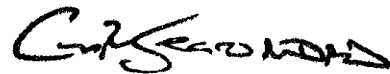
VII. QA/QI

- A. All patients receiving the hypothermia protocol will be reviewed for accuracy of treatment and outcome of patient.
- B. This policy will be reviewed in one year to assure compliance and to assure best practices are still being maintained.

—



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EMS Medical Director



Christopher R Solaro, MD, PhD
EMS Associate Medical Director

EMERGING INFECTIOUS DISEASE

I. Purpose

- A. To provide guidance for dispatch screening and EMS response to patients with suspected emerging infectious disease (such as Ebola virus disease, SARS) in order to prevent the transmission of the disease and enhance the safety of EMS providers and patients

II. Key points

- A. The likelihood of contracting Ebola is extremely low unless a person has direct unprotected contact with the blood or body fluids (urine, sweat, saliva, feces, vomit, semen) of a person who is sick with Ebola.
- B. The information in this policy is based on current knowledge of Ebola. The most current guidance can be found on the CDC Ebola webpage.
- C. Implementation of this policy will be upon the recommendation of local health departments and/or IDPH.

III. Preparedness

- A. Agencies should obtain appropriate personal protective equipment (PPE). The guidelines in this policy for PPE are based on guidance from the CDC for Ebola and are subject to change. The current recommendation for a healthcare worker caring for a symptomatic patient is to have no exposed skin.
 - 1. N-95 mask tested for tight fit or Powered Air-Purifying Resuscitator (PAPR)
 - 2. Impervious gown with hood to protect neck or impervious jumpsuit with covering over the zipper
 - 3. Double gloves – the outer pair should have long cuffs to prevent wrist exposure
 - 4. Eye protection
 - 5. Full face shield
 - 6. Impervious leg and shoe covers (may be incorporated into a full suit)
- B. Note that duct tape can be utilized to help ensure full skin coverage, however it has been identified as a potential issue related to contamination when removing the tape and PPE so caution is recommended.
- C. Education / Training:
 - 1. All EMS personnel who could respond to a patient with possible Ebola should be trained in the following:
 - a. Screening
 - b. N-95 mask fit test (agency may be able to coordinate this through the county health department if agency does not have fit-testing equipment)
 - c. PAPR if agency plans to use for staff who are unable to obtain a tight fit with the N-95 mask (such as staff with beards)
 - d. Donning and doffing PPE with use of a checklist and buddy system. There are checklists and videos available at cdc.gov
 - 2. All Public Safety Answering Points (PSAPs) / 9-1-1 dispatch staff should be educated on Emerging Infectious Disease Surveillance Tool (SRI/MERS/EBOLA) and the purpose behind screening patients which is ultimately safety for responders.

IV. Response Procedure

- A. PSAP / 9-1-1 Dispatch screening / dispatch for suspected emerging infectious disease.
1. When the dispatcher receives a call for a patient with any of the symptoms listed on the Emerging Infectious Disease Surveillance Tool they will ask additional screening questions. If the patient does not present with symptoms, the dispatcher can default out of this line of inquiry.
 - a) Note that the CDC has changed the body temperature to fever greater than 100.4° F
 2. Additional screening questions are listed on screening tool
 - a) Has the patient traveled internationally in the past 21 days? If so, where?
 - b) Has the patient had close contact with sick persons, dead bodies or exotic African animals? Note there are additional check boxes on the screening tool.
 3. IF the patient has symptoms AND has responded yes to either of the additional screening questions the dispatcher should:
 - a) Notify EMS to respond and to contact dispatch via phone for additional information regarding the possibility of infectious disease.
 - b) Notify EMS agency supervisory personnel of the situation.
 - c) Limit dispatch of additional resources unless requested by on scene crew
- B. EMS RESPONSE
1. Obtain additional patient information from dispatch via phone.
 2. Due to the need for extra precautions to maintain crew safety, initial contact with the patient may be delayed. Staff who are not in PPE should maintain a minimum 3 foot distance from the patient and maintain communications with the patient or family as possible.
 3. Use caution when approaching a patient with suspected infectious disease. Illness can cause delirium with erratic behavior that can place EMS personnel at risk of infection.
 4. Limit the number of care givers who interact with the patient to the minimum necessary to provide care. EMS students and ride-alongs are not to engage in care of the patient with suspected emerging infectious disease.
 5. Don personal protective equipment (PPE) prior to any patient contact. The current CDC recommendation to care for a symptomatic patient is for the healthcare worker to have no exposed skin.
 - a) N-95 mask tested for tight fit or PAPR
 - b) Impervious gown or impervious jumpsuit with covering over the zipper
 - c) Double gloves – the outer pair should have long cuffs to prevent wrist exposure
 - d) Eye protection
 - e) Full face shield
 - f) Impervious leg and shoe covers (may be incorporated into a full suit)
 - g) It is highly recommended that donning and doffing of PPE follow a checklist and buddy system to ensure compliance and protection.
 - h) Note that duct tape can be utilized to help ensure full skin coverage, however it has been identified as a potential issue related to contamination when removing the tape and PPE so caution is recommended.

6. Reducing the potential for contamination inside the ambulance could include removing unnecessary equipment prior to the transport and use of 12-15 mil plastic/vinyl drops cloths. Consider not using recirculating HVAC in the rear or cab and instead using the exhaust unit when available and having front windows open.
7. Provide necessary and supportive care based on patient condition. Do not perform interventions with sharps in a moving ambulance. When performing procedures such as open suctioning of airways, intubation or CPAP ensure all PPE is in place as these procedures may aerosolize the virus.
8. Communicate information to the receiving hospital regarding the patient with suspected infectious disease EARLY to minimize delays when arriving at the receiving facility.
9. Wait in the ambulance, in the ambulance bay until the Emergency Department is prepared to receive the patient. The hospital may provide specific route of travel to room destination.
10. Doffing personal protective equipment (PPE). It is crucial that this step be performed correctly as failure could result in contamination.
 - a) Utilize a PPE removal checklist and a buddy system to observe removal of PPE.
 - b) Doff PPE in a location specified by the receiving hospital staff.
11. Waste should be double bagged. Disposal of waste at the hospital should be coordinated with hospital staff.

C. Terminal cleaning / disinfection

1. Persons cleaning the ambulance and equipment should use appropriate PPE.
2. Clean and disinfect hard, non-porous surfaces with a 1:10 bleach solution or other EPA-registered disinfectant with a label claim for a non-enveloped virus (e.g. norovirus, rotavirus, adenovirus, poliovirus). Solely wiping surfaces and equipment with the disinfectant is not completely effective. A more rigorous disinfection such as repeated spraying of surfaces and air drying needs to occur after gross contaminants are removed.
3. All contaminated linens, pillows should be discarded as biohazard waste.
4. Dispose of cleaning cloths and wipes as well as other biohazard waste after consultation with receiving hospital staff.

V. Other general information:

- A. Follow QAEMS policy O-32 Preparedness to a System-Wide Crisis to report the suspected emerging infectious disease. ONE patient in this situation is considered a trend and must be reported.
- B. Remember that information regarding the patient with a suspected emerging infectious disease is still protected by patient privacy laws. Only those persons with a need to know should be involved in discussions of a specific patient or situation.
- C. In the event of a healthcare worker contaminated exposure, it should be considered a significant exposure and reporting/follow-up conducted according to agency policy. The agency should contact their county health department for guidance on monitoring and work restrictions



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Christopher R Solaro, MD, PhD
EMS Associate Medical Director

APPENDIX A
DROPS PER MINUTE TO MILLILITERS PER HOUR CONVERSION CHART

ML/HR	ABBOTT 15 drops/ml	TRAVENOL 10 drops/ml	McGAW 12 drops/ml	IVAC & CUTTER 20 drops/ml	MICRODRIP STANDARDIZED 60 drops/ml
100	25	17	20	33	100
105	26	18	21	35	105
110	28	18	22	37	110
115	29	19	23	38	115
120	30	20	24	40	120
125	31	21	25	42	125
130	33	22	26	43	130
135	34	23	27	45	135
140	35	23	28	47	140
145	36	24	29	48	145
150	38	25	30	50	150
160	40	27	32	53	160
170	43	28	34	57	170
180	45	30	36	60	180
190	48	32	38	63	190
200	50	33	40	67	200
210	53	35	42	70	210
220	55	37	44	73	220
230	58	38	46	77	230
240	60	40	48	80	240
250	63	42	50	83	250
275	69	46	55	92	275
300	75	50	60	100	300
325	81	54	65	108	325
350	88	58	70	117	350
375	94	63	75	125	375
400	100	67	80	133	400
425	106	71	85	142	425
450	113	75	90	150	450
475	119	79	95	158	475
500	125	83	100	167	500
525	131	88	105	175	525
550	138	92	110	183	550
575	144	96	115	192	575
600	150	100	120	200	600
625	156	104	125	208	625
650	163	108	130	217	650
675	169	113	135	225	675
700	175	117	140	233	700
725	181	121	145	242	725
750	188	125	150	250	750
775	194	129	155	258	775
800	200	133	160	267	800
825	206	138	165	275	825
850	213	142	170	283	850
875	219	146	175	292	875
900	225	150	180	300	900
925	231	154	185	308	925
950	238	158	190	317	950
975	244	163	195	325	975
1000	250	167	200	333	1000

(reviewed 8/01)

QUINCY AREA EMS SYSTEM MEDICATION LIST

Richard A. Saalborn, DO, EMS Medical Director

Christopher Solaro, MD, EMS Associate Medical Director

Adenosine (Adenocard)	M-1.1
Albuterol	M-1.2
Aspirin	M-1.3
Atropine	M-1.4
Calcium Chloride	M-1.5
50% Dextrose	M-1.6
Diazepam (Valium)	M-1.7
Diphenhydramine (Benadryl)	M-1.8
Dopamine (Intropin)	M-1.9
Epinephrine 1:1000	M-1.10
Epinephrine 1:10,000	M-1.11
Epi-pen	M-1.12
Furosemide (Lasix)	M-1.13
Glucagon	M-1.14
Lidocaine (Xylocaine)	M-1.15
Magnesium Sulfate	M-1.16
<i>Morphine</i>	<i>M-1.17</i>
Naloxone (Narcan)	M-1.18
Nitroglycerin	M-1.19
Oral Glucose Gel (Insta-Glucose, Glutose)	M-1.20
Oxytocin (Pitocin)	M-1.21
Phenergan	M-1.22
Sodium Bicarbonate	M-1.23
Verapamil	M-1.24
Metoprolol Tartrate	M-1.25
Plavix	M-1.26
Versed (Midazolam)	M-1.27
Norcuron	M-1.28
Zofran	M-1.29
<i>Fentanyl Citrate</i>	<i>M-1.30</i>
IV FLUIDS	
0.9% Sodium Chloride (Normal Saline)	M-2.1

ADENOSINE (ADENOCARD)	
CLASS	Antiarrhythmic; nucleoside
ACTION	<ul style="list-style-type: none"> Slows the heart rate by slowing conduction through the AV node. Blocks re-entry pathways in supraventricular tachycardias.
INDICATIONS	Narrow complex tachycardias; Supraventricular tachycardias (SVT)
CONTRAINDICATIONS	Second or third degree heart block, sick sinus syndrome, hypersensitivity to the drug
PRECAUTIONS	Can produce bronchoconstriction in asthma patients.
SIDE EFFECTS	Side effects are usually brief due to the short half life of the drug. <ul style="list-style-type: none"> Conversion arrhythmias Facial flushing Headache Shortness of breath Dizziness Lightheadedness Nausea Chest pain
ROUTE	Rapid IV bolus over 1-2 seconds via antecubital IV site. Follow each dose with 10 to 20 mL flush of normal saline and raise the arm.
DOSE	<ul style="list-style-type: none"> Initial dose = 6 mg Second dose of 12 mg in 1-2 minutes if rhythm does not convert Repeat 12 mg dose again in 1-2 minutes if rhythm does not convert
PEDIATRIC DOSE	<ul style="list-style-type: none"> 0.1 mg/kg very rapidly at closest central IV injection site Repeat dose is 0.2 mg/kg Maximum single dose = 12 mg Utilize Broselow tape or pediatric weight based dosing chart to confirm dose. Reference policy PED-5
ONSET	Immediate
DURATION	1-2 minutes
STOCK	(5) 6 mg/2 mL vials

ALBUTEROL (PROVENTIL, VENTOLIN)	
CLASS	Beta-2 agonist; synthetic sympathomimetic
ACTION	Stimulates beta 2 receptor sites in the smooth muscle of the bronchial tree to reverse bronchospasm.
INDICATIONS	Asthma, emphysema, bronchospasm associated with other conditions.
CONTRAINDICATIONS	Known hypersensitivity to the drug
PRECAUTIONS	Could cause severe paradoxical bronchospasm with repeated excessive use.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Tachycardia ▪ Palpitations ▪ Anxiety ▪ Tremors ▪ Headache ▪ Sweating ▪ Bad taste ▪ PVC's ▪ Hypotension
ROUTE	Inhalation via nebulizer
DOSE	2.5 mg
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Per order of Medical Control ▪ Reference policy PED – 7.2
ONSET	5 to 15 minutes
DURATION	2 to 3 hours
STOCK	(4) 2.5 mg/3 mL unit doses

Kelly Cox, M.D.
EMS Medical Director

re: 5/93, 1/94, 9/95, 11/97, 8/01, 9/04, 5/07
(reviewed: 8/95)

ASPIRIN CHEWABLE	
CLASS	Anti-inflammatory; platelet aggregation inhibitor
ACTION	Prevents formation of clots by blocking formation of thromboxane A2 which causes platelets to aggregate and arteries to constrict.
INDICATIONS	Acute coronary syndrome; acute MI; chest pain (non-traumatic)
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Known hypersensitivity to the drug ▪ Bleeding disorders ▪ Active ulcer disease ▪ Asthma
PRECAUTIONS	None
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Nausea/vomiting ▪ Heartburn ▪ GI bleeding ▪ Increased bleeding time ▪ Wheezing
ROUTE	Oral – have the patient chew all four tablets and swallow
DOSE	Four 81 mg chewable tablets
PEDIATRIC DOSE	None
ONSET	30 to 60 minutes
DURATION	4 to 6 hours
STOCK	(4) chewable tablets 81 mg each

ATROPINE SULFATE	
CLASS	Parasympathetic blocker; anti-cholinergic
ACTION	<ul style="list-style-type: none"> Increases the heart rate (positive chronotrope) by binding to muscarinic receptor sites to block the action of acetylcholine. Enhances both sinus node automaticity and atrioventricular conduction.
INDICATIONS	<ul style="list-style-type: none"> Symptomatic bradycardia Asystole Pulseless Electrical activity (PEA) with rate less than 60 Organophosphate poisoning
CONTRAINDICATIONS	<ul style="list-style-type: none"> Use with caution in high degree heart blocks with wide QRS Use with caution in the patient with MI as an increase in heart rate could increase cardiac workload
PRECAUTIONS	A dose less than 0.5 mg in the adult could result in paradoxical slowing of the heart rate.
SIDE EFFECTS	<ul style="list-style-type: none"> Tachycardia Hypertension Palpitations Headache Blurred vision Dilated pupils Dry mouth Confusion Drowsiness
ROUTE	<ul style="list-style-type: none"> IV push Endotracheal
DOSE	<ul style="list-style-type: none"> Symptomatic bradycardia: 0.5 mg every 5 minutes to maximum dose of 3 mg. Asystole/PEA: 1 mg every 3-5 minutes to maximum dose of 3 mg. Organophosphate poisoning: 2-5 mg IVP
PEDIATRIC DOSE	<ul style="list-style-type: none"> 0.02 mg/kg Minimum single dose is 0.1 mg. Maximum single dose 0.5 mg May repeat once Use Broselow tape or pediatric weight based dosing chart to confirm dose. Reference policy PED-3.2
ONSET	2 to 5 minutes
DURATION	20 minutes
STOCK	(5) 1 mg/10 mL Abbojects

CALCIUM CHLORIDE	
CLASS	Calcium salt
ACTION	Positive inotrope (increases the force of contraction) Increases myocardial automaticity
INDICATIONS	<ul style="list-style-type: none"> ▪ Calcium channel blocker overdose ▪ Hypocalcemia ▪ Magnesium intoxication ▪ Hyperkalemia
CONTRAINDICATIONS	Patients taking digitalis (Digoxin, lanoxin)
PRECAUTIONS	Precipitates with sodium bicarbonate – flush the IV line before and after administration.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Extravasation (infiltration) can cause necrosis, sloughing of skin or abscess. ▪ Hypotension
ROUTE	IV
DOSE	0.5 grams (500 mg) IV
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Per Medical Control ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose
ONSET	5 to 15 minutes
DURATION	Dose dependent (effects may last up to 4 hours)
STOCK	(1) 10 mL Abboject (100 mg/mL)

DEXTROSE 50%	
CLASS	Hyperglycemic agent; hypertonic agent
ACTION	Supplies supplemental glucose to elevate the blood sugar.
INDICATIONS	<ul style="list-style-type: none"> ▪ Hypoglycemia ▪ Suspected hypoglycemia in coma of unknown origin
CONTRAINDICATIONS	Do not administer to head injured patients unless they are hypoglycemic
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Extravasation (infiltration) can cause pain, tissue necrosis
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Irritation to vein with pain and redness
ROUTE	IV
DOSE	25 grams (50 mL)
PEDIATRIC DOSE	(0.5-1.0 g/kg): <ul style="list-style-type: none"> ▪ > 8yrs. D50% 1-2ml/kg IV/IO ▪ 1-8 yrs. D25% 2-4 ml/kg IV/IO ▪ <1 yr. D12.5% * 4ml/kg IV/IO for infants ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ To make D12.5% dilute D25% 1:1 with sterile water ▪ Reference policy PED-12.2
ONSET	30 to 60 seconds
DURATION	Depends upon the level of hypoglycemia
STOCK	(2) 25 gram/50 mL Abbojects (50% solution) (1) 2.5 gram/10 mL Abboject for children over 2 months (25% solution)

DIAZEPAM (VALIUM)	
CLASS	Benzodiazepine Anticonvulsant; skeletal muscle relaxant, sedative-hypnotic
ACTION	Anticonvulsant properties due to enhancement of GABA-mediated presynaptic inhibition at the spinal level as well as in the brain stem reticular formation. CNS depressant.
INDICATIONS	<ul style="list-style-type: none"> ▪ Active seizures ▪ Sedation prior to synchronized cardioversion ▪ Sedation prior to transcutaneous pacing ▪ Acute anxiety
CONTRAINDICATIONS	History of hypersensitivity to the drug.
PRECAUTIONS	<ul style="list-style-type: none"> ▪ May precipitate if mixed with other drugs – always flush the IV line before and after administration. ▪ Elderly patients may experience adverse effects more quickly – administer the medication slowly. ▪ Monitor level of consciousness, BP, pulse and respiratory status closely ▪ Be prepared to manage the airway
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ CNS depression; drowsiness ▪ Respiratory depression ▪ Hypotension ▪ Phlebitis; venous thrombosis
ROUTE	<ul style="list-style-type: none"> ▪ IV (administer no faster than 1 mg/minute) ▪ IM (Onset of action 15-30 minutes) ▪ Rectal
DOSE	<ul style="list-style-type: none"> ▪ Seizures: 5-10 mg slow IV push at 1 mg/minute. Maximum dose of 10 mg. ▪ Sedation prior to electrical therapy: 5-10 mg slow IV push at 1 mg/minute. Maximum dose of 10 mg. ▪ Acute anxiety: 2-5 mg IM or slow IV push.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ For Seizures: 0.1-0.3 mg/kg slow IV push over 2-3 minutes. ▪ Less than age 5 maximum dose = 5 mg ▪ Over age 5 maximum dose 10 mg ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose. ▪ Reference policy PED-11.2
ONSET	IV = less than 15 minutes IM = 15 to 30 minutes
DURATION	3 hours
STOCK	(2) 10 mg/2 mL syringes

DIPHENHYDRAMINE (BENADRYL)	
CLASS	Antihistamine
ACTION	<ul style="list-style-type: none"> ▪ Competes with histamine for H1 histamine receptor sites. ▪ Anticholinergic ▪ Antiemetic
INDICATIONS	<ul style="list-style-type: none"> ▪ Allergic reaction; anaphylaxis ▪ Dystonic reaction due to phenothiazines (Ex: Phenergan) ▪ Nausea/vomiting
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Known hypersensitivity to the drug ▪ Acute asthma attack
PRECAUTIONS	May cause drowsiness and sedation.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ CNS depression; drowsiness; confusion ▪ Dizziness; vertigo ▪ Excitement especially in children ▪ Tachycardia ▪ Palpitations ▪ Ataxia ▪ Dry mouth ▪ Blurred vision ▪ Headache ▪ Urine retention
ROUTE	<ul style="list-style-type: none"> ▪ IV (Slow IVP at 25 mg/minute) ▪ Deep IM
DOSE	25-50 mg
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ 1-2 mg/kg ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-10.2
ONSET	IV = 1 to 5 minutes IM = 15 minutes
DURATION	3 to 4 hours
STOCK	(1) 50mg/mL injectable

DOPAMINE (INTROPIN)	
CLASS	Vasopressor; Adrenergic; Catecholamine
ACTION	<ul style="list-style-type: none"> ▪ Acts on alpha and beta 1 receptor sites to vasoconstrict and increase heart rate. ▪ Positive chronotrope (increases heart rate) ▪ Positive inotrope (increases force of cardiac contraction) ▪ Vasopressor at higher doses (increases BP)
INDICATIONS	<ul style="list-style-type: none"> ▪ Symptomatic bradycardia refractory to atropine ▪ Cardiogenic shock with hypotension
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypersensitivity to the drug ▪ Hypovolemic shock ▪ Tachydysrhythmias ▪ Ventricular dysrhythmias (V-tach / V-fib)
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Dopamine is not a substitute for fluid or blood volume deficits ▪ Extravasation (infiltration) can cause necrosis with tissue sloughing ▪ Monitor vital signs every 5 minutes during administration ▪ Monitor cardiac rhythm closely.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Tachycardia ▪ Ectopic beats ▪ Angina ▪ Palpitations ▪ Headache ▪ Nausea; vomiting ▪ Hypertension
ROUTE	IV infusion (The infusion rate must be monitored precisely – preferred to use with an IV pump)
DOSE	<ul style="list-style-type: none"> ▪ Symptomatic bradycardia: 5-10 mcg/kg/minute ▪ Cardiogenic shock: 5-20 mcg/kg/minute
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Per Medical Control 5-20 mcg/kg/minute infusion ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-9.2
ONSET	5 minutes
DURATION	5 to 10 minutes
STOCK	(1) 1600 mcg/mL premix solution (800 mg/500 mL)

EPINEPHRINE 1:1000 SOLUTION	
CLASS	Sympathomimetic; Catecholamine; bronchodilator
ACTION	<ul style="list-style-type: none"> ▪ Beta-2 receptor agonist promotes bronchodilation ▪ Beta-1 receptor agonist = positive chronotrope (increases heart rate); positive inotrope (increases force of cardiac contraction)
INDICATIONS	<ul style="list-style-type: none"> ▪ Allergic reaction ▪ Anaphylaxis ▪ Asthma ▪ Exacerbation of some forms of COPD
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Patients with underlying cardiovascular disease ▪ Hypertension ▪ Pregnancy (safety in pregnancy and lactation not established) ▪ Patients with tachydysrhythmias
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Protect from light ▪ Monitor vital signs every 5 minutes ▪ Monitor cardiac rhythm closely
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Tachycardia ▪ Palpitations ▪ Anxiety; restlessness ▪ Tremors ▪ Headache
ROUTE	Subcutaneously
DOSE	0.3 mg SQ
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ 0.01 mg/kg up to 0.3 mg ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-10.2
ONSET	5 to 10 minutes
DURATION	20 minutes
STOCK	(3) 1 mg/mL ampules (1) 30 mL multidose vial (1 mg/mL)

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1/94; re: 11/97, 8/01, 9/04, 5/07
(reviewed: 8/95)

EPINEPHRINE 1:10,000	
CLASS	Catecholamine; cardiac stimulant
ACTION	<ul style="list-style-type: none"> ▪ Beta 1 and beta 2 adrenergic effects ▪ Positive chronotrope (increases heart rate) ▪ Positive inotrope (increases force of cardiac contraction)
INDICATIONS	<ul style="list-style-type: none"> ▪ Cardiac arrest with ventricular fibrillation, pulseless ventricular tachycardia, asystole, pulseless electrical activity (PEA) ▪ Anaphylaxis
CONTRAINDICATIONS	None when used in an emergency situation such as cardiac arrest
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Protect from light ▪ Can be deactivated by alkaline solutions – flush the IV line before and after administration
SIDE EFFECTS	Tachydysrhythmias
ROUTE	IV Endotracheal (ET)
DOSE	<ul style="list-style-type: none"> ▪ Cardiac arrest: 1 mg every 3-5 minutes; ET dose is 2 – 2.5 mg ▪ Anaphylaxis: 0.3-0.5 mg slow IVP
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ 0.01 mg/kg IV ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-2.2
ONSET	IV = immediate
DURATION	3 to 5 minutes
STOCK	(6) 1 mg /10 mL Abbojects

EPI-PEN	
CLASS	Catecholamine
ACTION	<ul style="list-style-type: none"> ▪ Produces bronchodilation ▪ Positive chronotrope (increases heart rate) ▪ Positive inotrope (increases force of cardiac contraction)
INDICATIONS	Anaphylaxis
CONTRAINDICATIONS	Chest pain consistent with angina/cardiac
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Protect from light ▪ Assess vital signs every 5 minutes
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Tachycardia ▪ Dizziness ▪ Nausea; vomiting ▪ Headache
ROUTE	Intramuscularly (IM)
DOSE	0.3 mg
PEDIATRIC DOSE	0.15 mg for pediatric patient 60 pounds or less
ONSET	5 to 10 minutes
DURATION	20 minutes
STOCK	BLS units (1) Adult Epi-Pen (1) Epi-Pen Junior

FUROSEMIDE (LASIX)	
CLASS	Diuretic
ACTION	A potent loop diuretic that inhibits sodium and chloride reabsorption at the proximal and distal tubules and ascending loop of Henle in the kidney to promote prompt diuresis.
INDICATIONS	<ul style="list-style-type: none"> ▪ Congestive heart failure (CHF) ▪ CHF with pulmonary edema
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Dehydration ▪ Hypotension ▪ Hypokalemia ▪ Pregnancy ▪ Anuria (inability to produce urine)
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Protect from light
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Vertigo, restlessness ▪ Headache ▪ Paresthesia ▪ Volume depletion; orthostatic hypotension ▪ Blurred vision ▪ Nausea; vomiting; anorexia; ▪ Hypokalemia, hypochloremic alkalosis; fluid and electrolyte imbalances
ROUTE	IV
DOSE	40-80 mg slow IVP over 1-2 minutes
PEDIATRIC DOSE	Per Medical Control
ONSET	5 to 10 minutes
DURATION	2 to 3 hours
STOCK	(2) 100 mg/10 mL vials

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1/94; re: 11/97, 8/01, 9/04, 5/07
(reviewed: 8/95)

GLUCAGON (GLUCAGEN)	
CLASS	Endocrine – pancreatic hormone
ACTION	<ul style="list-style-type: none"> ▪ Causes breakdown of glycogen stored in the liver to glucose ▪ Inhibits glycogen synthesis ▪ Elevates blood glucose level
INDICATIONS	Hypoglycemia when unable to establish an IV site
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypersensitivity to the drug ▪ Hypersensitivity to beef or pork protein
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Only effective if there are sufficient stores of glycogen in the liver ▪ Use with caution in patients with cardiovascular or renal disease ▪ Transport immediately after administration
SIDE EFFECTS	Nausea / vomiting
ROUTE	IM
DOSE	0.5 – 1 unit (1 unit = 1 mg)
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ 0.03 mg/kg – maximum dose 1 mg ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-12.2
ONSET	5 to 20 minutes
DURATION	20 to 30 minutes
STOCK	(1) 1 mg (1 unit) vial; with diluent

LIDOCAINE (XYLOCAINE)	
CLASS	Antiarrhythmic
ACTION	<ul style="list-style-type: none"> ▪ Class IB antiarrhythmic agent decreases depolarization, automaticity and excitability in the ventricles during the diastolic phase by direct action on the tissues especially the Purkinje network. ▪ Increases the ventricular fibrillation threshold making it more difficult for the heart to go into VF. ▪ Suppresses ventricular ectopic activity
INDICATIONS	<ul style="list-style-type: none"> ▪ Ventricular Tachycardia ▪ Ventricular fibrillation ▪ Malignant PVCs
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypersensitivity to the drug or to the amide-type local anesthetics. ▪ High degree heart blocks (2nd degree type II, 3rd degree) ▪ Ventricular ectopy in conjunction with bradycardia
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Monitor level of consciousness for signs of CNS toxicity. ▪ Consider maintenance infusion after bolus. ▪ Maintenance infusion dosage should be reduced if over age 70, liver disease, CHF or shock.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Confusion; lethargy ▪ Anxiety; restlessness; nervousness ▪ Lightheadedness ▪ Muscle twitching; seizures ▪ Bradycardia ▪ Hypotension ▪ Cardiac arrhythmias ▪ Cardiac arrest
ROUTE	<ul style="list-style-type: none"> ▪ IV push ▪ Endotracheal (ET) ▪ IV infusion
DOSE	<ul style="list-style-type: none"> ▪ 1 to 1.5 mg/kg initial dose. Repeat doses of 0.5 to 0.75 mg/kg can be repeated every 5 to 10 minutes to maximum of 3 mg. ▪ Ventricular ectopy: 1 to 1.5 mg/kg IVP; repeat doses every 10 minutes at 0.5 to 0.75 mg/kg IVP to maximum of 3 mg/kg. ▪ Maintenance drip: 2 to 4 mg/minute
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ 1 mg/kg – may repeat every 3 to 5 minutes to maximum of 3 mg ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-4
ONSET	45 to 90 seconds
DURATION	10 to 20 minutes
STOCK	(3) 100 mg/5 mL Abbojects (1) Premix bag 2 grams/500 mL Normal Saline

MAGNESIUM SULFATE	
CLASS	Anticonvulsant; magnesium supplement
ACTION	<ul style="list-style-type: none"> Acts as a physiologic calcium channel blocker to block neuromuscular transmission. Central nervous system depressant
INDICATIONS	<ul style="list-style-type: none"> Seizures associated with eclampsia Polymorphic ventricular tachycardia / Torsades de Pointe Ventricular fibrillation associated with hypomagnesemia
CONTRAINDICATIONS	<ul style="list-style-type: none"> Heart block Hypocalcemia Hypotension
PRECAUTIONS	<ul style="list-style-type: none"> Side effects can occur from too rapid administration or if given undiluted. Monitor vital signs, cardiac status and respiratory status closely.
SIDE EFFECTS	<ul style="list-style-type: none"> Drowsiness Depressed reflexes; flaccid paralysis Respiratory depression; respiratory paralysis Bradycardia, other arrhythmias Hypotension; cardiac collapse Hypothermia Flushed skin; rash; itching
ROUTE	IV
DOSE	<ul style="list-style-type: none"> Seizures associated with eclampsia: 2-4 grams of 50% solution diluted in 100-250 mL of Normal Saline and infused over 30 minutes. Polymorphic ventricular tachycardia: 1-2 grams of 50% solution diluted in 10 mL of sterile water and administered over 1-2 minutes. Ventricular fibrillation: 1-2 grams of 50% solution IVP
PEDIATRIC DOSE	None
ONSET	Immediate
DURATION	3 to 4 hours
STOCK	(1) 5 grams/10 mL 50% solution Abboject (500 mg/mL)

MORPHINE SULFATE	
CLASS	Opiate
ACTION	<ul style="list-style-type: none"> ▪ Narcotic analgesic that binds to opiate receptors in the brain to produce pain relief. (opiate agonist) ▪ Peripheral vasodilation decreases systemic vascular resistance and venous return (decreases preload and afterload) ▪ CNS depressant
INDICATIONS	<ul style="list-style-type: none"> ▪ Severe pain ▪ CHF with pulmonary edema
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ History of sensitivity to the drug ▪ Head injury ▪ Hypovolemia ▪ Hypotension ▪ Undiagnosed abdominal pain
PRECAUTIONS	Can cause hypotension and respiratory depression in higher doses. (Narcan should be available as a reversal agent.)
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Decreased level of consciousness ▪ Respiratory depression ▪ Hypotension ▪ Nausea; vomiting ▪ Dizziness ▪ Headache
ROUTE	<ul style="list-style-type: none"> ▪ IV ▪ IM
DOSE	<ul style="list-style-type: none"> ▪ IV: Standard initial dose is 2 mg. slow IVP. Additional doses may be given upon the order of Medical Control. ▪ <i>2nd dose: 2mg may be given prior to contact Medical Control</i>
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Per Medical Control ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose
ONSET	<ul style="list-style-type: none"> ▪ IV = Immediate ▪ IM = 5 to 30 minutes
DURATION	3 to 5 hours
STOCK	(5) 2 mg/mL tubexes

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NALOXONE (NARCAN)	
CLASS	Narcotic antagonist
ACTION	Reverses the effects of narcotics by competing for and blocking opiate receptors.
INDICATIONS	<ul style="list-style-type: none"> ▪ For complete or partial reversal of narcotics including: morphine, demerol, heroin, dilaudid, paregoric, percodan, fentanyl, methadone. ▪ For complete or partial reversal of synthetic narcotics such as: nubain, stadol, talwin, darvon. ▪ Coma of unknown origin with suspected narcotic involvement. ▪ Alcoholic coma
CONTRAINDICATIONS	Known hypersensitivity to the drug
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Administer with caution to patients dependent upon narcotics as it may cause withdrawal effects including seizures. ▪ Narcan is a short acting drug and the dose may need augmentation every 5 minutes. ▪ Larger than average doses (2-5 mg) may be needed for management of Darvon overdose or alcoholic coma. ▪ The patient may become combative upon reversal of the opiate. Appropriate precautions should be taken prior to administration to ensure the safety of emergency providers.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Nausea; vomiting ▪ Tremors ▪ Sweating ▪ Hypertension
ROUTE	<ul style="list-style-type: none"> ▪ IV ▪ IM ▪ Endotracheal (ET)
DOSE	<ul style="list-style-type: none"> ▪ 2 mg IVP. ▪ May repeat in 2 to 3 minute intervals for 2 to 3 doses if no response. ▪ Failure to obtain reversal after 2 to 3 doses indicates other disease process or overdose on other non-opioid type drugs.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Less than 20 kg = 0.1 mg/kg Maximum dose 2 mg ▪ Greater than 20 kg = 2 mg single dose ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose ▪ Reference policy PED-12.2
ONSET	IV = Immediate IM = 5 to 10 minutes
DURATION	20 to 30 minutes
STOCK	(1) 10 mL vial (0.4 mg/mL)

NITROGLYCERIN	
CLASS	Organic nitrate
ACTION	<ul style="list-style-type: none"> ▪ Relaxes vascular smooth muscle ▪ Dilation of coronary arteries ▪ Dilation of systemic arteries (reduces afterload) ▪ Venous dilation (reduces preload)
INDICATIONS	<ul style="list-style-type: none"> ▪ Chest pain suspected to be cardiac in origin ▪ Pulmonary edema
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypotension
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Monitor blood pressure before and after administration of each dose. ▪ Do not administer if systolic BP less than 90 ▪ Protect from light
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Headache ▪ Facial flushing ▪ Dizziness ▪ Hypotension ▪ Bradycardia (rare) ▪ Reflex tachycardia
ROUTE	<ul style="list-style-type: none"> ▪ Sublingual ▪ Topical
DOSE	<ul style="list-style-type: none"> ▪ Sublingual: place 1 tablet under the patient's tongue. May repeat every 5 minutes for a total of 3 tablets. ▪ Topical: Used for long transport times when sublingual nitroglycerin has been helpful in reducing chest pain. Place ½ inch of nitropaste on the ruled applicator measuring paper. Apply to a hairless are of the skin on the chest. Tape in place. Remove any previously applied nitroglycerin patches/ointment.
PEDIATRIC DOSE	None
ONSET	1 to 2 minutes
DURATION	15 to 30 minutes
STOCK	<ul style="list-style-type: none"> (1) 25 tablet bottle of 0.4 mg tablets (2) Unit doses of topical nitroglycerin and ruled applicator papers

ORAL GLUCOSE (INSTA-GLUCOSE; GLUTOSE)	
CLASS	Glucose
ACTION	Increases blood glucose levels
INDICATIONS	Known or suspected hypoglycemia in the diabetic patient
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Decreased level of consciousness that could lead to choking or risk of aspiration. ▪ Inability to swallow
PRECAUTIONS	None
SIDE EFFECTS	None
ROUTE	Oral
DOSE	30 grams (one tube)
PEDIATRIC DOSE	Only as ordered by Medical Control
ONSET	
DURATION	
STOCK	(1) 30 gram tube

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1/99, 8/01, 9/04, 5/07
(reviewed: 6/06)

OXYTOCIN (PITOCIN)	
CLASS	Hormone
ACTION	Stimulates uterine smooth muscle contraction to slow post-partum hemorrhage after expulsion of the placenta.
INDICATIONS	Post-partum hemorrhage
CONTRAINDICATIONS	Any condition other than post-partum hemorrhage
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Ensure that the placenta has delivered prior to administration of oxytocin. ▪ Ensure that there is not another fetus present prior to administration. ▪ Too rapid administration could result in uterine rupture.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Nausea; vomiting ▪ Seizures ▪ Hypotension ▪ Anaphylaxis ▪ Arrhythmias ▪ Coma
ROUTE	<ul style="list-style-type: none"> ▪ IM ▪ IV infusion
DOSE	<ul style="list-style-type: none"> ▪ IM: 3-10 units ▪ IV infusion: Mix 10 units in 1000 mL of Normal Saline. This yields 10 milliunits/mL. Start the infusion very slowly at 10 milliunits (1mL) per minute or as indicated by Medical control.
PEDIATRIC DOSE	None
ONSET	IV = Immediate IM = 3 to 5 minutes
DURATION	IV = 20 minutes after infusion is stopped IM = 2 to 3 hours
STOCK	(1) 10 USP units/mL vial

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5/93, 1/94, 11/97, 8/01, 9/04, 5/07
(reviewed: 8/95, 6/06)

PROMETHAZINE (PHENERGAN)	
CLASS	Phenothiazine Antihistamine
ACTION	Inhibits the chemoreceptor trigger zone in the medulla to produce anti-emetic effect. Blocks H1 and H2 histamine receptor sites.
INDICATIONS	Vomiting
CONTRAINDICATIONS	Acute asthma attack
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Extravasation (infiltration) can cause necrosis, tissue sloughing, gangrene ▪ Should be diluted in at least 10 mL Normal Saline ▪ Should be administered very slowly over several minutes ▪ Patient should be instructed to advise you if any pain or burning with administration
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Drowsiness; excess sedation; confusion ▪ Hypotension ▪ Dizziness ▪ Palpitations
ROUTE	IV
DOSE	12.5 mg diluted in 10 mL Normal Saline slow IVP. May repeat X 1 if necessary for a maximum dose of 25 mg.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Child over age 2 = 0.25 – 0.5 mg/kg with maximum dose of 25 mg ▪ Not for administration in patients under the age of two years. ▪ Dilute in 10 mL normal saline and administer very slowly over several minutes ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose
ONSET	3 to 5 minutes
DURATION	6 to 12 hours
STOCK	(2) 25 mg inj.

SODIUM BICARBONATE	
CLASS	Alkalinizing agent (buffer)
ACTION	Binds free hydrogen ions to form carbonic acid. Effectively increases the blood pH.
INDICATIONS	<ul style="list-style-type: none"> ▪ Acidosis associated with prolonged down time in cardiac arrest ▪ Tricyclic antidepressant overdose
CONTRAINDICATIONS	Alkalosis
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Correct dosage is essential to avoid overcompensation of pH. ▪ Flush IV line before and after administration of the drug. Is not compatible with many other drugs in the IV line. Precipitates with calcium chloride. Inactivates epinephrine and dopamine. ▪ Extravasation (infiltration) may cause ulceration, tissue necrosis or tissue sloughing at injection site.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Alkalosis ▪ Electrolyte imbalance
ROUTE	IV
DOSE	1 mEq/kg initially followed by 0.5 mEq/kg every 10 minutes.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Use pediatric 4.2% solution. ▪ 0.5-1 mEq/kg initial dose followed by 0.5 mEq/kg doses every 10 minutes as indicated. ▪ Utilize Broselow tape or pediatric weight based dosing chart to confirm dose
ONSET	Immediate
DURATION	30 to 60 minutes
STOCK	(1) 50 mL Abboject (1 mEq/mL) (2) (1) 10 mL Abboject 4.2% pediatric solution (0.5 mEq/mL)

VERAPAMIL (CALAN)	
CLASS	Calcium channel blocker
ACTION	<ul style="list-style-type: none"> ▪ Blocks the entry of calcium into the cell ▪ Slows conduction through the AV node ▪ Negative chronotrope (slows heart rate) ▪ Negative inotrope (decreased force of cardiac contraction)
INDICATIONS	To control the rate in hemodynamically stable atrial fibrillation or atrial flutter with rapid ventricular response.
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypotension ▪ Cardiogenic shock ▪ Myocardial infarction ▪ Wide complex tachycardias ▪ WPW syndrome ▪ Patients taking beta blockers
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Vital signs should be monitored closely. ▪ May induce or exacerbate CHF/pulmonary edema
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Headache ▪ Dizziness ▪ Sweating ▪ Seizures ▪ Bradycardia ▪ Heart blocks ▪ Hypotension ▪ Asystole ▪ Ventricular fibrillation
ROUTE	IV
DOSE	<ul style="list-style-type: none"> ▪ 2.5-5 mg slow IVP over 2-3 minutes. ▪ May repeat at 5-10 mg in 15-30 minutes if rhythm persists with no adverse effects after initial dose. ▪ Total dose should not exceed 30 mg in 30 minutes.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Verapamil is not recommended in the pediatric population in the absence of Medical Direction. ▪ Reference policy PED-5
ONSET	3 to 5 minutes
DURATION	2 hours
STOCK	(2) 5 mg/2 mL vials

METOPROLOL TARTRATE	
CLASS	Beta-Adrenergic blocking agent
ACTION	<ul style="list-style-type: none"> Exerts mainly beta-1 adrenergic blocking activity although Beta-2 receptors are blocked at high doses
INDICATIONS	<ul style="list-style-type: none"> Acute MI in hemodynamically stable patients
CONTRAINDICATIONS	<ul style="list-style-type: none"> MI in patients with a HR of less than 60 bpm 2nd or 3rd degree heart blocks Systolic BP is less than 100 Sinus Bradycardia
PRECAUTIONS	Use with caution in impaired hepatic function and during lactation
SIDE EFFECTS	<ul style="list-style-type: none">
ROUTE	<ul style="list-style-type: none"> PO
DOSE	<ul style="list-style-type: none"> 25 mg
PEDIATRIC DOSE	<ul style="list-style-type: none"> Not determined for children
ONSET	15 minutes
DURATION	
STOCK	25 mg tablet

PLAVIX	
CLASS	Anitplatelet drug
ACTION	<ul style="list-style-type: none"> ▪ works by preventing a natural substance called ADP from binding to its receptors on platelets ▪ ADP is one of the chemicals in the body that cause platelets to clump together.
INDICATIONS	<ul style="list-style-type: none"> ▪ Reduction of MI, Stroke and Vascular death in patients with atherosclerosis. ▪
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Lactation ▪ Active bleeding such as peptic ulcer or intracranial hemorrhage
PRECAUTIONS	Use with caution in those at risk of increased bleeding from trauma, surgery or other pathological conditions
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Edema ▪ Hypertension ▪ Intracranial hemorrhage ▪
ROUTE	<ul style="list-style-type: none"> ▪ PO
DOSE	<ul style="list-style-type: none"> ▪ 300 mg PO unless patient is older than 75 yrs and will be getting thrombolytics then dose is 75 mg.
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Not determined for children
ONSET	
DURATION	
STOCK	75 mg tablets x 4

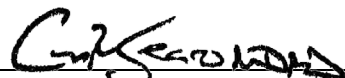
VERSED (MIDAZOLAM) Versed 10 mg/2ml, 5 mg/1ml vials	
CLASS	Benzodiazapine
ACTION	<ul style="list-style-type: none"> Short acting benzodiazepine that works as a central nervous system depressant. It is 3-4 times more potent than Valium.
INDICATIONS	<ul style="list-style-type: none"> Indicated for use in status epilepticus, pre-procedural sedation, severe anxiety, as an amnesic, and as an aid to anesthesia and intubation.
CONTRAINDICATIONS	<ul style="list-style-type: none"> Known hypersensitivity to the drug, or any of its components (propylene glycol). Patients with narrow angle glaucoma. <u>Pregnancy category D.</u>
PRECAUTIONS	
SIDE EFFECTS	<ul style="list-style-type: none"> As with all benzodiazepines, paradoxical reactions such as stimulation, mania, restlessness, agitation, aggression, psychosis, and hallucinations may occur.
ROUTE	<ul style="list-style-type: none">
DOSE	<ul style="list-style-type: none"> Adult: Given as 2-5 mg doses IV/IM
PEDIATRIC DOSE	<ul style="list-style-type: none"> Pediatric: 0.05-0.1 mg/kg IV or 0.1-0.15 mg/kg IM
ONSET	
DURATION	See SPECIAL CONSIDERATIONS below
STOCK	4 (5 mg / 5 ml vial)
<u>SPECIAL CONSIDERATIONS</u>	<p>Observe for signs of respiratory depression. Use with caution in patients who are hypotensive. Versed should be given in small titrateable doses over 2 minutes, with an additional 2 minutes of observation for maximal effect before additional doses are given. All patients should have monitoring equipment in place prior to administration, and equipment should be readily available to intubate, resuscitate the patient as necessary.</p>

NORCURON 10 mg/10ml reconstituted (Vecuronium Bromide):	
CLASS	Nondepolarizing skeletal muscle relaxant
ACTION	<ul style="list-style-type: none"> ▪ A non-depolarizing skeletal muscle relaxant of intermediate onset and duration. It can be used for maintenance of neuromuscular block. Acceptable intubating conditions can be achieved in approximately 3 minutes. Elimination is primarily through hepatic mechanisms with a half-life of approximately 70 minutes and duration of 30-60 minutes. Has minimal effects on hemodynamics and causes little or no histamine release.
INDICATIONS	<ul style="list-style-type: none"> ▪ Maintenance of neuromuscular blockade in intubated and ventilated patients. ▪ Neuromuscular blockade during rapid sequence intubation when succinylcholine is contraindicated.
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypersensitivity to drug. Pregnant and lactating women
PRECAUTIONS	
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Flaccid paralysis, respiratory depression
ROUTE	<ul style="list-style-type: none"> ▪
DOSE	<ul style="list-style-type: none"> ▪ Adult : 0.1 mg/kg IV bolus (10 mg max dose)
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Pediatric -0.1 mg/kg IV bolus (10 mg max dose)
ONSET	
DURATION	<ul style="list-style-type: none"> ▪ 25-30 minutes
STOCK	<ul style="list-style-type: none"> ▪ 20 mg vial
SPECIAL CONSIDERATIONS	<ul style="list-style-type: none"> • Prolonged recovery time in patients with liver disease. • Burn patients may require higher doses due to resistance to non-depolarizing agents in this population. • Pediatric patients, age 1-10 years of age may require a slightly higher initial dose and more frequent re-dosing. • Pediatric patients under age 1 year are more sensitive to the medication and may take 1 1/2 times longer to recover.

ONDANSETRON (ZOFTRAN):		
CLASS	Anti-emetic, selective Serotonin (5HT ₃) Receptor antagonist	
ACTION	<ul style="list-style-type: none"> ▪ Ondansetron reduces the activity of the vagus nerve which activates the vomiting center in the medulla oblongata, and also blocks serotonin receptors in the chemoreceptor trigger zone. It has little effect on vomiting caused by motion sickness. 	
INDICATIONS	<ul style="list-style-type: none"> ▪ Moderate to severe nausea, vomiting 	
CONTRAINDICATIONS	<ul style="list-style-type: none"> ▪ Hypersensitivity to the drug ▪ Prolonged QT syndrome ▪ Concurrent use of Apomorphine (Apokyn), an anti-parkinsonian drug 	
PRECAUTIONS	<ul style="list-style-type: none"> ▪ Not well studied in children less than 2 years of age ▪ Use with caution with patients concurrently using drugs which effect AT interval (i.e., Procainamide, amiodarone, TCA's, Haldol) ▪ Use with caution with hepatic impairment (consider prolonging dosage intervals or decreasing dose) 	
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Sedation ▪ Hypotension ▪ Tachycardia 	<ul style="list-style-type: none"> ▪ Angina ▪ Torsades de Pointes (rare) ▪ Constipation
ROUTE	<ul style="list-style-type: none"> ▪ IV/IO 	
DOSE (ADULT)	<ul style="list-style-type: none"> ▪ Adult – 4 mg, repeated once in 15 minutes PRN 	
PEDIATRIC DOSE	<ul style="list-style-type: none"> ▪ Pediatric –(>2 years of age) Contact Medical Control 	
ONSET	3–5 minutes	
DURATION	<ul style="list-style-type: none"> ▪ 2-4 hours 	
STOCK	<ul style="list-style-type: none"> ▪ 4 mg/2 ml vials 	
SPECIAL CONSIDERATIONS		



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FENTANYL CITRATE (SUBLIMAZE)	
CLASS	Opiate; synthetic narcotic
ACTION	A potent, short-acting opioid agonist; Relieves pain by stimulating receptors in the central nervous system. It has an analgesic effect approximately 50-100 times greater than that of morphine – a 50 mcg dose has roughly the same analgesic effect as 5 mg of morphine.
INDICATIONS	Non-cardiogenic pain Cardiogenic pain Aid in procedural sedation
CONTRAINDICATIONS	Hypersensitivity to the drug
PRECAUTIONS	Has an additive effect with other opiates and benzodiazepines / sedatives including alcohol which may contribute to respiratory depression. Rapid administration may result in spasm of respiratory muscles and chest wall rigidity resulting in difficulty or inability to ventilate the patient. Administer slowly to prevent this complication.
SIDE EFFECTS	CNS depression, respiratory depression, bradycardia, transient hypotension, ventilatory impairment in COPD patients, hives
ROUTE	IV
DOSE	Adult: 25 mcg slow IVP; may repeat dose prior to calling Medical Control
PEDIATRIC DOSE	Requires contact with Medical Control 0.1 mcg/kg slow IVP
ONSET OF ACTION	Immediate for IV route
DURATION OF ACTION	Peak effect 30-60 minutes
STOCK	2 100mcg/2ml bottles
NOTE:	Fentanyl Citrate should be mixed with 10ml of Normal saline flush prior to administration

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IV FLUIDS

0.9% SODIUM CHLORIDE (NORMAL SALINE)	
CLASS	
ACTION	<ul style="list-style-type: none"> • Fluid and sodium replacement
INDICATIONS	<ul style="list-style-type: none"> ▪ Heat-related problems (e.g., heat exhaustion, heat stroke) ▪ Freshwater drowning ▪ Hypovolemia ▪ Diabetic ketoacidosis ▪ IV Lifeline
CONTRAINDICATIONS	<ul style="list-style-type: none"> • None
PRECAUTIONS	<ul style="list-style-type: none"> • . Electrolyte depletion (K⁺, Mg⁺⁺, Ca⁺⁺, among others) can occur following administration of large amounts of normal saline • May cause fluid overload if rate is not closely monitored.
SIDE EFFECTS	<ul style="list-style-type: none"> ▪ Thirst
ROUTE	<ul style="list-style-type: none"> • IV Infusion
DOSE	<ul style="list-style-type: none"> • Dependent upon patient condition and situation being treated. In freshwater drowning and heat emergencies, the administration is usually rapid
PEDIATRIC DOSE	<ul style="list-style-type: none"> • Dose is dependent on patient size and condition • Trauma resuscitation 20 ml/kg initial bolus ▪ Utilize Broselow Tape or pediatric weight based dosing chart to confirm dose. Reference Policy PED-9
ONSET	
DURATION	
STOCK	

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QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

MEDICAL AUTHORITY PATTERN/SCENE MANAGEMENT AUTHORITY

- I. The EMS Medical Director is the designated final medical authority.
- II. The first arriving EMS team on the scene is responsible under the direct authority of the EMS Medical Director and will assume responsibility for carrying out appropriate patient care at the scene.
- III. Responsibility and authority for patient care management will be transferred to the team providing the highest level of care at the scene upon their arrival.
- IV. Levels of care from the highest to the most basic are:
 - A. Flight Teams
 - B. Transporting ALS Units
 - C. Non-transporting ALS Units
 - D. Transporting BLS Units
 - E. Non-Transporting BLS Units
 - F. First Responders
- V. In the event of unsafe scene conditions, authority/responsibility for patient care will begin once the scene has been declared safe and/or the patient has been moved to an area designated as safe by the appropriate law enforcement/fire/rescue agency in control of the scene as established by local incident command structure

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ABANDONMENT/UTILIZATION OF MANPOWER

- I. Advanced life support and basic life support ambulances shall respond as dispatched within their geographical area.
- II. Once medical care has been given, the prehospital care personnel are committed to the care of the patient until the patient is delivered to appropriate aid with the same degree or a superior degree of training and ability.
- III. The ALS team on the scene is responsible under the direct authority of the EMS physician and/or designated authority of the ECRN and will assume responsibility for carrying out appropriate patient care at the site and enroute to the hospital.
- IV. Triage is the responsibility of the paramedic with radio directions by the receiving hospital. In the event there are several patients and ALS treatment is begun on a patient who needs transportation, an EMT/paramedic must accompany the patient enroute to the hospital to assume continuity of care.
- V. BLS teams on the scene are under the medical direction of the ALS team on the scene. If it is impossible for an ALS team to respond to the call, BLS EMT/B manned team will assume authority at the scene under the direct radio supervision of the receiving hospital.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PHYSICIAN/NURSE AT THE SCENE

I. Physician is a Bystander:

- A. Require identification
- B. Determine if physician is willing to assume responsibility for patient care and accompany patient to the hospital.
- C. Confirm all orders with Medical Control.

II. Physician is Patient's Physician:

- A. Confirm identity as patient's physician
- B. Determine if physician is willing to assume responsibility for patient care and accompany patient to the hospital.
- C. If physician accompanies the patient, confirm and document physician's orders with the EMS physician and/or ECRN.
- D. In the event the physician orders therapy not consistent with the system medical protocol, he shall be requested to accompany the patient to the hospital to continue his therapy and assume responsibility. All therapy shall be confirmed and documented with Medical Control.
- E. If physician does not accompany the patient, confirm physician's orders with Medical Control. In the event of conflict or change in condition, follow orders of Medical Control.

III. Nurse is a Bystander:

- A. Require identification.
- B. Notify Medical Control.
- C. The nurse at the scene shall function under the direction of the ALS team.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

TRANSPORT TO AN APPROPRIATE HOSPITAL

- I. When known, the patient choice of hospital is to be honored with the following noted exceptions:
 - A. When the patient is unresponsive, or when the patient condition does not allow him to make an informed decision, and there is also no patient physician or agent with durable power of attorney for health care present to make his desires known. (The patient's physician can only make the decision if on scene, assumes control of the care, and accompanies the patient after conferring with Medical Control.)
 - B. If a critically ill or injured patient appears to be in need of specialized care available at only a specific hospital.
 - C. If the patient's choice is not either a trauma center or the closest hospital.
 - D. If the patient's choice of hospital would require the ambulance to travel an unreasonable distance from its primary coverage area.
- II. Medical Control must be consulted when A, B, C, or D, above exists. The ambulance crew will contact the medical control hospital and after field assessment is given, the hospital will evaluate and decide the disposition of the patient. (Refer to O-4A)
- III. The receiving facility may direct bypass when current resources are exceeded. Bypass may only be initiated if the receiving hospital emergency physician certifies that transport to the further hospital would not be detrimental to the patient and the bypass meets criteria in O-33.
- IV. Category I trauma patients should be transported to the nearest trauma center if one is within 25 minutes transport time from the scene.

QUINCY AREA EMS SYSTEM
PATIENT DISPOSITION

- I. When contacted by an ambulance requesting direction on where to transport a patient in accordance with policy O-4, the EMS Medical Director or his qualified designee will direct that ambulance to the nearest hospital, or trauma center in the Quincy Area EMS System.
- II. The ambulance may be directed to a more distant hospital or trauma center if the EMS Medical Director or his qualified designee has determined and certified that based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at a more distant hospital or trauma center outweigh the increased risks to the patient from transport to the more distant hospital.
- III. In order to certify the determination to transport any patient to a more distant hospital or trauma center, the EMS Medical Director or qualified designee must note on the ER radio log that determination and sign the record.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

RESOURCE HOSPITAL OVERRIDES/INTERVENTION

- I. Intervention policy shall be initiated when one of the following occurs:
 - A. No radio response by the receiving hospital after 3 attempts by the prehospital unit.
 - B. Deviation from Quincy System defined treatment protocols, disposition, or communication protocols.
 - C. Undue delay in initiation of treatment or delayed transport of critically ill or injured patients (greater than 25 minutes) without reasonable cause.
 - D. When the Associate Hospital requests the intervention.
 - E. When an ALS crew requests the intervention.
- II. Intervention should first be initiated as suggestions given to the treating physician via phone by the Resource Hospital physician.
- III. If this indirect intervention does not result in closer compliance to the Quincy Area EMS System standards then:
 - A. The Resource physician will notify the Associate Hospital physician via phone that the Resource physician is “overriding” the call.
 - B. The Resource Hospital Physician will notify the prehospital unit that the Resource Hospital is overriding the call.
 - C. The Associate Hospital will continue to monitor the call, but may not intercede via telemetry or phone conversation.
- IV. A summary of the intervention will be written by the Resource Hospital Physician and will include the reasons for the override. Copies of this report will be sent to the Quincy Area EMS System's Medical Director and the involved Receiving Hospital Medical Director.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

REFUSAL OF SERVICES

- I. Purpose: to clarify the First Responder, First Responder D, EMT, or paramedic's responsibility when a patient refuses treatment and/or transportation.
 - A. At no time should any EMS provider suggest or initiate patient refusal. Advise the patient of the nature of proposed care and the potential consequences of not receiving care.
- II. Who May Refuse Care: A patient may refuse medical care and/or transportation if he/she does not appear to be a threat to himself or others and meets the following criteria:
 - A. A competent, conscious adult over the age of 18
 - B. A minor (under age 18) who meets one or more of the following criteria:
 - 1) Has been granted legal emancipation and provides documentation
 - 2) Is pregnant
 - 3) Is a parent
 - C. A Durable Power of Attorney for Health Care may request to limit or refuse medical care.
 - D. The legal guardian or parent of a minor
- III. Refusal Procedure for Persons Meeting Criteria in Section II (Documentation should include the following information:)
 - A. Assess the patient and obtain vital signs. If the patient refuses assessment, document this in the narrative.
 - B. Explain to the patient or legal guardian the risks associated with their decision to refuse treatment/transport.
 - C. Medical Control MUST be contacted via radio or phone to verify the refusal.
 - D. After concurrence of Medical Control to accept the refusal, obtain signatures of the patient or legal guardian and the EMS provider obtaining the refusal. It is always preferable to have two witnesses if possible.
 - E. If the patient or legal guardian refuses treatment and/or transport after having been informed of the risks involved and also refuses to sign the refusal form, relay this information to Medical Control
- IV. Patient with Diminished Mental Capacity
 - A. Assess the patient as completely as possible and obtain vital signs. Consent is implied if the patient's mental status is such that he/she is incapable of making a rational decision.
 - B. Advise the patient of the risks associated with his decision to refuse treatment/transport

- C. If family members/friends are present, advise them of the risks associated with the patient's refusal of treatment/transport. They may be able to reason with the patient.
- D. If unsuccessful in reasoning with the patient and/or family, contact Medical Control for further instructions. You may be advised to obtain assistance from law enforcement to use reasonable force/restraints to provide treatment/transport.

V. Refusal by a Minor

- A. Assess the patient and obtain vital signs. If the patient refuses assessment, document this in the narrative.
- B. Determine patient age and if under age 18, determine emancipation status.
- C. If the minor does not meet the criteria listed in Section II.B., contact with a parent or legal guardian must be made.
- D. Contact the parent/legal guardian by phone and report circumstances of the incident and patient condition. Advise that the patient is refusing care and ask if they would like the patient to be treated/transported.
- E. If the parent/legal guardian refuses treatment/transport, advise them of risks and ask them to repeat the refusal to a witness if possible.
- F. Contact Medical Control for verification of the refusal.
- G. If contact with the parent/legal guardian is unsuccessful, contact Medical Control for further instructions.
- H. If this process would delay the treatment of another seriously ill or injured patient on the scene, refer to Section VI below

VI. Multiple Refusal Incident

- A. Initial EMS personnel on the scene should perform an initial triage to determine the number of victims/injuries and whether additional resources are needed. There may be many people involved in the incident, but few injuries requiring ambulance transport. A brief initial contact should be made with all potential patients.
- B. If the ambulance crew determines there are seriously ill or injured patients requiring their immediate attention, additional EMS personnel should be requested to assist with minor injuries and obtaining refusals.
 - 1. Additional EMS personnel may consist of additional ambulance crews or non-transport crews.
 - 2. The additional personnel will assess remaining potential patients and follow guidelines in previous sections for obtaining refusals.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

TREATMENT OF MINORS

- I. Definition of minor: Any person under the age of eighteen.
 - A. Anyone under the age of eighteen is to be considered a minor unless they meet one or more of the following criteria:
 - 1. Has been granted legal emancipation and can provide documentation of this
 - 2. Is pregnant
 - 3. Is a parent
- II. Treatment of a minor
 - A. Assess the patient
 - B. Obtain consent from the parent or legal guardian for treatment/transport
 - C. If a delay to locate the parent or legal guardian could adversely affect the patient, begin lifesaving measures and contact Medical Control for instructions.
- III. Refusal of Treatment: See Protocol O-6 Section V
- IV. Legal guardian: An adult who has been appointed or granted legal custody by the court. This person is legally responsible for the minor.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

BEHAVIORAL EMERGENCIES

- I. Definition: A behavioral emergency is a situation in which a patient's behavior becomes so unusual, bizarre, threatening or dangerous that it requires intervention.
 - A. Objective factors demonstrated by the patient that may indicate a behavioral or psychological condition exists when:
 - 1. Actions interfere with core life functions such as eating, sleeping, hygiene
 - 2. Actions pose a threat to the life or well-being of the patient or others
 - 3. Actions significantly deviate from the social norm
- II. Consents
 - A. The patient must be a conscious, competent adult
 - B. The patient may consent to treatment and transport through quiet cooperation or lack of resistance
 - C. Whenever possible also obtain consent from a relative of the patient, legal guardian or Power of Attorney for Healthcare
 - D. Refusal: refer to Policy O-6 Refusal of Services
- III. Restraint
 - A. Physical restraint may be necessary when EMS personnel have a reasonable belief that the patient may harm himself or others.
 - 1. Indications: A disoriented, combative or violent patient who has demonstrated behavior harmful to himself or other persons.
 - B. The objective of physical restraint is to restrict movement in order to stop dangerous behavior. Safety of EMS personnel should be a priority – do not attempt restraint without adequate assistance
 - 1. Request law enforcement respond to the scene and advise them of the situation.
 - 2. Prepare all equipment/stretchers in advance.
 - 3. Clear bystanders/unnecessary persons from the area.
 - 4. Utilize law enforcement to physically restrain the patient using the minimum force necessary.
 - 5. Appropriate restraining devices should be utilized including leather or soft anklets/wristlets, wide roller bandages, restraint jacket. Do not remove restraints until moving the patient in the Emergency Department unless an emergency situation requires it.
 - C. Monitoring/treating the restrained patient
 - 1. Position the patient in a manner that gives immediate access to the airway and allows visualization of breathing/chest rise.
 - 2. Check circulation in all limbs during transport.
 - 3. Provide emergency care as indicated.

4. Two attendants should be in attendance with the patient whenever possible. In extreme cases, or cases in which the EMS personnel feel uncomfortable with transporting the patient alone, law enforcement should be asked to accompany the crew.

IV. Documentation should be objective, clear and concise and should include:

- A. The initial physical assessment
- B. Behaviors noted that led you to believe the patient presented a danger to himself or others
- C. Measures taken to obtain consent for treatment/transport.
- D. Resources utilized for physical restraint including the type of restraints used.
- E. Physical assessment during transport including positioning, circulation, and treatment provided.

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

DEATH AT THE SCENE

- I. If a patient is pulseless and non-breathing and does not meet the criteria for initiation of resuscitative efforts, emergency personnel are to:
 - A. Advise the medical control physician
 - 1) Communicate pertinent medical history (use cell phone if possible)
 - 2) Transmit a sample EKG if requested
 - B. Notify the coroner on all prehospital deaths (after contact with Medical Control)
 - 1) Contact dispatch and advise of need for coroner
- II. If a crime is suspected:
 - A. Disturb the body and scene as little as possible
 - B. Request presence of law enforcement personnel if already not at the scene
- III. In all instances, document as much pertinent information as may be obtained from bystanders and/or observed at the scene such as:
 - A. Time patient collapsed
 - B. Time patient became pulseless and non breathing
 - C. When patient last seen
 - D. Recent medical history if available
 - E. Environmental observations
 - F. Pertinent physical findings

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RESUSCITATION

- I. All pulseless and non breathing patients are to receive full resuscitative efforts except when any of the following physical findings can be documented:

- A. rigor mortis
- B. tissue decomposition
- C. extreme dependent lividity
- D. injuries incompatible with life
 - 1. decapitation
 - 2. incineration
 - 3. etc

OR

- II. The duration of complete cessation of cardiovascular function can accurately be determined and documented to be greater than 15 minutes. To make a decision not to initiate CPR in this setting, the responder(s) must be confident that:

- A. Bystanders at the scene are able to recognize cardiac arrest.
- B. Bystanders at the scene are reliable in documenting the time elapsed.
- C. Bystanders are acting in good faith.
- D. No independent influences on central nervous system function, such as drugs or hypothermia are operative

OR

- III. A valid written DNR is received (see Policy O-9B)

- IV. It should be considered in all cases that the patient could have collapsed from a cardiac or non cardiac cause, yet continued to have cardiac activity sufficient to sustain the brain until the arrival of emergency personnel. When doubt exists, assume the patient has not sustained irreversible cessation of circulatory and respiratory functions and initiate full resuscitative efforts.

Thomas A. Cliatt, D.O., EMS Medical Director

5/88 re: 4/92, 11/97, 5/98
(reviewed: 8/95, 8/01)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DNR POLICY

- I. All field personnel (EMT-B, EMT-I, EMT-P, and prehospital RN) are authorized to recognize a valid “Do Not Resuscitate” (DNR) policy. The role of the on-line medical control physician is to interpret policy and provide guidance and direction to field personnel as needed.
- II. Upon receipt of a written DNR order from a long term care facility, hospice, or home care patient, or for any patient being transported by ambulance for any reason, EMS System participants within Region 3 will utilize the following procedure:
 - A. Beginning July 23, 2005, a valid DNR shall be written on a brightly colored form provided by Illinois Department Public Health which shall contain all the elements listed in B.
 1. Any DNR that has an effective date prior to July 1, 2001, can also be recognized if it contains the data elements listed in B.
 - B. Field personnel shall confirm the written DNR order contains at least the following information:
 1. name of patient
 2. name and signature of attending physician
 3. effective date
 4. the words written out “Do Not Resuscitate”
 5. evidence of consent either:
 - a) signature of patient; or
 - b) signature of legal guardian; or
 - c) signature of durable power of attorney for health care agent; or
 - d) signature of surrogate decision maker
 - C. Field personnel shall make a reasonable attempt to verify the identity of the patient.
 - D. Field personnel shall notify the treating hospital of the DNR order and the existence or absence of items B1, 2, 3, 4, and 5.
 - E. Emergency Communication RN’s (ECRN’s) shall summon the EMS physician to the radio control location and that physician will advise the prehospital personnel to honor the DNR order or reject it based upon all information available at that time.
- III. A DNR order shall be revoked in one or more of the following ways:
 - A. By the patient, or
 - B. The order is physically destroyed or verbally rescinded by the physician who signed the order, or
 - C. The order is physically destroyed or verbally rescinded by the person who gave written consent to the order.
- IV. The original or copy of the original written DNR order shall accompany the patient and be a permanent part of the EMS medical record. The copy is not required to brightly colored.

V. General Orders

- A. DNR orders can affect the treatment of patients prior to or during a full cardiac arrest. Please review section 2 of the DNR form.
- B. System personnel will submit a report regarding any difficulties experienced in complying with this policy. Problems will be evaluated as necessary by the Region 3 Advisory Committee.
- C. DNR cases will be reviewed by the EMS Office for policy compliance.
- D. An annual report will be submitted to IDPH delineating DNR issues which have been identified and the Systems' response to those issues.
- E. Education of the system personnel regarding this policy will be accomplished in one or more of the following manners:
 - 1. Agency CME by Training Officer
 - 2. System Wide Education Program
 - 3. Distribution of copies of the policy
 - 4. CME articles specific to DNR and this policy
- F. In the absence of a valid DNR order, CPR may only be withheld in accordance with the Systems policies on Death At The Scene and/or Resuscitation

VI. A living will by itself cannot be recognized by prehospital care providers.

VII. You can review "[DNR – Guidance for Health Care Providers and Professionals](#)" by logging on to www.idph.state.il.us and click on "Living Wills, DNR, Power of Attorney" icon.



Illinois Department of Public Health

(Page 1 of 2)

UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM**Patient Directive**

I, _____, born on _____, hereby direct the following in the event of:
 (print full name) (birth date)

1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):

- ☒ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
 (Measures to promote patient comfort and dignity will be provided.)

2. PRE-ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating):**SELECT ONE**

- ☐ **Do Attempt Cardiopulmonary Resuscitation (CPR) -OR-**
☐ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
 (Measures to promote patient comfort and dignity will be provided.)

Other Instructions _____

Patient Directive Authorization and Consent to DNR Order (Required to be a valid DNR Order)

I understand and authorize the above Patient Directive, and consent to a physician DNR Order implementing this Patient Directive.

 Printed name of individual Signature of individual Date

-OR-

 Printed name of (circle appropriate title):
 legal guardian Signature of legal representative Date
 OR agent under health care power of attorney
 OR healthcare surrogate decision maker

Witness to Consent (Required to have two witnesses to be a valid DNR Order)

I am 18 years of age or older and have witnessed the giving of consent by the above person.

 Printed name of witness Signature of witness Date

 Printed name of witness Signature of witness Date

Physician Signature (Required to be a valid DNR Order)

I hereby execute this DNR Order on _____.
 Today's date

 Signature of attending physician Printed Name of attending physician Physician's telephone number

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆



Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM

Patient's name _____

Summarize medical condition:**When This Form Should Be Reviewed**

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
If this form is to be voided, write "VOID" in large letters on the other side of the form.
After voiding the form, a new form may be completed.

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed
<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed
<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<u>Outcome of Review</u>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; no new form completed

Advance Directives

I also have the following advance directives:

Contact person (name and phone number)

- ☐ Health Care Power of Attorney
- ☐ Living Will
- ☐ Mental Health Treatment Preference Declaration

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

RESPONSIBILITY AT THE SCENE/LAW ENFORCEMENT PERSONNEL

- I. Law Enforcement personnel will be notified when the following circumstances occur:
 - A. Gunshot or knife wounds
 - B. Sexual assault
 - C. Attempted suicide
 - D. Abuse cases:
 - 1. child
 - 2. elderly
 - 3. any battery
 - E. Unlawful possession of controlled drugs
- II. EMT obligations at the scene of a violent crime.
 - A. Immediately notify law enforcement.
 - B. If the patient is obviously dead, the body and surrounding scene shall remain undisturbed.
 - C. Do not touch, move, or relocate any item at the scene unless absolutely necessary to provide treatment to an injured victim. Mark the location of any item that must be moved.
 - D. No onlookers or other unauthorized personnel on the premises of the crime scene.
 - E. Observe and note anything unusual, especially if the evidence may not be present when law enforcement arrives, i.e., smoke and odors.
 - F. Give immediate care to the victim.
 - G. Keep detailed records of the incident including observations of the victim at the scene
 - H. Once law enforcement arrives, do not hinder their work. Restrict your movements to those which relate to patient care. Give any information to the police which may be helpful but keep conversation to a professional level. Do not draw conclusions, but make observations.
- III. The police have broad legal authority to enforce the law. They also have the equal right to control a situation to the degree that it does not needlessly hinder emergency care. Law enforcement may let EMS personnel perform their work unhampered if they understand the reason and need for treatment, and are sure that the treatment will not delay them from their rights to enforce the law. If a conflict should exist between the EMS personnel and law enforcement the following guidelines shall apply:
 - A. Meet with law enforcement in private and try to agree on an approach that will satisfy their needs along with your own.
 - B. Explain why the treatment is needed, and how law enforcement work may hinder the treatment.
 - C. If they still refuse to let you start treatment, diplomatically advise that the incident will be noted in the run form.
 - D. Remember that they also have a duty to perform.
 - E. If an agreement can not be reached, you must give in to their demands, continue the treatment allowed and never abandon the patient.
 - F. You are not required to perform services or treatment demanded by law enforcement.
 - G. You can advise the patient about limits placed on treatment by law enforcement.
 - H. Contact Medical Control and advise of the situation.
 - I. Document objectively and clearly.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

CONFIDENTIALITY

- I. Prehospital personnel and others functioning within the Quincy Area EMS System will maintain confidentiality regarding patients and patient care.
- II. Information accorded to physicians and/or nurses at the receiving or Resource Hospital should be of a medical nature or pertinent to the care of the patient.
- III. Information will be provided to law enforcement agencies or other governmental agencies as required by Illinois law.
- IV. All records will be maintained in confidential files.

QUINCY AREA EMS SYSTEM

Major EMS Incident / Multiple Casualty Protocol

- I. Purpose: This policy shall serve as a guide to the overall responsibilities of EMS providers at the scene of a major EMS incident or disaster.

- II. Definitions:
 - A. Major EMS Incident: can include both man-made and natural situations or disasters that could include but not be limited to:
 1. An incident with multiple patients requiring more than two ambulances for transport.
 2. An incident with special hazards such as chemical, biological, radiologic, nuclear or explosive (CBRNE).
 3. A situation involving a difficult, prolonged rescue or extrication
 4. A situation in which EMS prehospital and/or hospital resources are overloaded

 - B. Mass casualty incident / disaster: Generally ten or more victims, or an unstable (open) incident that could likely escalate into more casualties. This type of event would be expected to greatly tax local providers.

 - C. Incident command system (ICS): designed to control field response operations by establishing functional areas under the direction of the Incident Commander.

 - D. Incident Commander (IC): the person in overall control of the incident site. The person in charge may change, but the overall function does not.

 - E. Unified command: the incident command system can be utilized across multi-jurisdictional boundaries. Realize that in a disaster situation you may be instructed to report to a person other than your usual supervisor.

- III. EMS Responsibilities
 - A. Incident commander: The senior EMT in the first responding unit can assume the role initially if incident command has not already been assumed by an authority having jurisdiction in the incident.
 1. Duties include:
 - a. Perform overall scene evaluation.
 - b. Identify yourself to dispatch and declare a major EMS incident / disaster
NOTE: Notify the local hospital(s) via MERCI or phone of the incident.
 - c. Determine need for and request additional resources.
 - d. Begin scene organization keeping in mind any potential hazards at the site.
 - Set up command post – may utilize the ambulance as a convenient initial command post
 - Designate a treatment area where all victims will be brought after triage while awaiting transport
 - Designate vehicle/crew/equipment staging area in an area that does not hamper entrance and egress from the disaster site.
 - e. Determine a plan of action for the event
 - f. Assigns EMS personnel to tasks
 - g. Due to limited EMS resources, this person should consider transfer of command as soon as is feasible. This could be to an EMS person that is more experienced and/or a person with more advanced trained person or to the authority having jurisdiction from another agency.

- B. Triage Officer: The person designated to oversee triage functions. The second senior EMT in the first responding unit will usually assume this role.
 - 1. Duties include:
 - a. Perform primary triage to count the initial number of victims and severity.
 - b. Provide numbers and severity information to the Incident Commander
 - c. Make recommendations to the Incident Commander concerning additional resources needed
 - d. Coordinate secondary triage in the treatment area until all patients are cleared from the scene
 - e. *Will use SMART tag as the approved triage tag (See 12-F)*
- C. Medical Branch Officer: In a very large scale operation, this person is responsible for all EMS functions. Designated by the Incident Commander.
- D. General responsibilities for other EMS providers responding to a disaster
 - 1. Response by personal vehicle
 - a. Be prepared to show medical provider identification to law enforcement to be allowed on scene.
 - b. Park personal vehicles in an area designated that will not hamper entrance and egress from the disaster site.
 - c. Report to the command post or to other designated areas for further instructions.
 - 2. Response by emergency vehicle
 - a. Check in and park emergency vehicles in designated staging areas.
 - b. You may be instructed to turn off emergency lights if doing so will not cause a hazard to you and the vehicle.
 - c. Report to the command post or to other designated areas for further instructions. You may be asked to remain with your vehicle.
 - 3. Response by aircraft
 - a. Will land in designated landing areas.
 - b. Staff will remain with the aircraft unless specifically instructed by the Incident Commander or designee.
 - 4. General duties of EMS providers
 - a. Assist with primary and ongoing triage
 - b. Assist with medical care on scene in the designated treatment area
 - c. Provide emergency care during transport
 - d. Provide emergency medical care to other personnel at the disaster site

IV. Declaration of a major EMS incident

- A. Enroute declaration: any EMS unit dispatched to a situation with the potential as a major EMS incident can declare a possible major EMS incident or disaster while enroute to the scene. The senior crew member should verify as soon as possible once they have arrived on scene whether a major EMS incident does or does not exist and relay this information to dispatch.
- B. On scene declaration: After arrival on scene the senior crew member determines in the scene size-up that a major EMS incident exists and makes the declaration.
- C. Upon declaration:
 - 1. The senior crew member will notify dispatch and advise them to activate the disaster plan, giving them as many specifics as are available at the time. If possible, this will include:
 - a. Disaster situation
 - b. Estimated number of victims
 - c. Location of the incident

- d. Potential for escalation
- e. Requests for additional EMS units and other resources
- f. Specifies hazards noted that could impact responding units
- 2. The senior crew member should also notify the local hospital(s) in order for the hospital to be prepared to receive patients.

V. Communications

- A. It should be noted that communications during a disaster is often a weak link due to overloading of radio frequencies.
- B. Communications between EMS providers/agencies should be conducted on MERCI radio frequency 155.340, by cell phone or on another specifically designated frequency.
- C. There should be no unnecessary radio traffic
- D. Patient report to the hospital: during transport communication should be through cell phone or MERCI and should be limited to the number of patients being transported in the vehicle, their severity based on the assigned *SMART Tag* color and estimated time of arrival to the Emergency Department. Do not attempt to give a full report as this may lead to overload of the communications system.

VI. Coordinating this policy with your county or local emergency medical disaster plan:

- A. The EMS Medical Director is responsible for medical oversight of EMS System personnel during routine and disaster operations.
- B. The Resource Hospital should be notified in the event of a disaster declaration in order for assistance with the overall EMS response to take place. Contact Blessing Hospital on the dedicated Medical Control phone line 217-224-7743 or on MERCI radio frequency 155.340. Advise of the type and location of the disaster and ask that the EMS System Coordinator be contacted.
 - 1. The EMS System Coordinator or designee will respond to the disaster site or to the Emergency Operations Center (EOC) if activated, to assist with overall EMS functions.

VII. EMS Disaster Resources

- A. Adams County Ambulance & EMS Mass Casualty Response Unit
 - 1. Contents: Disaster supplies sufficient for 50-100 patients including backboards. (There are fifty backboards on the trailer – if additional are needed be sure to specifically request.)
 - 2. Request by calling Quincy/Adams County 9-1-1 or request through your local 9-1-1 dispatch center to relay the request. Be prepared to provide the following information:
 - a. Your name, agency and contact number
 - b. Name of incident commander and radio frequency to use
 - c. Type of disaster
 - d. Location of disaster
 - e. Time the incident occurred
 - f. Route for entry to the staging area or location that the Incident Commander is requesting the trailer be located.
 - g. Directions

- B. Master list of all approved providers in the Quincy Area EMS System
 - 1. Can be utilized for request of additional providers to report to the scene
 - 2. Request by contacting the Resource Hospital at 217-224-7743 and detail type of provider needed. The Resource Hospital will contact the EMS System Coordinator or designee who will access this information.

- C. Master list of all non-system ambulance providers (ambulance services that border the Quincy Area EMS System)
 - 1. Can be utilized for request of additional ambulance and/or providers to report to the scene
 - 2. Request by contacting the Resource Hospital at 217-224-7743 and detail type of provider needed. The Resource Hospital will contact the EMS System Coordinator or designee who will access this information.

- D. Activation of State Emergency Medical Disaster Plan (see policy SEM OP-12a)
 - 1. Can be utilized for large scale request of additional equipment, supplies, *etc.* Request by contacting the Resource Hospital at 217-224-7743 and detail type of provider needed. The Resource Hospital will contact the EMS System Coordinator or designee who will access this information.

SMART TRIAGE TAG



**QUINCY AREA EMS SYSTEM
STATE EMERGENCY MEDICAL DISASTER PLAN ACTIVATION**

- I. Purpose: This plan may be put into effect when a state of emergency or medical disaster is declared in Illinois by the Governor or his delegate. If the disaster occurs outside of Region 3, we may be activated in order to determine the available resources within the Quincy Area EMS System or to supply aid to the disaster scene.

- II. Region 3 Activation
 - A. A disaster POD hospital is responsible for coordinating the disaster medical response within its region.
 - B. Designated disaster POD hospital for Region 3
 1. Memorial Medical Center, Springfield, IL (even years)
 2. St. John Hospital, Springfield, IL (odd years)
 - C. The disaster POD hospital is responsible for gathering resource information from all Resource Hospitals in Region 3.
 1. The call will come to Blessing ED (Resource Hospital for the Quincy Area EMS System). The POD will request initiation of the disaster contact list and will specify Phase I or Phase II.
 2. Phase I is a preliminary request for information. We would not be asked to activate staff or supplies to the scene.
 3. Phase II means that Region 3 will be involved in receiving patients or may be asked to send supplies or staff to a disaster site. This phase could occur hours to days after the original phase I call.

- III. Resource Hospital responsibilities during an activation:
 - A. Phase I: Utilize the packet/checklist designated for Phase I.
 1. Resource Hospital Consolidated Regional Resource Availability Worksheet Phase I (O-12a F-1)
 - a) Contact Blessing departments as indicated on the checklist to obtain the needed information for Blessing. Enter this information onto the form.
 - b) Contact System hospitals – advise that we have had a Phase I activation, instruct them to complete the Associate or Participating Hospital Availability Worksheet for Phase I (O-12a F-2) and fax it to Blessing within 30 minutes. Enter this information onto the consolidated worksheet.
 - c) Fax the Phase I consolidated worksheet to the POD within 1 hour of initial contact.
 2. Contact Air Evac V only if requested to do so by the POD. If requested, complete the Helicopter Availability Worksheet (O-12a F-3) and fax to the POD within 30 minutes of initial contact.

3. Contact EMS Non-MABAS ambulance providers only if requested to do so by the POD. Have them complete the Ambulance Provider Availability Worksheet (O-12a F-4) and fax it to Blessing within 30 minutes of contact. Consolidate all ambulance provider information onto the EMS Non-MABUS Ambulance Provider Worksheet (O-12a F-5) and fax to the POD within 30 minutes of initial contact.
 4. Once the POD contact issues an “all clear”, contact all persons/agencies that you have made contact with to advise of this status.
- B. Phase II: :Utilize the packet/checklist designated for Phase II
1. Resource Hospital Consolidated Regional Resource Availability Worksheet Phase II (O-12a F-6)
 - a) Call appropriate departments as listed on the checklist to determine the needed information for Blessing. Enter this information on the form.
 - b) Contact System hospitals and instruct them to complete the Associate or Participating Hospital Availability Worksheet for Phase II (O-12a F-7). They should fax it to blessing within 30 minutes. Enter information from these forms onto the consolidated worksheet.
 - c) Fax the completed consolidated worksheet to the POD within 1 hour of initial contact.
 2. Once the POD issues an “all clear”, contact any agencies/persons that you have been in contact with to relay this information.

RESOURCE HOSPITAL SYSTEM CONSOLIDATED RESOURCE AVAILABILITY WORKSHEET (PHASE I)
TO BE COMPLETED BY RESOURCE HOSPITAL

Region _____
 RH Name: _____
 RH Phone: _____
 RH Fax: _____
 RH Contact: _____

INFORMATION PROVIDED BY POD CONTACT

POD Hospital Name: _____ Disaster Activated Date/Time: _____
 Contact Date/Time: _____ Disaster Location: _____
 Contact Name: _____ Type of Incident: _____
 Contact Phone: _____ Number of Victims: _____
 Contact Fax: _____ Helicopter Needed* Yes / No
 Ambulance Needed* Yes / No
 Special Needs Specified** Yes / No

* If ambulance or helicopters needed complete provider worksheet

** Write in special needs *i.e., drugs, equipment) in columns below

Hospital Names	Phone #s	ED Avail Y/N	Trauma Center Y/N	Adult Monit Beds	Ped Monit Beds	Total Other Beds	Total Units Blood	Vents #			Field Bags #	Decon Walking/ Hour #	Decon Litter/ Hour #	SPECIAL NEEDS		
								Adult	Ped	Both						

RESOURCE HOSPITALS CONTACT THEIR ASSOCIATE/PARTICIPATING HOSPITALS REQUESTING IDPH REQUESTED DATA AND COMPLETE THEIR SYSTEM WORKSHEETS. FAX FINDINGS TO PODS WITHIN ONE HOUR

ASSOCIATE OR PARTICIPATING HOSPITAL AVAILABILITY WORKSHEET (PHASE 1)

To be completed by Associate or Participating Hospital

Hospital Name _____
 Phone _____
 Fax _____
 Contact Name _____
 Date/Time Initial RH Contact _____

Information provided by resource hospital contact

RH Name _____
 Contact Name _____
 Contact Phone _____
 Contact Fax _____
 Disaster Location _____
 Type of Incident _____
 Number of Victims _____
 Special Needs Specified* _____ Yes/No
 *If "yes", write in special needs below

*****SPECIAL NEEDS*****

If special items such as drugs, equipment or staff are needed the Resource Hospital will identify and describe needs. Write in each item and indicate the number of units available at your hospital.

Items requested

Units available (i.e., doses, people)

1. _____
2. _____
3. _____
4. _____

- | | | |
|-----|--|----------|
| 1. | Is your Emergency Department currently able to receive patients? | YES / NO |
| 2. | Is your hospital a Trauma Center? | YES / NO |
| 3. | Total ADULT MONITORED BEDS currently available? | _____ |
| 4. | Total PEDIATRIC MONITORED BEDS currently available? | _____ |
| 5. | Total NON-MONITORED BEDS currently available (adult and pediatric combined)? | _____ |
| 6. | Total UNITS OF BLOOD currently available (whole and packed cells combined)? | _____ |
| 7. | Total ADULT VENTILATORS currently available? | _____ |
| 8. | Total PEDIATRIC VENTILATORS currently available? | _____ |
| 9. | Total UNIVERSAL (adult or pediatric) ventilators currently available? | _____ |
| 10. | Total FIELD DISASTER BAGS (with contents included) currently available? | _____ |
| 11. | Total -AMBULATORY (walking) HAZMAT VICTIMS CAN YOU DECONTAMINATE PER HOUR? | _____ |
| 12. | Total NON-AMBULATORY (liter) HAZMAT VICTIMS CAN YOU DECONTAMINATE PER HOUR? | _____ |
| 13. | Time completed worksheet was faxed to Resource Hospital? | _____ |

Associate and participating hospitals complete this worksheet and fax or phone findings per resource hospital request to resource hospital within one-half hour, keep a copy for your files.

HELICOPTER PROVIDER WORKSHEET

To be completed by POD (or Resource Hospital upon request of POD)

Region _____
 Hospital Name _____
 Hospital Phone _____
 Hospital Fax _____
 Contact Name _____

Information provided IDPH or POD Contact
 Contact Date/Time _____
 Contacting Org (if not IDPH) _____
 Contact Name _____
 Contact Phone _____
 Contact Fax _____
 Disaster Activated Date/time _____
 Disaster Location _____
 Type of Incident _____
 Number of Victims _____
 Number of Helicopters Needed _____

Helicopter Provider	Helicopter Provider Phone Number	Number of Helicopters Available	Comments
Air Angels	1-877-247-5438		
Air Evac Lifeteam	1-800-247-3822		Please check on Marion, Quincy Springfield, Effingham, Mt Vernon, Troy MO bases
Arch Air Med	1-800-325-9191		
CareForce 1	217-359-0235 1-800-315-2911		
Flight for Life	815-344-1000 OR 1-800-344-1000		
Lifeflight Evansville, IN	1-800-426-0911		
Life Flight Peoria, IL	1-800-252-5433		
Life Star	1-800—888-5862		
Lifeline	1-800-350-5433		
Med Force	1-866-633-3228		
R.E.A.C.T.	1-800-637-3228		
U of C Aeromedical	773-702-3222 OR 1-800-621-7827		

Fax to POD within one half hour of initial contact.

POD fax to IDPH within one hour of initial contact.

**EMS NON-MABAS AMBULANCE PROVIDER
AVAILABILITY WORKSHEET
TO BE COMPLETED BY NON-MABAS PROVIDER**

Provider Name _____ Provider Phone _____

Provider Fax _____ Your Name _____

Initial contact by Resource/POD Hospital

Contact Time/Date _____ Disaster Activation Time/Date _____

Contact's Name _____ Disaster Location _____

Contact's Phone _____ Type of Incident _____

Contact's Fax _____ Number of Victims _____

Contact's Organization _____

Information Reported to Resource/POD Hospital

Ambulances available locally _____

Ambulances available to travel (>50 miles) _____

EMT's available locally B _____ I _____ P _____

EMT's available to travel (>50 miles) B _____ I _____ P _____

**FAX TO CONTACT HOSPITAL AT (____) _____ WITHIN
ONE HALF HOUR OF INITIAL CONTACT TIME.
TIME OF "ALL CLEAR"**

EMS NON-MABUS AMBULANCE PROVIDER WORKSHEET
To be completed by POD (or Resource Hospital upon request of POD)

Region _____
Hospital Name _____
Hospital Phone _____
Hospital Fax _____
Contact Name _____

Information provided IDPH or POD Contact
Contact Date/Time _____
Contacting Org (if not IDPH) _____
Contact Name _____
Contact Phone _____
Contact Fax _____
Disaster Activated Date/time _____
Disaster Location _____
Type of Incident _____
Number of Victims _____
of Ambulances Needed _____

Provider Name	Provider Phone No.	Ambulances		EMT Personnel					
		Local < 50 miles	Travel > 50 miles	Local (<50 miles)			Travel (>50 miles)		
				P	I	B	P	I	B

FAX TO POD WITHIN ONE HALF HOUR OF INITIAL CONTACT.
POD FAX TO STATE WITHIN ONE HOUR OF INITIAL CONTACT.

**RESOURCE HOSPITAL SYSTEM CONSOLIDATES RESOURCE AVAILABILITY WORKSHEET (PHASE II)
TO BE COMPLETED BY RESOURCE HOSPITAL**

Region _____
 RH Name: _____
 RH Phone: _____
 RH Fax: _____
 RH Contact: _____

INFORMATION PROVIDED BY POD CONTACT:

POD Hospital Name: _____ Disaster Activated Date/Time: _____
 Contact Date/Time: _____ Disaster Location: _____
 Contact Name: _____ Type of Incident: _____
 Contact Phone: _____ Number of Victims: _____
 Contact Fax: _____

Hospital Names	Phone #s	Medicine	Psych	Surgery	Ortho	Burns	Spinal Cord	OB/GYN	Peds	Neg. Air Pressure Rms.	Total

RESOURCE HOSPITALS CONTACT THEIR OWN ASSOCIATE/PARTICIPATING HOSPITALS REQUESTING ASSOCIATE/PARTICIPATING WORKSHEETS.
 FAX THIS SYSTEM WORKSHEET TO PODS WITHIN ONE HOUR. Do not fax associate/participating worksheets to POD.

ASSOCIATE OR PARTICIPATING HOSPITAL AVAILABILITY WORKSHEET (PHASE II)

To be completed by Associate or Participating Hospital

Hospital Name _____
 Phone _____
 Fax _____
 Contact Name _____
 Date/Time Initial Resource _____
 Hospital Contacted _____

Information provided by Resource Hospital contact

RH Name _____
 Contact Name _____
 Contact Phone _____
 Contact Fax _____
 Disaster Location _____
 Type of Incident _____
 Number of Victims _____

AVAILABLE IN-PATIENT BEDS	NUMBER OF BEDS CURRENTLY AVAILABLE
Medicine (including critical care monitored beds)	
Psychiatry	
Surgery (including critical care monitored beds)	
Orthopedics	
Burns	
Spinal Cord Injury	
OB/GYN	
Pediatrics (including critical care monitored beds)	
Negative Air Pressure Rooms (A room equipped with a ventilation system that prevents air from leaking out or circulating in other parts of the facility.)	
Total Available Beds	

Time completed worksheet faxed to Resource Hospital _____

Associate and participating hospitals complete this worksheet and fax or phone per resource hospital instructions to your resource hospital within one-half hour of contact.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**START TRIAGE - ADULT
Simple Triage and Rapid Treatment**

- I. Purpose: To clarify a simple, quick and effective way to triage numerous patient in a short period of time.
- II. Procedure
 - A. Start where you stand and walk either clockwise or counterclockwise until the entire area has been triaged.
 - B. As you approach, identify the uninjured or “walking wounded”
 - 1. Move them out of danger or use them (until additional help has arrived)
 - a) To control bleeding
 - b) To maintain an airway
 - C. Proceed to the victims that cannot move.

STEP 1: Respiration's (breathing)

- 1. None, open airway, still no breathing, tag DECEASED
- 2. Respiration's greater than 30/min or less than 10/min , tag IMMEDIATE
- 3. Respiration between 10-30/min, go on to Step 2

STEP 2: Perfusion check (radial pulse) or use capillary refill test

- 1. If color regains in greater than 2 seconds or no radial pulse, tag IMMEDIATE
- 2. If color returns in less than 2 seconds or has a radial pulse, tag DELAYED
- 3. If severe bleeding, apply a quick bandage “walking wounded” can assist
- 4. Raise legs to return blood to heart if time permits

STEP 3: Mental Status

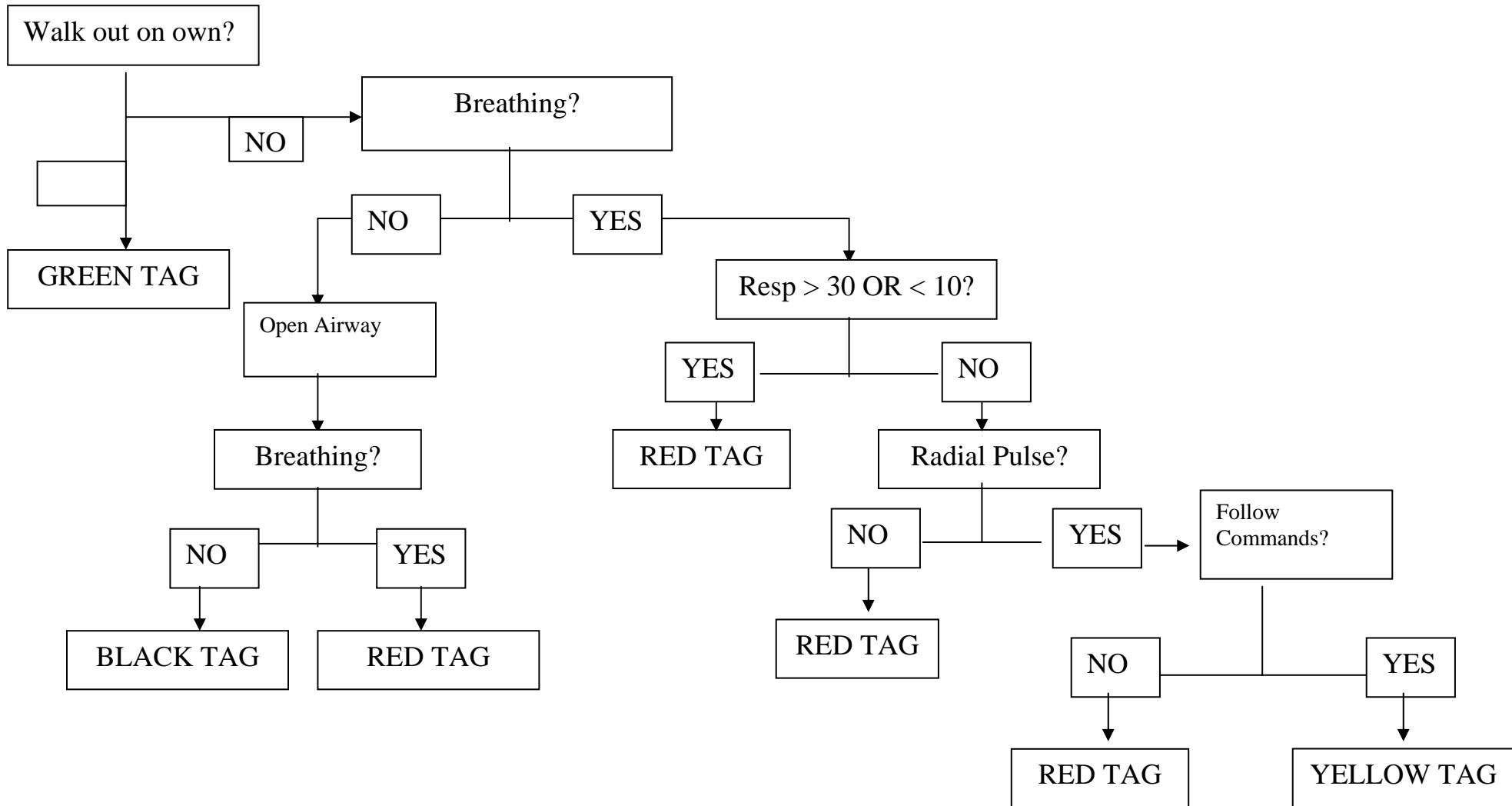
- 1. Altered mental status is in the ability to follow simple commands, tag IMMEDIATE
- 2. Able to follow commands, tag DELAYED
- 3. If victim is unconscious, tag as IMMEDIATE

NOTE: Some minor changes on pediatric START. See Pediatric Algorithm O12b.3

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

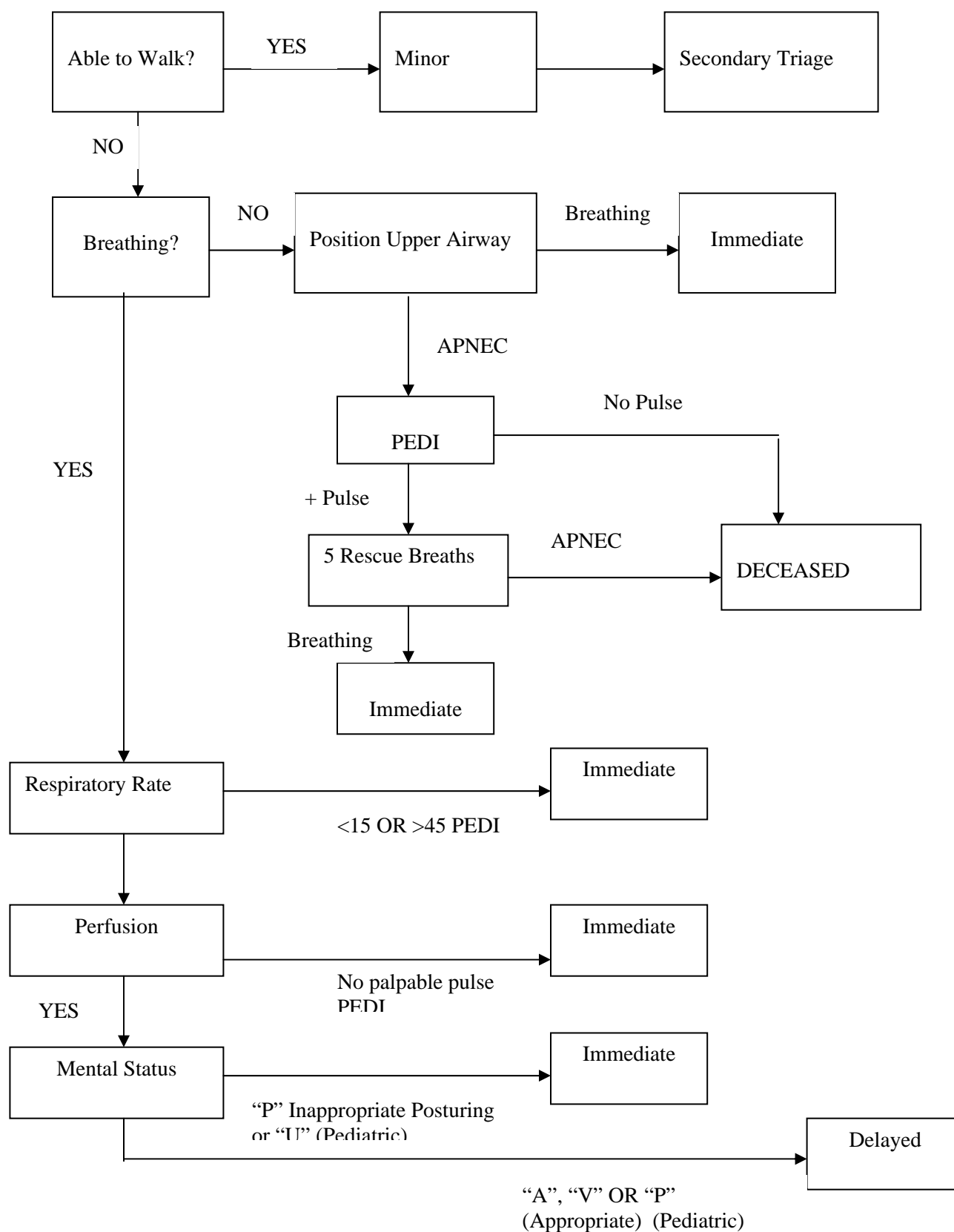
O-12b.2

START TRIAGE
Simple Triage and Rapid Treatment



QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

PEDIATRIC START TRIAGE



QUINCY AREA EMERGENCY MEDICAL SERVICE SYSTEM**RESTOCKING OF EMS DRUG BOXES**
(non controlled substance medication)

- I. Purpose: Provides the procedure to be followed for restock of medications used during the care of the prehospital patient.
 - A. Facilitates restocking of the EMS drug box and assures compliance with Medicare and Illinois EMS rules and regulations regarding restocking.
 - B. The procedures for controlled substances are in policy O-13B.
- II. Responsibilities of the Resource/Associate Hospitals
 - A. Initial stock
 - 1. The Resource and Associate Hospitals will initially stock the EMS drug boxes with the medications listed in QAEMS System policy O-14 at a cost to the ALS agency of cost plus 10%.
 - B. All medications utilized in prehospital patient care will be restocked on a 1:1 basis.
 - 1. The ALS ambulance agency will complete the charge sheet, present it to the pharmacy and receive the medications for restock.
 - 2. The agency will be billed for the medications restocked.
 - C. Replacement of Expired Medications
 - 1. All drugs, according to the FDA are dated with an expiration date on the outside of the box. If dated with month and year only, the drug will expire on the last day of the indicated month (example: 10/2006 would expire on 10/31/2006.)
 - 2. Expired medication will be replaced at cost plus 10%.
 - 3. No medications stored in the EMS drug boxes may be exchanged for credit.
 - D. Replacement of Damaged/Soiled Medications
 - 1. All damaged or soiled medications will be replaced at cost plus 10%.
 - 2. A charge sheet for these medications must be completed by the ALS agency with information regarding the circumstances.
 - 3. Damaged or soiled medications must be disposed of properly by the ALS agency. Controlled substances require witnessed waste. (See Policy O-13B)

E. Maintenance of Records by the Resource (Blessing) and Associate (Illini) Hospitals

1. A copy of the Quincy Area EMS System Emergency Department Radio Log with the physician's name is verification of the order for the medication. The ER physician must sign the radio log.
2. The original Quincy Area EMS System Emergency Department Radio Log is maintained by the Blessing Hospital EMS Department for seven years.

F. Oversight/ QA

1. Blessing Hospital EMS Department may complete EMS System audits of Illinois PCR forms for all calls in which a medication is given. Abnormal findings will be reported to the EMS Medical Director for follow-up. Illinois PCR forms and EMS System audits are maintained in the Blessing EMS Department or in storage for a period of seven years.
2. Oversight of agency outdate checks - The ALS agency has the responsibility of checking outdates of medication in the EMS drug boxes on a monthly basis. The agency will maintain a written record of these checks. Copies shall be made available to the Blessing EMS Department upon request.

III. Responsibilities of the ALS Provider Agency: Each ALS agency has the following responsibilities / accountabilities for the EMS Drug boxes assigned to their agency:

A. Securing the EMS Drug Boxes

1. In ambulances: medication and/or drug box should be secured to assure accountability (narcotics must be secured in a double lock system), i.e. example – drug box stored in a locked compartment inside a locked vehicle.
2. Storage of extra EMS drug boxes: must be in a secure area, double locks are required. (Example – drug boxes are stored in a locked cabinet inside a locked room or building.)
NOTE A: Drug boxes used for transfers do not need checked daily, however must be opened and checked before and after each time they are required for a transfer by a minimum of two (2) paramedics. If two medics are not available, the EMTB on the transfer may count with the medic. An event report must be completed anytime an EMTB assists with count and sent to your administration and EMS Coordinator.
3. In some cases medications (non-narcotic) may be located in locations other than drug box (See O-14). These medications must be secured the same as in #1.
4. **NOTE B:** While these medications do not have to be secured within a locked bag within a locked compartment, it will be the responsibility of the paramedic going on duty to assure medications are accounted for at the beginning of each shift.

B. Restocking Medications Used on a Run

1. Complete a charge sheet for all medications used.
2. To restock a controlled substance see Policy O-13B
3. Take the charge sheet to pharmacy to obtain the medications needed for restock
4. Replace the medications in the EMS drug box.
5. Check the box against the inventory list.
6. Obtain plastic lock tag and seal the box. (Note that plastic lock tags should be numbered and the ALS agency should determine a method to purchase and maintain accountability of these tags.)
7. Complete and place a label into the luggage tag holder with date the box was checked, name of the paramedic checking the box, expiration date of the first drug to expire and lock number.

C. Restock of Expired or Damaged/Soiled Medications

1. Complete a charge sheet – mark “Restock” and reason for restock.
2. You may return outdated medications to the pharmacy for disposal.
3. You may not return damaged/soiled medication to the pharmacy. They should be disposed of properly. Flush contents of syringes/vials down a sink or hopper and place needles into needle boxes.
4. Controlled substances require witnessed waste with documentation on the Narcotic Administration and Waste Log. Attach a copy of the log to the Restock form.
5. Complete the restocking process as listed in III. B above.
6. Replacement of damaged medications requires that a Quincy Area EMS System Event Report be completed. Send the event report to the Blessing EMS Department in care of the EMS System Coordinator. Send a copy to your agency director.

D. Checking for Outdates: Each ALS agency will develop an internal policy for checking outdates and maintaining written records of these checks. To ensure compliance, Blessing EMS Department will periodically request copies of these records.

E. Discrepancies in Inventory: If a check of the EMS Drug box reveals that medications are missing or there is suspected tampering, the paramedic will take the following measures:

1. Complete a charge sheet for all missing medications, noting on the charge sheet that restock is due to a discrepancy in stock.
2. Present the charge sheet to the pharmacy.
3. Receive medications to be restocked.
4. Replace medications in the EMS drug box.
5. Obtain plastic lock tag and seal box.

7. Complete and place a label into the luggage tag holder with date the box was checked, name of the paramedics checking the box, expiration date of the first drug to expire and lock number.
8. A verbal/telephone report should be made immediately by the paramedic to the ALS agency director/administrator or designee.
9. Complete a QAEMS System event report regarding the discrepancy before the end of your shift – send 1 copy to the EMS System Coordinator and 1 copy to your ALS agency director/administrator.
- 10.

F. Charging/Billing of Medications

1. The ALS agency will be billed for the restocked medications by the Hospital pharmacy at cost plus 10%.
2. The Hospital pharmacy will not bill patients for the medications used.
3. The ALS agency can bill the patient for medications as per their own agency and regulatory policies.

IV. Restocking from a pharmacy not at Blessing Hospital.

- A. Specific procedure may vary. However, a paper trail must exist to assure auditing of medications given, wasted, outdated or in a case of a discrepancy.
1. Minimum paperwork
 - a) Charge sheet
 2. Drug boxes will be secured in locked compartment when in ambulances

V. Storage of Drug Boxes used on transfers

Drug boxes stored to be used on transfers or as replacement boxes for daily activity must be stored in a secured locked compartment. These drug boxes will not require a daily check however each time a drug box is pulled from storage it must be opened and the narcotics checked by at least two ALS personnel. This can be two paramedics, a paramedic and RN or physician, or a paramedic and someone designated within your pharmacy that has the authority to sign that the medications are accounted for. If the drug boxes were used for a transfer, the drug box must be opened and re-checked in the same manner as when it was pulled for use to assure all narcotics are still present and accounted for. The Controlled Substance Log (O-14-F2) will be kept with the stored drug boxes and forwarded to Service Administration weekly, Service Administration will forward to EMS coordinator *by the 5th of the following month.*



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EMS Medical Director



Christopher R Solaro, MD, PhD
EMS Assistant Medical Director

QUINCY AREA EMS SYSTEM
Controlled Substance Policy

- I. Purpose: To provide a comprehensive structure for obtaining, possessing, and administering controlled substances in the pre-hospital environment. Controlled substances currently approved for ALS ground crews include Morphine, Valium, Versed and Vecuronium.
 - A. Facilitates restocking of the EMS drug box and assures compliance with Medicare and Illinois EMS rules and regulations regarding restocking.
 - B. The procedures for narcotics are based on the requirements set forth by the U.S. Department of Justice Drug Enforcement Agency (DEA) for accountability of all Schedule II controlled substances used by Advanced Life Support agencies.
- II. Scope: Applies to ALS EMS agencies that carry any of the controlled substances listed above.
- III. Definitions
 - A. **Controlled Substances:** those drugs that are classified into five schedules according to their abuse potential. The schedules range from schedule I, which have a high potential for abuse and no approved medical use, through schedule V, which have minimal abuse potential. All scheduled drugs will be treated as controlled.
 - B. **Double lock:** Double lock means that there are two specific control locks to access the medications. One must be a key or combination lock and the other may be the numbered lock on the medication box. Preferred method would be to have the medications in a number sealed container in a cabinet with a key or combination lock inside a locked ambulance.
- IV. Forms
 - A. Controlled Substance Log: This log is for the daily stock counts and to document usage of controlled substances including waste and breakage. This form should be kept in the same locked container as the medications. A new log should be started the first day of each month. The old log should be reviewed by the administrator of the service and stored/filed with other required paperwork of the service. A copy of the log will be forwarded to the EMS System Coordinator by the 5th of the following month. See attached form O 14 F-2
 - B. Controlled Substance Usage Form: This form will be used to receive Controlled Substance Narcotics from the Pharmacy. It will also be used to have documentation back to Pharmacy when a medication is used to allow for a replacement. (See O-14 F-1)
- V. Controlled Substance Storage
 - A. All controlled substances are to be left in the manufacturer's tamper proof packaging.
 - B. Controlled Substance medications in EMS Drug Boxes are required to be secured through a double lock system. (see definition above)

VI. Accountability for Controlled Substance Medications

- A. Shift check of all medications will be done each time there is a crew change.
- B. The counting of controlled substances in the EMS Drug boxes is the responsibility of all ALS crew members.
- C. The count will be completed by two ALS staff each time there is a crew change.
- D. Seal will be broken on the box and controlled substances counted and inspected for any signs of tampering.
- E. Document the count on the controlled substance log (O-14 F2). Both ALS staff sign the log.
- F. Reseal and secure the EMS Drug box.
- G. Note: In some cases, controlled substances may not be stored in the EMS drug box but must be secured with a numbered lock and the procedure will be the same as noted above.
- H. Drug boxes used for transfers do not need checked daily, however must be opened and checked before and after each time they are required for a transfer by a minimum of two (2) paramedics. If two medics are not available, the EMTB on the transfer may count with the medic. An event report must be completed anytime an EMTB assists with count and sent to your administration and EMS Coordinator.

VII. Discrepancies in Inventory: If a check of an EMS Drug Box reveals that controlled substances are missing or there is suspected tampering the paramedic will take the following measures:

- A. Verbal or telephone report immediately to the ALS agency director/administrator or designee. The director/administrator will notify the EMS System Coordinator immediately.
- B. Complete a QAEMS System event report regarding the discrepancy as soon as possible upon completion of the call. Send 1 copy to the EMS System Coordinator and 1 copy to the ALS agency Director/Administrator.

VIII. Paramedic Responsibility: Each Paramedic is charged with the proper safeguarding and handling of controlled substances.

- A. Review and sign a "Paramedic Contract for Controlled Substances" (O-14 F3) which requires the paramedic to have read this policy in its entirety and agree to abide by it.
- B. Ensure that the seal on the single use vial is intact.
- C. Report any loss or discrepancies to agency director/administrator or designee and EMS System Coordinator immediately after finding a discrepancy.
- D. Complete all required documentation related to use and administration or inventory of any controlled substance.

- E. Administer controlled substances pursuant to the direction of Medical Control or in accordance with QAEMS system protocols.
- F. While these medications do not have to be secured within a locked bag within a locked compartment, it will be the responsibility of the paramedic going on duty to assure medications are accounted for at the beginning of each shift

IX. Agency Responsibility

- A. Will assure that ALL crew members will follow this policy.
- B. Assure that controlled substances are secured using a double lock system.
- C. At least weekly, review the Controlled Substance Usage Form and ensure that the records of the usage correlate to ALS calls/PCR forms.
- D. Maintains all records related to obtaining, delivering and administering controlled substances for a period of 7 years.
- E. Forward documentation to the Blessing Hospital EMS System Coordinator by the 5th of each month.
 - 1) Documentation to be sent:
 - a) O-13-F-2 (controlled substance log) for each unit
 - b) O-14-F1 (Controlled Substance Usage Form)
- F. Securing the EMS Drug Boxes
 - 1) In ambulances: medication and/or drug box should be secured to assure accountability (controlled substances must be secured in a double lock system), i.e. example – drug box stored in a locked compartment inside a locked vehicle.
 - 2) Storage of extra EMS drug boxes: must be in a secure area, double locks are required. (Example – drug boxes are stored in a locked cabinet inside a locked room or building.)
 - 3) In some case medication (non-narcotic) may be stored in various locations in a jump bag to facilitate a quicker response for the patient (list of medications on O-14). While these medications do not have to be secured within a lock bag within a locked compartment, it will be the responsibility of the paramedic going on duty to assure the medication are present in the jump bag at the beginning of each shift.
 - 4) Drug boxes stored to be used on transfers or as replacement boxes for daily activity must be stored in a secured locked compartment. These drug boxes will not require a daily check however each time a drug box is pulled from storage it must be opened and the narcotics checked by at least two ALS personnel. This can be two paramedics, a paramedic and RN or physician, or a paramedic and someone designated within your pharmacy that has the authority to sign that the medications are accounted for. If the drug boxes were used for a transfer, the drug box must be opened and re-checked in the same manner as when it was pulled for use to assure all narcotics are still present and accounted for, (See note above “VI. H.” in this policy. The Controlled Substance Log (O-14-F2) will be kept with the stored drug boxes and forwarded to Service Administration weekly, Service Administration will forward to EMS coordinator *by the 5th of the following month.*

X. Responsibilities of the Resource/Associate Hospitals

- A. Initial stock
 - 1) The Resource and Associate Hospitals will initially stock the EMS drug boxes with the medications listed in QAEMS System policy O-14 at a cost to the ALS agency of cost plus 10%
- B. All medications utilized in prehospital patient care will be restocked on a 1:1 basis
 - 1) The ALS ambulance agency will complete retrieve and supply to pharmacy:
 - a) Charge sheet O-13-F-2
 - b) Controlled substance usage form O-14 F1
 - c) Copy of green radio log for the call (C-9F-1a or C-9F-1b if used on a call)
 - 2) The agency will be billed for the medications restocked.

XI. EMS System Coordinator Responsibilities

- A. Shall function as a resource for the administration of this policy and assure that ALS agencies are adhering to the policy
- B. Review monthly usage reports.
- C. Conduct prompt follow up on any issues regarding discrepancies.
- D. Promptly report issues to the EMS Medical Director as determined to be a concern which will include a monthly report of controlled substance given.

XII. Restocking Controlled Substances Used on a Run

- A. Complete a charge sheet for all medications used.
- B. To restock Controlled Substances, you will also need a copy of the Emergency Department radio log signed by the ED physician. The copy of the radio log with physician name serves as the order for Morphine or *Versed*. You will also complete a Narcotics Usage Form showing which medication was used. This form will be signed by the Paramedic and Pharmacy personnel.
- C. Take the charge sheet, (and copy of radio log and Narcotics Usage Form for Controlled Substances) to pharmacy to obtain the medications needed for restock
- D. Replace the medications in the EMS drug box.
- E. Check the box against the inventory list.
- F. Obtain plastic lock tag and seal the box. (Note that plastic lock tags should be numbered and the ALS agency should determine a method to purchase and maintain accountability of these tags.)
- G. Complete and place a label into the luggage tag holder with date the box was checked, name of the paramedic checking the box, expiration date of the first drug to expire and lock number.

XIII Wasting of narcotics: when the entire amount of a narcotic is not used, the remainder must be wasted in the presence of a witness and both persons should sign the QAEMS System Controlled Substances Log sheet.

- A. For patients being transported to the facility that gave the Controlled Substance order (Blessing or Illini Hospital) – sign the Narcotic Waste Log on the back of the Emergency Department Radio Log.
- B. For patients transported to another facility, complete and sign a Narcotic Waste Log form (RN from receiving facility should also sign) and fax it to the QAEMS System Medical Control hospital that gave the Controlled Substance order. The form will be maintained with the radio log

XIV Replacement of Expired Medications

- A. All drugs, according to the FDA are dated with an expiration date on the outside of the box. If dated with month and year only, the drug will expire on the last day of the indicated month (example: 10/2006 would expire on 10/31/2006.)
- B. Expired medication will be replaced at cost plus 10%.
- C. No medications stored in the EMS drug boxes may be exchanged for credit.
- D. All medications utilized in prehospital patient care will be restocked on a 1:1 basis
 - 1) The ALS ambulance agency will complete to pharmacy:
 - a) charge sheet O-13-F-2
 - b) controlled substance form O-14 F1
 - c) copy of green radio log for the call (C-9F-1a or C-9F-1b if used on a call)
 - 2) The agency will be billed for the medications restocked.

XV. Replacement of Damaged/Soiled Medications

- A. All damaged or soiled medications will be replaced at cost plus 10%.
- B. A charge sheet for these medications must be completed by the ALS agency with information regarding the circumstances.
- C. Damaged or soiled medications must be disposed of properly. Controlled substances require witnessed waste.
- D. The ALS ambulance agency will complete retrieve and supply to pharmacy:
 - 1) charge sheet O-13-F-2
 - 2) controlled substance usage form O-14 F1
 - 3) copy of green radio log for the call (C-9F-1a or C-9F-1b if used on a call)

XVI. Charging/Billing of Medications

- A. The ALS agency will be billed for the restocked medications by the Hospital pharmacy at cost plus 10%.
- B. The Hospital pharmacy will not bill patients for the medications used.
- C. The ALS agency can bill the patient for medications as per their own agency and regulatory policies.

XVII Maintenance of Records by the Resource (Blessing) and Associate (Illini) Hospitals

- A. A copy of the Quincy Area EMS System Emergency Department Radio Log with the physician's name is verification of the order for the medication. The ER physician must sign the radio log.
- B. The original Quincy Area EMS System Emergency Department Radio Log is maintained with the Illinois Patient Care Report form (PCR) by the Blessing Hospital EMS Department for seven years.

XVIII. Oversight/ QA

- A. Blessing Hospital EMS Department may complete EMS System audits of Illinois PCR forms for all calls in which a controlled substance was given. Abnormal findings will be reported to the EMS Medical Director for follow-up. Illinois PCR forms and EMS System audits are maintained in the Blessing EMS Department or in storage for a period of seven years
- B. Oversight of agency outdate checks - The ALS agency has the responsibility of checking outdates of medication in the EMS drug boxes on a monthly basis. The agency will maintain a written record of these checks. Copies shall be made available to the Blessing EMS Department upon request.



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**QUINCY AREA EMS SYSTEM
EMS DRUG BOXES RESTOCK LIST / CHARGE SHEET**

Date: _____ Reference ## _____ EMS Box # _____

Agency: **ADAMS COUNTY AMBULANCE & EMS**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Paramedic Name (PRINT): _____ Paramedic Signature: _____

- ☐ Restock – medications used on patient
- ☐ Restock – medications expired (**Take the expired medication to Pharmacy**)
- ☐ Restock – medications damaged (**Event Report Required**) Comments: _____
- ☐ Restock – discrepancy in box (**Event Report Required**) Comments: _____

Quantity Needed	Required Number in Box	Medications
_____	2	BOX
_____	3	VERAPAMIL 5MG/2ML VIAL
_____	2	EPINEPHRINE 1:1000 AMP (0.4 mg/ml)
_____	1	NALOXONE 400MCG/ML 10ML VIAL
_____	1	NITROSTAT 0.4MG (1/150GR)
_____	4	OXYTOCIN 10USP UNITS/ML VIAL
_____	4	ALBUTEROL INHALATION SOLUTION 3ML U/D
_____	5	ASPIRIN BABY 81 MG
_____	2	ADENOCARD 6MG/2ML VIAL
_____	1	FUROSEMIDE 100 MG/10ML VIAL
_____	2	DIPHENHYDRAMINE 50MG/ML INJ
_____	2	DIAZEPAM 10MG/2ML CARPUJECT
_____	5	MORPHINE SULFATE 2MG/ML CARPUJECT
_____	2	PROMETHAZINE (PHENERGAN) 25 MG/ML INJ
_____		BAG
_____	1	GLUCAGON 1MG (1 UNIT)
_____	1	10% CALCIUM CHLORIDE ABBOJECT 10ML
_____	1	EPINEPHRINE 1:1000 30ML VIAL
_____	1	MAGNESIUM SULFATE 50% ABBOJECT 10ML
_____	1	PEDIATRIC SODIUM BICARB 8.4% ABBOJECT 10ML
_____	1	INFANT 25% DEXTROSE ABBOJECT 10ML
_____	3	NITROGLYCERIN OINTMENT U/D W/PAPERS
_____	5	ATROPINE 1MG/10ML ABBOJECT
_____	6	EPINEPHRINE 1:10,000 ABBOJECT 10ML
_____	1	2GM LIDOCAINE PREMIX/ 500ML BAG
_____	1	DOPAMINE HCL 800MG/ 500ML BAG
_____	3	LIDOCAINE 2% ABBOJECT 5ML
_____	2	SODIUM CHLORIDE 30ML
_____	2	50% DEXTROSE ABBOJECT 50ML
_____	1	8.4% SODIUM BICARB ABBOJECT 50ML
_____	1	ORAL GLUCOSE (30 GRAM TUBE)
_____	1	METOPROLOL 25 MG TABLETS
_____	4	PLAVIX 75 MG TABLETS
_____	4	VERSED 5MG/5ML
_____	2	NORCURON 20 MG VIAL
_____	2	ZOFRAN 2MG/ML INJ 2ml vials
_____	2	FENTANYL 100mcg/2ml

Pharmacy Tech (Print): _____ Pharmacy Tech Signature: _____

Pharmacist Name (Print): _____ Pharmacist Signature: _____

**QUINCY AREA EMS SYSTEM
EMS DRUG BOXES RESTOCK LIST / CHARGE SHEET**

Date: _____ Reference ## _____ EMS Box # _____

Agency: BROWN COUNTY AMBULANCE

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Paramedic Name (PRINT): _____ Paramedic Signature: _____

- ☐ Restock – medications used on patient
- ☐ Restock – medications expired (**Take the expired medication to Pharmacy**)
- ☐ Restock – medications damaged (**Event Report Required**) Comments: _____
- ☐ Restock – discrepancy in box (**Event Report Required**) Comments: _____

Quantity Needed	Required Number in Box	Medications
_____	2	BOX
_____	3	VERAPAMIL 5MG/2ML VIAL
_____	2	EPINEPHRINE 1:1000 AMP (0.4 mg/ml)
_____	1	NALOXONE 400MCG/ML 10ML VIAL
_____	1	NITROSTAT 0.4MG (1/150GR)
_____	4	OXYTOCIN 10USP UNITS/ML VIAL
_____	4	ALBUTEROL INHALATION SOLUTION 3ML U/D
_____	5	ASPIRIN BABY 81 MG
_____	2	ADENOCARD 6MG/2ML VIAL
_____	1	FUROSEMIDE 100 MG/10ML VIAL
_____	2	DIPHENHYDRAMINE 50MG/ML INJ
_____	5	DIAZEPAM 10MG/2ML CARPUJECT
_____	2	MORPHINE SULFATE 2MG/ML CARPUJECT
_____	2	PROMETHAZINE (PHENERGAN) 25 MG/ML INJ
_____		BAG
_____	1	GLUCAGON 1MG (1 UNIT)
_____	1	10% CALCIUM CHLORIDE ABBOJECT 10ML
_____	1	EPINEPHRINE 1:1000 30ML VIAL
_____	1	MAGNESIUM SULFATE 50% ABBOJECT 10ML
_____	1	PEDIATRIC SODIUM BICARB 8.4% ABBOJECT 10ML
_____	1	INFANT 25% DEXTROSE ABBOJECT 10ML
_____	3	NITROGLYCERIN OINTMENT U/D W/PAPERS
_____	5	ATROPINE 1MG/10ML ABBOJECT
_____	6	EPINEPHRINE 1:10,000 ABBOJECT 10ML
_____	1	2GM LIDOCAINE PREMIX/ 500ML BAG
_____	1	DOPAMINE HCL 800MG/ 500ML BAG
_____	3	LIDOCAINE 2% ABBOJECT 5ML
_____	2	SODIUM CHLORIDE 30ML
_____	2	50% DEXTROSE ABBOJECT 50ML
_____	1	8.4% SODIUM BICARB ABBOJECT 50ML
_____	1	ORAL GLUCOSE (30 GRAM TUBE)
_____	1	METOPROLOL 25 MG TABLETS
_____	4	PLAVIX 75 MG TABLETS
_____	4	VERSED 5MG/5ML
_____	2	NORCURON 20 MG VIAL
_____	2	ZOFRAN 2MG/ML INJ 2ml vials
_____	2	FENTANYL 100mcg/2ml

Pharmacy Tech (Print): _____ Pharmacy Tech Signature: _____

Pharmacist Name (Print): _____ Pharmacist Signature: _____

1/07; re: 5/08, 5/09; 11/09, 3/10, 9/10, 1/11, 2/11, 2/14, 1/15, 7/15

**QUINCY AREA EMS SYSTEM
EMS DRUG BOXES RESTOCK LIST / CHARGE SHEET**

Date: _____ Reference ## _____ EMS Box # _____

Agency: **HANCOCK COUNTY AMBULANCE**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Paramedic Name (PRINT): _____ Paramedic Signature: _____

- ☐ Restock – medications used on patient
- ☐ Restock – medications expired (**Take the expired medication to Pharmacy**)
- ☐ Restock – medications damaged (**Event Report Required**) Comments: _____

☐ Restock – discrepancy in box (**Event Report Required**) Comments: _____

Quantity Needed	Required Number in Box	Medications
_____	2	BOX
_____	3	VERAPAMIL 5MG/2ML VIAL
_____	2	EPINEPHRINE 1:1000 AMP (0.4 mg/ml)
_____	1	NALOXONE 400MCG/ML 10ML VIAL
_____	1	NITROSTAT 0.4MG (1/150GR)
_____	1	OXYTOCIN 10USP UNITS/ML VIAL
_____	4	ALBUTEROL INHALATION SOLUTION 3ML U/D
_____	4	ASPIRIN BABY 81 MG
_____	5	ADENOCARD 6MG/2ML VIAL
_____	2	FUROSEMIDE 100 MG/10ML VIAL
_____	1	DIPHENHYDRAMINE 50MG/ML INJ
_____	2	DIAZEPAM 10MG/2ML CARPUJECT
_____	5	MORPHINE SULFATE 2MG/ML CARPUJECT
_____	2	PROMETHAZINE (PHENERGAN) 25 MG/ML INJ
_____		BAG
_____	1	GLUCAGON 1MG (1 UNIT)
_____	1	10% CALCIUM CHLORIDE ABBOJECT 10ML
_____	1	EPINEPHRINE 1:1000 30ML VIAL
_____	1	MAGNESIUM SULFATE 50% ABBOJECT 10ML
_____	1	PEDIATRIC SODIUM BICARB 8.4% ABBOJECT 10ML
_____	1	INFANT 25% DEXTROSE ABBOJECT 10ML
_____	3	NITROGLYCERIN OINTMENT U/D W/PAPERS
_____	5	ATROPINE 1MG/10ML ABBOJECT
_____	6	EPINEPHRINE 1:10,000 ABBOJECT 10ML
_____	1	2GM LIDOCAINE PREMIX/ 500ML BAG
_____	1	DOPAMINE HCL 800MG/ 500ML BAG
_____	3	LIDOCAINE 2% ABBOJECT 5ML
_____	2	SODIUM CHLORIDE 30ML
_____	2	50% DEXTROSE ABBOJECT 50ML
_____	1	8.4% SODIUM BICARB ABBOJECT 50ML
_____	1	ORAL GLUCOSE (30 GRAM TUBE)
_____	1	METOPROLOL 25 MG TABLETS
_____	4	PLAVIX 75 MG TABLETS
_____	4	VERSED 5MG/5ML
_____	2	NORCURON 20 MG VIAL
_____	2	ZOFRAN 2MG/ML INJ 2ml vials
_____	2	<i>FENTANYL 100mcg/2ml</i>

Pharmacy Tech (Print): _____ Pharmacy Tech Signature: _____

Pharmacist Name (Print): _____ Pharmacist Signature: _____

QUINCY AREA EMS SYSTEM
EMS DRUG BOXES RESTOCK LIST / CHARGE SHEET

Date: _____ Reference ## _____ EMS Box # _____

Agency: **QUINCY FIRE DEPARTMENT**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Paramedic Name (PRINT): _____ Paramedic Signature: _____

- ☐ Restock – medications used on patient
- ☐ Restock – medications expired (**Take the expired medication to Pharmacy**)
- ☐ Restock – medications damaged (**Event Report Required**) Comments: _____

☐ Restock – discrepancy in box (**Event Report Required**) Comments: _____

Quantity Needed	Required Number in Box	Medications
_____	2	BOX
_____	3	VERAPAMIL 5MG/2ML VIAL
_____	2	EPINEPHRINE 1:1000 AMP (0.4 mg/ml)
_____	1	NALOXONE 400MCG/ML 10ML VIAL
_____	1	NITROSTAT 0.4MG (1/150GR)
_____	1	OXYTOCIN 10USP UNITS/ML VIAL
_____	4	ALBUTEROL INHALATION SOLUTION 3ML U/D
_____	4	ASPIRIN BABY 81 MG
_____	5	ADENOCARD 6MG/2ML VIAL
_____	2	FUROSEMIDE 100 MG/10ML VIAL
_____	1	DIPHENHYDRAMINE 50MG/ML INJ
_____	2	DIAZEPAM 10MG/2ML CARPUJECT
_____	5	MORPHINE SULFATE 2MG/ML CARPUJECT
_____	2	PROMETHAZINE (PHENERGAN) 25 MG/ML INJ
_____		BAG
_____	1	GLUCAGON 1MG (1 UNIT)
_____	1	10% CALCIUM CHLORIDE ABBOJECT 10ML
_____	1	EPINEPHRINE 1:1000 30ML VIAL
_____	1	MAGNESIUM SULFATE 50% ABBOJECT 10ML
_____	1	PEDIATRIC SODIUM BICARB 8.4% ABBOJECT 10ML
_____	1	INFANT 25% DEXTROSE ABBOJECT 10ML
_____	3	NITROGLYCERIN OINTMENT U/D W/PAPERS
_____	5	ATROPINE 1MG/10ML ABBOJECT
_____	6	EPINEPHRINE 1:10,000 ABBOJECT 10ML
_____	1	2GM LIDOCAINE PREMIX/ 500ML BAG
_____	1	DOPAMINE HCL 800MG/ 500ML BAG
_____	3	LIDOCAINE 2% ABBOJECT 5ML
_____	2	SODIUM CHLORIDE 30ML
_____	2	50% DEXTROSE ABBOJECT 50ML
_____	1	8.4% SODIUM BICARB ABBOJECT 50ML
_____	1	ORAL GLUCOSE (30 GRAM TUBE)
_____	1	METOPROLOL 25 MG TABLETS
_____	4	PLAVIX 75 MG TABLETS
_____	4	VERSED 5MG/5ML
_____	2	NORCURON 20 MG VIAL
_____	2	ZOFRAN 2MG/ML INJ 2ml vials
_____	2	<i>FENTANYL 100mcg/2ml</i>

Pharmacy Tech (Print): _____ Pharmacy Tech Signature: _____

Pharmacist Name (Print): _____ Pharmacist Signature: _____

**QUINCY AREA EMS SYSTEM
EMS DRUG BOXES RESTOCK LIST / CHARGE SHEET**

Date: _____ Reference ## _____ EMS Box # _____

Agency: **QUINCY FIRE DEPARTMENT FOR ACA (MARK ONLY FOR MEDS USED ON PATIENT. BILL ACA)**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Paramedic Name (PRINT): _____ Paramedic Signature: _____

- ☐ Restock – medications used on patient
- ☐ Restock – medications expired (**Take the expired medication to Pharmacy**)
- ☐ Restock – medications damaged (**Event Report Required**) Comments: _____

☐ Restock – discrepancy in box (**Event Report Required**) Comments: _____

Quantity Needed	Required Number in Box	Medications
_____	2	BOX
_____	3	VERAPAMIL 5MG/2ML VIAL
_____	2	EPINEPHRINE 1:1000 AMP (0.4 mg/ml)
_____	1	NALOXONE 400MCG/ML 10ML VIAL
_____	1	NITROSTAT 0.4MG (1/150GR)
_____	1	OXYTOCIN 10USP UNITS/ML VIAL
_____	4	ALBUTEROL INHALATION SOLUTION 3ML U/D
_____	4	ASPIRIN BABY 81 MG
_____	5	ADENOCARD 6MG/2ML VIAL
_____	2	FUROSEMIDE 100 MG/10ML VIAL
_____	1	DIPHENHYDRAMINE 50MG/ML INJ
_____	2	DIAZEPAM 10MG/2ML CARPUJECT
_____	5	MORPHINE SULFATE 2MG/ML CARPUJECT
_____	2	PROMETHAZINE (PHENERGAN) 25 MG/ML INJ
_____		BAG
_____	1	GLUCAGON 1MG (1 UNIT)
_____	1	10% CALCIUM CHLORIDE ABBOJECT 10ML
_____	1	EPINEPHRINE 1:1000 30ML VIAL
_____	1	MAGNESIUM SULFATE 50% ABBOJECT 10ML
_____	1	PEDIATRIC SODIUM BICARB 8.4% ABBOJECT 10ML
_____	1	INFANT 25% DEXTROSE ABBOJECT 10ML
_____	3	NITROGLYCERIN OINTMENT U/D W/PAPERS
_____	5	ATROPINE 1MG/10ML ABBOJECT
_____	6	EPINEPHRINE 1:10,000 ABBOJECT 10ML
_____	1	2GM LIDOCAINE PREMIX/ 500ML BAG
_____	1	DOPAMINE HCL 800MG/ 500ML BAG
_____	3	LIDOCAINE 2% ABBOJECT 5ML
_____	2	SODIUM CHLORIDE 30ML
_____	2	50% DEXTROSE ABBOJECT 50ML
_____	1	8.4% SODIUM BICARB ABBOJECT 50ML
_____	1	ORAL GLUCOSE (30 GRAM TUBE)
_____	1	METOPROLOL 25 MG TABLETS
_____	4	PLAVIX 75 MG TABLETS
_____	4	VERSED 5MG/5ML
_____	2	NORCURON 20 MG VIAL
_____	2	ZOFRAN 2MG/ML INJ 2ml vials
_____	2	<i>FENTANYL 100mcg/2ml</i>

Pharmacy Tech (Print): _____ Pharmacy Tech Signature: _____

Pharmacist Name (Print): _____ Pharmacist Signature: _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS DRUG BOXES SUPPLY LIST

- I. Medications/solutions: It is expected that packaging/concentration of medications may vary according to the pharmacy which supplies the drug box. The total amount of the drug carried in each drug box should be consistent throughout the EMS System.

**adenosine (Adenocard)	6 mg/2 ml vials	5
**albuterol inhalation solution (Proventil, Ventolin)	2.5 mg/3 ml unit dose	4
**aspirin	81 mg tablets	4
**atropine	1 mg/10 ml abboject	5
calcium chloride 10%	100 mg/ml 10 ml abboject	1
**dextrose 50%	25 grams/50 ml abboject	2
dextrose 25% (infant)	2.5 grams/10 ml abboject	1
diazepam (Valium)	10 mg/2 ml syringe	2
*diphenhydramine (Benadryl)	50 mg/ml injectable	1
dopamine (Intropin)	800 mg/500 ml bag (1600 mcg/ml) premix bag	1
**epinephrine 1:10,000	1 mg/10 ml abboject	6
epinephrine 1:1000	1 mg/ml 30 ml multi-dose vial	1
**epinephrine 1:1000	1 mg/ml ampule	3
**furosemide (Lasix)	100 mg/10 ml vial	2
glucagon	1 mg (1 unit)	1
**lidocaine 2%	100 mg/5 ml abboject	3
lidocaine premix	2 gm/500 ml premix bag	1
magnesium sulfate 50%	500 mg/ml 10 ml abboject	1
morphine sulfate	2 mg/ml tubex	5
*naloxone (Narcan)	0.4 mg/ml 10 ml vial	2
nitroglycerin ointment	Unit dose with paper	3
**nitroglycerin	0.4 mg (1/150 gr) tablets 25/bottle	1
oral glucose gel	30 gram tube	1
oxytocin (Pitocin)	10 USP units/ml vial	1
**phenergan	25 mg injectable	2
sodium bicarbonate	1 mEq/ml 50 ml abboject	1
sodium bicarbonate (pediatric)	0.5 mEq/ml 10 ml abboject	1
sodium chloride	0.9% 50 or 100 ml bags	4
sodium chloride	30 ml vial	2
verapamil (Calan)	5 mg/2 ml vial	1
metoprolol	25 mg tablets	4
plavix	75 mg tablets	5
versed	5 mg/5 ml vial	4
norcuron	20 mg vial	2
zofran	2 mg/ml INJ 2ml vials	2
<i>Fentanyl</i>	<i>100mcg/2ml</i>	2

(5 minute meds)

*** These medications will be stored in jump kits on first out ambulances on Adams County Ambulances**

****These medications will be stored in jumpkit and drug box on Adams County Ambulance**

II. Other:

Carpject holder	1
Tubex holder	1
Syringes: 3 ml, 6 ml, 12 ml, 20 ml, 35 ml	2 each
Needles: 22 or 23 gauge 1 inch (IM injection pediatric)	2
22 or 23 gauge 1 ½ inch (IM injection adult)	2
25 or 27 gauge 5/8 inch (SQ injection)	2
Filter needle (draw up solution from ampule)	4
18,19, or 20 gauge 1 inch (IV push, draw up solution from vial)	2
Clave needleless adapter (drug boxes supplied by Blessing Hospital)	1
Microdrip IV tubing	2
Alcohol prep pads	
Medication added labels	
3 way stop cock	
10 ml saline flushes	4



Richard A Saalborn, DO, FACEP, FACOEP
EMS Medical Director



Christopher R Solaro, MD, PhD
EMS Assistant Medical Director

Re:5/98, 8/01, 3/02, 4/05, 6/06, 1/07 12/07, 4/08, 6/08, 11/09,3/10, 9/10, 1/11, 2/11, 2/14, 1/15, 7/15
reviewed: 8/12/02, 5/09

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
ALTERNATE RESPONSE VEHICLE**

EMS DRUG BOXES SUPPLY LIST

- I. Medications/solutions: It is expected that packaging/concentration of medications may vary according to the pharmacy which supplies the drug box. The total amount of the drug carried in each drug box should be consistent throughout the EMS System.

adenosine (Adenocard)	6 mg/2 ml vials	5
albuterol inhalation solution	2.5 mg/3 ml unit dose	4
aspirin	81 mg tablets	4
atropine	1 mg/10 ml abboject	5
dextrose 50%	25 grams/50 ml abboject	2
dextrose 25% (infant)	2.5 grams/10 ml abboject	1
diphenhydramine (Benadryl)	50 mg/ml injectable	1
epinephrine 1:10,000	1 mg/10 ml abboject	6
epinephrine 1:1000	1 mg/ml ampule	3
furosemide (Lasix)	100 mg/10 ml vial	2
lidocaine 2%	100 mg/5 ml abboject	3
magnesium sulfate 50%	500 mg/ml 10 ml abboject	1
naloxone (Narcan)	0.4 mg/ml 10 ml vial	2
nitroglycerin	0.4 mg (1/150 gr) tablets 25/bottle	1
sodium bicarbonate	1 mEq/ml 50 ml abboject	1
sodium chloride	0.9% 50 or 100 ml bags	4
10 ml saline flushes	10ml flush	4

II. Other:

carpuject holder	1
tubex holder	1
syringes: 3 ml, 6 ml, 12 ml, 20 ml, 35 ml	2 each
needles: 22 or 23 gauge 1 inch (IM injection pediatric)	2
22 or 23 gauge 1 ½ inch (IM injection adult)	2
25 or 27 gauge 5/8 inch (SQ injection)	2
Filter needle (draw up solution from ampule)	4
18,19, or 20 gauge 1 inch (IV push, draw up solution from vial)	2
clave needleless adapter (drug boxes supplied by Blessing Hospital)	1
alcohol prep pads	
3 way stop cock	



Richard A Saalborn, DO, FACEP, FACOEP
EMS Medical Director



Christopher R Solaro, MD, PhD
EMS Assistant Medical Director

**QUINCY AREA EMS SYSTEM
BLESSING HOSPITAL CLASS II CONTROLLED DRUGS
RECORD OF PREHOSPITAL ADMINISTRATION**

CONTROLLED SUBSTANCE USAGE FORM

Date	Time	Medication	Amount Given	Amount Wasted	Patient Name	Ordering Physician	Paramedic Signature	RN Signature

Copy of green radio log to be attached

Kelly Cox MD
EMS Medical Director

8/2011

QUINCY AREA EMS SYSTEM
CONTROLLED SUBSTANCE LOG UNIT # _____

O-14 F-2

DATE	TIME	VERSED	MORPHINE	VECURONIUM	VALIUM	FENTANIL	LOCK NUMBER	OFF-GOING PARAMEDIC	ON-GOING PARAMEDIC	COMMENTS

Richard A Saalborn, DO, FACEP, FACOEP
EMS Medical Director

Christopher R Solaro, MD
EMS Associate Medical Director

8/2011; re 1/15

QUINCY AREA EMS SYSTEM
PARAMEDIC CONTRACT FOR CONTROLLED SUBSTANCES

_____ Has read policies O-13A and O-13B and do
understand and will follow the policies on controlled substances to assure we
meet or exceed the requirements for all medications (including all necessary
paperwork) while functioning in the Quincy area EMS System

Print Name

Signature

Date

Kelly Cox, MD
EMS Medical Director

8/2011

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

UTILIZATION OF BLS/ALS NON TRANSPORT TEAM WITHIN THE QUINCY AREA EMS SYSTEM

It is the goal of the Quincy Area EMS System to provide emergency medical assistance to all who are in need of such service within this system. It is recognized however, that there may be an instance in which the need for assistance depletes the regular prehospital emergency care resources. In preparation of such occurrence, the Quincy Area EMS System has incorporated into its plan a procedure for accessing additional BLS/ALS resources to be made available in emergency situations upon request.

OBJECTIVE: To provide prehospital emergency care to patients in need when a transporting ambulance is not immediately available.

I. ADAMS COUNTY: Quincy Fire Department ALS Non-Transport located Quincy, IL

A. Criteria For Implementation:

1. 3A15 unavailable with expected response greater than 4-6 minutes.
2. 3A16 unavailable with expected response greater than 4-6 minutes.
3. Need identified as a bona fide emergency.
4. Response indicated within the Quincy Ambulance District.
5. Response not to assist an incoming ALS or BLS unit.
6. Response to health care facility based upon dispatch information/Adams County Ambulance crew decision.

NOTE: 801 or 802 (ARV's) may respond if available)

B. Staffing:

1. Staffing will be the responsibility of the Quincy Fire Department and will include, but is not limited to, at least one EMT-P and one EMT-B responding to the call.

C. Vehicle Equipment:

1. The responding vehicle will be the Quincy Fire Department Rescue Unit and an appropriate engine company. These designated vehicles will be equipped with emergency care supplies as required by the EMS Medical Director.

D. Procedure For Implementation:

The plan is to be implemented upon receipt of a request for an ambulance when none is available for immediate response.

1. Dispatcher identifies nature of the call.

2. Dispatcher forwards information pertinent to the call to the crew of 3A15 or 3A16.
3. 3A15 or 3A16 crew identifies that all criteria have been met.
4. 3A15 or 3A16 crew directs dispatcher to request assistance from Quincy Fire Department.
5. Dispatcher contacts Quincy Fire Department, makes request, and forwards all pertinent information
6. Quincy Fire Department dispatches appropriate vehicles to the scene.
7. First available ambulance responds to assist Quincy Fire Department and assumes responsibility

II. HANCOCK COUNTY – Nauvoo Fire Department BLS Non-Transport located Nauvoo, IL

A. Criteria for implementation:

1. Call is received by Hancock County Dispatch within the response area of the Nauvoo Fire Department.

B. Staffing

1. Staffing is the responsibility of the Nauvoo Fire Department and will include a minimum of two EMT-B's.

C. Vehicle Equipment

1. The responding vehicle will be equipped with emergency care supplies as required by the EMS Medical Director.

III. It is the responsibility of the Non Transport Team to remain at the scene with the patient(s) while rendering care until responsibility for the patient is transferred over to the ambulance crew. The team shall be responsible to relay pertinent patient information to the receiving hospital and keep that hospital advised of any change in patient status.

IV. Upon completion of a call, the Non Transport Team shall complete the Illinois Patient Care Report form, or other form approved for use in the System..

V. Non-transport agencies are required to have mutual aid agreements on file with transporting ambulance providers.

**QUINCY AREA EMERGENCY MEDICAL SERVICE SYSTEM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

- I. Patients with prolonged illness may invoke the right to choose a person to make health care decisions for them in the event that their mental functions become impaired.
- II. A properly executed Durable Power of Attorney for Health Care is a legal document which formalizes the decision described in I.
- III. EMS personnel should honor patient request expressed through a valid Durable Power of Attorney for Health Care. If a question arises regarding this issue, contact Medical Control for further direction.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM**INFECTION CONTROL****I. HANDWASHING**

- A. All prehospital care personnel must wash their hands before and after contact with any patient regardless of the use of gloves. Utilize an anti-bacterial hand gel/cleaner between patients if handwashing facilities are unavailable.
- B. Each ambulance should carry a 1:10 bleach solution pre-mixed daily or approved commercial cleaner for handwashing whenever there has been direct blood exposure to the skin.

II. NEEDLES AND SYRINGES

- A. Needles must be disposed in a rigid puncture resistant container.
- B. Needles should not be recapped, bent, or broken.
- C. Needle cutting devices should not be used.

III. CLEANSING OF AMBULANCE AND EQUIPMENT

- A. The ambulance and any equipment coming into contact with blood, body fluids or a patient with known or suspected infectious disease should be cleaned with a 1:10 bleach solution or an approved commercial cleaner.
- B. Gloves should be used when cleaning any contaminated surface.

IV. SOILED CLOTHING

- A. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage.

V. MASKS

- A. Masks should be worn whenever there is direct contact with patients that have transmissible respiratory disease (i.e., tuberculosis).
- B. Masks should also be worn whenever there is the risk of blood or body fluids splashing onto mucous membranes.

VI. PROTECTIVE EYE WEAR

Use of glasses or goggles is recommended when there may be splattering of blood or body fluids.

VII. GLOVES

- A. Gloves should be worn when there will be contact with blood or body fluids.
- B. Open cuts or skin dermatitis on prehospital personnel should be covered with a sealed moisture proof covering

VIII. CARDIOPULMONARY RESUSCITATION

- A. Resuscitating masks with one-way valves should be carried on all ambulances.
- B. No one should perform unprotected mouth to mouth resuscitation.

IX. SIGNIFICANT EXPOSURE

- A. Each agency will have a policy in place which will provide guidelines for prehospital personnel who have had a significant exposure to infectious materials.
- B. List of potentially infectious diseases (most common)
 - 1. Human Immunodeficiency Diseases
 - 2. Hepatitis
 - 3. Tuberculosis
 - 4. Meningitis
 - 5. chicken Pox
 - 6. Measles
 - 7. Mumps
 - 8. Rubella
 - 9. Antibiotic resistant infections (MRSA, VRE)

**QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM
POLICY AND PROCEDURE**

PHYSICIAN AT THE OPERATIONAL CONTROL POINT

- I. An operations control point for a Medical Emergency Communications of Illinois (MERCİ) VHF/UHF base station with telemetry receiving and monitoring shall be maintained by the Resource Hospital.
- II. The ECRN at the resource hospital will call the EMS Medical Director or a designated physician to the operational control point (radio) whenever:
 - A. A decision regarding where a patient is to be transported needs to be made by the resource hospital. (see policy O-4)
 - B. Intervention by the resource hospital is indicated. (see policy O-5)
 - C. A major EMS incident is declared.
 - D. When a Quincy ALS unit is requesting permission to respond to a second and simultaneous dual response.
 - E. When an ALS crew is requesting an infield service level downgrade.
- III. The ECRN at the Resource or Associate hospital will call the EMS Medical Director or a designated physician to the operational control point (radio) whenever:
 - A. A patient is reported to have no blood pressure, no pulse, and no spontaneous respirations.
 - B. Orders are requested by prehospital personnel that are inconsistent with system policy and procedure.
 - C. A physician is at the scene requesting medical responsibility for a patient. (see policy O-3)
 - D. A patient refusing care is incapable of making a rational or informed decision to refuse
 - E. A major EMS incident is declared. (see policy O-12)
 - F. Treatment/refusal by a minor (O-6 and O-7)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRANSPORTING TO THE HOSPITAL

- I. The transportation of a patient from the scene to the hospital will be performed under COLD (10-40) conditions (no lights or sirens) except when the patient's condition, signs or symptoms indicate any of the following:
 - A. cardiac or respiratory arrest
 - B. diabetic ketoacidosis or insulin shock
 - C. acute respiratory distress
 - D. anaphylaxis
 - E. decreased level of consciousness
 - F. hypotension
 - G. hypertensive crisis
 - H. amputation
 - I. severe burn (partial thickness burn over 30% BSA, full thickness burns over 5% BSA, inhalation injury)
 - J. chest pain
 - K. O.B. with complications
 - L. status epilepticus
 - M. uncontrolled bleeding
 - N. open or penetrating chest or abdominal wound
 - O. emergency call pending requiring HOT (10-33) response
- II. In the absence of any of the above listed conditions, transport may be provided HOT (10-33) only under direction of the treating hospital.
- III. The treating hospital will be responsible for advising all incoming ambulance of mode HOT (1033) or COLD (10-40) of transport to be used to the hospital, after receiving a patient report.
- IV. Ambulance crews shall advise the Dispatch Center whether they are enroute to the hospital HOT (10-33) or COLD (10-40)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

IN-FIELD SERVICE LEVEL UPGRADES

- I. ALS personnel may board a BLS vehicle in the field to render a higher level of prehospital emergency care thereby temporarily upgrading that BLS vehicle to the status of an ALS vehicle.
 - A. The appropriate ALS equipment, supplies and radios must be transferred to the BLS unit.
 - B. The ALS personnel will assume responsibility for the patient during the remainder of the transport.

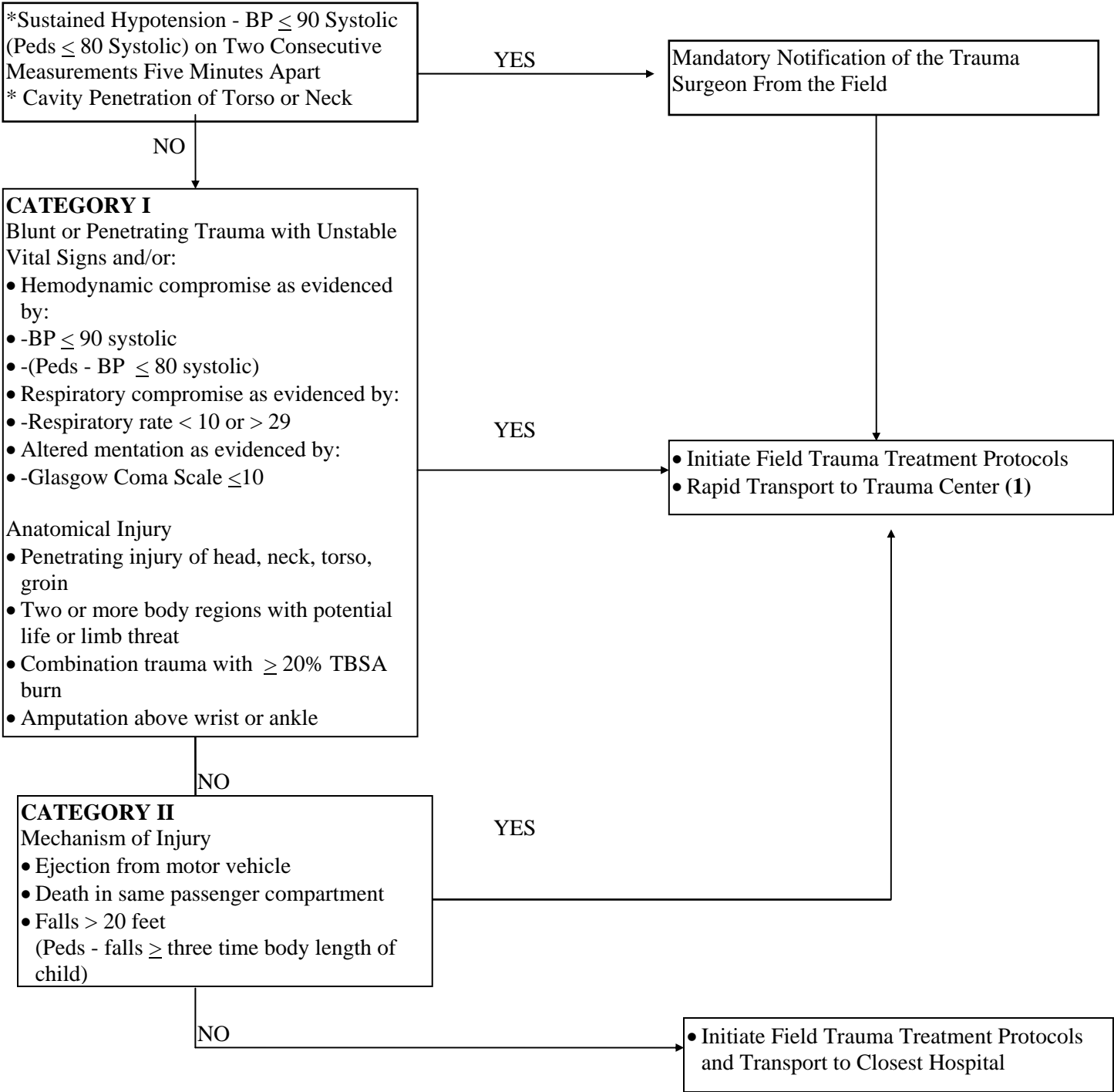
**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

CANCELED AMBULANCES

- I. An ambulance dispatched to the scene of an emergency may honor a request to cancel only under the following circumstances
 - A. A request to cancel is received from an ambulance at the scene that is licensed and staffed at the same or higher level
 - B. A request to cancel is received from an ambulance at the scene that is licensed or staffed at a lower level after that ambulance has given a patient report to the resource or associate hospital.
 - C. A request to cancel is received from an individual EMT, First Responder or First Responder-D at the scene who has identified his/her name, after making a patient report to the resource or associate hospital, and if they acquire a signed refusal of services.
 - D. A request to cancel is received from the patient, patients family, or original caller through the dispatcher.
 - E. In all instances in which an ambulance honors a request to cancel, a Patient Care Report must be completed including documentation of who and under what circumstances the request for cancellation was made.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE TRAUMA TRIAGE CRITERIA

I.



- (1) > 25 minutes from Trauma Center, transport to nearest participating trauma hospital.
> 30 minutes from Trauma Center or participating trauma hospital, transport to nearest hospital.
> 45 minutes from Trauma Center or participating trauma hospital in a rural area where there is no comprehensive emergency department available, transport to nearest hospital.

Trauma Triage Criteria (continued)

- II. Unless delayed by extrication or other mitigating circumstances, the goal is to have a total on-scene time of under 10 minutes. (See Policy #O-23)

Kelly Cox, M.D., EMS Medical Director

re: 4/98, 1/04
(reviewed 8/01)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TRAUMA LOAD AND GO

- I. Certain signs/symptoms require the trauma patient to be immediately loaded onto a spine board, transferred to the ambulance, and transported rapidly with lights and siren. Nonlife-saving procedures (such as splinting and bandaging) may be needed but should be done during transport. Life-saving procedures must not delay transport. The following are critical situations that require “load and go”
 - A. Cardiac/respiratory arrest
 - B. Obstructed airway
 - C. Decreased level of consciousness
 - D. Respiratory difficulty
 - E. Signs of shock
 - F. Injuries that will rapidly lead to shock or respiratory difficulty:
 - * flail chest
 - * open pneumothorax
 - * tender abdomen
 - * unstable pelvis
 - * bilateral femur fractures
 - * poorly controlled major bleeding

- II. Unless delayed by extrication or other mitigating circumstances, the goal is to have a total on-scene time of 10 minutes or less.
 - A. The following procedures are appropriate to provide on scene in a load and go situation.
 - 1. Airway management
 - 2. Oxygen
 - 3. Stabilize flail chest
 - 4. Seal open pneumothorax
 - 5. Needle chest decompression
 - 6. Stabilize impaled objects
 - 7. Spinal immobilization
 - 8. Control major bleeding

 - B. All other procedures including IV therapy, splints, bandaging should be performed enroute unless the patient is entrapped and the procedures can be done during extrication.

6/96, re: 11/97, 8/01

Thomas A. Cliatt, D.O., EMS Medical Director

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DISTRIBUTION OF THE EMS SYSTEM MANUAL

I. PURPOSE:

A copy of the EMS System manual is available at www.blessinghealthsystem.org to each EMS System participant to ensure that they and their employees have an up to date resource for system policies, procedures, and protocols. The manual will include the following sections:

- | | |
|--------------------------------|-----------------------------|
| 1) Additional Procedures | 8) Operational Policies |
| 2) <i>Approved Procedures</i> | 9) Organizational Structure |
| 3) Communications | 10) Pediatric Protocols |
| 4) <i>Continuing Education</i> | 11) Personnel |
| 5) Equipment | 12) Problem Solving |
| 6) Medical Protocols | 13) Quality Assurance |
| 7) Medications | |

II. EMS System Amendments

- A. Upon revision of any portion of the EMS System Plan, participants will be notified by inservice, memorandum, *or email*.
1. Inservices regarding policy/protocol changes will be approved by the Resource Hospital and will include all providers in the system.
 2. Minor revisions of the EMS system plan will be distributed to all providers in the form of a memorandum, letter, *or email via the leader of each service*.

Kelly Cox, MD., EMS Medical Director

11/97;
re: 6/99, 8/01, 1/09, 12/11

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS RESOURCE CENTER

I. EMS Resource Center:

A. Location

1. An audiovisual library containing EMS resources is located in the Blessing Hospital EMS Department.

B. Loan of Materials

1. Students and system participants may utilize materials in the resource center upon availability.
2. Equipment loans will be for no longer than three days or per agreement with the Director of Emergency Medical Services.
3. Videotape, audiotape, periodical or book loans will be for one week or per agreement with the Director of Emergency Medical Services.
4. The borrower is responsible for loaned items and will be billed for the replacement value or repair of any item lost, stolen or damaged while in their possession.
5. Failure to return loaned materials on time may result in refusal of future requests.

II. EMS System Activities/Regional Activities

A. Participants in the EMS System will be notified of activities in the following manner:

1. letter/memorandum
2. announcement at inservices
3. postings on bulletin board in the EMS Department

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DUTY TO PERFORM SERVICES WITHOUT DISCRIMINATION

- I. The Quincy Area EMS System providers will perform all services deemed necessary during an emergency ambulance call without regard to color, race, religion, national origin, sex, ancestry, or age. (See PS-2)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
IN-FIELD SERVICE LEVEL DOWNGRADE**

- I. Purpose: This protocol may be utilized when an ALS crew is requesting to downgrade the level of care for transport from ALS to BLS..
- II. Indications:
 - A. It is expected that this protocol would be used only in a situation where transportation by the ALS crew would leave their county with only BLS resources
 - AND
 - B. The emergency being experienced by the patient is of a nature that does not require ALS procedures
- III. Procedure:
 - A. The EMT-P will thoroughly assess the patient and obtain the history.
 - B. Medical Control at the Resource Hospital will be contacted with a request that the EMS Physician be called to the operational control point (radio).
 - C. The EMT-P will relay the physical assessment data, history and the request to downgrade.
 - D. The EMS Physician will determine whether the call can be downgraded and will relay that information to the EMT-P or will delegate the ECRN to relay this information.
 - E. If the downgrade was approved, the BLS crew will transport the patient. If not approved, the ALS crew will transport the patient and provide the ALS care ordered.
 - F. If patient condition deteriorates at any time during the BLS transport, Medical Control will be contacted immediately and an ALS unit will be sent to assist.
 - G. Document thoroughly.

**QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM
POLICY AND PROCEDURE**

AIR AMBULANCE UTILIZATION PROTOCOL

- I. Purpose:
To assure a mechanism for ground ambulance crews and First Responders to request a scene response by a helicopter air ambulance when specific criteria exist. *In all cases, the dispatch agency will be contacted to assure closest available aircraft is utilized.*
- II. Criteria:
 - A. Category I trauma or seriously ill patient in remote or off-road locations not easily accessible to ground ambulances, or whose location may cause delay in transport time.
 - B. MVC or incident with prolonged extrication time anticipated (> 20 minutes).
 - C. Special environmental conditions such as extreme heat or cold which affect potential patient outcome or prohibit ground access to the hospital (road or bridge damage).
 - D. No available trauma center within 20 minutes by ground transport time.
 - E. Reduction in transport time to a trauma center compared to ground transport for the seriously injured patient
 - F. Ground transport resources are exhausted or exceeded (multi-casualty or multiple calls).
- III. Procedure:
 - A. Determination of need.
 - 1. When dispatch information indicates existence of any of the previous criteria, the responder will initiate helicopter response *by contacting the local dispatch agency.*
 - 2. When preliminary information or mechanism of injury indicates any possibility that helicopter transport may be indicated, *the closest available aircraft* should be immediately placed on standby.
 - 3. After arrival at the scene and a full patient assessment by the ambulance crew, *The closest available aircraft* should be notified whether their response is indicated or if they may be canceled.
- IV. Patient Preparation
 - A. Treat injuries/illnesses per protocol.
 - B. Utilize full spinal immobilization for trauma patients.
 - C. Package all patients for transport on a long spine board.
 - D. Secure all loose objects.
 - E. Provide a concise report to the helicopter crew.

V. Landing Zone Criteria

- A. Landing zone designation and preparation will usually be the responsibility of the responding fire department. If time permits, it is advisable to evaluate the landing zone yourself for safety.
- B. General
 - 1. Solid, fairly flat surface
 - 2. Free of potentially loose debris
 - 3. Free of obstacles such as trees, power/telephone/light poles, wires, vehicles, animals or people
 - 4. Should be located approximately 100 yards from the scene.
- C. Dimensions:
 - 1. Daylight: *100X100* foot area
 - 2. Night: 100X100 foot area

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PROFESSIONAL CONDUCT/CODE OF ETHICS

- I. Prehospital personnel are expected to conduct interaction with patients and colleagues in a manner consistent with the EMT Code of Ethics. Failure to do so could result in suspension from the System (See PS-2)

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

EMS ASSISTANCE FUNDS

- I. The EMS System Coordinator or designee will distribute information regarding available grants to all agencies participating in the system after being made aware that these funds are available.
- II. Any agency receiving grant funds will be responsible for reporting to Illinois Department Public Health every 6 months regarding fund status. Such agencies will also submit a final report consisting of a financial report and brief narrative describing the completed project.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

SYSTEM UTILIZATION OF FIRST RESPONDERS

It is the goal of the Quincy Area EMS System to provide emergency medical assistance to all who are in need of such service within this system. It is recognized however, that there may be an instance in which the need depletes regular prehospital emergency care resources. In preparation of such occurrence, the Quincy Area EMS System has incorporated into its plan, a procedure for accessing additional resources.

- I. Objective: To provide first response services to patients in need of care prior to the arrival of an ambulance or helicopter.
- II. Staffing: In rural areas of the system, first responders and first responder AED's will be recruited and utilized.
- III. Equipment (As a minimum this equipment must be immediately available to the First Responder)
 - A. Triangular bandage
 - B. Roller type bandage
 - C. Universal dressing
 - D. Gauze pads
 - E. Occlusive dressings
 - F. Bandage scissors
 - G. Adhesive tape
 - H. Stick (for impaled object/tourniquet)
 - I. Blanket
 - J. Upper extremity splint
 - K. Lower extremity splint (set)
 - L. O2 equipment and masks (adult and pediatric)
 - M. Bag mask resuscitator
 - N. Oropharyngeal airways (adult, child, infant)
 - O. Optional equipment: AED (for First Responder AED only)

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

PREPAREDNESS TO A SYSTEM-WIDE CRISIS

- I. **Purpose:** Natural and technological crises may place an intense demand on EMS and emergency department resources. The potential exists for these crises to occur or evolve without adequate warning or notification and to overload the resources of the EMS System. Recognition of an impending or active System-wide crisis will better prepare hospitals and ambulance providers within the System to handle the situation.
 - A. Examples of possible System-wide crises:
 1. Heat emergency
 2. Communicable disease
 3. Influenza epidemic
 4. Terrorist act involving a nuclear, biological or chemical agent
- II. **Recognition:** Upon recognition of a potential evolving trend or influx of patients with similar signs and symptoms, the Resource Hospital should be notified. Utilize the System-wide crisis worksheet (O 23-F-1).
 - A. Dispatch agencies may note an unusual increase in the number of calls in one area with patients complaining of similar signs and symptoms
 - B. Ambulance providers may see an unusual increase in calls with patients complaining of similar signs and symptoms
 - C. Participating/Associate hospitals may see an unusual increase of patients with similar symptoms
- III. **Notification**
 - A. The Resource Hospital emergency department shall document any notification received from dispatch agencies, hospitals, or ambulance providers within the System of recognition of a potential evolving trend/potential crisis. Forward all notifications to the EMS System Coordinator, Blessing EMS Department.
 1. If the Resource Hospital receives more than one notification of the same evolving trend/potential crisis, the EMS Medical Director will be notified of the situation.
 2. The EMS System Coordinator or EMS Medical Director will then:
 - a) Check with other agencies in the area to determine if they are also seeing an increase in patients with similar symptoms
 - b) Contact the Illinois Poison Control Center if feasible to see if they are receiving additional calls for similar type problems
 - c) Contact the local health department medical director for further information
 3. If there appears to be a definite trend, either prehospital or hospital, the EMS System Coordinator or EMS Medical Director will page the Emergency Officer for the Illinois Department of Public Health at 1-800-782-7860.

IV. Plan of Action

- A. Once notified that there may be a potential for increased utilization of resources, the EMS System Coordinator will contact dispatch agencies, System hospitals and local ambulance providers to inform them of the situation.
- B. Dispatch agencies will be notified to closely monitor ambulance response and transport times and report increases to the EMS System Coordinator
- C. The EMS System Coordinator will request that each hospital take steps to avoid ambulance diversion and alert them to the possible need to mobilize additional staff, resources or activate their internal disaster plan. Any diversions must meet the criteria found in System Bypass Policy O-24.
- D. If ambulance response and transport times become excessive due to an increase in calls or due to a hospital being on bypass, the Chief of EMS at Illinois Department Public Health will be contacted. The Chief of EMS will assist in contacting emergency department charge nurses and senior administrators of System hospitals to advise them to activate internal disaster plans so that they may rapidly come off bypass. They will be given a specific time frame in which to accomplish this.
- E. During an impending or actual System-wide crisis, the local municipality may request mutual aid through pre-existing agreements from the surrounding areas.
- F. All information should be documented by the EMS System Coordinator or designee on the "System-Wide Crisis Form" (O 23 F1) developed by the Illinois Department of Public Health.

V. All Clear

- A. The Director of Public Health or his designee will contact the Resource Hospital when the response to the crisis appears to be over
- B. The EMS System Coordinator will then contact dispatch agencies, ambulance providers and hospitals within the System to advise same.

Kelly Cox, M.D
EMS Medical Director

10/01, 11/04, 3/05

**EMS PROVIDER/ASSOCIATE & PARTICIPATING HOSPITAL
WORK SHEET
SYSTEM-WIDE CRISIS**

Name of Hospital/Provider

Date

Time

Name of Person Reporting

HOSPITALS ONLY

Number of Patients with Same/Like Symptoms Seen in Last Six (6) Hours

PROVIDERS ONLY

Number of Patients Transported to Emergency Departments by All ambulances
in Our Service with Same/Like Symptoms

Any Increase in Response Time

☐
Yes

☐
No

HOSPITALS AND PROVIDERS

Common Like Complaints by Patients: _____

ANY OTHER PERTINENT INFORMATION: _____

**EMS PROVIDER/ASSOCIATE & PARTICIPATING HOSPITAL
WORK SHEET
SYSTEM-WIDE CRISIS (CONTINUED)**

Resource Hospital Contacted

☐

Yes

☐

No

Person Contacted at Resource Hospital:

Name_____
Title

How was Information Reported?

Phone

☐

Fax

☐

Page

☐

Dedicated Phone Line

☐

Person to Person

☐

Other

☐

Names/Organizations and/or Titles of Other Persons Contacted:

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

SYSTEM BYPASS POLICY

- I. General Bypass Rules apply to all Quincy Area EMS System hospitals).
 - A. The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, during the next business day following any bypass or resource limitation decision. This notification can be faxed. Utilize Form O 33-F)
 1. Fax to: Illinois Department of Public Health at 217-524-0966
 2. Include the following information:
 - a) Name of facility
 - b) Date and time of bypass decision
 - c) Name of person making the bypass decision
 - d) Reason for the bypass decision
 - B. The receiving hospital may direct bypass when current resources are limited for the following conditions:
 1. There are no critical or monitored beds available in the hospital.
 2. An internal disaster has occurred, including but not limited to a power failure.
 3. Staffing is seriously insufficient after attempts have been made to call in additional staff (in accordance with your facility call back policy and internal disaster plan).
 4. For trauma centers, see additional reasons for bypass in Section II.C.
- II. Trauma Bypass: Blessing Hospital as a Level II Trauma Center will provide Trauma Services in compliance with the rules and regulations of the Illinois Trauma Center Code. With respect to a Trauma Bypass Policy, the following shall apply:
 - A. When known, the patient choice of hospital is to be honored with the following **exceptions**:
 1. When the patient is unresponsive, or when the patient's condition does not allow him to make an informed decision and there is no family patient physician or agent with durable power of attorney for health care present to make his desires known.
 2. When the 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 the transport to the more distance facility or trauma center.
 3. When there is a life-threatening condition, a patient may be transported to the closest facility whether or not that facility is on bypass status.
 4. When the patients choice is neither a trauma center or the closest hospital.
 5. When the patients choice of hospital would require the ambulance to travel an unreasonable distance from its primary coverage area.
 - B. The trauma hospital/medical control hospital must be consulted when A: 1,2,3,4,5, above exists. The ambulance crew will contact the hospital and after field assessment is given, the Emergency Department physician will evaluate and decide the disposition of the patient.

- C. The receiving facility may direct bypass when current resources are limited for the following conditions:
 - 1. An internal disaster occurs in the hospital.
 - 2. There are no critical or monitored beds available in the hospital.
 - 3. All staffed operating suites are in use or fully implemented with on-call teams, and at least one or more of the procedures is an operative case.
 - 4. The CAT scan is not working.
- D. Bypass status may not be honored if three or more hospital in the geographic areas are on bypass status and transport time by ambulance to the nearest facility exceeds fifteen (15) minutes.
- E. Bypass may only be initiated if the receiving hospital emergency physician certifies that transport to the farthest hospital would not be detrimental to the patient.
- F. Category I trauma patients should be transported to the nearest trauma center if one is within twenty-five (25) minutes transport time from the scene.

Fax form to IDPH EMS within 24 hours of start of bypass (217/524-0966)

RESOURCE HOSPITAL SYSTEM-WIDE CRISIS FORM

Date: _____

Time: _____

 Name of Resource Hospital

 Name of Person Filling
In Report/Title

 Telephone Number

Name of Associate Hospitals/Participating Hospitals Requesting Bypass or Who Have Seen an Increase in E.D. Visits:

Common Signs/Symptoms of Patients Who are Coming to the Emergency Department:

Name(s) of Provider(s) in the Area Who Have Seen an Increase in Runs:

Name and Time of EMS Coordinator or EMS Medical Director Notification:

Date/Time/Name of Person Notified at the State (i.e., Chief of EMS)

 Name

 How Contacted
(Pager, Phone, Fax)

 Time Notified

 Date Notified

**QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM
EMERGENCY VEHICLE RESPONSE OPERATIONS**

- I. Each agency will develop a policy to be approved by the EMS Medical Director establishing standards of driving specific to response to and transport of patients in both 10-33 and 10-40 mode. These standards will address at a minimum the following:
 - A. Headlights
 - B. Seatbelts
 - C. Speed
 - D. Passing
 - E. Use of warning devices
 - F. Approaching an intersection
 - G. Lane control
 - H. Transporting relatives and friends of patients
 - I. Safe following distances
 - J. Routes
 - K. Pre-call preparation
 - L. Distractions
 - M. All equipment secured in front and rear of ambulance
 - N. Sleep deprivation – specifically on long distance transfers
- II. In January of each year, the EMS Office must receive confirmation that each participant in the EMS System has received copies of their driving policy.
- III. Any person driving an emergency vehicle must meet all state credentialing.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM HAZARDOUS MATERIALS INCIDENTS – EMS RESPONSE

I. General

- A. In general, EMS providers should remain uphill, upwind, upstream and up-grade of a hazardous materials incident. You should follow instructions of the Incident Commander regarding staging and treatment areas.
- B. Individuals who respond to and function within the Hot Zone and Warm Zone must be members of specifically trained HazMat teams, trained in the use of self contained breathing apparatus, selection of appropriate chemical protective suits and how to function in these suits.
- C. Other EMS providers should be trained in HazMat Awareness in accordance with Federal OSHA standards identified in OSHA 29 CFR 1910.120.

II. Definitions

- A. Hot Zone (also known as the Exclusion Zone): is the area immediately around the spill or contamination.
- B. Warm Zone: the area between the Hot Zone and the Cold Zone. This area often includes a holding area for patients awaiting decontamination and the actual decontamination area.
- C. Cold Zone (also known as the Support Area): a clean area outside the contaminated areas. This is a safe area for EMS personnel to receive and begin treatment of contaminated patients. Secondary exposure to hazardous materials is not expected in this area and specialized suits are not required.

III. EMS Interface with HazMat teams

- A. Unified command: in a hazardous materials incident EMS providers and agencies will operate within the unified command structure under the authority having jurisdiction. Due to limited HazMat training, EMS will not usually maintain overall command of the incident.
- B. In the event of multiple casualties, a designated Medical Branch Supervisor may be designated to oversee EMS operations. This should be the senior EMS crew member on site.
- C. EMS will operate in the designated Cold Zone to receive patients after decontamination and to provide treatment/transport.
- D. EMS will relay information regarding the type of chemical and exposure (ingestion, absorption through skin etc.) to Medical Control as soon as that information has been relayed to them from Incident Command.
- E. Medical Control can make recommendations regarding patient treatment based upon the exposure.
- F. The *Bioterrorism Treatment Guidelines* booklet supplied by IDPH may be helpful in the treatment or determination of exposure during an event.
- G. The *Emergency Response Guidebook* may be helpful in the treatment or determination of the chemical and exposure.

IV. Patient management

- A. Contact Medical Control early in the incident for treatment regarding specific exposures.
- B. If a nerve agent or other WMD agent is suspected, follow policy O-36 Nerve Gas Auto-Injector Guidelines.
- C. Follow the major EMS incident plan, policy O-12 if appropriate.

STATE OF ILLINOIS
NERVE GAS AUTO-INJECTOR GUIDELINES

I. Purpose

- A. To provide Illinois EMS agencies with guidelines on the appropriate use of *Mark I/DuoDote* kits.
- B. The *Mark I/DuoDote* kit contains antidotes to be used in instances of exposure to nerve agents such as Sarin, Soman, Tabun, VS or to organophosphate agents such as Lorsban, Cygon, Delnavmalathion, Supracide parathion and carbopenthion.

II. Equipment

- A. Each *Mark I/DuoDote* kit consists of two auto-injectors:
 - 1. atropine sulfate 2 mg in 0.7 mL
 - 2. pralidoxime chloride (2PAM) 600 mg in 2 mL

III. Key provisions

- B. Only those licensed EMS providers governed by the State of Illinois EMS Act (210 ILCS 50/) are authorized by an EMS Medical Director to utilize the specialized equipment and medications needed in Weapons of Mass destruction (WMD) incidents including the *Mark I/DuoDote* auto-injectors.
 - 1. When appropriate conditions warrant, contact medical control.
 - 2. Other organized response teams not governed by the EMS Act may use the *Mark I/DuoDote* auto-injectors on themselves or other team members when acting under the Illinois Emergency Management Agency Act. (20 ILCS 3305)

IV. How to Access/Request *Mark I/DuoDote* Kits

- A. MABAS
 - 1. Contact local dispatch and request the local fire department contact MABAS for kits available in our region.
- B. IDPH
 - 1. Contact Medical Control by MERCI or phone and request CHEM PACKS
 - 2. Medical Control will contact EMS System Coordinator and a request through EMA will be initiated.

V. Guidelines

- A. The guidelines for the use of *Mark I/DuoDote* kits were developed by the EMS Committee of the Illinois College of Emergency Physicians (ICEP). They were then adopted by the Illinois Department of Public Health, the Illinois Terrorism Task Force, Illinois Medical Directors and Mutual Aid Box Alarm System (MABAS) to provide guidance to *EMS agencies and providers who are part of an EMS system*.
- B. There are ten provisions in the guidelines:
 - 1. To utilize these kits you must be an EMS agency or EMS provider within an Illinois EMS System and participate within an EMS disaster preparedness plan.
 - 2. The decision to utilize the *Mark I/DuoDote* antidote kit is authorized by following this State protocol.

3. You must be an Illinois First Responder or EMT at any level with additional training in the use of the auto-injector.
4. The kit is not used for prophylaxis. It is an antidote, not a preventive device. The *Mark I/DuoDote* kit can be self-administered if you are exposed and become symptomatic. You should exit immediately to the Safe Zone for further medical attention.
5. Use of the *Mark I/DuoDote* kit is based on signs and symptoms of the patient. The suspicious or identified presence of a nerve agent is not sufficient reason to administer these medications.
6. Atropine sulfate may be administered IV/IM in situations where *Mark I/DuoDote* kits are not available.
7. Auto-injectors are NOT to be used on children under 88 pounds (40 kilograms). Pediatric *Mark I/DuoDote* injectors are currently under review by the FDA. (See O-36F for pediatric usage)
8. If available, a paramedic or prehospital RN may administer diazepam (Valium) cautiously if seizures are not controlled by the antidote.
9. If the nerve agent was ingested, exposure may continue for some time due to slow absorption from the lower bowel. Fatal relapses have been reported after initial improvement. Continued monitoring and transport is required.
10. If dermal exposure has occurred, decontamination is critical and should be done with standard decontamination procedures. Continued monitoring and transport is required.

VI. Personal protection

- A. The first priority when encountering a potential nerve agent victim is self protection.
- B. Personal protective equipment (PPE) and decontamination are key elements in the successful management of exposed casualties.
- C. All persons entering a HOT Zone or working a decontamination station must wear full protective ensembles including full body and respiratory protection. Persons operating in these zones must be trained in the use of self contained breathing apparatus, selection of appropriate chemical protective suits and how to function in these suits.
- D. Do not cross contaminate yourself when handling patients in triage, treatment and staging areas or if you have begun treatment in the Hot Zone.

VII. Pre-hospital management

- A. Prehospital management for nerve agent or organophosphate poisoning is a two pronged attack focusing on countering the poison with antidotes and preventing death by supporting respirations and controlling seizures.
 1. The primary cause of death from these agents is respiratory failure; therefore aggressive airway control and ventilation are top priorities.
 2. With antidotal therapy, spontaneous respirations should resume within a short period of time.
- B. Notify receiving hospitals prior to transport so they can prepare the facility for your arrival and also consider activating local mass casualty protocols.

VIII. NERVE AGENT RECOGNITION AND TREATMENT

RECOGNITION OF EXPOSURE

1) Signs and symptoms consistent with exposure to nerve or organophosphate agents = mnemonic SLUDGE BAM:

- Salivation = excessive production of saliva
- Lacrimation = excessive tearing of the eyes
- Urination = uncontrolled urine production
- Defecation = uncontrolled bowel movements
- Gastrointestinal distress (cramps)
- Emesis = excessive vomiting

- Breathing difficulty / respiratory failure
- Arrhythmias = irregular heart beat or cardiac abnormalities
- Myosis = pinpoint pupils

- Other neuromuscular and CNS effects: twitching, weakness, paralysis, seizures, confusion, slurred speech

2) Determining severity of exposure

- Severe exposure: unconscious, cyanosis, seizures
- Moderate exposure: vomiting, drooling, pinpoint pupils
- Mild exposure: short of breath, wheezing, runny nose

EXPOSURE	CLINICAL FINDINGS	TREATMENT
Unknown – possibly not exposed	No clinical signs/symptoms	Removal of patient to the Cold Zone, decontamination, observation & transport
Mild exposure	Short of breath, wheezing, runny nose	<ul style="list-style-type: none"> ▪ Administer one <i>Mark I/DuoDote</i> kit or ▪ Atropine 2-4 mg IM/IV AND 2 PAM 600-1200 mg IM or 1 gram IV
Moderate exposure	Vomiting, diarrhea, drooling, pinpoint pupils	<ul style="list-style-type: none"> ▪ Administer one-two <i>Mark I/DuoDote</i> kits or ▪ Atropine 2-4 mg IM/IV AND 2PAM 600-1200 mg IM or 1 gram IV
Severe exposure	Unconsciousness, paralysis, cyanosis, seizures	<ul style="list-style-type: none"> ▪ Administer three <i>Mark I/DuoDote</i> kits in rapid succession (stacked) OR ▪ Atropine 6 mg IM/IV AND ▪ 2 PAM 1800 mg IM or 1 gram IV repeated twice at hourly intervals. ▪ Valium per Medical Control for seizures

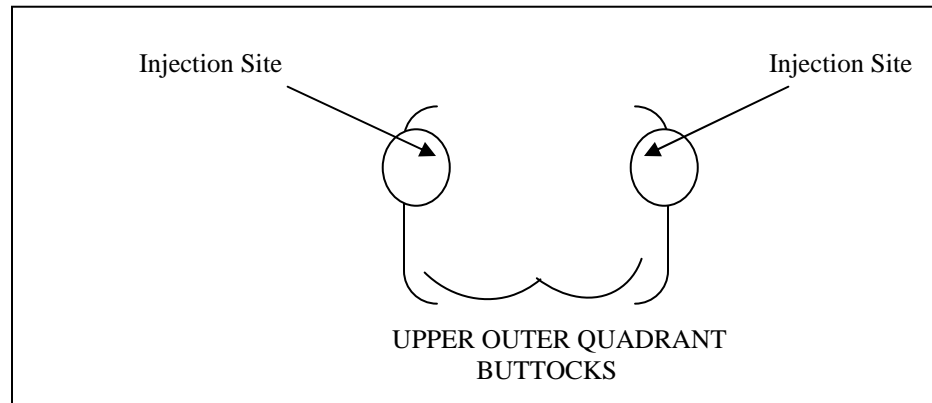
IF SYMPTOMS RESOLVE, CONTINUE TO MONITOR THE PATIENT AND TRANSPORT.

IX. Procedure

IMPORTANT: Do not remove gray safety release until ready to use.

CAUTION: Never touch the green tip (needle end)

- A. Only those persons specifically trained and equipped with the appropriate personal protective equipment should enter the Warm or Hot Zones. (see policy –O-35 Hazardous Materials Incidents-EMS Response)
- B. Injection site selection: the injection site is normally in the outer thigh muscle. If the individual is very thin, the injection can be administered into the upper outer quadrant of the buttocks. See below.



- Immediately put on your protective mask
 - Remove the antidote kit.
 - With your non-dominant hand, hold the auto-injectors by the plastic clip so that the larger auto-injector is on top and both are positioned at eye level.
- C. Arming the auto-injector
 1. With your non-dominant hand, hold the auto-injector by the plastic clip so that the larger auto-injector is on top. Position at eye level.
 2. With your dominant hand, grasp the atropine auto-injector (the smaller of the two) with your thumb and first two fingers.
 3. Do NOT cover or hold the needle end with your hand, thumb or fingers – you might accidentally inject yourself.
 4. Pull the auto-injector out of the clip with a smooth motion. It is now armed and ready to administer.
 - D. Self-administration (You should immediately self-administer the nerve gas antidote if you experience any or all of the nerve agent poisoning symptoms).
 1. Hold the auto-injector with your thumb and two fingers (pencil writing position). Be careful not to inject your self in the hand as this will NOT administer an effective dose.
 2. Position the green (needle) end of the injector against your thigh.
 3. Apply firm even pressure to the injector until it pushes the needle into your thigh.
 4. Hold the injector in place for at least 10 seconds.
 5. Carefully remove the auto-injector from the injection site.
 6. Pull the 2PAM auto injector (the larger of the two) out of the clip
 7. Now inject yourself in the same manner as above holding the black (needle) end against your outer thigh.
 8. Wait 5-10 minutes, during which decontamination procedures should be started.

- E. Administration to a patient in the Hot Zone
1. Squat – do NOT kneel next to the patient. (kneeling can force the chemical agent through your protective clothing).
 2. Apply a mask to the patient
 3. Position the patient on his side
 4. Administer the *Mark I/DuoDote* kit as above in the self-administration section.
 5. Mark, label or tag the patient in such a way that rescuers in the Warm Zone or triage areas can identify that medication has been administered.

X. *Signs and Symptoms of Nerve Agent Exposure*

<i>Exposure</i>	<i>(from mild to severe)</i> <i>Signs & Symptoms</i>
MILD	✓ <i>Unexplained runny nose</i>
↓	✓ <i>Tightness in the chest</i>
MODERATE	✓ <i>Difficulty breathing</i>
↓	✓ <i>Bronchospasm</i>
↓	✓ <i>Pinpoint pupils resulting in blurred vision</i>
SEVERE	✓ <i>Drooling</i>
↓	✓ <i>Excessive sweating</i>
↓	✓ <i>Nausea and/or vomiting</i>
↓	✓ <i>Abdominal cramps</i>
↓	✓ <i>Involuntary urination and/or</i>

STATE OF ILLINOIS
RECOMMENDATIONS*FOR NERVE AGENT THERAPY
PREHOSPITAL MANAGEMENT

		Antidotes ¹	
Patient Age		Mild/Moderate symptoms ²	Severe Symptoms ³
Infant	0-6 months < 7g	Atropine: 0.25 mg IM 2-PAM Cl: 15 mg/kg IM	Atropine: 0.5 mg IM 2-PAM Cl: 25 mg/kg IM
Infant	7 months – 2 years 7-13 kg	Atropine: 0.5 mg IM 2-PAM Cl: 15 mg/kg IM	Atropine: 1 mg IM 2-PAM Cl: 300 mg IM
Child	3-7 years 14-25 kg	Atropine: 1 mg IM 2-PAM Cl: 300 mg IM	Atropine: 2 mg IM 2-PAM Cl: 600 mg IM
Child	8 - 14 years 26-50 kg	Atropine: 2 mg IM 2-PAM Cl: 600 mg IM	Atropine: 4 mg IM 2-PAM Cl: 1200 mg IM
Adolescent	>14 years > 51 kg	Atropine: 2-4 mg IM 2-PAM Cl: 600-1200 mg IM	Atropine: 4-6 mg IM 2-PAM Cl: 1200-1800 mg IM
Adult		Atropine: 2-4 mg IM 2-PAM Cl: 600-1200 mg IM	Atropine: 6 mg IM 2-PAM Cl: 1800 mg IM
Elderly / Frail		Atropine: 1 mg IM 2-PAM Cl: 10 mg/kg IM	Atropine: 2-4 mg IM 2-PAM Cl: 25 mg/kg IM

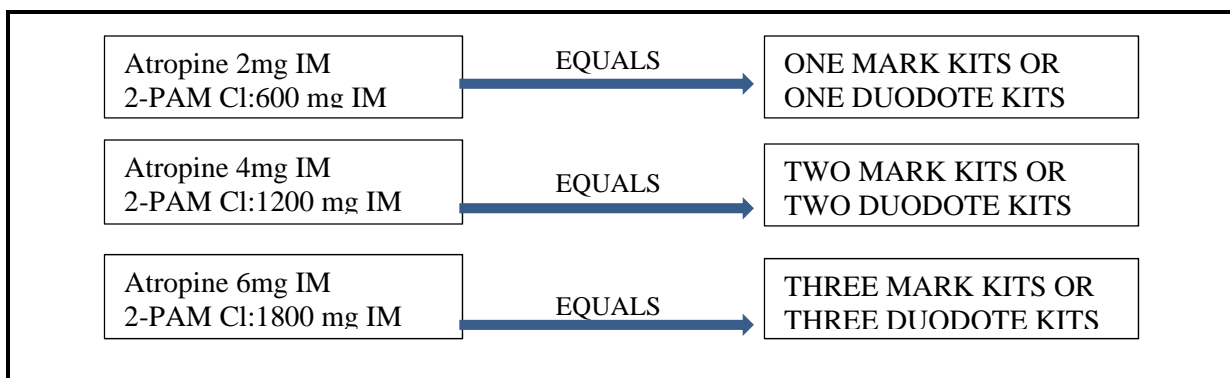
***Weight based chart, then age of patient to determine closing category.**

¹ 2-PAM Cl solution needs to be prepared from the ampule containing 1 gram of desiccated 2-PAM Cl: Inject 3 ml of saline, 5% distilled or sterile water into ampule and shake well. Resulting solution is 3.3 ml of 300 mg/ml.

Symptoms:

² **Mild/Moderate:** localized sweating, muscle fasciculations, nausea, vomiting, weakness, dyspnea

³ **Severe:** unconsciousness, convulsions, apnea, flaccid paralysis



Other Treatment

** Assisted ventilation should be started after administration of antidotes for severe exposures.

** Repeat Atropine at 5-10 min intervals until secretions diminished, breathing comfortable or airway resistance near normal.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

SCHOOL BUS INCIDENT

I. Purpose

This policy governs the handling of school bus accidents/incidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with System's policies including mass casualties. The goal of this policy is to eliminate the transport of uninjured children/students to the hospital and to reduce EMS scene time and utilization of resources.

Each ambulance service provider within the System is required to design and implement a procedure for discharging uninjured children/students to their parents/legal guardians or to local school officials. Such procedures will facilitate transferring custody of uninjured children/students to the parents/legal guardians or school officials consistent with System and Regional policies. It is recommended that these policies be developed in coordination with school officials and provider's legal counsel.

II. Procedure

A. Determine the category of the accident/incident

1. **Category I** bus accident/incident – significant injuries present in one or more children/students or there is a documented mechanism of injury that could reasonably be expected to cause significant injuries.
2. **Category II** bus accident/incident – minor injuries only, present in one or more children/students and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children/students also present.
3. **Category III bus accident/incident – no injuries present in any children/students and no significant mechanism of injury present.**

B. Category II or III bus accident/incident. **Do not implement this policy if the accident/incident is a Category I bus accident/incident** – follow multiple victim and disaster preparedness policies for all Category I bus accident/incidents, and transport all children/students to the hospital.

1. Contact Medical Control, advise of the existence of a Category II or III bus accident/incident and determine if a scene discharge of uninjured children/students by the emergency department physician in charge of the call is appropriate.
2. Injured children/students by exam and/or complaint are treated and transported as deemed necessary and appropriate by EMS personnel or at the request of the child/student.
3. Implement provider procedures for contacting school officials or parent/legal guardians to receive custody of the uninjured children/students consistent with region III policy. Procedure may include option of ambulance service provider escorting bus, if operable, back to school of origin or other appropriate destination.
4. Medical Control, after consulting with scene personnel, will discharge the uninjured children/students to the custody of the ambulance service provider who then will transfer the custody of the children/students, consistent with appropriate department and regional policies and procedures, to patient/legal guardians or school officials.

5. Authorized school representatives will sign the log sheet indicating acceptance of responsibility for the children/students after medical clearance by the EMS personnel finding NO evidence of injury. The school representative will then follow their own policies to include informing the parents/legal guardians as regards the accident/incident.
6. Any child/student having reached the age of 18 or older and any adult non-student present on the bus will initial the log sheet adjacent to their name and address when in agreement that they have suffered no injury and are not requesting medical care and/or transport to the hospital.
7. Complete one Prehospital Care Report Form in addition to the School Bus Incident Form.

This policy addresses discharge disposition of uninjured children/students only. Thus, no release/AMA signatures are necessary. An isolated abrasion/superficial wound can be regarded as uninjured should the EMS personnel, Medical Control, and the child/student all concur.

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

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
SCHOOL BUS INCIDENT LOG

All individuals on the bus age 18 and older should initial in the indicated space adjacent to their name when uninjured. Parent/legal guardian should initial in the indicated space adjacent to their child's name when uninjured. Initials indicate agreement that no injury has been suffered and no transportation is required to the hospital.

Date:	Location:	District Name:	Bus Number:
Time of Incident:			

Run Report #	Dept. Alarm #:	Total # of Persons	# Transported	# Not Transported:

Adult Name (Non-student)	Function	Address & Telephone	Initials

Child/student Name	Age	Address & Telephone	Initials if age >18 or parent/guardian

The children/students listed above have been determined to be uninjured. Medical Control has been contacted and approved release to the custody of school officials (or parent/legal guardian) or to self if age 18 or older.

Name of (EMS) Ambulance Service Provider

Name of School authorized representative

Signature

Date

Signature

Date

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
SCHOOL BUS INCIDENT LOG

Notice of Emergency Medical Services Response to a Minor

DATE:

FROM: (Chief or President of Provider Agency)
(Provider Agency)
(Address)
(Phone number to contact)

CHILD'S NAME:

Members of our Emergency Medical Services agency were called to evaluate your son/daughter/ward today as a result of a bus collision/incident

After responding to the above incident, we evaluated the child. Based on our assessment and statements made by the child, it was determined that he or she did not require emergency care and/or transportation to an emergency department at that time

QUINCY AREA EMERGENCY MEDICAL SERVICE SYSTEM

CONCEAL CARRY POLICY

I. Purpose

- A. The purpose of this policy is to outline the responsibilities of EMS providers regarding the carrying, (concealed or not concealed) of a weapon.

II. Policy:

- A. The Quincy Area Emergency Medical Service policy is that EMS personnel who have a Conceal Carry Weapon permit shall not knowingly bring any firearm onto any prohibited area.
- B. At no time shall open carry ("OC") &/or Conceal Carry Firearm ("CCW") be permitted when on official EMS business, to include: meetings, emergency response, training or any other function of the QAEMS area or on any EMS organizations' properties. The only exception to this is if the EMS provider is a sworn law enforcement officer that is on duty at the time. (If functioning as an EMS provider, the weapon should be secured at home or in their vehicle.)
- C. It is further the policy of QAEMS that patients and visitors shall not have weapons on their persons while on any and all EMS property which also includes transport and/or non-transport vehicles.
- D. If functioning as a TEMS "Tactical EMS", weapons may be carried if activated for a tactical response.

III. General Guidelines:

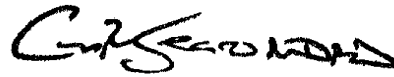
- A. EMS Agencies are encouraged to designate themselves as a weapons-free facility. No-carry signage should be clearly posted in emergency squads and EMS facilities. Law enforcement shall be called if patients insist on carrying weapons in emergency vehicles or in hospitals that have carrying weapons in emergency vehicles or in hospitals that have declared themselves as no-carry zones.
- B. At no time shall open carry ("OC") &/or Conceal Carry Firearm ("CCW") be permitted when on official EMS business, to include: meetings, emergency response, training or any other function of the Region 3 area or on any EMS organizations' properties. The only exception to this is if the EMS provider is a sworn law enforcement officer that is on duty at the time. (If functioning as an EMS provider, the weapon should be secured at home or in their vehicle.)
- C. Under no circumstances should an emergency responder or healthcare worker compromise his/her safety in regards to these guidelines. When in doubt about a patient with a weapon or the weapon itself, emergency responders and healthcare personnel should contact local law enforcement while treating your patient. Use "situational awareness" on all calls.

NOTE: *Do not ask the patient whether he/she has the right to carry a weapon. If the person has no legal right, they may become alarmed and cause EMS personnel harm.*

Until specific procedures have been approved, all EMS providers should assure a safe scene before treatment should begin.



Richard A Saalborn, DO, FACEP, FACOEP



Christopher R Solaro, MD, PhD

2/2015

QUINCY AREA EMS SYSTEM

EMS SYSTEMI. Medical Facilities**Resource Hospital**

- A. Name of Facility: Blessing Hospital, Broadway at 11th, PO 7005, Quincy, IL 62305-7005
- B. EMS Medical Director: Kelly Cox, M.D.
- C. Alternate EMS Medical Director: Richard Saalborn, D.O.
- D. EMS Administrative Director: Kathy Muder, R.N.
- E. EMS Manager: Sandy Behl
- F. EMS System Coordinator: Randy L. Faxon, NREMT-P
- G. Trauma Coordinator: Michael Richard, R.N.
- H. SEMSV Medical Director: Kelly Cox, M.D.
- I. Prehospital Coordinator: Marcheta Hays, R.N., EMT-P
- J. Emergency Preparedness Coordinator: Erica Russell

Associate Hospital

- A. Name of Facility: Illini Community Hospital
- B. Medical Director: Travis Moore, D.O.
- C. Administrator: Connie Schroeder
- D. EMS Coordinator/Emergency Room Manager: Kathy Willman

Participating Hospital

- A. Name of Facility: Carthage Memorial Hospital
- B. Medical Director: Edward McKenney, D.O.
- C. Administrator: Ada Bair
- D. Emergency Room Supervisor: *Carla Rodeffer, RN*

II. Prehospital ServicesA. **SEMSV: Air Evac Helicopters**

Location	Agency	Contact Person
a) Quincy	Air Evac Lifeteam	<i>Joe Grygiel</i>
b) Mt Vernon	Air Evac Lifeteam	<i>Joe Grygiel</i>
c) Springfield	Air Evac Lifeteam	<i>Joe Grygielt</i>
d) Effingham	Air Evac Lifeteam	<i>Joe Grygiel</i>
e) Marion	Air Evac Lifeteam	<i>Joe Grygielt</i>
f) Troy, MO	Air Evac Lifeteam	<i>Joe Grygiel</i>
g) Evansville, IN	Air Evac Lifeteam	<i>Joe Grygiel</i>
h) Ft. Madison, IA	Air Evac Lifeteam	<i>Joe Grygiel</i>
i) Brazil, IN	Air Evac Lifeteam	<i>Joe Grygiel</i>
j) Perryville, MO	Air Evac Lifeteam	<i>Joe Grygiel</i>
k) Sikeston, MO	Air Evac Lifeteam	<i>Joe Grygiel</i>

B. ALS Transport Units

Location	Unit ID	Service Area	Agency	Contact Person
1. ADAMS COUNTY				
a) Quincy	3A15	Adams County	Adams County Ambulance EMS	Paul Davis
b) Quincy	3A16	Adams County	Adams County Ambulance EMS	Paul Davis
c) Camp Point	3A17	Adams County	Adams County Ambulance EMS	Paul Davis
d) Mendon	3A18	Adams County	Adams County Ambulance EMS	Paul Davis
e) Liberty	3A19	Adams County	Adams Count Ambulance EMS	Paul Davis
2. BROWN COUNTY				
a) Mt.Sterling	3B19	Brown County	Brown County Amb Service	Brian Gallaher
b) Mt.Sterling	3B16	Brown County	Brown County Amb Service	Brian Gallaher
3. HANCOCK COUNTY				
a) Carthage	3A30	Hancock County	Hancock County Ambulance	Perry Cameron
b) Carthage	3A31	Hancock County	Hancock County Ambulance	Perry Cameron
4. PIKE COUNTY				
a) Pittsfield	3G14	Pike County	Pike County EMS	<i>Adam Hammitt</i>
b) Pittsfield	3G19	Pike County	Pike County EMS	<i>Adam Hammitt</i>

C. ALS Non-transport Units

Location	Service Area	Agency	Contact Person
1. ADAMS COUNTY			
a. Adams County 801	Adams County	Adams County Ambulance EMS	Paul Davis
b. Adams County 802	Adams County	Adams County Ambulance EMS	Paul Davis
2. QUINCY RESCUE	Adams County	Quincy Fire Department	Joe Henning

D. BLS Transport Units

Location	Unit ID	Service Area	Agency	Contact Person
1. BROWN COUNTY				
a) Mt.Sterling	3B15	Brown County	Brown County Ambulance Service	Brian Gallaher
b) Mt.Sterling	3B14	Brown County	Brown County Ambulance Service	Brian Gallaher
2. HANCOCK COUNTY				
a) Augusta	3A25	Hancock County	Hancock County Ambulance	Perry Cameron
b) Warsaw	3A14	Hancock County	Hancock County Ambulance	Perry Cameron
c) Carthage	3A22	Hancock County	Hancock County Ambulance	Perry Cameron
d) Carthage	3A28	Hancock County	Hancock County Ambulance	Perry Cameron
e) Nauvoo	3A78	Nauvoo	Nauvoo Fire Rescue	Dan Gallaher
3. PIKE COUNTY				
a) Pittsfield	3G12	Pike County	Pike County EMS	<i>Adam Hammitt</i>
b) Pittsfield	3G17	Pike County	Pike County EMS	<i>Adam Hammitt</i>
c) Griggsville	3G11	No Pike County	Pike County EMS	<i>Adam Hammitt</i>
d) Pleasant Hill	3G13	So Pike County	Pike County EMS	<i>Adam Hammitt</i>
e) Hull	3G15	Hull/Kinderhook	Pike County EMS	<i>Adam Hammitt</i>

E. BLS Non-transport Units

Nauvoo Rescue	Nauvoo	Nauvoo Fire Department	Dan Gallaher
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E. First Responders

Location	Agency	Contact Person
1. ADAMS COUNTY		
a) ACERS	Adams County Emergency Responders	<i>Brad Denton</i>
b) Tri-Township	Adams County	Rick Zaer
c) Payson	Payson Fire & Rescue	Ken Steffen
2. BROWN COUNTY		
Versailles Fire Dept	Versailles	Curt Hannig
3. HANCOCK COUNTY		
a) West Point (Hancock Co)	West Point Fire Dept Response Area	
b) Warsaw Fire Department	Warsaw FD First Responders	Steve Siegreist
c) Warsaw Ambulance	Warsaw Ambulance First Responders	Perry Cameron

III. Minimum Staffing Criteria For Program Participation

Resource Hospital	At least 1 ECRN nurse and 1 EMS physician in-house 24 hours.
Associate Hospital	At least 1 ECRN nurse and 1 EMS physician in-house 24 hours
Participating Hospital	At least 1 RN 24 hours in-house and 1 physician available on call 24 hours.
ALS Transport	At least 1 EMT/P and 1 EMT/B
BLS Transport	At least 2 EMT/B's
ALS Non-transport	At least 1 EMT/P and 1 EMT/B
BLS Non-transport	At least 2 EMT/B's
FR Non-transport	At least 1 First Responder

***NOTE: On volunteer BLS ambulances only, the ambulance may respond to the scene and meet additional crew members at the scene. The ambulance cannot transport unless fully staffed.**

Kelly Cox, M.D.
EMS Medical Director

re: 12/84, 6/87, 11/87, 8/89, 9/92, 3/94, 8/96, 4/98, 12/99, 8/01,
8/02, 8/05, 2/07, 9/08, 12/08, 4/10

QUINCY AREA EMS SYSTEM

Definitions of Organizations within the EMS system

First Responder Services: a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the First Responder curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

BLS Non-Transport: a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

BLS-Transport: a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act). Transport in a BLS ambulance

ALS Alternate Response Vehicle: Ambulance assistance vehicles are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. These assistance vehicles include fire engines, trucks, squad cars or chief's cars that contain the staff and equipment required by this Section. These vehicles shall not function as assist vehicles if staff and equipment required by this Section are not available. These vehicles shall be identified by the agency as a program plan amendment outlining the type and level of response that is planned. The vehicle shall not be a primary response vehicle but a supplementary vehicle to support EMS services. The vehicle shall be dispatched only if needed. (Section 515.825)

ALS Non-Transport: an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act).

ALS Transport: an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act). Transport in an ALS ambulance.

Specialized Emergency Medical Services Vehicle or SEMSV – a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads. (Section 3.85 of the Act)

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprehensive Emergency Department with 24-hour physician coverage. It must have a functioning Intensive Care Unit and/or a Cardiac Care Unit.

Participating Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital.

Resource Hospital – the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire program, including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.



Kelly Cox, MD, EMS Medical Director

4/2010
Reviewed: 10/2012

QUINCY AREA EMS SYSTEM
REGION 3 STANDARD MEDICAL PROTOCOL: PEDIATRICS

Standard Medical Protocols.....	PED 1.1
BLS Cardiac-respiratory arrest.....	PED-2.1
ALS Cardiac-respiratory arrest	PED-2.2
BLS Bradycardia	PED-3.1
ALS Bradycardia.....	PED-3.2
BLS Tachycardia.....	PED-4.1
ALS Tachycardia.....	PED-4.2
BLS Respiratory Arrest.....	PED-6.1
ALS Respiratory Arrest.....	PED-6.2
BLS Respiratory Distress	PED-7.1
ALS Respiratory Distress.....	PED-7.2
BLS Tracheostomy with Respiratory Distress	PED-8.1
ALS Tracheostomy with Respiratory Distress	PED-8.2
BLS Shock.....	PED-9.1
ALS Shock	PED-9.2
BLS Allergic Reaction	PED-10.1
ALS Allergic Reaction	PED-10.2
BLS Seizures	PED-11.1
ALS Seizures.....	PED-11.2
BLS Altered Level of Consciousness.....	PED-12.1
ALS Altered Level of Consciousness	PED-12.2
BLS Toxic Exposures/Ingestion.....	PED-13.1
ALS Toxic Exposures/Ingestion	PED-13.2
BLS Hypothermia	PED-14.1
ALS Hypothermia	PED-14.2
BLS Hyperthermia	PED-15.1
ALS Hyperthermia	PED-15.2
BLS Near Drowning.....	PED-16.1
ALS Near Drowning	PED-16.2
BLS Burns	PED-17.1
ALS Burns.....	PED-17.2
BLS Trauma	PED-18.1
ALS Trauma.....	PED-18.2
BLS Head Trauma.....	PED-19.1
ALS Head Trauma	PED-19.2
BLS & ALS Suspected Child Abuse & Neglect	PED-20.1
BLS Neonatal Resuscitation.....	PED-21.1
ALS Neonatal Resuscitation	PED-21.2

**QUINCY AREA EMS SYSTEM
REGION #3 STANDARD MEDICAL PROTOCOLS
PEDIATRIC INITIAL ASSESSMENT
ALS/BLS GUIDELINE**

I. Scene size up

- Identify possible hazards.
- Assure safety for patient and responder.
- Observe for mechanism of injury/nature of illness.
- Note anything suspicious at the scene, i.e., medications, household chemicals, other ill family members.
- Assess any discrepancies between the history and the patient presentation, i.e., infant fell on hardwood floor; however floor is carpeted.
- Initiate appropriate body substance isolation (BSI) precautions.
- Determine the number of patients.

II. General Approach to the Stable/Conscious Pediatric Patient

- A. Assessments and interventions must be tailored to each child in terms of age, size and development.
- Smile if appropriate to the situation.
 - Keep voice at even quiet tone, don't yell.
 - Speak slowly; use simple, age appropriate terms.
 - Use toys or penlight as distractors; make a game of assessment.
 - Keep small children with their caregiver(s); encourage assessment while caregiver is holding child.
 - Kneel down to the level of the child if possible.
 - Be cautious in use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
 - Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, LMP, sexual activity, child abuse.
- B. While walking up to the patient, observe/inspect the following:
- General appearance, age appropriate behavior. Does child have a malnourished appearance? Is child looking around, responding with curiosity or fear, playing, sucking on a pacifier or bottle, quiet, eyes open but not moving much or uninterested in environment?
 - Obvious respiratory distress/increased work of breathing: retractions, nasal flaring, accessory muscle use, head bobbing, grunting.
 - Color: pink, pale, flushed, cyanotic, mottled.
 - Position of the child. Are the head, neck or arms being held in a position suggestive of spinal injury? Is the patient sitting up or tripodding?
 - Level of consciousness, i.e., awake vs asleep or unresponsive.
 - Muscle tone: good vs limp.
 - Movement: spontaneous, purposeful, symmetrical.
 - Obvious injuries, bleeding, bruising, impaled objects or gross deformities.
 - Assess for pain.
 - Determine weight - ask child or caretakers or use length/weight tape.

III. Initial Assessment

- A. Airway Access/Maintenance with Cervical Spine Control
- Maintainable with assistance: positioning.
 - Maintainable with adjuncts: oral airway, nasal airway.
 - Maintainable with endotracheal tube.
 - Listen for any audible airway noises, i.e., stridor, snoring, gurgling, wheezing.
 - Patency: suction secretions as necessary.

- B. Breathing
 - Rate and rhythm of respirations. Compare to normal rate for age and situation.
 - Chest expansion: symmetrical.
 - Breath sounds: compare both sides and listen for sounds (present, absent, normal, abnormal).
 - Positioning: sniffing position, tripod position.
 - Work of breathing: retractions, nasal flaring, accessory muscle use, head bobbing, grunting.
- C. Circulation
 - Heart rate: compare to normal rate for age and situation.
 - Central/truncal pulses (brachial, femoral, carotid): strong, weak or absent.
 - Distal/peripheral pulses: present/absent, thready, weak, strong.
 - Color: pink, pale, flushed, cyanotic, mottled.
 - Skin temperature: hot, warm, cool.
 - Blood pressure: compare to normal for age of child. Must use appropriately sized cuff.
 - Hydration status: anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output history.
- D. Disability - Brief Neuro Examination
 - Assess Responsiveness
 - A** Alert
 - V** Responds to verbal stimuli
 - P** Responds to painful stimuli
 - U** Unresponsive
 - Assess pupils.
 - Assess for transient numbness/tingling.
- E. Expose and Examine
 - Expose the patient as appropriate based on age and severity of illness.
 - Initiate measures to prevent heat loss and keep the child from becoming hypothermic.

IV. Focused History/Physical Assessment

Tailor assessment to the needs of the patient. Rapidly examine areas specific to the chief complaint.

- A. Patient History - Acquire during/incorporate into physical exam.
 - S Signs & Symptoms** as they relate to the chief complaint.
 - A Allergies** to medications, foods, environment
 - M Medications:** prescribed, over-the-counter, compliance with prescribed dosing regimen, time, date and amount of last dose
 - P Past Pertinent Medical History**
 - Pertinent medical or surgical problems
 - Preexisting diseases/chronic illness
 - Previous hospitalizations
 - Currently under medical care
 - For infants, obtain a neonatal history (gestation, prematurity, congenital anomalies, was infant discharged home at the same time as the mother)
 - L Last oral intake** of liquid/food ingested.
 - E Events surrounding current problem**
 - Onset, duration and precipitating factors
 - Associated factors such as toxic inhalants, drugs, alcohol
 - Injury scenario and mechanism of injury
 - Treatment given by caregiver
- B. Responsive Medical Patients
 - Perform rapid assessment based on chief complaint. A full review of systems may not be necessary. If chief complaint is vague, examine all systems.
- C. Unresponsive Medical Patients
 - Perform rapid assessment: ABC's, quick head-to-toe exam.
 - Emergency care is based on signs/symptoms, initial impressions and standard operating procedures

- D. Trauma patient with **NO** significant mechanism of injury.
 - Focused assessment is based on specific injury site.
- E. Trauma patient **WITH** significant mechanism of injury
 - Perform rapid assessment of all body systems.

V. Detailed Assessment

- A. Performed to detect non-life threatening conditions and to provide care for those conditions/injuries. Usually performed enroute. May be performed on scene if transport is delayed.
 - Inspect and palpate each of the major body systems for the following:
 - Deformities
 - Contusions
 - Abrasions
 - Penetrations/punctures
 - Burns
 - Lacerations
 - Swelling/edema
 - Tenderness
 - Instability
 - Crepitus
 - Auscultation of breath and heart sounds as well as blood pressure readings may be required in the field.

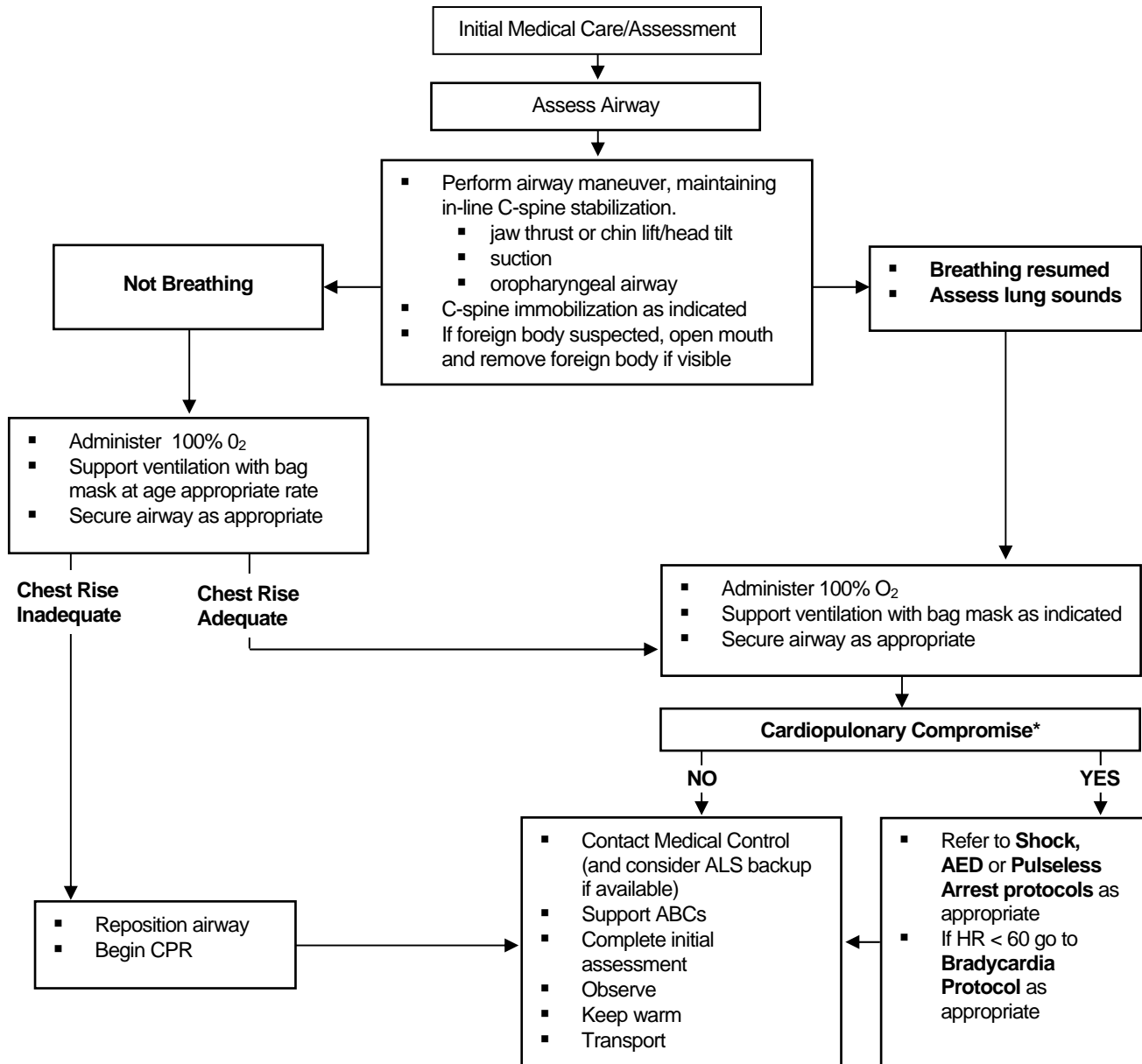
VI. Ongoing Assessment

To effectively maintain awareness of changes in the patient's condition, repeated assessments are essential and should be performed **at least every 5 minutes on the unstable patient**, and **at least every 15 minutes on the stable patient**.

VII. Considerations for Children with Special HealthCare Needs (CSHCN)

- Track CSHCN in your service community and become familiar with both the child as well as their anticipated emergency care needs.
- Refer to child's emergency care plan formulated by their medical providers, if available. Understanding the child's baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional level/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
- Regardless of underlying condition, assess in a systematic and thorough manner.
- Use parents/caregivers/home health nurses as medical resources at home and enroute.
- Be prepared for differences in airway anatomy, physical development, cognitive development and possibly existing surgical alterations or mechanical adjuncts. Common home therapies include: respiratory support (oxygen, apnea monitors, pulse oximeters, tracheostomies, mechanical ventilators), nutrition therapy (nasogastric or gastrostomy feeding tubes), intravenous therapy (central venous catheters), urinary catheterization or dialysis (continuous ambulatory peritoneal dialysis), ostomy care, orthotic devices, communication or mobility devices, or hospice care.
- Communicate with the child in an age appropriate manner. Maintain communication with and remain sensitive to the parents/caregivers and the child.
- The most common emergency encountered with these patients is respiratory related and so familiarity with respiratory emergency interventions/adjuncts/treatment is appropriate.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC CARDIAC/RESPIRATORY ARREST
BLS CARE GUIDELINE**

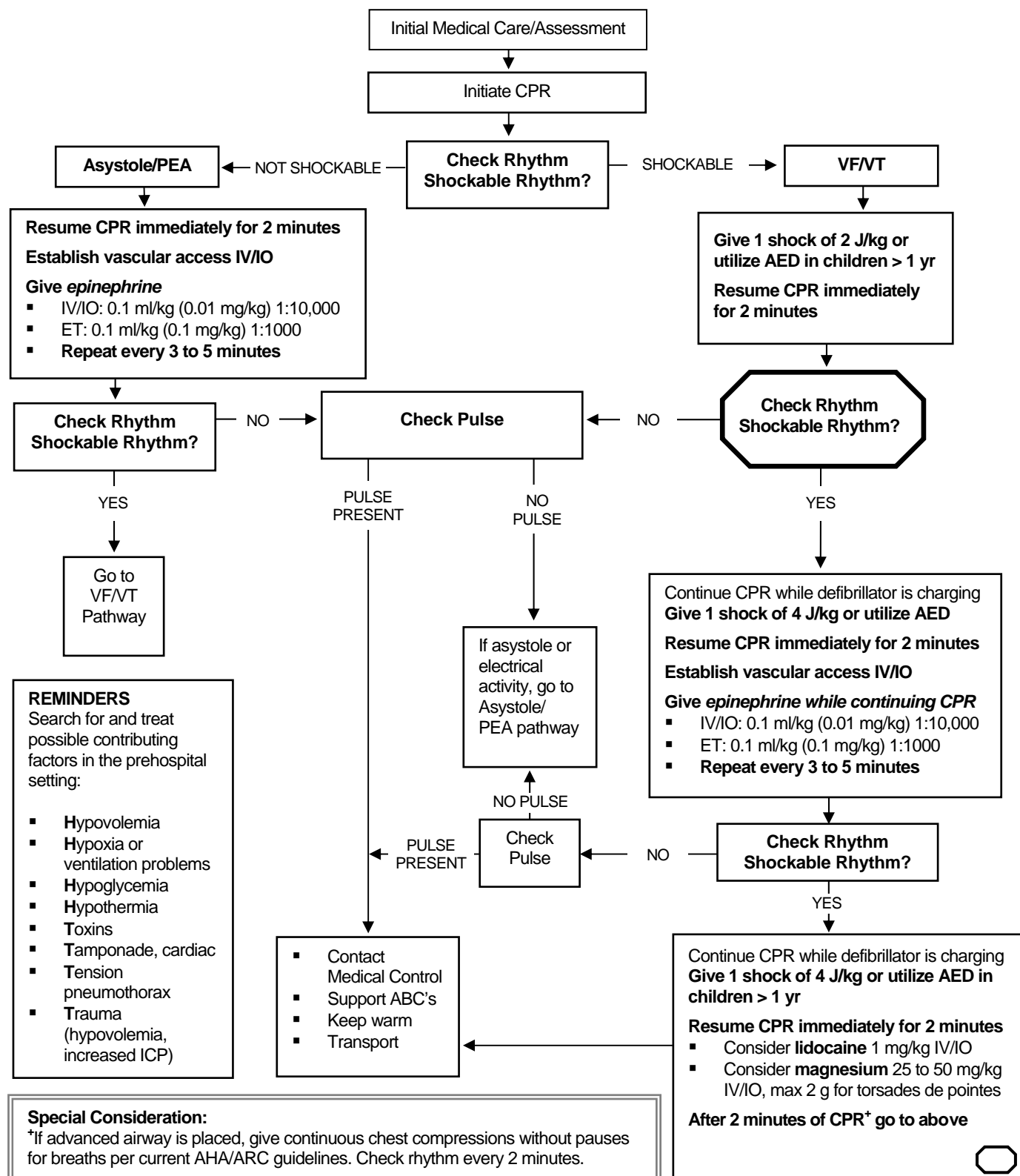


Special Considerations:

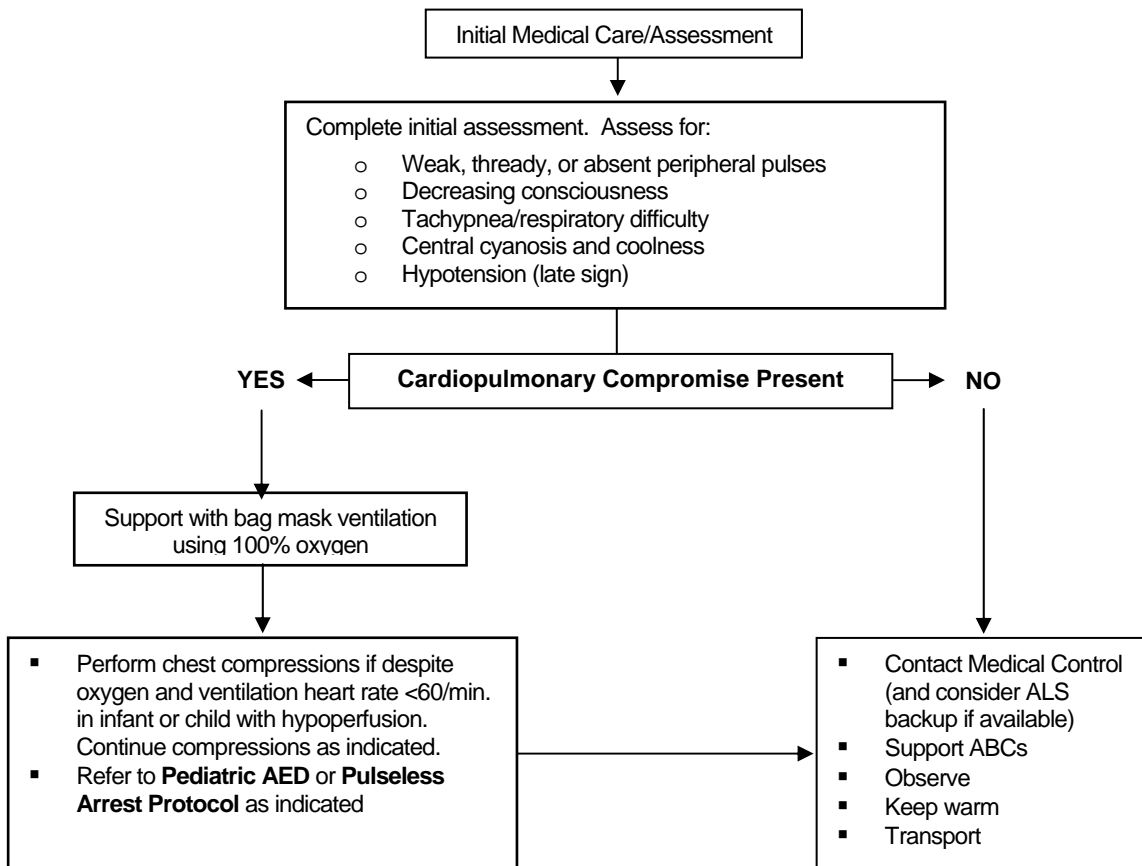
- Respiratory arrest may be a presenting sign of a toxic ingestion, metabolic disorder or anaphylaxis.
- Refer to Respiratory Distress Protocol as appropriate.

*Refer to Vital Signs and Cardiopulmonary Compromise Resource for signs and symptoms of decreased perfusion in children.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC CARDIAC/RESPIRATORY ARREST
ALS CARE GUIDELINE**



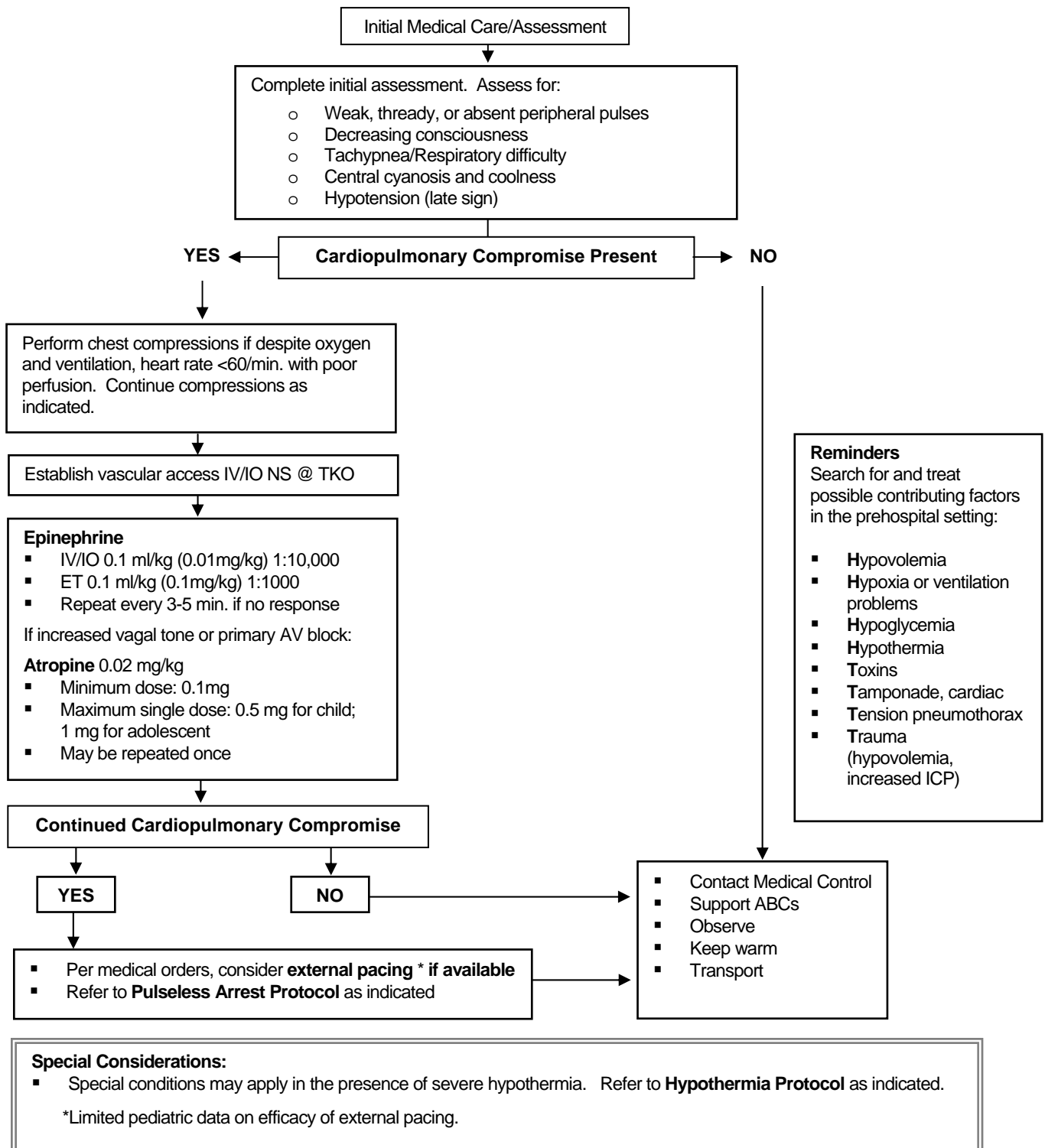
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
BRADYCARDIA PROTOCOL
BLS CARE GUIDELINE**



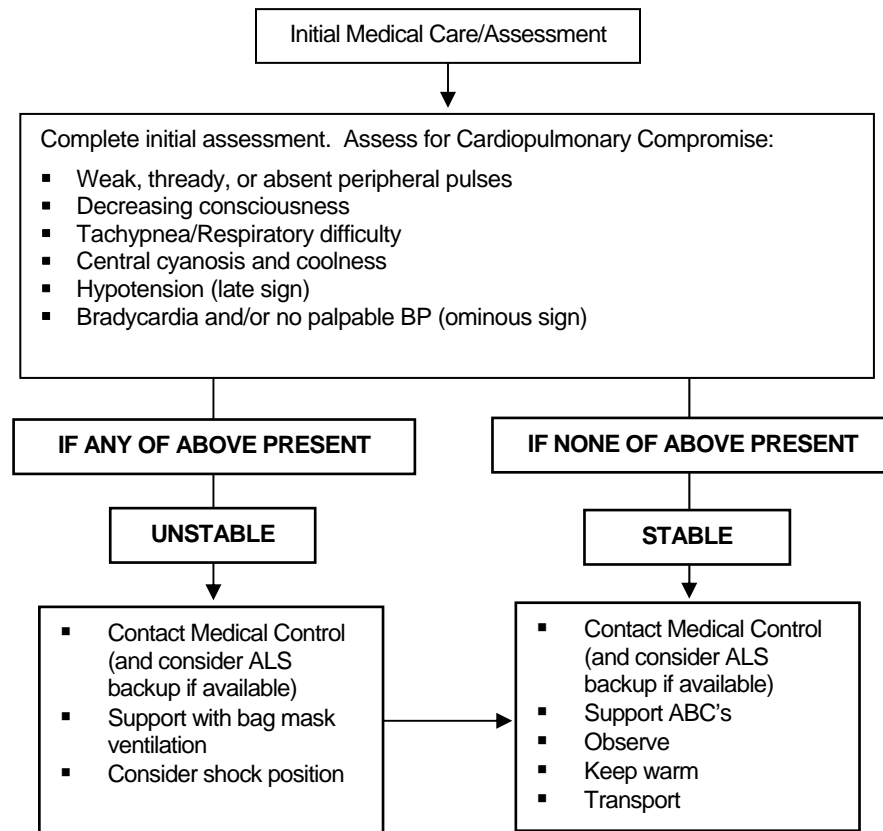
Special Considerations:

- Hypoglycemia has been known to cause bradycardia in infants and children.
- Special conditions may apply in the presence of severe hypothermia. Refer to **Hypothermia Protocol** as indicated.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
BRADYCARDIA PROTOCOL
ALS CARE GUIDELINE**



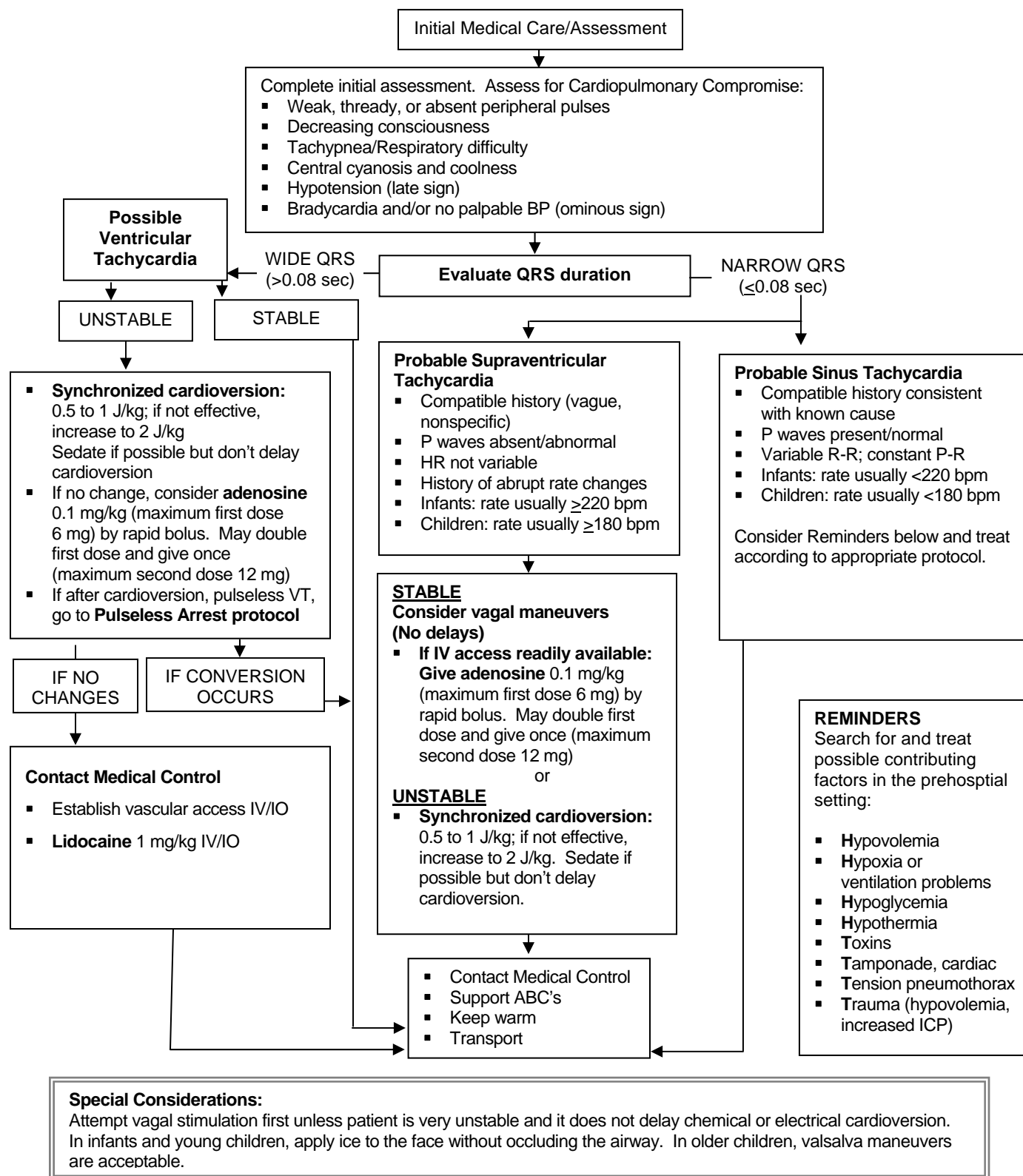
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
TACHYCARDIA PROTOCOL
BLS CARE GUIDELINE**



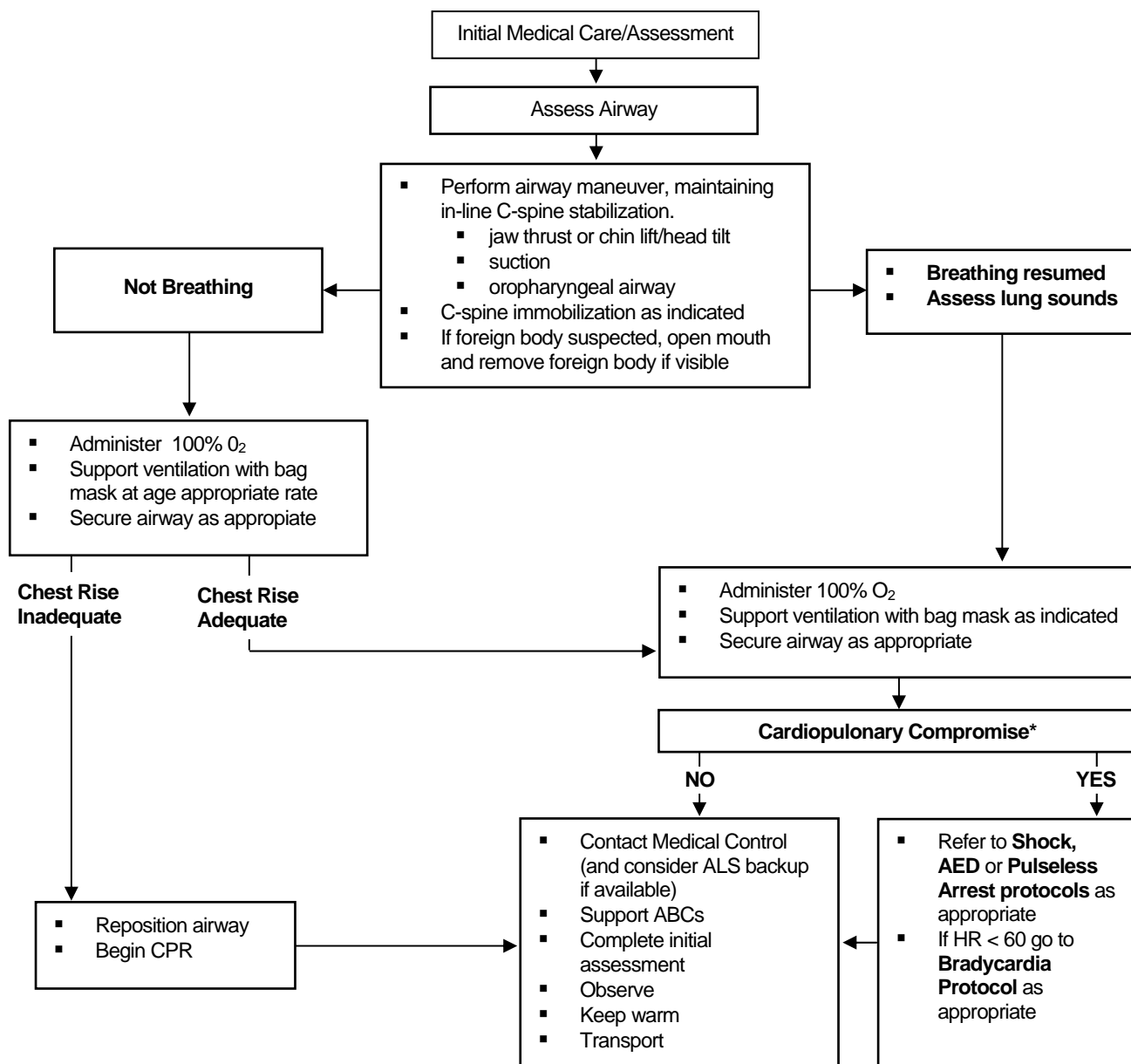
Special Considerations:

Be prepared for respiratory or cardiac arrest. Consider **AED**, **Pulseless Arrest** or **Respiratory Arrest** protocols.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
TACHYCARDIA PROTOCOL
ALS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC RESPIRATORY ARREST PROTOCOL
BLS CARE GUIDELINE**

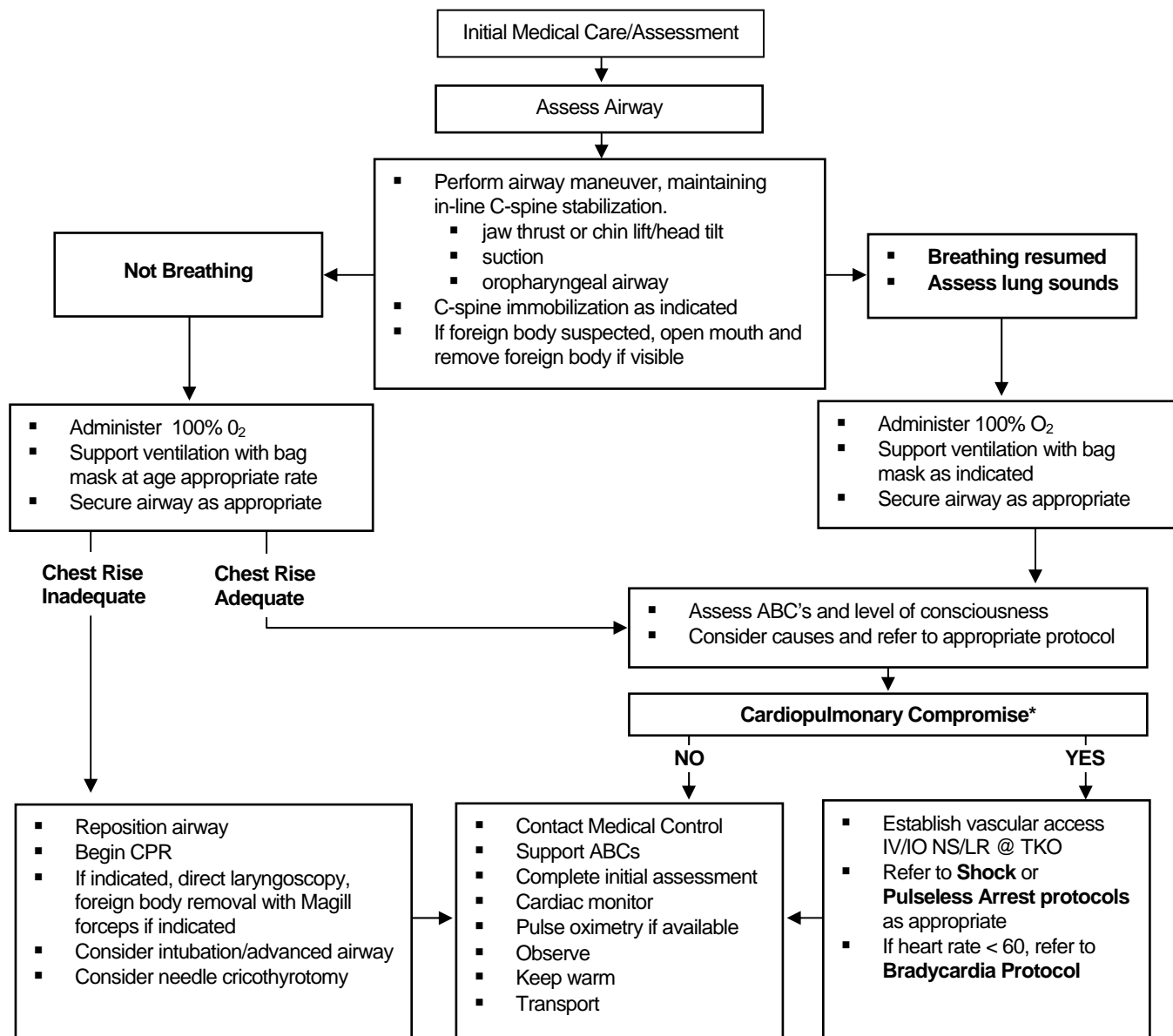


Special Considerations:

- Respiratory arrest may be a presenting sign of a toxic ingestion, metabolic disorder or anaphylaxis.
- Refer to Respiratory Distress Protocol as appropriate.

*Refer to Vital Signs and Cardiopulmonary Compromise Resource for signs and symptoms of decreased perfusion in children.

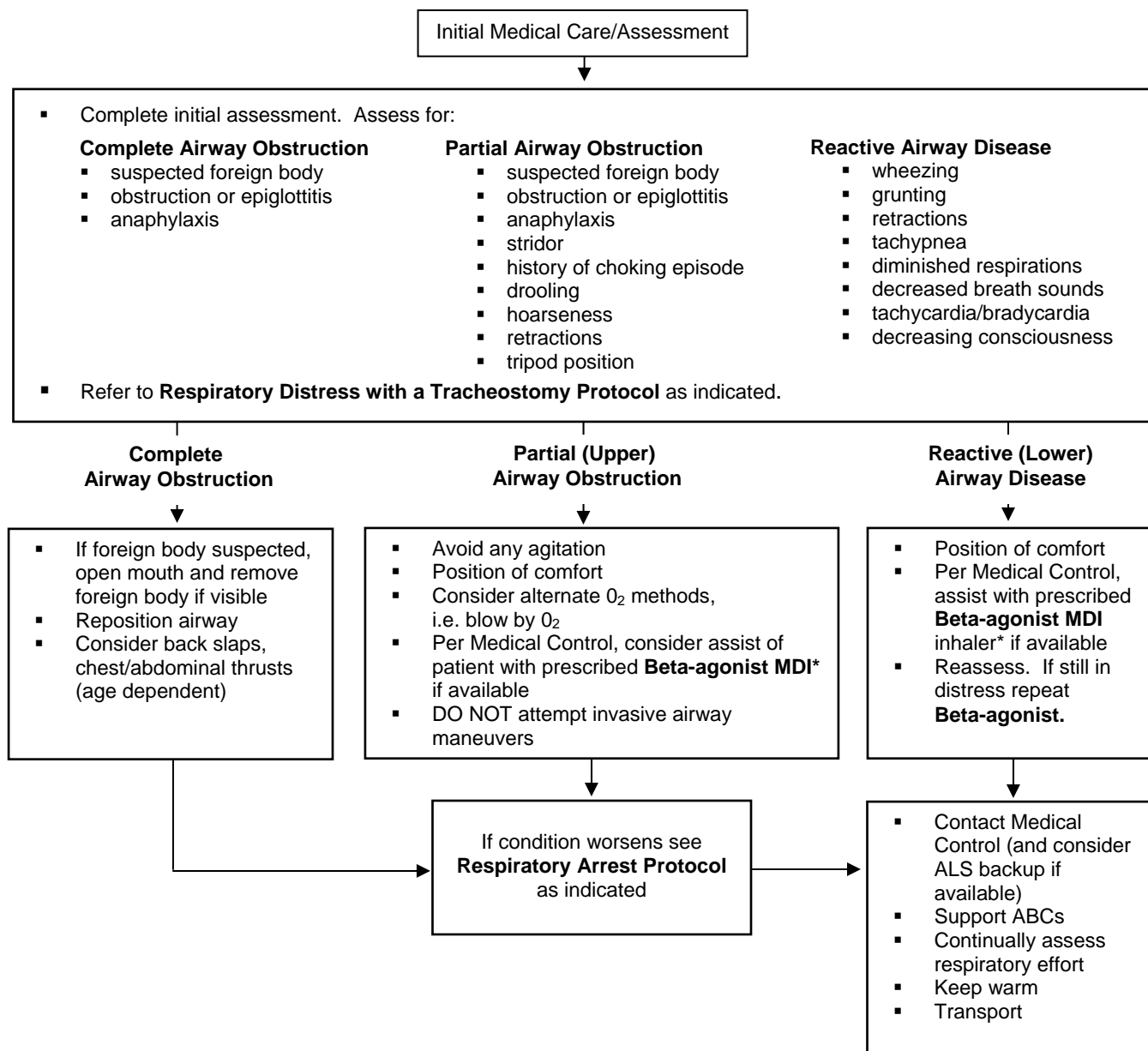
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC RESPIRATORY ARREST PROTOCOL
ALS CARE GUIDELINE**

**Special Considerations:**

- Respiratory arrest may be a presenting sign of a toxic ingestion, metabolic disorder or anaphylaxis.
- Consider **naloxone**, **flumazenil** or **glucose** per Medical Control.

*Refer to Vital Signs and Cardiopulmonary Compromise Resource for signs and symptoms of decreased perfusion in children.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC RESPIRATORY DISTRESS PROTOCOL
BLS CARE GUIDELINE**



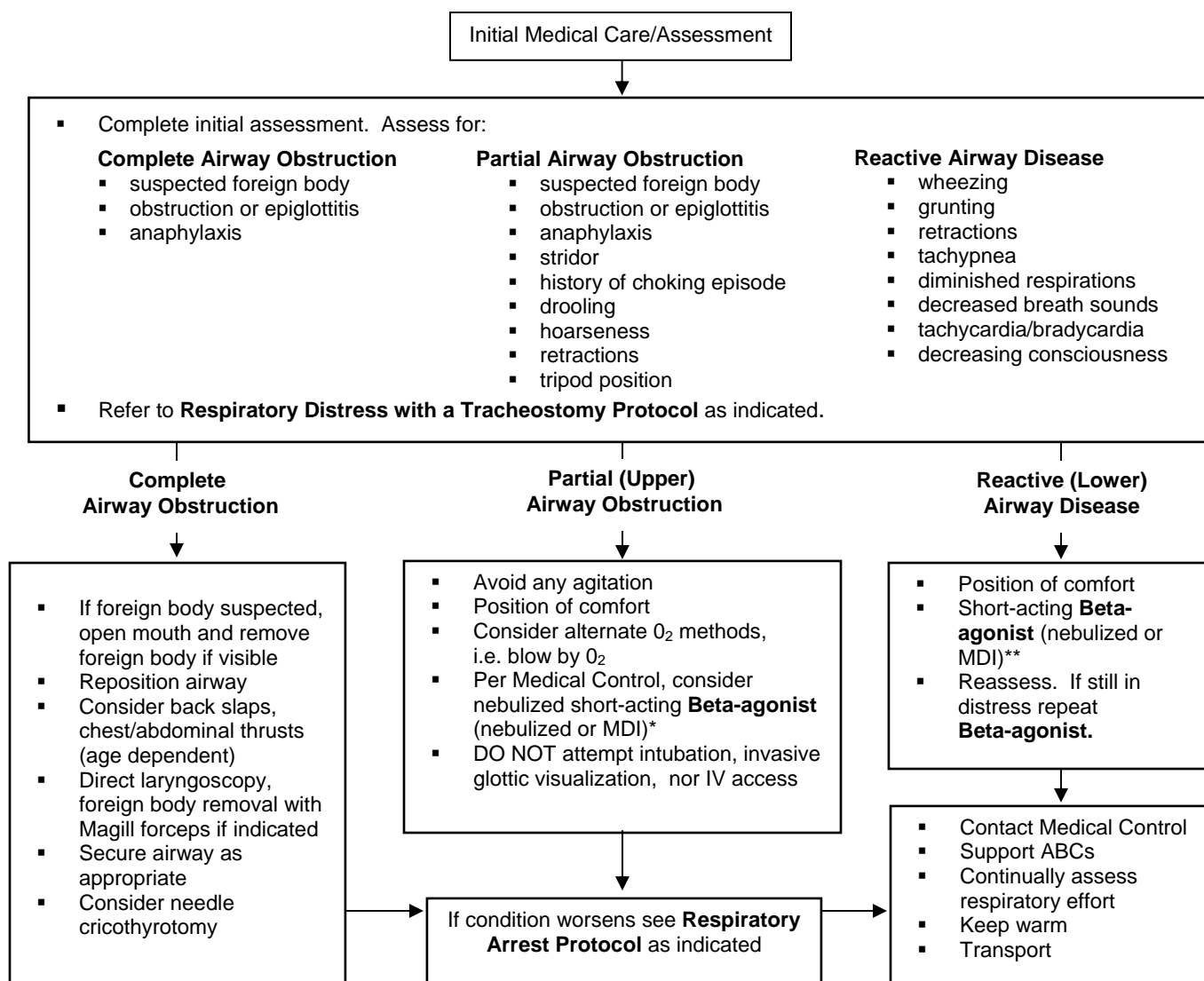
Special Considerations:

*Per Medical Control, severe upper airway obstruction secondary to croup may be relieved with **Beta-agonists**.

***Beta-agonist MDI** inhalers include, among others, **Albuterol (Proventil, Ventolin)** and **Levalbuterol (Xopenex)**.

*An inhaler should be administered through a holding chamber or spacer device, if available.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC RESPIRATORY DISTRESS PROTOCOL
ALS CARE GUIDELINE**

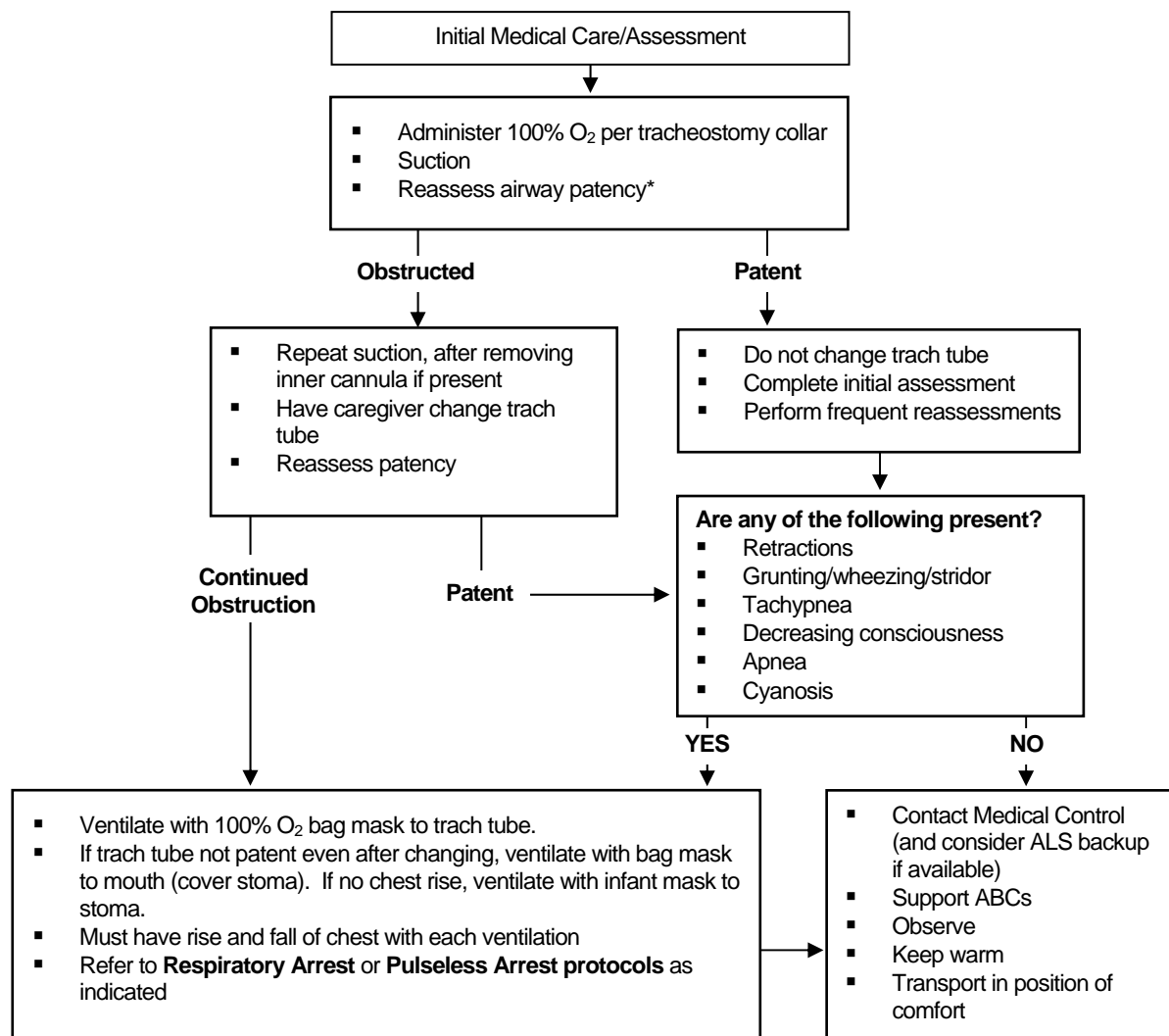


Special Considerations:

****Beta-agonist MDI** inhalers include, among others, **Albuterol (Proventil, Ventolin)** and **Levalbuterol (Xopenex)**.

**An inhaler should be administered through a holding chamber or spacer device, if available.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRACHEOSTOMY WITH RESPIRATORY DISTRESS PROTOCOL
BLS CARE GUIDELINE**



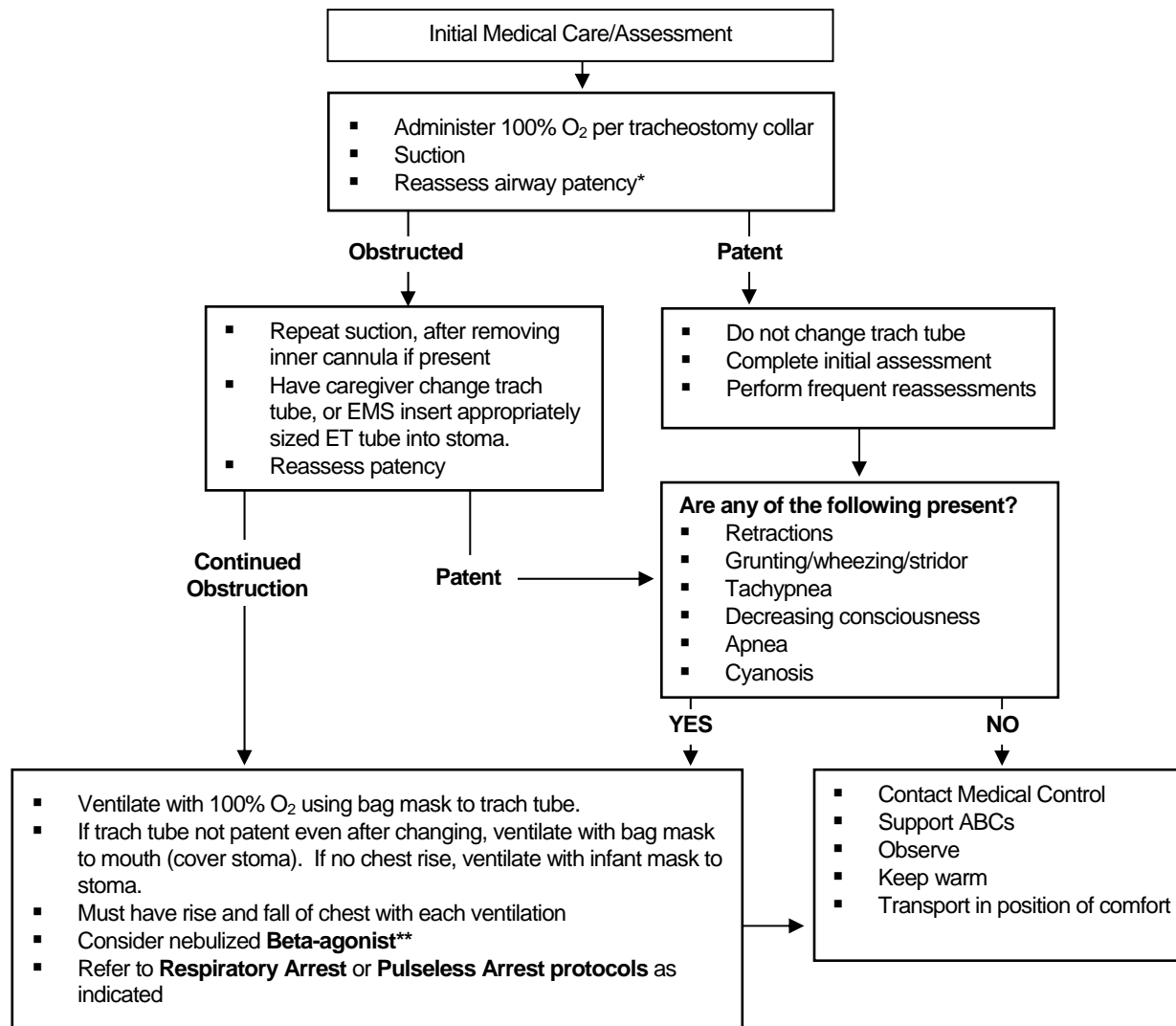
Special Considerations:

*If chest rise inadequate:

- Reposition the airway.
- If using mask to stoma, consider inadequate volume delivered. Compress bag further and/or depress pop-off valve.

Consider allowing caregiver to remain with child regardless of child's level of responsiveness.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRACHEOSTOMY WITH RESPIRATORY DISTRESS PROTOCOL
ALS CARE GUIDELINE**



Special Considerations:

*If chest rise inadequate:

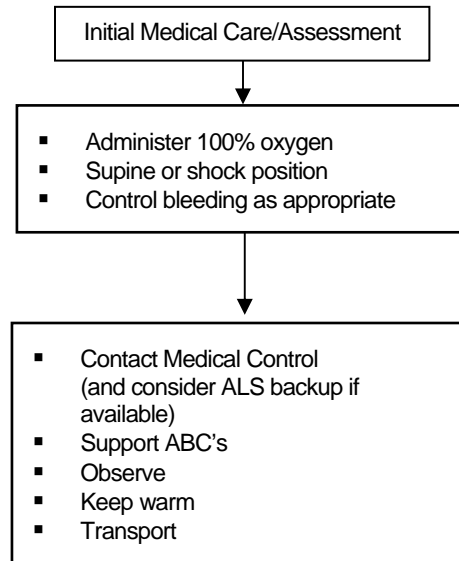
- Reposition the airway.
- If using mask to stoma, consider inadequate volume delivered. Compress bag further and/or depress pop-off valve.

**Only bronchodilator (Beta-agonist MDI) inhalers should be administered.

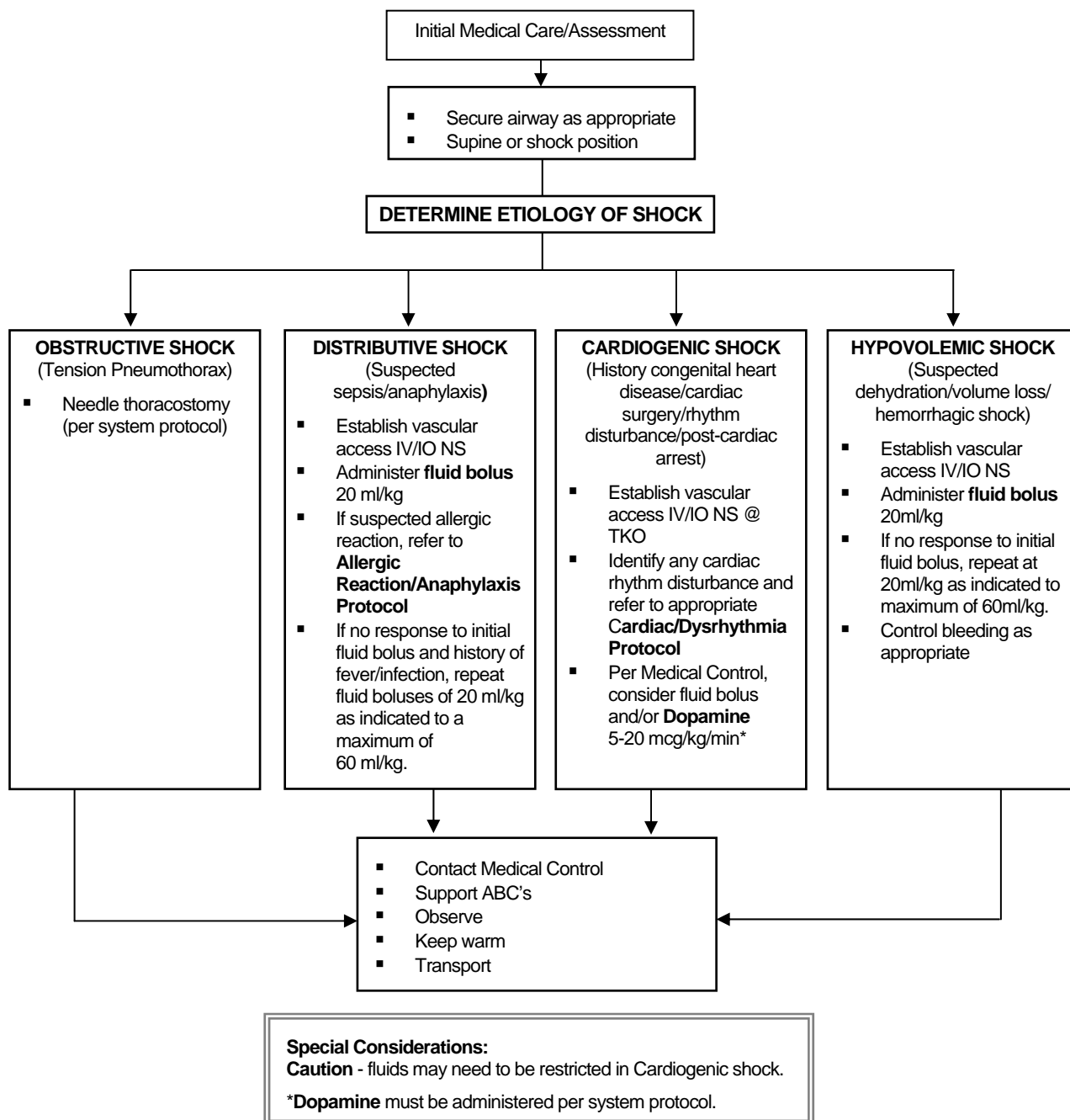
- **Beta-agonist MDI** inhalers include, among others, **Albuterol (Proventil, Ventolin)**
- An inhaler should be administered through a holding chamber or spacer device, if available.

Consider allowing caregiver to remain with child regardless of child's level of responsiveness.

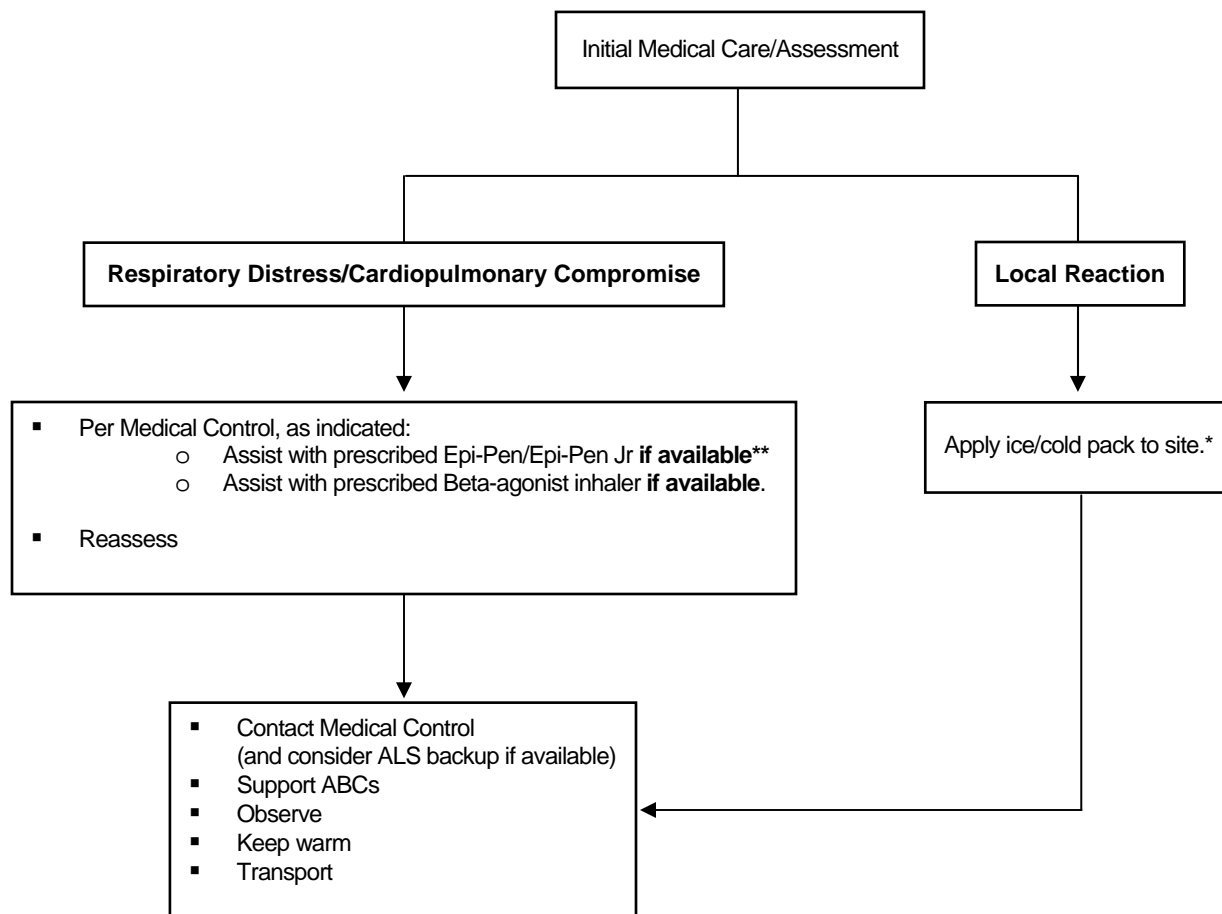
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC SHOCK
BLS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC SHOCK
ALS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS
BLS CARE GUIDELINE**



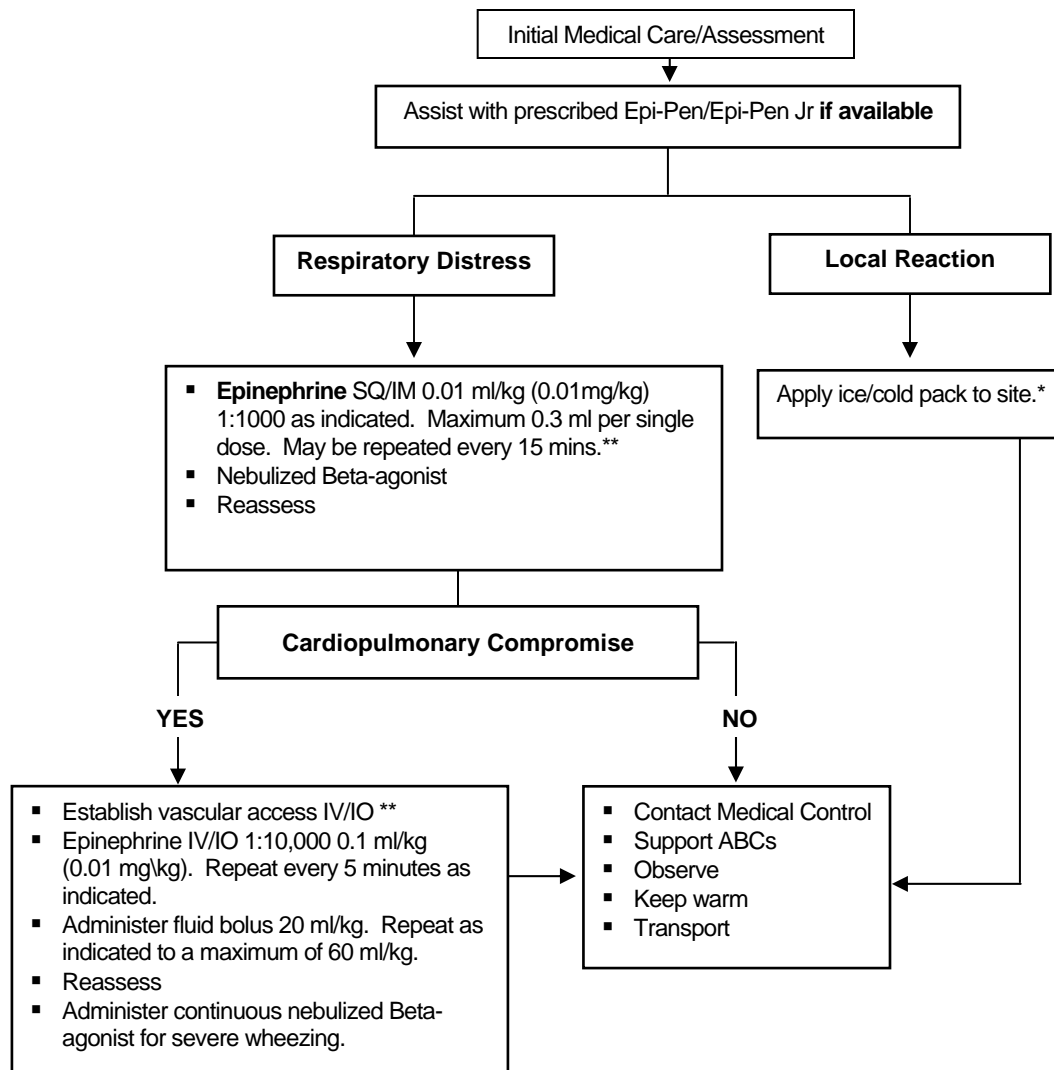
Special Considerations:

- **Epi-Pen** – use a 0.3mg auto-injector for children over 30kg and Epi-Pen Jr 0.15mg auto-injector for children less than 30kg.
- **Beta-agonist MDI** inhalers include, among others, **Albuterol (Proventil, Ventolin)** and **Levalbuterol (Xopenex)**. An inhaler should be administered through a holding chamber or spacer device **if available**.
- Combination Beta-agonist/corticosteroid inhaler can be used per medical direction.

*Simple hives without airway complaints may not require any additional field treatment.

**Avoid medication administration into same extremity as bite or allergen site.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS
ALS CARE GUIDELINE**



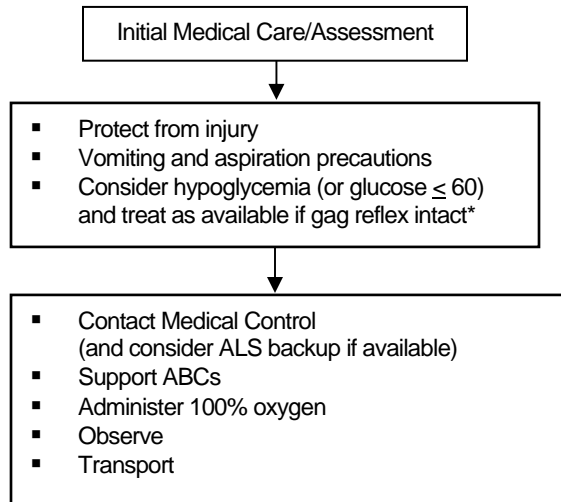
Special Considerations:

- **Epi-Pen** – use a 0.3mg auto-injector for children over 30kg and Epi-Pen Jr 0.15mg auto-injector for children less than 30kg.
- **Beta-agonist MDI** inhalers include, among others, **Albuterol (Proventil, Ventolin)**. An inhaler should be administered through a holding chamber or spacer device **if available**.
- Combination Beta-agonist/corticosteroid inhaler can be used per medical direction.
- If prolonged transport, per Medical Control consider IV Diphenhydramine 1mg/kg slow IVP over 2-3 minutes. (Max dose 50 mg)
- Consider IV steroids via intravenous route as per Medical Control.

*Simple hives without airway complaints may not require any additional field treatment.

**Avoid IV initiation or medication administration into same extremity as bite or allergen site.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC SEIZURES
BLS CARE GUIDELINE**



Special Considerations:

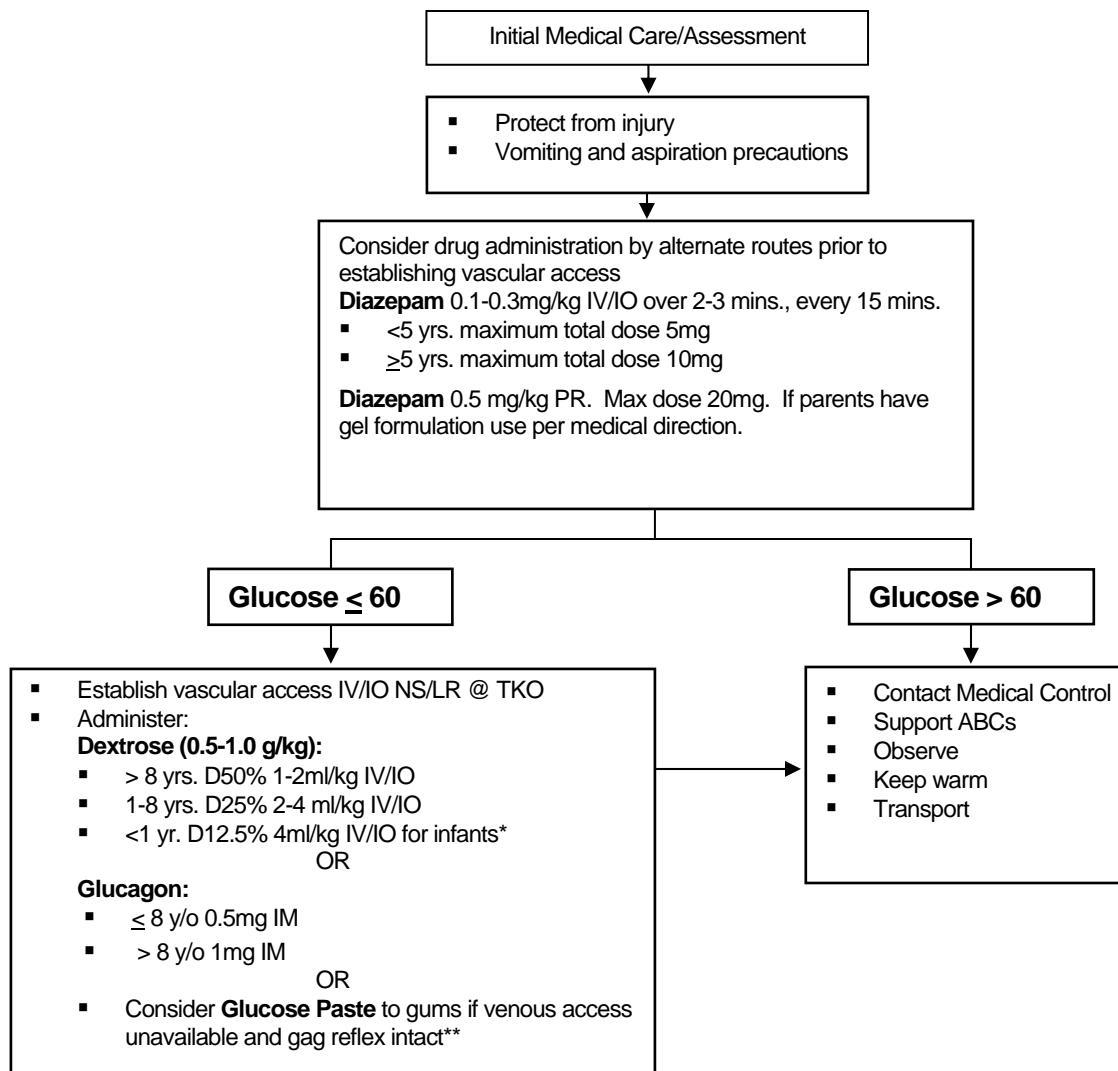
*Examples of treatment for hypoglycemia if gag reflex intact: glucose paste, sugar, cake icing.

- Refer to **Respiratory Arrest Protocol** as indicated.
- Parents may have given medication prior to EMS arrival, so watch for respiratory depression.
- Document medications administered prior to transport.

Dr. Kelly Cox, MD, EMS Medical Director

08/01 Re: 7/08

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC SEIZURES
ALS CARE GUIDELINE**

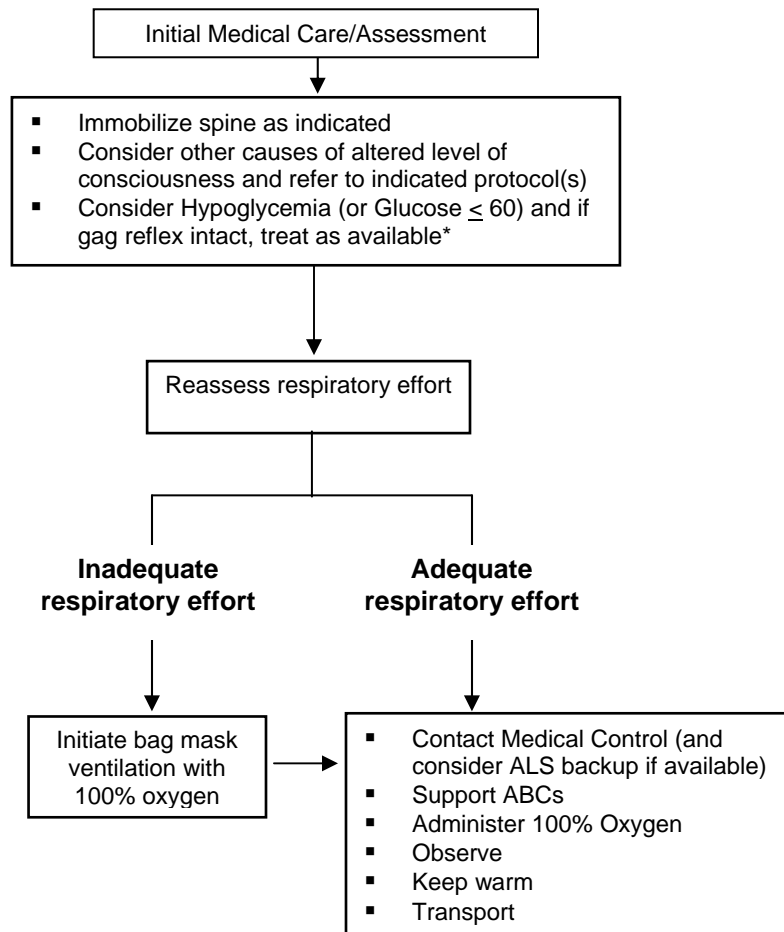
**Special Considerations:**

- Anticipate respiratory depression if **Diazepam** is administered.
- Refer to **Respiratory Arrest Protocol** as indicated
- Parents may have given medication prior to EMS arrival, so watch for respiratory depression.

*To make **D12.5%**, dilute **D25%** 1:1 with sterile water.

**Examples of treatment for Hypoglycemia if gag reflex intact: glucose paste, sugar, cake icing.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS
BLS CARE GUIDELINE**



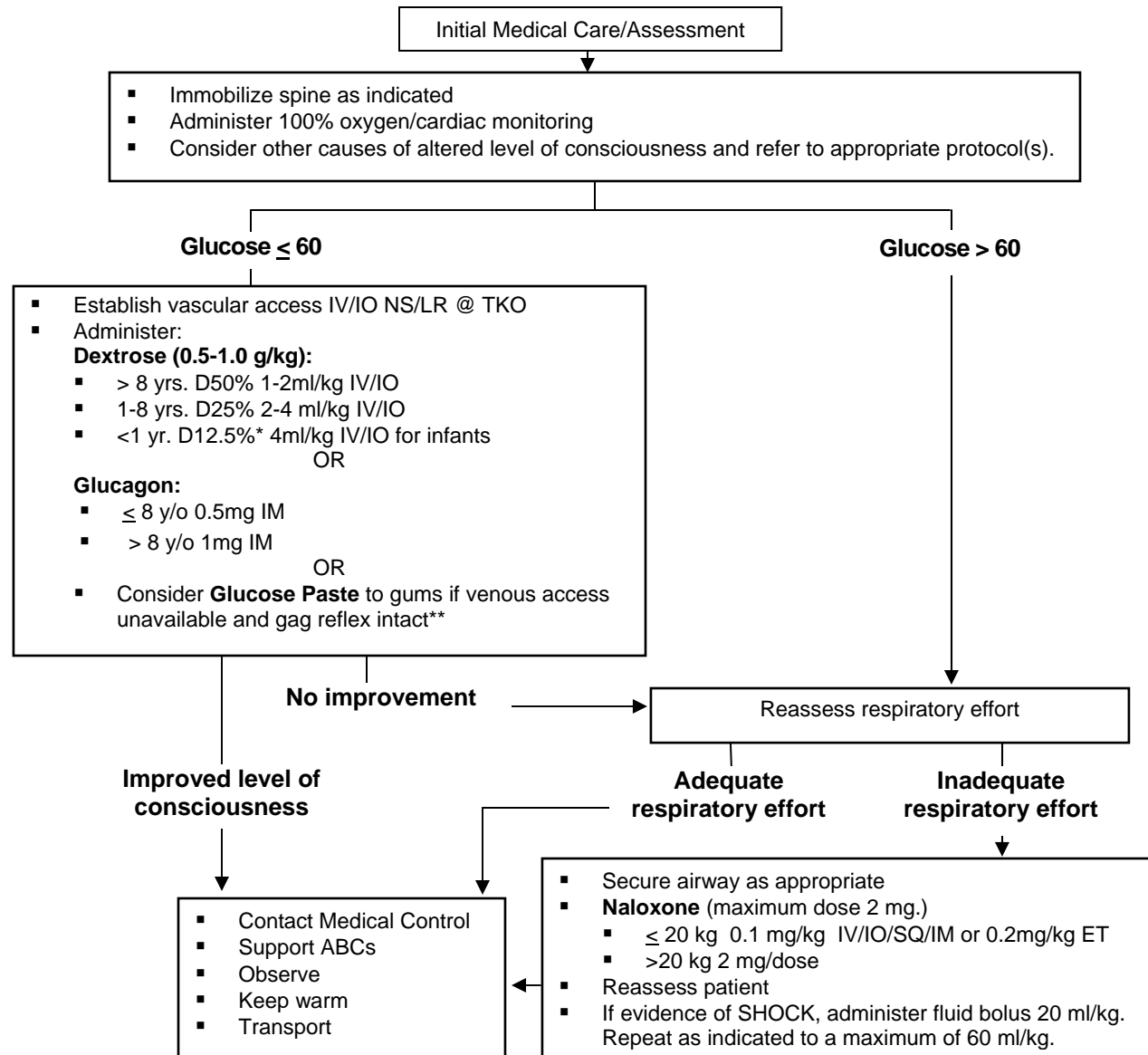
Special Considerations:

Consider causes:

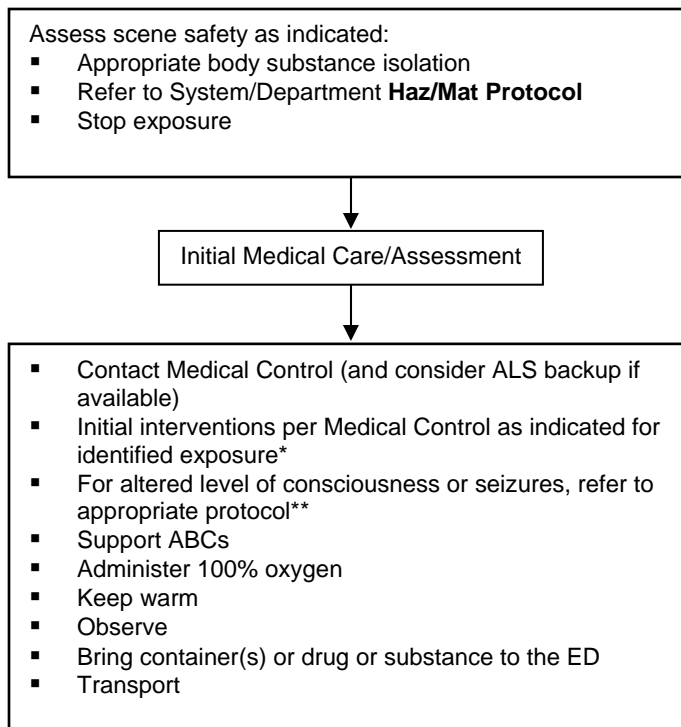
A Alcohol, abuse	T Trauma, temperature
E Epilepsy, electrolytes, encephalopathy	I Infection, intussusception, inborn errors
I Insulin	P Psychogenic
O Opiates, overdose	P Poison
U Uremia	S Shock, seizures, stroke, space-occupying lesion, subarachnoid hemorrhage, shunt

*Examples of treatment for hypoglycemia if gag reflex intact: glucose paste, sugar, cake icing.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS
ALS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TOXIC EXPOSURES/INGESTIONS
BLS CARE GUIDELINE**



Special Considerations:

- Do not induce vomiting, especially in cases where caustic substance ingestion is suspected.
- Consider DCFS methamphetamine protocol.
- Poison Center phone # 1-800-222-1222

***Refer to back of page for list of potential ingestions and exposures.**

**** Anticipate vomiting, respiratory arrest, seizure, dysrhythmias and refer to indicated protocols.**

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TOXIC EXPOSURES/INGESTIONS
BLS CARE GUIDELINE**

POTENTIAL TREATMENT

- **DO NOT INDUCE VOMITING, ESPECIALLY IN CASES WHERE CAUSTIC SUBSTANCE INGESTION IS SUSPECTED.**
- Contact direct medical oversight for specific information about individual toxic exposures and treatments.

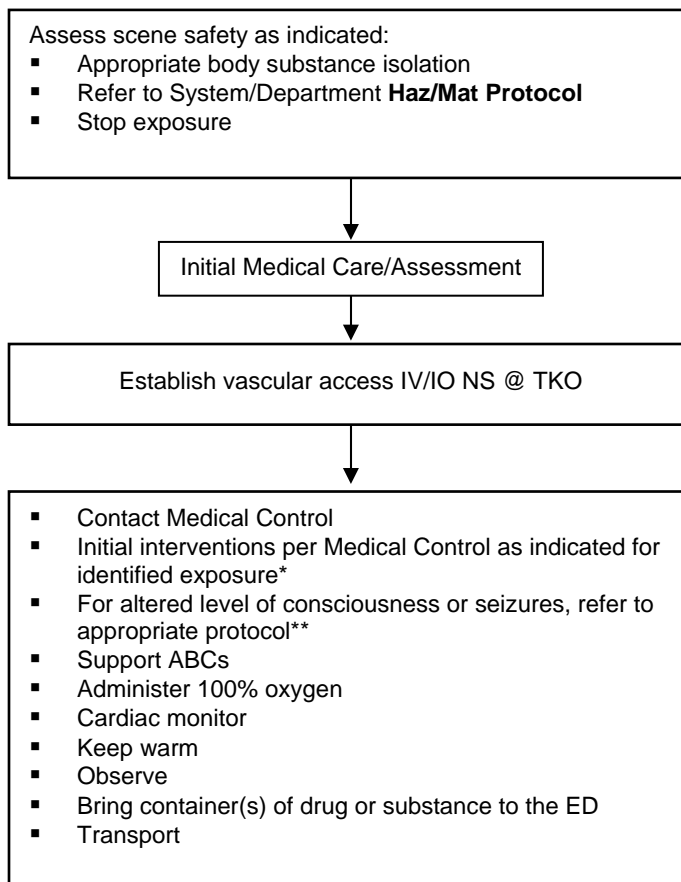
POTENTIAL EXPOSURES

- | | |
|---------------------------------|---|
| ▪ Burning overstuffed furniture | = Cyanide |
| ▪ Old burning buildings | = Lead fumes and Carbon monoxide |
| ▪ Pepto-Bismol™ like products | = Aspirin |
| ▪ Pesticides | = Organophosphates & Carbamates |
| ▪ Common Plants | = Treat symptoms and bring plant/flower to ED |

SMELLS

- | | |
|-----------------|--|
| ▪ Almond | = Cyanide |
| ▪ Fruit | = Alcohol |
| ▪ Garlic | = Arsenic, parathion, DMSO |
| ▪ Mothballs | = Camphor |
| ▪ Natural gas | = Carbon monoxide |
| ▪ Rotten eggs | = Hydrogen sulfide |
| ▪ Silver polish | = Cyanide |
| ▪ Stove gas | = Think CO (CO and methane are odorless) |
| ▪ Wintergreen | = Methyl salicylate |

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TOXIC EXPOSURES/INGESTIONS
ALS CARE GUIDELINE**



Special Considerations:

- Intubate for GCS <8
- Do not induce vomiting, especially in cases where caustic substance ingestion is suspected.
- Consider DCFS methamphetamine protocol.
- Poison Center phone # 1-800-222-1222

***REFER TO BACK OF PAGE FOR LIST OF POTENTIAL ANTIDOTES, INGESTIONS AND EXPOSURES.**

**** Anticipate vomiting, respiratory arrest, seizure, dysrhythmias and refer to indicated protocols.**

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TOXIC EXPOSURES/INGESTIONS
ALS CARE GUIDELINE**

POTENTIAL TREATMENT

- For altered level of consciousness:
 - Weight \leq 20 kg, administer Naloxone 0.1 mg/kg, IV/ IO/SQ/ IM, or 0.2 mg/kg ET
 - Weight > 20kg, administer Naloxone 2.0mg /dose
- **DO NOT INDUCE VOMITING, ESPECIALLY IN CASES WHERE CAUSTIC SUBSTANCE INGESTION IS SUSPECTED.**
- Contact direct medical oversight for specific information about individual toxic exposures and treatments.
- Treatment for toxic exposures may be instituted as permitted by medical direction, including the following:
 - High-dose atropine for organophosphates
 - Sodium bicarbonate for tricyclic antidepressants
 - Glucagon for calcium channel blockers or beta-blockers
 - Diphenhydramine for dystonic reactions
 - Dextrose for insulin overdose

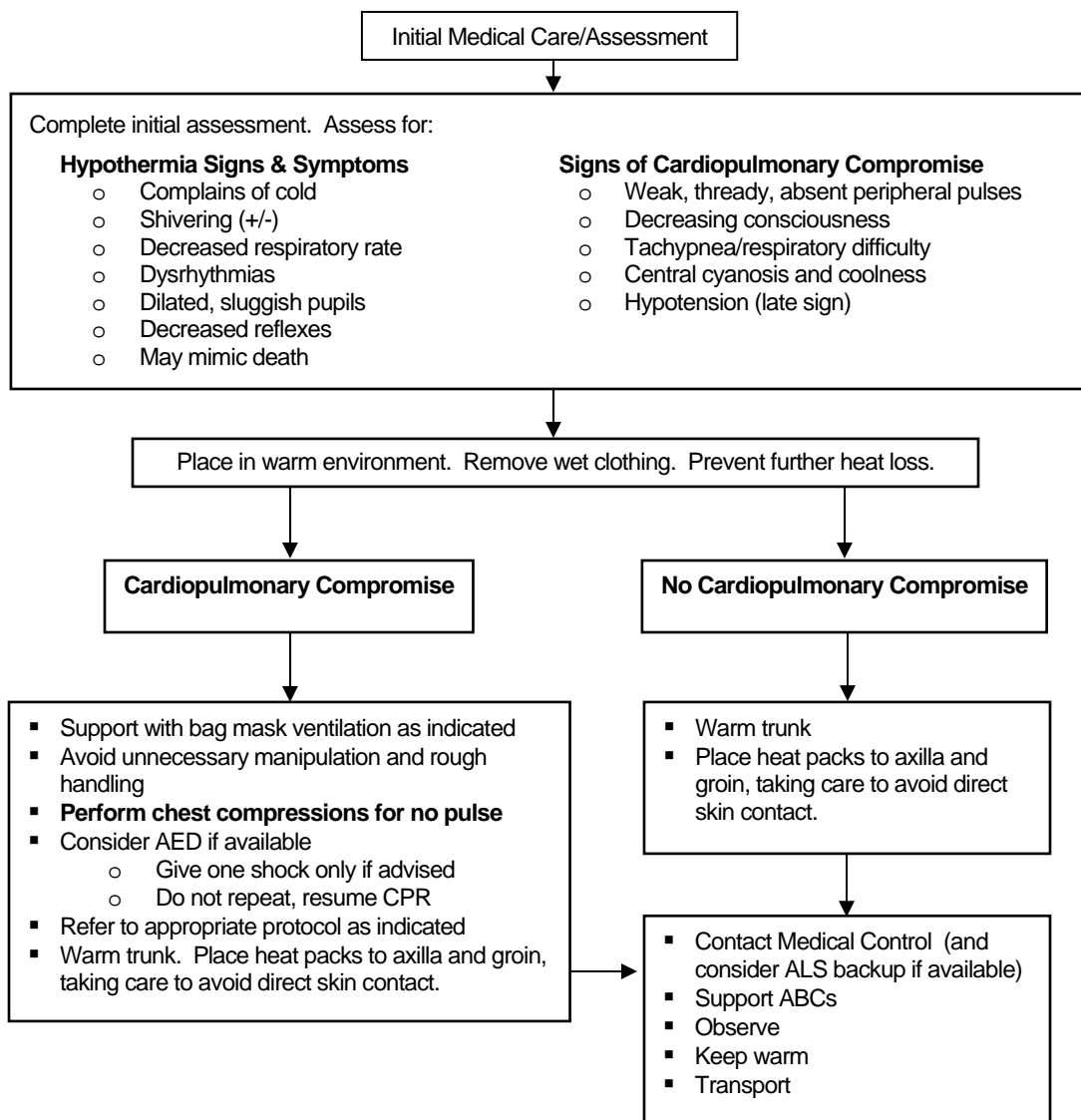
POTENTIAL EXPOSURES

- | | |
|---------------------------------|---|
| ▪ Burning overstuffed furniture | = Cyanide |
| ▪ Old burning buildings | = Lead fumes and Carbon monoxide |
| ▪ Pepto-Bismol™ like products | = Aspirin |
| ▪ Pesticides | = Organophosphates & Carbamates |
| ▪ Common Plants | = Treat symptoms and bring plant/flower to ED |

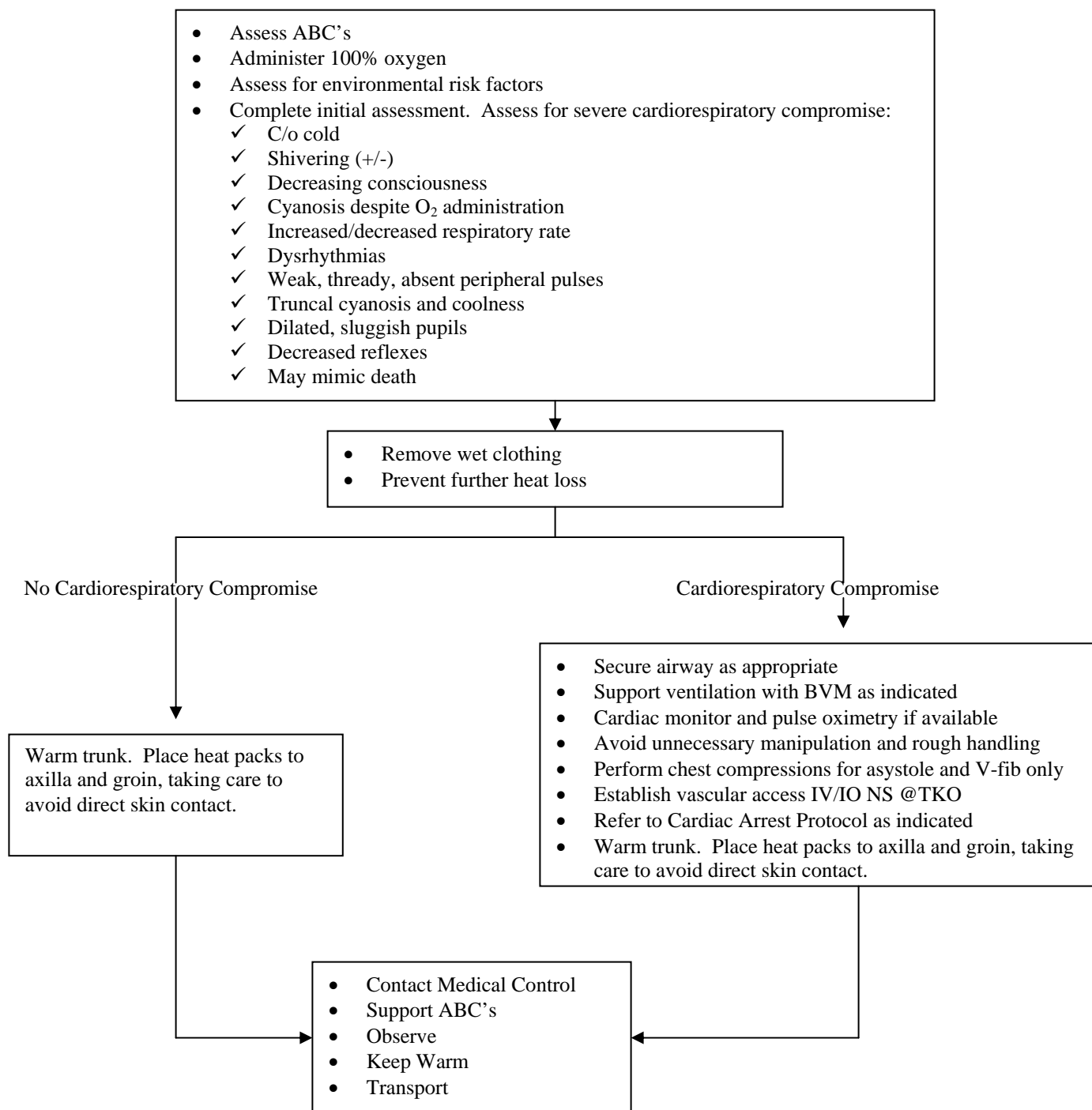
SMELLS

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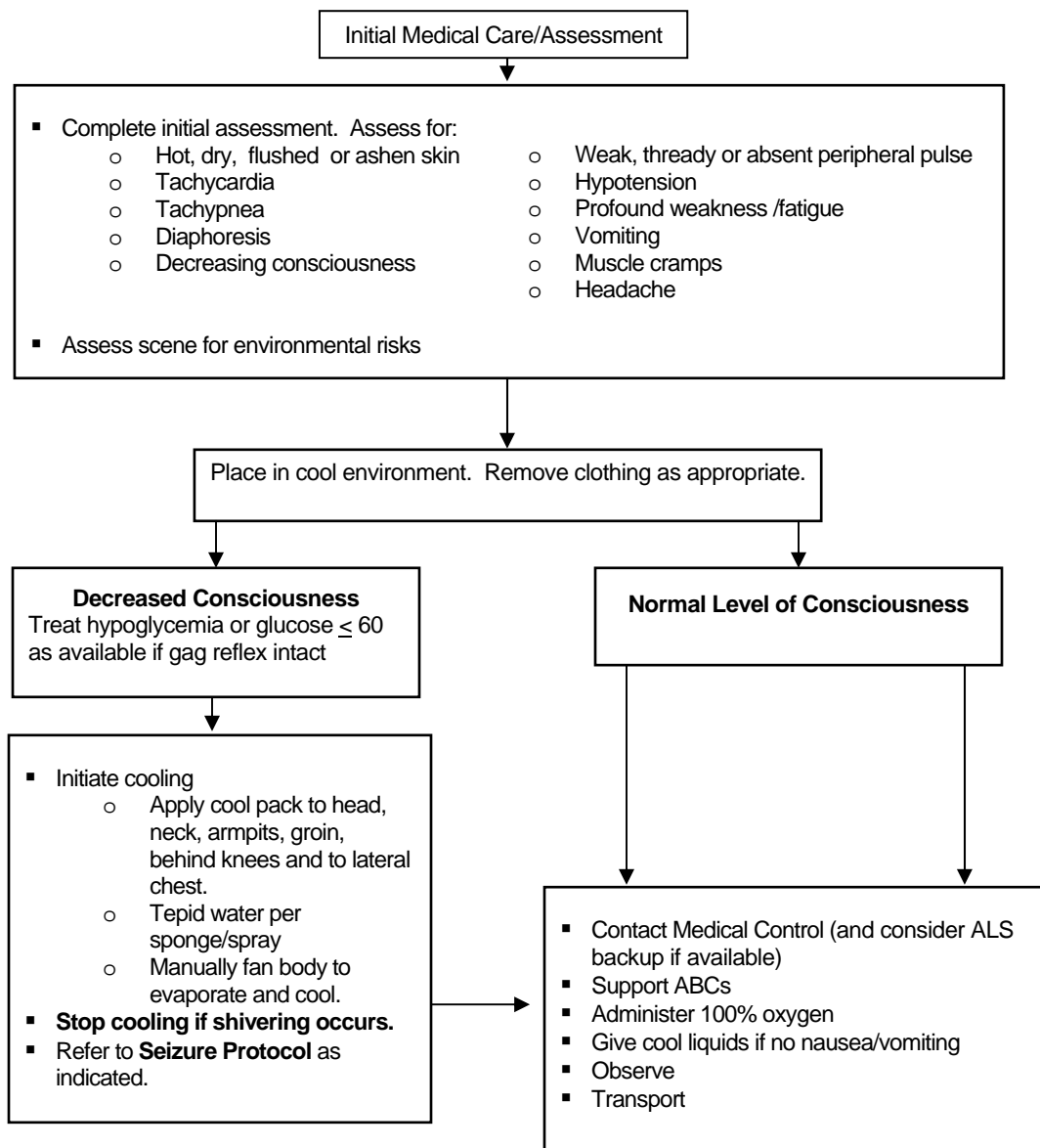
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HYPOTHERMIA
BLS CARE GUIDELINE**



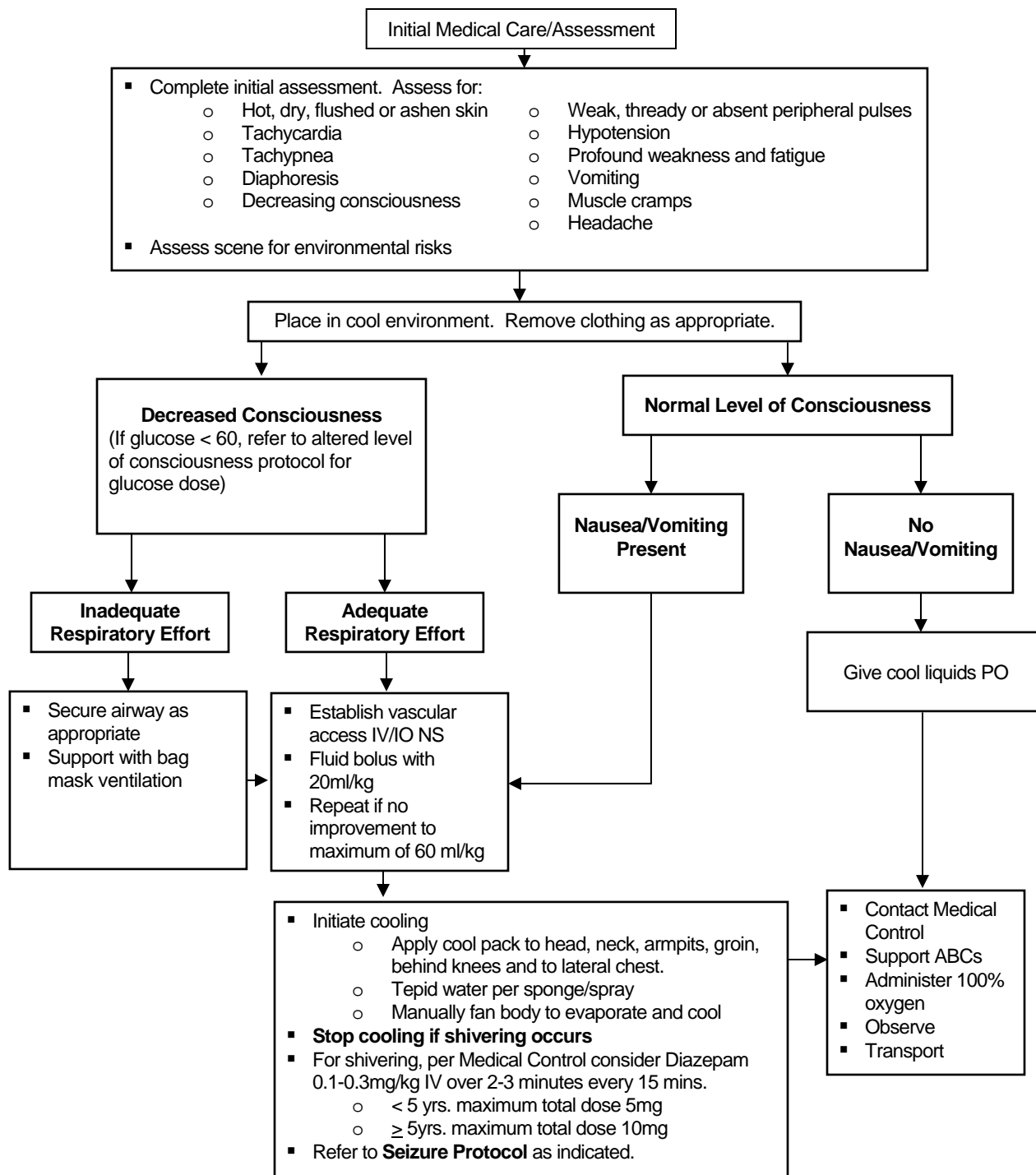
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HYPOTHERMIA ALS CARE GUIDELINE**



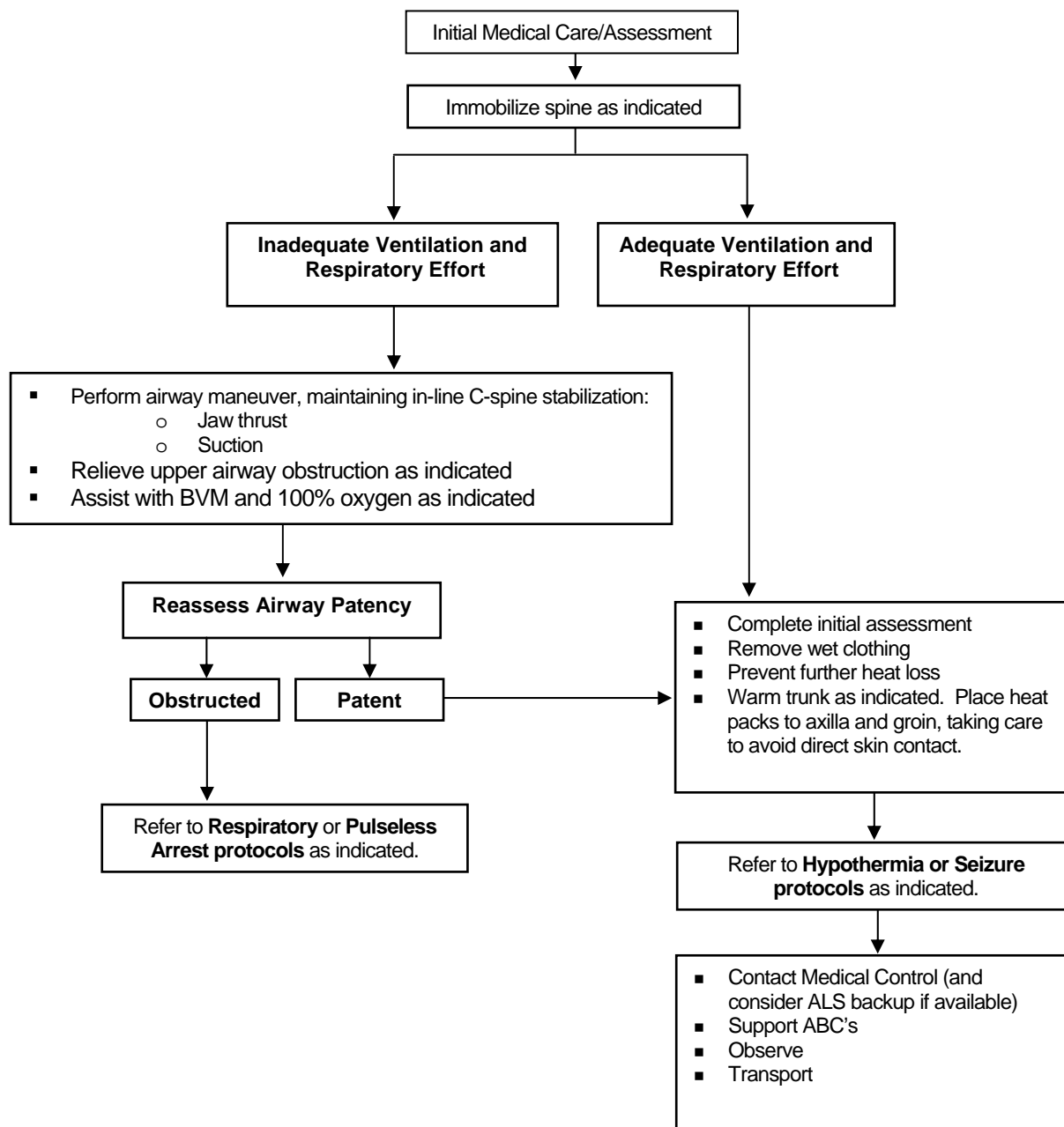
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HYPERTHERMIA
BLS CARE GUIDELINE**



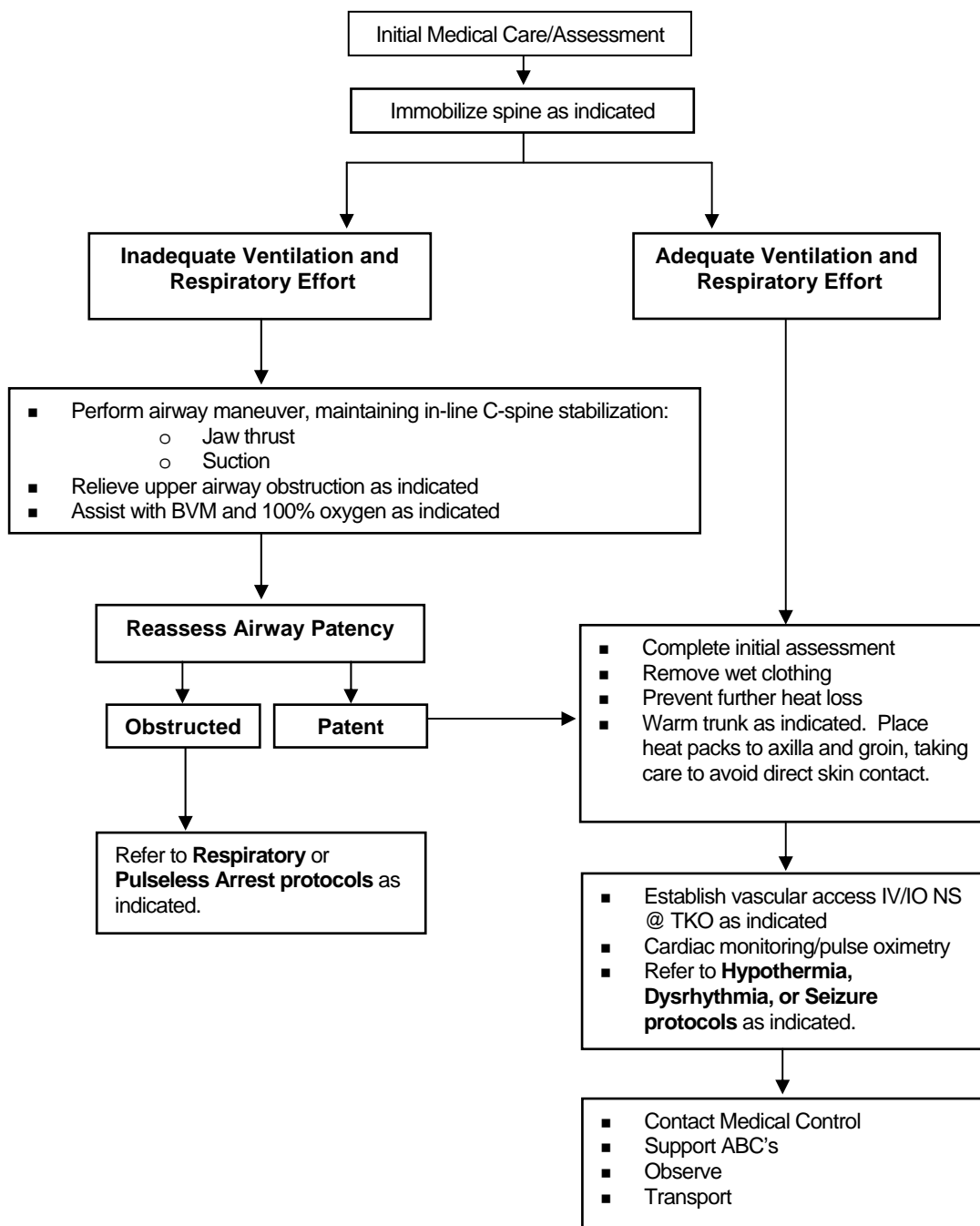
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HYPERTHERMIA
ALS CARE GUIDELINE**



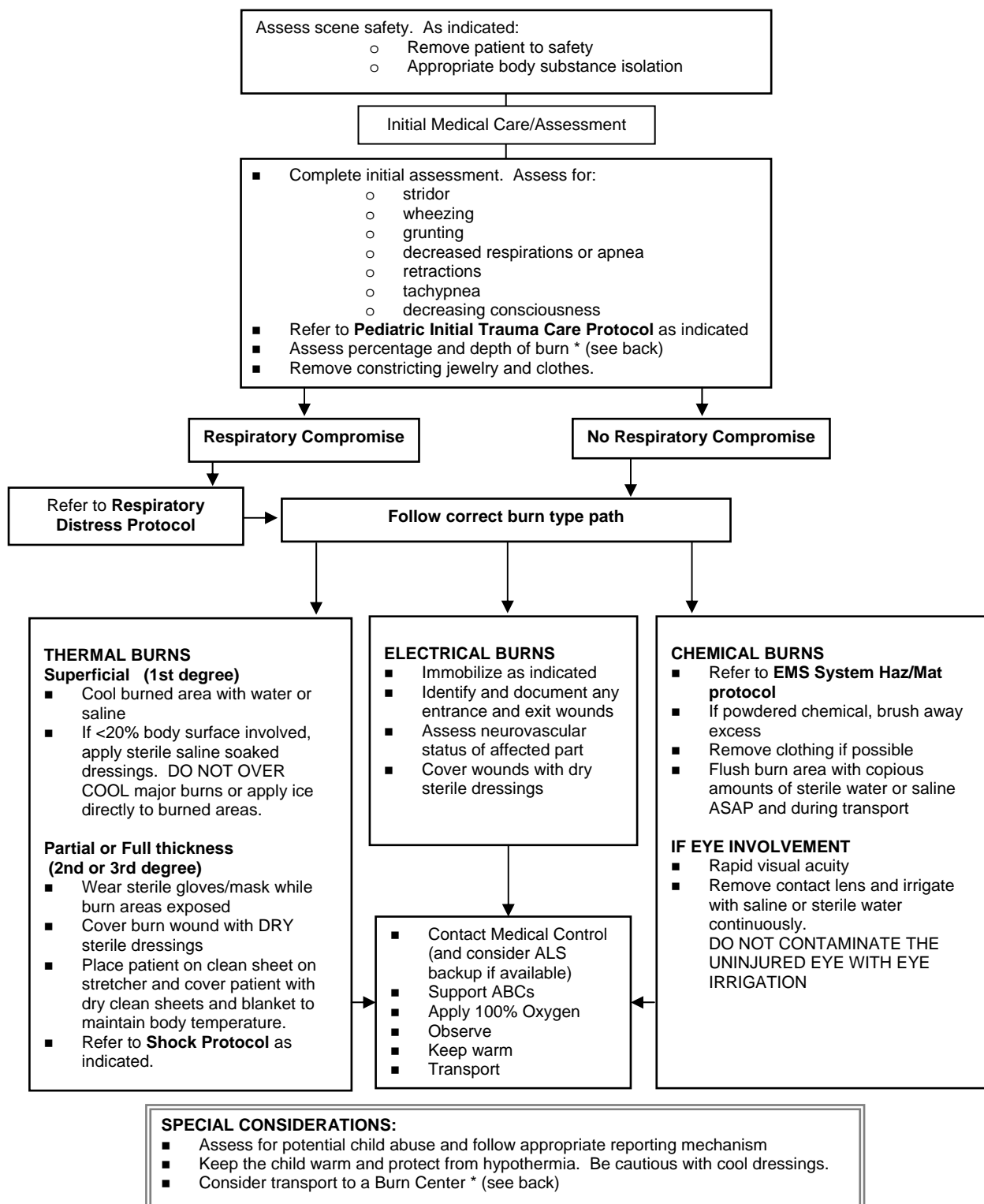
**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC NEAR DROWNING
BLS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC NEAR DROWNING
ALS CARE GUIDELINE**

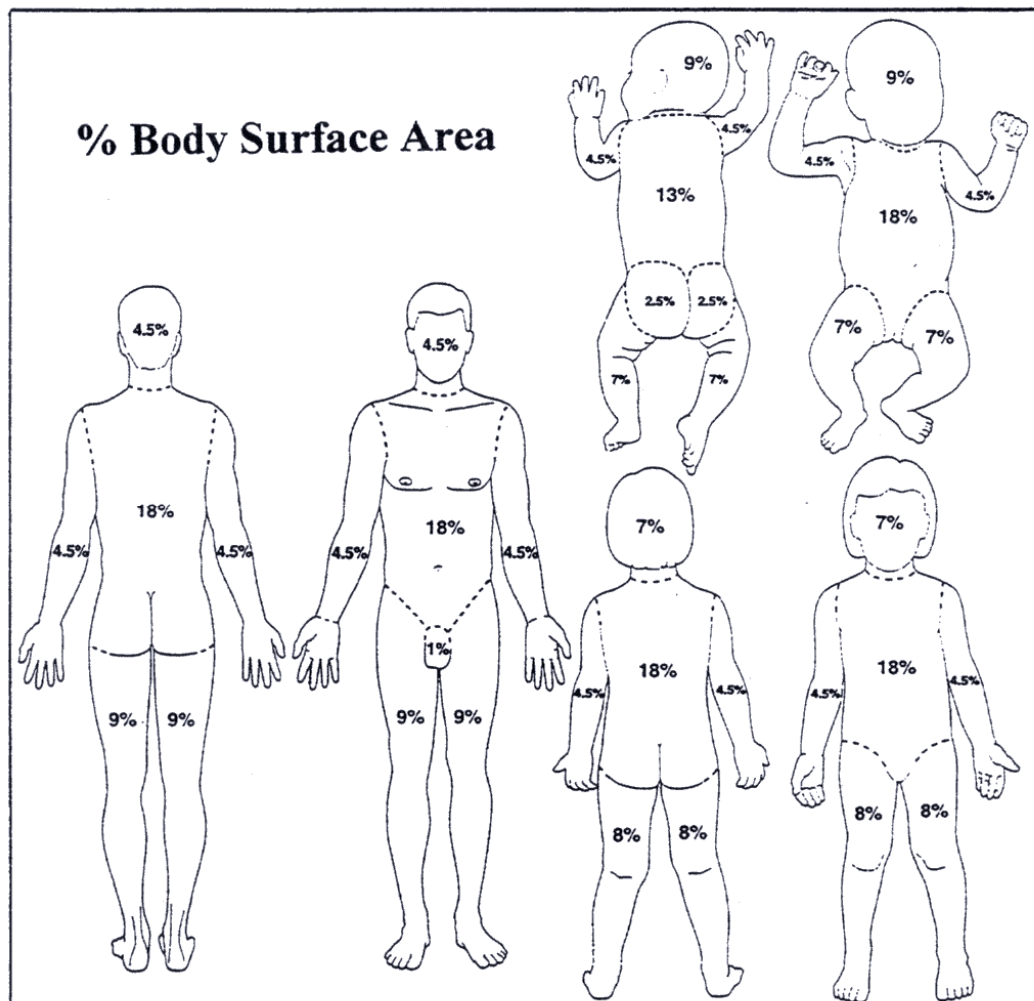


**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC BURNS (THERMAL, ELECTRICAL, CHEMICAL)
BLS CARE GUIDELINE**



**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC BURNS (THERMAL, ELECTRICAL, CHEMICAL)
BLS CARE GUIDELINE**

PED-17.1.2

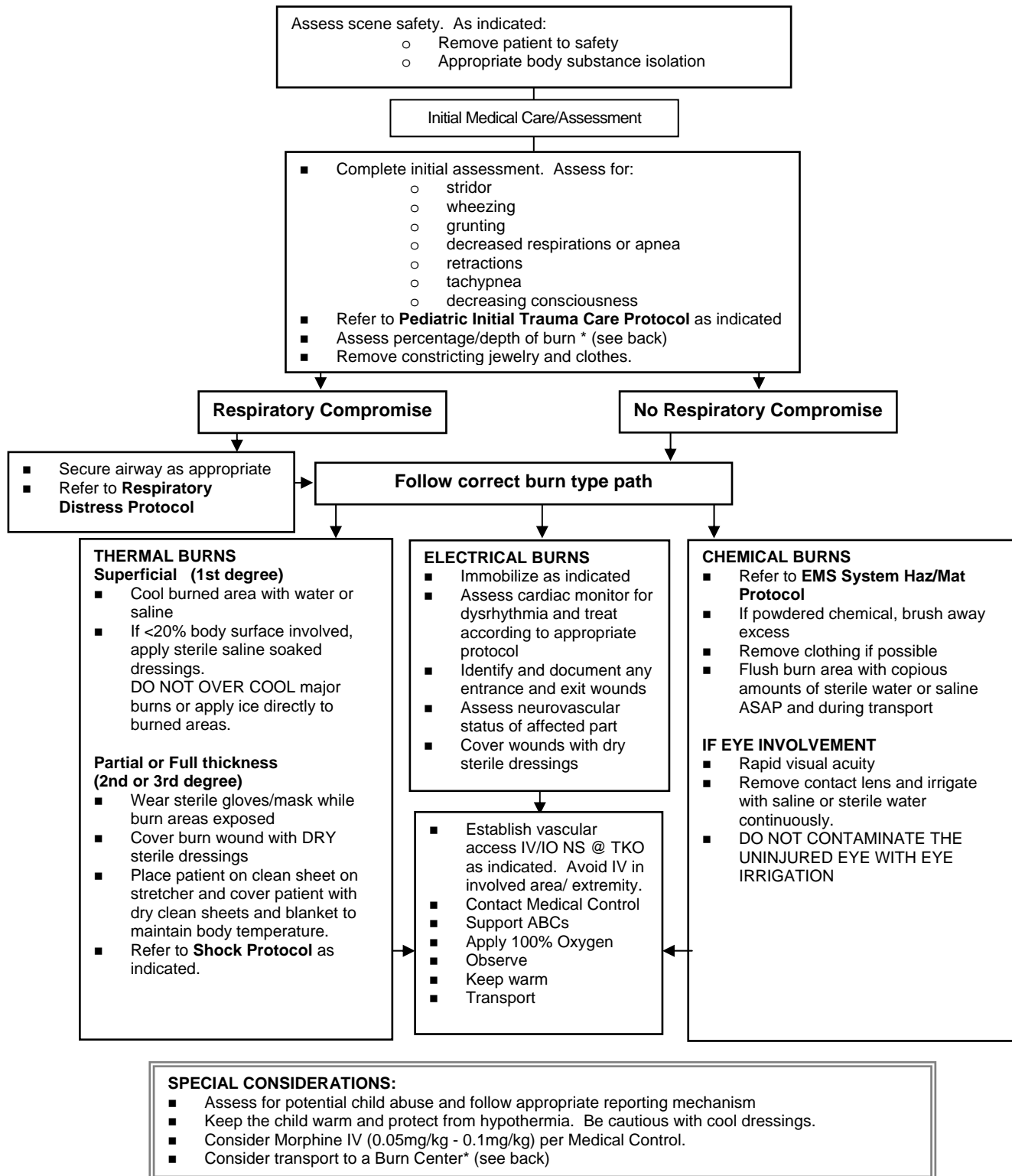


Palm of hand (including fingers) of infant or child = 1% of the total body surface

Any patient with a life threatening condition should be treated until stable at the nearest appropriate facility before being transferred to a burn center. Listed below is the American Burn Association criteria for pediatric patients to be transported to a burn center.

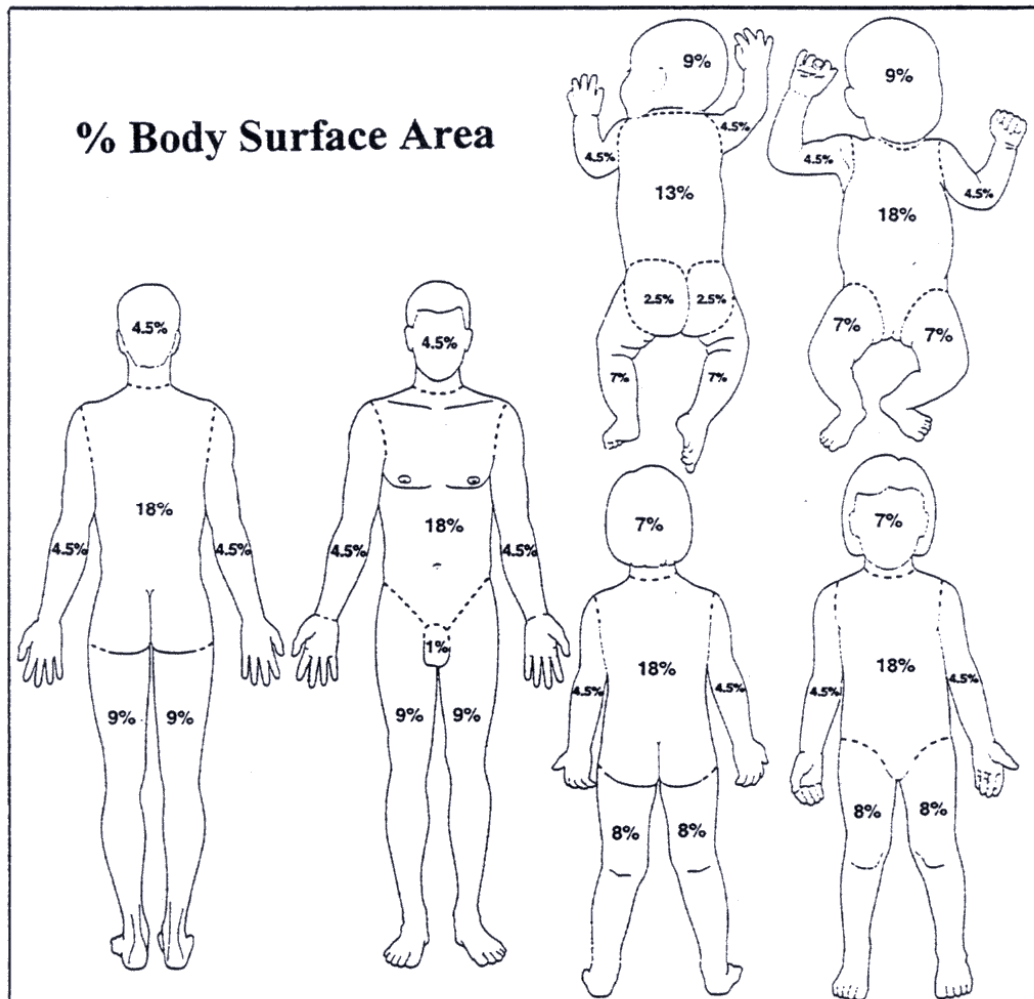
1. Partial thickness burns of greater than 10% total body surface area (TBSA)
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints
3. Third-degree burns in any age group
4. Electrical burns (including lightning injury)
5. Chemical burns
6. Inhalation injury
7. Burn injury in patient with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality
8. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols
9. Burned children in hospitals without qualified personnel or equipment for the care of children
10. Burn injury in patients who will require special social, emotional, or long-term rehabilitative intervention

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC BURNS (THERMAL, ELECTRICAL, CHEMICAL)
ALS CARE GUIDELINE**



QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC BURNS (THERMAL, ELECTRICAL, CHEMICAL)
ALS CARE GUIDELINE

PED-17.2.2

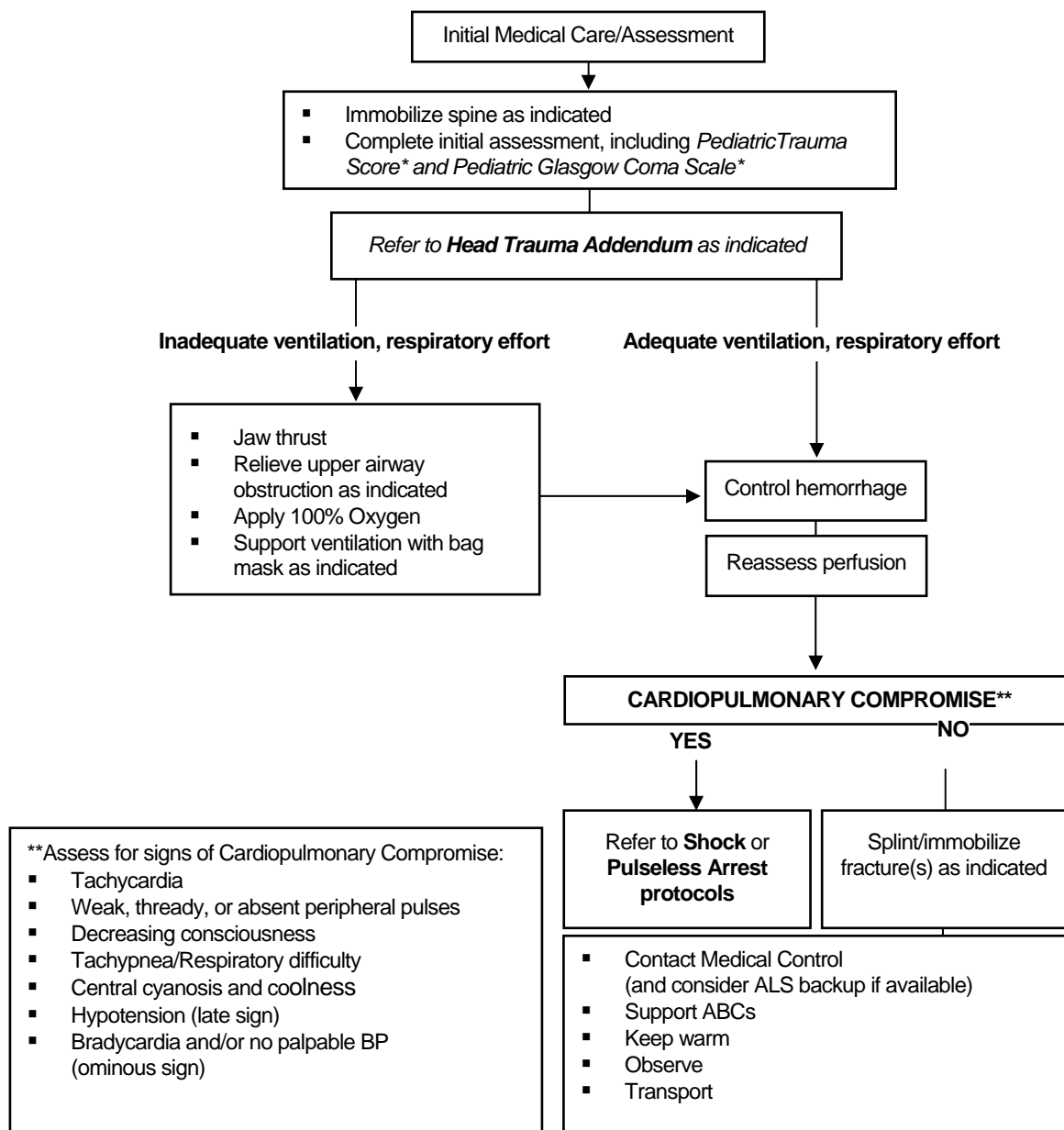


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**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRAUMA
BLS CARE GUIDELINE**



***Refer to back of protocol for Pediatric Trauma Score and Pediatric Glasgow Coma Scale.**

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRAUMA
BLS CARE GUIDELINE**

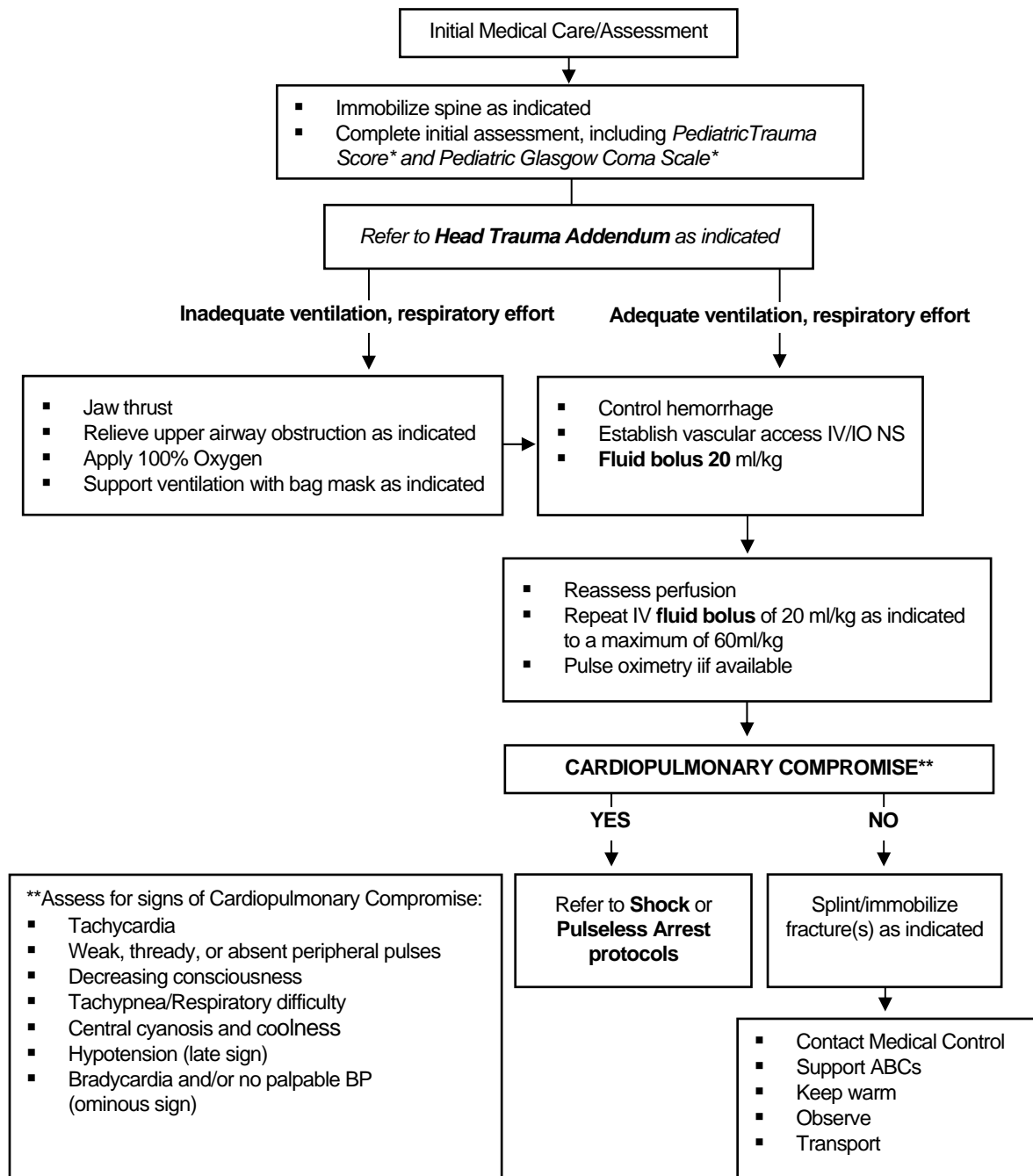
PEDIATRIC GLASGOW COMA SCALE (PGCS)				
	> 1 Year		< 1 Year	Score
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	2-5 Years	0-23 months	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				(3-15)

PEDIATRIC TRAUMA SCORE (PTS)			
Component	+ 2	+ 1	- 1
Size	Child/adolescent > 20 kg	Toddler 11 – 20 kg	Infant ≤ 10 kg
Airway	Normal	Maintainable	Unmaintained or Intubated
Systolic BP	> 90 mmHg	50 – 90 mmHg	< 50 mmHg
CNS	Awake	Obtunded/Lost consciousness	Coma/Unresponsive
Skeletal Injury	None	Closed Fracture	Open/Multiple Fractures
Open Wounds	None	Minor	Major/Penetrating

If a proper sized blood pressure cuff is not available, blood pressure can be rated as:
+ 2 = palpable at wrist, **+ 1** = palpable at groin, **- 1** = no pulse palpable

A PTS of ≤ 8 indicates the need for evaluation at a Trauma Center.
 Score range is from – 6 to + 12.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRAUMA
ALS CARE GUIDELINE**



***Refer to back of protocol for Pediatric Trauma Score and Pediatric Glasgow Coma Scale.**

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC TRAUMA
ALS CARE GUIDELINE**

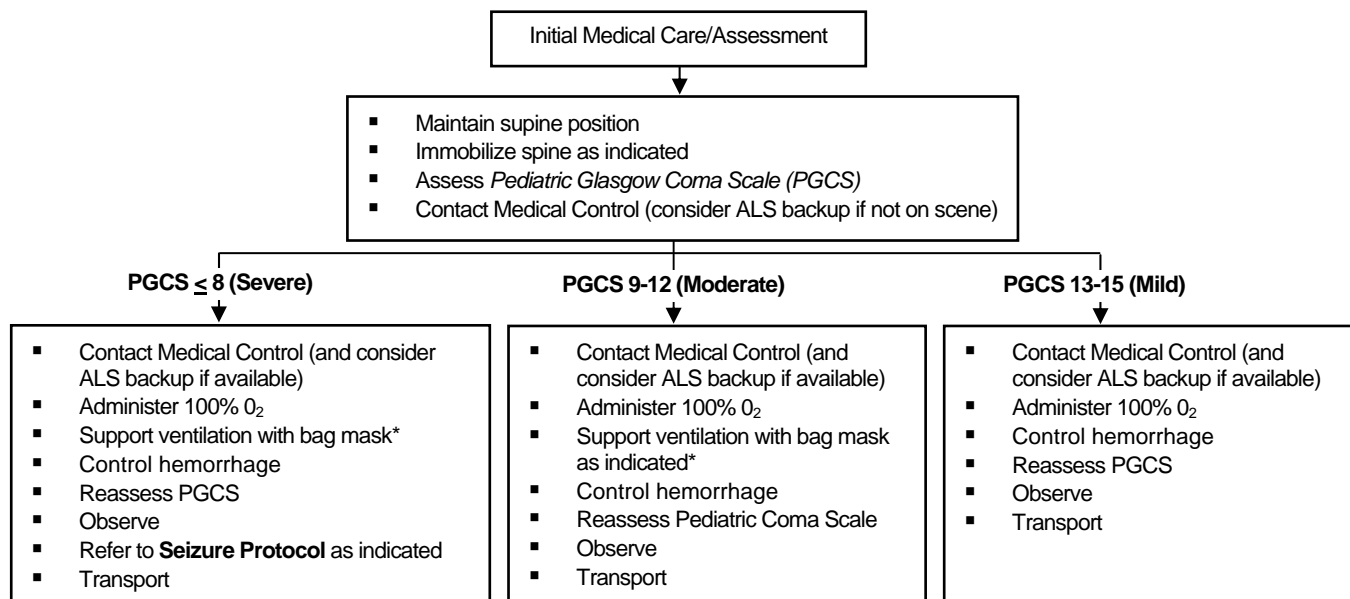
PEDIATRIC GLASGOW COMA SCALE (PGCS)				
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MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	2-5 Years	0-23 months	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				(3-15)

PEDIATRIC TRAUMA SCORE (PTS)			
Component	+ 2	+ 1	- 1
Size	Child/adolescent > 20 kg	Toddler 11 – 20 kg	Infant ≤ 10 kg
Airway	Normal	Maintainable	Unmaintained or Intubated
Systolic BP	> 90 mmHg	50 – 90 mmHg	< 50 mmHg
CNS	Awake	Obtunded/Lost consciousness	Coma/Unresponsive
Skeletal Injury	None	Closed Fracture	Open/Multiple Fractures
Open Wounds	None	Minor	Major/Penetrating

If a proper sized blood pressure cuff is not available, blood pressure can be rated as:
+ 2 = palpable at wrist, **+ 1** = palpable at groin, **- 1** = no pulse palpable

A PTS of ≤ 8 indicates the need for evaluation at a Trauma Center.
 Score range is from – 6 to + 12.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HEAD TRAUMA
BLS CARE GUIDELINE**



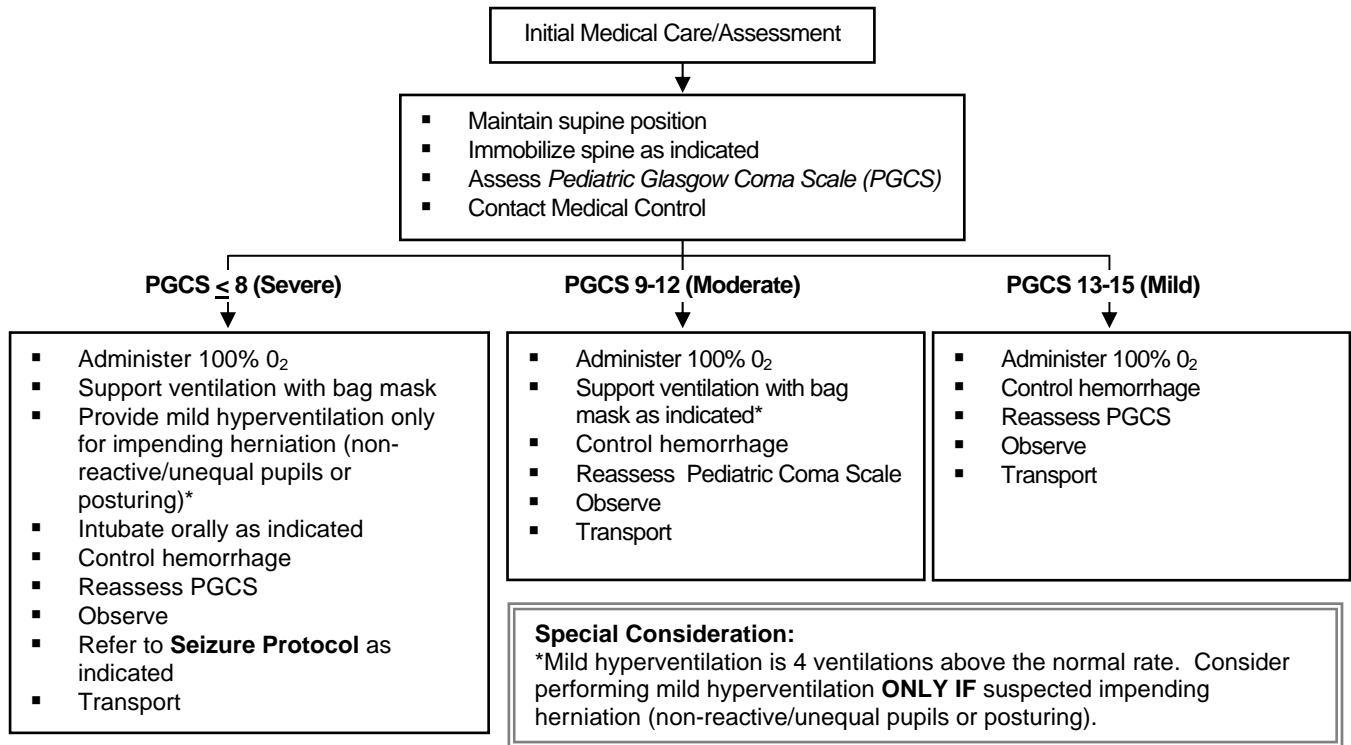
Special Consideration:

*Mild hyperventilation is 4 ventilations above the normal rate. Consider performing mild hyperventilation **ONLY IF** suspected impending herniation (non-reactive/unequal pupils or posturing).

PEDIATRIC GLASGOW COMA SCALE (PGCS)

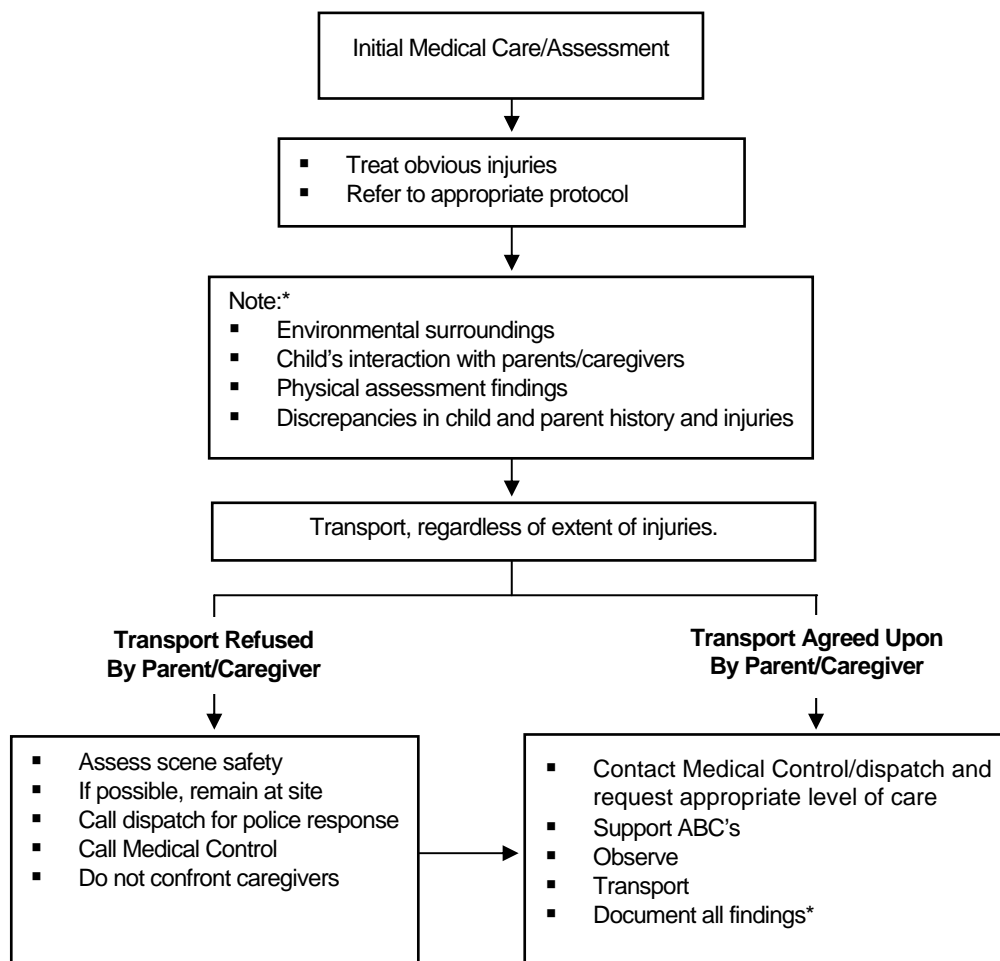
	> 1 Year		< 1 Year	Score
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	2-5 Years	0-23 months	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				(3-15)

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
PEDIATRIC HEAD TRAUMA
ALS CARE GUIDELINE**



PEDIATRIC GLASGOW COMA SCALE (PGCS)				
	> 1 Year		< 1 Year	Score
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	2-5 Years	0-23 months	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				(3-15)

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
SUSPECTED CHILD ABUSE & NEGLECT
BLS/ALS CARE GUIDELINES**



**REPORT SUSPICIONS TO ED PHYSICIAN, ED CHARGE NURSE AND DCFS (1-800-25-ABUSE).
WHEN CONTACTING DCFS, IDENTIFY SELF AS A STATE MANDATED REPORTER TO EXPEDITE
PROCESS.**

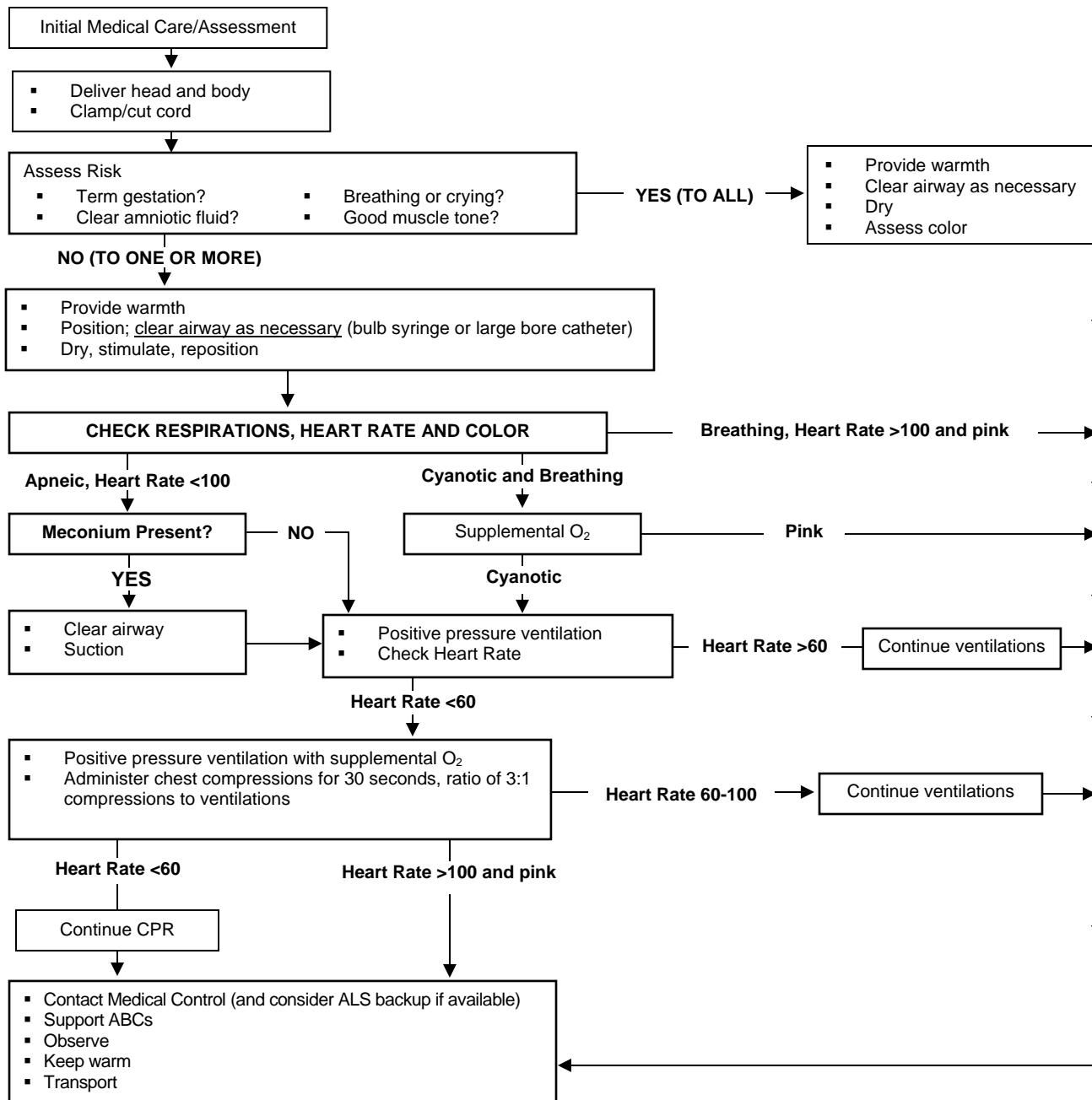
*Refer to back of page for special considerations.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
SUSPECTED CHILD ABUSE & NEGLECT
BLS/ALS CARE GUIDELINES**

SPECIAL CONSIDERATIONS:

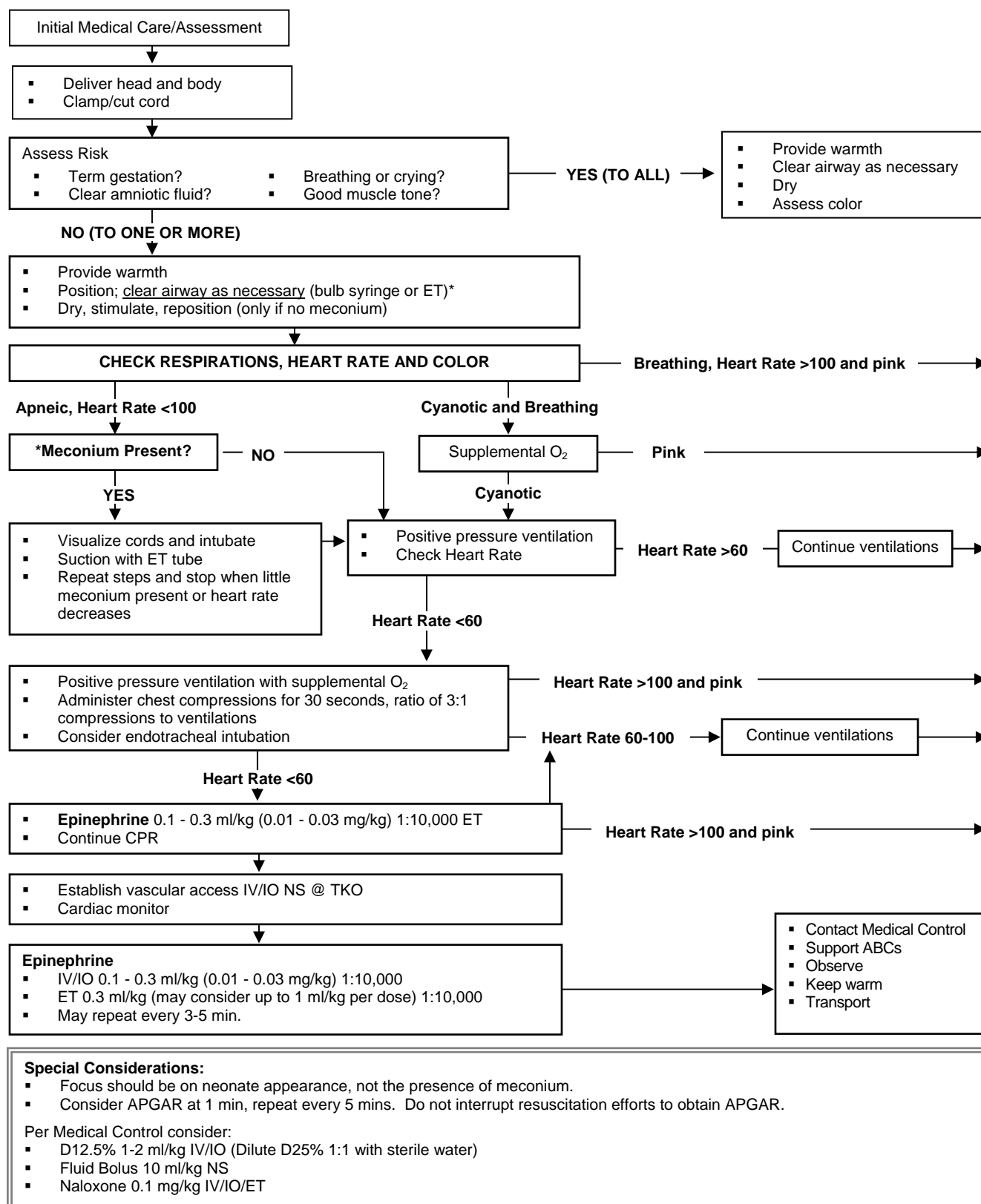
1. You are required by law to report your suspicions.
2. Document findings objectively:
 - Body location of the injury
 - Severity of the injury
 - Patterns of similar injury over time
 - Include verbatim statements offered by the child
 - Note verbatim statements from the parent/caregiver
3. Suspect battered or abused child if any of the following is found:
 - A discrepancy exists between history of injury and physical exam.
 - Caregiver provides a changing or inconsistent history.
 - There is a prolonged interval between injury and the seeking of medical help.
 - Child has a history of repeated trauma.
 - Caregiver responds inappropriately or does not comply with medical advice.
 - Suspicious injuries are present, such as:
 - injuries of soft tissue areas, including the face, neck and abdomen,
 - injuries of body areas that are normally shielded, including the back and chest,
 - fractures of long bones in children under 3 years of age,
 - old scars, or injuries in different stages of healing,
 - bizarre injuries, such as bites, cigarette burns, rope marks, imprint of belt or other object,
 - trauma of genital or perianal areas,
 - sharply demarcated burns in unusual areas,
 - scalds that suggest child was dipped into hot water.
4. The following are some common forms of neglect:
 - Environment is dangerous to the child (e.g., weapons within reach, playing near open windows without screen/guards, perilously unsanitary conditions, etc.).
 - Caretaker has not provided, or refuses to permit medical treatment of child's acute or chronic life-threatening illness, or of chronic illness, or fails to seek necessary and timely medical care for child.
 - Child under the age of 10 has been left unattended or unsupervised. (Although in some situations children under 10 years of age may be left alone without endangerment, EMS personnel cannot make such determinations.) All instances should be reported for DCFS investigation.
 - Abandonment
 - Caretaker appears to be incapacitated (e.g., extreme drug/alcohol intoxication, disabling psychiatric symptoms, severe illness) and cannot meet child's care requirements.
 - Child appears inadequately fed (e.g., seriously underweight, emaciated, or dehydrated) inadequately clothed, or inadequately sheltered.
 - Child is found to be intoxicated or under the influence of an illicit substance(s).

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
NEONATAL RESUSCITATION
BLS CARE GUIDELINE**

**Special Considerations:**

- Focus should be on neonate appearance, not the presence of meconium.
- Consider APGAR at 1 min, repeat every 5 mins. Do not interrupt resuscitation efforts to obtain APGAR.

**QUINCY AREA EMS SYSTEM
ILLINOIS EMSC
NEONATAL RESUSCITATION
ALS CARE GUIDELINE**



QUINCY AREA EMS SYSTEM SYSTEM PERSONNEL

P-1	Listing of ECRN's, EMS Physicians
P-2	EMT-P Duties
P-3	EMT-B Duties
P-4	EMT-D Skills —DELETED 4/15
P-5	Field Evaluator Description
P-5 F1	Field Evaluation Form —DELETED 11/10
<i>P-5 F2</i>	Field Evaluator Qualifications Checklist & Agreement
<i>P-5 F3</i>	Field Evaluation Application
<i>P-6</i>	System candidate requirement
P-6Fa	System candidate ER Clinical Form EMTP/PHRN level
P-6Fb	System candidate ALS ambulance call management form
P-6Fc	System candidate ALS ambulance clinical form
P-6Fd	System candidate evaluation of ambulance clinical
P-7F	Change of Address Form
P-7-Fa	Quincy Area EMS System Entrance Application
P-7-Fb	Candidate Requirement Check Off Form
<i>P-8</i>	<i>EMT-P</i> Relicensure Requirements
P-9	EMS Medical Director Job Description
P-10	EMS System Coordinator Job Description
P-11	EMS Physician Duties
P-12	EMS Physician Education
P-13	Emergency Communications RN Duties
P-14	DELETED ECRN Prerequisites
P-15	DELETED ECRN Training Requirements
P-16	ECRN Recertification
P-17	Inactive Status
P-18	EMS Administrative Director
P-19	EMT-D Prerequisites/Training
P-20	Annual AED Skill Validation DELETED 2/11/11
P-21	DELETED Prehospital RN Prerequisites/Training
P-22	DELETED Prehospital RN Rectification
P-23	EMT-B Recertification
P-24	Extensions
P-25	Alternate EMS Medical Director
P-26	State Written Exam Testing Fees
P-27	Updating the IDPH Webpage for Relicensure
P-28	Renewal EMS Lead Instructor
P-29	Voluntary Reduction of Certification/Reinstatement
P-30	First Responder
P-31	First Responder AED
P-32	Emergency Medical Dispatcher
P-33	TNS Recertification
P 34	<i>Reinstatement of Expired License</i>

Revised 4/2010; 11/10, 2/12, 3/15

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
EMS SYSTEM PERSONNEL**

BLESSING HOSPITAL ECRN'S

- | | |
|-----------------------------------|-----------------------|
| 1. Baird, Deanna | 23. Miller, Sondra |
| 2. Bartells, Dana | 24. Mittelberg, Karen |
| 3. Behl, Dennis | 25. Mohr, Marie |
| 4. Behrens, Michael | 26. Muder, Kathy |
| 5. Bischel, Joan | 27. Nord, Janice |
| 6. Brown, Jessica | 28. Osborn, Diana |
| 7. Cepeda, Cristina | 29. Parrack, Laura |
| 8. Coonrod, William | 30. Phillips, Tim |
| 9. Doellman, Holly | 31. Powell, Tara |
| 10. Ehresman, Alision | 32. Richard, Michael |
| 11. Franks, Angela | 33. Roberts, Jennifer |
| 12. Gallaher, Jennifer | 34. Schroeder, Lori |
| 13. Garner, Linda | 35. Shelts, Sara |
| 14. Harpole, Laura | 36. Smith, Ed |
| 15. Harris, Heidi | 37. Walton, Chris |
| 16. Harris, Kendra | 38. Webster, Kristin |
| 17. Helmke (Billingsley), Lyndsay | 39. Wells, James |
| 18. Hilgenbrick-Cassens, Erica | 40. Williams, Nicole |
| 19. Klingler, Kimberly | 41. Williams, Susan |
| 20. Knochel, Rick | 42. Wiley, Randi |
| 21. Lewellen (Siefert), Erin | 43. Yeater, Susan |
| 22. Loos (Ebbing), Jessica | 44. |

ILLINI COMMUNITY HOSPITAL ECRN'S


- | | |
|--------------------|---------------------|
| 1. Barnes, Jane | 7. Sargent, Carrie |
| 2. Collard, Candy | 8. Sebastino, Joann |
| 3. Ford, Sarah | 9. Smith, Heather |
| 4. Frazier, Teresa | 10. Syrcle, Cheryl |
| 5. Freeman, Nancy | 11. Wassell, Chris |
| 6. Martin, Amy | |

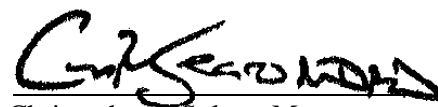
BLESSING HOSPITAL EMS PHYSICIANS

- | | |
|-------------------------|---------------------------|
| 1. Dr. Thomas Cliatt | 6. Dr. Christopher Solaro |
| 2. Dr. Scott Hough | 7. Dr. Bruce Stooops |
| 3. Dr. Craig Huston | 8. Dr. Joseph Tirado |
| 4. Dr. Stuart Pyatt | 9. Dr. Antony Wollaston |
| 5. Dr. Richard Saalborn | |

ILLINI COMMUNITY HOSPITAL EMS PHYSICIANS

- | | |
|----------------|--------------------|
| 1. Dr. Alrhan | 6. Dr. Kuhananthan |
| 2. Dr. Alzein | 7. Dr. Raso |
| 3. Dr. Glasgow | 8. Dr. Semenza |
| 4. Dr. Holden | 9. Dr. Solaro |


Richard A. Saalborn, D.O., FACEP, FACOEP
EMS Medical Director
Quincy Area EMS System


Christopher R. Solaro, M
Associate Medical Director
Quincy Area EMS System

10/87
re: 8/89, 9/91, 9/92, 3/94, 8/95, 11/97, 5/98
12/99, 8/01, 1/02, 8/02, 8/05, 2/10, 3/15

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

PARAMEDIC DUTIES

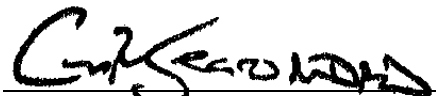
NOTE: In addition to all Basic Life Support patient care procedures approved for use in this system, paramedics may also perform the following Advanced Life Support patient care procedures.

1. 12 Lead EKG
2. Advanced patient assessment
3. Cardiac monitoring
4. Combitube airway insertion
5. Cricothyrotomy
6. Defibrillation
7. Endotracheal bolus administration
2. Endotracheal intubation and ventilation techniques
3. External cardiac pacing
4. External jugular vein cannulation
3. Insertion and ventilation using esophageal airways
4. Intramuscular injections
5. Intraosseous infusion
6. Intravenous bolus medication administration
7. Intravenous drip infusion
8. Nasotracheal intubation and ventilation techniques
5. Nebulizer medication administration
6. Needle chest decompression
5. Oral medication administration
6. Peripheral intravenous cannulation
7. Retrieval of a foreign body from the airway using direct laryngoscopy
8. Subcutaneous injections
9. Sublingual medication administration
10. Synchronized cardioversion
11. Tracheal suctioning
12. Transtracheal needle ventilation
11. Venous phlebotomy
12. CPAP

Any procedure/process as described in this policy manual



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QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

EMT-B DUTIES

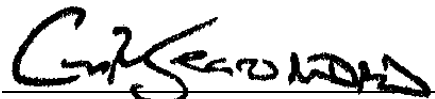
NOTE: EMT's in the Quincy Area EMS System may perform the following Basic Life Support patient care procedures when indicated.

1. Abdominal thrusts
2. Administration of oral and sublingual glucose
3. Assist patients with taking certain medications
4. Bag-valve mask ventilation
5. Cardiopulmonary resuscitation
6. Demand valve ventilation
7. Emergency vehicle operation
8. Hemorrhage control
9. Insertion of nasopharyngeal airways
10. Insertion of oropharyngeal airways
11. Mouth to mask ventilation
12. Obtain a patient history
13. Open an airway using the head tilt-chin lift, and jaw thrust methods
14. Patient extrication
15. Patient packaging
16. Pneumatic anti-shock garment application
17. Positive pressure ventilation
18. Primary survey
19. Record and communicate information gathered during the patient examination
20. Secondary survey
21. Supplemental oxygen delivery
22. *Defib with AED*

NOTE: Any procedure/process as described in this policy manual at a BLS level.



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EMS Medical Director
Quincy Area EMS System



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Associate Medical Director
Quincy Area EMS System

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMT-D SKILLS

NOTE: In addition to all the Basic Life Support patient care procedures approved for use in this system, EMT-D's may also perform the following Advanced Life Support patient care procedures:

1. Defibrillation with a semi-automated defibrillator


voided 3-1-2015

QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE

QUINCY AREA EMS SYSTEM PARAMEDIC FIELD EVALUATOR

- I. Purpose of the QAEMS System paramedic field evaluator program: To ensure that EMS students and candidates entering the Quincy Area EMS System have a consistent training experience and evaluation process led by experienced paramedics who serve as role models exemplifying the standards of excellence for the EMS system.
- II. QAEMSS Field Evaluator Description
 - A. The paramedic Field Evaluator shall function as a resource, coach, facilitator and guide and is valued as a teacher but also as a role model.
 - B. Possesses a thorough knowledge of QAEMSS policies and procedures.
 - C. Is responsible and accountable for decisions made regarding patient care while supervising students and system candidates.
 - D. Orients, coaches, teaches and evaluates students and candidates in a fair and impartial manner.
- III. Program oversight
 - A. The EMS student or system candidate functions under the direct authority and license of the QAEMS System EMS Medical Director and designee(s) while under the direct supervision of the field evaluator.
 - B. The paramedic field evaluator provides direct clinical oversight to the EMS student or candidate during ambulance clinical while maintaining overall responsibility for the care of the patient.
 - C. The Field Evaluator is accountable to his/her employer, the EMS System Coordinator and the EMS Medical Director or designee.
 - D. QAEMSS field evaluators are not employees of Blessing Hospital or John Wood Community College.
- IV. Initial Requirements for Field Evaluator
 - A. Current valid Illinois Paramedic or Prehospital RN license.
 - B. Currently on the roster of an approved ALS-transport provider agency within the QAEMS System.
 - C. Minimum of three years experience as a licensed paramedic.
 - D. Must have the written approval of their agency administrator, the Blessing paramedic program director, the QAEMS EMS System Coordinator and EMS Medical Director.
 - E. Must have written recommendations from two current field evaluators (peers).
 - F. Complete the field evaluator orientation sponsored Blessing Hospital EMS Dept.
 - G. Complete the field evaluator application and the field evaluator agreement.
- V. Continuing requirement to maintain recognition of Field Evaluator
 - A. Attend a minimum of two meetings per year out of four (50%).
 - B. Complete any required mandatory updates , education or requirements by established deadlines.
 - C. Demonstrate ongoing clinical competence as assessed through routine system audits.
 - D. Must have no major patient care or operational issues that required serious disciplinary action.
 - E. Demonstrate effective communication skills in and out of the clinical setting.
 - F. Demonstrate leadership, respect and a professional manner of interacting with people in and out of the clinical setting.
 - G. Demonstrate the ability to fairly evaluate all students and to make evaluations based on performance.
 - H. Discuss and sign student clinical paperwork during the shift when possible and within 24 hours when not possible.

VI. Removal of Field Evaluator status is upon the direct authority of the EMS Medical Director or designee and is based upon not meeting the requirements outlined in section V. The status could be revoked permanently or for a period of time deemed appropriate.


Richard A. Saalborn, D.O., FACEP, FACOEP
EMS Medical Director
Quincy Area EMS System


Christopher R. Solaro, MD, PhD
Associate Medical Director
Quincy Area EMS System

6/84, re: 9/86, 7/92, 11/97, 8/01, 5/07, 3/15
(reviewed: 7/95)

**QUINCY AREA EMS SYSTEM
PARAMEDIC FIELD EVALUATOR QUALIFICATIONS CHECKLIST & AGREEMENT**

QUALIFICATIONS FOR NEW FIELD EVALUATOR

FE Initials	Program director initials	Valid Illinois paramedic or PHRN license
		Minimum of three years of experience as a paramedic or PHRN; currently employed by an ALS-transport agency in the QAEMS System.
		Written approval of ALS agency administration:
		Approval of EMS System Coordinator (signature below)
		Approval of Blessing Paramedic Program Director (signature below)
		Approval of EMS Medical Director or designee (signature below)
		Two written recommendations on file from FE peers:
		Completed application and this form on file
		Orientation completed

FIELD EVALUATOR EXPECTATIONS AND AGREEMENT

	I understand the purpose of a paramedic field evaluator is to provide a consistent training experience and fair evaluation process for EMS students and EMS system candidates.
	I understand that I must maintain knowledge of current paramedic practice and QAEMS System policies and procedures.
	I understand that I am responsible and accountable for decisions made regarding patient care while I am supervising students and EMS System candidates.
	I understand that students and system candidates function under the license and authority of the EMS Medical Director or designee and that all interventions must be performed under direct supervision.
	I agree to attend a minimum of two meetings per year (50%) and to complete all required or mandatory education or updates.
	I understand that I am a role model and that I should utilize effective means of communication to facilitate understanding by the student. This includes ensuring that all call managements are discussed with the student or system candidate within 24 hours.
	I agree that discussion of student or system candidate performance should be conducted in a professional manner and not in a manner that is belittling or judgmental or could lead to lead other evaluators to prejudging the student or system candidate.
	I understand that I have the authority to request remediation of student skills by contacting course faculty, the paramedic program director or the EMS System Coordinator.
	I understand that I have the authority to uphold student dress code and other rules for student conduct during the field internship.
	I fully understand the three phases of the paramedic program field internship and understand my role in each of those phases. I understand that I will be coaching through prompting, remediating on skills as needed and using good communication skills to discuss performance.

I affirm that I understand and agree to abide by QAEMS System policy P-5 and that deviation from the stated expectations may result in termination of my status as a QAEMS System field evaluator.

Field Evaluator Name – PRINT

Field Evaluator Signature

Date

EMS Medical Director / Designee

EMS System Coordinator

Blessing Paramedic Program Director

**Quincy Area EMS System
Field Evaluator Application**

I. General Information

Name: _____

Address: _____

Phone: _____

E-Mail address: _____

QAEMSS ALS-Transport Provider Agency(ies): _____

II. Education

Year licensed as a paramedic: _____

Please check all that apply

☐ High school diploma or GED

☐ College / University:

☐ Some college courses – major: _____

☐ Certificate: _____

☐ Degree: _____

☐ Degree: _____

Educator certifications – check box if current

☐ Illinois EMS Lead Instructor

☐ ACLS instructor

☐ BTLS or PHTLS instructor

☐ PALS or PEPP instructor

☐ Other instructor credentials – please list:

III. Experience as an instructor/coach/trainer

Briefly describe any experience that you have had as a coach/trainer/educator. This can include experience outside of EMS. (If you are an EMS Lead Instructor list courses / inservices / skills taught in past 2 years.)

What qualities do you possess that make you a good candidate for a Field Evaluator?

☐ Check if interested in being a mentor – Mentors are assigned each year prior to the beginning of the field internship. A mentor goes above and beyond the normal FE duties by allowing the student to contact them during and outside of work when they need some extra help or advice. Mentors have been instrumental in turning things around for students who are struggling with grades or with the field internship.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE
SYSTEM CANDIDATE REQUIREMENTS**

- I. Purpose: Demonstrates requirements/procedures for a First Responder, First Responder-D, Emergency Medical Dispatcher, ECRN, PHRN, EMT-B , or EMT-P to join the Quincy Area EMS System.
- II. FR, FRD, EMT-B, EMD
 - A. Prerequisites for all candidates listed as First Responder, First Responder-D, EMT-B, or EMD (*must continue to possess active licenses and credentials to stay active*)
 1. A completed application file which includes;
 - a) a completed Quincy Area EMS System Application (P-7-1 Fa)
 - b) copy of current Illinois First Responder, First Responder-D, EMD, or EMT-B, licensure.
 - c) A copy of current CPR
 - d) Interview with EMS Medical Director or EMS System Coordinator if requested by Medical Director (to clarify question that arose from any item in A. 1.)
 - e) Successful completion of the Quincy Area EMS System test for EMD, FR, FRD, and EMTB's (80% minimum score).
 - f) Successful completion (80% minimum)of START Triage PowerPoint for EMD, FR, FRD, EMTB, ECRN, and EMTP's
 - g) A copy of a current PEPP/PALS card effective 1/1/2012 (for FR, FRD, EMTB only) (If new to the system, you will have 6 months to complete)
 - h) A copy of a current PHTLS/ITLS card effective 1/1/2014 (for FR, FRD, EMTB only) (If new to the system, you will have 6 months to complete)
 - B. Applicants from outside the Quincy Area EMS System who hold an Illinois licensure for any of the above must meet the same requirements as noted above and successful skills validation on the following skills:
 1. Finger stick glucose
 2. Traction splint
 3. Patient assessment – medical
 4. Patient Assessment – trauma
 5. Cardiac arrest management with AED
 6. Spinal immobilization on long spine board
 7. Spinal immobilization on KED
- III. EMT-Paramedic, ECRN, or PHRN
 - A. Prerequisites for all candidates listed in B. and C below.
 1. A completed application file which includes:
 - a) A completed System Entrance Application (P-7 Fa)
 - b) A copy of current Illinois EMT-P, ECRN, or Prehospital RN licensure
 - c) A letter of recommendation from the EMS Medical Director or EMS System Coordinator from either the applicants training site or last system of participation. This letter should include skills and continuing education completed since last license renewal.
 - d) Interview with either the EMS Medical Director or EMS System Coordinator if requested by Medical director (to clarify any questions that arose from any item in A.1.)
 - e) Successful completion of the Quincy Area EMS System written examination (80% minimum score).
 - f) A copy of current CPR for health care providers card or certificate.
 - g) A copy of current AHA ACLS card or certificate.
 - h) Successful completion (80% minimum)of START Triage PowerPoint for EMD, FR, FRD, EMTB, ECRN, and EMTP's


- i) Signed Paramedic Contract For Controlled Substances(Policy O-14 F3)
 - j) A copy of current PEPP/PALS card (effective 1/1/2012 for EMTP and PHRN only) (If new to the system, you will have 6 months to complete)
 - k) A copy of current PHTLS/ITLS card (effective 1/1/2014 for EMTP and PHRN only) (If new to the system, you will have 6 months to complete)

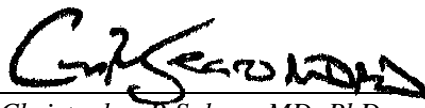
- B. Applicants from outside the Quincy Area EMS System who hold an Illinois EMT-P license or Prehospital RN license
 - 1. 24 hours of ER clinical meeting required objectives (must use form P-6-Fa)
 - a) Three IV insertions rated at proficiency level of "3"
 - b) Three IVP medication administration rated at proficiency level of "3"
 - c) Three cardiac rhythm interpretations rated at proficiency level of "3"
 - 2. 40 hours ALS ambulance clinical under supervision of a Field Evaluator with successful completion of 10 ALS calls as the team leader, one of which must be a priority one call (must use forms P-6-Fb, P-6-Fc, P-6-Fd)
 - 3. Successful skills validation on the following skills:
 - a) Needle chest decompression
 - b) Cricothyrotomy
 - c) Combitube airway
 - d) Twelve lead EKG
 - e) Intraosseous. EZIO
 - f) Transtracheal needle ventilation
 - 4. Review PowerPoint and complete quizzes on the following:
 - a) Chest Pain Protocol
 - b) Start Triage
 - c) Transfer and infusion medication update
 - d) EZIO
 - e) Hypothermia
 - f) Controlled substance policy (sign O-14-F3)
 - g) CPAP

- C. Applicants who hold licensure or certification as a paramedic or Prehospital RN from another jurisdiction other than Illinois must acquire Illinois licensure then complete A & B above.

- D. Any applicant who had been a participant in the Quincy Area EMS System that had left (*for 9 months or more*) and wants to return must complete the following:
 - 1. A and B above
 - 2. Complete all mandatory education on new and/or revised policies from the period that they were not functioning in the Quincy Area EMS System.

- E. All candidates must be affiliated with an existing provider service recognized by the Quincy Area EMS System.


 Richard A. Saalborn, D.O., FACEP, FACOEP
 EMS Medical Director
 Quincy Area EMS System


 Christopher R. Solaro, MD, PhD
 Associate Medical Director
 Quincy Area EMS System

QUINCY AREA EMS SYSTEM

SYSTEM CANDIDATE CLINICAL FORM EMT-P / PHRN LEVEL

INSTRUCTIONS:

1. All advanced level skills are to be performed ONLY under direct supervision by a RN, physician or ERT-II (paramedic level).
2. Do not perform any skill outside your scope of practice.
3. The candidate completes first 2 columns – date and information about the skill. The person supervising the skill completes skill proficiency level, comments and signs.

IV INSERTION				
DATE	IV site; catheter size; reason for IV insertion.	SKILL LEVEL	STAFF COMMENTS	SIGNATURE: RN; PHYSICIAN; EMT-P

IV PUSH MEDICATION ADMINISTRATION				
DATE	Drug name and dose; reason for administration	SKILL LEVEL	STAFF COMMENTS	SIGNATURE: RN; PHYSICIAN; EMT-P

CARDIAC RHYTHM INTERPRETATION				
DATE	Rhythm interpretation	SKILL LEVEL	STAFF COMMENTS	SIGNATURE: RN; PHYSICIAN; EMT-P

SKILL PROFICIENCY LEVELS

LEVEL 1: Beginning level; requires assistance and prompting to complete the procedure/ skill or improperly performs procedure or potentially dangerous action.

LEVEL 2: Good technique; Requires minimal prompting.

LEVEL 3: Proficient; good technique, requires no assistance.

QUINCY AREA EMS SYSTEM
ALS AMBULANCE CLINICAL CALL MANAGEMENT FORM

SECTION 1: GENERAL INFORMATION – CANDIDATE COMPLETES

DATE: _____ CANDIDATE NAME: _____

ALS Agency: ☐ Adams County Ambulance ☐ Hancock County Ambulance ☐ Pike County Ambulance

Check appropriate category for the call:

☐ ALS ☐ BLS ☐ Priority 1 ☐ Priority 2 ☐ Priority 3

Priority 1: Immediate threat to life or limb requiring intervention or multifarious call consisting of many different and disparate signs/symptoms that requires treatment under multiple pathways. Examples = respiratory arrest; cardiac arrest; chest pain / cardiac / STEMI; cardiac condition requiring meds or electrical intervention; category I or II trauma requiring immediate interventions.

Priority 2: Potential threat to life or limb but no need of immediate intervention.

Priority 3 : No immediate threat

☐ Pediatric birth to age 18 ☐ Adult age 19-64 ☐ Geriatric age 65 or >

Chief complaint/ MOI: _____

SECTION 2: PERFORMANCE – FIELD EVALUATOR COMPLETES

ALL CANDIDATES AT THE EMT-P OR PHRN LEVEL ARE BEING EVALUATED AT THE EVALUATION PHASE LEVEL

Circle the word “prompt” and check the skill that was prompted to indicate that a prompt was given.

Important: Were the candidate’s actions timely, appropriate, safe, within protocol? If yes, consider the action as satisfactory.

Scene *Assesses scene safety, need for additional personnel, takes appropriate actions, utilizes appropriate PPE. Timely contact with the patient. Able to delegate, multi-task and make decisions.*

Prompt: ☐ Safety ☐ Delegation ☐ Multitasking ☐ Decisions (what to do, when to do, how to do)

Comment: _____

Initial Assessment *Completes the initial assessment (airway/breathing/circulation/mental status/expose) within 1 minute of patient contact and addresses any problems found.*

Prompt: ☐ C-spine ☐ Airway/reposition/adjunct ☐ Breathing/O2/BVM ☐ Circulation/CPR/Bleeding control ☐ AVPU ☐ Expose

Comment: _____

History *Obtains chief complaint, SAMPLE history*

Prompt: ☐ Chief complaint ☐ SAMPLE ☐ OPQRST ☐ Other: _____

Comment: _____

Physical Exam *Completes all pertinent components of physical exam based on chief complaint/MOI*

Mark type of assessment done: ☐ Focused ☐ Rapid trauma assessment ☐ Detailed

Prompt: ☐ Pulse ☐ BP ☐ RR ☐ Lung sounds ☐ Pupils ☐ Pulse ox ☐ EtCO2 ☐ PMS ☐ Palpate ☐ Monitor ☐ 12 lead

☐ Cincinnati stroke scale ☐ Blood sugar ☐ Other: _____

Comment: _____

Protocols/Standard of Care *Intervenes within the framework of accepted medical standards, protocols and standing orders. Begins appropriate treatment within an acceptable time frame. The student should be treating the patient based on their assessment, not basing decisions on what they think the Field Evaluator wants them to do.*

Prompt: ☐ Differential diagnosis ☐ Knowledge of protocols ☐ Implementation ☐ Understands rationale for actions

Comment: _____

Reassessment *Reassesses after interventions and for change in condition.*

Prompt: ☐ C/C ☐ Vital signs ☐ ABC’s ☐ Lung sounds ☐ Pulse ox ☐ Pupils ☐ PMS ☐ Pain scale

Comment: _____

Professionalism *Fulfills responsibilities for professional conduct during the call.*

Prompt: ☐ Honesty ☐ Courtesy ☐ Confidentiality ☐ Accountability ☐ Accepts constructive criticism

Comment: _____

Communication *Establishes and maintains effective lines of communication during and after the call.*

Prompt: ☐ Listening ☐ Patient ☐ Family/Caregiver/Bystander ☐ EMS Crew ☐ Law enforcement/fire department

Comment: _____

SECTION 3: SKILLS CANDIDATE CIRCLE P FOR SKILL PERFORMED; FIELD EVALUATOR RATE SKILL

- 1 = Required more than two prompts during skill performance and/or poor technique.
2 = Required 1-2 prompts and good technique
3 = Required no prompts and good technique

Note: Skills should be performed in accordance within parameters of EMTP standard of care. Reference current paramedic text.

P 1 2 3 Basic airway adjunct	P 1 2 3 Combitube airway	P 1 2 3 Endotracheal intub.
P 1 2 3 Tracheal suctioning	P 1 2 3 Magill forceps	P 1 2 3 Bag valve device
P 1 2 3 Oxygen administration	P 1 2 3 Pulse oximetry	P 1 2 3 EtCO2
P 1 2 3 Blood glucose / FSG	P 1 2 3 Peripheral IV therapy	P 1 2 3 Access CVAD
P 1 2 3 Oral/SL med admin.	P 1 2 3 SubQ or IM injection	P 1 2 3 IVP medication
P 1 2 3 Nebulizer	P 1 2 3 Topical medication	P 1 2 3 IVPB / Med infusion
P 1 2 3 Cardiac monitor	P 1 2 3 Cardiac rhythm interp.	P 1 2 3 12 lead ECG
P 1 2 3 Defibrillation / synch CV	P 1 2 3 Transcutaneous pacing	P 1 2 3 CPR
P 1 2 3 PASG	P 1 2 3 Hemorrhage control	P 1 2 3 Splinting
P 1 2 3 Spinal immobilization	P 1 2 3 Needle chest decomp.	P 1 2 3 Intraosseous infusion
P 1 2 3 OB delivery	P 1 2 3	P 1 2 3

☐ Prompt(s)- (specify): _____

☐ Remediation by Field Evaluator after call (specify): _____

☐ Requires remediation by EMS System Coordinator and re-validation of the skill (specify) _____

Verbal Reports *Radio or cell phone contact with medical control/ receiving hospital; Gives concise report and requests orders as needed; Gives complete hand off report to appropriate staff member at receiving facility.*

1 2 3

Prompt (specify):

Comment:

Documentation *Provides complete documentation using Illinois PCR form or Intermedix.*

1 2 3

Prompt (specify):

Comment:

SECTION 4: OVERALL SCORE – FIELD EVALUATOR COMPLETES, DISCUSSES WITH CANDIDATE, BOTH SIGN

- ☐ Successful / Satisfactory
☐ Unsuccessful / unsatisfactory

EVALUATION PHASE: Unsuccessful if more than one prompt OR any repetitive prompt OR severity of any one prompt.

A repetitive prompt means that this candidate has already received a prompt for the same skill or situation during that shift or have been advised of an issue regarding this candidate and a repetitive prompt.

Field Evaluator comments: (Be specific about what went well and what the candidate must correct in order to obtain a satisfactory rating on future runs. _____

Field Evaluators must discuss performance with the candidate either during the shift or by phone within 24 hours.

- ☐ Discussed with candidate during shift
☐ Discussed with candidate by phone

Field Evaluator Signature: _____

Candidate Signature: _____

ALL PAPERWORK IS TO BE SUBMITTED TO BLESSING EMS DEPT. WITHIN 24 HOURS OF END OF SHIFT. RETURN TO CANDIDATE FOR SUBMISSION OR FIELD EVALUATOR CAN SUBMIT IN PERSON OR VIA INTERDEPARTMENTAL MAIL IN A SEALED ENVELOPE. MANILA ENVELOPES WILL BE PROVIDED BY THE EMS DEPARTMENT UPON REQUEST.

**QUINCY AREA EMS SYSTEM
ALS AMBULANCE CLINICAL**

SECTION 1 - GENERAL INFORMATION – CANDIDATE COMPLETES		
CANDIDATE NAME	DATE	SHIFT START: END: TOTAL HOURS
CLINICAL LOCATION <input type="checkbox"/> ADAMS COUNTY AMBULANCE <input type="checkbox"/> HANCOCK COUNTY AMBULANCE <input type="checkbox"/> PIKE COUNTY AMBULANCE		
ALL LICENSED PARAMEDIC OR PHRN LEVEL APPLICANTS FROM OUTSIDE THE QAEMS SYSTEM ARE BEING EVALUATED AT THE EVALUATION PHASE LEVEL.		
SECTION 2 – DAILY BEHAVIORAL EVALUATION – FIELD EVALUATOR COMPLETES		
YES/NO	ACTIVITY	COMMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	On time, follows dress code, good hygiene, has necessary equipment.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Completed assigned tasks outside of ambulance runs such as rig checks.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Discussed objectives & needs for this clinical experience.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Actively participated in calls and solicited feedback after the call.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Communicated effectively with staff, patients and others on and off scene.	
SECTION 3 – OVERALL RATING OF SHIFT BY FIELD EVALUATOR – MARK 1 BOX BELOW		
<input type="checkbox"/> Satisfactory (Good communication, candidate listens and follows instructions, satisfactory shift) <input type="checkbox"/> Unsatisfactory (Poor communication, candidate not receptive to constructive criticism, problem with skills or other – please specify in comments below)		
COMMENTS BY FIELD EVALUATOR:		

EMT/P/FIELD EVALUATOR SIGNATURE

CANDIDATE SIGNATURE

**QUINCY AREA EMS SYSTEM
ALS AMBULANCE CLINICAL**

EVALUATION PHASE

GOALS: To evaluate the candidate's overall ability to function in the field as an effective paramedic and team leader.

OBJECTIVES:

1. Complete a minimum of forty hours ALS ambulance clinical with approved QAEMS System Field Evaluators. (See list of Field Evaluators) If Field Evaluator not available, contact EMS System Coordinator.
2. Team lead a minimum of 10 ALS calls with a satisfactory rating.
3. Team lead a minimum of one "priority 1" ALS call (included in the 10 above).
4. Achieve a success rating on ALS call management of 80% or higher by the end of this clinical rotation.

CALL LEVEL PRIORITY

Priority 1: Immediate threat to life or limb requiring intervention or multifarious call consisting of many different and disparate signs/symptoms that requires treatment under multiple pathways. Examples = respiratory arrest; cardiac arrest; chest pain / cardiac / STEMI; cardiac condition requiring meds or electrical intervention; category I or II trauma requiring immediate interventions; other medical condition requiring immediate intervention with medications.

Priority 2: Potential threat to life or limb but no need of immediate intervention.

Priority 3: No immediate threat

PAPERWORK TO BE SUBMITTED TO THE EMS DEPARTMENT AT THE END OF SHIFT. IF DEPARTMENT IS CLOSED PLACE COPIES IN THE PROVIDED ENVELOPE, LABEL IT ATTN RANDY FAXON, SEAL IT AND SLIDE IT UNDER THE EMS SECRETARY OR EMS SYSTEM COORDINATOR'S DOOR.

1. For each shift completed submit 1 completed clinical sheet (this form).
2. For each call management completed submit the completed call management form with a copy of the run sheet.
3. For each shift completed submit a copy of the candidate shift evaluation.

QUINCY AREA EMS SYSTEM
CANDIDATE EVALUATION OF AMBULANCE CLINICAL EXPERIENCE

PRINT Candidate Name:	Date:
Field Evaluator Name(s):	

Instructions: This form is to be completed by the candidate after each ambulance clinical shift. Return the form to the EMS System Coordinator with other required paperwork for the shift.

Ratings: 4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly Disagree

Evaluate Items	Rating	Comments (Must comment if rating of 1 or 2)
The Field Evaluator greeted you, made you feel welcome & treated you as a part of the EMS team.		
The Field Evaluator discussed your objectives for this clinical session after you initiated the discussion.		
The Field Evaluator encouraged patient contact and provided effective coaching while observing you perform patient care.		
The Field Evaluator served as an effective resource to answer your questions.		
The Field Evaluator demonstrated tact and impartiality in the evaluation of your activities.		
The Field Evaluator encouraged and engaged you in discussion of calls that you participated in.		
The Field Evaluator provided you with constructive feedback on your performance.		

YOUR OVERALL EXPERIENCE ON THIS CLINICAL SHIFT WAS

<input type="checkbox"/> Excellent	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	<input type="checkbox"/> TOTALLY UNSATISFACTORY
------------------------------------	-------------------------------	-------------------------------	-------------------------------	--

Candidate comments: (If rating of Fair, Poor or Totally Unsatisfactory you MUST explain below.)

Candidate Signature & Title: _____

EMS System Coordinator Signature: _____

.....

EMS System Coordinator follow up on comments: _____

☐ Follow up with EMS Medical Director

☐ Follow up with Field Evaluator

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

CHANGE OF ADDRESS FORM

Purpose: To assure that proper communication by mail can be completed, all members of the Quincy Area EMS System must notify the EMS Office within 10 days of a change of address using the form below.

Complete the checklist below and submit to the Quincy Area EMS System Coordinator within 10 days of address change.

Date submitted: _____

1. Name: _____
(Last) (Maiden *if applicable) (First) (Middle)

Date of Birth: _____ Sex: M F # of Years in EMS: _____

Old Address: _____
(Street) (City) (State) (Zip)

New Address: _____
(Street) (City) (State) (Zip)

Phone #: _____
(Home #) (Work #) (Cell phone #) (Pager #) (Fax #)

Email: _____
(Home email) (Work email)

2. Provider Level: EMD FRD EMTB EMTP PHRN ECRN ERP

License #: _____ Expiration Date: _____

Driver's License #: _____ State: _____

Social Security #: _____

3. Agency #1: _____ Agency #2: _____

Office Use Only (initial): _____ Database changed _____ IDPH data changed _____ Copy to file _____
--

Quincy Area EMS System, Blessing Hospital @14th Street, PO 7005, Quincy IL 62305-7005
Phone: (217) 223-8400, extension 6590 Fax: (217) 223-2087

**6/08
reviewed 3/15**

QUINCY AREA EMS SYSTEM APPLICATION

PERSONAL DATA

Name (Last)	(First)	Initial	Date of Birth
Address (Street)	(City)	(Zip Code)	SSN
Telephone Number (Home)	Cell Phone	E-mail address	
Height: ft inches	Hair Color:	Eye Color:	SSN #:

EMS ORGANIZATION

Service	Job Title
Business Address (City)	Telephone Number
Immediate Supervisor (Name)	Job Title

CURRENT EMPLOYMENT/OCCUPATION

Employer	Job Title
Business Address (City)	Telephone Number
Immediate Supervisor (Name)	Job Title

☐ **EMD**
 ☐ **FR**
 ☐ **FRD**
 ☐ **ECRN**
TRAINING

Training Location	Instructor
Date Training Completed	IL Certification # Expires

☐ **EMT-B**
 ☐ **EMT-I**
 ☐ **EMT-P**
 ☐ **PHRN**
TRAINING

EMT Training Location	Instructor
Date Training Completed	IL Certification Number Expires

EMS LEAD INSTRUCTOR

Course Location	Date
IL Certification #	Expires

FIELD EVALUATOR (EMT-P/PHRN ONLY)

☐ Currently Function at Field Evaluator Level

Field Evaluator Training - Year	Location
---------------------------------	----------

IMERT

BACKGROUND INFORMATION

Have your privileges in Emergency Medical Services ever been revoked or suspended? ☐ Yes ☐ No

Have you been placed into a disciplinary process related to your EMT certification/or licensure level? ☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

If any of the above answers are yes, please explain below:

Provider shall have a primary affiliation with an EMS system.

Your primary affiliation is with: _____

Are you affiliated with any other EMS System ☐ Yes ☐ No.

If yes, document any other EMS system : _____

I have read and I am familiar with the policies and procedures contained in the Quincy Area EMS Policy Manual:

Our policy manual is located: _____

Print Name: _____ Date: _____

PLEASE NOTE: Falsification of any of the above information will result in suspension from practice in the Quincy Area EMS System

APPLICANT SIGNATURE

DATE

EQUAL OPPORTUNITY CLAUSE

The Quincy Area EMS System will make no discrimination because of race, sex, religion, national origin, ancestry or political affiliation.

FOR OFFICE USE ONLY

Date Application Received:

Information Complete/Incomplete:

☐ LICENSE COPY ON FILE

☐ PICTURE ON FILE

☐ REVIEWED BY EMS MEDICAL DIRECTOR OR DESIGNEE

Reviewed 8/01
Revised 2/03, 2/13, 3/15

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE****CANDIDATE REQUIREMENTS****NAME:** _____**DATE:** _____

Purpose: To determine whether a candidate (EMT-P or Prehospital RN) has completed the requirements necessary to join the Quincy Area EMS System

I. Requirements for all candidates:

- ☐ A complete QAEMS System application
- ☐ Copy of current Illinois EMT-P/PHRN license.
- ☐ Copy of current AHA ACLS.
- ☐ PEPP/PALS (effective 01/01/2012) *(If new to the system, you will have 6 months to complete)*
- ☐ PHTLS/ITLS (effective 01/01/2014) *(If new to the system, you will have 6 months to complete)*
- ☐ Copy of current health care provider CPR.
- ☐ Letter of recommendation from the EMS Medical Director or EMS System Coordinator from the applicant's training site OR last EMS System of participation. The letter should include clinical, skill and didactic training hours. For new graduates it should also include grade average and skill competencies.
- ☐ Interview with either the EMS Medical Director or the EMS System Coordinator if requested.
- ☐ Successful completion of the QAEMS System written examination (80% minimum score).
- ☐ 24 hours ER clinical demonstrating proficiency in skills. (Form P-6-Fa must be completed and returned to EMS Office)
- ☐ Up to 40 hours System ALS ambulance under supervision of a Field Evaluator. (Form P-6-Fb, P-6-Fc, P-6-Fd must be completed and sent to EMS Office)
- ☐ Completion of basic and advanced skill validation.
- ☐ Photograph for file

Requirements for all candidates (continued):

- ☐ ID Card Issued
- ☐ Complete quiz on Chest Pain Protocol
- ☐ Start Triage
- ☐ Transfer and infusion medications
- ☐ EZIO
- ☐ Hypothermia protocol
- ☐ Controlled substance policy (sign O-14-F3)
- ☐ CPAP Protocol
- ☐ *Zofran Protocol*
- ☐ *Phenergan Protocol*

Date all requirements completed: _____

EMS System Coordinator

EMS Medical Director

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE****CANDIDATE REQUIREMENTS**

Purpose: To determine whether a candidate (FR, FRD, EMTB, EMD) has completed the requirements necessary to join the Quincy Area EMS System

NAME: _____

DATE: _____

- ☐ System Application
- ☐ Copy of current Illinois license _____ Expires: _____
- ☐ Copy of current CPR card: Date issued: _____ Expires: _____
- ☐ START Triage: _____
- ☐ Interview with Medical Director of EMS System Coordinator (if needed)
- ☐ System Test (80% minimum) _____
- ☐ Member of existing service: _____
- ☐ PEPP/PALS: Date issued: _____ Expires: _____
- ☐ PHTLS/ITLS Date issued: _____ Expires: _____
(effective 1/1/2014)

Date all requirements were completed: _____

EMS System Coordinator_____
EMS Medical Director

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMT-P/PHRN RELICENSURE REQUIREMENTS

To maintain status as a fully licensed EMT/Paramedic authorized to participate in the Quincy Area EMS System, and to remain eligible for relicensure every four years, the following established requirements must be met.

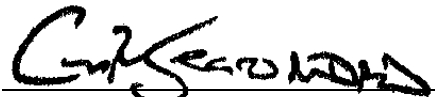
- I. Participation in 25 hours of approved continuing medical education per year. (100 hrs/4 year period)
 - A. 75% of continuing education classes must be at ALS level (90 hours in 4 years)
 - B. 16 hours/4 year period **MUST** be pediatric related programs.
 - C. Other hours may be obtained by attendance at approved seminars, courses, or other educational programs, i.e., ACLS, BTLIS, PALS. (See Policy CET-1)
 - D. No more than 25% of total hours may be in the same subject.
 - E. At least 50% of the total hours required *must* be earned through system taught/approved courses.
 - F. See Policy CET 1 for additional information.
- II. Maintain current American Heart Association CPR provider certification or equivalent and provide documentation of this upon each recertification.
- III. Maintain current American Heart Association ACLS provider certification and provide documentation of this upon each recertification. *Current PEPP/PALS; Current PHTLS/ITLS.*
- IV. System recertification every 2 years
 - A. On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS System Coordinator.
 - B. On the even years, all members will update all licensing and certificates.
 - C. A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).
- V. Demonstrate and maintain a high level of proficiency in all practical skills.
 - A. Paramedics having low numbers of ALS patients and/or whose experiences indicate a below standard skill level may be required to participate in additional educational programs and/or clinical hours at the discretion of the EMS Medical Director. Clinical hours could include any of the following:
 - 1. Surgery: completion of a minimum of two intubations.
 - 2. Emergency Department: completion of a minimum of two IV lines.
 - 3. ALS ambulance: completion of a minimum of two ALS runs.

- VI. An EMT-P whose license has expired may within 60 days of the license expiration, submit all relicensure material as required and a fee of \$50.00 in the form of a certified check or money order. If all material is in order and there is no disciplinary action pending against the EMT-P, the Department will relicense.
- VII. Any EMT-P whose license has expired for a period of more than 60 days shall be required to reapply for licensure, complete the training program and pass the test, and pay the fees required for initial licensure.

NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.



Richard A. Saalborn, D.O., FACEP, FACOEP
EMS Medical Director
Quincy Area EMS System



Christopher R. Solaro, MD, PhD
Associate Medical Director
Quincy Area EMS System

re: 7/86, 12/86, 6/87, 8/89, 7/92, 11/93, 11/97
5/98, 8/01, 1/02, 5/08, 2/10, 10/10, 3/15
(reviewed: 8/95, 11/2000)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS MEDICAL DIRECTOR

I. DEFINITION:

A physician who is medically and legally responsible for the Emergency Medical Services System. The EMS Medical Director is a licensed physician who demonstrates a high degree of competence in the trauma and critical care field of medicine. He is responsible for setting the standards of and coordinating the activities of the total EMS System within the designated geographical area. He is the primary liaison between the Resource Hospital and the Illinois Department of Public Health, the Associate Hospital Medical Director, and the Ambulance Services.

II. QUALIFICATIONS:

- A. A physician licensed to practice medicine in all its branches in Illinois and certified by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.
- B. Must be licensed by the State of Illinois and have the ability to diagnose and initiate therapy.
- C. Demonstrate an interest in the improvement of EMS and knowledge of the problems involved.
- D. Demonstrate a willingness to further his own education in areas of emergency care.
- E. Demonstrate a willingness to cooperate with the providers of ambulance services in the local area.
- F. Demonstrate leadership ability and initiative.
- G. Be thoroughly knowledgeable about and able to demonstrate all skills included in the scope of practices of all levels of EMS personnel within the System.
- H. Have or make provision to gain experience instructing students at a level similar to that of levels of EMS personnel in the System.
- I. Have experience on EMS vehicle at the highest level available within the System, or be willing to make provisions to gain such experience within 12 months prior to the date responsibility for the System is assumed or within 90 days after assuming the position.
- J. Successfully complete a Department approved EMS Medical Director's Course.

EMS MEDICAL DIRECTOR (CONTINUED)

III. DUTIES AND RESPONSIBILITIES:

- A. Create the policies to be utilized in the field and hospital operations of the EMS System.
- B. Obtain and keep current all necessary system approvals.
- C. Set up standards and curriculum for the training of EMT/B's and paramedics. To include keeping experience records on all EMT/P's and for collecting pertinent program data.
- D. Incorporate the policies of IDPH into the program's policies for certification and recertification of the paramedics.
- E. Initiate and approve the drug and treatment protocol to be used in the EMS System.
- F. Take complete medical legal responsibility for all paramedics recommended for certification and recertification.
- G. Insure a level of required quality control on all professionals who have patient contact within the EMS System.
- H. Evaluate the EMS runs, the type of care given to specific patients by EMT's in the field and physicians and nurses on telemetry and emergency department.
- I. To cooperate with the state personnel and associated hospitals for the improvement of the program.
- J. To be flexible and open to newer learning in order to upgrade the program.
- K. Have the verbal ability to present ideas and subject matter to trainees.
- L. Act as a resource person for professionals, administration, and the public.
- M. Direct responsibility to EMS Administrative Director of the EMS System in keeping him advised of all program operations.
- N. Designate an Alternate EMS Medical Director to supervise the system in his absence.
- O. Sets minimum qualifications of personnel within the EMS System and oversee that qualifications are met and kept.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS SYSTEM COORDINATOR

I. DEFINITION:

The designated individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System.

II. QUALIFICATIONS:

- A. A registered professional nurse or an EMT/P licensed in the State of Illinois.
- B. Be trained and knowledgeable in dysrhythmia identification and treatment in conjunction with a diverse background in critical care.
- C. Be knowledgeable in the care of the critically ill or injured patient.
- D. Within one year of being appointed, complete in-field observation and/or participation on at least ten ambulance runs at the highest level of service provided by the System.

III. DUTIES AND RESPONSIBILITIES

- A. The EMS System Coordinator is responsible for the following aspects as designated by the EMS Medical Director:
 - 1. Data collection and evaluation
 - 2. Coordination, Planning, and supervision of clinical, didactic, and field experience training, and physician and nurse education.
 - 3. EMS System Quality Assurance
 - 4. Monitors conformance of all participants to system policies and procedures.

Thomas Cliatt, D.O., EMS Medical Director

re: 9/86, 6/87, 11/87, 11/97, 8/01
(reviewed: 8/95)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS PHYSICIAN

DUTIES AND RESPONSIBILITIES

- I. An EMS Physician is a physician who has been approved by the EMS Medical Director, and is assigned the following responsibilities and duties:
 - A. Give voice orders to system participants via communications equipment in accordance with system approved treatment protocols.
 - B. When directions are not given via a ECRN, document calls completely and accurately recording information as required on the emergency department radio log.
 - C. Sign the patient report form of the transporting unit, indicating transfer of patient care to the receiving hospital when appropriate.
 - D. Monitor, supervise, and assist prehospital personnel fulfilling educational requirements in the clinical setting.
 - E. Perform other duties as may be assigned by the EMS Medical Director.
 - F. Monitor conformance to system policy and procedure.

Thomas Cliatt, D.O., EMS Medical Director

7/87, 11/97, 5/98, 1/02
(reviewed: 8/95, 8/01)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS PHYSICIAN

PREREQUISITE, TRAINING, AND CONTINUING EDUCATIONAL REQUIREMENTS

I. PREREQUISITES

- A. Graduate of an approved medical school
- B. Licensed to practice medicine in all of its branches
- C. Completion of a residency program in emergency medicine or have extensive critical care experience, including documented competency in advanced life support
- D. CPR certification by the American Heart Association or equivalent
- E. Employment by, or function within the Quincy Area EMS System
- F. Provide documentation of above to the EMS Office

II. TRAINING REQUIREMENTS

- A. Completion of a 4 hour orientation into the Quincy AREA EMS System which shall include:
 - 1. role of the EMS personnel
 - 2. policies and procedures
 - 3. standard operating protocols
 - 4. medication lists
- B. Successful completion of the Quincy Area EMS System written exam.
- C. Become a certified provider of ACLS, PALS, and ATLS within one year after completion of the certification examination if not board certified in emergency medicine.

III. CONTINUING MEDICAL EDUCATION REQUIREMENTS

- A. Attend one six hour session regarding EMS per year
- B. Maintain current CPR certification or equivalent
- C. Completion of a written recertification examination every two years
- D. Maintain current certification in ACLS

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMERGENCY COMMUNICATIONS REGISTERED NURSE

I. DUTIES AND RESPONSIBILITIES

A Emergency Communications Registered Nurse (ECRN) is a qualified registered professional nurse who has been approved by the EMS Medical Director to participate in the Quincy Area EMS System and perform the following duties and responsibilities:

- A. Give voice orders to system participants via radio in accordance with System approved protocols.
- B. Document calls for which direction was given completely and accurately recording information as required on the emergency department Radio Log.
- C. Sign the patient report form of the transporting unit indicating transfer of patient care to the receiving hospital.
- D. Monitor, supervise, and assist hospital personnel fulfilling educational requirements in the clinical setting.
- E. Perform other duties as may be assigned by the EMS Medical Director.
- F. Monitor conformance to system policy and procedure.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ECRN PREREQUISITES

I. PREREQUISITE

A. To enroll in a ECRN Course, the applicant must meet the following criteria:

1. have a current license as a registered professional nurse in Illinois.
2. have completed the orientation in an emergency department.
3. have demonstrated competency in dysrhythmia identification by:
 - a) ACLS certification (Preferred), or
 - b) successful completion of a dysrhythmia course approved by the EMS Medical Director, or
 - c) successful completion of a pre-entrance screening exam
4. sponsorship by a hospital participating in the Quincy Area EMS System.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ECRN TRAINING REQUIREMENTS

- I. Prerequisites
 - A. Current Illinois RN license
 - B. Completed emergency department orientation
 - C. Demonstrated competency in dysrhythmia identification (See CET-9.2)
 - D. Sponsorship by a Resource or Associate hospital in the Quincy Area EMS System.
- II. Completion Requirements:
 - A. Successful completion of a forty (40) hour ECRN Course. Classroom/practical to include:
 - 1. Successful completion of ACLS (8 hours)
 - 2. 24 hours didactic/skills
 - 3. A minimum of eight (8) hours lab experience under direct supervision of an ECRN.
 - 4. Successful completion (80%) of the Quincy Area EMS System written exam with a score of 80% or higher.
 - 5. Successful completion of a practical exam
 - B. Completion of 8 hours field observation on an ALS unit.
- III. When all criteria are met, the EMS Medical Director will verify and send to IDPH for approval.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

ECRN RECERTIFICATION REQUIREMENTS

To maintain status as a fully approved ECRN authorized to participate in the Quincy Area EMS System, the ECRN will submit the following requirements to the EMS Office every four years. The materials listed will be due on the first day of the expiration month shown on their state license.

To remain eligible for renewal every four years, the following established requirements must be met:

- I. *Participation in 48 hours of continuing medical education classes (12 per year)*
 - A. *75% of continuing education classes must be at ALS level*
 - B. *No more than 25% of total hours may be in the same subject.*
 - C. *At least 50% of the total hours required should be earned through system taught/approved courses.*
 - D. *24 hours may be obtained in the areas such as PALS, ACLS, CPR, or other approved programs (see Policy CET 1)*
- II. *System recertification every 2 years*
 - A. *On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS Office.*
 - B. *On the even years, all members will update all licensing and certificates by submitting copies to the EMS Office (ACLS, PALS, PHTLS, PEPP, etc.).*
 - C. *A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).*
- III. *Current CPR certification by the American Heart Association or equivalent*
- IV. *Current ACLS certification*
- V. *Current PALS certification*

NOTE: ECRN's who have failed to meet these requirements will be considered for removal from the listing of those recommended to IDPH and be restricted from functioning within the Quincy Area EMS System as an ECRN.

NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.

re: 12/84, 5/86, 7/87, 11/93, 11/97, 8/01, 1/02, 2/10, 7/10, 11/10. 5/11
Kelly Cox MD, EMS Medical Director (reviewed: 8/95)

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

INACTIVE STATUS

- I. Request for Inactive Status (*EMD, FR, FRD, EMTB, EMTP, ECRN, PHRN*)
 - A. Prior to the expiration of the current license, a provider may request to be placed on inactive status if all relicensure requirements have been met by the date of the application for inactive status.
 - B. The request shall be made in writing to the EMS Medical Director and must include name, date of licensure, licensure type, *IDPH license* ID number, circumstances requiring inactive status and a statement that relicensure requirements have been met to that date.
 - C. *Person requesting inactive status must complete and sign the IDPH EMS Extension Application Form (available from the EMS System Coordinator) and forward to IDPH with license and letter requesting Inactive Status.*
 - D. The EMS Medical Director will sign and forward the request to the Illinois Department of Public Health.
 - E. The Department will review and notify the EMS Medical Director in writing of its decision.
 - F. If the request for inactive status is granted, the EMS Medical Director will forward the EMT's license to the Department.
 - G. During inactive status, the *licensee* shall not function *in the system* at any level.

NOTE: All system and licensure extension must be requested a minimum of 30 days prior to expiration date.

NOTE: If a request for inactive status is made within 30 days of expiration date, a \$30 fee must be paid to Blessing Hospital EMS Office prior to processing the extension.

- II. Request for Reactivation
 - A. An inactive provider seeking to become reactivated must make application to the EMS Medical Director in writing on a Reactivation Form available from the EMS Office.
 - B. Prior to the application being approved, the following requirements must be met:
 1. current CPR certification
 2. current ACLS certification
 3. successful completion of the system written exam
 4. successful completion of a practical exam
 5. complete a conditional period of not less than 100 hours under the direct supervision of another provider of the same category or higher with at least three years experience in the system
 - C. Upon completion of all requirements, the Reactivation Form will be processed and sent to the Illinois Department of Public Health.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

EMS ADMINISTRATIVE DIRECTOR

I. DEFINITION:

- A. The Administrator, appointed by the Resource Hospital with the approval of the EMS Medical Director, responsible for the administration of the EMS System.

II. QUALIFICATIONS:

- A. Must possess the authority to make decisions regarding Resource Hospital participation within the system.

III. DUTIES AND RESPONSIBILITIES:

- A. Monitors Resource Hospital participation with the system and its relationship with participating agencies.
- B. Grants authority to EMS Medical Director and EMS System Coordinator to make necessary operational changes in the EMS System Plan and forward to IDPH for approval .
- C. Plans, develops and monitors EMS budget needs for the Resource Hospital..

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PREREQUISITES AND TRAINING REQUIRED FOR EMT-B/D

I. Prerequisites

- A. Current Illinois EMT-B licensure, or the course may be included as part of the initial EMT-B license training program.

II. Training

- A. Completion of a training course based upon Section 9 of the United States Department of Transportation, Emergency Medical Technician-Intermediate: National Standard Curriculum.
- B. Successful completion of the Quincy Area EMS System written and practical examination for EMT-B/D.
- C. Upon request of the Department, the system will have available copies of the written and practical examination and the requirements for successful completion used in the automated defibrillation course.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ANNUAL AED SKILL VALIDATION

- I. Purpose: to ensure competency in AED performance.
- II. An AED skill validation and written quiz will be given annually for First Responder-D level providers and for EMT-Bs utilizing an AED.
- III. Personnel qualified to administer the annual skill validation should hold one of the following qualifications AND be approved by the EMS System Coordinator.
 - A. EMS Physician
 - B. EMS Lead Instructor
 - C. RN
 - D. EMT-P
 - E. Agency training officer (This person may be a licensed EMT-B with System approval)
- IV. Guidelines for skill validation
 - A. The FR-D or EMT-B will demonstrate competency in the use of the AED by performing the proper sequences to a satisfactory performance level as outlines on the practical skills assessment sheet.
 - B. The FR-D or EMT-B will complete the written quiz with a minimum score of 80%
- V. Documentation
 - A. The person conducting the skill validation will complete the skill assessment sheet and send it with the completed written quiz to Blessing EMS Department.
 - B. A blue continuing education report will be issued to the FR-D or EMT-B for 1 hour credit.
 - C. Blessing EMS Department will maintain the master check list for verification of annual skill completion.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PREREQUISITES AND TRAINING REQUIRED FOR LICENSURE AS A PREHOSPITAL RN

- I. Prerequisites / Co-requisites
 - A. Registered nurse, licensed in Illinois.
 - B. Current American Heart Association CPR provider certification or equivalent.
 - C. Current American Heart Association ACLS provider certification.
 - D. Current Trauma Nurse Specialist certification or Trauma Nurse Core Curriculum.
 - E. Current BTLS or PHTLS certification.
- II. Training
 - A. Successful completion of the Quincy Area EMS System Prehospital RN Training Course (CET-8.1, 8.2). Didactic/lab to include a minimum of 24 hours in the following topics:
 - 1. Roles and responsibilities
 - 2. EMS Systems
 - 3. Medical/Legal
 - 4. EMS Communications
 - 5. Rescue
 - 6. Major Incident Response
 - 7. Stress Management
 - 8. Airway and ventilation
 - 9. Quincy Area EMS System Protocols
 - B. Clinical Requirements
 - 1. Surgery rotation: 40 hours and minimum of 10 intubations
 - 2. Field internship on a System approved ALS ambulance: complete a minimum of 10 ALS calls to include call management and skills supervised by an approved Field Evaluator.
 - C. Successful completion of the Quincy Area EMS System written examination with a minimum score of 80%.
 - D. Successful completion of skills validation.
- III. The EMS Medical Director will submit the names of approved Prehospital RN's to Illinois Department Public Health and will inform IDPH of any changes in the status of approved Prehospital RN's.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

PREHOSPITAL RN RENEWAL

- I. To maintain status as a fully approved prehospital RN authorized to participate in the Quincy Area EMS System, and to remain eligible for renewal every four years, the following established requirements must be met.
- A. Maintain a valid Illinois RN license.
 - B. Participation in 30 hours of approved continuing medical education per year.
 - 1. 8 hours must be obtained by attendance at Quincy Area EMS System monthly Continuing Medical Education classes per year. (Available monthly at Blessing Hospital).
 - 2. 16 hours/4 years must be pediatric related programs
 - 3. Other hours may be obtained by attendance at approved seminars, courses, or other educational programs, i.e., ACLS, BTLIS, PALS (See Policy CET-1)
 - 4. No more than 25% of total hours may be in the same subject.
 - C. Maintain current American Heart Association CPR healthcare/provider certification, or equivalent, and provide documentation of this upon each recertification.
 - D. Maintain current American Heart Association ACLS provider certification and provide documentation of this upon each recertification.
 - E. Successful completion of a written and practical evaluation administered by the EMS Office every 2 years
 - 1. The practical exam will consist of an ALS skill chosen by the EMS Medical Director.
 - 2. A minimum score of 80% will be required for the written evaluation.
 - F. Demonstrate and maintain a high level of proficiency in all practical skills
 - 1. Prehospital RN's having low numbers of ALS patients and/or whose experiences indicate a below standard skill level may be required to participate in additional educational programs and/or clinical hours upon the discretion of the EMS Medical Director. Clinical hours could include any of the following:
 - a) Surgery: completion of a minimum of two intubations
 - b) Emergency Department: completion of a minimum of two IV lines.
 - c) ALS ambulance: completion of a minimum of two ALS runs.
 - G. A prehospital RN whose license has expired may within 60 days of the license expiration, submit all relicensure material as required and a fee of \$50.00 in the form of a certified check or money order. If all material is in order and there is no disciplinary action pending against the PHRN, the Department will relicensure.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

EMT-B RECERTIFICATION REQUIREMENTS

- I. To maintain status as a fully licensed EMT-B authorized to participate in the Quincy Area EMS System, and to remain eligible for re-licensure every four years, the following established requirements must be met:
 - A. Participation in 120 hours of approved continuing medical education every four years. No more than 25% of those hours may be in the same subject.
 - B. Maintain current American Heart Association CPR provider certification , or equivalent
 - C. 8 hours/4-year period must be pediatric related programs.
 - D. At least 50% of the total hours required for relicensure should be earned through system taught/approved courses.
 - E. See Policy CET 2 for additional information.
- II. An EMT-B whose license has expired may within 60 days of the license expiration, submit all re-licensure material as required and a fee of \$50.00 in the form of a certified check or money order. If all material is in order and there is no disciplinary action pending against the EMT-B, the Department will re-license the EMT-B.
- III. Any EMT-B whose license has expired for a period of more than 60 days shall be required to reapply for licensure, complete the training program and pass the test, and pay the fees required for initial licensure.
- IV. System recertification every 2 years
 - A. On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS Office.
 - B. On the even years, all members will update all licensing and certificates (CPR, ACLS, PEPP, etc).
 - C. A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).

NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee must be paid to Blessing Hospital EMS Department prior to processing the renewal.

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

EXTENSIONS (*ALL LICENSURE LEVELS*)

I. System Extensions

If an individual has not met the educational requirements of the Quincy Area EMS System at the end of any deadline (90 days, annually, two years), the provider may request a system extension in order to maintain their active status.

- A. A request for a system extension must be made in writing to the EMS Medical Director.
- B. The request should include the reason the extension is desired and the amount of time being requested.
- C. If the provider is unable to maintain the continuing education requirements of the Quincy Area EMS System including any additional hours that may be required during an extension period, the EMS Medical Director may determine that the provider not be allowed to function within the System until the requirements are met.
- D. *Repeated extensions requests for same licensure period will not be honored.*
- E. *Due to the amount of hours needed in four years, extensions will not be allowed for FR and FRD licenses.*

II. Licensure Extensions

If any individual provider has not met all continuing education requirements by the end of a four year licensure period, the provider may apply to extend a relicensure date in order to complete relicensure requirements.

- A. *Request for an IDPH extension must be made in writing to the EMS Medical Director.*
- B. The provider must complete Part A of an Extension Request Form and submit it to the EMS Office for further processing.
- C. If the EMS Medical Director recommends the extension, Part B of the form will be completed and the application will be sent to the Illinois Department of Public Health.
- D. If the EMS Medical Director opposes the extension, the application will be sent to the Illinois Department of Public Health without a recommendation to grant the extension.
- E. *Due to the number of hours needed in four years, a recommendation will not be made for FR and FRD's.*

NOTE: All system and licensure extension must be requested a minimum of 30 days prior to expiration date.

NOTE: If a request for extension is made within 30 days of expiration date, a \$30 fee must be paid to Blessing Hospital EMS Office prior to processing the extension.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

ALTERNATE EMS MEDICAL DIRECTOR

I. DEFINITION:

A physician who is medically and legally responsible for the Emergency Medical Services System in the absence of the EMS Medical Director .

II. QUALIFICATIONS:

- A. A physician who is a graduate of an approved accredited medical school and has completed a post-graduate study or approved residency in emergency medicine or have extensive critical or emergency care experience.
- B. Must be licensed by the State of Illinois and have the ability to diagnose and initiate therapy.
- C. Demonstrate an interest in the improvement of EMS and knowledge of the problems involved.
- D. Demonstrate a willingness to further his own education in areas of emergency care.
- E. Demonstrate a willingness to cooperate with the providers of ambulance services in the local area.
- F. Demonstrate leadership ability and initiative.
- G. Be thoroughly knowledgeable about and able to demonstrate all skills as presented in EMT/B and paramedic training programs, excluding demonstration of extrication skills.
- H. Have the ability to teach and instruct nurses and EMT's.
- I. Have or make provisions to gain experience instructing students at a level similar to EMT/P's.
- J. Have experience on EMS vehicle, or be willing to make provisions to gain experience on the vehicle.

III. DUTIES AND RESPONSIBILITIES:

In the absence of the EMS Medical Director, the Alternate EMS Medical Director will:

- A. Insure that the EMS System protocol is followed.
- B. Take medical-legal responsibility for the EMS System
- C. Act as a resource person for professionals, administration, and the public.
- D. Keep the Administrative Director and EMS System Coordinator informed of program operations.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

STATE WRITTEN EXAM TESTING FEES

- I. As described in Section 515.530, of the EMS Act, all candidates making application for the Illinois Department of Public Health's written exam for licensure will be required to pay the appropriate testing fee prior to taking the exam.
 - A. EMT-B examination fee \$20.00
 - B. EMT-P examination fee \$40.00
 - C. (Retest fees are the same)
- II. Testing fees may be submitted to IDPH as follows:
 - A. The candidate will include a certified check or money order payable to IDPH, Or
 - B. The course instructor will collect fees from each candidate and submit them to IDPH on the candidates behalf.
- III. Considerations
 - A. All fees submitted for licensure examination are non-refundable.
 - B. Failure to appear for the exam on the scheduled date and location shall result in forfeiture of the exam fee.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RELICENSURE THROUGH IDPH WEBSITE

- I. The following procedure will be followed for updating the IDPH website for *EMD's*, *FR's*, *FRD's*, *EMT-B's*, *EMT-P's*, *Prehospital RN's*, and *ECRN's*:
- A. All documentation for recertification (including a Child Support Statement completed and signed) will be submitted 30 days prior to the due date.
 - B. The EMS Coordinator or designee will review the documentation.
 - C. If the documentation meets the requirements for recertification and the licensee is in good standing in the Quincy Area EMS System, *the IDPH webpage will be updated thus allowing a new license to be printed and sent to the licensee* for recertification using Department approved procedures.

OR

Should the documentation for recertification be incomplete and not meet the state requirements, the EMS Coordinator or designee will contact the person submitting the material immediately and notify them of the deficiencies.

- D. If the EMS System Coordinator or designee has concerns with regard to recertification, that file will be sent to the EMS Medical Director. If the EMS Director does not recommend relicensure, he/she shall submit all reasons for denial in writing to the EMT and the Department.

NOTE: All system and licensure renewals must be requested a minimum of 30 days prior to expiration date.

NOTE: If a request for renewal is made within 15 days of expiration date, a \$30 fee must be paid to Blessing Hospital EMS Office prior to processing the renewal.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RENEWAL OF EMS LEAD INSTRUCTOR

- I. Renewal: To maintain status as a recognized EMS Lead Instructor authorized to participate in the Quincy Area EMS System and remain eligible for renewal every 4 years, the following requirements must be met:
- A. The EMS Lead Instructor has satisfactorily coordinated/taught programs for the EMS System during the four year relicensure period. Provide an accurate list of classes taught, (including date, times, subject matter and hours taught).
 - B. Documentation of 10 hours of continuing education annually (40 hours for 4 years). (Programs used to fulfill other professional continuing education requirements, i.e., EMT, ECRN, may be used).
 - C. Conduct courses in accordance with the curriculum as prescribed by *the* EMS Act.
 - D. Comply with protocols prescribed in Section 3.65(b)(7) of the Act.
 - E. Complete a Child Support Statement
 - F. Provide a current copy of EMTD, EMTI, EMTP, RN, or physician license.
 - G. Current copy of CPR (Healthcare provider) or equivalent.
 - H. *A letter of support from EMS Medical Director or EMS System Coordinator*
 - I. *Maintain a current curriculum vitae or similar educational resume on file with Quincy Area EMS Office.*
- II. Non-Renewal: A letter stating the reasons for non-renewal approval will be sent to the EMT-B Education Coordinator, Central Office, Springfield, IL, by the EMS Medical Director.

NOTE: All system and licensure renewals must be requested a minimum of 30 days prior to expiration date.

NOTE: If a request for renewal is made within 30 days of expiration date, a \$30 fee must be paid to Blessing Hospital EMS Office prior to processing the extension.



Kelly Cox, MD., EMS Medical Director

12/97
re: 8/01, 7/10, 2/13

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

RENEWAL OF EMS LEAD INSTRUCTOR

- I. Renewal: To maintain status as a recognized EMS Lead Instructor authorized to participate in the Quincy Area EMS System and remain eligible for renewal every 4 years, the following requirements must be met:
- A. The EMS Lead Instructor has satisfactorily coordinated/*taught* programs for the EMS System during the four year relicensure period. *Provide an accurate list of classes taught, (including date, times, subject matter and hours taught).*
 - B. Documentation of 10 hours of continuing education annually (40 hours for 4 years). (Programs used to fulfill other professional continuing education requirements, i.e., EMT, ECRN, may be used).
 - C. Conduct courses in accordance with the curriculum as prescribed by *the* EMS Act.
 - D. Comply with protocols prescribed in Section 3.65(b)(7) of the Act.
 - E. *Complete a Child Support Statement*
 - F. *Provide a current copy of EMTD, EMTI, EMTP, RN, or physician license.*
 - G. *Current copy of CPR (Healthcare provider) or equivalent.*
- II. Non-Renewal: A letter stating the reasons for non-renewal approval will be sent to the EMT-B Education Coordinator, Central Office, Springfield, IL, by the EMS Medical Director.

NOTE: All system and licensure renewals must be requested a minimum of 30 days prior to expiration date.

NOTE: If a request for renewal is made within 30 days of expiration date, a \$30 fee must be paid to Blessing Hospital EMS Office prior to processing the extension.

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

VOLUNTARY REDUCTION OF CERTIFICATION AND REINSTATEMENT

- I. **EMT-P Reduction of Certification to EMT-B Level:** Prior to the expiration of the current license, an EMT-P may request a reduction of certification to EMT-B. The procedure is as follows:
- A. The request shall be made in writing to the EMS Medical Director.
 - B. The EMS Medical Director will apply to the Department in writing and request the EMT-P's reduction of certification.
 - C. The application shall contain the following information:
 - 1. Name of individual
 - 2. Date of licensure
 - 3. License type
 - 4. License identification number
 - 5. Circumstances requiring reduction of certification
 - 6. A statement that re-licensure requirements have been met by the date of the application for reduction of certification
 - D. The Department will review requests and shall notify the EMS Medical Director in writing of their decision.
 - E. If reduction is granted, EMS Medical Director shall forward the EMT-P's license to the Department.
- II. **Reinstatement of Certification to EMT-P Level** An EMT-P who has reverted to EMT-B status may be subsequently re-licensed as an EMT-P by the following:
- A. Submit a written request to the EMS Medical Director including the following documentation:
 - 1. Copy of current Illinois EMT-B license
 - 2. Copy of current Health Provider CPR card
 - 3. Copy of current ACLS course completion
 - B. Complete 40 hours of ER clinical, eight of which must be with the EMS Medical Director.
 - C. Participation in a minimum of ten supervised ALS ambulance responses demonstrating proficiency in all EMT-P skills.
 - D. Successful completion of the Quincy Area EMS System written examination (80% minimum score).
 - E. Successful completion of Skills Validation.

- F. After verification by the EMS Medical Director that the individual's knowledge and clinical skills are at an active EMT-P level and that all retraining education and testing have been satisfactorily completed, a letter of recommendation for re-licensure will be sent to the Department by the EMS Medical Director. The Department will review the request and shall notify the EMS Medical Director in writing of their decision.
- III. **EMT Reduction to First Responder Level:** At any time prior to the expiration of their current license, an EMT may revert to First Responder status for the remainder of the license period.
- A. The request shall be made in writing to the EMS Medical Director who will forward the request to the Department.
 - B. Once registered as a First Responder, the individual must meet requirements for First Responder registration.
 - C. Once registered as First Responder, the provider can not be reinstated to EMT status unless the entire training program is taken.

NOTE: If a Reduction Request is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

FIRST RESPONDER

- I. Definition: A person who has successfully completed a course of instruction in emergency response as outlined in the National Standard Curriculum for First Responders and provides first response services prior to the arrival of an ambulance or helicopter.
- II. First Response Services (Duties):
 - A. CPR
 - B. Monitoring vital signs
 - C. Control of bleeding
 - D. Use of oropharyngeal airways/nasopharyngeal airways
 - E. Oxygenation/assist ventilations with pocket mask or bag valve mask
 - F. Splinting/bandaging
- III. Qualifications
 - A. Age 18 or over
 - B. High school diploma or GED
- IV. Training
 - A. D.O.T. Emergency Medical Services First Responder Training Course: 44 hours (See CET-23)
 - B. Minimum of 10 hours ER observation
 - C. Upon completion of the course will be registered with the State and the System.
- V. *Relicensure*
 - A. Will submit documentation of 12 hours of approved continuing education to the EMS Office or to IDPH every two years (6 hours/year).
 - B. Will maintain current AHA CPR certification (or equivalent) each year.

VI. *System Recertification Every 2 Years*

- A. *On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS System Coordinator.*
- B. *On the even years, all members will update all licensing and certificates.*
- C. *A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).*

NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.

QAEMS will not honor extension request for FR and FRD due to only needing 24 hours in a 4-year period to renew license.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM**FIRST RESPONDER AED**

- I. Definition: A person who has successfully completed both a course of instruction in emergency response as outlined in the National Standard Curriculum for First Responders, as well as an IDPH approved course in automated defibrillator operation, and provides first response services prior to the arrival of an ambulance or helicopter.
- II. First Response Services (Duties):
 - A. CPR
 - B. Monitoring vital signs
 - C. Control of bleeding
 - D. Use of oropharyngeal airways/nasopharyngeal airways
 - E. Oxygenation/assist ventilations with pocket mask or bag valve mask
 - F. Splinting/bandaging
 - G. AED use
- III. Qualifications
 - A. Age 18 or over
 - B. High school diploma or GED
- IV. Training
 - A. D.O.T. Emergency Medical Services First Responder Training Course: 44 hours (See CET-11)
 - B. AED Course based on Section 9 of the D.O.T. EMT-I National Standard Curriculum (See CET-10)
 - C. Minimum of 10 hours ER observation

Upon completion of the course will be registered with the State and the System.
- V. *Relicensure:* To maintain status as a registered First Responder authorized to participate in the Quincy Area EMS System, the following established requirements must be met:
 - A. Participate in 24 hours of continuing education every four years (6 hours per year). Submit documentation of these hours to the EMS Office at least 75 days prior to the registration expiration.

Relicensure (cont)

- B. Will maintain current AHA CPR certification (or equivalent). Submit a copy to the EMS Office at least 75 days prior to the registration expiration.

VI. System Recertification Every 2 Years

- A. On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS System Coordinator.
- B. On the even years, all members will update all licensing and certificates.
- C. A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).

NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.

QAEMS will not honor extension request for FR and FRD due to only needing 24 hours in a 4-year period to renew license.

VII. Expired registration

- A. If expired for less than 60 days, the First Responder AED may submit re-registration materials and a fee of \$50 in the form of a certified check or money order to IDPH.
- B. If expiration is greater than 60 days, they must complete the entire training program as before.

QUINCY AREA EMERGENCY MEDICAL SERVICES SYSTEM

EMERGENCY MEDICAL DISPATCHER

- I. Definition: A person who has successfully completed a dispatching course that meets or exceeds the National Curriculum of the United States Department of Transportation.
- II. EMD Duties:
 - A. Accepts calls from the public for emergency medical services
 - B. Dispatches designated emergency medical services personnel and vehicles
 - C. Provides pre-arrival medical instructions to the caller in accordance with protocols approved by the EMS Medical Director.
- III. Re-registration: To maintain status as a registered EMD and to meet state requirement, the following established requirements must be met:
 - A. Participate in 48 hours of continuing education every four years (12 hours per year). Submit documentation of these hours to the EMS Office at least 75 days prior to the registration expiration.
 - B. Will notify the EMS Office of any change of address and/or change in employment
 - C. Will maintain current AHA CPR certification (or equivalent). Submit a copy to the EMS Office at least 75 days prior to the registration expiration.
- IV. *System Recertification Every 2 Years*
 - A. *On the even years, all members will complete a change of address form (P7-F) to confirm or update address. This form needs to be emailed or sent to EMS System Coordinator.*
 - B. *On the even years, all members will update all licensing and certificates.*
 - C. *A skill may be chosen by EMS Medical Director on odd years. Each member will be required to complete the skill station (may be BLS or ALS skill, level will determine who must complete).*
- V. *NOTE: If a renewal is received within 15 calendar days prior to expiration, a \$30 fee MUST be paid to Blessing Hospital EMS Office prior to processing the renewal.*

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

TNS RECERTIFICATION GUIDELINES

To obtain recertification as a Trauma Nurse Specialist (TNS), the TNS will comply with the following guidelines:

- I. Complete a **TNS CE Summary Sheet by Category** form
 - A. List EACH trauma related CEUs obtained during the licensure period on the form under the appropriate category.
 - B. Attach documentation to support EACH listing on the CE Summary Sheet. CEUs submitted without proper documentation will be denied.
 - C. CE Summary Sheet forms may be obtained from the TNS Course Coordinator (TNSCC) or on-line at traumanurse.info
 - D. Note: some Categories have **MAXIMUM** allowable hours. Hours submitted over maximum allowable hours for that category will be denied.
 - E. Some courses do not carry TNS credit (i.e. INSTRUCTOR COURSES). Please consult the TNSCC for guidance.
 - F. Seminar/Conferences containing medical and trauma topics will be awarded trauma CEUs according to the Seminar/Conference agenda and not the total CEUs listed on the certificate of completion. (Hours will be denied unless an agenda is provided.)
- II. Submit completed/signed **Child Support Statement** with ALL information required by IDPH.
- III. Submit **required hours** for renewal to the TNS Course Coordinator at least 40 days prior to expiration date.
 - A. Number of hours required for renewal is listed on the renewal form.
 - B. Incomplete CE Summary Sheet forms will be returned.
 - C. \$10.00 late fee will be assessed for packets submitted less than 14 days from date of TNS certification expiration.
 - D. Late forms submitted will be subject to IDPH late fees as applicable.

Kelly Cox, MD, EMS Medical Director

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

REINSTATEMENT OF EXPIRED LICENSE

- I. This policy defines the steps necessary for reinstating the license of Emergency medical Service (EMS) personnel who have failed to comply with licensure renewal requirements or who voluntarily surrendered their license within the last 36 consecutive months.
- II. Reinstatement shall require the following:
 - A. Provide a copy of an approved CPR and if licensure applicable, PHTLS, ACLS, and PALS.
 - B. Copies of continuing education as required for current licensure renewal period.
 - C. Evidence of successful completion of system permitted skills and initial requirements (Policy P-6: 2A or 3B)
 - D. All levels of personnel not having practiced clinically within the system for greater than 6 months must successfully complete a refresher course as appropriate for licensure level.
 - E. Completion of the QAEMS system exam with a minimum score of 80% as applicable to licensure level.
 - F. Completion and submission of an IDPH “Renewal/Child Support Form” and an “Electronic Transaction Form.”
 - G. A letter from the person requesting reinstatement to IDPH asking to test for reinstatement of their license at the level sought to be reestablished.
 - H. A fee (ONLY money order or cashier’s check) made payable to Illinois Department of Public Health will be assessed for applicants seeking reinstatement of previously expired license.
- III. Illinois Department of Public Health Reinstatement Requirements
 - A. To allow submission of a request for reinstatement of a license to Illinois Department of Public Health, all requirements of the Administrative Code Section 515.640 must be completed.
 1. The applicant must submit satisfactory proof of completion of continuing medical education requirements in accordance with the following:
 - a) Continuing education in accordance with IDPH requirements with Sections 515.560, 515.570, 515.580.
 - b) EMT training in accordance with Section 515.500, 515.510 or 515.520
 2. The applicant shall submit a positive recommendation from an EMS Medical Director attesting to the applicant’s clinical qualifications for retesting. The EMS Medical Director shall verify that the applicant has demonstrated competency of all skills at the level of EMT licensure sought to be reinstated
 3. The applicant shall pass a department approved test for the level of EMT license sought to be reinstated in accordance with Section 515.530 (Section 3.50(d)(5) of the Act.

QUINCY AREA EMS SYSTEM

PROBLEM SOLVING

Local System Review Board	PS-1
Suspension.....	PS-2
Problem Solving	PS-3
Event Report.....	PS-3.1-F
Suspected Chemical Abuse on Duty	PS-4
Appeal of the Local System Review Board Decision	PS-5
Disciplinary Action Form	PS-6
Notice of Corrective Action “Record of Disciplinary Action”	PS-6-F
Filing a Complaint with the IDPH Central Complaint Registry	PS-7

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

LOCAL SYSTEM REVIEW BOARD

- I. Purpose: The Resource Hospital shall designate a Local System Review Board for the purpose of reviewing a decision of the EMS Medical Director to suspend an individual, individual provider or participant from participation in the Quincy Area EMS System.
- II. Local System Review Board Members
 - A. *An EMS Medical Director may suspend from participation within the System any individual, individual provider or other participant considered not to be meeting the requirements of the Program Plan of that approved EMS System.*
 - B. *The EMS Medical Director shall provide the individual, individual provider or their participant with a written explanation of the reason for the suspension; the terms, length, and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review board shall be provided.*
 - C. *Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review board hearing.*
 - D. *The Resource Hospital shall designate the Local System Review Board, consisting of at least three members, one of whom is an emergency department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. The EMS Medical director shall prepare and post, in a 24-hour accessible location at the Resource Hospital, the System Review Board List.*
 - E. The Board will consist of three members
 - F. Board Make-up
 - 1. One Emergency Department physician with knowledge of EMS
 - 2. One EMT
 - 3. One person of the same professional category as the suspended individual, individual provider or participant requesting the hearing.
 - G. Board Selection
 - 1. The System Review Board list shall consist of six persons in each provider category, selected at random from system agencies.
 - 2. The System Review Board list shall be reviewed annually and will be posted in the Resource Hospital Emergency Department.
 - 3. Upon request for a Local System Review Board Hearing, the EMS Medical Director will select the three persons to make up the review board as indicated in II.B. from the System Review Board List.

III. Procedure to Request Hearing

- A. *If the Local system Review Board affirms or modifies the EMS Medical director's suspension order, the individual, individual provider or other participant shall have the opportunity for a review of the Local board's decision of the State EMS Disciplinary Review board.*
- B. *If the Local System Review board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the opportunity for review of the Local board's decision by the State EMS Disciplinary Review board. (See Policy PS-5)*
- C. *Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and highway Safety, within 10 days after receiving the Local Board's decision or the EMS Medical Director's suspension order shall be enclosed.*
- D. Within 15 days of a suspension notice, the suspended participant may request a hearing from the EMS Medical Director in writing via certified mail.
- E. The EMS Medical Director will schedule the Board to meet within 21 days after receipt of the written request.
- F. The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing, and the Local System Review Board's written decision shall be retained in the custody of the EMS System.
- G. The Board shall review and consider any testimony and documentation related to the issue offered by either party.
- H. The Board shall state in writing to the EMS Medical Director its decision to affirm, reverse, or modify the suspension. The subject of the hearing shall also be given a copy of the written decision within 5 business days after the conclusion of the hearing.
- I. The suspension shall commence when:
 - 1. The provider has waived the opportunity for a hearing before the Local Review Board. Failure to request a hearing within 15 days shall constitute a waiver to the right to a Local System Review Board Hearing.
 - OR
 - 2. The suspension order has been affirmed by or modified by the local board and the provider has waived the opportunity for review by the State Board.
 - OR the suspension order has been affirmed or modified by the State Board.
- J. The EMS Medical Director shall notify in writing, within five (5) business days after the Board's decision to either uphold, modify, or reverse the EMS Medical Director's suspension of an individual, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.

IV. Immediate Suspensions (prior to due process)

- A. The suspended party will be issued immediate verbal notification followed by a written suspension order including duration, terms and basis for suspension.

- B. Within 24 hours following commencement of the suspension, the EMS Medical Director will deliver to the Department by messenger or telefax, a copy of the suspension order and written materials related to the suspension.
- C. The EMS Medical Director must inform the suspended party that within 24 hours following the suspension they may deliver to the Department by messenger or telefax, a written response to the suspension order and written material related to the response.
- D. The EMS Medical Director will be notified by the Department within 24 hours following receipt of the suspension order or the suspended parties' written response. The EMS Medical Director must inform the provider or EMT immediately upon receipt of this determination.
- E. *An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information in his or her possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS Medical Director which states the length, terms and basis for the suspension*
1. *Within 24 hours following the commencement of the suspension, the EMS Medical Director 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 Medical Director's decision to suspend the EMT or provider.*
 2. *Within 24 hours following the commencement of the suspension, the suspended EMT or provider may deliver to the Department, by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMT or provider feels relate to that response.*
 3. *Within 24 hours following receipt of the EMS Medical Director's suspension order or the EMT's or provider's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the EMT's or provider's opportunity for hearing or review in accordance with the 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 Medical Director, who shall immediately notify the suspended EMT or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.*



Kelly Cox, M.D., EMS Medical Director

12/84 (reviewed: 8/95; 12/09)
re: 7/86, 7/87, 8/89, 4/92, 7/92, 11/97, 5/98,
3/01, 7/01, 1/02, 12/02, 3/07, 8/12

**QUINCY AREA EMS SYSTEM
SYSTEM REVIEW BOARD**

- I. Names and Categories of System Review Board Members. This list will be updated yearly and posted in Blessing Emergency Department

EMT-B

Joe Doellman
Donald Haage
Howard Hubbard
Chad Kunkel
Chad Hummell
Shane McKoon

EMT/P

Brian Gallaher
Kasey Kendall
Kyle Dixon
Michael Bellovich
Demond Dade
Tony Slater

ECRN

Kendra Mueller
Nancy Freeman
James Wells
Ed Smith
William Coonrod
Jessica Bolton

PREHOSPITAL RN

Sandy Behl
Michael Richard
Lisa Howell
Aaron Struabe
Dawn Sweet
Melissa Rainey

FIRST RESPONDER

Gene Sikes
Kevin McCallister
Greg Jeffers
James Elliott
Randy Tripp
(only 5 FR's in system)

FIRST RESPONDER/AED

Scott Trautvetter
Robert Simmons
Jerry Taylor
Marilyn Boone
Chris Becker
Kenny Melon

EMERGENCY ROOM PHYSICIAN

Dr. Stuart Pyatt
Dr. Thomas Cliatt
Dr. Chris Solaro
Dr. Antony Wollaston
Dr. Richard Saalborn
Dr. Craig Huston



 Kelly Cox, M.D., EMS Medical Director

August 1989
re 4/92, 6/92, 1/94, 7/96, 12/97, 5/98, 2/99,
9/99, 7/01, 1/02, 12/02, 3/07, 12/09, 8/12

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

Suspension

- I. The EMS Medical Director may suspend from participation within the system any individual or individual provider within the system.
- II. Any such suspension may be based on one or more of the following:
 - A. Failure to meet the educational and training requirements of the State or by the EMS Medical Director.
 - B. Violation of the EMS act or any rule promulgated under it.
 - C. Failure to maintain proficiency in the provision *in the level of skills for when the provider is licensed*.
 - D. Failure to comply with System Policies and Procedures.
 - E. *During the provision of medical services, the EMT engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public, use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status.*
 - F. *The EMT has failed to maintain or has violated standards of performance and conduct as prescribed by the Department or his/her EMS System's Program Plan.*
 - G. *The EMT has demonstrated medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care or the EMT's license has been revoked, denied or suspended by the Department.*
 - H. Falsification of any reports or orders, or making misrepresentations involving patient care.
 - I. Abandoning or neglecting a patient requiring emergency care.
 - J. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, health care facility, institution, or other work place location.
 - K. Performing or attempting emergency care, techniques or procedures without proper permission, certification, training, or suspension.
 - L. Discriminating in rendering care due to race, sex, creed, religion, national origin or ability to pay.
 - M. Medical misconduct or incompetence.
 - N. Physical impairment to the extent that emergency care and life support functions for which the provider is certified, cannot be physically performed.

- O. Mental impairment to the extent that the appropriate judgment, skill and safety required for performing the emergency care and life support functions for which the provider is certified cannot be exercised.
- P. The EMS Medical Director believes that the continuation in practice by the provider would constitute an imminent danger to the public.
- Q. Committing a felony act while on or off duty.



Kelly Cox, MD., EMS Medical Director

re: 12/84, 7/86, 7/87, 8/89, 4/92, 6/92, 11/97, 8/12
(reviewed: 8/95, 8/01, 3/07)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

PROBLEM SOLVING

I. Reporting and documentation requirements:

The use of an event report form is mandatory in the Quincy Area EMS System. This form shall be used to report any unusual occurrence or deviation from accepted standard of care. This form shall serve the following functions:

- A. Improving the management and treatment of patients in the system
- B. Inservice education of personnel
- C. Administrative supervision
- D. Medico-legal coverage

II. The event report form shall be filled out by the individual who observed or who was involved in the event. The form will be filled out as completely as possible using wording carefully chosen to avoid implication of blame and retribution. The facts of the event shall be carefully stated with no conclusions drawn.

III. The event form shall be completed and sent (in a timely manner) to the Quincy Area EMS System Coordinator.

IV. If provider's administration request a copy of the Event Report, it will be the individual's responsibility to forward that copy. The EMS System Coordinator should receive the report from the individual who wrote the report.

V. *Failure to follow "Event Report" procedure will be considered a failure to comply with System Policy PS-2.*



Kelly Cox, MD., EMS Medical Director

6/87, 11/97, 3/07, 8/12
(reviewed 8/95, 8/01)

QUINCY AREA EMS SYSTEM

EVENT REPORT

DATE: _____ REPORTER: _____

DATE OF INCIDENT: _____

WAS THERE A NEGATIVE OUTCOME TO PATIENT: ☐ YES ☐ NO

[illegible]

Event reports should be completed *as soon as possible after the call*, when any of the following occur:

- 1) deviation from policy and procedure including medical protocol of the Quincy Area EMS System
- 2) violation of any rule or regulation of the Illinois Department of Public Health or state statute, (i.e., Illinois EMS Act)
- 3) equipment problems that have or may affect patient care.
- 4) interagency personnel conflicts
- 5) instances in which the system did not work (inadequacy of policy and procedure as well as medical protocol)
- 6) complaints in general
- 7) *Any time any situation/occurrence could or did affect patient care.*

In narrative form, relate the details of the event including the details leading up to the event, i.e., who, what, where, when, why. Be as objective as possible giving only factual information. Do not include personal opinion or conjecture.

The EMS Office will initially review the event with the reporter and then again within 30 days contact the reporter for a follow up.



Kelly Cox, MD., EMS Medical Director

11/97, 10/00, 8/12
(reviewed: 8/95, 8/01, 3/07)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

SUSPECTED CHEMICAL ABUSE ON DUTY

- I. Reporting suspected intoxication/personal misuse of drugs
 - A. When to report
 - 1. You observed the provider misusing an intoxicating substance
 - 2. You observe behaviors/signs/symptoms that you believe the provider is under the influence of an intoxicating substance.
 - 3. The provider is scheduled on duty, either paid or volunteer.
 - B. How to report
 - 1. Contact the Resource Hospital ER physician and provide information.
 - 2. Follow up with an Event Report to the EMS Department within 24 hours.
- II. Physical Exam/Lab work.
 - A. The Resource Hospital ER physician will request the provider voluntarily submit to a physical exam.
 - 1. If physical findings indicate possible substance abuse, a urinalysis and toxicological screen will be performed.
 - B. If the Resource Hospital ER physician finds no indication of substance abuse, the provider will be returned to duty.
 - C. If the exam/lab corroborates substance abuse or the provider refuses the exam, they will be placed "off-duty" for the remainder of their shift. A full investigation will be conducted by the EMS Medical Director.
- III. In the event that this policy conflicts with or duplicates a provision of a collective bargaining agreement that requires testing for drug use, the provider will contact their representative.
- IV. *The Resource Hospital emergency department physician may request the provider in question to be evaluated by a physician at another Resource Hospital, Affiliate or Associate Hospital*



Kelly Cox, MD., EMS Medical Director

11/89, 1/94, 11/97, 8/01, 3/07, 8/12
(reviewed: 8/95)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

APPEAL OF THE LOCAL SYSTEM REVIEW BOARD DECISION

- I. In the event that the Local System Review Board affirms or modifies the suspension order, the individual, individual provider, or other participant will be afforded the opportunity for review of the decision by the State EMS Disciplinary Review Board.
- II. In the event that the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director will have the opportunity for review of the decision by the State EMS Disciplinary Review Board.
- III. Requests for review must be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety within ten (10) days after receiving the Local Boards decision or the EMS Medical Director's suspension order, whichever is applicable. You must include a copy of the decision or suspension order.



Kelly Cox, MD., EMS Medical Director

11/89, re: 11/97, 5/98
(reviewed: 8/95, 8/01, 3/07, 8/12)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

DISCIPLINARY ACTION FORM

- I. Use: for documentation of disciplinary action taken by the EMS Medical Director
 - A. Verbal Counseling
 - B. Written warning
 - C. Suspension
 - D. Probation
- II. Procedure for verbal counseling/written warning:
 - A. The EMS Medical Director or designee will contact the person(s) involved.
 - B. A meeting time will be agreed upon.
 - C. The EMS Medical Director and/or designee will discuss the concern/problem and the corrective action to be taken.
 - D. The form will be signed by the provider receiving disciplinary action, the EMS System Coordinator, and the EMS Medical Director.
 - E. The original will be placed into the providers file in the EMS Department with copies going to the involved provider and their agency director.
 - F. *The supervisor of the person involved will be given the opportunity to be present during this meeting.*
- III. Suspension Procedure
 - A. The EMS Medical Director may suspend from participation within the System any individual, individual provider or other participant considered not to be meeting the requirements of the System Program Plan. (Refer to policy PS-2)
 - B. The EMS Medical Director shall provide a written explanation of the reason for suspension, the terms, length, and condition of the suspension; and the date the suspension will commence unless a hearing is requested.
 - C. The procedure for requesting a hearing is outlined in policy PS-1.
 - D. Immediate suspension policy outlined in PS-1.
 - E. The disciplinary action form will be completed as in II. D. and II.E. above.

IV. Probation Procedure

- A. The EMS Medical Director may elect to place an individual on probationary status if skills or knowledge base is determined to be insufficient to allow independent function.



Kelly Cox, MD., EMS Medical Director

12/99, re: 8/01, 1/02, 8/12
(reviewed 3/07)

QUINCY AREA EMS SYSTEM POLICY AND PROCEDURE

Filing a Complaint with the IDPH Central Complaint Registry

- I. Purpose of this policy: to familiarize System participants and provider agencies with the procedure for filing a complaint with the Illinois Department of Public Health Central Complaint Registry.
- II. Definition of complaint: a report of an alleged violation of the EMS Act or Administrative Rules pursuant to the Act by any System participants and/or providers covered under the Act. A complaint should be defined as problems related to the care and treatment of a patient.
- III. Procedure for Complaint Submission
 - A. Submit the complaint to:
 1. IDPH Central Complaint Registry** and/or
 2. EMS Medical Director***
 3. Trauma Center Medical Director (only if related to a trauma patient)***

**Complaints received by IDPH will be forwarded to the EMS System Medical Director and/or the Trauma Center Medical Director.

*** The EMS Medical Director and/or Trauma Center Medical Director will forward the complaint to the IDPH Central Complaint Registry within five working days of receipt of the complaint.
 - B. Form of submission
 1. Telephone call
 - a. IDPH Central Complaint Registry: 1-800-252-4343
 - b. EMS Medical Director: 217-223-8400 ext. 6590
 - c. Trauma Center Medical Director: 217-223-8400 ext. 6590
 2. Letter
 3. Fax
 4. In Person
 - C. Information required
 1. Date and time or shift of occurrence
 2. Names of the patient, EMS personnel, family members, and other persons involved.
 3. Relationship of the complainant to the patient or to the provider.
 4. Condition and status of the patient
 5. Details of the situation
- IV. Complaint investigation
 - A. Confidentiality: IDPH and the EMS Medical Director and/or the Trauma Center Medical Director shall not disclose the name of the complainant unless the complainant consents in writing to the disclosure.

- B. Notification of involved parties
 - 1. The substance of the complaint shall be provided in writing to the System participant and/or provider agency no earlier than at the commencement of an onsite investigation.
- C. Investigation
 - 1. Conducting the investigation
 - a) IDPH will conduct the investigation jointly with the EMS Medical Director or the Trauma Center Medical Director if a death or serious injury has occurred or there is imminent risk of death or serious injury, or if the complaint alleges action or conditions that could result in a denial, non-renewal, suspension or revocation of license or designation.
 - b) If the complaint alleges a violation by the EMS Medical Director, EMS System Coordinator or Trauma Center Medical Director, IDPH will conduct the investigation.
 - c) If the complaint alleges a violation that would not result in licensure or designation action, the IDPH will forward the complaint to the EMS Medical Director or Trauma Center Medical Director for review and investigation.
 - d) The EMS Medical Director or Trauma Center Medical Director may request the assistance of IDPH at any time during an investigation.
 - e) In a case between EMS Systems, the IDPH will be involved as mediator or lead investigator.
 - 2. Results of investigation
 - a) The EMS Medical Director or Trauma Center Medical Director will forward the results of the investigation and any disciplinary action resulting from a complaint to IDPH.
 - (1) Documentation of the investigation will be retained at the hospital in accordance with EMS System improvement policies and will be available to IDPH upon request.
 - (2) The investigation file will be considered privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101].
 - b) Based on the information submitted by the complainant and the results of the investigation conducted, IDPH will determine whether the Act or part of the Act is being or has been violated.
 - c) IDPH will have final authority in the disposition of a complaint and will classify the complaint as “valid”, “invalid” or “undetermined”.
 - d) IDPH will inform the complainant and the System participant or provider of the complaint results within twenty days after its determination.

- e) A complainant or EMS System participant or provider who is dissatisfied with the determination or investigation by IDPH may request a hearing pursuant to section 515.160 of the EMS and Trauma Center Code. A request for a hearing shall be submitted to IDPH within thirty days after the determination is mailed.



Kelly Cox, M.D., EMS Medical Director

12/04; re: 8/12
(reviewed 3/07)

QUINCY AREA EMS SYSTEM QUALITY ASSURANCE

Data Collection and Evaluation -----	QA-1
Illinois Patient Care Report Form-----	QA-1F
Quality Assurance Guidelines and Standards -----	QA-2
Case Audit Form -----	QA-2F
Blood Glucometer-----	QA-3
Manual Defibrillator and Battery System Tests -----	QA-4

**QUINCY AREA EMS SYSTEM
DATA COLLECTION AND EVALUATION**

- I. An Illinois patient care report form will be completed by each vehicle service provider for every emergency prehospital or interhospital transport and on all refusals (*any time you are dispatched a PCR form should be completed*).
- II. First Responders will complete a first responder form for all emergency prehospital calls and on all refusals (*any time you are dispatched a PCR form should be completed*).
- III. Disposition of forms copies
 - A. The copy designated “receiving facility” is to be left at the receiving hospital emergency department prior to the crew departing unless another emergent call is dispatched. This copy is to be included with the patient’s permanent medical record. (If the crew must depart the facility prior to completion of the PCR form, the entire form should remain at the facility at an assigned location and complete at the earliest possible time.*)

*Note: PCA forms for patients taken to facilities outside the Agency’s service area may remain with the crew, completed at the earliest time and faxed to the receiving facility.
 - B. The copy designated “EMS Resource Hospital” and/or IDPH copy is to be forwarded to Blessing Emergency Medical Services department for purposes of data collection/quality assurance.
 - C. The copy designated “Service/Provider” is to be maintained by the vehicle service providers agency.
 - D. *An individual should not maintain personal records of PCR forms.*
 - E. *If using electronic format, a copy of the PCR form should be sent to receiving hospital electronically before leaving the received facility.*
- IV. All PCR forms and first responder forms must be completed and sent to EMS Office by the 15th of the following month. *If using electronic format, information must be sent to IDPH electronically and an email confirming completion must be sent to EMS Coordinator.*
- V. The Resource Hospital shall submit a data report to IDPH on March 1, June 1, September 1, and December 1 of each year, covering run report data from the preceding quarter. The data shall be in one of the following formats:
 - A. The scannable patient care report form
 - B. A data diskette containing prescribed data elements
 - C. Electronically

**QUINCY AREA EMS SYSTEM
QUALITY ASSURANCE GUIDELINES AND STANDARDS**

- I. Objectives of quality assurance reviews
 - A. Review effectiveness of policies and procedures
 - B. Detect trends and repeated errors
 - C. Identify and acknowledge exceptional performance
 - D. Identify and correct substandard performance
 - E. *Identify educational opportunities*
- II. Analysis screens
 - A. Illinois patient care report forms – *including electronic PCR form*
 - B. System event reports
 - C. ER radio logs
 - D. Patient report tapes
 - E. Complaints
- III. Corrective Measures
 - A. Plan and conduct educational activities
 - B. Quarterly trauma/case reviews
 - C. Create policy and procedure
 - D. Amend policy and procedure
 - E. Issue commendations
 - F. Take disciplinary actions
- IV. Review Indicators: May change as specific System needs are identified
 - A. Cardiac/respiratory arrest (transported to the hospital)
 - 1. Documentation of airway management
 - 2. Documentation of CPR
 - 3. ACLS/System protocol followed
 - 4. Any problems/unusual circumstances
 - 5. *Was hypothermia protocol used*
 - B. Chest Pain/Cardiac
 - 1. Documentation of oxygen
 - 2. Documentation of 12 lead EKG
 - 3. Documentation of Aspirin, and Nitroglycerin

- C. Pediatric (one day old to 13 years old)
 - 1. Documentation of assessment
 - 2. Vital signs
 - 3. Treatment appropriate for condition

- G. Stroke/CVA
 - 1. Documentation of the Cincinnati stroke scale
 - 2. Documentation of onset
 - 3. Documentation of blood sugar
 - 4. Documentation of oxygenation

- H Other Review Indicators
 - 1. Cases requested for review
 - 2. Incomplete forms
 - 3. Unusual circumstances
 - 4. Exceptional performance

QUINCY AREA EMS SYSTEM CASE AUDIT FORM

DATE: _____

Form / IO # # _____

SITUATION/PATIENT COMPLAINT: _____

REVIEW INDICATOR:

☐ Cardiac Arrest (*includes hypothermia*)

☐ Incomplete Form

☐ Chest Pain

☐ Unusual Circumstances

☒ Stroke/CVA

☐ Request for Review

☐ Pediatric(one day to 13 years old)

☐ Random Audit

Comments: _____

Recommended Corrective Measures: _____

Auditor Signature: _____

Date: _____

Date Sent: _____

Date Received: _____

Date Reviewed: _____

Audit Completion: ☐ No Further Action

☐ Action Taken: _____

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

**DAILY EQUIPMENT CHECKS
BLOOD GLUCOMETER**

- I. Glucometer tests will be used to identify and resolve significant sources of error.
 - A. A daily operation test will be performed on each Glucometer at the beginning of each shift using the plastic test strip provided with the instrument.
 - B. A control will be performed weekly on each blood Glucometer according to the manufacturers recommended procedures.
 - C. If any control test exceeds limits, do not use that instrument for patient testing until the problem is reconciled.
 - D. A written record will be maintained of each test which documents the instrument tested and the results of the test. This record will be kept on the ambulance with the blood Glucometer until the next test is performed. The previous test record may be transferred to a central location to be kept on file. Copies shall be made available to the EMS office upon request.
 - E. Each test record must consist of at least the following:
 - 1. serial number, make and model of the instrument
 - 2. date of test
 - 3. results of test
 - 4. signature of person performing the test
 - 5. steps taken to resolve any problem with the instrument or controls
 - F. After each patient use, record the Glucometer reading on the test record and the results of the control test performed.

Kelly Cox, M.D., EMS Medical Director

4/95, re: 11/97, 2/06
(reviewed 8/01)

**QUINCY AREA EMS SYSTEM
POLICY AND PROCEDURE**

MANUAL DEFIBRILLATOR AND BATTERY SYSTEM TESTS

Tests will be regularly conducted on manual defibrillators and battery systems to identify and resolve conditions that could lead to possible malfunction.

1. A daily operational test of all manual defibrillators in service will be conducted and documented utilizing the manufacturer's guidelines. Operator's Shift Checklist as recommended by the manufacturer's guidelines.
2. A quarterly evaluation and recondition will be performed on each battery in service utilizing the manufacturer's recommended procedure. The Reconditioning Procedure and Shelf Life Tests will be alternated every 90 days.
3. If any discrepancy in either defibrillator/monitor operation or battery condition is found, appropriate corrective action must be taken immediately.
4. Records of all tests and documentation or corrective actions taken must be kept on file by each service a minimum of 2 years. Copies shall be made available to the EMS office upon request.

LATEST REVISION APPROVED BY IDPH

7/15	C-9-F-1a	Blessing Emergency Department Radio log	8/28/2015
7/15	C-9-F-1b	Illini Emergency Department Radio log	8/28/2015
7/15	CET 5	Requirements for EMS Clinical at Blessing Hospital	8/28/2015
7/15	CET 5a	Requirements for EMS Clinical at Blessing Hospital Form	8/28/2015
7/15	O-13-F2a	EMS Drug Boxes Restock List/Charge Sheet – Adams County	8/28/2015
7/15	O-13-F2b	EMS Drug Boxes Restock List/Charge Sheet –Brown County	8/28/2015
7/15	O-13-F2c	EMS Drug Boxes Restock List/Charge Sheet – Hancock County	8/28/2015
7/15	O-13-F2d	EMS Drug Boxes Restock List/Charge Sheet - QFD	8/28/2015
7/15	O-13-F2e	EMS Drug Boxes Restock List/Charge Sheet – QFD for ACA	8/28/2015
7/15	O-14	EMS Drug Supply List	8/28/2015
7/15	O-14 ARV	EMS Drug Supply List ARV	8/28/2015
7/15	AP 6.1A	Endotracheal Intubation –Adult ALS using (SALT) (NEW POLICY)	8/30/2015
7/15	AP 27	Tourniquet Application (NEW POLICY)	8/30/2015
7/15	AP 28	Less than Lethal Weapons (NEW POLICY)	8/30/2015
7/15	E-3	Ambulance Supplies (ALS)	8/30/2015

Latest Revisions sent to State (4/1/2015)

3/15	P1	EMS System Personnel	4/20/15
3/15	P2	Paramedic Duties	4/20/15
3/15	P3	EMTB Duties	4/20/15
3/15	P4	EMTD Skills (DELETED)	4/20/15
3/15	P-5	Paramedic Field Evaluator	4/20/15
3/15	P5 F2	Field Evaluator Qualifications Checklist & Agreement	4/20/15
3/15	P5 F3	Field Evaluator Application	4/20/15
3/15	P6.Fa	EMTP or PHRN Emergency Department Clinical form	4/20/15
3/15	P6-Fb	ALS Ambulance Clinical Call Management form	4/20/15
3/15	P-6-Fc	ALS Ambulance Clinical	4/20/15
3/15	P-6-Fd	Candidate Evaluation of Ambulance Clinical Experience	4/20/15
3/15	P-7.1a F	QAEMS Application form	4/20/15
3/15	P-7F	Change of Address form	4/20/15
3/15	P-7-Fb	Candidate Requirements (EMTP or PHRN)	4/20/15
3/15	P-7-Fc	Candidate Requirements (FR, FRD, EMTB, EMD)	4/20/15
3/15	P-8	EMTP/PHRN Relicensure Requirements	4/20/15
3/15	C-9-F1a	ED Radio Log (Blessing)	4/20/15
3/15	C-9-F1b	ED Radio Log (Illini)	4/20/15

LATEST REVISIONS APPROVED			
1/15	MP-Index	Medical Protocols Index	1/20/15
1/15	MP-5.1	Burns	1/20/15
1/15	MP-6.1a,1b	EMS Chest Pain/Suspected Cardiac Event	1/20/15
1/15	MP-6.3	Bradycardia	1/20/15
1/15	MP-6.4a, 4b	Unstable Tachycardia	1/20/15
1/15	MP-29	Pain Management	1/20/15
1/15	M-Index	Medication Index	1/20/15
1/15	M-1.17	Morphine Sulfate	1/20/15
1/15	M-1.30	Fentanyl Citrate (Sublimaze)	1/20/15
1/15	O-14 ARV	EMS Drug Boxes Supply List	1/20/15
1/15	O-14	EMS Drug Boxes Supply List	1/20/15
1/15	O-14-F2	EMS Drug Boxes Supply List	1/20/15
1/15	O-14-F2a	Adams County EMS Drug boxes Restock List/Charge Sheet	1/20/15
1/15	O-14-F2b	Brown County EMS Drug boxes Restock List/Charge Sheet	1/20/15
1/15	O-14-F2c	Hancock County EMS Drug boxes Restock List/Charge Sheet	1/20/15
1/15	O-14-F2d	Quincy Fire Dept EMS Drug boxes Restock List/Charge Sheet	1/20/15
1/15	O-14-F2e	QFD for Adams Co EMS Drug boxes Restock List/Charge Sheet	1/20/15

2/15	O-13A	Restocking of EMS Drug Boxes (non substance control med)	2/3/15
2/15	O-13B	Controlled Substance Policy	2/3/15
2/15	O-38	Conceal Carry (NEW POLICY)	2/3/15
2/15	MP-30	Hyperthermia Post	2/3/15
2/15	MP-31	Emerging Infectious disease (New Policy)	2/3/15

LATEST REVISIONS APPROVED			
2/14	CET-7	EMTB Course	2/7/14
2/14	CET-3aF	Con Ed sheet with Evaluation	2/7/14
2/14	MP-28	Nausea/Vomiting	2/7/14
2/14	O-13F	EMS Drug Boxes Restock List	2/7/14
2/14	O-14	EMS Drug Box List	2/7/14
2/14	C-9-F1a	Emergency Department Radio Log (Blessing)	2/7/14
2/14	C-9-F1b	Emergency Department Radio Log (Illini)	2/7/14
2/14	M-1.29	Zofran	2/7/14

LATEST REVISIONS APPROVED			
8/12	Appendix C(a)	Dual Response	8/13/12
8/12	Appendix C(b)	Helicopter Launch	8/13/12
8/12	C-5	Radio transmission	8/13/12
8/12	C-6	Routine Transfer	8/13/12
8/12	C-9	ED Radio Log	8/13/12
8/12	C-9-F-1a	Blessing Radio Log	8/13/12
8/12	C-9-F-1b	Illini radio Log	8/13/12
8/12	PS-1	Local system Review Board	8/13/12
8/12	PS-2	Suspension	8/13/12
8/12	PS-3	Problem solving	8/13/12
8/12	PS-3.1F	Event Report	8/13/12
8/12	PS-4	Suspected Chemical Abuse	8/13/12
8/12	PS-6	Disciplinary Action form	8/13/12

LATEST POLICIES REVIEWED			
8/12	Cet 1	Dispatch Pattern	8/13/12
8/12	C-2	Incoming Ambulances	8/13/12
8/12	C-3	EMS Recorded Line	8/13/12
8/12	C-4	Radio Protocol	8/13/12
8/12	C-7	Radio and time Checks	8/13/12
8/12	C-7-F	Daily Radio Check Log	8/13/12
8/12	C-8	Tapes and Recordings	8/13/12
8/12	C-10	ETA	8/13/12
8/12	C-11	EMD	8/13/12
8/12	PS-5	Appeal/System Review Board	8/13/12
8/12	PS-7	Filing a Complaint/IDPH	8/13/12

LATEST REVISIONS APPROVED			
4/12	Cet 6.1	Paramedic Program	6/8/12
5/12	C-9 F1a	Radio Log (Blessing)	6/8/12
4/12	O-36	Nerve Gas Auto Injector	6/8/12
4/12	O36 F	Nerve Agent Therapy	6/8/12
4/12	P-7Fc	Candidate Requirements	6/8/12
8/01	P-19	Prerequisites & Training for EMT B/D (DELETED)	6/8/12
6/12	P-23	EMTB Recertification Requirements	6/8/12
6/12	MP-6.12	PEA Algorithm	6/8/12
6/12	MP 5	Burns	6/8/12

LATEST REVISIONS APPROVED Approved 3/26/12 (verbal approval 2/26/12)			
1/12	AP-26	CPAP	
2/12	E-3	Ambulance Supplies ALS	
2/12	P-6	System Candidate Requirements	
2/12	P-7fb	System Candidate Requirements Form	

LATEST REVISIONS APPROVED Approved 3/26/12 (verbal approval 2/26/12)			
2/12	P-34	Reinstatement of Expired Policy (NEW POLICY)	
2/12	MP-4	COPD/SOB	
2/12	MP-6	Cardiogenic Shock	
2/20/12	P-7Fb	System Candidate Requirements Form	
2/20/12	P-6	System Candidate Requirements	

LATEST REVISIONS APPROVED 1/4/12			
12/11	O-13A	Restocking of EMS Drug Boxes	1/4/12
12/11	O-13B	Controlled Substance Policy	1/4/12
12/11	O-24	Distribution of EMS Manual	1/4/12
12/11	P-6	System Requirements	1/4/12
12/11	P-6-Fb	Candidate Requirements	1/4/12
12/11	MP-6.9	Ventricular Fibrillation	1/4/12