TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

DESCRIPTION OF PREHOSPITAL ADVISORY BOARD POLICY # 1 - 01

PURPOSE:

To provide a forum for prehospital care providers to learn of new legislation, equipment, skills, and to address the concerns of prehospital care providers

POLICY:

1. Promote and provide an optimum level of prehospital care to our communities
2. Promote camaraderie, teamwork, and understanding among all prehospital providers
3. Improve communications and exchange of information between the prehospital provider agencies and local hospitals
4. Maximize prehospital care through standardization of equipment, procedures and protocols between prehospital providers and local hospitals
5. Evaluate the delivery of emergency services in our region and effectively deal with any questions or problems encountered
6. Provide ongoing education and educational offerings to prehospital providers
7. Plan for the future of EMS care delivered in our system

MEETINGS:

The Prehospital Advisory Board meets the first Wednesday of designated months. All prehospital providers are welcome to attend. Membership is afforded to all Trinity EMS System services.

For additional information about the Prehospital Advisory Board, contact:

Trinity Office of EMS
2701 17th St
Rock Island, IL 61201
(309)779-7756
Fax (309)779-7746

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

GENERAL SYSTEM REQUIREMENTS/ RECOMMENDATIONS POLICY # 1 - 02

PUROPSE:

To identify for all Trinity EMS System personnel general system requirements not identified in other policies. To delineate for Trinity Medical Center EMS Provider Agencies recommendations (non-mandatory) policies the agency may wish to develop

POLICY:

1. All ALS/Trinity Medical Center EMS System personnel will determine a patient is either ALS or BLS by the highest level of care provider on scene. If the patient is determined ALS, then a monitor will be used in addition to any other treatments necessary.

2. All patients who require intermediate/advanced treatments should have them started **regardless of distance to destination**. If protocols indicate treatment or Medical Control issues orders, then begin treatment as indicated. If transport time is extremely short, contact Medical Control for treatment decisions. Do not arbitrarily determine transport time is too short to begin ALS treatment without checking with Medical Control. However, **do not delay transport** to perform interventions or procedures if medically feasible

3. All patients requiring ALS intervention should be ALS if it can be done in a timely manner and does not delay transport or arrival to destination. For example, an ambulance expecting an ***ALS tier should not stop if their expected wait time is in excess of their time to destination***

4. The Trinity EMS Office maintains an open door policy and encourages discussion of protocols, policies, emerging issues and system concerns

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

REMEDIATION
POLICY # 1 - 03

PURPOSE:

To identify for Trinity EMS System personnel when supervision, remediation, or re-education (minor infractions) is required such as, but not limited to: documentation problems, non-professional conduct, patient care issues, language offenses, clinical techniques, continuing education questions. These infractions are such that they can be cleared up with re-education/remediation process. In these situations the EMS system personnel may ask for due process

POLICY:

1. EMT's should always follow their agencies chain of command, but the EMS Department is available to discuss specific case issues

2. The EMS Medical Director may at any time call a provider to the office for discussion regarding poor standard of performance, documentation, and/or patient care. After notification of the personnel, the provider's agency will be notified. Documentation of these discussions will be maintained in the EMT's file at the resource hospital and not at the provider agency. The information/ documentation files will be signed by the EMS personnel when presented. Information will be protected under the Medical Studies Act

3. The EMS Medical Director will decide when the offense is criteria for removal from being scheduled on the agency ambulance. He will notify the EMT at the time of a scheduled discussion and note the length of time off ambulance, remediation and inform the EMT of all recourses. The EMS Medical Director will notify the Agency Director of the EMT's removal from work and expected time of return(See **System Participation Suspension Policy**)

4. Upon completion of remediation, the provider's agency will be notified of reinstatement and return to service. Written confirmation will be provided to the agency of completion of remediation and return to active service, and documentation will be kept in the provider's personnel file in the Trinity Office of EMS

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM PARTICIPATION SUSPENSION POLICY # 1 - 04

PURPOSE:

To identify the grounds and process by which a Trinity Medical Center System participant may be suspended or have revocation of licensure. The EMS Medical Director may recommend for suspension a license or refuse to license any EMR, EMT, AEMT, or Paramedic where he/she has been found in failure to comply with the EMS System Act and/or the policies and standards of TMC/EMS system. The severity of the infraction shall determine the degree of action taken by the EMS Medical Director

POLICY:

A. SYSTEM PARTICIPATION SUSPENSIONS:

Suspensions may be based on one or more of the following:

1. Failure to meet the initial and continuing education requirements
2. Violation of the Act, Rules, and Regulation
3. Failure to maintain proficiency in the provision of basic, intermediate, or advanced life support services
4. Failure to comply with the provisions of the System's Program Plan approved by the department
5. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substance, or other drugs or stimulants in such a manner as to adversely affect the delivery, performance or activities in the care of patients requiring medical care(For the purposes of this subsection, adversely affected means anything which could harm the patient or treatment that is administered improperly)
6. Intentional falsification of any medical reports or order, or making misrepresentations involving patient care
7. Abandoning or neglecting a patient requiring emergency care
8. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility, institution or other work place location
9. Performing or attempting emergency care, techniques, or procedures without proper permission, licensure, education, or supervision
10. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay
11. Behavior or conduct inappropriate or unbecoming of a member of the Trinity EMS System including social media and the internet
12. EMTALA or HIPAA violations

11. Medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care
12. Violation of the system's standards of care
13. Physical impairment of an EMT to the extent that he/she cannot exercise the appropriate judgment, skill, and safety for performing the emergency care and life support functions for which he/she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part; or
14. Mental impairment of an EMT to the extent that he/she cannot exercise the appropriate judgment, skill, and safety for performing the emergency care and life support functions for which he/she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part

B. SYSTEM PARTICIPATION IMMEDIATE SUSPENSIONS:

This policy defines under what grounds a system participant may be immediately suspended. The EMS Medical Director may immediately suspended from participation within the system any individual or individual provider if he/she finds that the information in their possession indicates that the continuation in practice by an individual or individual provider would constitute an imminent danger to the public. The suspended individual or individual provider shall be issued an immediate verbal notification followed by a written suspension order to the individual or individual providers by the EMS Medical Director which states the length, terms, and basis for the suspension

1. Within 24 hours the EMS Medical Director shall deliver to the Department (IDPH) a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the individual or individual provider
2. Within 24 hours the suspended individual or individual provider may deliver to the Department (IDPH) a written response to the suspension order and copies of any written materials which the individual or individual provider feels related to that response
3. Within 24 hours of receipt of the suspension order or the response, whichever is later, the Department (IDPH) shall determine if the immediate suspension should be stayed or continued pending the individual or individual provider's opportunity for hearing or review

Approved by EMS Medical Director 2020

SYSTEM PARTICIPATION SUSPENSIONS POLICY # 1 - 04

C. SYSTEM SUSPENSIONS:

1. The EMS Medical Director may suspend a provider from participation in the system for not meeting system requirements
2. The EMS Medical Director shall provide the individual with a written explanation of the suspension including terms, length, and date of commencement, and that a hearing can be held with the State Disciplinary Review Board
3. The individual must request, in writing, the hearing within 15 days or the right is waived
4. The individual still has the right to review by the State EMS Disciplinary Review Board
5. All documents and transcripts of the hearing/proceedings shall be retained in the custody of Trinity EMS System
6. Upon reinstatement, the individual and the provider's agency will be notified in writing and documentation of the incident will be kept in the Trinity EMS System personnel records

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM PARTICIPATION SUSPENSIONS POLICY # 1 - 04

TRINITY EMS SYSTEM
RECORD OF DISCIPLINARY ACTION FORM

Name_____ Date_____

Job Classification_____ Agency_____

You are here by officially counseled for the following incident(s) which occurred on_____

ISSUE/COUNSELING/ACTION:

ACTION TAKEN/DATE:

Verbal Counseling_____/_____

Written Warning_____/_____

Suspension_____/_____

Probation_____/_____

Was due process offered and explained? Yes_____No_____Not Applicable_____
Has previous disciplinary action been given for this offense? Yes_____No_____

A copy of this notice is being placed in your personnel file. You are warned that further incidents of poor conduct or performance may lead to your termination from the Trinity EMS System.
This is a quality improvement/corrective action plan intended for the use of EMS system quality improvement and is protected by the Medical Studies Act.

Reviewed by:_____
EMS System Coordinator Date

Reviewed by:_____
EMS Medical Director Date

*I have reviewed and understand the above:*_____
Signature Date

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

PHARMACY-BASED OPTION FOR MEDICATIONS POLICY # 1 - 05

PURPOSE:

To establish a medication program for Trinity EMS System that meets or exceeds the requirements of Iowa/Illinois Code, Drugs in Emergency Medical Service Programs

POLICY:

The interaction of the physician medical director, pharmacist, service leadership and EMS providers is critical for the success of the medication program. All staff must understand their role, responsibilities and duties as part of the team. Every team member shall receive an initial orientation to this policy and be provided with an opportunity for input and updates when amended. The pharmacist in charge and service director shall develop, implement an adhere to these written pharmacy procedures for the operation and management with respect to prescription drugs.

1. The service shall maintain documentation of periodic reviews of these policies and procedures by the pharmacist in charge or designee, medical director and service director.
2. The service shall maintain documentation of staff training to the service pharmacy agreement and policies and procedures when initiated and amended.
3. All records regarding prescription drugs shall be maintain and be available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.
4. **Identification, Access and Administration:**
    a. The service shall ensure that access if limited to appropriate staff and proper documentation is maintained.
    b. The service shall maintain records that log access to prescription drugs and records regarding procurement, storage and administration of the drugs.
    c. The log shall be maintained in a readily-retrievable manner and be made available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.
    d. The log shall include the staff printed name and signature, printed and signed initials, level of certification and other unique identification used in the service records.
    e. Access to prescription drugs shall be limited to certified EMS providers that are listed on the pharmacy signature log and system registry roster.
    f. Drugs, excluding Schedule II controlled substances, may be administered beyond the limits of the patient care protocols provided that online or verbal medical direction has been obtained prior to administration.

Approved by EMS Medical Director 2020

PHARMACY-BASED OPTION FOR MEDICATIONS POLICY # 1 - 05

5. **Procurement, Storage, Inspection, and Inventory Control**
   a. The pharmacist in charge or designee shall order, receive and distribute prescription drugs.
   b. Records of ordering and receipt of drugs shall be maintained by the pharmacy.
   c. The service shall maintain, at the primary site, an accurate list of all prescription drugs.
   d. The service shall maintain records of monthly inspections of all drugs at the primary site and all satellites.
   e. The inspection shall include removal of outdated drugs one month prior to expiration or removal of adulterated drugs that are quarantined for disposal.
   f. Yearly inventory will be done no later than January 31st but not before January 1st. All yearly inventory sheets will be turned into the EMS Coordinator.
   g. Staff may handle drugs within their current scope of practice as defined by the Bureau of EMS.
   h. Storage at the primary site and all satellites will be in a designated, secure, clean and free of debris climate-controlled area.
   j. Environmental temperatures shall be recorded on a daily basis, as a minimum.
   k. Refrigerated drugs will have daily recorded temperatures at a minimum.
   l. Drugs exposed to extreme temperatures (>104 degrees and <13 degrees Fahrenheit) shall not be administered to patients and removed from usable stock and quarantined for proper disposal.
   m. The pharmacist in charge shall notify the service regarding recalls and ensure removal and replacement.
   n. Expired, recalled and damaged drugs (except controlled substances) shall be removed from usable stock and returned to the pharmacy.
6. **Replenishment**
   a. Service staff may request replenishment of drugs maintained at the primary program site or satellites provided that the pharmacy has been supplied with administration records justifying the order.
   b. The pharmacist shall approve every drug taken from the pharmacy's dispensing stock. The pharmacist shall document and maintain verification of approval.

Approved by EMS Medical Director 2020

PHARMACY-BASED OPTION FOR MEDICATIONS POLICY # 1 - 05

7. Protocols, Administration of Drugs Beyond the Limits of Protocols, Patient Care Reports

a. The medical director shall approve patient care protocols for all drugs carried by the service

b. The service will ensure the pharmacist in charge receives the patient care protocols when state or local updates are approved by the medical director

c. The pharmacist in charge and service director shall ensure that the drugs and controlled substances carried by the service match the drug list in the approved patient care protocols

d. Drugs, excluding Schedule II controlled substances, may be administered beyond the limits of the patient care protocols provided that online or verbal medical direction has been obtained prior to administration

e. Verbal orders for drugs not covered in the patient care protocols shall be repeated back to the physician or designee for verification

f. Drugs administered outside the parameters of the approved patient care protocols shall be documented in the patient care report including the name of the authorizing prescriber and any person that may have relayed the order

g. Patient care reports that include drugs administered outside the parameter of the approved patient care protocols are subject to an immediate written audit of the patient care report per the service Continuous Quality Improvement Policy

8. Controlled Substances Administration, Destruction & Disposal, Inventories and Record Maintenance, Suspicion of Loss or Theft

a. The service shall deliver an order signed by the prescriber to the pharmacy within seven days of the date the administration was authorized, for all Schedule II controlled substances.

b. Every inventory and other required records shall be maintained by the pharmacy and the service and shall be readily retrievable and available for inspection and copying by the Board of Pharmacy and the Bureau of EMS.

c. A perpetual inventory (electronic or manual) of Schedule II controlled substances shall be maintained at the primary program site:

i. The electronic inventory shall provide for a hard-copy print out for any specified period of time and shall include the current inventory quantities for each drug at the time the record is printed

ii. Electronic entries may not be changed once recorded. Adjustments or corrections shall require a separate entry that includes the identity of the person making the correction and the reason for the correction

iii. The perpetual inventory shall identify all receipts and disbursements of Schedule II controlled substances by name or National Drug Code

iv. The perpetual inventory shall include patient administration, wastage, return to the pharmacy and disposal

v. The record of receipt shall identify the source of the drug, the strength and dosage form, the quantity, the date, and name or the unique identification of the individual verifying receipt of the drug

vi. The record of disbursement shall identify where and to whom the drug is disbursed or administered, the strength and dosage form, the quantity, the date, and the name or the unique identification of the individual verifying receipt of the drug

vii. The pharmacist in charge or designee shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance monthly

vii. Any discrepancy shall be reported to the EMS Coordinator

d. The service shall document an annual accurate inventory of Schedule II controlled substances at the primary site and any satellites that carry controlled substances

e. All controlled substance records for the primary program site and any satellites shall be maintained at the primary site. The records will clearly identify which records are for the primary site and each of the satellite(s)

f. The pharmacy and primary program site shall maintain records of destruction or disposal of controlled substances

i. Outdated, adulterated or unwanted supply shall be quarantined until the controlled substance can be returned to the pharmacy. EMS personnel shall not destroy controlled substances, except during wastage

ii. For destruction and disposal of controlled substances the pharmacist shall use the services of a DEA-registered and licensed disposal firm or other means approved by the board

iii. EMS personnel, the medical director or pharmacist may destroy or dispose of the unused portion of a controlled substance resulting from administration to a patient

1. Wastage shall be conducted in the presence an EMS provider authorized to administer the drug or a licensed healthcare professional

2. Written or electronic records of controlled substance wastage shall be maintained by the service and pharmacy

3. The records shall include legibly printed names and the signatures or other unique identification of the witness and of the individual wasting the controlled substance and:
    a. The controlled substance wasted;
    b. The date of destruction or disposition;
    c. The quantity or estimated quantity of the wasted controlled substance;
    d. Patient identification;

g. Upon suspicion of loss or theft of any controlled substance, the service shall notify, in writing (email preferred), The EMS System Office and the pharmacist in charge within 48 hours of the discovery of the theft or loss.

h. The pharmacist in charge shall notify, in writing, the DEA and the Board of Pharmacy of any theft or significant loss of any controlled substance within two weeks of the discovery of the theft or loss.

i. The incident report shall be maintained at the pharmacy and at the EMS System office.

9. **Misuse or Diversion**

A. This is a criminal offense, which may result in loss of employment, immediate suspension from the system and/or revocation of license

B. The agency Director, Chief or designee is responsible to review the count records frequently

C. If a pattern evolves of continued breakage or documentation by one EMT the Director or Chief should follow up with interview and/or drug screen (Policy of the agency)

D. Report any infractions to the EMS System office(See system participation suspension policy)

E. If system personnel are proven to abuse drugs or alcohol while on duty they will be subject to system disciplinary action(see system suspension policy)

F. Immediate system suspension will occur if the system personnel use on duty and/or distribute controlled substances for other than their intended use. This may also involve termination of their current employment

A complete copy of the Pharmacy-based Option Policy can be obtained from the Trinity EMS System Office upon request.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

MEDICAL CONTROL COMMUNICATION/ OVERRIDES POLICY# 1 - 09

PURPOSE:

To identify for the Trinity Medical Center Emergency Communication Registered Nurse personnel and the Emergency Room Physicians their responsibilities in regard to the communications of medical orders to prehospital care providers. To delineate a course of action should the Resource Hospital Medical Control need to override medical orders from any other hospital to Trinity Medical Center System personnel

POLICY:

1. An Emergency Communications Registered Nurse in the Trinity Medical Center EMS System, who has received the entire course of ECRN instruction and passed the required system examination is approved to communicate via radio to personnel in the field
2. The ECRN must follow the Standing Operating Guidelines of the EMS Medical Director and/or relay orders from the designated Emergency Room Physician. If the Medical Control Physician is not in direct communication with the ECRN, the ECRN must begin orders in strict adherence to SOG's
3. The designated Emergency Room Physician should be notified and called to the console as soon as possible
4. The Emergency Room Physician may deviate from the SOG's for certain patient situations, but may not advise the field personnel to administer any treatments/medications which have not been previously approved through the EMS Medical Director
5. Suggestions for change of Policy/Procedure may be made to the System EMS Medical Director
6. Overriding other Medical Control Communication may occur if the ECRN/ Medical Control Physician determines that those orders could be harmful or dangerous to either the field personnel/patient
7. Document fully any override situations or unusual occurrences and send to EMS MD/EMS System office
8. Medical Control Physicians may also override decisions of transports to facility based on the interpreted condition of the patient(See **Closest Hospital/ Transport Decision Policy**)

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SPECIAL EVENTS REQUIREMENTS POLICY # 1 - 10

PURPOSE:
To illustrate steps for Trinity EMS personnel necessary to cover special events

POLICY:
A Special Events Form is to be completed as an amendment to an existing EMS System plan by an ambulance provider who will be providing coverage at the specific event. This form with attachments, if appropriate, should be submitted to the EMS Department ideally **45 days** prior to the event. The form will be filed in the EMS Department and will be sent to the Illinois Department of Public Health if requested.

A copy of the Special Events Form and the items required by the EMS System for each level of care can be found on the IDPH Department of EMS website or requested from the EMS office, titled **Emergency Medical Service (EMS) Systems Special Events Request Application.**

1. EMR Assist Vehicles inclusive of:
   - A. Bicycle
   - B. Boat
   - C. Paramedic Engines

2. Transport/Non-Transport Vehicle Assist

3. Basic Life Support Transport Vehicles

4. Advanced Life Support Transport Vehicles

Approved by EMS Medical Director 2025

COMPLAINT
POLICY # 1 - 11

The EMS MD or Trauma Center Director shall forward the results of the investigation and any disciplinary action resulting from a complaint to the Department. Documentation of the investigation shall be retained at the hospital in accordance with the Resource Hospital record retention policy and shall be available to the Department upon request. The investigation file shall be considered privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8-2101].

Based on the information submitted by the complainant and the results of the investigation conducted in accordance with subsection (e), the Department will determine whether the Act or this Part is being or has been violated. The Department will review and consider any information submitted by the System participant or provider in response to an investigation.

The Department will have final authority in the disposition of a complaint. Complaints shall be classified as valid, invalid, or undetermined.

The Department will inform the complainant and the System Participant or provider of the complaint results (i.e., whether the complaint was found to be a violation, no violation, or undetermined) within 20 days after its determination.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

COMPLAINT
POLICY # 1 - 11

PURPOSE:"complaint" means a report of an alleged violation of the Act or this Part by any System Participants or providers covered under the Act, or members of the public. Complaints shall be defined as problems related to the care and treatment of a patient

POLICY:

A person who believes that the Act or this Part may have been violated may submit a complaint by means of a telephone call, letter, fax, or in person. An oral complaint will be reduced to writing by the Department. The complainant is requested to supply the following information concerning the allegation:

1) Date and time or shift of occurrence;
2) Names of the patient, EMS Personnel, entities, 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; and
6) The name of the facility where the patient was taken.

All complaints shall be submitted to the Department's Central Complaint Registry or to the EMS MD. The substance of the complaint shall be provided in writing to the System participant or provider no earlier than at the commencement of an on-site investigation pursuant to subsection (e).

The Department and the EMS MD or Trauma Center MD shall not disclose the name of the complainant unless the complainant consents in writing to the disclosure.

The Department may conduct a joint investigation with the EMS MD, EMS Coordinator or Trauma Center MD 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 licensure or designation. If the complaint alleges a violation by the EMS MD, EMS Coordinator or Trauma Center MD, the Department shall conduct the investigation. If the complaint alleges a violation that would not result in licensure or designation action, the Department shall forward the complaint to the EMS MD or Trauma Center MD for review and investigation. The EMS MD or Trauma Center MD may request the Department's assistance at any time during an investigation. In the case of a complaint between EMS Systems, the Department will be involved as mediator or lead investigator.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

EMS DISPATCH CENTER TIME
POLICY # 1 - 11

PURPOSE:
The EMS Dispatch Center Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot(with lights and siren) response.

POLICY:
The EMS Dispatch Center Time is defined as the time interval beginning with the time the initial 911 phone call is received requesting EMS services and ending with the dispatch time of the EMS unit responding to the event.

The purpose of the policy is to:

- Provide the safest and most appropriate level of response to all EMS events within the EMS system
- Provide a timely and reliable response for all EMS events within the EMS system
- Provide quality EMS service and patient care to the citizens

Any EMS Center Time delays resulting in a prolonged EMS Dispatch Center Time for emergent events should be documented in the patient care report(PCR) and reported as a “EMS Dispatch Delay” to the Trinity EMS System Office.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

EMERGENCY MEDICAL DISPATCH
POLICY # 1 - 12

PURPOSE:

The purpose of the policy is to provide quality patient care, develop a uniform level of response for the EMS system, provide a means for continuous quality improvement, and provide for the safest and most appropriate level of response to EMS events.

POLICY:

1. Persons calling for emergency assistance will never be required to speak with more than two persons to request emergency medical assistance.

2. Each EMS unit shall remain in the response zone assigned by CAD. To avoid dispatch errors, movement outside of this area must be directed or reported to the communications center.

3. Emergency medical units will be dispatched by EMD's in accordance to the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.

4. Emergency Medical Units will initially respond emergency("hot") to all requests. As more information becomes available, from the telecommunications center or the on scene medical responders, the mode of response may be downgraded to non-emergency("cold"). A non-emergency response is appropriate for alpha and omega level responses as soon as this can be established.

5. Emergency Medical Units dispatched for cold response will not upgrade to emergent response unless:
    1. Public Safety personnel on-scene request a hot(10-39) response
    2. Telecommunications determine that the patient's condition has changed, and request an upgrade to a hot(10-39) response

6. An Ambulance may divert from a cold call to a higher priority call and then:
    1. The diverting ambulance must notify the telecommunicator of their diversion to the higher priority call
    2. The diverting ambulance ensures that an ambulance is dispatched to the original call

7. An ambulance may divert from one emergency call to another emergency call if:
    1. The other call is clearly of a higher priority(e.g., Echo vs Charlie) -or-
    2. The EMS unit comes upon what appears to be a higher priority call(e.g., en-route to a Charlie call and comes upon an MVC with high potential for Trauma Alert patients)

An ambulance may by-pass what appears to be a lower priority situation and continue to the originally assigned call. The communications center should be notified to ensure another EMS resource may be assigned to the lower priority situation.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

PATIENT ABANDONMENT
POLICY # 2 - 01

PURPOSE:
To identify for all system personnel the term abandonment and those aspects which may constitute abandonment

POLICY:

- Abandonment is the unilateral severance of the EMT-patient relationship without reasonable notice, when further medical treatment is required. Abandonment occurs when the EMT-patient relationship, once created, is terminated intentionally and unjustifiably by the EMT. Very often abandonment takes the form of negligence or an act of omission
- Abandonment can ensure after the patient-EMT relationship is formed, i.e. when an ambulance is dispatched and arrives at the scene of an emergency and the EMT begins treatment or begins contact with the patient, the relationship is formed, then leaving care of the patient to anyone of a lesser level than the responding service EMT's constitutes abandonment

There are only three (3) ways the patient-EMT relationship can be terminated without abandonment

1. The patient does not require further medical care
2. The patient terminates the relationship
3. The patient is transferred to another qualified medical professional of equal or greater licensure. You cannot turn the patient over to lesser licensed personnel

Recommendations to eliminate abandonment questions are:

A. Once you start treatment, or accept the duty to provide service, then remain with the patient until he/she is safely transferred to the care of another provider of equal or greater licensure.

B. Do not leave a patient who decided he/she may not require emergency care unless you obtain a refusal (See **System Refusal Policy**)

C. Never leave a patient in an Emergency Department until you have provided the staff with all the required reports and information and the staff has assumed care of the patient. Document the name of the doctor and/or nurse you turned the patient over to by having them sign your run/bedside report form

D. Do not leave the patient or discontinue treatment because of police interference. If you receive a direct order from police to desist and the patient is removed from you under direct police custody, you no longer have the option to treat, but you must document fully the statements of police and police ID's, as well as immediately notify Medical Control

E. In a triage situation, it is advisable to summon an adequate number of personnel to assure that all patients are treated and transported in a timely fashion

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

PATIENT INTERACTION/UNLAWFUL DISCRIMINATION POLICY # 2 - 02

PURPOSE:
To identify for system personnel at all levels their responsibility to patient care and unlawful discrimination

POLICY:
The patient is to be considered primary at anytime you are called to serve.

1. Once you are dispatched you are to offer any care/treatment to your patient at the level of your licensure (that of the vehicle you serve on)
2. You are responsible to know the laws of your state and the regional/system policies and Standard Operating Guidelines of your system
3. You must provide for the well-being of the patient while rendering the necessary interventions relevant to your licensure level
4. You must be cognizant of the patient's ability to understand and comprehend your applications of treatment and his/her rights to refuse any part or all treatments. You must fully explain any risks involved with refusal of treatment and/or refusal of transport with this refusal. It is your responsibility to have the appropriate refusal signed and to document the explanation of risks in the narrative report
5. Provide privacy/confidentiality and allow patients to maintain dignity
6. Allow access to relatives and caregivers on request if appropriate
7. Make all emotional and physical needs of the patient a priority
8. Maintain honest/open discussions of events and procedures to the patient and their families
9. Explain the process of procedures
10. Recognize and respect all rights of property, patient, and families
11. Recognize the emotional needs of the infant and pediatric patient as well as the adult and elderly
12. Physical contact should be limited to treatments or therapeutic interventions
13. Maintain professional attitude at all times
14. Use appropriate language and do not try to overwhelm a patient with technical language
15. Allow interpreters and/or those who "sign" to accompany the patient

Discrimination:

1. No service/agency or EMT can refuse an emergent patient service based on race, sex, age, religion, mental competency/capacity, or ability to pay
2. When an ambulance is called, it is a call for help and appropriate response, care must be given
3. Any refusal to care for patient, even those who are in need, will result in system discipline and/or licensure suspension

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

PRESERVATION OF EVIDENCE REPORTING SUSPECTED CRIMES POLICY # 2 - 03

PURPOSE:

To identify for the Trinity Medical Center EMS System personnel the procedures to preserve a chain of evidence. To identify necessary reporting of crime and circumstances in which reporting is mandated. It is recommended that EMS management work closely with the police to avoid any interaction problems. Police/ EMS joint education may be helpful. Trinity Medical Center EMS personnel must keep in mind that the patient is your primary responsibility

POLICY:

Dying Declaration: is a statement or declaration from the dying patient is meant to be communicated to others you must: (this statement may indicate who the perpetrator of the crime is)

1. Record the message in as much detail as possible. Have the written record signed by two witnesses who may have heard the declaration
2. Communicate the message to the immediate police
3. A declaration may also be regarding property, particularly regarding valuables or burial instructions. Also turn the documentation over to authority Police/ Hospital and family if indicated

Suspicious Death: You must work with police and not disturb evidence. Police should never ask you not to examine the patient or transport if necessary. Ask police if you can move patient to a “non-crime area” to begin treatment. (If this will not endanger the patient). Patient exam and treatment is your responsibility and must be done and documented

1. Move nothing at a crime scene unless it is necessary to immediately treat a patient
2. If you must move something document its original location and give to police
3. Any bottles etc. that may be taken with you in transport must stay in a chain of custody. You are responsible for that chain until turned over the MD/police document who receives the property

Arrest: Police may wish to place restraints on the patient. Discuss the EMS policy for restraints with the officer prior to transport. Contact medical control if any questions arise which you may feel can compromise patient care. Document all information that pertains

Approved by EMS Medical Director 2020

PRESERVATION OF EVIDENCE REPORTING SUSPECTED CRIMES POLICY # 2 - 03

Reportable crimes are as follows but not limited to:

Child/Elder Abuse

- Provide care/comfort to the child/adult
- Report all evidence you find or see
- Should you be called to an abused child/adult, and a parent/guardian arrives and refuses care, immediately call police and standby to render aid after police arrive
- Document any and all evidence of abuse

Domestic Violence

- Provide comfort and care to the victim
- Report all evidence noted
- Do not place yourself in a position of danger. Call police immediately
- Document all evidence

Rape

- Comfort, treat injuries, appropriate assessment, call Rape Crisis if requested.
- Do not force unwanted questions about the rape.
- Do not examine or treat the genital area unless hemorrhage is present. Save all clothing.
- Do not allow the patient to wash, urinate or defecate until at the hospital
- Document all information/evidences and notify the police.

Alcohol/Drug Abuse/Controlled Substances

- Document fully all evidence of use
- Bring any evidence of use with you if possible
- Document behavioral effects

Suicide

- Document all evidence including statements that could point to suicide or attempted suicide
- Bring appropriate bottles, poisons, or notes with you if the patient is transported

Animal Bites

- Care for the patient. Document information and report to authorities, identify animal (if possible) for police

Other Reportable Crimes

- Gunshot/knife wounds, other assaults, injuries, MVA's, etc.
- When in doubt, call police/Medical Control

MAKE NO STATEMENTS TO THE MEDIA

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CHILD ABUSE RECOGNITION AND REPORTING POLICY # 2- 04

POLICY # 2 - 04

PURPOSE:

Child abuse is the physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare. The recognition of abuse and the proper reporting is a critical step to improving the safety of children and preventing child abuse

POLICY:

Assessment of a child abuse case based upon the following principles:

- ✓ **Protect** the life of the child from harm, as well as that of the EMS team from liability
- ✓ **Suspect** that the child may be a victim of abuse, especially if the injury/illness is not consistent with the reported history
- ✓ **Respect** the privacy of the child and family
- ✓ **Collect** as much evidence as possible, especially information

PROCEDURE:

1. With all children, assess for and document psychological characteristics of abuse, including excessively passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders
2. With all children, assess for and document physical signs of abuse, including and especially any injuries that are inconsistent with the reported mechanism of injury
3. With all children, assess for and document signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition
4. Immediately report any suspicious findings to both the receiving hospital (if transported) and to the Department of Children and Family Services(DCFS). While law enforcement may also be notified, the law requires the EMS provider to report the suspicion of abuse to DCFS. EMS should not accuse or challenge the suspected abuser. This is a legal requirement to report, not an accusation. In the event of a child fatality, law enforcement must also be notified

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

INFANT ABANDONMENT
POLICY # 2 - 05

PURPOSE:

Illinois provides a mechanism for unwanted infants to be taken under temporary custody by a law enforcement officer, social services worker, healthcare provider, or EMS personnel if an infant is presented by the parent within 30 days of birth. Emergency Medical Services will accept and protect infants who are presented to EMS in this manner, until custody of the child can be released to the Department of Social Services

POLICY:

To Provide:

- ✓ Protection to infants that are placed into the custody of EMS under this law
- ✓ Protection to EMS systems and personnel when confronted with this issue

PROCEDURE:

1. Initiate the **Pediatric Assessment Procedure**
2. Initiate **Newly Born Protocol** as appropriate
3. Initiate other treatment protocols as appropriate
4. Keep infant warm
5. Call local Department of Children and Family Services or the county equivalent as soon as infant is stabilized
6. Transport infant to medical facility as per local protocol
7. Assure infant is secured in appropriate child restraint device for transport
8. Document protocols, procedures, and agency notifications in the PCR

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

DOMESTIC VIOLENCE RECOGNITION AND REPORTING POLICY # 2 - 06

POLICY:

Domestic violence is physical, sexual, or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality health care, and preventing further abuse

Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of a caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and wellbeing of senior citizens

PURPOSE:

Assessment of an abuse case based upon the following principles:

- ✓ **Protect** the patient from harm, as well as protecting the EMS team from harm and liability
- ✓ **Suspect** that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the report history
- ✓ **Respect** the privacy of the patient and family
- ✓ **Collect** as much information and evidence as possible and preserve physical evidence

PROCEDURE:

1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessive passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition
4. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, also contact the Department of Children and Family Services (DCFS) or equivalent in the county
5. EMS personnel should attempt in private to provide the patient with the phone number of the local domestic violence program, or the National Domestic Violence Hotline, 1-800-799-SAFE

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

EMOTIONALLY DISTURBED
POLICY # 2 - 07

PURPOSE:
To identify for the System personnel information to deal with the emotionally disturbed

POLICY:
The emotionally disturbed patient is defined as:
One who would intentionally or unintentionally physically injure himself or others. One who is unable to care for himself and guard himself from physical injury and who cannot provide for his own physical needs. The emotionally disturbed patient may be in need of treatment and is not able to comprehend the risks in refusing or needing treatment.

The emotionally disturbed does not include a person whose mental processes have:

A. Been weakened or impaired by advanced years
B. Effects from an overdose of drugs or the ingestion of mind-altering hallucinogens or psychosis causing controlled substances
C. Alcoholic beverages that bring the patient to the point of intoxication
D. Anxiety, depression, suicidal tendency, or metabolic disease
E. Emotional distress caused from accidents or other life crisis

Approach to the Emotionally Disturbed:

A. Provide a calm atmosphere, reassurance, and well defined explanations. Have someone with the patient at all times
B. Document any criteria which confirms your opinion of decisional capacity of the patient evidence by:
    - Patient's general behavior
    - Inappropriate conversation/responses
    - Evidence of drug or alcohol abuse or use
    - Confirming statements of family/bystanders
C. When the patient consents to treatment, you may treat as usual and transport. If the patient is quiet and does not consent but does not actively resist, decide in favor of treatment, particularly when the patient appears extremely psychotic
D. Some emotional disorders show behavior that may be harmful to you, themselves or others. Under these circumstances you may treat and transport the patient without consent. This is done under the legal theories of:
    Emergency Doctrine- if the patient had the mental capacity to, they would consent
    Police Powers- this is the power to protect citizens from people who can cause themselves bodily harm
E. If it is necessary to restrain the patient follow the **Region II Restraint Policy**

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

REGION II RESTRAINT
POLICY # 2 - 08

PURPOSE:

To identify for Region II EMS personnel when restraints are necessary and the application procedure for restraining the violent patient. A restraint is identified as a manual or physical mechanical device that restricts the patient's freedom or movement or normal access to his/her body and cannot be easily removed

POLICY:

Patients will only be restrained if clinically justified. The use of restraints is only utilized if the patient is violent and may cause bodily harm to themselves or to others. Restraints are a last result in caring for the emotionally disturbed patient

CLINICAL JUSTIFICATION:

- Aggression
- Behaviors out of control/combative
- Appears the patient will cause injury to themselves or others
- Impulsive striking out/throwing objects
- Self abuse
- Assaultive behavior/threats with weapons
- Mental confusion/incompetence with aggression

PROCEDURE:

1. To restrain the patient, use minimum of 4 people. Have 1-2 of those as the same sex as the patient, if possible
2. As soon as possible contact medical control for guidance
3. May use police protective custody if available. Notify as soon as possible
4. Protect and preserve privacy and dignity of the patient
5. Explain procedure to the family and patient if possible/ One person (team leader) should communicate with the patient
6. Do not spend time in bargaining with patient. Once the decision is made, move to restrain. For example: a patient under the influence of drugs such as Bath Salts will not listen
7. Remove any equipment from your person, which can be used as a weapon against you
8. Assess the patient and area for any other types of potential weapons
9. Approach the patient keeping the team leader near the head to continue communications
10. Have a restrainer at 3 limbs and the team leader at the head

Approved by EMS Medical Director 2020

REGION II RESTRAINT POLICY # 2 - 08

11. Move patient to back board/stretcher
12. Have patient supine and place soft disposable restraints on 3-4 limbs and fasten to backboard. Do not restrain prone. Monitor airway frequently throughout transport
13. The restraint is fastened to the backboard and the backboard strapped to the stretcher. This allows ease in moving the patient if necessary to their side (May be necessary to prevent aspiration)
14. Continue verbal contact with the patient
15. Transport as soon as possible to nearest receiving hospital
16. Stay with the patient at all times after restraining
17. Document circulation checks every 15 minutes of restrained limbs, physical assessment, justifying factors for restraints, time of application of restraints, notification time of police and medical control. Document if police are on scene and accompany you to the receiving facility

SAFETY:

- Safety of yourself and the patient should be the most important factor at all times
- Stay with the patient
- Be prepared for the unexpected
- Continue to monitor for weapons the patient may have access to
- Police to accompany you in transport if possible
- Do not use metal restraints or requiring keys
- Do not remove restraints until released by medical personnel at the nearest receiving hospital

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

MINOR PATIENT/GUARDIAN CONSENT POLICY # 2 - 09

PURPOSE:

To delineate for the Trinity Medical Center EMS System personnel the steps to take in releasing a minor who refuses treatment in the field and/or continuing to treat without specific consent. To identify for the Trinity Medical Center EMS System personnel definition of emancipated minor, minor and guardianship. Adults have legal authority to make health care decisions, MINORS DO NOT HAVE AUTHORITY

Minor: a minor is defined as one who is under the age of 18 years

Emancipated Minor: In the state of Illinois is defined as one who is under the age of 18, married and/or self supporting or living independently or in the military service

Guardianship: When one is granted legal appointment by a court to manage another person's affairs, i.e. parents or court appointed guardians

Competent Adult: A person 18 years or older with no mental confusion or impairment who can understand risks of non-treatment and treatments needed

Minor Consent of Minors: Minors over the age of 12 may consent for treatment of:

- Sexually Transmitted Disease (STD)
- Treatment of ETOH use and alcoholism
- Treatment of drug use

Treatment of Minors:

A. The EMT may at any time treat a minor without parental or guardian consent where life-threat exists or he deems that the minor requires immediate care to prevent serious injury

B. Parents or guardians should be notified as quickly as possible(May be done by the Police)

C. When a condition is non-life threatening a parent or guardian should be contacted to obtain permission to treat. If this is not possible in the field, notify the police and transport the child for treatment to the appropriate facility

D. Complete documentation is required for treatment with or without parental or guardian consent, explaining the need to treat

E. An emancipated minor should have a legal document recognizing emancipation. If they do not, document carefully the identification of their own emancipation and treat under informed consent

F. If a child appears to need treatment to prevent further injury, contact Medical Control by radio, report the circumstances and receive permission. Always treat a child rather than not treat

Permission Acceptance:

You may accept permission for treatment from either **parent, older sibling, grandparents, aunts or uncles, or police officer**(in that order) when parents are not immediately available

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM REFUSALS
POLICY # 2 - 10

PURPOSE:

To identify for system personnel the procedure for refusal and the criteria to utilize when allowing a refusal to be written

POLICY:

A. ***An approved system refusal form must be used on all refusals***. The EMT is responsible to do an adequate assessment to make sound refusal decisions. Medical control should be contacted as soon as possible with the refusal decision if the patient appears to be high risk. High risk can be identified but not limited to, the following:

- ●Head injury
- ●Presence of alcohol/drugs
- ●Loss of consciousness
- ●Impaired judgment
- ●Minors

Low risk does not require medical control contact such as:

- ●Slow speed accidents without injury
- ●Competent patient with minimal complaint

B. The approved form should be signed by the patient who refuses medical help and/or transportation and does not appear to be a threat to himself or others

C. Risks of not receiving medical care must be carefully explained to the patient. In the case of minors the parent/guardian must sign the refusal form and receive the full explanation of risks for refusal of medical care (see **Minor Patient/Guardian Consent Policy**)

D. In the care of the patient (with decisional capacity) making the decision to transport to a farther care facility and/or inappropriate hospital the risks must be fully explained. Explain the benefits of transport to the closest or most appropriate facility. For example, chest pain to cardiac lab facility, suspected strokes to a stroke ready hospital, or traumas to an appropriate level trauma hospital. Utilize the refusal form to denote this decision. Please inform medical control of this decision and ask for assistance

E. If a patient or guardian refuses a part of the treatment this must be fully documented in the run record and on the refusal form. Call medical control to discuss alternatives or further orders

F. Contact medical control as soon as possible on any patient who appears to be unstable and wishes to refuse. The patient may have to be stabilized at the closest hospital and then transferred on to the facility of their choice

G. Document carefully in any areas of these situations

H. Have a witness sign the refusal form with you. If an officer is on the scene, he may sign as the witness. Note the name and badge number on form

Note: Family members cannot refuse treatment and transportation of a patient to a hospital unless they have durable power of attorney for healthcare

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM REFUSAL
POLICY # 2 - 10

PURPOSE:

The EMS Patient Disposition/Refusal Information form has been designed to be used by EMS personnel to legally document a variety of situations. This duplicate form consists of a single page. The front of the page is used to describe the situation and the back lists a variety of specific patient instructions by complaint. The form should be used to document any refusal of care by a patient (complete refusal or refusal of specific aspects of care) and to document the patient/guardian's understanding of medical instructions. Common scenarios of refusal are:

1. **COMPLETE REFUSAL OF EMS CARE OR TRANSPORT**: The first box "Patient Refusal" should be marked. In the first section, the appropriate blocks for "EMS Recommendation" should also be marked. This section should be explained to the patient or guardian, who should understand that their refusal may result in complications up to and including death. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation and the information provided. If the situation warrants, the EMT should explain the risks of the refusal using the patient instructions section and the back of the form for assistance. If the instructions section is used, the appropriate blocks should also be checked

2. **REFUSAL OF A SPECIFIC PROCEDURE** (IV THERAPY, C-COLLAR): The first box "Patient Refusal" should be marked. In the first section, the specific refused procedure should be marked. The first section should be explained to the patient or guardian, who should understand the potential consequences of their refusal. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation

3. The box "**Patient Instructions**" and the appropriate blocks in that section should be marked. This section and the specific instructions (on the back) should be carefully explained to the patient and/or guardian, who understands them. The patient or guardian should be asked to sign the form, indicating that he/she understands the instructions and the seriousness of the situation

In all situations, the top part of the form should be completed, and as much of the signature portion as necessary. It is preferable to have witnesses, particularly if the patient or guardian refuses to sign. The original form should be kept on file, while a duplicate copy provided to the parent or guardian

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CORONER POLICY
POLICY # 2 - 11

PURPOSE:
This policy is for all System personnel as a guideline for identifying and reporting a death to the coroner's office, and to note common types of reportable deaths

POLICY:
● In all cases in which you do not resuscitate, the coroner's office should be notified. You or the police officer on scene are responsible for that notification. The responding EMS personnel are required to stay with the body until the coroner or their designee arrives
● You may, however, return to service if a police officer or coroner representative relieves you of your responsibility
● You are not required by law to transport the body and be taken out of service. If you or your service do assist in this process, please see that your territory/service area is covered for emergency care
● Please notify Medical Control about non-transport of the deceased person if there are any questions about procedures

Reportable deaths include:

A. Traumatic violent death (suicide, homicide, accidental) to include but not limited to:
   Alcohol/Drug Causes, Burn, Crushing, Drowning, Elderly Abuse, Electrocution, Fall, Gunshots, Poison, Radiation Injury, Sex Crime Related, Stabbing, Starvation, Strangulation, Sudden Unexplained Death, Suffocation, Suspected Child Molestation/Abuse, Suspicious Circumstances, Vehicular Accidents, Weather Related
B. Jailed Victims
C. Deaths following procedures (i.e. at clinic or MD's office)
D. Nursing Home/Extended Care Deaths
E. Birth/Death of Newborn delivered outside of Hospital

Exposure:

A. If any ambulance/police personnel are exposed to blood or body fluid, please notify the Coroner or Deputy at once so that a sufficient amount of blood can be held for testing. You are responsible to see that this occurs
B. Follow Infection Control Policy for the agency

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CRITERIA FOR DEATH/ WITHHOLDING RESUSCITATION POLICY # 2 - 12

PURPOSE:
To identify for EMS personnel patients which it is acceptable to withhold medical care

POLICY:
CPR and ALS treatment are to be withheld only if the patient is obviously deceased per the criteria below or a valid **Do Not Resuscitate** form (see separate policy) is present:

INDICATIONS:
One or more of the following is present:

- ✓ **Rigor mortis and/or profound dependent lividity**
- ✓ **Decapitation**
- ✓ **Incineration**
- ✓ **Decomposition**
- ✓ **Mummification**
- ✓ **Frozen State**
- ✓ If arrest is traumatic in origin, go to **Traumatic Arrest Protocol**

Do not resuscitate any patient who meets the above criteria. If resuscitation efforts are in progress, consider discontinuing the resuscitation efforts (**Paramedic Only**) per the **Discontinuation of Prehospital Resuscitation Policy**

The pronouncement may be done only by the Trinity Medical Control Physician in the following situations:

1. When, in the medical judgment of the physician, the patient has died and the **initiation** of medical treatment by paramedics is not appropriate

If at anytime the ALS personnel are not certain which policy applies (**DNR** or **Criteria for Death** or **Discontinuation of Prehospital Resuscitation**) begin treatment and contact Medical Control for orders/assistance

Notify law enforcement/coroner of the patient's death according to the **Deceased Persons Protocol**

NOTE: If you are unsure whether the patient meets the above criteria, resuscitate

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

DISCONTINUATION OF PREHOSPITAL RESUSCITATION POLICY # 2 - 13

PURPOSE:

The purpose of this policy is to allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate ALS therapy by **Paramedics only,** when, *in the medical judgment of the medical control physician*, the patient has died and **continued** treatment of the patient would be ineffective and, therefore, inappropriate

POLICY:

Unsuccessful cardiopulmonary resuscitation (CPR) and other advanced life support (ALS) interventions may be discontinued ***prior to transport or arrival*** at the hospital when this procedure is followed

1. Discontinuation of CPR and ALS intervention may be implemented with contact to **Medical Control if ALL** the following criteria have been met:
   - Patient must be **18 years of age or older**
   - Adequate **CPR** has been administered
   - An advanced **Airway** has been placed such as endotracheal intubation, Blind Insertion Airway Device(BIAD), or cricothyrotomy
   - **IV or IO** access has been achieved
   - Rhythm appropriate **medications** and **defibrillation** have been administered according to **ACLS guidelines**
   - **Persistent VF, asystole or agonal rhythm** is present
   - A minimum of **25 minutes** of resuscitation
   - All EMS paramedic personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate
2. If all of the above criteria are not met and discontinuation of pre-hospital resuscitation is desired, *contact Medical Control*
3. Document all patient care and interaction with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the patient care report (PCR)

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2014

DO NOT RESUSCITATE FORM
POLICY # 2 - 14

POLICY:

Any patient presenting to any component of the EMS system with a completed **Do Not Resuscitate (DNR)** form shall have the form honored. Treatment will be limited as documented on the DNR form

PURPOSE:

- ✓ To honor the terminal wishes of the patient
- ✓ To prevent the initiation of unwanted resuscitation

1. When confronted with a patient or situation involving the DNR form, the following form content must be verified before honoring the form request.
   1) Name of the patient;
   2) Name and signature of authorized practitioner;
   3) Effective date;
   4) The phrase "Do Not Resuscitate" or "Practitioner Orders for Life-Sustaining Treatment" or both;
   5) Evidence of consent:

   A) signature of patient;
   B) signature of legal guardian;
   C) signature of durable power of attorney for health care agent; or
   D) signature of surrogate decision-maker.

2. A valid DNR form may be overridden by the request of:
   - ●The patient
   - ●The guardian of the patient
   - ●An on-scene physician

   If the patient or anyone associated with the patient requests that a DNR form not be honored, EMS personnel should contact *Medical Control* to obtain assistance and direction

3. A living will or other legal document that identifies the patient's desire to withhold CPR or other medical care may be honored with the approval of Medical Control. This should be done when possible in consultation with the patient's family and personal physician
   Note: In any case not covered by this policy and/or there is not a signed DNR order then resuscitation procedures must be followed
4. In all cases in which you do not resuscitate, the coroner's office must be notified. Either you or the police officer are responsible for this notification
   - ● You are responsible to stay with the body until the coroner or deputy coroner arrives
   - ● You may return to service if a police officer or coroner representative relieves you of your responsibility
   - ● ALL pre-hospital deaths MUST be reported to the coroner and follow the **Deceased Person Protocol**

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

ON-SCENE NONSYSTEM PHYSICIANS POLICY # 2- 15

PURPOSE:

To identify for System Personnel procedural steps to take in those prehospital emergency situations where physicians volunteer to help

POLICY:

Patient's local attending physician at the scene

A. Work with the physician to provide any and all necessary emergency care to the patient. Establish contact with Medical Control and advise them of physician on-scene after informing the physician on-scene you are mandated by Illinois law to take orders only from Medical Control

B. Ask the physician to accompany you to the hospital and assume responsibility for care of the patient. If there is a discrepancy or conflict in the care of the patient, you may request them to speak with Medical Control

C. If agreement cannot be reached as to the care of the patient, the Trinity Medical Control has the ultimate responsibility for the patient. Begin transport and re-contact Medical Control

Physician/nurses on-scene and offer services

A. The above procedure should prevail and if the physician is unknown to you and please ask them for their name and identification and verify with Medical Control any orders given provided the orders encompass skills and/or medications approved by both the EMS System Medical Director

Note: Remember you are licensed to receive orders from a state approved EMS system or a TMC EMSS ECRN. The ER Physicians of Trinity Medical Center are the only physicians directed by our EMS Medical Director to give orders to Paramedics in the field, and their orders will always take precedence, either by the ECRN or the on-line MD

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CLOSEST HOSPITAL TRANSPORT DECISIONS POLICY # 2 - 16

PURPOSE:

To identify for all levels of EMS Provider in the Trinity EMS System appropriate destinations for transportation of the sick and injured. State law requires transport to the nearest hospital unless there is documented criteria for a different decision. The nearest hospital should be that facility which would be defined closest by travel time. These decisions still allow the patient, or power of attorney/healthcare to choose the facility they prefer, unless the risk outweighs the benefit of this transfer

POLICY:

All sick or injured persons requesting transport who do not express a preference for a hospital will be transported without delay to the closest appropriate local hospital unless circumstances meet one of the following:

1. The patient is competent or a competent parent for a minor or POA agent and refuses transport to the nearest hospital then:
   - A. Contact medical control
   - B. Communicate the circumstances of patient condition, travel time and reasons the patient gives (i.e. the patient records/physicians are at the further facility)
   - C. Medical control will weigh the risks and benefits to the transfer and certify the decision
   - D. Then medical control physicians may determine the risks outweigh the benefits for a further transport
   - E. If the transport decision is confirmed this will be documented on the radio log sheet and the run record
   - F. If the transport is denied and the patient still insists on the further facility, they may be transported but against medical advice and must have a refusal signed
   - G. The patient must have all risks and benefits explained to them regarding the bypass to a further facility
   - H. Have the medical control ECRN contact the more distant hospital in advance to assure acceptance of the patient request for the more distant transfer. The ECRN will then document this information on the radio log sheet
   - I. Should the responding ambulance service be a municipal agency which cannot transport to the further hospital then they must stay with the patient and initiate all ALS/BLS appropriate treatment until another private transport service can assume care

Approved by EMS Medical Director 2020

CLOSEST HOSPITAL TRANSPORT DECISIONS POLICY # 2 - 16

J. Continued monitoring and treatment of the patient condition must occur while waiting for the transport service. Contact with medical control should continue as needed. Any changes of patient condition treatments must be documented on the radio log sheet by the ECRN and the run record by the EMT

2. The patient must be informed of the obvious risks of transportation of a greater distance. Document your discussion with the patient
   A. Have a refusal form signed if patient refuses to go to the nearest most appropriate hospital (see **Systems Refusal Policy**)
3. It is mandatory for transport decisions other than the closest hospital that there is consultation with medical control and a well documented written report
4. If the patient is judged incompetent or unable to make an educated decision they must be transported to the nearest hospital. Document all findings such as actions, behavior, statement, and or physical assessment, which indicated the patient, is unable to make a competent decision
5. If the patient requires specialized services, which are available only at the more distant hospital, document the need for hospital destination. Patients whose condition is covered by a formal destination protocol **(ROSC/Post-Resuscitation, STEMI, Stroke, Trauma**, etc.) shall be transported in accordance with those specialty algorithms. All other patients should be transported per the policy
6. Mass causality situations: follow the multiple casualty incident/crisis plan.
7. Hospital resource limitations : refer to the bypass policy.
8. Trauma Transport: All trauma patients are to follow the **Trauma Field Criteria Destination Protocol**
   The plan indicates:
   A. Those patients with appropriate criteria should be transported to the nearest level I or II Trauma Center unless that transport time is greater than 30 minutes
   B. If transport time is greater than 30 minutes, the closest hospital prevails. Notify Medical Control that you will need assistance in making the decision. Give indications of patient's condition and ETA to the nearest hospital. If prolonged transport, consider air medical transport

When in doubt, transport to Trauma Center

Note: For all refusals to the nearer hospital, use the Disposition/ Refusal form. If a patient also refuses to sign the refusal of service form, clearly document the patients refusal on the run record and refusal

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

BYPASS
POLICY # 2 - 17

PURPOSE:

To provide an explanation and a written procedure in the event that the question of bypass arises. Bypass can be to another hospital other than which transport was originally intended or to a larger more comprehensive facility. To provide an explanation and procedure if an area hospital places itself on bypass for limited bed availability. The patient has the right to select a hospital of their choice (see **Closest Hospital/ Transport Decisions Policy**)

POLICY:

A. To bypass nearest hospital in favor of another, please confirm with Medical Control, decision should be determined by Medical Control based on the risks and benefits to the patient for the condition reported at the time, as well as, the level of Emergency Room at the hospital which is bypassed

B. When a hospital places itself on bypass due to limited bed availability or internal disaster the EMT must contact Medical Control to determine the best transport decision for the patient.
- Give Medical Control all patient information and transport time to assist in making a transport decision
- All Critical unstable patients must be taken to the nearest facility and disposition to a farther facility made after stabilization
- Use Mutual Aid/Outreach to assist if necessary in more distant transfers
- Do not sit on-scene with potentially unstable patients to wait for Mutual Aid

C. Hospitals may go on bypass due to lack of monitored beds, but the Emergency Room may well be able to take the patient. Please clarify this with Medical Control if you suspect such a condition exists

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM TRANSFER-TREATMENT STANDBY POLICY # 2 - 18

PURPOSE:

To define for the Intermediate and Paramedic personnel the conditions and requirements of interfacility transfer of patients. To identify that an interfacility transfer is a patient who has been diagnosed and treated under a licensed hospital facility and physician and to be transferred to another licensed hospital facility and physician. The ALS agency who transports may do so if there is adequate coverage in their 911 response areas(can be mutual aid).

POLICY:

The Intermediate within the Trinity Medical Center System may perform interfacility transfers in an approved ALS vehicle with approved ALS crew following this criteria

1. Run sheet documentation with inclusion of patient exam, condition, history and medications(medication information and that of history can be obtained from the transferring facility)
2. May transfer patients with the following:
   A. Heparin/Saline Lock
   B. IV fluids to include and IV/IO Pumps and Infusions
3. Maintenance IV established
4. The patient's hospital record will accompany the patient

The Paramedic within the System may perform the interfacility transport an approved ALS vehicle with an approved ALS crew following:

1. Run Sheet Documentation with inclusion of patient exam, condition, history, and medications, patient, and hospital record
2. Documentation of Medications or IV drips which may be in use during transfer
3. Drips must be maintained at rate ordered by the attending physician

Notify Medical Control of the ensuing transfer and the general condition of the patient.

1. It is the responsibility of the transferring service to obtain any specific orders form the patient's personal physician before beginning transport. A complete report should be given to the transporting crew by the facility caring for the patient
2. Patient condition should be monitored frequently through transport. Document your findings and if any changes, call Medical Control immediately and refer to the proper protocol for treatment

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

INTERCEPT ALS ON SCENE
POLICY # 2 - 19

PURPOSE

To identify for Trinity EMS System personnel activation and communication for ALS intercept

POLICY:

To outline procedures of TMC EMSS ALS Ambulance Intercept Policy and ALS on scene

A. The first responding ambulance arriving **on scene** shall perform rapid patient assessment and determine the need for ALS intercept. Need for ALS intercept shall be determined by, but **not limited** to the following:

- Any patient care issue in which the EMT feels the need to call ALS
- Cardiac and Respiratory Arrest
- Chest pain (medical or trauma)
- Shortness of breath
- Unconscious patient
- Seizure
- Overdose/Ingestion
- Shock
- Childbirth
- Multi-casualty incidents
- Haz-Mat responses
- Trauma with potential for significant injury

B. Radio Reports are to be transmitted without delay so Medical Control also has the option to send ALS Intercept if they deem it necessary. **Any request for ALS intercept by Medical Control is to be considered a direct order**

C. Medical Control is the only party to cancel any ALS intercept request

D. Contact the intercepting ALS vehicle at once to predetermine an appropriate intercept point

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

INTERCEPT ALS ON SCENE
POLICY # 2 - 19

Transport

A. No more than **four (4)** ambulance personnel should be in patient care area of the ambulance at any time

B. If there are two (2), each patient must have an appropriate level of provider with them (i.e. ALS/Paramedic, BLS/Basic)

ILS/ALS on Scene

A. If the ALS System personnel are on scene of a BLS call, they may assist BLS personnel with assessment of patients to determine if a higher level of care is needed. If ALS is needed, follow intercept policy

B. If ALS system personnel assumes responsibility, BLS must remain with the higher level of crew and assist in the care of the patient

C. **Off-duty non-system personnel are not allowed to participate in the patient care**

D. ALS system personnel are on scene and have no equipment and/or ambulance, they may still assist in the assessment of need of the higher level of care, but of course may not treat the patient beyond the BLS level. When the ALS intercept vehicle/personnel arrive, the ALS system personnel on scene may only participate in care if the intercepting agency has provisions for this, i.e. liability policies

E. These assessments must not delay transport or care of the patient

ALS intercepts are meant to improve care and be beneficial for the treatment of the patient, but should not unnecessarily delay transport to definitive care at the destination hospital

Note: If you feel the ALS assessments/transfer of care would jeopardize the condition of the patient, it is mandatory that you call Medical Control and they will make the decisions

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

AIR TRANSPORT
POLICY # 2 - 20

PURPOSE:
To identify for Trinity EMS System personnel guidelines which may assist in identification of patients who may benefit from aeromedical transport

POLICY:

A helicopter may be utilized when ALL of the following criteria are present:

1. Patient meets criteria for trauma center evaluation
2. The patient is entrapped and extrication is expected to last greater than 20 minutes
3. The ground transport time is greater than 15 minutes
4. The patient is not in traumatic cardiac arrest

A helicopter may be utilized when any of the following is present:

1. A situation approved by the EMS Medical Director/medical control physician OR
2. Mass Casualty Incident (MCI) OR
3. The patient meets burn center criteria OR
4. The patient meets STEMI criteria and ground transport is greater than 15 minutes OR
5. The patient meets Stroke thrombolytic criteria and ground transport time is greater than 30 minutes

POLICY:

1. The need for a helicopter should be determined by both the service controlling the scene and the service taking care of the patient. The on-scene First Responder may request the helicopter in order to expedite transport
2. The on-scene service will request the helicopter from dispatch
3. A safe landing zone will be established
4. If the helicopter does not arrive prior to the extrication of the patient, the patient should be placed in the ambulance and transport started to the nearest appropriate hospital
5. Under *no circumstances* should transport of a patient be delayed to use a helicopter

Licensing:

All helicopter services shall follow all the rules outlined in section 515.920, 515.935,515.940,515.945 and 515.955. This should be identified in application and submitted to system office for service plan.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CONCEALED CARRY/ WEAPONS POLICY #2 - 21

PURPOSE:

To identify for System Personnel procedural steps to take in instances where a patient or family member lawfully carry a concealed weapon. The intent is to respect the citizens rights while ensuring the safety of EMS, healthcare providers, and the public

POLICY:

A **weapon** can be defined as a firearm, a device capable of producing death or great bodily harm, or an electronic weapon

A. EMS should always anticipate that a person may have a concealed weapon. Always ask a patient if they have any weapons on their person

B. All ambulances and EMS agencies should designate themselves weapons-free facilities or "No-carry zones". It should be clearly posted

C. It is not the job of EMS to determine if a patient is in violation of the law

D. Optimally, weapons should be secured in the patient's residence and not Transported. If transported, they should be secured in a firearms safety box inside a lockable cabinet or compartment

E. Always contact law enforcement to assist. Never put yourself at risk

F. A **conscious pt willing to relinquish a weapon** away from home should turn the weapon over to law enforcement on-scene. If law enforcement is not available and the condition of the pt warrants immediate transport, the weapon should be place in a designated locked location and transported to the destination with report to medical control of a weapon. The weapon should be turned over to facility security or law enforcement on arrival. Document in the PCR the chain of custody in detail

G. A **conscious pt unwilling to relinquish a weapon** should have law enforcement called to intervene until "scene safety" is assured. A person carrying a concealed weapon in a "No-carry zone" is violating the law

H. Patients with **altered levels of consciousness** demand extreme caution when found with a concealed weapon. Law enforcement should be called to disarm the patient. If the condition of the patient demands immediate transport, EMS personnel may attempt to safely and cautiously remove the weapon if able. Secure the weapon in a designated locked location and transport with notification to medical control of a weapon. The weapon should be turned over to facility security or law enforcement on arrival. Document in the PCR the chain of custody in detail

I. **Absolutely no family members or friends are to be transported with an unsecured weapon**

ALWAYS ASSUME EVERY WEAPON IS LOADED. ALWAYS HANDLE WITH CAUTION. NEVER ATTEMPT TO UNLOAD A WEAPON

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

IN-FIELD UPGRADE
POLICY # 2 - 22

PURPOSE

To identify for Trinity EMS System personnel the process for system In-Field Upgrade

POLICY:

A. An ambulance operated by a rural ambulance service provider or a specialized a emergency medical services vehicle or alternate response vehicle operated by a rural vehicle service provider may be upgraded, as defined by the EMS system Medical Director with prior approval of the proposal, **to the highest level of EMT licensure** (ALS/Paramedic, Advanced EMT, BLS) held by any person staffing the ambulance, specialized emergency services vehicle, or alternate response vehicle

B. All service vehicles must meet the following requirements:

1. Protocol to store all ALS equipment, medications, and supplies
2. Written CQI and QA program approved by the EMS System
3. Advertisement and promotion of the service only at the level that can be provided in continuity
4. Annual inspections by the department and EMS system
5. A written statement and internal policy submitted detailing the security, environmental controls, and access by personnel to the advanced medical equipment
6. A written plan submitted outlining the time frame for obtaining equipment and training of personnel, including trauma education (by 2018)

C. All system personnel that hold a license and work for a BLS service may run at the appropriate license level upon completion of skills verification and passing the system advanced level protocol test

D. All advanced level providers will need to have at a minimum

- **AHA CPR card**
- **AHA ACLS card**
- **AHA PALS card**
- **Appropriate State Licensure**

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

TREATMENT OF SUSPECTED OPIATE OVERDOSE # 2 - 23

POLICY # 2 - 23

PURPOSE

Provide protocols and policy for EMR's, EMS providers, and non-medical personnel to treat suspected opiate overdose with the use of **Naloxone(Narcan)**

POLICY:

A. Opiate overdoses are a significant and rising cause of death and disability. Rapid administration of the antidote, Naloxone, may reverse the side effects within 2 minutes the deadly side effects that cause victims to stop breathing and become comatose. Opiates or narcotics come in many forms and names. There are prescription pills such as Hydrocodone(Vicodin/Norco), Oxycodone(Percocet), and Codeine. Fentanyl has a commonly used patch for chronic pain. Illicit drugs such as heroin are often used IV. The rapid administration of Naloxone is intended to save their lives, and may be given in either in the nose or injected in a muscle, likely the thigh. Intranasal use may be preferred due to the ease of administration, avoidance of potential needle stick injuries, and cost. Intramuscular(IM) may be facilitated by the use of an auto-injector.

B. Personnel responding to a victim should administer Naloxone if there is a suspicion of opiate overdose by either a history or exam. The hallmarks of opiate overdose are:

Respiratory Depression Coma/Decreased Consciousness Pinpoint Pupils

Providers responding to an unconscious person, not breathing, with or without a pulse may give Naloxone and begin CPR.

C. For Intranasal use by EMR, EMT, AEMT, and Paramedic levels;

1. For the prefilled syringe Naloxone 2mg/2mL, remove the yellow caps from the syringe.
2. Next remove the red cap from the medication vial.
3. Now attach the nasal atomizer(often a **MAD®** device) to the syringe tip.
4. Screw the syringe into the medication vial.
5. Now place the device into the nose, occluded the other nostril, and briskly push 1mL or half of the medication, and repeat on the other side.

D. For Intramuscular use by EMT, AEMT, and Paramedic levels:

1. Remove the auto-injector(e.g. Evzio®) from the package and remove the red safety cap.
2. Place the black end on the patient's middle lateral thigh, with or without clothing.
3. Press firmly for 5 seconds until a click and hiss are heard.
4. Dispose of the device in and appropriate sharps container.

E. Patients with no response may receive a second dose after 3 minutes, by either route, if opiate overdose is still suspected or there is only a mild response.

F. All patients who are given Naloxone must be transported by EMS, and if necessary, Police Custody. NO REFUSALS ARE ALLOWED. Naloxone has a short duration and some opiates last much longer. The victim may lapse back into a coma if allowed to refuse treatment and must be transported for medical care.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

INTERFACILITY TRANSFERS
POLICY # 2 - 24

PURPOSE

To provide guidance regarding transporting a patient from a medical facility to another medical facility that requires Advanced Life Support care during transport and the facility does not send a registered nurse to attend the patient.

POLICY:

A. Trinity EMS personnel may provide interfacility transfers for time-critical and non-time-critical conditions as deemed appropriate by the medical providers, and the patient is being transported to an appropriate receiving facility.

B. The transporting EMS providers may maintain any infusion deemed necessary for the interfacility transport by the medical providers, providing that:

1. The EMS provider is familiar or educated with the medication being infused.
2. The medication is being regulated by an IV pump while en-route to the receiving facility.
3. The patient has stable vital signs prior to departure from the facility.

C. The transporting EMS providers should ensure that all appropriate documentation accompanies the patient.

D. While in transit to the receiving facility, all appropriate standing orders shall remain in place.

E. If the patient deteriorates in transit, the transferring facility or Medical Control should be notified via radio or cellular phone.

F. If further orders are needed for patient care, the transferring facility, Medical Control, or the receiving facility may be contacted for further instruction or orders if appropriate for patient care.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM ENTRANCE REQUIREMENTS FOR TRINITY EMS POLICY # 3 - 01

PURPOSE:

To identify for prehospital personnel (EMR, EMT, AEMT, Paramedic, PHRN) the requirements to be completed before they may function independently of a preceptor in the Trinity EMS System

POLICY:

System Entrance Process (EMR, EMT, AEMT, Paramedic, PHRN)

Application and entrance packet:

Complete Application to the system and return with the applicable attachments:

- Copy of current Illinois license
- Copy of current Iowa license if applicable
- Copy of National Registry Certification if applicable (not required in Illinois)
- Copy of letter of good standing from previous system
- Letter of course completion from educational program
- Copy of current CPR card (Health Care Provider)
- Copy of valid drivers license
- Copy of any certifications (ACLS, BTLS, PHTLS, PALS, NRP, TNS)

Application and entrance packet must be returned completed to the EMS System Office at : 2701 17th Street, Rock Island, IL 61201

EMR:

A. Attend System Protocol and Policy review at Agency
B. Review and return demonstration of Skills Competency
C. Return letter of competency completion to the system(Included in entrance packet). Once the system requirements are completed, the system will issue a letter of independence to the agency

EMT:

A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Return the letter of competency completion to the system(Included in the entrance packet)
D. A period of preceptorship with agency will be completed per agency's guidelines or bylaws. The Training Officer or an approved Trinity Preceptor will fill out a Field Evaluation tool, provided in packet, showing field competency
E. Complete and pass a system BLS protocol and policy exam(at Trinity EMS System office)
F. Once the system requirements are complete, the system will issue a letter of independence to the agency

Approved by EMS Medical Director 2020

SYSTEM ENTRANCE REQUIREMENTS FOR TRINITY EMS POLICY # 3 - 01

EMT:

A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Complete and pass a system protocol and policy exam(at Trinity EMS office)
D. A period of preceptorship with agency will be completed per agency's guidelines or bylaws. The training officer or an approved Trinity Preceptor will complete a Field Evaluation Tool, provided in packet, showing field competency
E. Return the letter of competency completion to the system (included in the entrance packet)
F. Once the system requirements are complete the system will issue a letter of independence to the agency

Paramedic/PHRN:

A. Attend System Protocol and Policy review at agency
B. Review and return demonstration of Skills Competency
C. Complete and pass a system ALS Protocol and Policy exam(at Trinity EMS Office)
D. A period of preceptorship with agency will be completed per agency's guidelines or bylaws. The Training Officer or an approved Trinity Preceptor will fill out a Field Evaluation Tool, provided in packet, showing field competency
E. Return the letter of competency completion to the system(Included in the entrance packet)
F. Once the system requirements and files are completed, the system will send a letter of independence to the EMS agency

2. If after completion of all entrance requirements the agency does not feel the applicant can work independently of a preceptor, the agency must notify the system in writing noting deficiencies. Once this is reviewed the system will arrange education (if applicable). Education may consist of:

- Auditing classes
- Video review
- Testing
- Skills validation
- Clinical rotation
- Surgical rotation for intubation
- Field precepting at a system recommended agency

Approved by EMS Medical Director 2020

SYSTEM ENTRANCE REQUIREMENTS FOR TRINITY EMS POLICY # 3 - 01

3. If the Applicant cannot complete all requirements for their respective level they will not be recommended to enter the system

4. The Applicant can retake all skills validations and system exams up to 3 times. If not successful in 3 retakes the EMS Medical Director will decide what further process the applicant must take or deny entrance to the System

5. The EMS System reserves the right to selectively do random testing on any personnel to assess knowledge and practical skills ability

Transfer from out of state:

A. EMT's transferring from out of state who wish to function in Illinois as an EMT (of any level) may apply to the Illinois Department of Public Health EMS and Highway Safety Division for Licensure reciprocity

B. Once the license is awarded, the EMT may apply to the Trinity EMS System for entrance to the system

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2014

LICENSE, RECIPROCITY AND RENEWALS POLICY # 3 - 02

PURPOSE:

To clarify for the EMS System personnel licensure, reciprocity, and renewal criteria

POLICY:

1. Original Licensure:

FR-D

- See First Responder Policy

EMT-B

- Must pass the Illinois EMT-B exam or the National Registry EMT-B exam
- Function in a state approved BLS system verified by that System's EMS Medical Director
- Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled

EMT-I

- Must pass the Illinois EMT-I exam
- Function in a state approved ILS system verified by the EMS Medical Director
- Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled

EMT-P

- Must pass the Illinois EMT-P exam or the National Registry EMT-P exam
- Function in a state approved ALS system verified by the EMS Medical Director
- Original request for licensure comes from the Education Program/System in which the EMT is educated so that the license can be generated after the state exam is passed. Transaction cards for licensure are submitted to IDPH by the education program provided by the System Resource Hospital at the time exam is scheduled

Approved by EMS Medical Director 2025

LICENSE, RECIPROCITY AND RENEWALS POLICY # 3 - 02

An EMD, EMR, EMT, A-EMT, Paramedic licensed or certified in another state, territory or jurisdiction of the United States who seeks licensure in Illinois may apply to the Department for licensure by reciprocity on a form prescribed by the Department available on the Department's Division of EMS website

The Department will review applications for EMS Personnel licensure from honorably discharged members of the armed forces of the United States with military emergency medical training.

A) The Department will provide application forms. Applications shall be filed with the Department within one year after military discharge and shall contain the following:

1) Documentation that the application is being filed within one year after military discharge;

2) Proof of successful completion of military emergency medical training or National Registry certification;

3) A detailed description of the emergency medical curriculum completed, including official documentation demonstrating basic coursework and curriculum; and

4) A detailed description and official documentation of the applicant's clinical experience or current National certification.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

INACTIVE/REDUCTION IN LEVEL POLICY # 3 - 03

PURPOSE:

To delineate for the prehospital personnel of the Trinity EMS System what constitutes inactive status and the requirements

POLICY:

I. INACTIVE STATUS

A. The EMT, AEMT, Paramedic may apply in writing to the EMS Medical Director to be put on inactive status. The application made must be prior to expiration of the current license and contain:
- Name, date of licensure, level, EMT-ID number
- Circumstances which require inactive status
- Length of time of inactive status needed
- Documentation that relicensure requirements have been met to the date of application for inactive status

B. The EMS Medical Director, EMS System office will then review the information and if all requirements are met will submit to IDPH a request for inactive status form. The licensee will surrender his/her license with application

C. The EMS applicant will be notified by the EMS System office of acceptance or denial of the application following return notification of Illinois Department of Public Health. If the inactive status is granted, the EMT's license shall be forwarded to IDPH

D. For the EMT to return to active status, the EMS Medical Director will make an application to IDPH. Included in that application is documentation that the EMT has been examined and is capable to return to active status. Testing will include but may be not limited to :
- System entrance requirements in full
- Continuing education, current
- Refresher as necessary

E. While the EMT is on inactive status he is not allowed to work in any prehospital capacity or level in any system

F. The inactive EMT is not under the policies of the system other than the inactive policies while on approved inactive status
- The request to reduce must be made in writing to IDPH and the Paramedic license must be surrendered to IDPH

INACTIVE/REDUCTION IN LEVEL POLICY # 3 - 03

● If, after a period of time as an active EMT, the Paramedic wished to be relicensed as a Paramedic, he/she may apply in writing to the EMS Medical Director and the EMS Medical Director will verify knowledge and skills of the appropriate level and resubmit to IDPH for the requested Paramedic license. Licensure will only be at the level the EMT has been previously educated and licensed

II. Voluntary Reduction in Level:

A. EMT-Reduction to EMR:

● Any level of EMT may reduce to the level of EMR prior to the expiration of their current license. They may revert to EMR status for the remainder of the license period. The EMT must make this request in writing to the Department of Public Health. To re-register, the individual must follow EMR registration requirements. The EMT who reduces to EMR level cannot revert from EMR to an EMT level

B. AEMT or Paramedic to EMT or AEMT:

● A Paramedic may at any time, prior to current expiration date, revert to an EMT status and is then required to meet EMT relicensure criteria

● The request to reduce must be made in writing to IDPH and the AEMT/ Paramedic license must be surrendered to IDPH

● If, after a period of time as an active EMT, the AEMT/Paramedic wishes to be relicensed as an AEMT/Paramedic, he/she may apply in writing to the EMS Medical Director and the EMS Medical Director will verify knowledge and skills of the appropriate level and resubmit to IDPH for the requested AEMT/ Paramedic license. Licensure will only be at the level the EMT has been previously educated and licensed

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SCOPE OF PRACTICE
POLICY # 3 - 04

PURPOSE:

The purpose of this policy is to define for Trinity EMS System personnel the circumstances under which Emergency and Non-Emergency Medical Services can be performed in accordance with their level of licensure and their EMS System

POLICY:

A. Each EMT(all levels) is required to be associated with an approved EMS System. In this case the EMT can work in the following areas but will work in conjunction with the equipment, protocols and policies of the system which has medical oversight for that area of practice. If you are in the Trinity EMS System you must have a direct reporting relationship with Trinity EMS System or we accept no responsibility for your licensure(i.e., The public event, function must be approved through special events form by IDPH and the system). Other areas of work include:

- Prehospital emergency setting, i.e. ambulance, EMR service
- Non-emergency transport, i.e. ambulance, wheelchair van
- Locations which are not Health Care Facilities but which utilize EMT's to render prehospital emergency care, i.e. industry, athletic events, public functions, public places
- Industry prehospital (EMR) requires the industry to enter the appropriate EMS System, and you must follow the dictates of that system

B. Any EMT may practice in an ER or other health care setting as follows:

- For Continuing Education
- As personnel hired by the Health Care Agency*
- Industrial Health Care*
- Clinics*

**Requires appropriate job description and orientation by the hiring agency. Individuals may at any time seek other credentials to enhance their ability to work in the healthcare setting under the jurisdiction of that employer, but they may not specifically utilize their EMS license as they enter criteria to work in these healthcare settings*

C. Student EMT's must follow the student policies of the system and work directly under an approved preceptor for the system

D. Anyone can work in 2 different systems but must follow the protocols, policies, and procedures of the system which has medical oversight

E. The EMT should list which system is his/her primary system

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

EMERGENCY DISPATCHER
POLICY # 3 - 05

PURPOSE:

An Emergency Medical dispatch program is based on curriculum established by the U.S. Department of Transportation-National Highway Traffic and Safety Administration, The Illinois State Police and the Illinois Department of Public Health

POLICY:

A. This course is designed to educate Emergency telecommunicators who receive calls for Emergency Medical Assistance from the public to provide pre-arrival instructions to callers in order to aid persons needing assistance prior to the ambulance arrival

B. Any Emergency Medical Dispatch Center and Emergency Medical Dispatcher may enter the Trinity EMS System by application with documentation of an approved dispatch course

C. State Registration

- Submission to IDPH a request for application with name, address system affiliation and employer
- Documentation of an approved medical dispatcher course meeting or exceeding the National DOT dispatcher curriculum
- Documentation of continuing education meeting IDPH standards

D. Medical prearrival instructions will be provided in accordance with the protocols established by the EMS System

E. A state of Illinois lead instructor may teach an Emergency Medical Dispatch program following the appropriate IDPH approval process and approved by the system

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

Emergency Medical Responder
POLICY # 3 - 06

PURPOSE:

EMR means a person who has successfully completed a course of instruction in Emergency Medical Responder which meets or exceeds the National DOT curriculum in the EMR. A EMR agency should enter the EMS System to provide approved care

POLICY:

A. A person under the age of 18 shall not be issued an EMR license. A person between the ages of 16 and 18 who has successfully completed a Department-approved EMR course and successful completion of the final examination may apply to the Department for a provisional EMR license. Upon satisfaction of all other applicable requirements, the Department will issue a provisional license, subject to the following limitations:

1) A person with a provisional license shall not use his or her provisional license except when affiliated with a recognized Illinois EMS System and with the written authorization of that System's EMS MD;

2) A provisional licensee shall not be placed in a position of primary response to emergencies by any licensee of the Department, unless the assignment satisfies all other provisions of this Part;

3) A provisional licensee shall function as an EMR only while under the direct, personal and continuous supervision of at least one other non-provisional EMR, EMT, A-EMT, EMT-I, Paramedic, PHRN, PHAPRN, PHPA licensed at or above the level of the provider's license. Nothing in this Part shall preclude a provisionally licensed EMR from providing nationally recognized basic first aid when not participating as part of the emergency medical response of his or her affiliated agency;

4) A provisional licensee shall not operate, drive or maneuver a Department licensed transport vehicle, rescue vehicle or non-transport agency owned vehicle in connection with an emergency response or the transportation of any patient; and

5) A provisional licensee will be recognized by the Department as an unrestricted EMR upon turning 18 years of age as required in Section 515.725.

Approved by EMS Medical Director 2025

Emergency Medical Responder
POLICY # 3 - 06

A.) An EMR education program shall be pre-approved by the Department and conducted only by an EMS System or a community college under the direction of the EMS System.

b) Applications for approval of EMR education programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS MD and EMS System Coordinator.

c) Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class.

d) The EMS MD of the EMS System shall attest on the application form that the education program will be conducted according to the national EMS education standards. The EMR education program shall include all components of the national EMS education standards, including all modifications required by the Department. The course hours shall minimally include 52 hours of didactic education.

e) The EMR education program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the education program and shall be approved by the Department based on requirements of Section 515.700.

f) The EMS MD shall authorize the electronic submission-of licensure application documents to the Department for an EMR candidate who is at least 18 years of age and has completed and passed all components of the education program, has successfully passed the final examination, and has paid the appropriate initial licensure fee (see Section 515.460). The initial licensure fee may be waived pursuant to Section 515.460(c).

g) All approved programs shall maintain course and student records for seven years, which shall be made available to the Department upon request.

h) CE classes, seminars, workshops, or other types of programs shall be approved by the Department before being offered to EMR candidates. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department at least 60 days prior to the scheduled event.

Approved by EMS Medical Director 2025

Emergency Medical Responder
POLICY # 3 - 06

i) Approval will be granted provided that the application is complete and the content of the program is based on topics or materials from the national EMS education standards for the EMR.

j) EMRs shall be responsible for submitting written proof of CE attendance to the EMS System Coordinator or, for independent renewals, to the Department Regional EMS Coordinator. The EMS System Coordinator or Department Regional EMS Coordinator shall verify whether specific CE hours submitted by the EMR qualify for renewal.

k) EMRs shall maintain copies of all documentation concerning CE programs that he or she has completed.

l) To renew an EMR license, the applicant shall submit the following to the Department at least 60 days, but no more than 90 days, before the license expiration. The renewal licensure fee may be waived pursuant to Section 515.460(c).

1) The submission of an electronic transaction by the EMS MD will satisfy the renewal application requirement for an EMR who has been recommended for re-licensure by the EMS MD.

2) The licensee shall file a written or electronic application for renewal with the Department no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the license expiration may not be processed by the expiration date and will be subject to a late fee.

3) EMRs whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the EMR, the Department will relicense the EMR.

4) An EMR who has not been recommended for relicensure by the EMS MD shall independently submit to the Department an application for renewal. The EMS MD shall provide the EMR with a copy of the application form.

h) CE classes, seminars, workshops, or other types of programs shall be approved by the Department before being offered to EMR candidates. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department at least 60 days prior to the scheduled event.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

ECRN REQUIREMENTS/ RECIPROCITY POLICY # 3 - 07

PURPOSE:

To delineate for all Emergency Department, Trauma Center nursing personnel the requirements and reciprocity for Emergency Communication Registered Nurse Certification in the Trinity Emergency Medical Services System. To define the ECRN rules and regulations of the EMS Act of Illinois. Section 515.740 mandates that an ECRN must notify within 30 days of name or address change

POLICY:

A. An ECRN must be a licensed registered nurse under the Illinois Nursing Act of 1987 and complete a course of instruction required by the EMS Act of Illinois under the design and direction of Trinity EMS Medical Director

B. Those persons with the following current certifications may possibly be exempt from the Trauma and Cardiac portions of the ECRN course
- A course in Trauma either TNS or TNCC
- Advanced Cardiac Life Support Provider or Instructor

C. Everyone, regardless of their current certifications, must attend the Protocol/ Policy Section and Communication Sections and take the final exam

D. The ECRN course shall consist of didactic, practical, and clinical components including:
- Medico-legal roles and responsibilities
- Communications, telemetry, and nurse at the console
- Cardiac and Rhythm review
- Trauma Assessment/Treatment review/Pediatric Trauma
- Protocol/Policy
- Final exam

E. Complete 8 hours of field experience and 4 hours of EM dispatch authorized by the EMS MD

Licensure

A. The ECRN will complete an application for licensure and the EMS MD will license them for a four (4) year period after documentation of successful course completion

B. Renewals will be through the EMS MC/System with documented 32 hours of continuing education in a four (4) year period

Approved by EMS Medical Director 2020

ECRN REQUIREMENT/ RECIPROCITY POLICY # 3 - 07

Reciprocity

Those nurses trained in another Illinois Resource System will be granted reciprocity on the basis of four (4) year license period and with the following:

- Copy of current licensure
- Trinity System entrance exam completion
- Attendance of TMC SMO/Policy lecture, communication lecture
- Trinity System ECRN final exam completion

Inactive Status

A. Prior to expiration of current certification the ECRN may request to be placed on inactive status

B. Make the request to the EMS Medical Director in writing and include:

- Name and date
- Date of approval
- Circumstances of inactive status
- Statement of meeting current CE requirements

C. The EMS MD will allow return to active status:

- By examination of mental/physical capability to return
- Knowledge and skills of the system
- Acknowledging the disability has ceased if applicable

D. During inactive status the individual must not function as an ECRN at any level

State Notification

Will be done by the EMS MD for approvals, re-approvals, or inactive status within 10 days of the status change

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

PREHOSPITAL RN/TNS
POLICY # 3 - 08

PURPOSE:

To define the requirements for completion of Prehospital nurse program and continuing education requirements for rectification as set forth in the Trinity Medical Center Emergency Medial Services System and by the Illinois Department of Public Health through rules of the EMS Act. To delineate reciprocity into Trinity Medical Center EMS System of a prehospital RN from another system. The PHRN is required by EMS Act Section 515.730 to notify the IDPH within 30 days of any address or name change

POLICY:

A. Must be a Registered Nurse licensed in Illinois under the "Illinois Nursing Act" of 1987 and an ECRN in the TMC EMS System

B. Will have a system developed prehospital RN course which contains telecommunications, prehospital cardiac and trauma, pediatrics and other specific courses delineated by the EMS MD (See prehospital RN course syllabus)

C. Must be currently ACLS/PALS certified as a provider, ACLS/PALS instructor preferred, but not mandatory

D. Complete a field internship of 10 ALS runs requiring monitor, drugs, IV's, and if possible, at least one with field intubation (May be Trauma/Medical mix) (Candidate may return to OR for intubation if necessary)

F. When all classroom educational requirements are completed successfully, the student must pass a system prehospital registered nurse exam

G. The prehospital nurse candidate must also complete a final practical exam covering:

- Intubation, in-line, orotracheal, nasal
- Intraosseous access
- Chest Decompression
- Jugular vein access, transtracheal jet insufflation, cricothyrotomy
- Traction splint and other immobilization techniques

Approved by EMS Medical Director 2020

PREHOSPITAL RN/TNS
POLICY # 3 - 08

I. Once these requirements are completed, the prehospital RN will submit an application and the EMS Medical Director of Trinity Medical Center EMS program will sign and issue Illinois Department of Public Health prehospital RN card and send notification of certification to the State Office of EMS and Highway Safety Illinois Department of Public Health

J. The prehospital RN will be certified for a period of four (4) years

K. Continuing education requirements for the field RN renewal are:

- Meet minimum guidelines for CE for renewal
- CE hours can be obtained as listed in system CE policy
- Maintain CPR, ACLS, PALS and Trauma Certifications

L. It is the responsibility of the prehospital RN to obtain the continuing education requirements and once obtained, and is in the prehospital RN personnel EMS file, the RN will be renewed

M. Reciprocity will be given to PHRN trained in another system on the basis of:

- Presentation of the course outline and practicum from the preceding system which is an approved in Illinois
- Completion of the Trinity ECRN course, or those portions indicated by the System EMS MD, and validation of skills of Trinity Medical Center EMS system not performed in previous system with written and practical exam

N. Re-licensure policy for PHRN shall follow the same requirements as Paramedic policy

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

CLINICAL FIELD PRECEPTOR
POLICY # 3 - 09

PURPOSE:

To delineate the qualifications of a Trinity EMS System Field Preceptor

POLICY:

Preceptor Qualifications

A. The preceptor may be a Registered Nurse in the State of Illinois with current licensure and a current Prehospital RN license. ACLS and BTLS provider certifications are preferred but not mandatory. The nurse preceptor must review all policies and educational programs of the system, with the EMS department educators

B. The preceptor may be a Physician currently licensed in Illinois and familiar with the Protocols and other operating policies of Trinity EMS System

C. The preceptor may be the EMS Medical Director or Alternate EMS Medical Director of Trinity Emergency Medical Services System

D. The preceptor may be an Emergency Medical Technician-Paramedic currently licensed in Illinois for a period not less than one year. This paramedic must be actively working on an ALS vehicle.

- The paramedic should apply to the EMS Medical Director to be a preceptor and notify his agency of that desire
- The paramedic shall be approved by the EMS Medical Director and working in the Trinity EMS System
- The paramedic shall review, through an education program provided by the Trinity Emergency Medical Services Department, all educational policies and precepting policies, forms for students, as well as observe at least one run review, meet with EMS System office educators to identify current, correct procedures

E. Once all above requirements are completed the paramedic may then function as a system preceptor

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

EMS LEAD INSTRUCTORS
POLICY # 3 - 10

PURPOSE:

To define for EMS Lead Instructors, within the Trinity EMS system, a method of obtaining a Lead Instructor Licensure/Renewal

POLICY:

LICENSURE:

The candidate who wishes to take a lead instructor course will submit to IDPH, through the appropriate training institution, the following

a. Completed application
b. Recommendation letter from the EMS System Medical Director
c. A Lead Instructor application (IDPH) which includes, but is not limited to, name, address, and resume
d. A copy of a current EMT-B/I/P,RN/MD license
e. A minimum of four (4) years experience in prehospital Emergency Care
f. Documentation of at least two (2) years of teaching experience with documentation of classroom experience (i.e., BTLS,PHTLS,CPR,PALS)
g. Documented successful completion of the Illinois EMS Instructor Education Course
h. License will then be sent and valid for four (4) years

EDUCATION:

TMC EMS Medical Director approves the candidate to take an IDPH approved course anywhere in the State

RENEWAL:

License renewal shall be as listed for a four (4) year period

- Approval letter from EMS Medical Director that the instructor has successfully coordinated programs for the EMS System
- Meet minimum CE guidelines for license renewal

Approved by EMS Medical Director 2025

EMS LEAD INSTRUCTORS POLICY # 3 - 10

TMS EMS System approves the following as continuing education:

- Seminars on education, continuing education, and teaching techniques
- Continuing education within the system
- Coordination of a full education course
- Coordination of certification courses (i.e., PALS,BTLS,ACLS,BCLS)
- Preceptor education courses within Trinity Education
- Trinity Education Department courses which are pertinent to the curricula of EMT-B,I,P,PHRN, and ECRN
- Degree work in an accredited college/university pertinent to healthcare/ education
- Appropriate nursing education

Non-Renewal

May be determined by IDPH following a hearing based on:

- Not conducting a course in accordance with curriculum prescribed in the Act
- Not complying with protocols in Section 3.65 (b)(7) of the Act

EMS MD may ask the lead instructor to stop functioning within TMC EMSS for the above or for non-compliance with policies and protocols of TMC EMS educational program

To apply for relicensure, the EMS LI shall submit the following to the Department at least 30 days, but not more than 60 days, prior to the LI's license expiration:

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

EMT AEMT and PARAMEDIC TESTING POLICY # 3 - 11

Purpose: To define requirements for testing to achieve EMS licensure

a) All candidates shall hold a high school diploma or high school equivalency certificate and be 18 years of age or older to be licensed.

b) After completion of an approved education program and a recommendation to test by the EMS MD or designee, candidates shall take the NREMT cognitive and an EMS System approved psychomotor examinations.

c) Candidates qualifying for licensure examinations may register for examinations through the NREMT. Application information may be found on the NREMT website. All candidates for licensure examinations shall be approved by the EMS System. Candidates shall register to take a licensure examination within 90 days after course completion, including all clinical and field requirements.

d) A failure rate per course of 30 percent or greater on the licensure examination will subject the particular education program to review by the EMS System or the Department.

e) Candidates shall follow the NREMT policy for initial licensure examination within 12 months after initial authorizations to test.

d) An accredited Paramedic program shall be conducted only by an EMS System or an academic institution whose curriculum has been approved by the EMS System.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

Critical Care Transport
POLICY # 3 - 12

Purpose: To define Critical Care Transports / Teams

1) Department-approved critical care transport providers, not owned or operated by a hospital, utilizing EMT-Paramedics with additional training, nurses, or other qualified health professionals; or

2) Hospitals, when utilizing any vehicle service provider or any hospital-owned or operated vehicle service provider. Nothing in the Act requires a hospital to use, or to be, a Department-approved critical care transport provider when transporting patients, including those critically injured or ill. Nothing in the Act shall restrict or prohibit a hospital from providing, or arranging for, the medically appropriate transport of any patient, as determined by a physician licensed to practice medicine in all of its branches, an APRN, or a PA. (Section 3.10(f-5) of the Act)

3) Physician medical direction for critical care, approved by the EMS MD, shall have the qualifications consistent with the acuity and conditions of the critical care patients transported. Such medical direction includes an Illinois licensed practicing physician with competency in critical care transport medicine and board certification in a specialty relevant to the provider agency mission or experience in critical care transport medicine consistent with the types, acuity and severity of patients transported.

Minimum Staffing:
System authorized Paramedic, PHRN, PHPA or PHAPRN; and System authorized Paramedic, PHRN, PHPA, PHAPRN or physician who is critical care prepared and who shall remain with the patient at all times.

Initial Advanced Formal Education:
At a minimum, 80 didactic hours of established higher collegiate critical care education nationally recognized; or two years of experience in critical care or emergency care with completion of an EMS MD or SEMSV MD approved critical care training program (consisting of, at minimum, 80 didactic hours) and obtaining a nationally recognized advanced certification within two years and Demonstrated competencies

CE Requirements: The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures. The following current credentials, as a minimum, shall be maintained: ACLS, PEPP or PALS, ITLS or PHTLS, TPATC or ATLS;A minimum of 40 hours of critical care level education shall be completed every four years; Experience. Minimum of one year experience functioning in the field at an ALS level for Paramedics, PHRNs, PHPAs, and PHAPRNs and one year experience in an emergency department for physicians.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2014

DOCUMENTATION AND REPORTING OF PROBLEMS POLICY # 4 - 01

PURPOSE:

To define a mechanism for reporting of problems not identified elsewhere in the System Manual

POLICY:

A. Reporting and documentation of problems may include:

- Communication issues
- Non-territory transfer
- Family conflict
- Non-system MD/Nurse
- Order conflicts (medications, treatments not accepted in System)
- Out-of-system treatment requests
- Equipment failure(see **Medical Devices Policy**)
- Personnel injury
- Exposure(follow the Infection Control Policy of your agency)
- Refusal to sign refusals or for pertinent areas of treatment

B. Make a separate, full written explanation of the incident and attach a copy of run report and send to EMS System office within 24 hours of the event. Utilize the **EMS Incident Report** form located in **Appendix D**. Include immediate steps of remediation in your written explanation

C. Report ALL communication problems immediately so it can be resolved as soon as possible

D. If supplies are not functioning properly or equipment fails, pull it from the service, contact your agency EMS Coordinator and agency manager. Exchanges or replacement need to be made and explanations given to the oncoming crew

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2014

DOCUMENTATION/ CHART FORM POLICY # 4 - 02

PURPOSE:

The purpose of this policy is to aid in the collection of data, which serves as legal documentation of prehospital assessment and care. This policy also includes forms approved by the Trinity EMS System and under what circumstances the forms are to be utilized

POLICY:

A. A Trinity EMS Run Sheet/Ambulance Report must be completed on all EMS runs regardless of the nature or outcome of the call. The run sheet is a legal medical record and is discoverable through subpoena. Ambulance reports will also be completed on refusal

B. EMS personnel are responsible for making certain that all information noted is factual to the best of their ability and that all data has been correctly entered on the form, whether electronic or paper, so it represents a thorough and accurate record of the run before copies are distributed

FORM COMPLETION GUIDELINES:

General Information:

1. **Date of Run-**Month, day and year of the run. Be accurate when a run extends from one day to the next. Note date on which run began
2. **Vehicle Number/License Plate Number-** Numbers of all vehicles responding to this call, i.e. 1J22 or T4 and all plate numbers. This is a state requirement to assure that all ambulances providing care are approved and registered by IDPH. Medicare will not pay for services of an unapproved provider
3. **Agency Name-** i.e. RIFD
4. **Incident Number-** Provider issued number
5. **Supplemental Report-** Document the completion of additional forms/ supplemental reports, i.e., child abuse, petition form, etc. This assists in identifying all written documents for one call
6. **Treatment Prior to Arrival or by Others-** Treatment rendered before the arrival of EMS personnel. It is useful in cardiac arrest situations to document patient down time. It is important to document care provided by persons other than EMS personnel
7. **Ambulance Requested By-** Originator of the call, i.e., police, citizen, co-worker, family member, friend, unknown, etc.

Time Information:

Use 24-hour clock times as given by department or dispatcher

1. **Dispatch**-Time dispatchers alert EMS personnel of the call
2. **Enroute**-Time the ambulance/squad leaves quarters or begins to respond, if already in motion
3. **Location**-Time of arrival at the scene
4. **Patient Contac**t-Time of actual ability to touch or assess
5. **To Hospital**-Time departed scene. May also be interpreted as time departed to destination if an interfacility transport
6. **At Hospital**-Time arrived at receiving facility
7. **In Service**-Time available to handle another call
8. **Quarters**-Time back at the station/garage
9. **Total Time**-Total time elapsed from dispatch to in-service

Road Conditions:

Note road and traffic conditions which may have affected your response to the scene.

1. **Light**- No impedance by traffic
2. **Moderate**- Some traffic but caused minimal delay
3. **Heavy**- Roads filled with vehicles-caused response delay
4. **Dry**
5. **Wet**
6. **Icy**

Call Location:

Address of call, not the name of the company or institution

Nature of Call:

When categorizing a call, take into account the patient's CHIEF COMPLAINT and your ultimate impression/diagnosis

1. **Cardiac**- An problem traceable to a cardiac condition/disturbance; i.e., chest pain, pulmonary edema, CHF, Cardiac Arrest, Dysrhythmia, Cardiogenic Shock
2. **Medical**- Infections, allergic reactions, hypertension, isolated pain, acute and chronic pulmonary diseases; diabetes, stroke, seizures, GI/GU problems, heat/ cold emergencies, poisoning, and gynecologic problems, etc.
3. **Vehicle Accident**- Automobile/bus, motorcycle/bicycle crashes or pedestrians who are struck by a moving vehicle
4. **Trauma**- All other trauma. Note the specific mechanism of the injury
5. **Burn**- Thermal, chemical, electrical, and/or radiation exposure

6. **Psychiatric**- Mental illness or behavior disorders, suicidal ideations
7. **Chemical Abuse**- Drug and/or alcohol abuse and/or overdose
8. **OB**- Pre-partum complications, labor, delivery and/or post-partum complications up to one month after delivery
9. **Inter-Hospital**- Transport from one medical facility to another
   Intra-Hospital- Between campuses
10. **Code Blue**- cardiopulmonary arrest victims

Hospital Contacted:

Hospital contacted for medical orders

Communications:

Document the type and quality of communication with the hospital

1. **UHF**-voice- Quality of transmission over telemetry radio
2. **EKG**- transmission of 12 lead EKG's
3. **MERCI**- Quality of VHF transmission
4. **Phone**- Landline phone
5. **Cellular phone**- Cellular phone contact
6. **Good**- Able to clearly hear majority of transmission with little static or interference
7. **Poor**- Transmission broken- unable to hear much of communication but could finish run
8. **Unable**- Either the hospital did not answer after reasonable attempts to contact them or the quality of communication was so poor that another method of communicating became necessary. Insert comments if poor or unable is marked

Outcome of Run:

Check all the boxes that apply to this patient

1. **ALS**- Patients requiring ALS services per System guidelines
2. **ILS**- Patients requiring ILS services per System guidelines
3. **BLS**- Patients requiring BLS services per System guidelines
4. **Assess/Treat**- Patient was assessed and given ALS or BLS treatment
5. **Transport**- Patient was transported
6. **No Contact**- No patient contact was made. No person found at the address to which you responded

7. **No Assessment**- Arrived at a scene where a mechanism of injury did occur or a situation exists that could potentially result in illness(noxious gas leak). Person present but refuses all EMS services. Person denies illness or injury and none are apparent to responders. No patient assessment is completed. No care is rendered. Example: MVA where you are called by police and none of the passengers wish medical attention. If one person involved: complete the run sheet with any information available to you about the scene and/or person. Must include mental status exam to document **decisional capacity**. Obtain refusal in accordance with the **System Refusals Policy**
8. **Refused Care**- Patient is assessed but refuses any treatment. Requires full disclosure of risk and a release signed in accordance with **System Refusals Policy**
9. **Refused Transport**- Patient may have been assessed and treated but refuses to be transported. Requires full disclosure of risk and a release signed in accordance with **System Refusals Policy**
10. **Release Signed**- Indicated that the Release of Liability Form has been signed and witnessed after the patient has been given full disclosure of risks and has been advised to seek further medical care in accordance with System Refusal
11. **Police on Scene**- Note an officer's department, name, if present on scene
12. **Patient Taken To**- Patient destination. Write hospital name. If a patient with decisional capacity requests a more distant hospital, a system refusal form may be completed to bypass a closer appropriate treating hospital

Patient Demographics:

Completely document on all patients. The only exception should be no patient contacts and no patient assessments.

1. **Name**- If the identity of the patient is unknown, indicate John or Jane Doe. Note personal information that assists in identifying the patient
2. **Home Address**- If known
3. **Phone**- If known
4. **Date of Birth**- Estimate age if not known
5. **Sex**- Gender, male or female
6. **Weight**- Enter weights on all pediatric patients and those receiving meds with weight dependent doses, i.e., lidocaine, dopamine
7. **Medications patient now taking**- List all known medications. If unknown or none, place an "X" in the appropriate box. May document, patient's list attached if numerous
8. **Allergies**- List known allergies. Check box if patient denies any allergies. If patient is uncertain, check unknown

History:

1. **Chief complaint, presenting problem, history of present, illness, cause of injury**- Record the patient's chief complaint in his/her own words. If the patient is a minor, enter the parent or guardian's statement. Note when and how this current condition occurred; what prompted this call; and why or how is it different from the past. Include precipitating factors, quality, recurrent, severity, onset and duration of the complaint. The section should be sufficient to refresh the clinical situation after it has faded from memory
2. **Past Medical History**- Check applicable boxes provided. Note any other pertinent illness/surgeries in the space provided. Check box if valid DNR/ Advance Directive present on scene

Assessment:

1. The times noted for the first assessment will be interpreted as being the time of patient contact
2. **Pupils**- Document on all calls involving an altered mental status, head injury, stroke, seizure, or symptoms indicating possible neurologic causes or involvement. Note the size and reactivity of each pupil and whether pupils are equal or unequal
3. **Level of consciousness**- Document on all patients
   - A&Ox3- Alert and oriented to person, place, and time
   - Verbal- Responds to verbal stimuli- record GCS
   - Pain- Responds to painful stimuli- record GCS
   - Unresponsive- Unresponsive to any stimulus- record GCS
   - Combative- Patient agitated/fighting. Must be noted if restraints applied
4. **Glasgow Coma Score**- Document on all calls where the patient has a mechanism of trauma that could result in a head injury and all patients with an altered mental status. Record the patient's BEST response.
5. **Respiratory Effort**- Document on all patients
6. **Lung Sounds**- Document on all patients c/o respiratory and/or cardiovascular distress, chest trauma, a history of lung disease and/or chest pain
7. **Skin**- Document color, moisture, temperature on all patients
8. **Pain**- Patients should be asked to rate pain on a scale of 0 to 10, 0=no pain and 10=worst pain imaginable. Document initial pain rating and subsequent pain reassessment scores

DOCUMENTATION/ CHART FORM POLICY # 4 - 02

Vitals/RX:

Document **at least two sets** on all patients unless they are refusing assessment and care, are too combative or an exemption applies and is noted in the comments section

1. **Vital signs** shall be reassessed and documented every 15 minutes or more frequently, as indicated by the patient's condition
2. **EKG Strips**- Interpret and note all EKG rhythms obtained on ALS calls. Document all rhythm changes. When recording rhythm strips, run at least 20 seconds. Attach a 6-second strip (30 large boxes) and leave copies
3. **Defibrillation** -Time and wattage used for each defibrillation/cardioversion
4. **Drugs/Solutions/Dose/Route/Response**- Time, drug, dose, route and response for all medications/solutions given

Exam:

Note all significant **positive and negative** findings for each of the body systems. Each system should have a notation as either showing pathology or being within normal limits (WNL). It is not necessary to repeat findings that have been noted in other areas of the record

Treatment:

Capillary glucose readings should be noted on all patients with an altered mental status. Note the site, type of fluid, gauge of the catheter, flow rates, and amount administered in the field for all IV's. Note the liters per minute and delivery device for all oxygen administration. Indicate if ventilations were assisted and the number of breaths per minute.

Comments:

Document any other observations or care that was given, any pertinent findings or responses to treatment **not** covered in other areas of the sheet. Example: irrigated both eyes with NS. Document any unusual occurrences that happen to the patient before arrival of EMS personnel, during pre-hospital care or during transport. May also use to continue the narrative from the Chief Complaint/HPI/Mechanism of injury section

Paramedic Impression: Correlate the findings of the chief complaint, PMH, History, Present illness and Patient assessment to determine a presumptive diagnosis upon which all pre-hospital treatment shall be based. Whenever possible, record all impressions in professional medical terminology. This area is not to be used for (subjective) comments. Be as specific/objective as possible

Crew:

ALS runs must be signed by a minimum of two crew members, one of which is EMT-P level or pre-hospital RN, directly providing care. The names and system identifier numbers of all responding EMS personnel providing care must be noted. BLS/ILS runs must be signed by a minimum of two EMT-B's or EMT-I's with their system identifier numbers listed. Providers are responsible for assigning responsibility for completing the report

Addendums/Corrections:

1. After completing an ambulance report, it is occasionally discovered that important information was omitted, an amendment is necessary, or information needs to be added to clarify the report or more thoroughly document the incident. Every effort must be made to avoid any discrepancy between the provider's copy of the report and the hospital's medical record copy. If an error is noted before distribution of the copies; draw a single line through the entry and date initial notation. Enter the correct information. Never obliterate an entry by scratching it out with heavy line, marker, or white out

Distribution of EMS Rescue and Ambulance Report Form:

Transport to a system hospital:

Original copy- Original form used as the official run report for legal and agency records. This copy must be filed out completely, have the EKG strips attached, and shall be retained by the provider agency

Second copy- Forward to Emergency Department personnel caring for the patient. This copy should be added to the patient's permanent medical record kept in the medical records division of that hospital. EKG strips to be attached if obtained

Preliminary Report Form (ambulance short form):

The **Preliminary report form** (short form) is designed to be an intricate part of Trinity Medical Center's EMS reporting system. It is utilized by transporting and non-transporting agencies. This form produces initial information pertaining to the patient's chief complaint, treatment, medical history, and response to care. The use of the preliminary report aids the emergency department staff with vital information pertaining to patient care and permits pre-hospital care services to return to their districts in a timely manner. Every effort though should be to leave the completed run sheet (paper or electronic) at the ER with the patient

1. The Preliminary Report form (short form) will be accepted by the staff at the Emergency Department if the following conditions are satisfied:
    - Approval from the Emergency Department RN or MD
    - Full verbal report will be given to the receiving RN upon arrival to the Emergency Department
    - The signature of the receiving RN must be on the form
2. The approved system Preliminary Report Form (short form) will be in duplicate and copy #1 is given to the Emergency Department RN or staff. Copy #2 is retained by the transporting service and attached to the computer generated run report. Remember the preliminary report form is a **legal document** and must be maintained as such
3. The Preliminary Report form (short form) is **not** intended to be used in the following circumstances.
    - When the patient's condition is critical, whether due to trauma or a medical cause
    - Cases that may have legal concerns need to have the full report left at the Emergency Department before the EMT leaves the facility
4. When the Preliminary Report Form (short form) is used, the paper or computer generated ambulance report must be received in the hospital within 12 hours after leaving the Emergency Department

Radio Report Form:

The Radio Report form is designed to be an intricate part of Trinity Medical Center's EMS reporting system. It is utilized by the Emergency Communications Registered Nurse when taking report on patients. This form produces initial information pertaining to the patient's chief complaint, treatment, medical history, and response to care. The use of the preliminary report aids the Emergency Department staff with vital information pertaining to patient care and permits pre-hospital care services to return to service in a timely manner

1. The Radio Report form will be used by the staff at the Emergency Department in the following situations.
    - The patient information per UHF or VHF/Cellular Transmissions
    - A second full verbal report will be given to the receiving RN at the bedside
    - The signature of the receiving RN or ER Physician must be on the form

2. The approved system Radio Report form is kept as part of the Trauma Center chart. The Radio Report form is a **legal document**

Electronic Submission:

The only approved pre-hospital computer programs for TMC, EMSS are:

1. Trinity PCR: copies may be obtained from the EMS System office
    - If a system provider chooses to utilize another software they must submit system required data in a form that will link to our database. This required information must be submitted monthly
2. Runs shall be submitted every month to TMC EMS to download into TMC data base. TMC EMS will upload the appropriate State data to the Illinois Department of Public Health
3. Suggestions for change and other considerations are to be reported to TMC EMS and the vendor will be contacted
4. If there is a problem with the computer software, please utilize a regular run sheet until the problem is resolved by your agency director. Then re-enter the appropriate information in to the main agency computer to transfer to the EMS System office. The paper run sheet will be left at the receiving hospital
5. The transport vehicle provider shall submit patient care report data to the EMS System. When an EMS System is unable to import data from one or more providers, those providers may, with EMS System approval, submit their patient care report data directly to the Department. The Department will make the patient care report data available to the EMS System upon request. Every EMS System and EMS provider approved to submit data directly shall electronically submit all patient care report data to the Department by the 15th day of each month. The monthly report shall contain the previous month's patient care report data and shall be submitted to the Department no later than the 15th day of the following month. The Department shall make information about the data errors available to data

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

DOCUMENTATION OF VITAL SIGNS
POLICY # 4 - 03

PURPOSE:

Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component

POLICY:

To insure evaluation of every patient's cardiovascular status and documentation of a complete set of vital signs

1. An **initial** complete set of vital signs includes:
   - **Heart rate**
   - **Systolic AND diastolic blood pressure**
   - **Respiratory rate**
   - **Pain/severity**(when appropriate to patient complaint)
   - **GCS** for Injured Patients
2. When no ALS treatment is provided, palpated blood pressures are acceptable for **REPEAT** vital signs
3. Based on patient condition and complaint, vital signs may also include:
   - **Pulse Oximetry**
   - **Temperature**
   - **End Tidal CO2** (if Invasive Airway Procedure)
4. If the patient refuses this evaluation, an assessment of decisional capacity and a **Patient Disposition Form** must also be completed
5. When any components of vital signs were obtained using a cardiac monitor, the data should be included in the patient care report
6. Document situations that preclude the evaluation of a complete set of vital signs
7. Record the time vital signs were obtained
8. **Any abnormal vital sign should be repeated** and monitored closely

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

MEDICAL DEVICE EQUIPMENT FAILURE POLICY # 4 - 04

PURPOSE:

To define for the Trinity EMS System personnel reporting mechanisms for all medical devices carried on ambulance's rescue vehicles. When a device does not function properly and/or in it's malfunction may injure a patient. To comply with the Safe Medical Devices Act

POLICY:

Occurrence/Documentation

A. If a device fails and/or injures anyone in it's failure the device must be preserved in the condition at the time of failure
B. Document date and time, if possible
C. Document a description of the failure and the injury/harm caused by it's failure
   - Note that equipment was removed from service at this time
   - Note description of any injury and MD/Physicians who examined the patient/injured party, patient diagnosis, age
   - Note the manufacturer of the equipment and last maintenance/ inspection date. Note why routine maintenance is not applicable or is applicable
   - Note if procedure to patient could not be completed due to failure
   - Add complete location of incident information
   - Include brand name, model number, lot number, serial number, any analysis post failure

Reporting/Record

A. Send documentation of any incident to Trinity EMS Department within 24 hours
B. EMS System office will relay information to Risk Manager of TMC for further reporting guidance
C. If applicable, you will assist in compiling: FDA Form #3500A to send to Secretary of Health and Human Services and to the manufacturer
D. All records will be maintained at the agency and a copy filed with the EMS System office on any reportable device failure

Medical Devices

A. Include: Any instrument, apparatus or other article that is used to prevent, diagnose or treat a disease or to affect the structure of the human body

If the device fails, but there is no harm to patient and/or change in treatment, the report **may not** have to be made to the FDA. But manufacturers will need to be notified and Risk Management and/or other legal counsel can assist in making these judgments

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2014

CONTINUING EDUCATION
POLICY # 5 - 01

PURPOSE:

To delineate for Trinity EMS personnel requirements for Continuing Education(CE)

POLICY:

I. Number and Type of Hours Required Per Year:

A. The Illinois Department of Public Health, Division of EMS, publishes rules and regulations stipulating requirements for CE for each level of service. **Re-licensure will occur in accordance with the re-licensure policy when all of the following are complete.** It is recommend that CE be completed each year of licensure. No more than 25% of the CE may be in the same subject. **Trinity EMS System requires at least 50% of CE be in formal education hours**

- **First Responder-D 24**
- **EMT-B 60**
- **EMT-I 80**
- **EMT-P/PHRN 100**
- **ECRN 32**
- **Dispatcher 48**
- **CCP 20**

B. All CE records are logged and maintained at the service that the provider works for and made available to the System Resource Hospital. Each pre-hospital provider/pre-hospital RN is responsible for keeping their own records and maintaining a copy of time accrued. All CE records either obtained elsewhere or with the appropriate CE number and signature must be filed in the appropriate service file. **The responsibility for completing state required CE hours in a timely manner rests fully with the individual. Eligibility for system recommended re-licensure rests in great measure on the completion of these hours**

C. All license levels are required to request license renewal from the Resource Hospital. The Resource Hospital will then review CE for appropriateness and endorse the provider to IDPH for license renewal

D. All license renewals are due to the State office 30 days prior to expiration, therefore submit the request to the system resource hospital no later than 45 days prior to expiration. **There will be no requests for extensions from the resource hospital unless for illness or extreme circumstances.** The individual license holder is responsible to submit online the IDPH renewal in accordance with the renewal process. Upon completion the licensee will receive a confirmation page which should be submitted to the system office. The license renewal will be held by the state until CE is submitted to the system. Should the license expire during the time the department is awaiting CE submission to the system, the licensee cannot work following this expiration and will need to submit the appropriate late fee. IDPH will also not honor renewal attempts after the licensee renewal date

II. Approval of Hours:

A. The EMS Medical Director (EMS MD) of the system in which the EMT/Pre-hospital RN functions shall determine whether a particular didactic CE program is acceptable for credit within that system. Approval for all hours rests with the system

III. Options for Accruing DIDACTIC HOURS in the TMC EMS System:

A. At least half of the total didactic hours per year must be obtained within the system approved CE, unless prior authorization has been granted. This includes in-station CE, viewing videotapes, and attending classes conducted by a system provider or hospital. **All pre-planned continuing education classes need a State site code assigned before credit can be awarded.** The system EMS Coordinator/EMS MD must pre-approve agency CE before submission to IDPH for State site code. Use appropriate IDPH form for submission. CE is the responsibility of the service and the individual EMT. While the resource hospital may provide some CE, it will not determine monthly in-services and apply for them. Application for CE site codes/approvals must be obtained through the Regional EMS Coordinator (IDPH) after endorsement by Trinity EMS MD. Applications for approvals **must** be submitted **60 days** prior to the start date of the program. Trinity EMS System requires monthly CE requests to be submitted in October of each year for the subsequent year. All other CE requests must follow the 60 day request and be submitted to the Trinity EMS System office for approval prior to submission to the State

At least 3 objectives for each level are needed for each CE subject requested. Objectives are to be written on a form obtained from Trinity EMS and delineated into Basic, Intermediate, Paramedic or First Responder status

B. Verification of attendance at offerings not sponsored by the resource hospital or system agency with approval must be submitted by the sponsoring agency with accompanying site code to the TMC/EMS System office for documentation. All Illinois education with site code is acceptable, as is Iowa advanced training centers

C. Video Taped Presentations- hour for hour to a maximum of 4 didactic hours/ year will be granted for viewing approved videotapes. The tapes may be viewed at any system hospital or in the provider's quarters with verification of viewing submitted by the provider EMS Coordinator or EMS Coordinator/Educator to the resource hospital

D. CPR- Must be recognized by American Heart Association (AHA) or Red Cross

- **2 hour of didactic credit** will be awarded for the renewal of CPR Healthcare provider recognition every year. Copies of current CPR cards must be provided to the EMS System office each year or every other year as required by the service
- **4 hours of didactic credit** will be awarded once every two years for successful completion of a **CPR instructor** or re-recognition course for any level. The individual must submit a copy of the current CPR instructor card to receive credit
- **4 hours of didactic credit** can be awarded/year for **teaching CPR**. Submit copies of the class roster(s) sent to the AHA Community Training Center(CTC)

E. Teaching- hour for hour credit, up to a **maximum of 10 hrs/year**, will be granted to individuals who participate in teaching EMT-B course, EMT-I/P course, auto extrication, hazardous materials, CISM,TNS, ACLS, PHTLS, BTLS, or first responder courses. The course director must verify the date, topic taught and the number of teaching hours. These hours may be credited as didactic or clinical time, depending on the subject matter, and approved by the EMS Medical Director/ Systems Coordinator(i.e. clinical with skills, or lecture)

F. ACLS, ATLS, PALS/APLS, PHTLS, BTLS- Hour for hour up to 16 hours of didactic (8hrs) of clinical (8hrs) will be awarded for initial completion of one of the above courses. To receive credit, the Basic/Intermediate/Paramedic/Pre-Hospital RN shall submit a photocopy of the card received after successful completion of the course

G. Renewal- an individual can receive 4 hours total of didactic credit per course. To receive credit, submit a photocopy of the new card

H. Hazardous Materials- A one time award of **16 hours** time may be awarded for completion of the State site coded 40 hour HazMat operations level course. To receive credit, submit a photocopy of the State certificate or a letter from the department. Four hours of didactic time may be awarded every 2 years for Agency HazMat training with approved Site code number. Documentation of attendance is necessary to receive credit. CE credit will not be awarded in the same year as initial certification. Credit will also be given up to 16 hours for CE based on biological response

I. Drive, Trench, Rope Rescue and Confined Space Rescue- Two hours didactic time/year for initial or refresher training in these areas

J. EMT-P National Registry Exam and Refresher Training- A one time award of 8 hours didactic will be awarded for successful completion of the National Registry Paramedic Exam. To receive a credit, the Paramedic shall submit a photocopy of the card received. National Paramedic Refresher Training, with approval site code, will award hour for hour credit

K. Preceptors- Approved paramedic preceptors may be granted up to 10 hours didactic and 8 clinical hours of time/year for executing their duties appropriately. Eligibility will be confirmed by the Agency/EMS Coordinator/Physician with whom they communicate

IV. Out-Of System Hours:

A. A maximum of 50% of the total didactic hours per year may be obtained by attending classes sponsored outside of the System provided the content followings the US DOT Curriculum and the faculty is knowledgeable in pre-hospital concepts and treatment protocols. 50% must be obtained in TMC EMS System approved courses. Approval must be requested in advance from the Resource Hospital by submitting the program brochure outlining the dates, times, topics, and faculty. Verification of class attendance must be submitted to the Resource Hospital. Any Illinois EMS Region II System is acceptable for continuing education and is considered in system. Any education with an Illinois or Iowa approved site code is acceptable

B. College Courses: Select college courses may be considered for didactic credit toward yearly continuing education. Upon successful completion of a course, the Basic/Intermediate/Paramedic/Pre-Hospital RN must submit the following to receive credit:

- Copy of class outline/syllabus
- Number of credit hours achieved
- Name and credentials of instructor
- Name of educational institution
- Verification of successful course completion

The EMS MD or his designee will review the course for applicability to pre-hospital practice and determine eligibility for CE credit

V. Additional Time Options:

A. Mass Casualty Drills- Drill and Preparatory classes/workshops (hour for hour) can be obtained by participating in a System-recognized drill. To receive credit, submit a letter from the drill director or the drill sign-in sheet documenting type or participation, number of hours (8 hours maximum)

B. Prom Night- Two hours per year of didactic credit for participation in prom night activity in system

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

TRAIN THE TRAINER
POLICY # 5 - 02

PURPOSE:

This is to define quarterly education information dissemination to all trainers at each EMS service of TMC System. The policy will also define the roles and responsibilities of the trainer

POLICY:

A. Definition:

- A trainer is the person who is responsible in the TMC EMS System Provider Service for education and monitoring of continuing education of the individual personnel of that service

This includes-

- EMS Coordinators, Training Officers

Levels Include-

- EMR, EMT, AEMT, Paramedic, Pre-Hospital RN

B. Method:

- Trainers will be given updated system/education/information as necessary. They are then responsible to disseminate this information and/or educate the individual personnel of their corresponding service
- Education will include, but not be limited to:
  - Cardiac Topics
  - Stroke Education
  - Pediatrics
  - Trauma Education
  - Protocol and Policy Guidelines
  - Monthly Service Education

C. Sessions-

- Will be taught by TMC staff, faculty or EMS Medical Director

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

CONTINUING EDUCATION APLICATION POLICY # 5 - 3

Purpose: To develop a process to request and obtain CE for continuing education purposes at all levels

Continuing education classes, seminars, clinical time, workshops or other types of programs shall be approved by the Department before being offered to EMTs. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1) Name of applicant, agency and address;
2) Lead Instructor's name, license number, address and contact information, including e-mail address;
3) Name and signature of the EMS MD and the EMS System Coordinator;
4) Type of education program;
5) Dates, times and location of the education program (submit course schedule);
6) Goals and objectives at or above the license level;
7) Methods and materials, text books, and resources, when applicable;
8) Content consistent with the national EMS education standards;
9) Description of evaluation instruments; and
10) Requirements for successful completion, when applicable.

Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the national EMS education standards, as modified by the Department. Upon approval, the Department will issue a site code to the course, seminar, workshop or program.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

RUN REVIEW QUALITY IMPROVEMENT POLICY # 6 - 01

PURPOSE:

The Trinity EMS department holds the responsibility for monitoring the run reviews of the services and evaluating the quality of patient care by the prehospital care providers. The responsibility is then delegated to the EMS Coordinator/QI representative of the service and the EMS Department. It is the responsibility of the caregiver to participate in data collection and action planning

POLICY:

Providing care to patients in the prehospital setting involves much more than just rendering medical treatment. The following is to be reviewed in an ongoing manner by all services

1. The EMS Coordinator/Medical Director may audit any patient encounter for review and quality control/improvement
2. The EMS Coordinator/Director of the agency will be notified for any runs selected by the EMS System office to be reviewed and that Coordinator/ Director will notify:
    - All crew members
    - Deputy chiefs, chiefs, or other officers will be notified after crew members and at the agency preference
3. Agency EMS Coordinator/Director will relay to the crew concerns, if any, from EMSS/Medical Director involved in runs selected by EMSS office
4. When a patient care encounter is selected for review because of request, concern, or patient care issues, the agency EMS Coordinator/Director will review the facts of the run privately with the appropriate crew members and relay the information to EMSS office. The EMSS retains the right to continue investigation if so necessary and make recommendations
5. All run reviews should be attended by the involved crew members, agency officers, Trinity EMS coordinator and/or Medical Director
6. All run reviews will be documented on a formatted run review sheet
7. All run review information will be kept confidential in the EMS system office
8. Due process will be offered, explained and documented
9. This is a quality improvement and is protected by the Medical Studies Act
10. The EMS Systems and providers shall have a quality improvement program, approved by the Department, that uses national standards performance indicators to evaluate the appropriateness and quality of patient care. The method and results of the quality improvement projects shall be available to the Department upon request.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SYSTEM QUALITY IMPROVEMENT POLICY # 6 - 02

PURPOSE:

Maintain and continually provide high quality care from the Trinity EMS System and its providers

POLICY:

Responsibility-

The EMS Medical Director and the EMS System Coordinator/Director and or their designee shall review the quality of patient care relating to overall statistical data. Information is returned to the service requesting documentations. Overall patterns will be evaluated and recommendations made through the Medical Director to that affected service

Scope-

1. **EMS Quality Improvement-**
   Monthly reports are generated by the EMS System office and sent to the services to be reviewed. Documentation and justification of the times are to be sent to the EMS System office.
   - Response Time > 6 minutes
   - Trauma Scene Time > 15 minutes
   - Medical Scene Time > 25 minutes

   Continual monitoring of the above perimeters will be done by the system by selecting 10% of the services runs in the future.

2. **IDPH Scan Data**
   This will be reviewed by the EMS Medical Director for patterns and recommend changes if required then returned to the provider agency for documentation.

3. **Advanced Scope QI**

4. **Run Review Quality Improvement**

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

MASS CASUALTY INCIDENT
POLICY # 7 - 01

PURPOSE:

To delineate for Trinity EMS system personnel responses to mass casualty incidents which the number of patients or severity of injuries may overwhelm the providers

POLICY:

A. Mass Casualty:

At times EMT's may find themselves in a situation where the number of injured patients exceeds the available personnel to care for them and resources available. In these situations the patients must be triaged according to the severity of their injuries in order to do the most good for the greatest number of patients. In such multiple casualty situations, several normal conventions may need to be set aside in order to meet the objective

B. MCI for FR-D/BLS/ILS/ALS-

1. Prioritize patients according to a recognized system
2. In mass casualty situations, the **S.T.A.R.T.** method of triage is recommended
3. Identify patient priority through the use of color coded triage tags
4. Rapidly assess (60 seconds or less) each patient, stopping only to open an airway or to control profuse bleeding. As you move through the scene, affix a triage tag to each patient according to their priority
5. Treat and transport those patients who are viable and have life-threatening injuries first, according to the resources available
6. Treat and transport those patients who have impending or potential life threats next
7. Walking wounded, those patients without life-threatening injuries, should be transported last. In some major incidents, these patients may even be transported by means other than ambulance
8. Non-viable patients, those in cardiac arrest or with obvious mortal wounds, should not be treated or transported unless adequate resources/personnel are available

*The unique situation of a **lightening strike** causing a mass causality event presents the exception to the above rule. In this situation, when the victims have been struck by lightening, the cardiac arrest victims are treated and transported. Victims not in cardiac arrest rarely deteriorate and can wait while those in arrest are given top priority*

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

MASS CASULATY INCIDENT TRIAGE POLICY # 7 - 02

PURPOSE:

To aid Trinity EMS system personnel in the rapid triage of MCI patients

POLICY:

Any disaster plan or program designed to handle a large volume of patients in a short period can only work if the triage process is rapid and efficient. The following method of prioritization should be used for triage, treatment and transport to maximize the percentage of victims surviving a disaster

Priority I- Immediate/Critical(RED)- Immediate Care:

Highest priority: victims requiring immediate care and transportation. These victims must be treated first at the scene and transported as soon as possible. Victims may have one or more of the following problems whose chances of survival depend on immediate emergency care:

- Airway and breathing difficulties
- Hemorrhage
- Open chest or abdominal wounds
- Severe head injuries or head injuries with decreasing level of consciousness
- Major or complicated burns
- Tension pneumothorax
- Pericardial tamponade
- Impending shock and complicating severe medical problems
- Diabetes with complications
- Poisonings
- Pregnancy

Priority II- Urgent(YELLOW)- Urgent Care:

Intermediate priority: victims whose treatment and transportation can be delayed temporarily. Victims may have one or more of the following problems that need medical attention prior to transportation, but do not need immediate care to survive

- Blunt abdominal or thoracic trauma
- Major extremity or soft tissue injury
- Dislocations
- Major burns and electrical burns

Approved by EMS Medical Director 2020

MASS CAUSUALTY INCIDENT TRIAGE POLICY # 7 - 02

Priority III- Delayed(Green)- Delayed Care:

Delayed or low priority(walking wounded); victims whose treatment can be delayed. Victims may have one or more of the following problems that require only simple emergency care or who appear to be uninjured and need only observation

- Fractures
- Sprains
- Lacerations
- Soft tissue injuries and other lesser injuries

Priority IV- Deceased(Black)-No Care Required:

Lowest priority; victims who are dead or are near death. Victims are already deceased or have such devastating injuries that they have little chance for survival

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S.T.A.R.T. Triage System

(Simple Triage and Rapid Transport)

Step 1: **CLEAR THE SCENE OF ANY WALKING WOUNDED**

- These patients are considered to be in the **DELAYED** category

Step 2: **ASSESS VENTILATIONS IN REMAINING PATIENTS**

- No respiratory effort: **Dead/Non-Salvageable**
- Respirations above 30: **Critical/Immediate**
- Respirations below 30: **Delayed**

Step 3: **ASSESS PERFUSION**

- No radial pulse: **Critical/Immediate**
- Pulse present: **Delayed**

Step 4: **ASSESS NEUROLOGICAL STATUS**

- Unconscious: **Critical/Immediate**
- Altered Level of consciousness: **Critical/Immediate**
- Altered mental processes: **Critical/Immediate**
- Normal mental processes: **Delayed**

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

SCHOOL BUS ACCIDENTS
POLICY # 7 - 03

PURPOSE:

To manage school bus accidents with appropriate resources; to ensure the children involved are dispositioned accurately and injured children identified rapidly

POLICY:

1. Initiate appropriate personal protective equipment
2. Assess and establish scene safety
3. Establish triage area and triage victims
4. Determine the **Accident Category:**
   - **A**. Significant injuries present in one OR more children or there is a documented mechanism of injury that can be reasonably expected to cause significant injuries.
   - **B**. Minor injuries present in one or more children AND NO documented mechanism of injury that can be reasonably expected to cause significant injuries. Uninjured children are also present
   - **C**. No injuries present in any children AND NO mechanism of injury that can be reasonably expected to cause injury
   - **D**. Pediatric patients with special healthcare needs or communication issues
5. Determine responses to Accident Category and utilize the **School Bus Accident Special Response Protocol** and **School Bus Incident Release Form**
6. Discharge any uninjured children to the custody of a school official(s) of their designee(s). Complete the **School Bus Incident Release Form** approved by the system. Ensure signatures are in place before release of children
7. School officials or their designee(s) will then disposition the uninjured children according to their own policies and procedures
8. If school officials or their designee(s) have any objections to the release, transport all children to the appropriate facility by ambulance or bus if appropriate with appropriate number of EMS personnel on board

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2020

POISON CONTROL
POLICY # 7 - 04

PURPOSE:

The state poison center may be utilized by the 911 centers and the responding EMS services to obtain assistance with the prehospital triage and treatment of patients who have a potential or actual poisoning. The purpose of this policy is to:

- Improve the care of patients with poisonings, envenomations, and environmental/ biochemical terrorism exposures in the prehospital setting
- Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene
- Integrate the State Poison Center into the prehospital response for hazardous materials and biochemical terrorism responses

POLICY:

1. The 911 call center will identify and if EMD capable, complete key questions for the Overdose/Poisoning Animal Bites/Attacks, or Carbon Monoxide/Inhalation/HazMat emergency medical dispatch complaints and dispatch the appropriate EMS services and/or directly contact the State Poison Center for consultation
2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **State Poison Center at 800-222-1222.** If possible, dispatch personnel should remain on the line during conference evaluation
3. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner. If dispatch personnel are not on-line, the Specialist will re-contact the 911 center and communicate these recommendations
4. If the patient is determined to need EMS transport, the Poison Center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options
5. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient
6. Minimal information that should be obtained from the patient for the State Poison Center includes:
   ●Name and age of Patient ●Substance(s) involved ●Time of Exposure ●Any treatment given ●Signs and symptoms
7. Minimal information which should be provided to the State Poison Center for mass poisonings, including biochemical terrorism and HazMat, includes:
   ●Substance(s) involved ●Time of Exposure ●Any treatment given ●Signs and symptoms

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

COMMUNICATIONS
POLICY # 1 - 06

PURPOSE:
To define for Trinity EMS System Personnel the type of communication methods and acceptable equipment to be used

POLICY:

A. FR,BLS, ILS, ALS

1. All services, whether transport or non-transport, will communicate to Medical Control via Merci (VHF) radio, Med channel 6, or a recorded cellular line on tones assigned by IDPH
2. In any instance where communication is not possible on Merci, cellular communication should be used. If this is not possible, call from a landline before leaving the site

C. Use unit identifier number in all communication. This unit number will be used for re-contact and should use common terms, i.e., “Moline Ambulance 11”

D. See standard operating guidelines and policy for radio report contents and care initiated prior to contact of medical control

COMMUNICATIONS TO FACILITIES:

A. Should there be a phone communication failure at Trinity, use MERCI radio (recorded line)

B. Reports of patient transfer to another facility may be repeated and/or given by the ECRN at TMC by phone and/or radio to the receiving facility

C. Services may use P25 , 700,800 radios as well as MERCI and cell phone recorded channels for emergent and non Emergent online medical control

D. Communication orders may be received only from Trinity RI Campus, ECRN’s/MD’s. Hammond Henry Hospital is approved as an associate hospital at the ILS level and may give orders to BLS, ILS in the TMC system. Hammond Henry Hospital provides system approved ECRN’s and is monitored by TMC

E. All medical control communications will be recorded and maintained for a minimum of 365 days.

F. All telecommunications equipment shall be maintained to minimize service interruptions. Procedures shall be established to provide immediate action to be taken by operating personnel to utilize secondary forms of communication ie a different radio or cell comms and ensure rapid restoration in case breakdowns do occur.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2023

VEHICLE STAFFING REQUIREMENTS POLICY # 1 - 07

PURPOSE:

This policy is to identify minimum accepted staffing patterns for all system vehicles and process to follow if you are unable to meet this criteria on a constant basis.

POLICY:

FR

1. All First Response vehicles are to be staffed 24 hours a day, 365 days a year with First Responders trained at that level
2. Other Appropriate personnel trained to a minimum of CPR

BLS

1. All BLS transport vehicles are to be staffed 24 hours a day, 365 days a year with one of the following: (Drivers may be used anytime, but not in place of EMT staff)
   - A. Two (2) EMT-B's, licensed appropriately per state law
   - B. One (1) EMT-B and system field PHRN or ILS,ALS personnel working at the BLS level licensed appropriately per state law

ILS

1. All ILS transport vehicles are to be staffed 24 hours a day, 365 days a year with one of the following: (Drivers may be used anytime but not in place of licensed EMT staff)
   - A. Two (2) EMT-I's licensed appropriately per state law
   - B. One (1) EMT-B or system field PHRN, one (1) EMT-I or ALS personnel working at the ILS level, licensed appropriately per state law

ALS

1. All ALS vehicles transport are to be staffed 24 hours a day, 365 days a year with one of the following crews: (Drivers may be used but not in place of licensed EMT staff)
   - A. Two (2) EMT-P's
   - B One (1) EMT-P, one (1) EMT-I, EMT-B or system PHRN

Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as National Fire Protection Association, Ground Vehicle Standards for Ambulances, the Federal Specifications for the Star of Life Ambulance, or the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances.

Approved by EMS Medical Director 2023

VEHICLE STAFFING REQUIREMENTS POLICY # 1 - 07

RESCUE NON-TRANSPORT/AMBULANCE ASSIST VEHICLES

1. FR must staff/arrive with appropriate FR personnel at the level of the service offered
2. BLS responders must arrive with appropriate BLS personnel appropriately licensed per state law and at the level of the service offered
3. ILS responders must staff/arrive with ILS personnel appropriately licensed per state law and at the level of the service offered
4. ALS responders must arrive with ALS personnel appropriately licensed per state law
5. All levels BLS, ILS, and ALS Transport/ non-transport first responding provider agencies must carry system equipment and state required equipment for the level of the vehicle license(See EMS Act for state required equipment and system required supplies policy) and follow system policies, procedures, and standing operating guidelines
6. All services will be responsible for replacing there equipment used through authorized system vendors. No hospital will be required to replace used equipment

STAFFING WAIVERS

1. Staffing waivers may be approved by the EMS Medical Director system services. Waivers are completed and sent to the Illinois Department of Public Health for final approval. The department will approve the waiver if it determines there is no reduction in the quality of care established by the act and/or if full compliance with the regulation in the act at issue would constitute a hardship for the applicant
2. Anytime that a service can not meet it's staffing obligation due to extenuating circumstances, please contact the EMS System office at once to review the problem and, if applicable, request a staffing waiver
3. All staffing waivers must be approved by the EMS Medical Director and sent to the Department of Public Health

LICENSURE

1. All staff will be licensed by IDPH and approved to work in the EMS system
2. The EMS Medical Director in Illinois is responsible for all levels of EMT licensure in that he/she will approve CE and other requirements listed by IDPH and present the provider for licensure and relicensure
3. Healthcare facilities may send assist personal to aid in transport up to but not limited to Nursing , Respiratory , CT and Physicians. Paramedics in system are still responsible for all in the back aspects of patient care and must remain with patient at all times.

Approved by EMS Medical Director 2023

VEHICLE STAFFING REQUIREMENTS POLICY # 1 - 07

Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as National Fire Protection Association, Ground Vehicle Standards for Ambulances, the Federal Specifications for the Star of Life Ambulance, or the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances.

Equipment Requirements – Basic Life Support Vehicles Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection: See ambulance inspection form

Equipment Requirements – Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS MD in the System in which the ambulance and its crew participate. Medications shall include both adult and pediatric dosages. These vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

All licensed EMS personnel will participate in a process to physically demonstrate the correct use of defined pediatric-specific equipment minimally every recertification period with there onsite system coordinator.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

VEHICLE RESPONSE REQUIREMENTS POLICY # 1 - 08

PURPOSE:

To delineate for agencies in the Trinity Medical Center EMS System tiered response, time response, and caller information. To provide information for entering the Trinity EMS System

POLICY:

VEHICLE RESPONSE:

1. Any agency may respond with one vehicle to a call. That vehicle will be of the level and type that is indicated in the provider application. Staffing shall be as listed for that level of response/vehicle and according to Trinity Medical Center EMS **Vehicle Staffing Requirements Policy**
2. Any agency may respond with a second vehicle to the scene such as: Fire Engine, Rescue Vehicle. The second vehicle may or may not be utilized as EMS Responders, but as extra personnel for manpower. If these responders are trained as EMS Providers they may assist medically if they are in the System and recognized by the Medical Director
3. If a call to a scene has dual responding ambulances, the highest level provider will determine the need of the patient
4. All First Responding vehicles in the System will be listed in the provider application and licensed as required. Each subsequent vehicle will be listed as transport/non-transport and may be designated as FR, BLS, ILS, or ALS if system equipment, staffing requirements are met

TIERED RESPONSE:

1. Any agency may participate in a tiered response to patient care providing that response is listed in the system plan and documented in the agency commitment.
2. Any Agency may utilize:
   - A. Ambulance assist vehicle
   - B. Transport vehicle of another agency
   - C. First responding vehicle
   - D. Non-transport vehicle (Dispatched Prior to Ambulance staffed 24/7 by two EMS staff EMT or higher)
3. Designation with mutual aid or by contract for the transport vehicle must be made and attached to the commitment to the system
4. Staffing must be maintained as listed in the vehicle staffing policy

Approved by EMS Medical Director 2023

VEHICLE RESPONSE REQUIREMENTS POLICY # 1 - 08

TIME RESPONSE:

1. All system ambulances, assist/non-transport vehicles and rescue vehicles listed in the system plan/commitment must adhere to the response time listed in EMS Act section 515.810
2. A commitment to optimum response times up to 6 minutes for the primary coverage areas, 6-15 minutes in the secondary coverage areas, and 15-20 minutes in the outlying coverage areas

SYSTEM APPLICATION:

1. Each provider entering Trinity Medical Center EMS System must provide application as determined by the Illinois Department of Public Health and all attachments requested in the application. All vehicles using EMS providers at any level must be included in the application
2. All provider agencies will have Mutual Aid Agreements established and submitted in the provider application
   - A. Fire, Municipal within it's own agency, i.e. Paramedic Engine Company level as it is. Agency needs a transport agency agreement.
   - B. Fire, Municipal with First Response and requires another agency to transport does need a transport agreement signed with that agency
3. Any First Responding, non-transport agency will provide a transport agreement with the agency utilized to transport
4. Renewal of applications will be with renewal of the EMS System Plan as requested by IDPH

Each application shall be accompanied by a fee of $35 for each vehicle included in the initial license application and due at the time of each annual inspection for up to 100 individual vehicles. A fee of $3500 shall be submitted for initial applications and due at annual inspections for providers with 100 or more vehicles. Inspection fees not paid after 30 days from the documented annual inspection date will incur a late fee of $25 per vehicle for up to 100 vehicles.

A Vehicle Service Provider utilizing ambulances shall have a primary affiliation with an EMS System within the EMS Region in which its Primary Service Area is located. This does not apply to Vehicle Service Providers that exclusively utilize Limited Operation Vehicles. (Section 3.85(b)(2) of the Act)

Approved by EMS Medical Director 2025

VEHICLE RESPONSE REQUIREMENTS POLICY # 1 - 08

Alternate Rural Staffing :

1. A Vehicle Service Provider that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers, paid-on-call personnel or a combination to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMS Personnel licensed at or above the level at which the vehicle is licensed, plus one EMR when two licensed EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs, PHPAs, PHAPNs or physicians are not available to respond.

2. The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates not to exceed 48 months

Alternate Response :

1 A Vehicle Service Provider that exclusively uses volunteers or paid-on-call personnel or a combination to provide patient care who are not required to be stationed with the vehicle may apply to the Department for alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed by at least one licensed EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician.

2. A Vehicle Service Provider operating under alternate response authorization shall ensure that a second licensed EMS Personnel is on scene or in route to the emergency response location.

3. Unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h), the Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with:

Equipment Requirements

Each vehicle used as an alternate response vehicle shall meet the following equipment requirements, as determined by the Department by an inspection. See the State Inspection form

Approved by EMS Medical Director 2023

VEHICLE RESPONSE REQUIREMENTS POLICY # 1 - 08

Alternate staffing for Private Ambulance Providers :

1. An ambulance provider may request approval from IDPH to use an alternative staffing model for interfacility transfers for a maximum of one year in accordance with the requirements for Vehicle Service Providers
2. An ambulance provider requesting alternative staffing for BLS ambulances for interfacility transfers will provide the following to IDPH:
   - A) Assurance that an EMT will remain with the patient at all times and an EMR will act as driver.
   - B) Certificate of completion of a defensive driver course for the EMR and validation that the EMT has one year of pre-hospital experience.
   - C) A system plan modification form stating this type of transport will only be for identified interfacility transports or medical appointments excluding dialysis.
   - D) Dispatch protocols for properly screening and assessing patients appropriate for transports utilizing the alternative staffing models.
   - E) A quality assurance plan which must include monthly review of dispatch screening and outcome.

Alternate Response Secondary Response :

1 A Vehicle Service Provider that uses volunteers or paid-on-call personnel or a combination to provide patient care, and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one System authorized licensed EMT, A-EMT, EMT-I, PHRN, PHPA, PHAPN or physician.

Other Considerations:

1) All EMS system vehicles will provide aid to law enforcement animals when available to do so under the current law. At minimum BLS measures should be attempted
2) The system vehicle will comply with transportation of Service animals as long as the patient can provide official paperwork calcifying the animal as such. Contact medical control with questions

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2025

WATERCRAFT OFF-ROAD SEMSV POLICY #1-13

PURPOSE:

To establish an outline for EMS operations in SEMSV vehicles and to meet IDPH Code for staffing and operations

POLICY:

1. All SEMSV licensed vehicles /boats will be approved for use by the EMS medical director.
2. All personal operating these licensed vehicles will follow the current established Trinity EMS system SMO to there assigned and authorized level of care
3. The service will establish a plan with the system to ensure there is appropriate medical equipment on the SEMSV for trat both adult and pediatric patients.
4. The service will ensure that there is a continuous method for both online medical control and communications with dispatch 24/7
5. The service will identify procedures for transferring of care of the patient to approved transport providers

Watercraft Vehicle Specifications and Operation

1. All watercraft shall meet the requirements of Article IV of the Boat Registration and Safety Act.
2. All watercraft shall carry equipment included on the state check sheet and in section 515.970
3. Each watercraft crew member shall document, appropriate to their scope of practice, completion of the following: Education as identified by the EMS MD; and A boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act [625 ILCS 45].

Off-Road Vehicle Specifications and Operation

1. The off-road SEMSV shall have sufficient space for the vehicle operator, a patient in a supine position, and personnel rendering medical care alongside the patient.
2. Each vehicle shall have a locking mechanism to secure the patient transport litter/stretcher to the off-road SEMSV.
3. Each vehicle shall have safety restraints for all persons in the vehicle.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2023

Infection Control Exposure
POLICY # 4 - 05

Purpose:

1). To provide prehospital providers and paramedics in all agencies with the guidelines to protect themselves when caring or transferring patients with a potentially dangerous or communicable disease. To provide a means of reporting exposure and providing follow-up information to the employee. Prehospital care providers have an ethical and moral responsibility to provide care to all patients to the best of their abilities. In this role they place themselves in certain circumstances, at a higher risk of being exposed to blood and body fluids that might contain the HIV, Hepatitis, or other bloodborne pathogens. When administering care to patients, you will not always be aware or informed that these patients may be potentially infectious. Therefore, the following precautions are mandatory for prehospital care providers at all times.

A. Those At Risk:

Those prehospital personnel considered at high risk of exposure to bloodborne pathogens are defined as those persons who frequently face unpredictable, uncontrollable dangerous, life threatening situations. They may be defined as, but not limited to the following:

1. EMT-B's, 2. EMT-I's AEMT, 3. EMT-P's/PHRN's, 4. First Responders, 5. Drivers, 6. Fire Personnel, 7. Police Personnel, 8. Rescue Personnel.

Identification of a high risk source may be as follows:

1. Injecting non-prescription drug user.
2. Men who have sex with other men.
3. Heterosexual contact with men who have sex with other men and/or injecting drug user.
4. Recipients of clotting factor concentrates (esp. patients with classic hemophilia).
5. Children of HIV infected women.

B. Contact is defined as:

1. A splash of blood or other body fluid in the eye, mouth, or other mucous membrane, or **non-intact** skin.
2. Skin contact with large amounts of blood or prolonged contact with blood especially when exposed skin is chapped, abraded, or with dermatitis.
3. Performing mouth-to-mouth resuscitation without the safety of a pocket mask with a one-way valve.
4. Receiving a contaminated puncture wound, such as a needle stick.
5. Unmasked performance of endotracheal intubation/suctioning and/or aerosol medication treatment of known and/or suspected patients with mycobacterium tuberculosis.

All of the above types of contact must be reported.

Approved by EMS Medical Director 2023

Infection Control Exposure
POLICY # 4 - 05

HANDWASHING:

All prehospital care personnel MUST wash their hands after contact with any patient. Gloves are also to be worn when in contact with patient's and there is risk of exposure to blood and body fluids. This applies to: blood and body fluids, body fluids which contain visible blood, semen, and vaginal secretions, tissues and cerebral spinal fluid, senovial fluid, pleural fluid, pericardial fluid, and amniotic fluid.

Each ambulance must have the availability for the crew members to clean their hands or skin surface immediately when there has been direct blood exposure to the skin or other body surface areas. An antiseptic hand cleaner, clean paper towels, or antiseptic towelettes should be available.

A squirt bottle, filled with clean water, should be available to immediately flush any contamination from the body as soon as possible.

Crew members are required to wash their hands immediately as soon as a sink, soap and water are available. Hands must be washed after each patient contact even if gloves are utilized.

NEEDLES AND SYRINGES

Needles are to be disposed of in a rigid, puncture resistant container with biohazard label attached in an upright position in the patient compartment of the ambulance within easy reach of the crew. Needles are not to be recapped or intentionally bent, sheared or broken. Needles must be placed directly into the puncture resistant containers. Do not lay them on counters or stab them into a seat or other product as a temporary device.

CLEANSING OF AMBULANCE AND EQUIPMENT

The ambulance, and any equipment used directly on the patient, is to be cleaned with an appropriate disinfectant after each patient use. (1:10 bleach solution or EPA approved commercial disinfectant.) Gloves are to be used when cleaning any surface contaminated with any body fluids and then disposed of properly.

Approved by EMS Medical Director 2023

Infection Control Exposure
POLICY # 4 - 05

PERSONAL PROTECTIVE EQUIPMENT (PPE)

All blood and body fluids are considered contaminated, thereby making PPE mandatory in any circumstances requiring them. This applies to: blood and body fluids, body fluids which contain visible blood, semen, and vaginal secretions, tissues and cerebral spinal fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid.

Ambulance staff will have all of the necessary PPE on the units at all times. PPE will be located in a convenient, readily accessible area in the ambulance. Each unit will carry enough PPE for the crew on duty and a minimum of two (2) additional sets. PPE will include the following:

A. Surgical caps or other device that covers the hair and ears of the caregiver.
B. Face mask and face shields. This equipment must cover the eyes, nose, and mouth of the caregiver. Mask must be used in conjunction with goggles or face shield.
C. Surgical gowns or coveralls. Disposable gowns will be worn whenever there is a high potential for exposure.
D. Shoe covers will also be worn in conjunction with the other PPE listed above.
E. Gloves of the proper size are to be utilized whenever there will be contact with blood or body fluids from a patient. Any open cut or any skin dermatitis that leaves skin open (i.e., eczema psoriasis) on prehospital care personnel, need evaluation for excessive potential of exposure.

Note: Those persons with latex allergy are to be provided with non-allergenic gloves of the proper size.

F. Form fitted masks, for mycobacterium tuberculosis of the type NIOSH.N95 or comparable criteria. Masks are recommended to be fit tested so that they are adaptable to <u>all</u> crew members. Protective clothing must be worn whenever the possibility of contact with blood or body fluid is likely. You are required by OSHA to take the time to put PPE on prior to rendering care to the patient unless the patient's life is at risk. If PPE is not utilized, the caregiver must submit, in writing to the EMS System office and the director of your agency, why PPE was not worn/applied.

Latex and Powder Free Equipment:

All providers in system will only use system approved equipment and medical devises. All equipment will be restocked at the service level and the resource/ any associated/ Participating hospitals will not be responsible for restocking. All equipment will be latex and powder free.

TRINITY EMS SYSTEM STANDARDS POLICY

Approved by EMS Medical Director 2023

Infection Control Exposure
POLICY # 4 - 05

EXPOSURES POLICY REPORTING PROCEDURE:

Note: **Reporting of the blood/body fluid exposure and the inception of treatment should be within (2) two hours. Therefore, the exposed personnel must report immediately to receive counseling and treatment, if necessary. Wash area with soap, water, or a chemical cleansing agent and report immediately. Any injuries or line of dutie deaths will be reported to the system in 24 hours the system will notify the department when this information is obtained**

1) All agencies will follow there agencies protocol for exposure treatment. Off hours the Emergency Department at Trinity Rock Island will serve as a location for exposure treatment.

2) All exposures will be reported to there services administration and service administration will notify the system.

FOLLOW-UP PROCEDURE FOR INFECTIOUS DISEASE, EXPOSURE, AND BLOODBORNE PATHOGENS EXPOSURE:

A. When the Infection Control Department is notified that a patient has a communicable or infectious disease, they will identify all persons who have had contact with the patient.

B. The Infection Control Department will contact the EMS System office if any prehospital care providers are involved.

C. A letter of notification will then be sent and/or called to the prehospital care personnel and paramedics agency.

D. This letter will be sent within 72 hours after the hospital has actual knowledge of a confirmed diagnosis of any of the diseases listed except AIDS, AIDS Related Complex, or HIV infection.

Approved by EMS Medical Director 2025

Infection Control Exposure
POLICY # 4 - 05

The EMS Medical Director may allow for the Administration of an Initial Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation Questionnaire on behalf of fire personnel provided the following is in place:

1) A licensed EMT, AEMT, EMT-I, Paramedic, PHRN, PHAPRN, or PHPA may administer the OSHA respiratory medical evaluation questionnaire according to the employer's written respiratory protection program and if permitted by the EMS System Medical Director and according to the policy submitted to the Department for approval as part of the System Plan;

2) The licensed EMT, AEMT, EMT-I, Paramedic, PHRN, PHAPRN, or PHPA must have the appropriate training and education to administer the respiratory evaluation questionnaire;

3) Training and education on the administration of the respiratory evaluation questionnaire is the responsibility of the employer;

4) Any individual who administers the respiratory evaluation questionnaire shall make the appropriate referrals for medical examination with a Licensed Physician, APRN, or Physician Assistant as indicated in the Employer's Respiratory Protection Program;

5) The employer must maintain all records regarding training and education of EMS personnel designated to administer the respiratory medical evaluation questionnaire and EMS Medical Director approval of their ability to administer the medical evaluation questionnaire at their agency. All records shall be made available to the EMS System or the Department upon request.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

12 LEAD EKG
PROCEDURE # 1

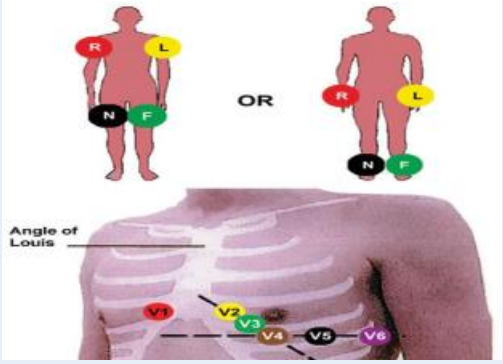
CLINICAL INDICATIONS

- ✓ Suspected cardiac patient
- ✓ Suspected overdose
- ✓ Electrical injuries
- ✓ Syncope

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE

1. Assess patient and monitor cardiac status.
2. Administer oxygen as patient condition warrants.
3. If patient is unstable, a definitive treatment is the priority. If patient is stable or stabilized after treatment, perform a 12 lead EKG. In general, a 12 lead should be obtained in the first 10 minutes of the patient encounter.
4. Prepare EKG monitor and connect patient cable with electrodes.
5. Enter the required patient information into the 12 lead EKG device.
6. Expose chest and prep as necessary. Modesty of the patient should be respected.
7. Apply chest leads and extremity leads using the following landmarks:
   - ✓ RA – right arm
   - ✓ LA – left arm
   - ✓ RL – right leg
   - ✓ LL – left leg
   - ✓ V1 – 4th intercostal space at the right sternal border
   - ✓ V2 – 4th intercostal space at the left sternal border
   - ✓ V3 – Directly between V2 and V4
   - ✓ V4 – 5th intercostal space at midclavicular line
   - ✓ V5 – level with V4 at left anterior axillary line
   - ✓ V6 – level with V5 at the left midaxillary line



8. Instruct patient to remain still.
9. Press the appropriate button to acquire the 12 lead EKG.
10. Transmit the 12 lead to Medical Control. EMT's may only transmit 12 lead EKG's and are not permitted to monitor or interpret cardiac monitors or 12 lead EKG's.
11. Contact the receiving hospital to notify them of 12 lead EKG transmission.
12. Treat the patient per the appropriate treatment protocol.
13. Download data per guidelines and attach copy to PCR.
14. Document procedure, time, and results on PCR.

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by Trinity EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: BPAP
PROCEDURE # 2

CLINICAL INDICATIONS FOR BILEVEL POSITIVE AIRWAY PRESSURE (CPAP USE):

- ✓ Bilevel Positive Airway Pressure (BPAP) aids in the oxygenation and ventilation of a variety of medical conditions
- ✓ Transport of patients receiving BPAP with a mechanical ventilator

LEGEND	
P	PARAMEDIC

CONTRAINDICATIONS:

- Suspected Pneumothorax
- Inability to maintain own airway
- Altered Mental Status or GCS <8
- Facial Trauma or Burns

PROCEDURE:

1. Confirm that the patient is tolerating the BPAP and meets criteria.
2. Assess the BPAP mask for comfort and fit.
3. Document and observe the underlying diagnosis, current settings, physical exam noting cranio-facial abnormalities, pulmonary and cardiac exam, baseline mental status and pulse oximetry.
4. Connect the transport BPAP to suitable oxygen supply.
5. Attach the breathing circuit to BPAP and check adequate function.
6. Apply and secure the circuit to the patient .
7. Evaluate the response of the patient assessing breath sounds, oxygen, saturation, and general appearance.
8. Titrate oxygen levels to the patient's response. Many patients respond to low FIO2 (30-50%).
9. Encourage the patient to allow forced ventilation to occur. Observe closely for signs of complications. The patient must be breathing for optimal use of the BPAP device.
10. Confirm settings and physician orders prior to transport.
11. Continuously monitor pulse oximetry.
10. Document time, complications and response on the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: CPAP
PROCEDURE # 3

CLINICAL INDICATIONS FOR CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP USE):

✓ CPAP is indicated in patients for whom inadequate ventilation is suspected. This could be as a result of pulmonary edema, pneumonia, COPD, asthma, etc. In asthmatic patients, continuous monitoring is required to reduce the risk of respiratory depression or arrest

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Ensure adequate oxygen supply to ventilation device.
2. Explain the procedure to the patient.
3. Consider placement of a nasopharyngeal airway.
4. Place the delivery mask over the mouth and nose. Oxygen should be flowing through the device at this point.
5. Secure the mask with provided straps starting with the lower straps until minimal air leak occurs.
6. If the Positive End Expiratory Pressure (PEEP) is adjustable on the CPAP device adjust the PEEP beginning at 0 cm H2O of pressure and slowly titrate to achieve a positive pressure as follows:
   - 5-10 cm H2O for Pulmonary Edema, Near Drowning, possible aspiration or pneumonia
   - 3-5 cm H2O for COPD
7. Evaluate the response of the patient assessing breath sounds, oxygen saturation, and general appearance.
8. Titrate oxygen levels to the patient's response. Many patients respond to low FIO2 (30-50%).
9. Encourage the patient to allow forced ventilation to occur. Observe closely for signs of complications. The patient must be breathing for optimal use of the CPAP device.
10. Document time and response on the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: END-TIDAL CO2 DETECTOR PROCEDURE # 4

CLINICAL INDICATORS:

- ✓ The End-Tidal CO2 detector shall be used with any endotracheal tube or Blind Insertion Airway Device use

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Attach End-Tidal CO2 detector to the ETT/BIAD.
2. Note color change. A color change or CO2 detection will be documented on each respiratory failure or cardiac arrest patient.
3. The CO2 detector shall remain in place with the airway and monitored throughout the prehospital car and transport unless continuous capnography is used. Any loss of CO2 detection or color change is to be documented and monitored as procedures are done to verify or correct the airway problem.
4. Tube placement should be verified frequently and always with each patient move or loss of color change in the End-Tidal CO2 detector.
5. Document the procedure and results in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: ENDOTRACHEAL TUBE INTRODUCER PROCEDURE # 5

LEGEND	
P	PARAMEDIC

CLINICAL INDICATORS:

- ✓ Patients meet clinical requirements for oral intubation
- ✓ Initial intubation attempts are unsuccessful
- ✓ Predicted difficult intubation

CONTRAINDICATIONS:

- ✓ Three failed attempts at orotracheal intubation(use Failed Airway Protocol)
- ✓ Age less than 9 or ETT size less than 6.5 mm

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% oxygen.
2. Select the proper ETT without stylet, test cuff and prepare suction.
3. Lubricate the distal end and cuff of the ETT and the distal ½ of the ETT Introducer, i.e. Bougie (failure to lubricate may result in the inability to pass the ETT).
4. Using laryngoscope, visualize the vocal cords.
5. Introduce the Bougie with the curved tip anteriorly and visualize the tip passing the vocal cords or above the arytenoids if the cords cannot be seen.
6. Once inserted, gently advance the Bougie until you meet resistance or “hold-up” (if you do not meet resistance you have a probable esophageal intubation and insertion should be reattempted or the Failed Airway Protocol implemented.
7. Withdraw the Bougie ONLY to a depth sufficient to allow loading of the the ETT while maintaining proximal control of the Bougie.
8. Gently advance the Bougie and loaded ETT until you have “hold-up” again, thereby assuring tracheal placement and minimizing the risk of accidental displacement of the Bougie.
9. Wile maintaining a firm grasp on the proximal Bougie, introduce the ETT over the Bougie passing the tube to the appropriate depth.
10. If you are unable to advance the ETT into the trachea and the Bougie and ETT are adequately lubricated, withdrawal the ETT slightly and rotate the ETT 90 degrees counter-clockwise to turn the bevel of the ETT posteriorly.
11. Once the ETT is correctly placed, hold the ETT securely and remove the Bougie.
12. Confirm tracheal placement, inflate the cuff with 3-10 ml of air, auscultate for equal breath sounds and reposition if necessary.
13. When the final position is determined secure the ETT, reassess breath sounds, apply End-Tidal CO2 detector and/or capnography.
14. Document the procedure and the results in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: FOREIGN BODY OBSTRUCTION PROCEDURE # 6

CLINICAL INDICATIONS:

- ✓ Sudden onset of respiratory distress often with coughing, wheezing, gagging, or stridor due to a foreign-body obstruction of the upper airway
- ✓ Respiratory arrest where ventilation cannot be accomplished after repositioning of airway

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Assess the degree of foreign body obstruction
   - Do not interfere with a mild obstruction allowing the patient to clear their airway by coughing.
   - In severe foreign body obstructions, the patient may not be able to make a sound. The victim may clutch his/her neck in the universal choking sign.
2. **For an infant**, deliver 5 back blows (slaps) followed by 5 chest thrusts repeatedly until the object is expelled or the victim becomes unresponsive.
3. **For a child**, perform a subdiaphragmatic abdominal thrust(Heimlich Maneuver) until the object is expelled or the victim becomes unresponsive.
4. **For adults**, a combination of maneuvers may be required.
   - First, subdiaphragmatic abdominal thrust (Heimlich Maneuver) should be used in rapid sequence until the obstruction is relieved.
   - If abdominal thrusts are ineffective, chest thrusts should be used. Chest thrusts should be used primarily in morbidly obese patients and in the patients who are in the late stages of pregnancy.
5. If the victim becomes unresponsive, begin CPR immediately but look in the mouth before administering any ventilations. If a foreign body is visible, remove it.
6. **Do not perform blind finger sweeps in the mouth and posterior pharynx. This may push the object farther into the airway.**
7. In unresponsive patients, Paramedic level professionals should visualize the posterior pharynx with a laryngoscope to potentially identify and remove the foreign-body using Magil forceps.
8. Document the methods used and result of these procedures in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: INTUBATION NASOTRACHEAL PROCEDURE # 7

CLINICAL INDICATIONS:

- ✓ A spontaneously breathing patient in need of intubation (inadequate respiratory effort, evidence of hypoxia or carbon dioxide retention, or need for airway protection)
- ✓ Rigidity or clenched teeth prohibiting other airway procedures

CONTRAINDICATIONS:

- ✓ Non-breathing or near apneic patient
- ✓ Known or likely fracture/instability of mid-face secondary to trauma
- ✓ Relative contraindications:
  - Blood clotting abnormalities
  - Nasal Polyps
  - Upper neck hematomas or infections

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% oxygen.
2. Choose proper ET tube about 1mm less than for oral intubation.
3. Instill nasal spray into appropriate nostril if available.
4. Lubricate ET tube generously with water-soluble lubricant.
5. Pass the tube in the largest nostril with the beveled edge against the nasal septum and perpendicular to the facial plate.
6. Use forward, lateral back and forth rotating motion to advance the tube. **Never force the tube.**
7. Continue to advance the tube noting air movement through it.
8. Advance the tube quickly past the vocal cords during inspiration.
9. Inflate the cuff with 5 to 10cc of air.
10. Auscultate for absence of sounds over epigastrium and presence of equal bilateral breath sounds. If present unilaterally/unequal, adjust tube position and consider whether this may be patient's baseline. If unsure of placement, remove tube and ventilate with bag-valve mask.
11. **Apply end tidal carbon dioxide monitor. After 3 ventilations, ETCO2 must be >10. If less than 10 check for adequate circulation and check equipment. Remove the ET tube if pCO2 remains <10 in the absence of a physiologic explanation.**
12. If ETCO2 equipment failure occurs, use other means for confirmation.
13. Secure the tube to the patient's face.
14. Reassess airway, breath sounds, and ETCO2 after transfer to the stretcher and during transport. These tubes are easily dislodged and require close monitoring and frequent reassessment.
15. Document procedure and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: INTUBATION OROTRACHEAL PROCEDURE # 8

CLINICAL INDICATIONS:

- ✓ Inability to adequately ventilate a patient with a Bag Valve Mask or longer EMS transport distances require a more advanced airway
- ✓ An unconscious patient without a gag reflex who is apneic or is demonstrating inadequate respiratory effort
- ✓ Risk to benefit ratio of oral tracheal intubation to BIAD insertion

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% Oxygen.
2. If patient is in cardiac arrest, monitor pre-intubation ETCO2 for post-intubation comparison.
3. Select proper ET tube (and stylette), have suction ready.
4. Using laryngoscope, visualize vocal cords. (Use Sellick maneuver/BURP/bimanual laryngoscopy to assist you).
5. Limit each intubation attempt to 30 seconds with BVM between attempts.
6. Visualize tube passing through vocal cords then inflate the cuff with 3 to 10cc of air.
7. Auscultate for absence of sounds over epigastrium and presence of bilaterally equal breath sounds. If present unilaterally or unequal, adjust tube position or consider whether this may be patient's baseline. If unsure of placement, remove tube and ventilate patient with bag-valve mask.
8. **Apply end tidal carbon dioxide monitor. After 3 ventilations, ETCO2 should be >10 or comparable to pre-intubation valves. If <10 check for adequate circulation, check equipment, and check ventilatory rate. Remove the ET tube and ventilate by bag valve mask if ETCO2 still <10 and no obvious physiologic explanation.**
9. **Record initial, ongoing, and final ETCO2 values.**
10. **If ETCO2 monitor fails, use other means to confirm.**
11. Secure the tube to the patient's face.
12. Consider using BIAD if ET intubation efforts are unsuccessful.
13. Document ETT size, time, result (success), and placement location by the centimeter marks either at the patient's teeth or gums on/with the patient care report (PCR). Document all devices used to confirm initial tube placement. Also document positive or negative breath sounds before and after each movement of the patient.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: KING LT-D
PROCEDURE # 9-1

CLINICAL INDICATIONS:
- ✓ Cardiac arrest where initial BLS airway management has been completed per protocol or sufficient personnel are present to perform without interruption in other cardiac arrest care
- ✓ Non-Cardiac arrest patient without a gag reflex for whom at least one failed intubation attempt has occurred OR the King can be placed more rapidly or without less interruption to care
- ✓ Appropriate intubation is impossible due to patient access or difficult airway anatomy
- ✓ A **Blind Insertion Airway Device (BIAD)** utilized and preferred by Trinity EMS System

ABSOLUTE CONTRAINDICATIONS:
- ✓ Deforming facial trauma

RELATIVE CLINICAL CONTRAINDICATIONS:
- ✓ Pulmonary fibrosis
- ✓ Morbid obesity

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

WARNING:

This airway may not prevent aspiration of stomach contents

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% oxygen.
2. Choose King LT-D size per package recommendations.
3. Check the cuffs for proper inflation and deflation.
4. Apply chin lift and introduce device to corner of mouth.
5. Advance tip between tongue and soft palette rotating tube to midline.
6. Without excessive force, advance tube until base of connector aligns with teeth or gums.
7. Inflate the cuff per the manufacturer's recommendations until a seal is obtained.
8. Connect the LT-D to an ambu bag, ventilate, and slowly withdraw tube until ventilation becomes easy and free flowing (normal tidal volume with minimal airway pressure).
9. **Employ capnography and utilize the Impedance Threshold Device Procedure if appropriate.**
10. If necessary, adjust cuff inflation pressure to maximize seal.
11. Re-verify King LT-D placement after every move and upon arrival in the ED.
12. Document the procedure, time, and result on the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: i-gel® Supraglottic Airway Insertion Procedure # 9-2

CLINICAL INDICATIONS:

- ✓ Cardiac arrest where initial BLS airway management has been completed per protocol or sufficient personnel are present to perform without interruption in other cardiac arrest care
- ✓ Non-Cardiac arrest patient without a gag reflex for whom at least one failed intubation attempt has occurred OR the i-gel® can be placed more rapidly or without less interruption to care
- ✓ Appropriate intubation is impossible due to patient access or difficult airway anatomy
- ✓ A **Blind Insertion Airway Device (BIAD)** utilized and preferred by Trinity EMS System

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

ABSOLUTE CONTRAINDICATIONS:

- ✓ Trismus, impaired mouth opening, or obstruction of upper airway from mass or trauma
- ✓ Intact upper airway reflexes or gag, or intact consciousness

WARNING:

This airway may not prevent aspiration of stomach contents

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% oxygen
2. Choose appropriate sized i-gel® per package recommendations
3. Remove the device from the protective cradle, and place lubricant in cradle
4. Grasp the device on the bite block and lubricate the i-gel®
5. In the sniffing position, position the device with the outlet facing the chin, open the mouth by pressing down the chin, and advance the tip into the mouth towards the hard palate
6. Push the device with firm pressure continuous until a definitive résistance is met
7. The incisors should align with the integral bite block of the i-gel®
8. Secure the device in place
9. Attach the device to the BVM and confirm placement and ventilation
10. **Employ capnography and utilize the Impedance Threshold Device Procedure if appropriate**
11. Document the procedure, time, and result on the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: NEBULIZER INHALATION THERAPY PROCEDURE # 10

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

CLINICAL INDICATIONS:

✓ Patients experiencing bronchospasm

PROCEDURE:

1. Gather the necessary equipment.
2. Assemble the nebulizer kit.
3. Install the premixed drug(such as Albuterol or other approved drug) into the reservoir well of the nebulizer.
4. Connect the nebulizer device to oxygen at 6 liters per minute or adequate flow to produce a steady, visible mist. When necessary, this may be used in conjunction with CPAP at low positive pressures (less than or equal to 5 cm H20 where measurable), or with BVM ventilations.
5. For the spontaneously breathing patient, instruct them to inhale normally through the mouthpiece of the nebulizer or through the appropriate mask to which it is attached.
6. The treatment should last until the solution is depleted. Tapping the reservoir well near the end of the treatment will assist in utilizing all of the solution.
7. Monitor the patient for medication effects. This should include the patient's assessment of his/her response to the treatment and reassessment of vital signs, EKG, and breath sounds.
8. Document the treatment, dose, and route with the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: RAPID SEQUENCE INTUBATION PROCEDURE # 11

CLINICAL INDICATIONS:

- ✓ Need for advanced airway control in a patient who has a gag reflex or trismus (jaw clenching)
- ✓ ***Paramedics must be approved individually by the system Medical Director to perform this procedure***

LEGEND	
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Significant burns between 24 hours and 2 weeks old
- ✓ Known neuromuscular disease such as myasthenia gravis, amyotrophic lateral sclerosis, muscular dystrophy, Guillain-Barre syndrome
- ✓ Chronic renal failure and on hemodialysis
- ✓ Age less than 12 years
- ✓ Patient or family history of malignant hyperthermia
- ✓ Inadequate personnel to participate in patient care

PROCEDURE:

1. Prepare, position and oxygenate the patient with 100% oxygen via BVM or NRB mask.
2. Monitor oxygen saturation with pulse oximetry and heart rhythm with EKG.
3. Ensure functioning IV access.
4. Evaluate for difficult airway (LEMON).
5. Prepare equipment (laryngoscope, endotracheal tube, BVM, suction, medications, BIAD, cricothyrotomy kit, waveform capnography, ETCO2 detector).
6. Administer **Etomidate.**
7. Stroke/Head trauma suspected? If yes, **Lidocaine** 1mg/kg and consider **Fentanyl.**
8. Inline C-spine stabilization by second caregiver in trauma settings.
9. Administer **Succinylcholine/Rocuronium** and await paralysis as observed by fasciculations or muscle relaxation, generally 45 to 60 seconds.
10. Perform direct laryngoscopy and intubate trachea with visualization of tube passing through vocal cords with possible aid of Sellick's/BURP Maneuver or bimanual laryngoscopy.
11. Inflate balloon of ETT, verify placement with auscultation, fogging, capnography, ETCO2, and pulse oximetry.
12. Release cricoid pressure and secure the tube to the patient's face.
13. Reassess airway, breath sounds, and ETCO2 after transfer to the stretcher and during transport. Continuous capnography and pulse oximetry is recommended with pre-intubation, minimum levels during intubation, and post-intubation levels documented.
14. Document ETT size, results, placement in cm at the teeth and submit with PCR**.**

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: RESPIRATOR OPERATION # 12

CLINICAL INDICATIONS:

✓ Transport of an intubated patient

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Confirm the placement of the endotracheal tube.
2. Ensure adequate oxygen delivery to the respirator device.
3. Preoxygenate the patient with a BVM.
4. Remove the BVM and attach the ETT to the respirator.
5. Per the device instructions, set initial respiration values. For example, set an inspiratory/expiratory ratio of 1:2(for every 1 second of inspiration, allow 2 seconds of expiration) with a rate of 12-20, FiO2 40-100%, and PEEP 5-10.
6. Assess breath sounds. Allow for adequate expiratory time. Adjust respirator setting as clinically indicated.
7. Patient must be monitored with continuous pulse oximetry. It is strongly recommended the airway be monitored with continuous capnography. The ideal pulse oximetry should be >94% and a pCO2 of 30-35.
8. If the patient condition worsens, deteriorates, or there is a question about respirator function, disconnect from the respirator and resume BVM ventilation.
9. Document time, complications, and patient response in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms, as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: SUCTIONING- ADVANCED PROCEDURE # 13

CLINICAL INDICATORS:

✓ Obstruction of the airway (secondary to secretions, blood, or any other substance) in a patient currently being assisted by an airway adjunct such as a nasotracheal tube, endotracheal tube, combitube, tracheostomy tube, or a cricothyrotomy tube

LEGEND	
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Ensure suction device is in proper working order.
2. Preoxygenate the patient as is possible.
3. Attach suction catheter to suction device, keeping sterile plastic covering over catheter.
4. Using the suprasternal notch and the end of the airway into the catheter will be placed as guides, measure the depth desired for the catheter (judgement must be used regarding the depth of suctioning with cricothyrotomy and tracheostomy tubes).
5. If applicable, remove ventilation devices from the airway.
6. With the thumb port of the catheter uncovered, insert the catheter through the airway device.
7. Once the desired depth (measured in #4 above) has been reached, occlude the thumb port and remove the suction catheter slowly.
8. A small amount of Normal Saline (10ml) may be used if needed to loosed secretions for suctioning.
9. Reattach ventilation device (e.g., bag-valve mask) and ventilate the patient.
10. Document time and result in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: SUCTIONING-BASIC PROCEDURE # 14

CLINICAL INDICATORS:

✓ Obstruction of the airway (secondary to secretions, blood, or any other substance) in a patient who cannot maintain or keep the airway clear

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Ensure suction device is in proper working order with suction tip in place.
2. Preoxygenate the patient as is possible.
3. Explain the procedure to the patient if they are coherent.
4. Examine the oropharynx and remove any potential foreign bodies or material which may occlude the airway if dislodged by the suction device.
5. If applicable, remove ventilation devices from the airway.
6. Use the suction device to remove any secretions, blood, or other substance.
7. The alert patient may assist with this procedure.
8. Reattach ventilation device (e.g., bag-valve mask) and ventilate or assist the patient.
9. Record the time and result of the suctioning in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: SURGICAL CRICO-THYROTOMY PROCEDURE # 15

CLINICAL INDICATIONS:

- Surgical Airway as indicated by the Failed Airway Protocol using Rusch QuickTrach

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Pre-oxygenate patient when possible.
2. Assemble all available additional personnel.
3. Locate cricothyroid membrane at the inferior portion of the thyroid cartilage (with head in neutral position, membrane is approximately 3 finger widths above the sternal notch).
4. Have assistant hold skin taunt over membrane and locate the midline.
5. Prep area with betadine if possible.
6. Hold the needle bevel up at 90 degree angle, aimed inferiorly as you approach the skin.
7. Puncture the skin with the needle and continue with firm, steady pressure while aspirating for air with the syringe.
8. As soon as air is aspirated freely, stop advancing the needle/airway assembly.
9. Modify the angle to 60 degrees from the head and advance to level of the stopper.
10. Remove the stopper while holding the needle/airway assembly firmly in place. Do not advance the needle further. (NOTE: if the patient is obese and no air can be aspirated with the stopper in place, you may remove the stopper and continue advancing until air is aspirated. Be aware that without the stopper, risk of perforating the posterior aspect of the trachea is greatly increased.)
11. Hold the needle and syringe firmly and slide only the plastic cannula along the needle into the trachea until the flange rests on the neck. Carefully remove the needle and syringe.
12. Secure the cannula with the neck strap.
13. Apply the EtCO2 detector, then the connecting tube to the EtCO2 detector and connect the other end to the BVM.
14. Confirm placement with the use of breath sounds, pulse oximetry, and EtCO2.
15. Ensure 100% FiO2 to BVM via supplemental O2.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

AIRWAY: TRACHEOSTOMY TUBE CHANGE PROCEDURE # 16

CLINICAL INDICATIONS:

- ✓ Presence of Tracheostomy site
- ✓ Urgent or emergent indication to change the tube, such as obstruction that will not clear with suction, dislodgement, or inability to oxygenate/ventilate the patient without other obvious explanation

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Have all airway equipment prepared for standard airway management, including equipment for oral tracheal intubation and failed airway.
2. Have airway device (endotracheal tube or tracheostomy tube) of the same size as the tracheostomy tube currently in place as well as 0.5 size smaller available (e.g., if the patient has a #6.0 Shiley, then have a 6.0 and a 5.5 tube).
3. Lubricate the replacement tube(s) and check the cuff.
4. Remove the tracheostomy tube from mechanical ventilation devices and use a bag-valve apparatus to pre-oxygenate the patient as much as possible.
5. Once all equipment is in place, remove devices securing the tracheostomy tube, including sutures and/or supporting bandages.
6. If applicable, deflate the cuff on the tube. If unable to aspirate air with a syringe, cut the balloon off to allow the cuff to lose pressure.
7. Remove the tracheostomy tube.
8. Insert the replacement tube. Confirm placement via standard measures.
9. If there is any difficulty placing the tube, re-attempt procedure with the smaller tube.
10. If difficulty is still encountered, use standard airway procedures such as oral bag-valve mask or endotracheal intubation (as per protocol). **More difficulty with tube changing can be anticipated for tracheostomy sites that are immature, i.e. less than two weeks old. Great caution should be exercised in attempts to change immature tracheotomy sites**
11. Document procedure, patient response, and any complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

AIRWAY: VENTILATOR OPERATION PROCEDURE # 17

CLINICAL INDICATORS:

✓ Management of the ventilation of a patient during prolonged or interfacility transport of a patient

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Transporting personnel should review the ventilation of the patient with the treating personnel(physician, nurse, or respiratory therapy) in the referring facility prior to transport.
2. All ventilator setting, including respiratory rate, FiO2, mode of ventilation, PEEP/ PIP, and tidal volumes should be recorded prior to initiating transport. Additionally, recent trends in the oxygen saturations experienced by the patient should be noted.
3. Prior to transport, specific orders regarding any anticipated changes to ventilator settings as well as causes for significant alarm should be reviewed with the referring medical personnel.
4. Once in the ambulance, confirm adequate oxygen delivery to the ventilator.
5. Frequently assess breath sounds to assess for possible tube dislodgment during transfer.
6. Frequently assess the patient's respiratory status, noting any decreases in oxygen saturation or changes in tidal volume, peak pressure, etc.
7. Note any changes in the ventilator setting or patient condition in the PCR.
8. It is required that the patient be continuously monitored with pulse oximetry and strongly recommended that the patient be continuously monitored with capnography.
9. If any significant change in patient condition, including vital signs or oxygen saturation or there is a concern regarding ventilator performance/alarms, disconnect the ventilator and use BVM with 100% O2 to ventilate.
10. Document time and result in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

ARTERIAL LINE MAINTANENCE PROCEDURE # 18

CLINICAL INDICATORS:

✓ Transport of a patient with an existing arterial line

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Make certain arterial line is secured prior to transport, including intersection of arterial catheter and IV/monitoring lines.
2. Use available equipment for monitoring of arterial pressures via arterial line.
3. Do not use the arterial line for administration of any fluids or medications.
4. If there is any question regarding dislodgement of the arterial line and bleeding results, remove the line and apply direct pressure over the site for at least five minutes before checking to ensure hemostasis.
5. Document the procedure, results, and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

ASSESSMENT: ADULT PROCEDURE # 19

CLINICAL INDICATIONS:

- ✓ Any patient requesting a medical evaluation that is too large to be measured with a Broselow-Luten Resuscitation Tape

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Scene size-up, including universal precautions, scene safety, environmental hazards assessment, need for additional resources, by-stander safety, and patient/caregiver interaction.
2. Initial assessment includes a general impression as well as the status of a patient's airway, breathing, and circulation.
3. Assess mental status (e.g., AVPU) and disability (e.g., GCS).
4. Control major hemorrhage and assess overall priority of patient.
5. Perform a focused history and physical based on patient's chief complaint making efforts to protect patient privacy and modesty.
6. Assess need for critical interventions. If none are anticipated, downgrade or cancel additional responding units as appropriate.
7. Complete critical interventions and perform a complete secondary exam to include a baseline set of vital signs as directed by protocol.
8. Maintain an on-going assessment throughout transport; to include patient response/possible complications of interventions, need for additional interventions, and assessment of evolving patient complaints/conditions.
9. Document all findings and information associated with the assessment, performed procedures, and any administration of medications on the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skill stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

ASSESSMENT AND DOCUMENTATION: PAIN PROCEDURE # 20

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

CLINICAL INDICATIONS

✓ Any patient

DEFINITIONS

✓ Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

✓ Pain is subjective (whatever the patient says it is).

PROCEDURE

1. Initial and ongoing assessment of pain intensity and character is accomplished through the patient's self-report.
2. Pain should be assessed and documented in the PCR during the initial assessment, before starting pain control treatment, with each set of vitals after a pharmaceutical pain intervention, and until resolved or the last vital set for non-drug therapies.
3. Three pain scales are available 0 – 10, the Wong Baker "faces," and the FLACC:

✓ **0 – 10 Scale**: The most familiar scale used by EMS for rating pain with patients. It is primarily for adults and is based on the patient being able to expires their perception of the pain as related to numbers. Avoid coaching the patient; simply ask them to rate their pain on a scale of 0 – 10, where 0 is no pain at all and 10 is the worst pain ever.

✓ **Wong-Baker "FACES" scale**: this scale is primarily for use with pediatrics but may also be used with geriatrics or any patient with a language barrier. The faces correspond to numeric values from 0 – 10. This scale can be documented with the numeric value.

✓ **FLACC scale**: this scale has been validated for measuring pain in children with mild to severe cognitive impairment and in pre-verbal children (including infants).

CATEGORIES	SCORING		
	0	1	2
FACE	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant quivering chin, clenched jaw.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry (awake or asleep)	Moans or whimpers; occasional complaints	Crying steadily, screams, or sobs; frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to; distractible	Difficult to console or comfort

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skill stations, or other mechanisms as deemed appropriate by the Trinity EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

ASSESSMENT: PEDIATRIC PROCEDURE # 21

CLINICAL INDICATIONS:

- ✓ Any child that can be measured with the Broselow -Luten Resuscitation Tape

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Scene size-up, including universal precautions, scene safety, environmental hazards assessment, need for additional resources, by-stander safety, and patient/caregiver interaction. Take reasonable steps to protect patient privacy and modesty.
2. Assess patient using the pediatric triangle of ABC's:
   - Airway and appearance: speech/cry, muscle tone, inter-activeness, look/ gaze, movement of extremities
   - Work of breathing: absent or abnormal airway sounds, use of accessory muscles, nasal flaring, body positioning
   - Circulation to skin: pallor, mottling, cyanosis
3. Establish spinal immobilization if suspicion of spinal injury.
4. Establish responsiveness appropriate for age (AVPU, GCS, etc.).
5. Color code using Broselow-Luten tape.
6. Assess disability (pulse, motor function, sensory function, pupillary reaction).
7. Perform a focused history and physical exam. Recall that pediatric patients easily experience hypothermia and thus should not be left uncovered any longer than necessary to perform an exam. Concurrently, remember that pediatric patients unable to verbalize their own complaint should be fully exposed for assessment.
8. Record vital signs (BP >3 years of age, cap refill <3 years of age).
9. Include immunizations, allergies, medications, past medical history, last meal, and events leading up to injury or illness where appropriate.
10. Treat chief complaint as per protocol.
11. Document assessment, treatments, any complications, and medications administered in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

BLOOD GLUCOSE ANALYSIS PROCEDURE # 22

CLINICAL INDICATIONS:

- ✓ Patients with suspected hypoglycemia (diabetic emergencies, change in mental status, bizarre behavior, etc.)

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Gather and prepare equipment.
2. Blood samples for performing glucose analysis should be obtained through a finger-stick. Venous blood samples may produce artificially high blood glucose values and should be avoided due to this and the increased risk of needle stick.
3. Place correct amount of blood on reagent strip or site on glucometer per the manufacturer's instructions.
4. Time the analysis as instructed by the manufacturer.
5. Document the glucometer reading and treat the patient as indicated by the analysis and protocol.
6. Repeat glucose analysis as indicated for reassessment after treatment and as per protocol.
7. Perform Quality Assurance on glucometers at least once every 7 days, if any clinically suspicious readings are noted, and/or as recommended by the manufacturer and document in the log.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms, as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CAPNOGRAPHY
PROCEDURE # 23

CLINICAL INDICATIONS:

- ✓ Capnography shall be used as soon as possible in conjunction with any airway management adjunct, including endotracheal, nasotracheal, cricothyrotomy, Blind Insertion Airway Devices (BIAD) or BVM
- ✓ Capnography should also be used on all patients treated with CPAP, Magnesium, and/or epinephrine for respiratory distress

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Attach capnography sensor to the BIAD, endotracheal tube, or oxygen delivery device.
2. Note CO2 level and waveform changes. These will be documented on each respiratory failure, cardiac arrest, or respiratory distress patient.
3. The capnometer shall remain in place with the airway and be monitored throughout the pre-hospital care and transport.
4. Any loss of CO2 detection or waveform indicates an airway problem and should be documented.
5. The capnogram should be monitored as procedures are performed to verify or correct the airway problem.
6. Document the procedure and results in the Patient Care Report (PCR).
7. In all patients with a pulse, an ETCO2 >20 is anticipated. In the post-resuscitation patient, no effort should be made to lower ETCO2 by modification of the ventilatory rate. Further, in post-resuscitation patients without evidence of ongoing, severe bronchospasm, ventilatory rate should never be <6 breaths per minute.
8. In the pulseless patient, and ETCO2 waveform with a ETCO2 value >10 may be utilized to confirm the adequacy of an airway to include BVM and advanced devices when SpO2 will not register.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms, as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CARDIAC: EXTERNAL PACING PROCEDURE # 24

CLINICAL INDICATIONS:

✓ Patients with symptomatic bradycardia (less than 60 beats per minute) with signs and symptoms of inadequate cerebral or cardiac perfusion such as:

- Chest Pain
- Hypotension
- Pulmonary Edema
- Altered mental status, confusion, etc.
- Ventricular ectopy

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Attach standard three-lead monitor.
2. Apply defibrillation/pacing pads to sternal/apical(antero/lateral) or antero/ posterior positions:
   - One pad right infraclavicular chest and one pad left apical/inferior-lateral chest wall, lateral to the breast
   - One pad to left mid-chest next to sternum, one pad to upper left back next to spine
3. Rotate selector switch to pacing option.
4. Adjust heart rate to 70 BPM for adult and 100 BPM for a child.
5. Note pacer spikes on EKG screen.
6. Slowly increase output until capture of electrical rhythm on the monitor.
7. If unable to capture while at maximum current output, stop pacing immediately.
8. If capture observed on monitor, check for corresponding pulse and assess vital signs.
9. Consider the use of sedation or analgesia if patient is uncomfortable.
10. Document the dysrhythmia and the response to external pacing with EKG strips in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indication, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CARDIAC: INTERNAL PACEMAKER MAINTANENCE PROCEDURE # 25

CLINICAL INDICATIONS:

✓ Patients with a cardiac internal pacemaker and pulse generator device

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Document and note the reason for pacemaker, goal of therapy, patient's underlying rhythm, date of insertion, current status of pacemaker and settings.
2. Review and document type of pacemaker and transferring physician's orders.
3. Assess the patient's current cardiac rhythm, blood pressure, and distal pulses.
4. Assess the insertion site; dressing should be dry and pacing wires taped securely; assure the battery is charged and an extra battery is also charged and available.
5. Assess that all connections are secure and connected correctly, avoiding any tangling wires and tension on pacing catheter.
6. Patient shall be maintained on cardiac and pulse oximetry monitors throughout transport.
7. Obtain an initial rhythm strip and continually assess the mental, neurologic and hemodynamic status of the patient.
8. If problems with the pacemaker occurs (pericardial perforation, lead dislodgement or fracture) or there is a change in the cardiac, neurologic, or mental status from suspected pacing or sensing problems, contact Medical Control for further instruction.
9. If the device is shut off by order of Medical Control or fails to operate, appropriate ACLS protocols should be initiated.
10. Document the procedure, results, and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indication, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

CARDIOPULMONARY RESUSCITATION AUTOMATED PROCEDURE # 26

CLINICAL INDICATORS:

- ✓ Cardiac arrest in patients 8 years of age and older, where manual CPR may otherwise be used

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Patient less than eight(8) years of age
- ✓ Patients suffering obvious signs of penetrating injury directly beneath the device
- ✓ Patients who do not fit within the device
- ✓ Patients suffering traumatic arrest

PROCEDURE:

1. Initiate resuscitative measures following the current AHA guidelines and treatment protocols.
2. Manual CPR should be initiated and continued while the automated CPR device such as the Lucas Device or AutoPulse are prepared and placed.
3. Remove the clothing from the upper torso.
4. Apply defibrillation pads and electrodes.
5. Place the device per the manufacturer's recommendations and follow instructions on its use following appropriate prompts
    A. For the AutoPulse, place the patient on the AutoPulse board.
    B. Place the life belt across the chest.
    C. Turn on the AutoPulse.
    D. Press the green button. The lifebelt will adjust to the patient.
    E. Press the green button a second time. Compressions begin automatically.
6. Secure the patient and the automated CPR device to a long spine board but do not place a strap over the device.
7. Follow appropriate protocols for airway and cardiac rhythms.
8. After arrival in the ER, leave the device with the patient until no longer utilized.
9. Document the procedure, complications, and results in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

CARDIOPULMONARY RESUSCITATION MANUAL PROCEDURE # 27

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

CLINICAL INDICATIONS:

✓ Basic life support for the patient in cardiac arrest

PROCEDURE:

✓ 2010 AHA Guidelines now emphasize a C-A-B approach to CPR. AHA stresses quality compressions, and recommends deeper compressions than previous Guidelines.

1. Scan the patient for responsiveness and breathing for approximately 6 -10 sec.
2. Check a pulse for 10 sec (May be done simultaneously with scan for breathing)
3. Begin compressions at 30:2 ratio. Be sure to complete ***at least*** 100 compressions per minute.

AGE	COMPRESSIONS/ VENTILATIONS	DEPTH	RATE
INFANT	15:2	About 1½ (1/3 the anterior-posterior chest dimension)	At least 100/minute
CHILD	15:2	About 2 inches (1/3 the anterior-posterior chest dimension)	At least 100/minute
ADULT	30:2	At least 2 inches	At least 100/minute

4. Go to Cardiac Arrest Protocol. Begin ventilations in the adult as directed in the Cardiac Arrest Protocol. In this protocol, and all cardiac arrest protocols, 5 cycles of compressions means 2 minutes of uninterrupted chest compressions.
5. Provide no more than 12 breaths per minute with BVM. Use ETCO2 to guide your ventilations as directed in the Cardiac Arrest Protocol.
6. Chest compressions should be provided in an uninterrupted manner.
7. Document time and procedure in your PCR.

CERTIFICATIONS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of this procedure. Assessment of this knowledge may be accomplished by quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanism as deemed appropriate by the Trinity EMS System. Caregivers are expected to have knowledge of current AHA guidelines.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

CARDIOVERSION – SYNCHRONIZED PROCEDURE # 28

CLINICAL INDICATIONS:

- ✓ Unstable patient with tachydysrhythmia (rapid atrial fibrillation, supraventricular tachycardia, ventricular tachycardia)
- ✓ Patient is not pulseless (the pulseless patient requires unsynchronized cardioversion, i.e., defibrillation)

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Ensure the patient is attached properly to a monitor/defibrillator capable of synchronized cardioversion.
2. Have all equipment prepared for unsynchronized cardioversion/defibrillation if the patient fails synchronized cardioversion and the condition worsens.
3. Consider the use of pain or sedating medications.
4. Set energy selection to the appropriate setting. Recommended doses are:
   - **Atrial Fibrillation**: 120 - 200 joules
   - **Atrial Flutter**: 50 - 100 joules
   - **Supraventricular Tachycardia**: 50 - 100 joules
   - **Ventricular Tachycardia**: 100 - 200 joules
5. Set monitor/defibrillator to synchronized cardioversion mode.
6. Make certain all personnel are clear of patient.
7. Press and hold the shock button to cardiovert. Stay clear of the patient until you are certain the energy has been delivered. NOTE: It may take the monitor/defibrillator several cardiac cycles to "synchronize", so there may be a delay between activating the cardioversion and the actual delivery of energy.
8. Note patient response and perform immediate unsynchronized cardioversion/defibrillation if the patient's rhythm has deteriorated into pulseless ventricular tachycardia/ventricular fibrillation, following the procedure for Defibrillation-Manual.
9. If the patient's condition is unchanged, repeat steps 2-8 above, using escalating energy settings.
10. Repeat until maximum setting or until efforts succeed. Consider discussion with medical control if cardioversion is unsuccessful after 2 attempts.
11. Note procedure, response, and time in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CHEST DECOMPRESSION/ NEEDLE PROCEDURE # 29

CLINICAL INDICATIONS:

- ✓ Peri-arrest patients with hypotension (SBP <90), clinical signs of shock, and at least one of the following signs:
  - Jugular vein distention
  - Tracheal deviation away from the side of the injury
  - Absent or decreased breath sounds on the affected side
  - Hyper-resonance to percussion on the affected side
  - Increased resistance when ventilating a patient
- ✓ Patients in traumatic arrest with chest or abdominal trauma for whom resuscitation is indicated. These patients may require bilateral chest decompression even in the absence of the signs above

LEGEND	
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Bilateral decompression without positive pressure ventilations is contraindicated

PROCEDURE:

1. Don personal protective equipment (gloves, eye protection, etc.).
2. Administer high flow of oxygen.
3. Identify and prep the site:
   - Locate the second intercostals space in the mid-clavicular line on the same side as the pneumothorax.
   - As a last resort, lateral placement may be used at the fourth ICS mid-axillary line.
   - Prepare the site with povidone-iodine or chorhexidine ointment or solution.
4. Insert the catheter (12 or 14 gauge for adults) into the skin over the third rib and direct it just over the top of the rib (superior border) into the interspace.
5. Advance the catheter through the parietal pleura until a “pop” is felt and air or blood exits under pressure through the catheter, then advance catheter only to chest wall.
6. Remove the needle, leaving the plastic catheter in place.
7. Secure the catheter hub to the chest wall with dressings and tape.
8. Consider placing a finger cut from an exam glove over the catheter hub. Cut a small hole in the end of the finger to make a flutter valve. Secure the glove finger with tape or a rubber band. (Note-don’t waste much time preparing the flutter valve; if necessary control the air flow through the catheter hub with your gloved thumb).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CHEST TUBE MAINTANENCE PROCEDURE # 30

CLINICAL INDICATORS:

✓ Transport of a patient with an existing chest thoracostomy tube

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Document the location of the chest tube, breath sounds, tracheal position, and soft tissue exam at the chest tube site prior to transfer.
2. Pulse oximetry trends and current readings should be reviewed and documented and monitored throughout transport.
3. Review and document the chest tube is draining, and the current status of the tube in regards to clamped, place to gravity, or connected to suction(with special attention to the centimeter of water of suction).
4. All relevant chest X-rays and radiologic studies should accompany the patient.
5. The collection device must remain below the level of the chest to prevent drained fluid from re-entering the pleural space. Do not allow the collection receptacle to tip over.
6. If hemorrhage occurs through the tube, observe for signs and symptoms of respiratory distress or hypovolemia/shock and treat according to appropriate protocols.
7. If the thoracostomy tube is partially pulled out, do not push the tube back into the chest. Reassess the patient and secure the tube at the current position.
8. If the thoracostomy tube is completely pulled out, place a three sided occlusive dressing over the insertion site with the liberal application of lubricating jelly.
9. If an air leak occurs, reassess all connections and continually assess patency of entire system.
10. If patient becomes increasingly dyspneic, repeat the physical exam with attention to breath sounds and tracheal deviation. Contact Medical Control.
11. Document the procedure, complications, and results in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

CHILDBIRTH
PROCEDURE # 31

CLINICAL INDICATIONS:

- ✓ Imminent delivery with crowning

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Delivery should be controlled so as to allow a slow, controlled delivery of the infant. This will prevent injury to the mother and infant.
2. Consider additional resources as there will be two potential patients.
3. Support the infant's head as needed.
4. If the umbilical cord is surrounding the neck, slip it over the head. If unable to free the cord from the neck, double clamp the cord and cut between the clamps.
5. Suction the airway with a bulb syringe, mouth first then nares.
6. Grasping the head with hands over the ears, gently pull down to allow delivery of the anterior shoulder.
7. Gently pull up on the head to allow delivery of the posterior shoulder.
8. Slowly deliver the remainder of the infant.
9. Clamp the cord 2 inches from the abdomen with 2 clamps and cut the cord between the clamps.
10. Record APGAR scores at 1 and 5 minutes.
11. Follow the **Newly Born Protocol** for further treatment.
12. The placenta will deliver spontaneously, usually within 5 minutes of the infant. Do not force the placenta to deliver.
13. Massaging the uterus may facilitate the delivery of the placenta and decrease bleeding by facilitating uterine contractions. Uncontrolled bleeding is addressed in the childbirth protocol.
14. Document the procedure, time, and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

DECONTAMINATION PROCEDURE # 32

CLINICAL INDICATIONS:

✓ Any patient who may have been exposed to significant hazardous materials, including chemical, biological, or radiological weapons

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. In coordination with HazMAT and other Emergency Management personnel, establish hot, warm and cold zones of operation.
2. Ensure that personnel assigned to operate within each zone have proper personal protective equipment.
3. In coordination with other public safety personnel, assure each patient from the Hot Zone undergoes appropriate initial decontamination. This is specific to each incident; such decontamination may include:
   - Removal of patients from Hot Zone
   - Simple removal of clothing
   - Irrigation of eyes
   - Passage through high-volume water bath (e.g., between two fire apparatus) for patients contaminated with liquids or certain solids. Patients exposed to gases, vapors, and powders often will not require this step as it may unnecessarily delay treatment and/or increase dermal absorption of the agent(s).
4. Initial triage of patients should occur after step #3. Immediate life threats should be addressed prior to technical decontamination.
5. Assist patients with technical decontamination (unless contraindicated based on #3 above). This may include removal of all clothing and gentle cleansing with soap and water. All body areas should be thoroughly cleansed, although overly harsh scrubbing which could break the skin should be avoided.
6. Place triage identification on each patient. Match triage information with each patient's personal belongings which were removed during technical decontamination. Preserve these personnel affects for law enforcement.
7. Monitor all patients for environmental illness.
8. Transport patients per EMS protocol.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

DEFIBRILLATION: AUTOMATED AED PROCEDURE # 33

CLINICAL INDICATIONS:

- ✓ Patients in cardiac arrest (pulseless, non-breathing)
- ✓ Age <8 years, use Pediatric Pads if available

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

CONTRAINDICATION:

- ✓ Pediatric patients who are so small that the pads cannot be placed without touching one another

PROCEDURE:

1. **If multiple rescuers available, one rescuer should provide uninterrupted chest compressions while the AED is being prepared for use.**
2. Apply defibrillator pads per manufacturer recommendations. Use alternate placement when implanted devices (pacemakers, AICD's) occupy preferred pad positions.
3. Remove any medication patches on the chest and wipe off any residue.
4. If necessary, connect defibrillator leads: white to the anterior chest pad and the red to the posterior pad.
5. Activate AED for analysis of rhythm.
6. **Stop CPR and clear the patient for rhythm analysis. Keep interruption in CPR as brief as possible.**
7. Defibrillate if appropriate by depressing the "shock" button. **Assertively state "CLEAR" and visualize that no one, including yourself, is in contact with the patient prior to defibrillation.** The sequence of defibrillation charges is preprogrammed for monophasic defibrillators. Biphasic defibrillators will determine the correct joules accordingly.
8. Begin CPR (chest compressions and ventilations) immediately after the delivery of the defibrillation.
9. After 2 minutes of CPR, analyze rhythm and defibrillate if indicated. Repeat this step every 2 minutes.
10. If "no shock advised" appears, perform CPR for 2 minutes and then reanalyze.
11. Transport and continue treatment as indicated.
12. **Keep interruption of CPR compressions as brief as possible. Adequate CPR is a key to successful resuscitation.**
13. **If pulse returns please use the Post-Resuscitation Protocol.**

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

DEFIBRILLATION: MANUAL
PROCEDURE # 34

CLINICAL INDICATIONS:

✓ Cardiac arrest with ventricular fibrillation or pulseless ventricular tachycardia

LEGEND	
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. **Ensure that Chest Compressions are adequate and interrupted only when absolutely necessary.**
2. Clinically confirm the diagnosis of cardiac arrest and identify the need for defibrillation.
3. Apply hands-free therapy pads per manufacturer's instructions.
4. Set the appropriate energy level per protocol.
5. Charge the defibrillator to the selected energy level. **Continue chest compressions while the defibrillator is charging.**
6. **Hold compressions, assertively state, "CLEAR" and visualize that no one, including yourself, is in contact with the patient.**
7. Deliver the countershock by depressing the *Shock Button* for hands free operation.
8. Immediately resume chest compressions and ventilations for 2 minutes. After 2 minutes of CPR, analyze rhythm and check for pulse only if appropriate for rhythm.
9. Repeat the procedure every 2 minutes as indicated by patient response and EKG rhythm.
10. Keep interruption of CPR compressions as brief as possible. Adequate CPR is a key to successful resuscitation.
11. Document the procedure, time, and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

EKG MONITORING
PROCEDURE # 35

CLINICAL INDICATIONS:

- ✓ Patients with cardiac related symptoms, syncope, neurological complaints, cardiac arrest, shortness of breath, altered consciousness, abnormal vital signs, electrical injuries, hypothermia or any other symptom deemed significant

LEGEND	
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Attach the patient to a 3 Lead EKG monitor, utilizing either Lead I, II, or III.
2. Assess and document the rhythm interpretation and rate.
3. Obtain a six (6) second strip and attach to the PCR with documentation of the patient's name, date of birth (DOB) and interpretation.
4. Additional strips should be obtained with rhythm changes, before and after antiarrhythmic medications or cardioversion/defibrillation.
5. Document time and response on the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

IMPEDANCE THRESHOLD DEVICE PROCEDURE # 36

CLINICAL INDICATIONS:

- ✓ The ITD should be utilized to assist with control of ventilatory rate and improve cardiac preload for patients who are receiving CPR
- ✓ It may be utilized with an endotracheal tube, BIAD, or with a BVM

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ The ITD should not be utilized for patients who have spontaneous respirations. It should be removed from the endotracheal tube/BVM once spontaneous respirations have returned

PROCEDURE:

1. Ensure airway is adequate per airway/failed airway protocol.
2. If available, place an elbow O2 device in the top of the ITD.
3. Place the ITD between the bag and the EtCO2 detector (for intubated/BIAD patients) or between the bag and mask (for patients ventilated with the BVM). The elbow O2 device should be between the ITD and the bag.
4. Flip the red switch to the “on” position so that the respiratory timing lights flash.
5. Provide a rapid breath after each flash of the LED timing lights.
6. Perform chest compression per the CPR procedure.
7. Once there is return of spontaneous circulation and the EtCO2 climbs above 40, remove the ITD. Place the device near the patients head so that it may be replaced if the patient rearrests, and can be used to guide ventilations once removed. The ITD should also be removed if the patient has spontaneous respirations.
8. Carefully monitor the placement of the endotracheal tube after movement of the patient, placement of the ITD, and/or removal of the ITD.
9. Document the procedure and results in the Patient Care Report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

INJECTIONS: SUBCUTANEOUS & INTRAMUSCULAR PROCEDURE # 37

CLINICAL INDICATIONS:

✓ When medication administration is necessary and the medication must be given via the SQ (not auto-injector) or IM route, or as an alternative route in selected medications

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Receive and confirm medication order or perform according to standing orders.
2. Prepare equipment and medication expelling air from the syringe.
3. Explain the procedure to the patient and reconfirm patient allergies.
4. The most common site for subcutaneous injection is in the arm
   - Injection volume should not exceed 1 mL
5. The possible injection sites for intramuscular injections include the arm, buttock and thigh
   - Injection volume should not exceed 1 mL for the arm
   - Injection volume should not exceed 2 mL in the thigh or buttock
6. The thigh should be used for injections in pediatric patients and injection volume should not exceed 1 mL.
7. Expose the selected area and cleanse the injection site with alcohol.
8. Insert the needle into the skin with a smooth, steady motion.

   SQ: 45-degree angle skin pinched **IM: 90-degree angle skin flattened**
9. Aspirate for blood.
10. Inject the medication.
11. Withdrawal the needle quickly, activate needle stick prevention systems, and dispose of properly without recapping.
12. Apply pressure to the site.
13. Monitor the patient for the desired therapeutic effects as well as any possible side effects.
14. Document the medication, dose, route, and time in the patient care report (PCR)

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

INTRANASAL MEDICATION ADMINISTRATION PROCEDURE # 38

CLINICAL INDICATIONS:

- ✓ When medication administration is necessary and preferred or available route is intranasal
- ✓ Common uses include reversal of narcotic overdose with **Narcan**, treatment of seizures or status epilepticus with **Versed**, or treatment of pain with **Fentanyl**

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Receive and confirm medication order or perform according to standing orders.
2. Prepare the medication and the mucosal atomization device(MAD Nasal®) for use. Have patient clear nostrils with blowing or suctioning of mucus/blood.
3. Remove and discard the green vial adapter cap.
4. Pierce the medication vial with the syringe vial adapter.
5. Aspirate the proper volume of medication and an extra 0.1mL of medication for dead space in the device.
6. Remove (twist off) the syringe from the vial adapter.
7. Attach the MAD device to the syringe vial the luer-lock connector.
8. Using the free hand to hold the crown of the head stable, place the tip of the MAD snugly against the nostril aiming slightly up and outward (towards the top of the ear).
9. Briskly compress the syringe plunger to deliver half the medication into the nostril.
10. Move the device over to the opposite nostril and repeat delivery of the other half.
11. Use a maximum of 1mL per nostril, using the highest concentration of the drug available.
12. Monitor the patient for the desired therapeutic effects as well as any possible side effects.
13. Document the medication, dose, route, and time on/with the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

PULSE OXIMETRY
PROCEDURE # 39

CLINICAL INDICATIONS:

- ✓ Recommended with all patients as a routine part of vital signs
- ✓ Patients with suspected hypoxemia

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Apply probe to patient's finger or any other site as recommended by the device manufacturer.
2. Allow machine to register saturation level.
3. Record time and initial saturation percent on room air if possible on/with the patient care report (PCR).
4. Verify pulse rate on machine with actual pulse of the patient.
5. Monitor critical patients continuously until arrival at the hospital. If recording a one-time reading, monitor patients for a few minutes as oxygen saturation may vary.
6. Document percent of oxygen saturation every time vital signs are recorded and in response to therapy to correct hypoxemia.
7. In general, normal saturation is 97-99%. Below 94%, suspect a respiratory compromise.
8. Use the pulse oximetry as an added tool for patient evaluation. Treat the patient, not the data provided by the device.
9. The pulse oximeter reading should never be used to withhold oxygen from a patient in respiratory distress or when it is the standard of care to apply oxygen despite good pulse oximetry readings, such as chest pain.
10. Factors which may reduce the reliability of the pulse oximetry reading include:
    - Poor peripheral circulation (blood volume, hypotension, hypothermia)
    - Excessive pulse oximeter sensor motion
    - Fingernail polish (may be removed with acetone pad)
    - Carbon monoxide bound to hemoglobin
    - Irregular heart rhythms (atrial fibrillation, SVT, etc.)
    - Jaundice
    - Placement of BP cuff on same extremity as pulse ox probe.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

RESTRAINTS: PHYSICAL/ CHEMICAL PROCEDURE # 40

CLINICAL INDICATIONS:

- ✓ Any patient who may harm himself, herself, or others may be gently restrained to prevent injury to the patient or crew. This restraint must be in a humane manner and used only as a last resort. Other means to prevent injury to the patient or crew must be attempted first. These efforts could include reality orientation, distraction techniques, or other less restrictive therapeutic means. Physical or chemical restraint should be a last resort technique

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Attempt less restrictive means of managing the patient.
2. Request law enforcement assistance.
3. Ensure that there are sufficient personnel available to physically restrain the patient safely.
4. Restrain the patient in a lateral or supine position. No devices such as backboards, splints, or other devices will be on top of the patient. The patient will never be restrained in the prone position.
5. The patient must be under constant observation by the EMS crew at all times. This includes direct visualization of the patient as well as cardiac and pulse oximetry monitoring.
6. The extremities that are restrained will have a circulation check at least every 15 minutes. The first of these checks should occur as soon after placement of the restraints as possible. This MUST be documented on the PCR.
7. Documentation in the PCR should include the reason for the use of restraints, the type of restraints used, and the time restraints were placed.
8. If the above actions are unsuccessful, or if the patient is resisting the restraints, consider administering medications per protocol. (Chemical restraint may be considered earlier).
9. If a patient is restrained by law enforcement personnel with handcuffs or other devices EMS personnel can not remove, a law enforcement officer must accompany the patient to the hospital in the transporting EMS vehicle

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindication, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

SPINAL EXAMINATION PROCEDURE # 41

CLINICAL INDICATIONS:

- ✓ Suspicion of spinal/neurological injury
- ✓ Provider decision to utilize the Spinal Immobilization Clearance Protocol

LEGEND	
P	PARAMEDIC

- This procedure details the spinal examination process and must be used in conjunction with the Spinal Immobilization Clearance Protocol. It is not intended as a replacement for that protocol

PROCEDURE:

1. Explain to the patient the actions that you are going to take. Ask the patient to immediately report any pain, and to answer questions with a “yes” or “no” rather than shaking the head.
2. With the patient’s spine supported to limit movement, begin palpation at the base of the skull at the midline of the spine.
3. Palpate the vertebrae individually from the base of the skull to the bottom of the sacrum.
4. On palpation of each vertebral body, look for evidence of pain and ask the patient if they are experiencing pain. If evidence of pain along the spinal column is encountered, the patient should be immobilized.
5. If the capable patient is found to be pain free, ask the patient to turn their head first to one side (so that the chin is pointing toward the shoulder on the same side as the head is rotating) then, if pain free, to the other. If there is evidence of pain the patient should be immobilized.
6. With the head rotated back to its normal position, ask the patient to flex and extend their neck. If there is evidence of pain the patient should be immobilized.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

SPINAL IMMOBILIZATION PROCEDURE # 42

CLINICAL INDICATIONS:

- ✓ Need for spinal immobilization as determined by protocol
- ✓ Long spine boards(LSB) or scoop stretchers should only be used for extrication/ movement of the patient or during CPR as a firm surface, and patients placed directly on the cot maintaining in-line stabilization and minimal movement
- ✓ Spinal precautions should be maintained with the placement of a cervical collar, head blocks/towels, securing the patient tightly to the stretcher, manual inline-stabilization, and the log-roll technique, and use of slider boards or sheets
- ✓ Ambulatory patients who require spine precautions or patients who can self-extricate should be placed in a cervical collar and placed on the cot limiting spinal movement, and secured flat to the stretcher
- ✓ Patients with a ***penetrating injury should not be immobilized*** unless a hard focal neurologic deficit(numbness/weakness) is noted on exam
- ✓ Selective Spinal Immobilization with LSB may be used for:
  1. **Altered Mental Status, GCS<15**
  2. **Spinal deformity/tenderness**
  3. **Neurologic Deficits(Numbness/Weakness)**
  4. **Intoxication**

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Gather a LSB, equipment, and C-collar appropriate for patient's size
2. Explain the procedure to the patient
3. Place the patient in an appropriately sized C-collar while maintaining in-line stabilization of the C-Spine. This stabilization, to be provided by a second rescuer, should not involve traction or tension but rather simply maintaining the head in a neutral, midline position while the first rescuer applies the collar
4. Once the collar is secure, the second rescuer should still maintain their position to ensure stabilization (the collar is helpful but will not do the job by itself)
5. *First Responder shall place patient on long spine board if patient meets trauma criteria or for extrication purposes.* For all, if the patient is supine or prone, consider the log roll technique. For the patient in a vehicle or otherwise unable to be placed prone or supine, place them on a backboard by the safest method available that maximized maintenance of in-line stability
6. Stabilize the patient with straps and head rolls/tape or other similar device. Once the head is secured to the backboard, the second rescuer may release manual in-line stabilization. Extricate/move the patient to the cot, transferring the patient with minimal spinal movement and inline stabilization and secured to the cot with seatbelts/straps in a position of comfort
7. NOTE: Some patients, due to size or age, will not be able to be immobilized through in-line stabilization with standard backboards and C-collars. Never force a patient into a non-neutral position to immobilize them. Such situations may require a second rescuer to maintain manual stabilizations throughout the transport to the hospital
8. Document the time of the procedure in the patient care report (PCR)

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

SPLINTING
PROCEDURE # 43

CLINICAL INDICATIONS:

- ✓ Immobilization of an extremity for transport, either due to suspected fracture, sprain or injury
- ✓ Immobilization of an extremity for transport to secure medically necessary devices such as intravenous catheters

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Assess and document pulses, sensation, and motor function prior to placement of the splint. If no pulses are present and a fracture is suspected, consider reduction of the fracture prior to placement of the splint.
2. Remove all clothing from the extremity.
3. Select a site to secure the splint both proximal and distal to the area of suspected injury, or the area where the medical device will be placed.
4. Do not secure the splint directly over the injury or device.
5. Place the splint and secure with velcro straps, or bandage material (e.g., kling, kerlex, cloth bandage, etc.) depending on the splint manufacturer and design.
6. Document pulses, sensation, and motor function after placement of the splint. If there has been a deterioration in any of these 3 parameters, remove the splint and reassess.
7. If a femur fracture is suspected and there is no evidence of pelvic fracture or instability, the following procedure may be followed for placement of a femoral traction splint:
   - Assess neurovascular function as in #1 above.
   - Place the ankle device over the ankle.
   - Place the proximal end of the traction splint on the posterior side of the affected extremity, being careful to avoid placing too much pressure on genitalia or open wounds. Make certain the splint extends proximal to the suspected fracture. If the splint will not extend in such a manner, reassess possible involvement of the pelvis.
   - Extend the distal end of the splint at least 6 inches beyond the foot.
   - Attach the ankle device to the traction crank.
   - Twist until moderate resistance is met.
   - Reassess alignment, pulses, sensation, and motor function. If there has been deterioration in any of these 3 parameters, release traction and reassess.
8. Document the time, type of splint, and the pre and post assessment of pulse, sensation, and motor function in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

STROKE SCREEN: CINCINNATI PRE-HOSPITAL PROCEDURE # 44

CLINICAL INDICATIONS:

✓ Suspected Stroke Patient

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Assess and treat suspected stroke patients as per protocol.
2. The Cincinnati Stroke Screen should be completed for all suspected stroke patients, consisting of **Facial Droop, Arm Drift, and Abnormal Speech.**
3. Establish the "Time Last Normal" for the patient. This will be the presumed time of onset.
4. Perform the screen through physical exam:
   - Look for Facial Droop by asking the patient to smile
   - Have patient, while sitting upright or standing, extend both arms parallel to floor, close eyes, and turn their palms upward. Assess for unilateral drift of an arm
   - Assess Speech for inappropriate words, slurring, or mute
5. If one of these exam components if abnormal, it is considered a positive stroke screen. Document the finding on exam.
6. Evaluate **blood glucose** level results.
7. **If the "Last Know Well" is less than 24 hours, blood glucose is between 60 and 400, and at least one of the physical exam elements is positive, follow the EMS System Suspected Stroke Triage and Destination Plan, alerting the receiving hospital of a possible stroke patient as early as possible.**
8. All sections of the Cincinnati screen must be completed (Facial Droop, Arm Drift, and Speech
9. Document the exam, results, and destination in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

TEMPERATURE MEASUREMENT PROCEDURE # 45

CLINICAL INDICATIONS:

- ✓ Monitoring body temperature in a patient with suspected infection, hypothermia, hyperthermia, or to assist in evaluating resuscitation efforts

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. If clinically appropriate, allow the patient to reach equilibrium with the surrounding environment.
2. For adult patients that are conscious, cooperative, and in no respiratory distress, an oral temperature is preferred (steps 3 to 5 below). For infants or adults that do not meet the criteria above, a rectal temperature is preferred (steps 6 to 8 below).
3. To obtain an oral temperature, ensure the patient has no significant oral trauma and place the thermometer under the patient's tongue with appropriate sterile covering.
4. Have the patient seal their mouth closed around the thermometer.
5. If using an electric thermometer, leave the device in place until there is indication an accurate temperature has been recorded (per the "beep" or other indicator specific to the device). If using a traditional thermometer, leave it in place until there is no change in the reading for at least 30 seconds (usually 2 to 3 minutes). Proceed to step 9.
6. Prior to obtaining a rectal temperature, assess whether the patient has suffered any rectal trauma by history and/or brief examination as appropriate for patient's complaint.
7. To obtain a rectal temperature, cover the thermometer with an appropriate sterile cover, apply lubricant, and insert into rectum no more than 1 to 2 cm beyond the external anal sphincter.
8. Follow guidelines in step 5 above to obtain temperature.
9. Record time, temperature, method (oral, rectal), and scale (C^{o} or F^{o}) in Patient Care Report (PCR).

CETERFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

VENOUS ACCESS: EXISTING CATHETERS PROCEDURE # 46

CLINICAL INDICATIONS:

- ✓ Inability to obtain adequate peripheral access
- ✓ Access of an existing venous catheter for medication or fluid administration
- ✓ Central venous access in a patient in cardiac arrest

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Clean the port of the catheter with alcohol wipe.
2. Using sterile technique, withdraw 5-10 ml of blood and discard syringe in sharps container.
3. Using 5 cc of normal saline, access the port with sterile technique and gently attempt to flush the saline.
4. If there is no resistance, no evidence of infiltration (e.g., no subcutaneous collection of fluid), and no pain experienced by the patient, then proceed to step 5. If there is resistance, evidence of infiltration, pain experienced by the patient, or any concern that the catheter may be clotted or dislodged, do not use the catheter.
5. Begin administration of medications or IV fluids slowly and observe for any signs of infiltration. If difficulties are encountered, stop the infusion and reassess.
6. Record procedure, any complications, and fluids/medications administered in the Patient Care Report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

VENOUS ACCESS: EXTERNAL JUGULAR PROCEDURE # 47

CLINICAL INDICATIONS:

✓ External jugular vein cannulation is indicated in a critically ill patient ≥8 years of age who requires intravenous access for fluid or medication administration and in whom an extremity vein is not obtainable

LEGEND	
P	PARAMEDIC

PROCEDURE:

1. Place the patient in a supine head down position. This helps distend the vein and prevents air embolism.
2. Turn the patient's head toward the opposite side if no risk of cervical injury exists.
3. Prep the site as per peripheral IV site.
4. Align the catheter with the vein and aim toward the same side shoulder.
5. "Tourniqueting" the vein lightly with one finger above the clavicle, puncture the vein midway between the angle of the jaw and the clavicle and cannulate the vein in the usual method.
6. Attach the IV and secure the catheter avoiding circumferential dressing or taping.
7. Document the procedure, time, and result (success) on/with the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

VENOUS ACCESS: EXTREMITY
PROCEDURE # 48

CLINICAL INDICATIONS:

✓ Any patient where intravenous access is indicated (significant trauma or mechanism, emergent or potentially emergent medical condition)

LEGEND	
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Saline locks may be used as an alternative to an IV tubing and IV fluid in every protocol at the discretion of the ALS professional.
2. Providers can use intraosseous access where threat to life exists as provided for in the Venous Access: Intraosseous procedure.
3. Use the largest catheter bore necessary based upon the patient's condition and size of veins.
4. Fluid and setup choice is preferable:
   - ●Normal Saline with a macro drip (10 gtts/cc) for trauma or hypovolemia
   - ●Normal Saline with a macro drip (10 gtts/cc) for medical conditions, and
   - ●Normal Saline with micro drip (60 gtts/cc) for medication infusions
5. Inspect the IV solution for expiration date, cloudiness, discoloration, leaks, or the presence of particles.
6. Connect IV tubing to the solution in a sterile manner. Fill the drip chamber half full and then flush the tubing bleeding all air bubbles from the line.
7. Place a tourniquet around the patient's extremity to restrict venous flow only.
8. Select a vein and an appropriate gauge catheter for the vein and the patient's condition.
9. Prep the skin with an antiseptic solution.
10. Insert the needle with the bevel up into the skin in a steady, deliberate motion until the bloody flashback is visualized in the catheter.
11. Advance the catheter into the vein. **Never** reinsert the needle through the catheter. Dispose of the needle into the proper container without recapping.
12. Remove the tourniquet and connect the IV tubing or saline lock.
13. Open the IV to assure free flow of the fluid and then adjust the flow rate as per protocol or as clinically indicated.

    Rates are preferably:
    - ●Adult: KVO: 60 cc/hr (1 gtts/ 6 sec for a macro drip set)
    - ●Pediatric: KVO: 30 cc/hr (1 gtts/ 12 sec for a macro drip set)

    If Shock is present:
    - ●Adult: 500 cc fluid boluses repeated as long as lungs are dry and BP <90. Consider a second IV line.
    - ●Pediatric: 20 cc/kg boluses repeated PRN for poor perfusion up to three.
14. Cover the site with a sterile dressing and secure the IV and tubing.
15. Label the IV with date and time if able.
16. Document the procedure, time and result (success) on/with the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS system.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

VENOUS ACCESS: INTRAOSSEOUS PROCEDURE # 49

CLINICAL INDICATIONS:

- ✓ As the initial means of circulatory access in cardiac arrest
- ✓ Patients where rapid, regular IV access is unavailable with any of the following:
  1. Multisystem trauma with severe hypovolemia
  2. Severe dehydration with vascular collapse and/or loss of consciousness
  3. Respiratory failure/ Respiratory arrest

LEGEND	
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Fracture proximal to proposed intraosseous site
- ✓ History of Osteogenesis Imperfecta
- ✓ Current or prior infection at proposed intraosseous site
- ✓ Previous intraosseous insertion or joint replacement at the selected site

PROCEDURE:

1. Don personal protective equipment (gloves, eye protection, etc.).
2. **Humeral Head:** Place the patient palm on the umbilicus and elbow on the ground or stretcher. Use your thumb to identify humeral shaft, slide thumb towards humeral head with firm pressure. Locate tubercle by prominent bulge. Use the opposite hand to pinch inferior and anterior humerus ensuring that you are midline on the humerus.
   Proximal Tibia: Identify anteromedial aspect of the proximal tibia (bony prominence below the knee cap). The insertion location will be 1-2cm (2 finger widths) below this.
   Distal Tibia: If patient >12 years of age, identify the anteromedial aspect of the distal tibia (2cm proximal to the medial malleolus).
3. Prep the site with povidone-iodine or a chlorhexidine solution.
4. For manual pediatric devices, hold the intraosseous needle at a 60 to 90 degree angle, aimed away from the nearby joint and epiphyseal plate, twist the needle handle with a rotating grinding motion applying controlled downward force until a "pop" or "give" is felt indicating loss of resistance. Do not advance the needle any further.
5. For the EZ-IO intraosseous device, hold the intraosseous needle at a 60 to 90 degree angle, aimed away from the nearby joint and epiphyseal plate, power the driver until a "pop" or "give" is felt indicating loss of resistance. Do not advance the needle any further.
6. Remove the stylette and place in an approved sharps container.
7. Attach a syringe filled with at least 5 cc NS; aspirate bone marrow for manual devices only, to verify placement; then inject at least 5 cc of NS to clear the lumen of the needle.
8. Attach the IV line and adjust flow rate. A pressure bag may enhance flows.
9. Stabilize and secure the needle with dressings and tape.
10. You may administer 10 to 20 mg of lidocaine in adult patients who experience infusion-related pain. This may be repeated prn to a maximum of 60 mg.
11. Following administration of any other IO medications, flush the IO line with 10 cc of IV fluid.
12. Document the procedure, time, and result (success) on/ with the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

WELLNESS CHECK
PROCEDURE # 50

CLINICAL INDICATORS:

✓ When patient safety needs to be ensured for presumed non-urgent situations. These patients may be referred by other EMS providers or external entities

CONTRAINDICATIONS:

✓ Any patient for whom an emergency medical condition exists that would normally be treated under Trinity EMS System protocols

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Ensure scene safety and notify dispatch of location. When possible, remain available for high acuity calls.
2. Politely introduce yourself to the patient and family.
3. Determine the nature of the visit and record in PCR (diabetes, CHF, fall prevention, pediatric asthma, high-risk refusal follow-up, other).
4. Determine the name of the primary care physician.
5. Assist all patients with medication compliance. If pill minders or refills are needed, note this in the PCR. It is appropriate to communicate these needs to the primary care physician.
6. If the patient is diabetic, ensure daily blood glucose logs are being maintained. Asymptomatic patients with more than 2 consecutive blood glucose measurements above 350 should make contact with the primary care within 24 hours. If the blood glucose is above 500 or below 50, transport to the emergency department shall be recommended.
7. If the patient has CHF, ensure the patient has a scale and is performing weight checks. Asymptomatic patients with unexplained weight gain of more than 4 pounds should make contact with their primary care physician within 24 hours.
8. For patients with concern over fall prevention, ensure there are no loose rugs, handrails are present on all steps, and restrooms have hand rails and slip resistant surfaces in showers/tubs and communicate these issues to the patient/family.
9. For pediatric asthma patients, assure medications are available. If smoking in the home, encourage smoking cessation or outdoor smoking with the family.
10. For recently discharged patients or patients needing follow-up, review and verify needed appointments noting provider and specialty, date and time.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

WOUND CARE-GENERAL
PROCEDURE # 51

CLINICAL INDICATIONS:

✓ Protection and care for open wounds prior to and during transport

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. Use personal protective equipment, including gloves, gown, and mask as indicated.
2. If active bleeding, elevate the affected area if possible and hold direct pressure. Do not rely on “compression” bandage to control bleeding. Direct pressure is much more effective.
3. Once bleeding is controlled, irrigate contaminated wounds with saline as appropriate (this may have to be avoided if bleeding was difficult to control). Consider analgesia per protocol prior to irrigation.
4. Cover wounds with sterile gauze/dressings. Check distal pulses, sensation, and motor function to ensure the bandage is not too tight.
5. Monitor wounds and/or dressings throughout transport for bleeding.
6. Document the wound and assessment and care in the patient care report (PCR).

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director

WOUND CARE-TASER® PROBE REMOVAL PROCEDURE # 52

CLINICAL INDICATIONS:

- ✓ Patient with uncomplicated conducted electrical weapon (Taser®) probes embedded subcutaneously in non-sensitive areas of skin
- ✓ Taser probes are barbed metal projectiles that may embed themselves up to 13 mm into the skin

LEGEND	
T	EMT
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Patients with conducted electrical weapon (Taser®) probe penetration in vulnerable areas of body as mentioned below should be transported for further evaluation and probe removal
- ✓ Probes embedded in skin above level of clavicles, female breasts, or genitalia
- ✓ Suspicion that probe might be embedded in bone, blood vessel, or other sensitive structure

PROCEDURE:

1. Ensure wires are disconnected from weapon.
2. Stabilize skin around probe using non-dominant hand.
3. Grasp probe by metal body using dominant hand.
4. Remove probe in single quick motion.
5. Wipe wound with antiseptic wipe and apply dressing.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by EMS Medical Director 2020

WOUND CARE-TOURNIQUET PROCEDURE # 53

CLINICAL INDICATIONS:

- ✓ Life threatening extremity hemorrhage that can not be controlled by other means
- ✓ Serious or life threatening extremity hemorrhage and tactical considerations prevent the use of standard hemorrhage control techniques

LEGEND	
R	EMR
T	EMT
A	AEMT
P	PARAMEDIC

CONTRAINDICATIONS:

- ✓ Non-extremity hemorrhage
- ✓ Proximal extremity location where tourniquet application is not practical

PROCEDURE:

1. Place tourniquet proximal to wound.
2. Tighten per manufacturer instructions until hemorrhage stops and/or distal pulses in affected extremity disappear.
3. Secure tourniquet per manufacturer instructions.
4. Note time of tourniquet application and communicate this to receiving care providers.
5. Dress wounds per standard wound care protocol.
6. If delayed/prolonged transport or prolonged extrication and tourniquet application time over 2 hours contact medical control.
7. If the patient remains stable after 30 minutes of tourniquet time, EMS personnel may attempt to release the tourniquet (but leave in place in case reapplication is necessary). A pressure dressing should be applied to the wound prior to release.
8. Reassess bleeding and need for reapplication of tourniquet.
9. Document procedure, time, and complications in the PCR.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

TRINITY EMS SYSTEM SKILLS PROCEDURES

Approved by Trinity EMS Medical Director 2020

VACCINATION ADMINISTRATION PROCEDURE # 37

CLINICAL INDICATIONS:

✓ EMS providers are authorized to provide certain immunizations to assist in public health under the written order of the Medical Director

LEGEND	
A	AEMT
P	PARAMEDIC

PROCEDURE:

1. EMS providers will be informed of the effective dates of the vaccination program(start and end dates), agent to be administered, dosage and route(IM/ SQ/IN/PO), indications/contraindications, treatment of adverse reactions, precautions, and paperwork necessary for immunization.
2. EMS will ensure proper vaccine storage and security, adequate registration, screening, and education, vaccine administration and aftercare.
3. Register patients and obtain written consent, and in cases of minors/ dependents, the legal guardian. Include a screening questionnaire for contraindications in the patient registration. Inform recipients of potential adverse side effects and provide a Vaccine Immunization Statements(VIS) from the CDC at https://www.cdc.gov/vaccines/pubs/vis/
4. Patients will be provided with a vaccine card of the immunization, date, site address, administering provider, manufacturer, and lot number.
5. EMS shall record patient names, date, address site, immunization, manufacture and lot number, and adverse reactions in a Patient Care Report(PCR).
6. All adverse reactions should be reported to the Vaccine Adverse Event Reporting System(VAERS) at https://vaers.hhs.gov/index
7. Vaccines shall be administered following the manufacturers recommendations included in the packaging insert.
8. Monitor the patient for the desired therapeutic effects as well as any possible side effects.

CERTIFICATION REQUIREMENTS:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the EMS System.

Trinity EMS Medication Scope of Practice for Credentialed Personnel

Medication	EMR	EMT	AEMT	Paramedic
Acetaminophen			X	X
Adenosine				X
Albuterol	X	X	X	X
Amiodarone				X
Aspirin	X	X	X	X
Atropine			X	X
Calcium Chloride				X
Dextrose 25%			X	X
Dextrose 50%			X	X
Diazepam			X	X
Diphenhydramine			X	X
Dopamine				X
DuoDote®		X	X	X
DuoNeb®			X	X
Epinephrine 1:1,000	X[1]	X	X	X
Epinephrine 1:10,000			X	X
Etomidate				X[3]
Fentanyl			X	X
Glucagon		X	X	X
Glucose Oral	X	X	X	X
Lidocaine			X	X
Lorazepam			X	X
Magnesium Sulfate				X
Methylprednisolone				X
Midazolam			X	X
Morphine Sulfate			X	X
Naloxone	X	X	X	X
Nitroglycerin		X[2]	X	X
Normal Saline			X	X
Ondansetron			X	X
Oxygen	X	X	X	X
Rocuronium				X[3]
Sodium Bicarbonate				X
Succinylcholine				X[3]
Tranexamic Acid				X

EMS personnel at any level who administer medications must do so within an EMS system that provides medical oversight. Personnel must follow written treatment protocols and must complete appropriate medical education. All Trinity EMS System Guidelines, Procedures, and Policies are reviewed and approved by the Medical Director.

X[1] – EMR's may only administer Epinephrine 1:1,000 with auto-injector only
X[2] – EMT-B's may administer Nitroglycerin with IV in place only
X[3] – Only Paramedics approved by the system for RSI may direct administration of Etomidate, Rocuronium and Succinylcholine

Trinity EMS Procedure Scope of Practice for Credentialed Personnel

Procedure	EMR	EMT	AEMT	Paramedic
12 Lead EKG		X[1]	X	X
Airway: BIPAP				X
Airway: CPAP				X
Airway: ETCO2 Detector		X	X	X
Airway: Bougie				X[2]
Airway: Foreign Body	X	X	X	X
Airway: Intubation Nasotrachael				X
Airway: Intubation Orotracheal				X
Airway: King LTD/i-gel®		X	X	X
Airway: Nebulizer Therapy	X	X	X	X
Airway: RSI				X[2]
Airway: Respirator				X
Airway: Suctioning Advanced			X	X
Airway: Suctioning Basic		X	X	X
Airway: Surgical Cricothyrotomy				X
Airway: Tracheostomy Tube Change				X
Airway: Ventilator Operation				X
Arterial Line Maintenance				X
Assessment: Adult	X	X	X	X
Assessment: Pain	X	X	X	X
Assessment: Pediatric	X	X	X	X
Blood Glucose Analysis		X	X	X
Capnography		X	X	X
Cardiac: External Pacing			X	X
Cardiac: Internal Pacemaker Maintenance				X
CPR Automated		X	X	X
CPR Manual	X	X	X	X
Cardioversion			X	X
Chest Decompression/Needle			X	X
Chest Tube Maintenance				X
Childbirth	X	X	X	X

Trinity EMS Procedure Scope of Practice for Credentialed Personnel

Procedure	EMR	EMT	AEMT	Paramedic
Decontamination	X	X	X	X
Defibrillation: AED	X	X	X	X
Defibrillation: Manual			X	X
EKG Monitoring			X	X
Impedance Threshold Device		X	X	X
Injections: SQ and IM		X	X	X
IN Medication Administration	X	X	X	X
Pulse Oximetry	X	X	X	X
Restraints: Physical/ Chemical		X	X	X
Spinal Examination				X[3]
Spinal Immobilization	X	X	X	X
Splinting	X	X	X	X
Stroke Screen: Cincinnati		X	X	X
Temperature Measurement	X	X	X	X
Venous Access: Existing Catheters				X
Venous Access: External Jugular				X
Venous Access: Extremity			X	X
Venous Access: Intraosseous			X	X
Wellness Check		X	X	X
Wound Care - General	X	X	X	X
Wound Care - Taser®		X	X	X
Wound Care - Tourniquet	X	X	X	X

EMS personnel at any level who perform these skills must do so within an EMS system that provides medical oversight. Personnel must follow written treatment protocols and must complete appropriate medical education. All Trinity EMS System Guidelines, Procedures, and Policies are reviewed and approved by the Medical Director.

X[1] – EMT's may not monitor or interpret cardiac monitors or 12 lead EKG's
X[2] – Paramedics with approval from Trinity EMS System for Drug Assisted Intubation/RSI
X[3] – Paramedics with approval from Trinity EMS System may perform only in conjunction with the Spinal Immobilization Clearance Protocol

TRINITY EMS SYSTEM APPENDIX

APPROVED MEDICAL ABBREVIATIONS

A&O x 3	- alert and oriented to person, place, time
A&O x 4	- alert and oriented to person, place, time, event
A-FIB	- atrial fibrillation
AAA	- abdominal aortic aneurysm
ABD	- abdomen (abdominal)
ACLS	- advanced cardiac life support
AEMT	- Advanced Emergency Medical Technician
AKA	- above the knee amputation
ALS	- advanced life support
AMA	- against medical advice
APPROX	- approximately
ASA	- aspirin
ASSOC	- associated
BIAD	- blind insertion airway device
BG	- blood glucose
BILAT	- bilateral
BKA	- below the knee amputation
BLS	- basic life support
BM	- bowel movement
BP	- blood pressure
BS	- breath sounds
BTLS	- burns, tenderness, lacerations, swelling
BVM	- bag-valve-mask
C-SECTION	- caesarean section
C-SPINE	- cervical spine
C/O	- complains of (complaint of)
CA	- cancer
CABG	- coronary artery bypass graft
CAD	- coronary artery disease
CATH	- catheter
CC	- chief complaint
CHF	- congestive heart failure
CNS	- central nervous system
COPD	- chronic obstructive pulmonary disease

CP	- chest pain
CPR	- cardiopulmonary resuscitation
CSF	- cerebrospinal fluid
CT	- computed tomography
CVA	- cerebrovascular accident (stroke)
D5W	- 5% dextrose in water
DCAP	- deformities, contusions, abrasions, penetrations
DKA	- diabetic ketoacidosis
DNR	- do not resuscitate
DOA	- dead on arrival
DT	- delirium tremens
Dx	- diagnosis
ECG or EKG	- electrocardiogram
EEG	- electroencephalogram
EMR	- Emergency Medical Responder
EMT	- Emergency Medical Technician
ET	- endotracheal
ETA	- estimated time of arrival
ETOH	- ethanol (alcohol)
ETT	- endotracheal tube
EXT	- external or extension
FB	- foreign body
FLEX	- flexion
Fx	- fracture
g	- gram
GCS	- Glasgow Coma Scale
GI	- gastrointestinal
GSW	- gunshot wound
gtts	- drops
GU	- genitourinary
GYN	- gynecology (gynecological)

HA	- headache
HEENT	- head, eyes, ear, nose, throat
HR	- heart rate or hour
HTN	- hypertension
Hx	- history
ICP	- intracranial pressure
ICU	- intensive care unit
IM	- intramuscular
IV	- intravenous
JVD	- jugular vein distension
kg	- kilogram
KVO	- keep vein open
L-SPINE	- lumbar spine
L/S SPINE	- lumbosacral spine
L&D	- labor and delivery
LAT	- lateral
lb	- pound
LLQ	- left lower quadrant
LKW	- Last Known Well
LOC	- level of consciousness /loss of consciousness
LR	- lactated ringers
LUQ	- left upper quadrant
MAST	- military anti-shock trousers
MCA	- motorcycle accident
mcg	- microgram
MCI	- mass casualty incident
MED	- medicine
mg	- milligram

MI	- myocardial infarction (heart attack)
min	- minimum/minute
MVA/MVC	- motor vehicle accident/motor vehicle collision
N/V	- nausea/vomiting
N/V/D	- nausea/vomiting/diarrhea
NAD	- no apparent distress
NC	- nasal cannula
NEB	- nebulizer
NKDA (NKA)	- no known drug allergies (no known allergies)
NOAC	- new/novel oral anticoagulant
NRB	- non-rebreather
NS	- normal saline
NSR	- normal sinus rhythm
OB/GYN	- obstetrics/gynecology
PALP	- palpation
PAC	- premature atrial contraction
PE	- pulmonary embolus/physical exam
PERRL	- pupils equal, round, reactive to light
PERRLA	- pupils, equal, round, and reactive to light & accommodation
PMHx	- personal medical history
PO	- oral
PRB	- partial re-breather
PRN	- as needed
PT	- patient
PVC	- premature ventricular contraction
RLQ	- right lower quadrant
ROSC	- return of spontaneous circulation
RSI	- rapid sequence intubation
RUQ	- right upper quadrant

Rx	- prescription
S/P	- status post
SOB	- shortness of breath
SPO2	- pulse oximeter oxygen saturation
SQ	- subcutaneous
ST	- sinus tachycardia
SVT	-supraventricular tachycardia
S/S	- signs and symptoms
SZ	- seizure
T-SPINE	- thoracic spine
T	- temperature
TIA	- transient ischemic attack
TKO	- to keep open (IVs – may also use KVO)
Tx	- treatment
URI	- upper respiratory infection
UTI	- urinary tract infection
VAD	-Ventricular Assist Device
VF/Vfib	- ventricular fibrillation
VS	- vital signs
VT/Vtach	- ventricular tachycardia
WAP	- wandering atrial pacemaker
WNL	- within normal limits
YO/YOA	- years old/years of age
M or ♂	- male
F or♀	- female
Ø	- none
+	- positive
-	- negative

?	- questionable
Ψ	-psychiatric
~	- approximately
›	- greater than
≥	- greater than or equal to
‹	- less than
≤	- less than or equal to
=	- equal
↑	- increased (upper)
↓	- decreased (lower)
Δ	- change
L	- left
R	- right
1º	- primary
2º	- secondary

TRINITY EMS SYSTEM APPENDIX
APGAR SCORE

The Apgar score should be obtained and recorded at 1 and at 5 minutes with the birth of delivery of any infant.

- ✓ Each of the 5 parameters should be scored and then totaled
- ✓ The Minimum score is 0
- ✓ The Maximum score is 10

APGAR is the acronym for **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, and **R**espiration

SIGN	0	1	2
HEART RATE	ABSENT	< 100	> 100
RESPIRATORY RATE	ABSENT	WEAK CRY	STRONG CRY
MUSCLE TONE	LIMP	SOME FLEXION	GOOD FLEXION
REFLEX IRRITABILITY (WHEN FEET STIMULATED)	NO RESPONSE	SOME MOTION	CRY
COLOR	BLUE/PALE	BODY PINK/ EXT BLUE	PINK

TRINITY EMS SYSTEM APPENDIX

BURN RESOURCES/GUIDELINES

FORMULA FOR FLUID RESUSCITATION OF THE BURN PATIENT (ALSO KNOWN AS THE PARKLAND FORMULA)

Patient's weight x TBSA x 4 ml NS infused over 24 hours with half given in the first 8 hours

(For the equation, the abbreviations are PW x TBSA x 4 ml)

EMS focuses on the care given during the first hour or several hours following the event. Thus the formula as adapted for EMS and the first 8 hours is:

PW X TBSA X 4 ML ÷ 2

To take this hourly rate, divided the solution by 8 and the equation becomes:

PW x TBSA x 4 ÷ 2 ÷ 8 = total to be infused for each of the first 8 hours

Another way to state the equation is to use:

PW x TBSA x 0.25 ml = total to be infused for each hour of the first 8 hours

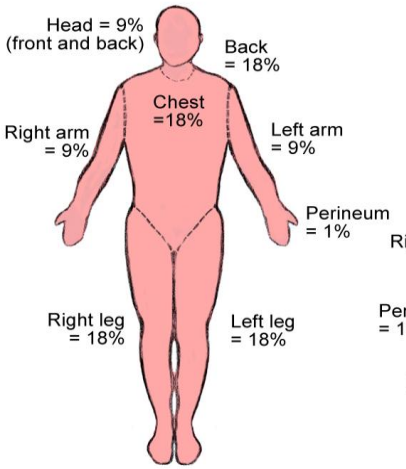
Example: 80 kg patient with 50% TBSA x 0.25 ml = 1000 ml

Remember:
Patient's weight in kg (2.2 lbs. = 1 kg)
220 lb. adult = 100 kg

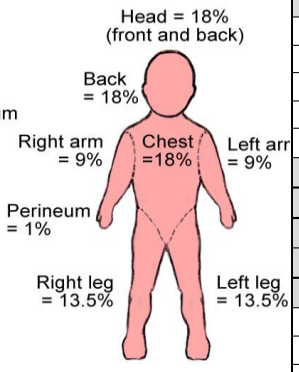
%TBSA = Rule of Nine Total Body Surface Area

Factor for 1st hour and each hour for the first 8 hours = 0.25

Reminder: If two IVs are running, divide the total amount to be infused each hour by 2



Adult



Child

Wt (kg)	% TBSA	Factor	/Hr for 1st 8 Hrs of Care	60 gtt set, gtt/ min	20 gtt set, gtt/ min	15 gtt set, gtt/ min	10 gtt set, gtt/ min
10	10	0.25	25	25	8.3	6.3	4.2
10	20	0.25	50	50	16.7	12.5	8.3
10	30	0.25	75	75	25.0	18.8	12.5
10	40	0.25	100	100	33.3	25.0	16.7
10	50	0.25	125	125	41.7	31.3	20.8
20	10	0.25	50	50	16.7	12.5	8.3
20	20	0.25	100	100	33.3	25.0	16.7
20	30	0.25	150	150	50.0	37.5	25.0
20	40	0.25	200	200	66.7	50.0	33.3
20	50	0.25	250	250	83.3	62.5	41.7
30	10	0.25	75	75	25.0	18.8	12.5
30	20	0.25	150	150	50.0	37.5	25.0
30	30	0.25	225	225	75.0	56.3	37.5
30	40	0.25	300	300	100.0	75.0	50.0
30	50	0.25	375	375	125.0	93.8	62.5
40	10	0.25	100	100	33.3	25.0	16.7
40	20	0.25	200	200	66.7	50.0	33.3
40	30	0.25	300	300	100.0	75.0	50.0
40	40	0.25	400	400	133.3	100.0	66.7
40	50	0.25	500	500	166.7	125.0	83.3
50	10	0.25	125	125	41.7	31.3	20.8
50	20	0.25	250	250	83.3	62.5	41.7
50	30	0.25	375	375	125.0	93.8	62.5
50	40	0.25	500	500	166.7	125.0	83.3
50	50	0.25	625	625	208.3	156.3	104.2
60	10	0.25	150	150	50.0	37.5	25.0
60	20	0.25	300	300	100.0	75.0	50.0
60	30	0.25	450	450	150.0	112.5	75.0
60	40	0.25	600	600	200.0	150.0	100.0
60	50	0.25	750	750	250.0	187.5	125.0
70	10	0.25	175	175	58.3	43.8	29.2
70	20	0.25	350	350	116.7	87.5	58.3
70	30	0.25	525	525	175.0	131.3	87.5
70	40	0.25	700	700	233.3	175.0	116.7
70	50	0.25	875	875	291.7	218.8	145.8
80	10	0.25	200	200	66.7	50.0	33.3
80	20	0.25	400	400	133.3	100.0	66.7
80	30	0.25	600	600	200.0	150.0	100.0
80	40	0.25	800	800	266.7	200.0	133.3
80	50	0.25	1000	1000	333.3	250.0	166.7
90	10	0.25	225	225	75.0	56.3	37.5
90	20	0.25	450	450	150.0	112.5	75.0
90	30	0.25	675	675	225.0	168.8	112.5
90	40	0.25	900	900	300.0	225.0	150.0
90	50	0.25	1125	1125	375.0	281.3	187.5
100	10	0.25	250	250	83.3	62.5	41.7
100	20	0.25	500	500	166.7	125.0	83.3
100	30	0.25	750	750	250.0	187.5	125.0
100	40	0.25	1000	1000	333.3	250.0	166.7
100	50	0.25	1250	1250	416.7	312.5	208.3

CRITICAL (RED)

>15% TBSA 2nd/3rd Degree Burn
Burns with multiple trauma
Burns with definitive airway compromise

SERIOUS (YELLOW)

5-15% TBSA 2nd/3rd Degree Burn
Suspected inhalation injury or requiring intubation for airway stabilization
Hypotension or GCS<14

MINOR (GREEN)

<5% TBSA 2nd/3rd Degree Burn
No inhalation injury
Not intubated
Normotensive
GCS>14

TRINITY EMS SYSTEM APPENDIX
DIFFICULT AIRWAY EVALUATION

Evaluating for the difficult airway

Nearly 1% of patients who require endotracheal intubation have airways that make intubation difficult, and around 1% will have failed intubation attempts. Recognizing those patients who may have a difficult airway allows the paramedic to proceed with systematic approach and prevent foreseeable complications. It also allows the paramedic to prepare additional equipment (such as a cricothyrotomy kit or BIAD). The pneumonic **LEMON** is useful in evaluating patients for signs that may be consistent with a difficult airway and should raise the paramedic's index of suspicion, and the use of RSI may be discouraged if the airway is predicted to pose difficulty in intubation.

Look externally

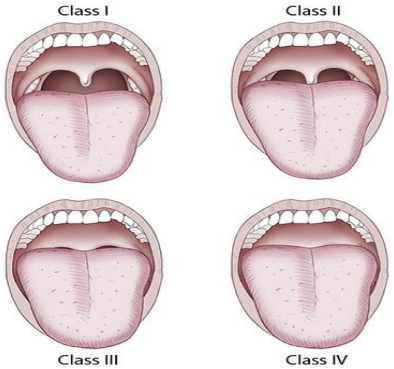
External indicators of either difficult intubation or difficult ventilation include: presence of a beard or moustache, abnormal facial shape, extreme cachexia, edentulous mouth, facial trauma, obesity, large front teeth or "buck teeth", high arching palate, receding mandible, short bull neck.

Evaluate 3-3-2 Rule

3 fingers between the patient's teeth (patient's mouth should open adequately to permit three fingers to be placed between the upper and lower teeth)
3 fingers between the tip of the jaw and the beginning of the neck (under the chin)
2 fingers between the thyroid notch and the floor of the mandible (top of the neck)

Mallampati

This scoring system is based on the work of Mallampati et al published in the Canadian Anaesthesia Society Journal in 1985. The system takes into account the anatomy of the mouth and the view of various anatomical structures when the patient opens his mouth as wide as possible. This test is performed with the patient in the sitting position, the head held in a neutral position, the mouth wide open, and the tongue protruding to the maximum. Inappropriate scoring may occur if the patient is in the supine position (instead of sitting), if the patient phonates or if the patient arches his or her tongue.



Class 1: Full visibility of tonsils, uvula and soft palate
Class 2: Visibility of hard and soft palate, upper portion of tonsils and uvula
Class 3: Soft and hard palate and base of the uvula are visible
Class 4: Only Hard Palate visible

Obstruction?

Besides the obvious difficulty if the airway is obstructed with a foreign body, the paramedic should also consider other obstructers such as tumor, abscess, epiglottis, or expanding hematoma.

Neck Mobility

Ask the patient to place their chin on their chest and to tilt their head backward as far as possible. Obviously, this will not be possible in the immobilized trauma patient.

TRINITY EMS SYSTEM APPENDIX
RAPID SEQUENCE INTUBATION AUDIT FORM

THE RAPID SEQUENCE INTUBATION FORM IS TO BE COMPLETED FOR ALL RAPID SEQUENCE INTUBATIONS/ DRUG ASSISTED INTUBATIONS EITHER SUCCESSFUL OR UNSUCCESSFUL. IT IS A PEER REVIEW, CONFIDENTIAL DOCUMENT THAT MUST BE COMPLETED AND SUBMITTED TO MAINTAIN APPROVAL FOR RSI IN THE TRINITY EMS SYSTEM .

PATIENT DEMOGRAPHICS:

DATE:_____
EMS AGENCY_____
PARAMEDIC_____
PATIENT AGE:_____
CHIEF COMPLAINT:_____

MAY PLACE PATIENT STICKER HERE

INDICATION FOR INTUBATION:

- ❑ APNEA/AGONAL RESPIRATIONS
- ❑ ABSENT GAG REFLEX/PROTECTIVE AIRWAY MECHANISMS
- ❑ INADEQUATE VENTILATION/OXYGENATION
- ❑ INJURY OR ILLNESS INVOLVING AIRWAY
- ❑ OTHER_____

PRE-RSI VITAL SIGNS:

BLOOD PRESSURE:_____
HEART RATE:_____
RESPIRATORY RATE:_____
PULSE OXIMETRY:_____
GCS:

EYE:	O (1) NONE	O (2) PAIN	O (3) VOICE	O (4) SPONTANEOUS		
VERBAL:	O (1) NONE	O (2) INCOMPREHENSIBLE	O (3) INAPPROPRIATE	O (4) CONFUSED	O (5) ORIENTED	
MOTOR:	O (1) NONE	O (2) EXTENSION	O (3) FLEXION	O (4) WITHDRAWALS	O (5) LOCALIZES	O (6) OBEYS

MEDICATIONS ADMINISTERED:

- ❑ LIDOCAINE
- ❑ FENTANYL
- ❑ ETOMIDATE
- ❑ SUCCINYLCHOLINE
- ❑ ROCURONIUM
- ❑ OTHER_____

ADJUVANT THERAPY:

- ❑ HIGH FLOW NASAL CANNULA O2
- ❑ SELLICK'S MANEUVER
- ❑ BOUGIE
- ❑ BURP MANEUVER
- ❑ BIMANUAL LARYNGOSCOPY
- ❑ IN-LINE C-SPINE IMMOBILIZATION

INTUBATION:

BLADE: MACINTOSH (CURVED) / MILLER (STRAIGHT)
ENDOTRACHEAL TUBE SIZE:_____
NUMBER OF ATTEMPTS (INSERTION PAST TEETH): _____
DEPTH AT TEETH:_____
CONFIRMATION: BREATH SOUNDS/ ETCO2

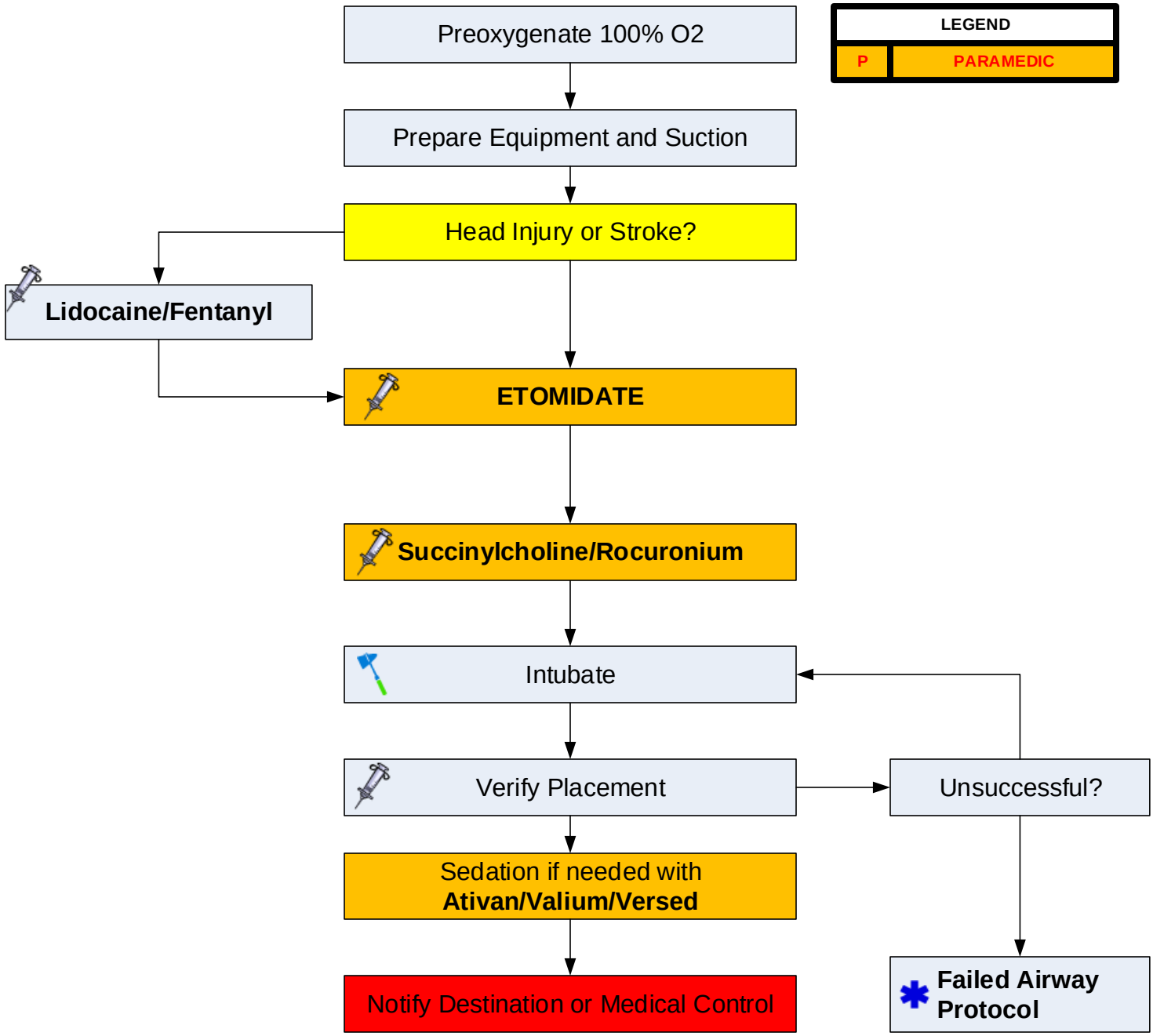
COMPLICATIONS:

- ❑ FAILED INTUBATION ATTEMPTS
- ❑ INJURY OR TRAUMA TO PATIENT
- ❑ ESOPHAGEAL INTUBATION
- ❑ ADVERSE DRUG REACTION
- ❑ DISLODGED TUBE
- ❑ RESCUE: BIAD/ CRICOTHYROTOMY
- ❑ OTHER_____

SUGGESTIONS FOR IMPROVEMENT: _____

TRINITY EMS SYSTEM APPENDIX

RAPID SEQUENCE INTUBATION FLOW CHART



PEARLS

- ✓ This flow chart is a visual aid for the RSI Procedure
- ✓ Intubations are only allowed in patients 9 years of age and older, on average 4 ft. and 50 lbs.
- ✓ Paralysis means you are responsible for the airway...Be Cautious at all times!!!
- ✓ Continuous wave form capnography is strongly recommended for all intubated patients
- ✓ Continuous pulse oximetry is required for all intubated patients
- ✓ At least two Paramedics are required for this procedure, with one being RSI certified by the Medical Director and Trinity EMS System
- ✓ Secure the ETT and patient to prevent dislodgement of ETT
- ✓ All RSI's performed should have an Audit form completed and submitted to the Trinity EMS System