References: National EMS Scope of Practice Model 2018; Illinois EMS Scope of Practice Model 2019; Illinois EMS Act, EMS Rules Section 515.550 Amended at 43 Ill. Reg. 4145, effective March 19, 2019; Region IX SOPs (2019) and NWC EMSS SOP effective 6/1/19; NWC EMSS Procedure Manual

I. POLICY

A. Assessments and initial interventions shall be performed on all pts at the point of contact unless it is unsafe, as circumstances allow, and the patient consents. Monitoring & intervention equipment/devices for EMS personnel to function to their level of licensure, in accordance with the level of service at which the EMS vehicle is operating must be brought to the patient so complete information is obtained that will allow treatment at the appropriate level of care without delay. Perform resuscitative interventions during the primary assessment as impairments are found.

B. Care should progress from BLS to ALS as required by patient condition, practitioner scope of practice, level of service, and System policy/procedure (2019 SOP IMC).

C. Appropriate patient disposition shall occur in compliance with System standards of care.

D. If a scene response, a reasonable search must be completed to determine if a patient is present – See policy A-1 (Abandonment) for full definition of a patient.

E. This policy shall be used as a guideline and should be used in conjunction with good common sense, emergency responder judgment, and/or OLMC direction.

II. DEFINITIONS

A. **BASIC LIFE SUPPORT (BLS) SERVICES**

Basic Life Support or BLS Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes medical monitoring, clinical observation, airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in the National EMS Education Standards relating to Basic Life Support and any modifications to that curriculum or standards specified in this Part. (Section 3.10(c) of the Act)

B. **ADVANCED LIFE SUPPORT (ALS) SERVICES**

Advanced Life Support Services or ALS Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the National EMS Education Standards relating to Advanced Life Support and any modifications to that curriculum or those standards specified in this Part. (Section 3.10(a) of the Act)

C. **Emergency Medical Technician** or EMT (AKA EMT-B) – *a person who has successfully completed a course in basic life support as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by* the *Act and* this Part *and practices within an EMS System.* (Section 3.50(a) of the Act)

D. **Paramedic** – *a person who has successfully completed a course in advanced life support care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)*

E. **Pre-Hospital Care Participants** – *Any EMS Personnel, Ambulance Service Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS Administrative Director, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN, Resource Hospital, Emergency Dispatch Center or*

physician serving on an ambulance or non-transport vehicle or giving voice orders for an EMS System and who are subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

F. **Pre-Hospital Registered Nurse or PHRN** – *a Registered Professional Nurse, with an unencumbered Registered Nurse license in the state in which he or she practices who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma or pediatric programs, the professional shall have an unencumbered license in the state in which he or she practices.*

III. SCOPES OF PRACTICE: Licensed EMTs/PHRNs

A. *Any person currently licensed as an EMT, EMT-I, A-EMT or Paramedic may only perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in this Part, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System. The Director may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not to exceed 180 days. (Section 3.55(a) of the Act)*

B. *An EMR, EMT, EMT-I, A-EMT or Paramedic may only practice as an EMR, EMT, EMT-I, A-EMT or Paramedic or utilize his or her EMR, EMT, EMT-I, A-EMT or Paramedic license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction of the EMS MD. For purposes of this Section, a "pre-hospital emergency care setting" may include a location, that is not a health care facility, which utilizes EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMT, EMT-I, A-EMT or Paramedic's level of care, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS MD. (EMS Rules, 2019)*

C. *This does not prohibit an EMR, EMT, EMT-I, A-EMT or Paramedic from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS MD. This also does not prohibit an EMT, EMT-I, A-EMT or Paramedic from seeking credentials other than his or her EMT, EMT-I, A-EMT or Paramedic license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer. (Section 3.55(b) of the Act)*

D. **An individual may only perform a skill or role for which that person is:**

EDUCATED (has been trained to perform the skill or role), **AND**
CERTIFIED (has demonstrated competence in the skill or role), **AND**
LICENSED (has legal authority issued by the State to perform the skill or role), **AND**
CREDENTIALED (has been authorized by medical director to perform the skill or role)
(National EMS Scope of Practice Model, 2018).

E. EMTs, Paramedics, and PHRNs with System privileges in good standing may perform **BLS Services** as defined by The National EMS Scope of Practice Model (2018), IDPH, EMS Rules, the NWC EMSS SOPs (2019) (see attached), and/or this policy using techniques specified in System standards of practice (Procedure Manual).

1. **BLS Monitoring**
   a. Apply an appropriate pulse oximetry sensor and interpret the findings.
   b. Apply $ETCO_2$ sensors
2. **BLS Airway/ventilatory management**
   a. BLS airway access: position, OPA/NPA
   b. Obstructed airway maneuvers
   c. BLS Rescue Breathing Techniques (Ntl Scope of Practice Model)
   d. Oral suctioning
   e. Tracheal-bronchial suctioning of an already intubated pt.
   f. They are considered skilled assistants when an advanced airway is necessary and may perform lip retraction and anterior laryngeal pressure, but are not authorized to perform the procedure
   g. O_2: NC, mask, NRM, BVM; BiPAP, CPAP, PEEP
   h. Occlusive dressing applied to a penetrating chest wound
3. **BLS Circulatory/cardiac management; vascular access**
   a. High perfusion CPR
   b. Use of a mechanical CPR Device (approved devices only)
   c. Use of telemetric monitoring devices/transmission of clinical data, including video data
   d. Control external bleeding using direct pressure, pressure dressings, hemostatic dressings and/or a tourniquet; wound/burn care with dressings and bandages
   e. Use an AED if available pending an ALS response. AEDs are required on BLS vehicles or BLS MedEngines included in the EMS System plan. *EMS Personnel who have successfully completed a Department-approved course in automated external defibrillator operation and who are functioning within a Department-approved EMS System may use an automated external defibrillator according to the standards of performance and conduct prescribed by the Department in this Part, and the requirements of the EMS System in which they practice, as contained in the approved Program Plan for that System. (Section 3.55(a-5) of the Act)*
   f. Application of 3-5 leads for ECG rhythm analysis
   g. 12 L ECG acquisition & transmission/submission to OLMC if available
   h. They may not perform venous access but they may assist in preparing the IV solution and priming the tubing under the supervision of a paramedic.
4. **BLS Psychomotor skills**
   a. Obtain and interpret a blood pressure reading (manual and automated)
   b. Obtain and interpret a capillary blood glucose reading
   c. Contact lens removal
   d. Monitoring of OG/NG tube already inserted
   e. Spine motion restriction
   f. Splinting/bandaging
   g. Vaginal delivery
   h. Measurement of a child using a length-based tape
   i. Application of mechanical restraints pending an ALS response
   j. Eye irrigation; eye patching, and stabilization of an impaled object in the eye pending an ALS response
   k. Assist an imminent vaginal delivery pending an ALS response
   l. Use of approved infant and child restraint systems for safe transport

5. **BLS Medications**
   a. Oral aspirin for chest pain of suspected ischemic origin
   b. Oral over the counter (OTC) analgesics (acetaminophen) for pain or fever if available
   c. Albuterol and ipratropium nebulized
   d. Calcium gluconate gel to a hydrofluoric acid burn pending an ALS response (optional per agency)
   e. Diphenhydramine PO
   f. Epinephrine (1mg/1mL) IM from vial
      An EMT, EMT-I, A-EMT or Paramedic who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine with him or her as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System. (Section 3.55 (a-7) of the Act)
   g. Glucagon IM or IN
   h. Oral glucose source for suspected hypoglycemia
   i. Mark I or DuoDote autoinjector antidotes for chemical/hazardous material exposure
   j. Naloxone IN & IM
   k. NTG sublingual for suspected acute ischemic chest pain
   l. Ondansetron ODT

6. The NWC EMSS does not use activated charcoal or glucose gel

F. **Paramedics (PMs) or Prehospital RNs (PHRNs)** with System privileges in good standing may perform all BLS and ALS Services as defined by The National EMS Scope of Practice Model (2018), IDPH, Illinois EMS Act and Rules, the NWC EMSS SOPs (2019) (see attached), and/or this policy using techniques specified in System standards of practice (Procedure Manual). If a patient requires any additional drugs, solutions, additives, or appliances a qualified healthcare professional must accompany the patient. **The following are considered ALS Services/care:**

1. **Advanced airway access**: Intubation by all approaches listed in the procedure manual; approved extraglottic airway; and needle and surgical cricothyrotomy
2. Use a bougie to facilitate videolaryngoscopy intubation and surgical cricothyrotomy
3. Insert an approved tube into the gastric access port of a KING LTS-D and/or i-gel to assist in stomach decompression
4. Removal of airway FB with Magill forceps
5. **Quantitative waveform capnography**: Confirm advanced airway placement, interpret adequacy of ventilation, perfusion, and metabolism
6. **Suction**: Oral and tracheal
7. **O_2 delivery**: automated transport ventilators as approved
8. Needle pleural decompression
9. **Vascular access**: Peripheral veins; AV shunt if that is the only site available and the patient is unstable; IO access of tibia or proximal humerus using the EZ-IO driver on adults and children. If peripheral IV unsuccessful / not advised, may use central venous access devices already placed based on OLMC. May administer approved IV fluids or cap line in a saline lock.
10. ECG rhythm and 12 lead interpretation
11. Synchronized cardioversion, defibrillation, transcutaneous pacing
12. Removal of taser probes per SOPs
13. Administration of vaccines as authorized by IDPH and the EMS MD

14. ALS Drugs/solutions as listed below.

ALS Drugs/Solutions	Acceptable routes
Normal saline (0.9% NaCl)	IV, IO
*Lactated Ringers solution	IV, IO
*D_5W, D5/.45 NS; D5/.9 NS; D5/LR	IV/IO
Adenosine	IVP, IO
Amiodarone	IVP, IVPB (IO if no IV accessible)
Aspirin (ASA)	PO
Atropine	IVP, IO
*Cardizem (diltiazem)	IVP, IO
Dextrose 10%	IVPB (may connect onto an IO line)
Diazepam	IVP/IO/IR
Diphenhydramine	IVP, IM, IO
Dopamine (alternate drug)	IVPB
Epinephrine 1mg/10mL (mixed for push-dose EPI based on OLMC)	IVP, IO, nebulized
Epinephrine 1mg/1mL	IM
Etomidate	IVP: IO if responsive & no IV)
Fentanyl	IVP/IO/IN/IM
*Furosemide	IVP/ IM/IO
Glucagon	IVP/IO/IM
*Heparin on a medication pump	IV pump
Ketamine	IVP/IN/IM (IO if responsive & no IV)
Ketorolac tromethamine injection (alternate)	IVP, IM
Lidocaine	IO (IVP OLMC)
Magnesium sulfate	IVP, IVPB, IO
Midazolam	IVP/IO/IN/IM
Morphine sulfate (alternate)	IVP, IM, IO, PCA pump
Naloxone	IVP, IO
Nitroglycerin (all indications)	SL, spray, transcutaneous, IV on pump
Nitrous oxide (Opt)	Inhaled
Norepinephrine	IVPB (may connect onto an IO line)
Ondansetron	IVP
Sodium bicarbonate	IVP, IO
*Steroids (Ex: methylprednisolone)	IVPB, nebulized
Tetracaine ophthalmic solution	topical gtts to eye
Verapamil	IVP/IO
*Vitamin additives to an IV	Added to IV solution

Medications noted with an * are not included in the SOPs and must be administered per transferring physician's written directions and OLMC authorization.

"Any drug listed in the SOPs and/or above that has a current abbreviation of "IV", "IVP", or "IVPB" may be transported on an IV pump by a system paramedic(s) without the assistance of a RN as long as that paramedic(s) have been trained/competencies on that IV pump"

15. **PMs/PHRNs ARE authorized to monitor and/or transport patients with the following:**

    a. Multilumen central line catheters (Hickman, Broviac); peripherally Inserted Central Catheters (PICC): (may not insert; may access based

on OLMC order). EMS personnel may NOT access surgically implanted medication delivery systems such as Portacath, Medi-port, or LAS Port®.

b. Indwelling urinary catheters (may not insert)
c. Long-term feeding tubes: Gastrostomy tube (GT) or Jejunostomy tube (JT)
d. Tracheotomy tube (may insert new tube if existing tube becomes fully dislodged; may remove and reinsert inner cannula to clear obstruction)
e. Surgical drains (may not access or manipulate)
f. Ventricular shunts (may not access or manipulate)
g. Ventricular assist devices – Always notify the VAD pager/Coordinator before any interventions. See SOP.
h. Insulin pumps (may not access or manipulate)

16. **Paramedics, without Critical Care Paramedic certification, are NOT authorized to perform and/or independently monitor/transport patients with the following:**

a. Chest tubes; arterial lines
b. Intra-aortic balloon pumps; hemodynamic monitoring catheters (CVP/Swan-Ganz);
c. Ventilators (other than those approved on Drug & Supply list);
d. Blood or blood products infusing
e. Fetal monitoring: internal or external;
f. Intracranial pressure monitors; or
g. Cervical traction devices (Garner-Wells tongs, halo devices, etc.)

17. Paramedics without Critical Care Paramedic certification are NOT authorized to independently transport critically ill neonates in isolettes.

Patients with the appliances/devices or transport needs as listed in 16 and 17 must be accompanied by a qualified nurse, physician, respiratory therapist, and/or perfusionist unless the PM has Critical Care certification and an expanded scope of practice and is authorized to provide that care by the EMS MD.

18. **PMs are NOT authorized to perform the following:**

a. Bimanual vaginal exams
b. Rectal exams

G. *A student enrolled in a Department-approved EMS Personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the System and the Department, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified RN or a qualified EMS Personnel, only when authorized by the EMS MD. (Section 3.55(d) of the Act)*

H. After appropriate agency plan submission, education, credentialing, and approval by IDPH and the EMS MD, EMTs and paramedics may be authorized to provide healthcare using patient-centered, mobile resources in the out-of-hospital environment that may include, but not be limited to, services such as conducting safety and wellness checks, providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care locations, not limited to hospital emergency departments.

IV. **INITIATION OF ALS and BLS Services / CARE**

A. Upon arrival at the scene, all EMS responders are to follow system SOPs with respect to responder safety, patient access, recognition and abatement of risk, application of personal protective devices/body substance isolation, patient assessment and initial interventions.

B. **The EMS MD has determined that the following minimum equipment should be taken with EMS personnel to the patient for use at point of patient contact:**

1. Assessment tools: Stethoscope, light source, BP cuff, glucose meter
2. Airway bag consistent with the responder's scope of practice. Ex. All responders should bring oral and nasal airways, suction and the ability to monitor pulse oximetry and $ETCO_2$. An ALS response should bring full advanced airway equipment.
3. Oxygen delivery and ventilatory devices (appropriate for scope of practice) and at least one cylinder (D or E) of oxygen filled to at least minimum inventory requirements. Two oxygen sources preferred when advanced airway insertion and/or cardiac arrest resuscitation is indicated.
4. Open chest wound vented/channeled dressings and bleeding control supplies and equipment
5. **BLS response**: AED
6. **ALS response**: Monitor/defibrillator capable of noninvasive BP (MAP) monitoring; SpO_2 and $EtCO_2$ monitoring; 12 L transmission capability and at least one set of pace/defib pads; real-time CPR feedback device/capability.
7. **ALS response**: Vascular access and IV fluid supplies and equipment
8. **ALS & BLS response**: Drugs as specified in scope of practice.
9. Patient conveyance equipment/spine motion restriction devices if indicated
10. EMS Providers may expand on this minimum point of care response requirement as they find practical or necessary based on preliminary dispatch information.

C. **INITIATION OF BLS Services/CARE**

Provided that scene safety is confirmed, BLS care **shall be initiated at the point of patient contact per the SOPs** for all patients requiring interventions consistent with the definition of BLS service per EMS Rules and this policy. Patients requiring the initiation of BLS care (that may or may not require further ALS interventions) may include, but not be limited to, the following:

1. Initial assessment findings within normal limits or not requiring ALS interventions.
2. Patients with an impaired airway requiring positioning, suctioning, and BLS adjuncts
3. Hypoxic patients requiring supplemental oxygen where hypoxia can be reversed by BLS O_2 delivery devices and not requiring ALS interventions per SOP
4. Hypoventilating or apneic patients that require ventilations per BVM pending an ALS response
5. Need to convert an open pneumothorax to closed
6. Patients in cardiac or respiratory arrest pending an ALS response
7. Bleeding controllable by direct pressure, hemostatic dressings and/or tourniquet and not requiring venous access and fluid resuscitation
8. Patients with altered mental status (AMS) and S&S consistent with opiate OD requiring administration of naloxone pending an ALS response

9. Patients with AMS and S&S consistent with hypoglycemia requiring administration of glucagon (pending an ALS response)
10. Patients with severe nausea requiring administration of ondansetron via ODT.
11. Patients with severe allergic reaction/anaphylaxis requiring administration of IM epinephrine per SOP pending an ALS response
12. Patients with mild respiratory distress and wheezing with a history of asthma or COPD requiring inhaled bronchodilators.
13. Isolated musculoskeletal trauma and soft tissue trauma requiring basic wound care and splinting pending an ALS response for pain management
14. Patients with suspected acute spine injury requiring extrication and/or selective spine motion restriction pending an ALS response
15. Childbirth and newborn care pending an ALS response
16. Acute illness or trauma without systemic implications and presenting in minimal distress
17. Long-term (chronic) diseases without new or acute distress

D. **INITIATION OF ALS Services/CARE**

1. Provided that scene safety is confirmed, any patient with an actual or potential life-threatening condition or one requiring ALS services shall have the following assessments/interventions initiated/attempted, **if indicated**, **at the point of patient contact prior to removal** to the ambulance:
   a. Advanced airway access per System procedure if needed unless further attempts are contraindicated
   b. O_2 per transport ventilators unless contraindicated, pleural decompression
   c. **Cardiac arrest management**: System recommends at least 5 EMS responders (combination of EMTs and PMs) for each cardiac arrest worked at the ALS level using the Pit Crew approach.
   d. **ECG rhythm/12 L interpretation/synchronized cardioversion/ defibrillation/pacing**. See SOP for details.
   e. **Vascular access** if actual/potential volume replacement and/or IV medications needed immediately. Vascular access should generally be performed enroute on patients meeting criteria for transport to a Level I or Level II Trauma Center as specified in the SOPs.
   f. **First line medications**: adenosine, albuterol, amiodarone, ASA, atropine, calcium gluconate gel (if available), diphenhydramine, etomidate, fentanyl, ketamine, ketorolac (alt pain med), epinephrine 1mg/1mL and 1mg/10mL, dextrose 10%, ipratropium, lidocaine, magnesium sulfate, midazolam (diazepam if available), naloxone, NTG, nitrous oxide (opt), norepinephrine, ondansetron, tetracaine drops, and verapamil. Appropriate pain intervention should be done prior to splinting or removal from point of contact if patient is in severe discomfort.
2. If initial attempts at ALS interventions are unsuccessful, attempt a recommended back-up procedure and contact OLMC for further orders. DO NOT prolong scene time with persistent unsuccessful efforts at airway or venous access.
3. **Patients requiring ALS services include, but may not be limited to, conditions covered by the System SOP's; PLUS the following:**
   a. Any persistent deviation from expected norms for patient in the primary assessment or breath sounds

b. Patients with abnormal VS accompanied by signs of hypoxia (SpO_2 <94), hyper- or hypocarbia ($ETCO_2$ <35 or >45), and/or hypoperfusion ($ETCO_2$ 31 or less plus altered mental status, VS and skin changes)

Guidelines for abnormal vital signs: ADULTS	
Pulse:	< 60 or > 100 or irregular rhythm; poor quality
Respiration:	< 10 or > 20 or abnormal pattern/effort/expansion
Systolic BP:	< 90 or > 150 mmHg (MAP < 65)

c. **PEDIATRICS** - See SOPs for normal and abnormal values

d. Chest/abdominal pain with positive assessment findings or GI bleeding

4. **ALS care should never be discontinued** once initiated unless a decisional patient refuses further intervention, they are given full disclosure of risk, a Refusal of Service has been appropriately executed, the patient's wishes are shared with OLMC while on the scene, and a physician or his/her designee grants permission to discontinue care.

5. If a patient has required any continuous monitoring during transport (ECG, SpO_2, $EtCO_2$), or any other continuous interventions while under EMS care (CPR, oxygen, assisted ventilations, etc.), those assessments and/or interventions shall continue until responsibility for the patient is transferred to ED personnel unless specially authorized to stop by OLMC. They shall not be discontinued in the ambulance for transfer into the hospital.

6. If scene, patient and/or rescuer safety is questionable or if EMS personnel are confronted with an uncooperative patient, the requirements to initiate BLS or ALS care at point of patient contact or during transport may be waived in favor of assuring that safety is protected and the patient is transported to an appropriate facility. Contact OLMC to discuss the situation prior to leaving the scene. Clearly document the circumstances leading to an abbreviation of customary practice.

E. **In-field service level upgrades**

1. All transfer of care decisions shall be made under the immediate direction of the nearest system hospital OLMC who shall determine the risk/benefit and appropriateness of a service level upgrade. Also see policy A-1.

2. BLS personnel at the scene of an emergency shall allow any ILS or ALS ambulance personnel at the scene access to the patient, for the purpose of assessing whether ILS or ALS care is warranted. If the ILS or ALS personnel determine that the patient requires ILS or ALS care, the BLS personnel shall transfer care of that patient to the ILS or ALS personnel.

3. If a patient is being initially treated in the field by BLS personnel and they identify that ALS monitoring or interventions are necessary, the BLS crew shall request an ALS response from the local municipal EMS agency, unless the initial responders are employees of a private provider and the private provider can provide an ALS response within six minutes.

4. Transfer of care shall not be initiated in either of the above scenarios if it would appear to jeopardize the patient's condition. If the BLS crew can transport to the nearest hospital faster than the local municipal ALS team can arrive, the BLS team shall contact the nearest System hospital OLMC, inform them of the patient's situation and ETA to the nearest hospital, seeking authorization to transport the patient immediately, providing BLS care enroute.

5. **When care is transferred from one EMS crew to another, the first responding personnel shall**
   a. remain with the patient and continue to provide appropriate care within their scope of practice according to System standards of care until patient responsibility is transferred to the transporting team;
   b. provide a verbal report to the transporting personnel that includes assessment and treatment data current to the point of transfer;
   c. complete a patient care report which notes patient assessment and treatment data current to the point of transfer; and
   d. provide a copy of their written report to the receiving hospital as soon as possible. See Policy A-1 Abandonment and R6 Refusal of Care policy.

V. *An EMR, EMT, EMT-I, A-EMT or Paramedic may transport a **police dog injured in the line of duty** to a veterinary clinic or similar facility if there are no persons requiring any medical attention or transport at that time. (Section 3.55(e) of the Act) EMS Systems that choose to transport police dogs injured in the line of duty shall develop written policies or procedures for all of the following:*

A. *Basic level first aid and safe handling procedures for injured police dogs, including the use of a box muzzle, developed in consultation with a local veterinarian. The provision of Intermediate and Advanced Life Support care is not authorized and shall not be permitted unless the individual EMS provider is also appropriately licensed under the Illinois Veterinary Medicine and Surgery Practice Act [225 ILCS 115];*

B. *Identification of local veterinary facilities that will provide emergency treatment of injured police dogs on short notice;*

C. *Proper and complete decontamination of stretchers, the patient compartment, and all contaminated medical equipment, when a police dog has been transported by ambulance or other EMS vehicle; and*

D. *The sterilization of the interior of an ambulance, including complete sanitizing of all allergens and disinfecting to a standard safe for human transport before being returned to human service. (Source: Amended at 43 Ill. Reg. 4145, effective March 19, 2019)*

VI. **CHRONICALLY DISABLED/IMPAIRED PATIENTS**

If EMS is dispatched to a patient who has a chronic, debilitating condition, but who appears stable with no new or acute findings, and the total scene and transport time is less than five minutes, they shall advise the receiving hospital of the situation and may request permission to abort ALS care in favor of immediate transport. At all times, the patient's needs, based on the present medical condition, must dictate the level of care delivered.

Matthew T. Jordan, M.D., FACEP
EMS Medical Director

Connie J. Mattera, M.S., R.N., LP
EMS Administrative Director

EMS Scopes of Practice

Includes IDPH additional Standards exceeding the National EMS Education Standards and National Scope of Practice Model as adopted by Region IX EMS MDs

See local policies/ procedures for details	EMR	EMT [BLS]	Paramedic/PHRN [BLS + ALS]
Monitoring	• Apply an appropriate pulse oximetry (SpO_2) sensor • Blood glucose monitoring	• Capnography monitoring • Interpret SpO_2 findings	• Blood chemistry analysis (point of care testing • ECG rhythm & 12 L interpretation
Airway/ventilatory management Oxygen delivery	• BLS airway access: position, OPA/NPA • Pulse oximetry	• Obstructed airway maneuvers • Oral suctioning • Tracheal-bronchial suctioning of an already intubated pt. • Capnography monitoring • O2: NC, mask, NRM, BVM • BiPAP, CPAP, PEEP • Occlusive dressing applied to a penetrating chest wound	• Magill forceps for airway FB removal • Trach and stoma suctioning • Tracheostomy tube replacement through a stoma • Intubation: Adult (bougie) • Extraglottic airways • Needle/surgical cricothyrotomy • Use of transport ventilators • Needle pleural decompression
Circulatory/cardiac mgt Vascular access	• Quality CPR • Hemorrhage control: Direct pressure; tourniquet • AED use	• Applications of 3-5 leads for ECG rhythm analysis • 12L ECG acquisition & submission to OLMC • Hemorrhage control: use of hemostatic agents • Spiking IV bag; priming tubing for vascular access	• ECG rhythm & 12L interpretation • Manual defibrillation; synchronized cardioversion • Transcutaneous pacing • Obtaining a blood sample • Vascular access: peripheral veins, IO (adult & peds) • Accessing central venous devices already placed based on OLMC
Psychomotor skills	• Use of backboard • Application of C-collar	• Monitoring of OG/NG tube already inserted • Selective spine precautions • Splinting/bandaging • Vaginal delivery • Limb restraints	• Eye irrigation *w/ Morgan lens* • Assess JVD & pulsations • Targeted temperature mgt after ROSC • ALS burn care • Protective equipment removal • Monitoring indwelling urinary catheter already placed
	Preparation and administration of drugs by the routes listed for all ages		
Pharmacology Medication administration	• ASA for chest pain PO • Oral glucose/glucose paste • Epinephrine: Assisted administration of pt's autoinjector • Epinephrine autoinjector • Naloxone IN; autoinjector IM	• *Acetaminophen PO* • Albuterol nebulized • Calcium gluconate gel • Diphenhydramine PO • Ipratropium bromide nebulized • Epinephrine (1mg/1mL) IM from ampule or vial • Glucagon IN or IM • Mark I or DuoDote autoinjector • Naloxone IN & IM • NTG (chest pain w/ suspected ischemia • Ondansetron ODT	PO, IN, IM, *subq,* IVP, IVPB, IO, SL, topical, IR depending on drug • Adenosine; Amiodarone • Atropine sulfate • Benzodiazepines • Cyanide antidotes • Dextrose 10% IVPB; *dopamine* • Diphenhydramine • Epinephrine all concentrations • Etomidate/Ketamine • Fentanyl, *Ketorolac*, morphine, *IV acetaminophen* • *Furosemide* • Lidocaine 2% • Magnesium sulfate • Naloxone; Norepinephrine, NTG • Ondansetron • Sodium bicarbonate • *Steroids* • Tetracaine ophthalmic solution • *Tranexamic acid (TXA)* • Verapamil • Vaccinations in approved program

Practice privileges are cumulative from EMR to Paramedic