NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM

EST 1972

February 2023 CE Handout

System Forms

Created by Kourtney Chesney BSN, RN, PM

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State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*

Patient Last Name	Patient First Name	MI

Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

☐ YES CPR: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)	☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.

☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.

☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.

☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.

☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)***	Date

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)***	Phone

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* X	Date ***(required)***

THIS PAGE IS OPTIONAL – use for informational purposes		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

NWC EMSS Helicopter Request - Worksheet

Information Needed by OLMC & Helicopter Dispatcher

Completed by OLMC at Resource Hospital (NCH):

Date	Time	Requesting Agency
Type of Incident Mechanism		# pts requiring air transport

LEVEL I: HIGH RISK for SEVERE INJURY – Transport to the highest level trauma center available within the geographical constraints of the regional trauma system*

	All patients	
☐ Penetrating inj. to head, neck, torso, proximal extremities ☐ Skull deformity, suspected skull fracture ☐ Suspected SCI with new motor or sensory loss ☐ Chest wall instability, deformity, or suspected flail chest ☐ Suspected pelvic fracture ☐ Suspected fracture of two or more proximal long bones ☐ Crushed, degloved, mangled or pulseless extremity ☐ Amputation proximal to wrist or ankle ☐ Active bleeding requiring a tourniquet or wound packing with continuous pressure	☐ Unable to follow commands (Motor GCS < 6) ☐ RR < 10 or > 29 ☐ Resp distress or need for ventilatory support ☐ RA SpO2 < 90%	☐ Age 0-9 years: SBP < 70 + (2 X age) ☐ Age 10-64 years: SBP < 90 mmHg HR > SBP ☐ Age ≥ 65 years: SBP < 110 mmHg HR > SBP

What is the estimated ground transport time to a Level I Trauma Center?

Is extrication required? ☐ NO ☐ YES Anticipated extrication time:

Need for specialized skills/equip not available on scene?
☐ NO ☐ YES Explain:

Age (DOB)	Gender	Weight

Patient condition
Acuity/Injuries

BP	P	R	SpO2	ETCO2	ECG

EMS care:

Desired receiving hospital

Order for Aeromedical Transport: ☐ **Approved** ☐ **Denied**
Physician (signature) ***X***

Scene/Ground contact person	Call back # - cell, radio frequency/PL

Aeromedical Service Contacted Time					ETA (minutes):
_____:_____	Life Net (Air Methods)	McHenry	1 RN, 1 PM	800– 995 -5862	
	SUPERIOR	DuPage	1 RN, 1 PM	877- 727- 6867	
	REACT	Rockford	2 RNs	800- 637- 3228	
	UCAN	Chicago	2 RNs	800- 621- 7827	

EMS Scene/Ground Personnel to communicate to HEMS service:

Landing description & site location (highways, road names, major landmarks, GPS coordinates, hazards):

Special needs or personnel requirements

Weather conditions at site if adverse

NCH OLMC – Fax worksheet to EMS office (x4489) within 24 hrs

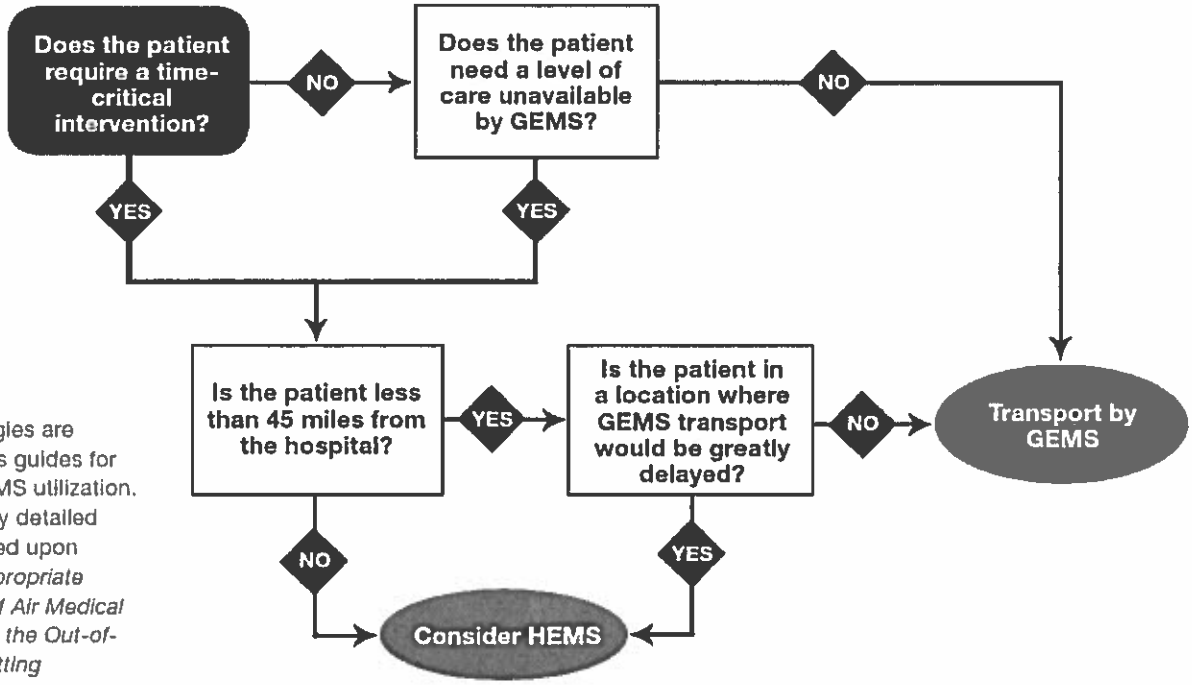
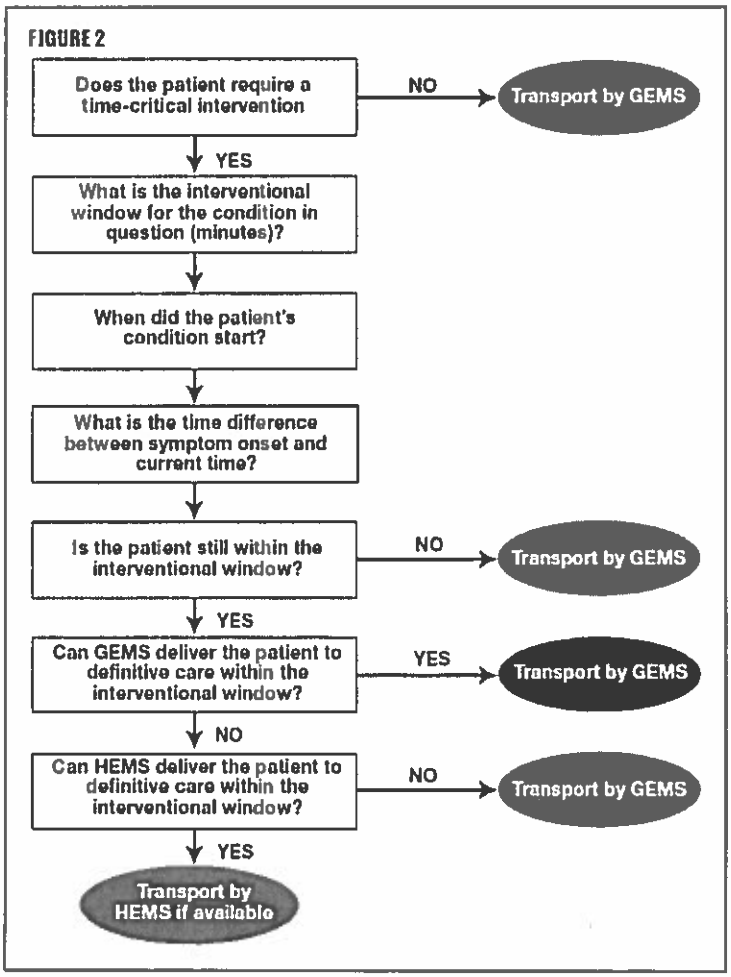


FIGURE 1

New strategies are emerging as guides for limiting HEMS utilization. The strategy detailed here is based upon ACEP's *Appropriate Utilization of Air Medical Transport in the Out-of-Hospital Setting*



GEMS = Ground EMS
HEMS = Helicopter EMS

Northwest Community EMS System

Abandoned Newborn Protection Checklist

If a person attempts to relinquish a newborn infant to you at the fire station, do the following:

Assess the infant. Look for any signs of abuse or neglect. ➢ **If the infant does not appear abused and is 30 days old or younger: Proceed under the Abandoned Newborn Protection policy.** The relinquishing parent has a right to remain absolutely anonymous and leave the fire station at any time and not be pursued or followed. DO NOT call the police. The act of relinquishing a child IS NOT considered abuse. ➢ If the infant **does appear abused, neglected,** or is clearly older than 30 days: Proceed under the **Child Abuse SOP** *and* the Abandoned Newborn Protection policy. If a relinquishing parent attempts to leave the fire station with a possibly abused infant, call the police and retain custody of the infant.	
CARE OF THE INFANT	
Initiate emergency treatment deemed necessary per SOP under implied consent	
Contact the nearest System hospital via ALS call mechanisms. Ask a physician to take temporary protective custody of the infant.	
Keep the infant warm and transport to the nearest hospital with the newborn secured appropriately in an infant car seat.	
Complete a patient care report. List infant's name as "Baby Girl/Boy Doe" if unknown. Identify the infant as relinquished in the comments section. Omit any descriptive information regarding the relinquishing individual unless you suspect abuse or neglect.	
INFORMATION TO SHARE WITH RELINQUISHING PARENT	
Offer the relinquishing parent the required information that includes the following: - Illinois Adoption Registry - Explanation - Illinois Adoption Registry Application - Illinois Adoption Registry Application Section C (2 pages) - Birth Parent Registration Identification - Medical Information Exchange authorization form - Denial of Information Exchange - Illinois Adoption Registry Medical Questionnaire (2 pages) - Illinois Adoption Registry website address and toll free phone number **Written notice of the following:** - No sooner than 60 days following the date of the initial relinquishment of the infant, the child-placing agency or IDPH will commence proceedings for the termination of parental rights and placement of the infant for adoption. - Failure of the parent of the infant to contact the Department of Public Health and petition for the return of custody of the infant before termination of parental rights bars any future action asserting legal rights with respect to the infant. - A resource list of providers of counseling services, including grief counseling, pregnancy counseling, and counseling regarding adoption and other available options for placement of the infant.	
A parent may be unwilling to wait for a discussion. Note on the infant's PCR that the required information was offered to the parent and whether or not it was received.	
If possible, **verbally inform the parent that:** - **His or her acceptance of the information is completely voluntary;** - Completion of the Illinois Adoption Registration form and Medical Information Exchange form is voluntary; however, the fee for filing the application is waived if the medical questionnaire is completed. - A Denial of Information Exchange form may be completed which would allow the relinquishing parent to remain anonymous to the infant and other parties involved in the infant's subsequent adoption; - The parent may provide medical information only and remain anonymous; and - By relinquishing the infant anonymously, he or she will have to petition the court in order to prevent the termination of parental rights and regain custody of the child.	
If a parent returns within 72 hrs to reclaim the infant, tell them the hospital to which the infant was transported	

Northwest Community EMS System

Request for Exposure Determination

Instructions: DICO will complete after consultation with EMS personnel immediately after a potential exposure as defined in System Policy I2.
If Exposure **is confirmed,** DICO will complete & transmit Request for Source Patient Testing to receiving facility to begin testing. Place this form in employee's file.

Pre-hospital Provider Information

EMS Agency:	Exposure date & time:	Date report filed:
Name(s) of all exposed personnel (PRINT):		
Name of individual followed by this report:		
DICO:	Date/time notified:	Date/Time responded:
Specific location where exposure took place:		

Source Patient Info

Name: Gender: Age: RUN #:

Type of exposure (Check all that apply)

☐ Bloodborne	☐ Airborne/respiratory	☐ Pt coughing	☐ Pt febrile	☐ Positive pt Hx	☐ < 3 ft. from pt.
☐ Needlestick	☐ Deep puncture	☐ Scratch	☐ Inhalation	☐ Blood splash	☐ Fluid splash

Type & amount of body fluids involved:

Blood visible in OPIM? [ ] Yes [ ] No

Percutaneous Exposure

Depth of injury.
Fluid injected? [ ] Yes [ ] No
Blood visible? [ ] Yes [ ] No

Skin / mucous membrane exposure

Duration of contact:

Condition of skin:[ ] Chapped [ ] Abraded [ ] Intact

Identify the specific part(s) of body exposed/injured: [ ] Hands [ ] Face [ ] Nose [ ] Mouth [ ] Eyes
Other:

Procedure being performed:
Explain how the exposure occurred:

Did sharp involved have engineered injury protection? **[ ] Yes [ ] No** Type & brand of device:
If yes, when did the injury occur? [ ] Before activation of protective mechanism [ ] After activation of protective mechanism

Classify the cause of the exposure (Check all that apply)

☐ Accidental	☐ Not wearing PPE	☐ Lack of awareness of environment
☐ Improper procedure	☐ Defective equipment	☐ Improper disposal of OPIM/sharps

Indicate the PPE in use at the time of exposure:

☐ Gloves	☐ Surgical mask	☐ N-95 mask	☐ Eye protection Type:	☐ Gown	☐ None

If none, explain circumstances that precluded use of barriers:

Health history of exposed individual: **File checked for:** Prior history of Hepatitis B? [ ] Yes [ ] No

Completed Hep B vaccine series [ ] Yes [ ] No Hepatitis AB test positive: [ ] Yes [ ] No	Prior hx +HIV test [ ] Yes [ ] No Date last tetanus:	Prior hx positive TB skin test [ ] Yes [ ] No Date last TB skin test or chest X-Ray:

This potential exposure is determined to be [ ] CONFIRMED [ ] NOT CONFIRMED

Receiving facility _____ Exposure reported to: _____

Request for source patient testing transmitted at: _____ **UNIQUE IDENTIFIER:** _____

Employee notified of Source Patient test results: [ ] Yes [ ] No Date: _____ Time: _____

Employee Medical Follow – Up Referred to _____

PRINT NAME/*Signature* of DICO: _____

Request for Source Patient Testing

Requesting agency is responsible for all charges related to specific testing in Section C

Instructions: To be completed by the Designated Infection Control Officer of the personnel exposed, after confirmation of an exposure per System Policy I2, and submitted to the receiving facility for determination of source patient status and follow-up.

DICO to complete Sections A, B, and C; submit to receiving facility. ALL INFO is CONFIDENTIAL

Receiving Facility to complete Section D. Notify the DICO of test results within two hours, or sooner, so that the appropriate follow-up may be started for any exposed employees.

A. Pre-hospital Provider Information

EMS Agency:	Date request filed:
Date / Time notified of exposure:	DICO Contact information: **Name:** **Phone:**
Specific location where exposure took place:	Designated Infection Control Officer signature
Unique Identifier (from Request for Exposure Determination Form)	

B. Type of exposure

[ ] Needlestick [ ] Deep puncture [ ] Scratch [ ] Airborne [ ] Blood splash [ ] Fluid splash [ ] Other
[ ] Droplet

C. Source Patient Information

Source Patient Name: Date of Birth:

Date / Time of Incident:

Requested Testing – Standing lab order for source patient. ***HIV, HBV & HCV testing MUST BE RAPID***

HbsAg Antigen [ ]	HIV (RAPID) Antigen/Antibodies [ ]	HIV (+) Viral Load [ ]	HCV (RAPID) Antigen/Antibodies [ ]	HCV (+) HCV RNA [ ]	Syphilis *If HIV or HCV + [ ]

D. Test Results and Facility Signatures (completed by receiving facility)

Positive [ ] Negative [ ]	Positive [ ] Negative [ ]	Positive [ ] Negative [ ]	Positive [ ] Negative [ ]	Positive [ ] Negative [ ]	Positive [ ] Negative [ ]

Exposure Occurred (source tests positive) [ ] No Exposure Occurred (source tests negative) [ ] Inconclusive Info [ ]

Receiving Facility Printed Name **Receiving Facility Staff Signature** **Receiving Facility Staff Printed Name**

Date & time Received from DICO:_____

Date & time results obtained and forwarded to DICO:_____

Other Information:_____

Original Copy: Return to the Designated Infection Control Officer that initiated the form.

Rev. March 2013

Northwest Community EMS System

REQUEST FOR CLARIFICATION

Date of occurrence:	Time of occurrence:
Prehospital Provider:	Hospital:
Patient initials (if applicable):	Patient age/Gender (if applicable):
Persons involved in occurrence or requesting clarification:	

Nature of Request/Occurrence: (Check all that apply)

☐ EMS Provider-related	☐ Deviations from SOPs	☐ Deviation from Policy	☐ E.D. Staff-related
☐ Equipment-related	☐ Patient-related	☐ Communications related	☐ Education-related
☐ Request clarification/review of incident		☐ Request review of patient outcome	

Situation/Occurrence Facts:

Occurrence Reported To: _____

By: _____ Date: _____

Action taken/feedback given at the time of the occurrence:

Forward to appropriate Hospital EMS Coordinator

Statement of investigation/clarification/recommended outcome by Hospital EMS Coordinator:

Signature _____ Date _____

Forward to Resource Hospital EMS Administrative Director

Statement of investigation/resolution by Resource Hospital (if necessary)

Signature _____ Date _____

cc: Originator of Report; Provider Agency; Hospital EMS File

Rev. 1/14

Northwest Community EMS System

Medical Device/Ambulance MALFUNCTION/FAILURE Report

CONTACT EMS MD: Serous pt/crew harm or death ASAP by phone: (847) 962-6008 All others: e-mail mjordan@nch.org

Submission of this report does not constitute an admission that medical personnel, a user facility, distributor, manufacturer or product caused or contributed to the event. This report constitutes CQI and is protected by the Medical Studies Act.

PATIENT INFORMATION

Initials (in confidence)	Age at time of event or date of birth:	Gender ☐ Female ☐ Male	Weight lbs. or kgs

EMS Agency: | EMS Incident #:

Adverse event or product problem: ☐ Adverse event ☐ Product problem

Status of patient pre-event: ☐ Stable ☐ Unstable ☐ Cardiac/respiratory arrest
Status of patient post-event: ☐ Stable ☐ Unstable ☐ Cardiac/respiratory arrest

Paramedic impression of patient's diagnosis at time of event:

Medical Device malfunction/failure: The equipment did not function/operate as intended and (check one):
- ☐ Did not affect patient care
- ☐ Affected patient care but caused no harm
- ☐ Affected patient care and may have caused or contributed to harm including injury, hospitalization, disability, or death (see below).

Outcomes attributed to adverse event (check all that apply)

☐ Death _____ (month/day/year) ☐ Life-threatening ☐ Hospitalization ☐ Disability

Date of event: | Date of this report:

MEDICAL DEVICE

Device name: | Brand name:

Manufacturer name, address, & phone #

Operator of device at time of malfunction:
- ☐ Health professional
- ☐ Lay user/patient
- ☐ Other:

Model #:
Catalog #:
Serial #:
Lot #:

Expiration/Use before date (if known):
How long in use:
Condition prior to malfunction:
Date last inspected or serviced:
If implanted, give date (if known):

Were other devices or accessories involved?
☐ Yes ☐ No
If yes, please describe:

Are other units of the same model similarly affected?
☐ Yes ☐ No
If a single-use device was involved, had it been reprocessed at any time before the incident?
☐ Yes ☐ No

Location in which device was being used:

Settings and modes operative at the time of event:

Describe problem/malfunction and how the device contributed to the event or problem:

Describe the medical interventions taken as a result of the event:

List any EMS workers who were injured:

Initials	Age	Gender	Status pre-event	Status post-event

Device available for evaluation? ☐ Yes ☐ No ☐ Returned to manufacturer on:

AMBULANCE MALFUNCTION/FAILURE

Time of failure: Time mutual aid arrived: Time arrived at hospital:

Describe the malfunction/hazard or problem in detail. Include how it was discovered, any action taken at the time

Potential or actual adverse impact to patient:

MEDICATION(s)

Name (give labeled strength & mfr/labeler, if known)
#1.
#2.

Dose, frequency & route used
#1.
#2.

Indications for use
#1.
#2.

Lot number, if known	Expiration date, if known:
#1. #2.	#1. #2.

INITIAL REPORTER

Name:		Agency:	
Phone: e-mail:	Health professional? ☐ Yes ☐ No	Occupation:	**Initial reporter also sent report to FDA?** ☐ Yes ☐ No

Northwest Community EMS System

EMS QI Review /Complaint Investigation form

Confidential under the Medical Studies Act. All information contained in or relating to any medical audit performed by the EMS MD (or his designee) o care rendered by System personnel, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure. Disclosure of such information to IDPH shall not be considered to be a violation of that Code. Please make the following notation on all Requests for Clarification (RFCs), Run Feedback Forms or notes, CE classes using a case-study format, and/or coaching notes:
PRIVILEGED AND CONFIDENTIAL - PEER REVIEW DOCUMENT - PATIENT SAFETY WORK PRODUCT. Protected under the Patient Safety and Quality Improvement Act. Do not disclose unless authorized by the NWC EMSS EMS MD or his designee.

"This report is not part of any patient's permanent medical record. All information provided, including any *appended materials, is furnished as a report of quality management and is privileged and confidential, to be used solely in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the quality of patient care in accordance with Illinois Law (735ILCS 5/8-2004 et seq)."*

Do NOT file or store QI-related notes or documentation near or with the PCRs to avoid inadvertent disclosure

Investigation Steps:

1. Review Patient Care Report; Telemetry Logs and recordings (if applicable)
2. Gather the facts, review relevant evidence and National/State/System standards of practice
3. Alert EMS MD, EMS Administrative Director, and others per local policy if a reportable event
4. Discuss call/allegation of misconduct with all involved parties
5. Determine and note the standards of performance reviewed in the investigation
6. Use the form to document findings, conclusions, & recommendations
7. Conduct a meeting and obtain signatures with those involved and agency leadership
8. Forward completed form to the EMS MD and EMS Administrative Director for final review

Date of incident:	Time of incident:	Location of incident:
EMS Agency	Incident #:	OLMC hospital:
Complaint/allegation/situation needing review/clarification:		
Person filing a complaint/requesting the review (contact info)		Date filed

Standards of Performance Reviewed		
☐ Accountability	☐ Follow up/follow through	☐ Respect
☐ Appearance and personal hygiene	☐ Integrity	☐ Self-motivation
☐ Assessment (patient, situational)	☐ Knowledge	☐ Self-confidence
☐ Care/competent delivery of service	☐ Patient advocacy	☐ Supervision (OLMC/students)
☐ Communication (team/OLMC)	☐ Planning	☐ Technique/skill proficiency
☐ Critical thinking	☐ Prioritization & delegation	☐ Time mgt; response, interventions, care
☐ Empathy	☐ Policy/procedure compliance	☐ Teamwork & diplomacy
(Other: Please explain)		

General category of allegation:

☐ **Duty to avoid causing an unjustifiable risk or harm**: "Don't do" allegation
Did the behavior cause a substantial and unjustifiable risk of harm for the safety of others?

☐ **Duty to follow procedural rule(s):** Was the act or omission not aligned with program values or standards?
Did the individual believe their act or omission was justified or insignificant?

☐ **Duty to produce an outcome**: "What to do" allegation ("Expected behavior and by when" violation)

Consider: Was the duty known to the individual? ☐ Yes ☐ No Was it possible to produce the duty? ☐ Yes ☐ No

Facts determined: What happened?

Root causes: What normally happens? What does the policy, procedure, or standards require? Why did this happen?

Mitigating circumstances:

Summary determinations for patient-related QI review

1.	**Patient Outcome**	2.	**Effect on patient care**
	No adverse outcome)		Care not affected)
	Minor adverse outcome (complete recovery expected		Increased monitoring/observation
	Major adverse outcome (recovery expected)		Additional treatment/intervention (e.g. IV fluids, reversal agents)
	Major adverse outcome (complete recovery NOT expected		Life-sustaining treatment/intervention (CPR)
	Patient did not survive		Other:
3.	**Documentation**	**4.**	**Communication**
	Documentation meets System standards		Communication complete, timely, meets System standards
	Documentation does not substantiate clinical course, treatment, and/or decisions made		Communication timely, incomplete understanding between sender and receiver of messages
	Documentation not timely to communicate with other caregivers		Communication not timely and/or complete and inconsistent with System standards
	Other:		Other

Outcome recommendation of the investigation

☐ **Non-sustained/no action**: Evidence was insufficient to either prove or disprove the complaint.
☐ **Sustained:** Complaint was supported by sufficient evidence to justify corrective coaching/disciplinary action. Determine nature of error below.
☐ **Unfounded/Not involved**: Means the facts revealed by the investigation did not support the complaint (e.g., the complained-of conduct did not occur or the accused individual was not involved).
☐ **Exonerated**: Means the complained-of conduct occurred, but based on all facts and circumstances considered for this occurrence, the accused individual's actions were deemed proper, within guidelines, or acceptable.

If sustained: Nature of error determination (check one)

☐ **Human error**: Unintentional mistake; requires remediation
☐ **At-risk behavior**: Behaviors that individuals engage in, knowing on some level that it could risk safety. Requires corrective coaching.
☐ **Reckless behavior**/willful defiance: conscious disregard for a substantial and unjustifiable risk. Disciplinary action warranted.

If sustained, disciplinary action recommendation (check one)

☐ **Verbal warning and remediation plan**
☐ **Written warning with corrective coaching/action plan:** If the violation would not warrant immediate suspension, the EMSC/educator will work with the involved parties to design a corrective action plan that will require ongoing assessment and monitoring of behavior/performance.
☐ **Final written warning** with a corrective action plan as above that may include restriction of practice in good standing and/or suspension recommended to IDPH, and with the caveat that serious consequences to licensure/practice will result if behaviors are repeated.
☐ Recommendation to **take action on the individual's EMS license**

Suggested resolution and conclusions; proposed corrective action(s), engineering controls, and/or education.
List suggested policy/procedure/form revisions. Ask how to avoid similar situations from happening again and identify opportunities for improvement.

EMS Agency/Hospital	EMS/ECRN personnel involved (print names)	EMS License #

Findings communicated: To whom: When and how:
Date:
Primary investigator(s):

Affirmations:

Each signature below signifies that the above findings have been reviewed and understood.

PRINT NAME | Signatures Date

Personnel involved

Personnel involved

Personnel involved

Personnel involved

Agency Leadership

Hospital EMS Coordinator/Educator conducting the discovery investigation

Forward the completed form to the EMS System Administrative Director with copies of the blinded PCR and Communication Log (if patient-related) and any other documents important to the investigation/outcome results

I agree with the findings, recommendations, and outcome conclusions:

Matthew T. Jordan, MD, FACEP; NWC EMSS EMS Medical Director

Notes of intent:

Even the most educated and careful individuals will learn to master dangerous shortcuts and engage in at-risk behaviors when the rewards for risk-taking are more immediate and positive than the potential for harm, which is remote and very unlikely.

These intentional and unsafe practice habits emerge in a culture where there is a normalization of deviance AND tolerance of at-risk behaviors. This type of culture is evident when there are more positive rewards (e.g., time-saving, high regard of colleagues) than negative rewards (e.g., patient harm or disciplinary action) for at-risk behaviors. Look deeper than the overt behavior to find the real contributing causes.

CJM: 3-22

Northwest Community EMS System

OVERRIDE REPORT FORM

Top half to be completed by Resource Hospital ED personnel handling Override call.

Date:	Time:	Comm. Log #:
Associate Hospital:	Assoc. MD/ECRN:	
EMS Provider:	Ambulance run #:	
Patient name:	Age:	Sex: [ ] M [ ] F
Chief complaint:		
Circumstances resulting in Override:		
Describe Resource Hospital's intervention and ultimate completion/outcome of the call:		
NCH Physician:	NCH ECRN:	

Notify Connie Mattera at 847/618-4485 or page 708/999-0141 or e-mail to cmattera@nch.org

Time contact made or message left:_____

Send this form & the Communications Log to the EMS System Office

Date of critique: Time:	Persons in attendance:
Discussion/conclusions:	
Resolution/corrective action, if any.	
EMS MD:	EMS Administrative Director:

CANTS 5
Rev. 10/00

State of Illinois
Department of Children and Family Services

WRITTEN CONFIRMATION OF SUSPECTED CHILD ABUSE/NEGLECT REPORT: MANDATED REPORTERS

DATE: _____

ABOUT: _____ _____
Child's Name Child's Birth Date

If you are reporting more than one child from the same family please list their names and birth date in the space provided on the reverse side of this form.

_____ _____ _____
Street Address City Zip Code

Parent/Custodians: _____
Name

_____
Address (if different than the child's address)

This is to confirm my oral report of _____, _____, made in accordance with the Abused and Neglected Child reporting Act (325 ILCS 5 et seq). Please answer the following questions. (If you need more space, use the back of this page.)

1. What injuries or signs of abuse/neglect are there?

2. How and approximately when did the abuse/neglect occur and how did you become aware of the abuse/neglect?

3. Had there been evidence of abuse/neglect before now? ☐ Yes ☐ No

4. If the answer to question 3 is "yes," please explain the nature of the abuse/neglect.

5. Names and addresses of other persons who may be willing to provide information about this case.

6. Your relationship to child(ren)

7. Reporter Action Recommended or Taken:

PLEASE CHECK THE APPROPRIATE RESPONSE:
☐ I saw the child(ren)
☐ I heard about the child(ren) From whom? _____
I ☐ **have** ☐ **have not** told the child's family of my concern and of my report to the Department.
I am ☐ **willing** ☐ **NOT willing** to tell the child's family of my concern and of my report to the Department.
I ☐ **believe** ☐ **do NOT believe** the child is in immediate physical danger.

_____ _____
(Name Printed) (Signature)

_____ _____
(Title) (Organization/Agency)

INSTRUCTIONS ON REVERSE SIDE

INSTRUCTIONS

The Abused and Neglected Child Reporting Act states that mandated reporters shall promptly report or cause reports to be made in accordance with the provisions of the ACT.

The report should be made immediately by telephone to the IDCFS Child Abuse Hotline (800-252-2873) and confirmed in writing via the U.S. Mail, postage prepaid, within 48 hours of the initial report.

MAILING INSTRUCTIONS

Mail the original to the nearest office of the Illinois Department of Children and Family Services, Attention: Child Protective Services.

2nd Child's Name (If Any)	2nd Child's Birth Date
3rd Child's Name (If Any)	3rd Child's Birth Date

ILLINOIS COALITION AGAINST DOMESTIC VIOLENCE
937 S. Fourth Street
Springfield, IL 62703
(217) 789-2830

There are many agencies ready to help. Please call one for information or assistance.

AGENCY	Contact info
National Domestic Violence Hotline	Call or text "START" to 800-799-7233
IL Domestic Violence Hotline	877-863-6338
WINGS (Women in Need Growing Stronger) North and Northwest suburbs of Cook and parts of Lake County criteria for transitional housing program Emergency shelter –no boundaries WINGS @NCH(counseling, advocacy and referrals)	www.wingsprogram.com 24 hotline: 847-221-5680 847-618-3208
National Organization for Victim Assistance (NOVA)	1-800-879-6682
Ill. Department of Children & Family Services Hotline	1-800-252-2873
CHICAGO	
APNA GHAR	773-334-4663
Chicago Abused Women Coalition	773-489-9081
Family Rescue	800-360-6619
Neapolitan Lighthouse	773-722-0005
The Greenhouse	773-278-4110 773-278-4566
Pro Bono Advocates	312-325-9155
Between Friends	800-603-4357
Mujeres Latinas En Accion	773-890-7676
Suburban Centers	
Arlington Heights: WINGS	24 h crisis line: 847-221-5680
Elgin: Community Crisis Center	847-697-2380
Evanston: Evanston Shelter for Battered Women	24 h crisis line: 877-718-1868
Waukegan: A Safe Place/Lake County Crisis Center	847-249-4450
DuPage Co.: Family Violence/ Women in Danger Family Shelter	630-469-5650

If you do not feel safe in accepting this resource listing, tell us to whom we can mail it for your reference.
Write their name and address on the back of this form.

Region IX EMS Plan

SCHOOL BUS INCIDENT Log

All individuals on the bus age 18 and older should initial in the indicated space adjacent to their name when uninjured. Parent/legal guardian should initial in the indicated space adjacent to their child's name when uninjured.
Initials indicate agreement that no injury has been suffered and no transportation is required to the hospital.

Date: Time of incident:	Location:	District name:	Bus number:

Run report #:	Dept. alarm #:	Total # of persons:	# transported:	# not transported:

Adult name (Non-student)	Function	Address and Telephone	Initials
	Driver		

Child/student name	Age	Address and Telephone	Initials if age ≥ 18 or parent/guardian

The children/students listed above have been determined to be uninjured. Medical control has been contacted and approved release to the custody of school officials (or parent/legal guardian) or to self if age 18 or older.

Name of (EMS) Ambulance Service Provider

Name of School authorized representative

Signature Date

Signature Date

School District Representative

Northwest Community EMS System
Mass Gathering Patient Log Sheet

Event:	Provider:	Date:

Error! Bookmark not defined. Time In/Out	Name & Address (Please print)	Age	Sex	Chief complaint/medical history/allergies/exam findings	Treatment & disposition	Signatures
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel
In:						Patient/guardian
Out:						EMS Personnel

(TO BE PRINTED ON INDIVIDUAL DEPARTMENT'S LETTERHEAD)

Notice of an Emergency Medical Services Response to a Minor

DATE:

TO: The Parents or Legal Guardians of: _____

FROM: (Chief or President of *Provider* Agency) _____

(Provider Agency) _____

Members of our Emergency Medical Services agency were called to evaluate your son/daughter/ward on:

Date:_____

Time: _____

He/she stated his/her age to be _____years.

Location of incident:_____

Nature of the incident:_____

_____

_____

_____

_____

After responding to the above incident, we evaluated the child. Based on our assessment and statements made by your child, it was determined that the child did not require emergency care and/or transportation at that time.

Whereas your child is a minor and not legally enfranchised, it is our duty to inform you of this incident so that an informed decision can be made as to whether follow-up evaluation with a physician is necessary.

If this incident involved a school bus your child was released to a designated school representative who accepted further responsibility for the child.

Additional comments:

_____

_____

_____

_____

If you wish any additional information, please contact: _____

at_____.
Telephone number

Northwest Community EMS System
NON-DISPOSABLE EQUIPMENT EXCHANGE RECEIPT

Please complete in duplicate: 1 copy to EMS personnel; 1 copy to hospital

(Name of Receiving Hospital) agrees to accept responsibility for the safekeeping of:

Quantity:	Type of equipment:	State of repair:

If lost within 48 hours of appropriate notice to the owner, we will replace it; and, if damaged while here and repairs are necessary, we agree to accept financial liability for said repair.

Date left:	Time:	Provider:
Name of Patient:		Vehicle No.:
EMS Signature:	RN signature:	Phone No:
Date/time called to retrieve article:	Date returned to provider:	Signature of receiving EMT:

Northwest Community EMS System
NON-DISPOSABLE EQUIPMENT EXCHANGE RECEIPT

Please complete in duplicate: 1 copy to EMS personnel; 1 copy to hospital

(Name of Receiving Hospital) agrees to accept responsibility for the safekeeping of:

Quantity:	Type of equipment:	State of repair:

If lost within 48 hours of appropriate notice to the owner, we will replace it; and, if damaged while here and repairs are necessary, we agree to accept financial liability for said repair.

Date left:	Time:	Provider:
Name of Patient:		Vehicle No.:
EMS Signature:	RN signature:	Phone No:
Date/time called to retrieve article:	Date returned to provider:	Signature of receiving EMT:

Northwest Community EMS System

EMS Recognition/Award Application

Date of call:	Date of submission:
EMS Agency:	Incident #:
Submitted by:	

Names of EMS personnel participating on the call:

Nature of incident/Actions deserving recognition:

EMS patient care report attached: [ ] Yes [ ] No

EMS Coordinator Comments:

Recommendation from Advisory Board:

- ☐ Letter of commendation: Date: _____
- ☐ Unit citation Date: _____
- ☐ Certificate of Merit Date: _____
- ☐ Service Award Date: _____
- ☐ Special Achievement Award Date: _____

Seek additional supporting information Date: _____

4/1/13