

# **EMS TRAUMA REGION X**

## **POLICY AND PROCEDURE MANUAL**

**April 2019**

**Origination: SEPTEMBER 1998**



## **OTHER REGION X DOCUMENTS**

- I. Disaster Management Services Committee, Multiple Patient Management Plan
- II. Region X Standard Operating Procedures

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## **EMS TRAUMA REGION X**

### **POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** April 1998

**REVISED:** February 2017

**POLICY TITLE:** **RESOLVING REGIONAL OR INTER-SYSTEM CONFLICTS**

**POLICY:** **1**

Disputes relating to patient care issues, expected standards of professionalism, or any other EMS/Trauma related issues, between Systems or Regions, are to be resolved emphasizing communication, chain of authority, and confidentiality as described in the procedure below. All paperwork shall be confidential for peer review only.

#### **PROCEDURE:**

1. In the event a Regional or Inter-System conflict arises, the concerned party shall provide written documentation of all identified issues to the EMS System Coordinator of the involved EMS System within 5 business days of the said conflict. A copy shall also be sent to the chair of the Region X EMS Trauma Region Committee and Illinois Department of Public Health.
2. Upon receiving the written documentation, the EMS System Coordinator shall immediately notify the EMS Medical Director. The complaint shall be investigated and resolution determined that is acceptable to all parties.
3. A written response shall be provided to the individual(s) who initiated the conflict documentation. This should occur within 30 days of receiving the complaint.
4. At the very next quarterly Region X Meeting a report of the conflict and its resolution may be presented by the chair or designee, in an effort to provide education to all members.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** March 1, 1998

**REVISED:** February 2017

**POLICY TITLE: REGIONAL CONTINUING EDUCATION REQUIREMENTS**

**POLICY: 2**

Continuing education hours for Paramedics, EMTs, EMDs and ECRNs are mandated by the Illinois Department of Public Health. Region X EMS System participants have widely different needs based on the geographies, demographics and types of EMS Providers. Therefore, continuing education topics may differ, but will contain a mix of trauma, medicine and pediatric topics. Region X EMS Systems have agreed to meet or exceed the state requirements for continuing education.

**PROCEDURE:**

1. Provider participants must follow the Continuing Education Policies set forth within their Primary EMS System. If a participant also functions within another Region X EMS System, only mandatory continuing education requirements of that System must be attended. Annual letters of good-standing will be provided to the secondary system upon request of the provider participant. There may be a fee for this service.
2. EMT/Paramedic Participants shall meet the continuing education requirements as set forth by the EMS system with Region X.

EMT/P Participants shall meet their System standard as follows:

VISTA HEALTH EMS SYSTEM:	30 Hours/year
HIGHLAND PARK EMS SYSTEM:	30 Hours/year
SAINT FRANCIS EMS SYSTEM:	25 Hours/year
CONDELL MEDICAL CENTER EMS SYSTEM	30 Hours/year

EMT Participants shall meet their System standard as follows:

VISTA HEALTH EMS SYSTEM:	30 Hours/year
HIGHLAND PARK EMS SYSTEM:	15 Hours/year
SAINT FRANCIS EMS SYSTEM:	15 Hours/year
CONDELL MEDICAL CENTER EMS SYSTEM	30 Hours/year

3. ECRNs shall have 8 hours of continuing education per year (32 hours total in the 4 year licensing period).
4. EMDs shall have 12 hours of continuing education per year (48 hours total in the 4 year licensing period).

5. Content for Paramedics, EMTs, EMDs and ECRN participants shall be consistent with IDPH State Education Committee, decided upon by individual EMS System needs as determined by PI and System activity with a mix of trauma, medicine and pediatric topics.
6. Teaching methods shall include the following domains: cognitive, psychomotor and affective.
7. Testing requirements are to be determined by each EMS System.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1, 1998

**REVISED:** February 2017

**POLICY TITLE:** **SPECIALIZED CARE TRANSFERS/DIVERSIONS**

**POLICY:** **3**

**Trauma**

1. Category I trauma patients
  - a. Transport to the closest Level I Trauma Center unless transport times from the scene exceed 25 minutes.
  - b. If transport times to the closest Level I Trauma Center exceed 25 minutes, the patient should be transported to the nearest Level II Trauma Center for initial resuscitation and stabilization.
  - c. Once stabilization is accomplished within the capability of the Level II Trauma Center, consider transfer to a Level I Trauma Center for further specialized care.
2. Medical Control may divert to a Level I Trauma Center at their discretion.
3. Transport to closest Trauma Center
  - a. Traumatic arrest
4. Transport to **closest** Comprehensive Emergency Department
  - a. No airway

**Stroke**

1. All EMS receiving hospitals in Region X are designated as Primary Stroke Centers; therefore patient transfer patterns will not be altered.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** March 2001

**REVISED:** April 2019

**POLICY TITLE: BYPASS/DIVERSION PROCEDURE FOR HOSPITALS - CASE BY CASE EVENTS**

**POLICY: 3a**

Guidelines have been established by Illinois Department of Public Health regarding circumstances in which a hospital may go on bypass. By incorporating this procedure in the Region X Plan, hospitals will not need to establish “Full Bypass” status under certain conditions. Once a peak census or surge capacity is reached, the hospital must have utilized its’ surge plan to prevent avoidable diversion status addressing ED, inpatient, and observation/outpatient procedure/surge beds; all reasonable efforts to resolve the essential resource limitation(s) have been addressed.

NOTE: Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest hospital exceeds 15 minutes. It is understood that a geographic area may cross regional boundaries.

During the period of resource limitation, a hospital can respond on a case-by-case basis and thereby divert a provider, through direct communication, only when absolutely necessary.

1. Types of resource limitations include but are not limited to:
  - a. CT scanner out of service
  - b. All staffed operating suites are in use
  - c. No critical care or monitored beds available in the hospital
  - d. Internal disaster
  - e. Number of staff (after attempts have been made to call in additional staff in accordance with facility policy)

**PROCEDURE:**

1. Upon determining that a resource limitation exists, a hospital designee shall contact the next closest acceptable facilities and alert the Emergency Department(s) of the limitation. In addition, the hospital shall notify the affected fire departments, private ambulance agencies and surrounding hospitals.
2. The hospital designee shall post the ED Status (Bypass) on EMResource, including reason for bypass and provide updates at least every 4 hours (<https://emresource.juvare.com/login>).
3. In the event that a patient has an unstable/time sensitive (for example: STEMI, stroke-like symptoms, categorized trauma) condition which would be detrimental to transport further, then the hospital on bypass may accept that patient, stabilize and transfer out when acceptable and necessary.



NOTE: Regarding unstable/time sensitive patients, the attending ED physician must be involved in the decision to accept or divert a patient while on bypass.

4. In the event a prehospital provider contacts the hospital on bypass, a full report shall be received from the provider unit, medical orders given, and transport time to the next closest facility determined. The attending Emergency Department physician or designee shall immediately notify the receiving facility and provide full EMS report and transport time.
5. When the resource limitation is corrected, the facilities and agencies originally notified, shall be contacted and updated.
6. EMResource shall be updated with the corrected status (Open).
7. Any complications which arise from this policy shall be directed to the Policy #1 Resolving Regional or Inter-System Conflicts.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1998

**REVISED:** February 2017

**POLICY TITLE: WITHHOLDING OR WITHDRAWING RESUSCITATIVE  
EFFORTS AND ADVANCED DIRECTIVES**

**POLICY: 4**

All EMS Personnel must initiate resuscitative efforts on all pulseless and apneic patients with the exception of those patients who present with one or more of the following indications that an irreversible (biological) death process has occurred.

- \* decapitation
- \* rigor mortis without profound hypothermia
- \* profound dependent lividity
- \* obvious body decomposition
- \* incineration from massive thermal burns
- \* transection
- \* obvious mortal trauma

**Note:** If there is any uncertainty regarding any of the aspect of this policy, institute care and contact Medical Control for direction.

**Specific Circumstances Regarding Resuscitative Efforts Include:**

**POLST (Physician's Orders of Life Sustaining Treatment)/DNR (Do Not Resuscitate)  
Orders**

1. Attempt to confirm that the POLST/DNR Order is valid.

**COMPONENTS OF A VALID DNR ORDER:**

- \* Must be a written document (IDPH provided form) which contains the following:
  - \* Name of patient
  - \* Name and signature of the attending practitioner (physician, physician's assistant, resident 2<sup>nd</sup> year or higher, advanced practice nurse)
  - \* Effective date
  - \* The Words "DO NOT RESUSCITATE" (DNR)
  - \* **Evidence of consent – either/or:**
    - A. Signature of the patient, or the patient's legal guardian.
    - B. Signature of durable power of attorney for Health Care agent;
    - C. Signature of surrogate decision maker.

**Medical Interventions**

1. Refer to IDPH POLST form for further information.

2. If resuscitative efforts were established prior to the POLST/DNR document being presented, efforts may be withdrawn once the validity of the POLST/DNR document is confirmed and Medical Control is contacted for confirmation of cessation of resuscitative efforts.

### **Advanced Directive**

If an individual represents themselves as having Power of Attorney to direct medical care of a patient and/or a document referred to as a Living Will is presented, follow these guidelines:

1. When EMS Personnel are presented with Durable Power of Attorney for Healthcare or Living Wills, EMS Personnel are to contact Medical Control for guidance since no form can address all the medical treatment decisions that may need to be made.
2. Living Will, by itself, cannot be recognized by prehospital care providers.
3. Bring all documentation to the receiving hospital or in the case of no transport, have documentation available for medical examiner/coroner.

### **Hospice Patients**

Terminally ill patient participating in a hospice program often have written treatment orders and may possess a valid DNR document. Medical Control is to be contacted regarding supportive treatment measures.

### **Sustained Cardiac Arrest Not Responding to Treatment**

Note: Only a Physician may make the determination to withdraw resuscitative efforts and pronounce the patient dead at the scene.

In event of communication failure, this policy not considered to be a standing order.

1. While continuing patient care, contact Medical Control and report the events of the call including estimated duration of cardiopulmonary arrest and treatment rendered.
2. Reaffirm all of the following:
  - \* The patient is a normothermic adult, and experienced an un-witnessed arrest.
  - \* Managed airway and IV/IO placement has been confirmed.
  - \* The patient remains in cardiopulmonary arrest despite aggressive BLS and ALS treatment modalities following the appropriate SOP.
3. If the Physician orders the termination of resuscitative efforts, note the time of death, and Physicians name that terminated the effort.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** March 10, 1998

**REVISED:** February 2017

**POLICY TITLE:** **DISBURSEMENT OF EMS ASSISTANCE FUNDS**

**POLICY:** **5**

This policy has been generated to provide for the disbursement of moneys received from the EMS Assistance Fund. These moneys shall be used for the purposes of organization, development and improvement of Emergency Medical Services Systems, including, but not limited to: training of personnel and acquisition, modification and maintenance of necessary supplies, equipment and vehicles.

**PROCEDURE:**

1. Any Region X EMS participant may apply for funds through Illinois Department of Public Health.
2. All Region X EMS participants will be notified by Illinois Department of Public Health. Application shall be made through the Illinois Department of Public Health Egrams software program.
3. The awarding of funds by IDPH shall be based on demonstrated need and one or more of the following:
  - a. Establishment of a new EMS agency, program or service where needed to improve emergency medical services available in an area;
  - b. Expansion or improvement of an existing EMS agency, program or service;
  - c. Replacement of equipment that is unserviceable or procurement of new equipment;
  - d. Establishment, expansion or improvement of EMS education and training programs including the adult and pediatric population.
4. Applications for regional requests will be forwarded by IDPH to the Chair of the Region X EMS Advisory Committee.
5. The Region X EMS Advisory Executive Group shall review all applications received before the deadline established by IDPH.
6. The amount of the award will be based upon the amount requested within the application, the recommendation of the Region X EMS Advisory Executive Group and the amount available in the Fund for distribution. The final decision rests with IDPH.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** December 1, 1999

**REVIEWED:** February 2017

**POLICY TITLE:** INTER-SYSTEM GUIDELINES FOR MEDICAL CONTROL

**POLICY:** 6

Within Region X there are four EMS Systems which coordinate Medical Control for prehospital care providers. One Standard Operating Procedure document exists for all four EMS Systems. It is in the patient's best interest to allow any Region X Resource or Associate Hospital to direct Medical Control. NOTE: Affiliated Associate Hospitals may be located outside of the Region X boundaries.

**PROCEDURE:**

1. Prehospital Provider Agency **MUST** be approved to function in Region X.
2. Medical Control **MUST** be obtained from a Region X Resource or Associate Hospital.
3. Providers are encouraged to contact Medical Control at the receiving hospital.
4. In the event the Provider cannot communicate with the intended facility, the Provider shall contact their Resource Hospital for Medical Control.
5. Individual EMS System's Override Policies will prevail in the event of a Medical Control conflict.
6. Conflicts regarding patient care or any other difficulties shall be addressed by using the Region X Inter-System Conflict Resolution Policy.
7. In the event of an Inter-System conflict, all written and or recorded documentation will be shared between involved Systems.
8. Authority for this policy has been delegated by each System EMS Medical Director.

**REGION X**  
**INTER-SYSTEM MEDICAL CONTROL**  
**COMMUNICATION POINTS**

**HOSPITAL CONTACTS**

NLC - NORTH LAKE COUNTY	HPH – HIGHLAND PARK	CMC – CONDELL MEDICAL CENTER	SF - ST. FRANCIS	
HOSPITAL	SYSTEM	CELLULAR TELEMETRY	RADIO TELEMETRY	
			MERCI 400	
Condell Medical Center	CMC	847-362-2963	MED 5 / MED 3	YES
Evanston Hospital	HPH/SF	847-492-9453	MED 2 / MED 5	YES
Glenbrook Hospital	HPH	847-729-9260	MED 2/ MED 5	YES
		847-657-6010		
Highland Park Hospital	HPH	847-432-2294	MED 2/ MED 5	YES
		847-432-2295		
Lake Forest Hospital	CMC/NLC	847-295-1440	NONE	YES
LF Grayslake Freestanding ED	CMC	847-535-8736	NONE	YES
St. Francis Hospital	SF	847-864-6564	MED 2/ MED 5	YES
		847-864-8550		
Skokie Hospital	HPH/SF	847-674-2665	MED 2/ MED 5	YES
Vista East Medical Center	NLC	847-360-4234	NONE	YES
Vista West Medical Center	NLC	847-360-2323	NONE	YES
Vista Lindenhurst Freestanding ED	NLC	847-356-4782		
North Chicago VA Hospital	NLC	224-610-1075		
		224-610-1076		
St. Catherine's	NLC	262-656-1151		
		262-656-1153		
Aurora Medical Center	NLC	262-694-1968		
		262-694-1973		

**REGION X**  
**INTER-SYSTEM PROVIDER LISTING**

NLC - NORTH LAKE CTY

HPH – HIGHLAND PARK

SF - ST. FRANCIS

CMC – CONDELL MEDICAL CENTER

<b>Provider</b>	<b>EMS System</b>	<b>Level of Service</b>
Abbott	CMC	BLS
A-TEC	NLC	BLS/ALS
Antioch Fire	CMC	ALS
Beach Park Fire	NLC	ALS
Countryside Fire	CMC	ALS
Deerfield Fire	HPH	ALS
Elite Ambulance	SF/NLC	BLS/ALS/CCT
Evanston Fire	SF	ALS
Glencoe Public Safety	HPH	ALS
Grayslake Fire	CMC	ALS
Great Lakes Fire Department	NLC	BLS/ALS
Gurnee Fire	HPH	ALS
Highland Park Fire	HPH	ALS
Houston PI	HPH	BLS
Knollwood	CMC	BLS
LJH Ambulance	NLC	BLS/ALS
Lake Bluff	CMC	BLS
Lake Forest Fire	CMC	ALS
Lake Villa Fire	NLC	ALS
Libertyville Fire	CMC	ALS
Lincolnwood Fire	SF	ALS
Mundelein Fire	CMC	ALS
Murphy Ambulance	NLC/CMC	BLS/ALS
Newport Fire	CMC	ALS
North Chicago Fire	NLC	ALS
Northbrook Fire	HPH	ALS
Northfield Fire	SF	ALS
Round Lake Fire	CMC	ALS
Sedgebrook	CMC	BLS
Six Flags/Great America	HPH	ALS/BLS
Skokie Fire	SF	ALS
Superior Ambulance	SF/ NLC/HPH	BLS/ALS/CCT
Wauconda Fire	CMC	ALS
Waukegan Fire	NLC	ALS
Wheeling Fire	SF	ALS
Wilmette Fire	SF	ALS
Winnetka Fire	SF	ALS
Winthrop Harbor Fire	NLC	ALS
Zion Fire Department	NLC	ALS

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** February 2000

**REVIEWED:** February 2017

**POLICY TITLE:** **SCHOOL BUS ACCIDENTS**

**POLICY:** **7**

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

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

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

**PROCEDURE:**

1. Upon arrival at the scene;
  - a. Determine the category of the accident:

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

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

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

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

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



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

- c. Other injured patients are treated and transported as required.  
For adults, follow your EMS System's policy.
  - d. Contact Medical Control, advise of the existence of a Category B or C bus accident, and determine if a scene discharge of uninjured children by the emergency department physician in charge of the call is appropriate.
  - e. Implement provider procedures for contacting parents/legal guardians or school officials to receive custody of the uninjured children.
  - f. The provider agency then transfers the custody of the minor children, consistent with its own policies and procedures, to parents/legal guardians or school officials.
  - g. The school representative will then follow their own policies to include informing the parent(s)/legal guardians as regards the accident/incident.
2. **DISPOSITION OF UNINJURED CHILDREN:** This policy only governs the disposition of uninjured children. A list of children who have been determined to be uninjured by medical personnel will be completed at the scene of the accident. All uninjured students will be discharged to the custody of school officials upon approval of Medical Control as per procedure in 1) F. Use your EMS System's approved form for such documentation.
3. **PROVIDER RESPONSIBILITY:** Once the decision is made by the emergency department physician to discharge the children at the scene, it is the responsibility of the local responding EMS agency in charge of the scene to make certain that these children are returned to their parents/legal guardians or appropriate school officials.

### CAVEAT

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

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** March 2001

**REVIEWED:** February 2017

**POLICY TITLE:** EMS SYSTEM-WIDE CRISIS PREPAREDNESS POLICY

**POLICY:** 8

To **enhance communication** and provide situational awareness between the EMS System Resource Hospital, Associate Hospitals, EMS providers and community agencies regarding a potential or actual area-wide crisis, including but not limited to such events as overcrowding events due to same like symptoms, weather, special events, or other potential or real crisis situations.

**PROCEDURE:**

1. Any individual in the above named organizations may identify a potential or actual crisis and initiate this policy.
2. That individual should contact their supervisor (i.e. Charge Nurse, Medical Officer, etc.).
3. The supervisor shall contact the Resource Hospital EMS System Coordinator or their designee and identify their concerns.
4. The EMS System Coordinator/Designee shall determine the need to activate this policy and notify the RHCC hospital (Highland Park Hospital).
5. If deemed appropriate, the EMS System Coordinator/Designee at the RHCC hospital will contact and discuss the situation with the IDPH Regional EMS Coordinator.
6. Communications shall continue between applicable agencies per the specifics of the situation.
7. Once the crisis is determined to be over, the EMS System Coordinator/Designee will recontact all agencies.
8. Appropriate documentation shall be maintained.
9. Discussion, critique and Performance Improvement measures regarding this policy and its activation will be conducted quarterly at the Region X EMS Trauma meetings.

**RESOURCE HOSPITAL WORKSHEET  
FOR  
SYSTEM-WIDE CRISIS FORM**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

\_\_\_\_\_  
Name of Resource Hospital

\_\_\_\_\_  
Name of Person Filling  
In Report/Title

\_\_\_\_\_  
Telephone Number

Names of Associate Hospitals/Participating Hospitals That Have Seen an Increase in E.D. Visits (Clusters, Similar Symptoms, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Common Signs/Symptoms of Patients Who are Coming to the Emergency Department:

\_\_\_\_\_  
\_\_\_\_\_

Names(s) of Providers(s) in the Area Who Have Seen an Increase in Runs:

\_\_\_\_\_  
\_\_\_\_\_

Name and Time of EMS Coordinator/Designee or EMS Medical Director Notification:

\_\_\_\_\_  
Date/Time/Name of Person Notified at the State (Regional EMS Coordinator)

Name	How Contacted	Time Notified	Date Notified
	(Pager, Phone, Fax)		



**EMS PROVIDER/ASSOCIATE & PARTICIPATING HOSPITAL  
SYSTEM-WIDE CRISIS - WORK SHEET CONTINUED**

**Page 2**

Resource Hospital Contacted:                     Yes                     No

Person Contacted at Resource Hospital:

Name	Title

How was Information Reported?	Phone	<input type="radio"/>
	Fax	<input type="radio"/>
	Page	<input type="radio"/>
	Dedicated Phone Line	<input type="radio"/>
	Person to Person	<input type="radio"/>
	Other	<input type="radio"/>

Names/Organizations and/or Titles of Other Persons Contacted:

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Upon completion, copy of report should be forwarded to Resource Hospital EMS System Coordinator.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1, 1998  
**REVISED:** October 2017

**POLICY TITLE:** TRAUMA CENTER DESIGNATION

**POLICY:** 9

<b>Hospital Designations for Specialty Transports</b>						
<b>Region 10 Hospitals</b>	<b>Location</b>	<b>EMS designation</b>	<b>Stemi Center</b>	<b>Trauma Center Level</b>	<b>Stroke Center</b>	<b>EDAP</b>
<b>Condell (Advocate)</b>	<b>801 S. Milwaukee Avenue Libertyville</b>	<b>Resource</b>	<b>Yes</b>	<b>1</b>	<b>Primary</b>	<b>Yes</b>
<b>NorthShore Evanston Hospital</b>	<b>2650 Ridge Avenue Evanston</b>	<b>Resource</b>	<b>Yes</b>	<b>1</b>	<b>Primary</b>	<b>Yes</b>
<b>NorthShore Glenbrook Hospital</b>	<b>2100 Pfingsten Glenview</b>	<b>Associate</b>	<b>Yes</b>	<b>2</b>	<b>Primary</b>	<b>Yes</b>
<b>NorthShore Highland Park Hospital</b>	<b>777 Park Avenue West Highland Park</b>	<b>Resource RHCC</b>	<b>Yes</b>	<b>2</b>	<b>Primary</b>	<b>Yes</b>
<b>NorthShore Skokie Hospital</b>	<b>9600 Gross Point Road Skokie</b>	<b>Associate</b>	<b>Yes</b>	<b>2</b>	<b>Primary</b>	<b>Yes</b>
<b>NWM Grayslake Freestanding Emergency Department</b>	<b>1475 E. Belvidere Road Grayslake</b>	<b>Associate</b>				
<b>NWM Lake Forest</b>	<b>660 N. Westmoreland Lake Forest</b>	<b>Associate</b>	<b>Yes</b>	<b>2</b>	<b>Primary</b>	<b>Yes</b>
<b>St Francis (Presence)</b>	<b>355 Ridge Avenue Evanston</b>	<b>Resource</b>	<b>Yes</b>	<b>1</b>	<b>Primary</b>	<b>Yes</b>
<b>Froedtert South</b>	<b>9555 76<sup>th</sup> Street Pleasant Prairie WI</b>	<b>Associate</b>		<b>2</b>	<b>Primary</b>	<b>No</b>

<b>St Catherine's Medical Center</b>						
<b>Aurora Medical Center</b>	<b>10400 75<sup>th</sup> Street Kenosha WI</b>	<b>Associate</b>	<b>No</b>	<b>2</b>	<b>No</b>	
<b>Vista Lindenhurst Freestanding Emergency Department</b>	<b>1050 Red Oak Lane Lindenhurst</b>	<b>Associate</b>	<b>No</b>	<b>N/A</b>	<b>No</b>	<b>Yes</b>
<b>Vista East Medical Center</b>	<b>1324 N. Sheridan Road Waukegan</b>	<b>Resource</b>	<b>Yes</b>	<b>2</b>	<b>Primary</b>	<b>Yes</b>
<b>Vista West Medical Center</b>	<b>2615 Washington Street Waukegan</b>	<b>Associate</b>	<b>No</b>	<b>N/A</b>	<b>No</b>	<b>Yes</b>

\*Emergency Department Approved for Pediatrics, (EDAP) certified facility

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1, 1998

**REVISED:** January 2017

**POLICY TITLE:** **TRAUMA PATIENT TRIAGE CRITERIA**

**POLICY:** **10**

*Pre-hospital providers and participating Level I and Level II Trauma Centers will categorize trauma patients based on the same criteria according to ACS "Resource".*

*1. Mandatory Categorization*

*A. Minimum Field Triage Criteria: Patients that are determined in the pre-hospital setting to have sustained hypotension, or are the victim of cavity penetration of the torso or neck, shall be classified as a Category I trauma patient in the field. Any EMS System transporting patients that are classified as a Category I require rapid transport to the highest level trauma center within 25 minutes.*

**B. Category I Criteria**

i. Unstable Vital Signs

1. Glasgow Coma Scale  $\leq$  13 with associated head trauma
2. Respiratory Rate  $<$  10 OR  $>$  29 ( $<$ 20 in infant  $<$  1 yr) or need for ventilatory support

ii. Anatomical Criteria

1. Penetrating injuries to head, neck, torso & extremities proximal to elbow or knee
2. Two or more proximal long bone fractures
3. Unstable pelvis
4. Chest wall instability or deformity (e.g. Flail chest)
5. Crushed, degloved, mangled or pulseless extremity
6. Open or depressed skull fractures
7. Amputation proximal to wrist or ankle
8. Paralysis

**C. Category II Criteria**

i. Mechanism of Injury

1. High Risk Auto Crash:
  - a. Ejection (partial or complete) from automobile
  - b. Death in same passenger compartment
  - c. Intrusion, including roof:  $>$  12 inches occupant site;  $>$  18 inches any site
  - d. Vehicle telemetry data consistent with a high risk for injury
  - e. Motorcycle crash  $>$  20 mph
  - f. Rollover (Unrestrained)
2. Falls
  - a. Adult Falls  $\geq$  20 feet (One story = 10 feet)
  - b. Peds Falls  $\geq$  feet or 2X the height of the child
3. Other
  - a. Auto vs. Pedestrian thrown or run over or with  $>$  20mph impact



- b. Auto vs. Bicyclist thrown, run over or with > 20mph impact

**D. Special Considerations (does not require pt to be categorized if no other criteria is met)**

- i. Age
    - 1. Adults > 55 yrs: risk of injury & death increases
    - 2. SBP < 110 might be shock age > 65 yrs
    - 3. Low impact mechanisms/standing falls may lead to severe injury
    - 4. Children should be transported to a trauma center
  - ii. Anticoagulation and bleeding disorders
    - 1. Pt with head injury are at high risk for rapid deterioration
  - iii. Burns
  - iv. Pregnancy > 20 weeks
2. Transport criteria:
- A. Category I:
    - i. Initiate Field Trauma Treatment protocols.
    - ii. Rapid transport to a Level I trauma center, unless transport time is >25 minutes.
    - iii. If transport times >25 minutes, transport to closest Level II trauma center.
    - iv. If transport times to closest Level I or Level II >30 minutes, transport to closest hospital.

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1, 1998

**REVISED:** January 2017

**POLICY TITLE:** **TRANSPORTATION OF TRAUMA PATIENTS**

**POLICY:** **11**

Within Region X there are three Level I and six Level II Trauma Centers, all of which are prepared to accept both adult and pediatric trauma patients. EMS Providers transport these patients to the appropriate level facility based on patient criteria, transport time and distance.

It is the responsibility of each EMS System to educate their providers as to the level status and location of all trauma centers within the provider's transport jurisdiction.

**PROCEDURE:**

See Region X Field Trauma Triage and Transport Criteria on next page.

**REGION X FIELD TRAUMA TRIAGE AND TRANSPORT CRITERIA**

**NOTE:** Traumatic Arrest – Transport to closest Trauma Center  
 No Airway – Transport to closest Comprehensive Emergency Department

<p><u>Systolic Blood Pressure</u>                  Adult <math>\leq 90</math> (2 consecutive measurements)                  Peds <math>\leq 80</math> (2 consecutive measurements)</p>	<p>⇒ Yes</p>	<p>Transport to <b>highest level</b> Trauma Center within 25 minutes transport time</p>
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No ↘

<p><b>Category I</b>  <u>Unstable Vital Signs</u>                  •Glasgow Coma Scale <math>\leq 13</math> with associated head trauma                  •Respiratory Rate <math>&lt;10</math> or <math>&gt;29</math> (<math>&lt;20</math> infant <math>&lt;1</math> year) or need for ventilatory support  <u>Anatomic Criteria</u>                  •Penetrating injuries to head, neck, torso and extremities proximal to elbow or knee                  •Two or more proximal long bone fractures                  •Unstable pelvis                  •Chest wall instability or deformity (e.g. flail chest)                  •Crushed, degloved, mangled or pulseless extremity                  •Open or depressed skull fractures                  •Amputation proximal to wrist or ankle                  •Paralysis</p>	<p>⇒ Yes</p>	<p>Transport to <b>highest level</b> Trauma Center within 25 minutes transport time</p>
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No ↘

<p><b>Category II Mechanism of Injury</b>  <u>High Risk Auto Crash</u>                  •Ejection from Automobile (partial or complete)                  •Death in same passenger compartment                  •Intrusion, including roof; <math>&gt;12</math> inches occupant site or <math>&gt;18</math> inches any site                  •Vehicle telemetry data consistent with a high risk for injury                  •Motorcycle crash <math>&gt;20</math> mph                  •Rollover (Unrestrained)  <u>Falls</u>                  •Adult Falls <math>\geq 20</math> feet (1 story = 10 feet)                  •Peds falls <math>\geq 10</math> feet or 2X height of the child  <u>Other</u>                  •Auto vs. Pedestrian thrown or run over or with <math>&gt;20</math> mph impact                  •Auto vs. Bicyclist thrown, run over or with <math>&gt;20</math> mph impact</p>	<p>⇒ Yes</p>	<p>Transport to <b>closest</b> Trauma Center</p>
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No ↘

<p><u>Special Considerations</u>  <u>Age:</u>                  Adults <math>&gt;55</math> years; risk of injury and death increases                  SBP <math>&lt;110</math>; might be shock if age <math>&gt;65</math> years                  Low impact mechanisms/standing falls may lead to severe injury                  Children should be transported to a trauma center  <u>Anticoagulation and bleeding disorders:</u> Patient with head injury is at high risk for rapid deterioration  <u>Burns:</u> MOI with or without trauma: transfer to closest trauma center  <u>Pregnancy</u> <math>&gt;20</math> weeks  <u>EMS Provider judgment</u></p>	<p>⇒ Yes</p>	<p>Transport to <b>closest</b> Trauma Center</p>
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No ↘  
**Transport to closest appropriate comprehensive emergency department**

**EMS TRAUMA REGION X  
POLICY STATEMENT AND PROCEDURE**

**EFFECTIVE:** June 1, 1998

**REVISED:** January 2017

**POLICY TITLE: REGION X TRAUMA PI PROTOCOLS**

**POLICY: 12**

All Trauma Centers within the region will perform quarterly PI reviews, which shall include the following criteria:

1. All trauma related deaths. This review should exclude trauma patients who were dead on arrival.
2. ISS review
  - a. Level I trauma center patients with an ISS  $\geq$  25
  - b. Level II trauma center patients with an ISS  $\geq$  20
3. Any QI indicators/audit filters determined by the Region.
4. Cumulative data reports will be made available to IDPH.

**Procedure:**

1. Data collected will be reviewed and discussed at the quarterly Region X Trauma Coordinator PI committee meeting.
2. Cases determined to be class III, or IV will be submitted and discussed at the quarterly Region X Trauma/EMS Executive committee meeting.
3. If further action is required it will be addressed by the Region X Executive committee, which includes a Region X designated Trauma Surgeon.
4. All trauma centers will maintain records of their PI reports/statistics discussed at the quarterly Region X Trauma Coordinator meetings.
5. All data collected will be maintained and available to IDPH upon request by the current Level I Trauma Coordinator.
6. The current Level I Trauma Center will maintain a copy of each hospital's report.
7. If there is more than one Level I Trauma Center, this role will rotate on a two year cycle.
8. All minutes will be confidential and protected by peer review.