



Appendices

Appendix Table of Contents

Document.....	Page
Approved Abbreviations	A 1
Hospital Transport Guidelines	A 2
Infection Prevention & Exposure Management	A 3
Interfacility Medical Staffing Requirements	A 4
Provider Clinical Performance Review Process	A 5
Patient Transport Classification System	A 6
Suspected Child Abuse	A 7
Vital Signs Parameters.....	A 8

Approved Abbreviations

To ensure consistency in patient care reporting, the following is a list of System approved abbreviations

-A-			
Â	Before	A&Ox3	Alert & oriented to (PPT)
AAA	Abdominal aortic aneurysm	Abd	Abdomen
AB	Abortion	ABC	Airway, breathing, circulation
ABG	Arterial blood gas	a.c.	Before meals
A/C	Aircraft	ACE	Angiotensin-converting enzyme
ACS	Acute Coronary Syndrome	a.d.	Right ear (auris dexter)
ADD	Attention deficit disorder	A.E.	Above elbow (amputation)
AED	Automated external defibrillator	A Fib	Atrial fibrillation
Af	Atrial flutter	AIDS	Acquired immunodeficiency syndrome
AIVR	Accelerated Idioventricular rhythm	A.K.	Above knee (amputation)
ALS	Advanced Life Support	AMI	Acute myocardial infarction
Ant	Anterior	AOS TF	Arrived On Scene To Find
APAP	Acetaminophen (APAP)	APS	Adult Protective Services
APGAR	Appearance, Pulse, Grimace, Activity, Respiratory effort	ARDS	Adult respiratory distress syndrome
AS	Left ear (auris sinistra)	ASA	Acetyl salicylic acid (Aspirin)
ATF	Arrived to find	AV	Atrioventricula
AVA	Alternate vascular access	AVM	Arteriovenous malformation
-B-			
BBB	Bundle branch block	BBS	Bilateral breath sounds
B.E.	Below elbow (amputation)	BGL	Blood glucose level
b.i.d.	Twice a day	B.K	Below knee (amputation)
BLS	Basic life support	BM	Bowel movement
BP	Blood Pressure	BS	Breath, bowel sounds
BSA	Body surface area	BVM	Bag valve mask

Approved Abbreviations

-C-

C	With	C°	Centigrade
C/C	Chief complaint	c/o	Complains / complaining of
CA	Carcinoma, cancer	Ca++	Calcium
CABG	Coronary artery bypass graft	CAD	Coronary artery disease
CAO x 3 or 4 or PPT	Conscious, Alert, & Oriented to Person, Place, Time & Events	CAT/CT	Computerized axial tomography scanner
CBC	Complete blood count	Cc	Cubic centimeter
Cm	Centimeter	CCB	Calcium channel blocker
CCU	Coronary / critical care unit	CHF	Congestive heart failure
CHI	Closed head injury	CID	Cervical Immobilization Device
CK	Creatine kinase	CK-MB	Creatine kinase myocardial band
Cl	Chlorine	CNS	Central nervous system
COPD	Chronic obstructive pulmonary disease	CO	Cardiac output / carbon monoxide
CO2	Carbon dioxide	+CMS	Positive circulatory, motor & sensory function
CNS	Central nervous system	CP	Chest pain
CPAP	Continuous positive airway pressure	CPR	Cardiopulmonary resuscitation
CPS	Child Protective Services	CRT	Capillary refill time
C-spine	Cervical spine	CSF	Cerebrospinal fluid
CSM	Carotid sinus massage	CTA	Clear to auscultation
CVA	Cerebrovascular accident	CVP	Central venous pressure
Cx	Chest	CXR	Chest x-ray

-D-

DCAP BTLS	Deformities, Contusions, Abrasions, Penetrations, Paradoxical movements, Burns, Tenderness, Lacerations, Swelling	DIC	Disseminating intravascular coagulation
Diff	Difficulty	Disch	Discharge
D&C	Dilatation & curettage	dL	Deciliter (1/10 liter: 100 ml)
DAE	Dysbaric air embolism	DKA	Diabetic ketoacidosis
DM	Diabetes mellitus	DNAR	Did not attempt resuscitation

Approved Abbreviations

DNR	Do-not-resuscitate	DOB	Date of birth
DOE	Dyspnea on exertion	DOS	Dead on scene
DPT	Diphtheria, pertussis, tetanus	DT's	Delirium tremens
D5W	Dextrose 5% in water	D10W	Dextrose 10% in water
D25W	Dextrose 25% in water	D50	50% Dextrose
DVT	Deep vein thrombosis	Dx	Diagnosis

-E-

ECG/EKG	Electrocardiogram	EDC	Estimated date of confinement
EEG	Electroencephalogram	EF	Ejection fraction
e.g.	For example	EPS	Electrophysiological study
ER/ED	Emergency room/department	Epi	Epinephrine
Est.	Estimated	ESRD	End stage renal disease
ETA	Estimated time of arrival	ET	Endotracheal
ETC02	End-tidal carbon dioxide	ETOH	Ethyl alcohol, alcoholic beverage
ETT	Endotracheal tube	EXP	Expansion
EXT	Extremity(s)		

-F-

F	Female	F°	Fahrenheit
FBAO	Foreign body airway obstruction	FHx	Family history
FHR	Fetal heart rate	Fr	French
FSP	Full spinal precaution	FUO	Fever of unknown origin
Fx	Fracture		

-G-

G (+ #)	Gravida (G3, G4 etc.)	GCS	Glasgow coma scale/score
GERD	Gastroesophageal reflux disease	GI	Gastrointestinal
Gm, g	Gram	Gtts	Drops
GU	Genitourinary	GYN	Gynecology

Approved Abbreviations

-H-			
h, hr	Hour	H/A	Headache
HAV	Hepatitis A virus	HBV	Hepatitis B virus
HCTZ	Hydrochlorothiazide	HCV	Hepatitis C virus
HEENT	Head, eyes, ears, nose, throat	H&H	Hemoglobin and hematocrit
Hg	Mercury	HIV±	Human immunodeficiency virus
HR	Heart rate	HRT	Hormone replacement therapy
hs	At bedtime	HTN	Hypertension
Hx	History		
-I-			
ICD	Implanted cardioverter defibrillator	ICP	Intracranial pressure
ICU	Intensive care unit	IDDM/DM I	Insulin dependent diabetes mellitus (Type I)
ILS	Intermediate life support	IM	Intramuscular
IMV	Intermittent mechanical ventilation	Inf	Inferior
IO	Intraosseous	IPPB	Intermittent positive pressure breathing
IU	International units	IV	Intravenous
IVP	IV push	IVR	Idioventricular rhythm
-J-			
J	Joules	JVD	Jugular venous distention
-K-			
K+	Potassium	KED	Kendrick extrication device
KTD	Kendrick traction device	KVO	Keep vein open
Kg	Kilogram		

Approved Abbreviations

-L-

L	Left or Liter	L spine	Lumbar spine
L&D	Labor and delivery	L/S	Lung sounds
Lac	Laceration	LAD	Left axis deviation / left anterior descending
Lbs	Pounds	LBBB	Left bundle branch block
LGL	Lown-Ganong-Levine syndrome	Liq	Liquid
LLQ	Lower left quadrant	LMA	Laryngeal Mask Airway
LMP	Last menstrual period	LOC	Level/loss of consciousness
Lpm	Liter per minute	LR	Lactated Ringer's
LSB	Long spine board	LSD	Lysergic acid diethylamide
LUQ	Left upper quadrant	LVAD	Left Ventricular Assist Device
LVH	Left ventricular hypertrophy		

-M-

m	Meter	M	Male
mA	Milliamperes	mg	Milligram
MAE	Moves all extremities	MAP	Mean arterial pressure
Mcg	Microgram	MCL	Midclavicular line, modified chest lead
MDI	Metered dose inhaler	mEq	Milliequivalent
mL	Milliliter	mm	Millimeter
MMR	Measles, mumps, rubella	MOI	Mechanism of injury
Mph	Miles per hour	MS	Morphine Sulfate, Multiple Sclerosis
MVA	Motor vehicle accident	MVP	Mitral valve prolapse

-N-

Na+	Sodium	NAD	No apparent / acute distress
N/C	Nasal canula	NES	Non-English Speaking
NGT	Nasogastric tube	NH	Nursing home
NICU	Neurological, neonatal intensive care unit	NIDDM/DM II	Non insulin dependent diabetes mellitus (Type II)
NKA	No known allergies	NKDA	No known drug allergies
NMB	Neuromuscular blockade	NOI	No obvious injury

Approved Abbreviations

NP	Nurse Practitioner	NPA	Nasopharyngeal airway
NPO	Nothing by mouth	NRB	Non-rebreather mask
NS	Normal saline	NSAID	Non-steroidal anti-inflammatory drug
NT	Nasotracheal	NTG	Nitroglycerin
N/V/D	Nausea, vomiting, diarrhea		

-O-

O2	Oxygen	OB	Obstetrics
OBS	Organic brain syndrome	OBV	Obvious
OD	Overdose, right eye (oculus dexter)	OLMC	On-line medical consultation
OOH	Out of hospital	OPA	Oropharyngeal airway
OPP	Organophosphate poisoning	OPQRST	Pain Assessment: onset, provocation, quality, radiation, severity, time
OS	Left eye (oculus sinister)	OR	Operating room
oz.	Ounce	OSS	Oregon Spine Splint
∅	No or none		

-P-

p	After	p.c.	After meals
P (+ #)	Parity (P3, P4 etc)	PA	Physician assistant, pulmonary artery
PAI	Pharmacologically assisted intubation, Pre-Arrival Instructions	PASTMED	Provoking incident, Associated chest pain, Sputum production, Time of onset, Meds, Exercise tolerance, Diagnosis
PCI	Percutaneous coronary intervention	pCO2	Carbon dioxide pressure
PCP	Phencyclidine, Primary Care Physician	PCT	Patient care to
PE	Physical exam, pulmonary emboli, pulmonary edema	PEA	Pulseless electrical activity
PEEP	Positive end expiratory pressure	PERRL	Pupils equal round reactive to light
PICU	Pediatric intensive care unit	PID	Pelvic inflammatory disease
PMD	Primary/Private medical doctor	Pn	Pain
PND	Paroxysmal nocturnal dyspnea	P02	Partial pressure of oxygen

Approved Abbreviations

PO	By mouth	POC	Position of comfort
post.	Posterior	POV	Privately operated/owned vehicle
p.r.	Per rectum	PRBC's	Packed red blood cells
PRN	As needed	PSVT	Paroxysmal supraventricular tachycardia
Pt.	Patient	PTA/PTOA	Prior to (our) arrival
PTS	Pediatric trauma score	PVC	Premature ventricular contraction
PVT	Polymorphic ventricular tachycardia	P/W/D	Pink warm and dry

-Q-

Q	Every	Qh	Every hour
q.i.d.	Four times a day		

-R-

R	Right	RAD	Right axis deviation, reactive airway disease
RBBB	Right bundle branch block	Rbc	Red blood cell, red blood (cell) count
RCA	Right coronary artery	RHD	Rheumatic heart disease
RLQ	Right lower quadrant	ROSC	Return of spontaneous circulation
+ROM	Positive range of motion	RN	Registered nurse
RR	Respiratory rate	RSV	Respiratory syncytial virus
RTS	Revised trauma score	RUQ	Right upper quadrant
Rx	Prescription		

-S-

š	Without	s/s	Signs / symptoms
SAO2	Oxygen saturation of arterial oxyhemoglobin	SARS	Severe acute respiratory syndrome
SBP	Systolic blood pressure	SC, SQ	Subcutaneous
SCI	Spinal cord injury	SCUBA	Self contained underwater breathing apparatus
SIDS	Sudden infant death syndrome	SL	Sublingual, Saline Lock
SOAPE	Subjective, Objective, Assessment, Plan, Enroute	SOB	Shortness of breath

Approved Abbreviations

SROM	Spontaneous Rupture of Membranes	St	States
STD	Sexually transmitted disease	SUV	Sport utility vehicle
SVT	Supraventricular tachycardia	Sx	Symptoms

-T-

T spine	Thoracic spine	TBI	Traumatic brain injury
Temp	Temperature	tab	Tablet
TB	Tuberculosis	Tbsp	Tablespoon
TCP	Transcutaneous pacing	TCA	Tricyclic antidepressant
TdP	Torsades de Pointes	TIA	Transient ischemic attack
t.i.d.	Three times a day	TKO	To keep open
TOT	Turned Over To	Tsp	Teaspoon
Tx	Treatment		

-U-

u	Unit	µg	microgram
U/A	Upon arrival, urine analysis	URI	Upper respiratory infection
UTI	Urinary tract infection	UTL	Unable to locate
UTO	Unable to obtain		

-V-

VD	Venereal disease	Vol	Volume
VO	Verbal order	VF	Ventricular fibrillation
VS	Vital signs	Vt	Tidal volume
VT	Ventricular tachycardia		

-W-

w/	With	w/o	Without, wide open
WDWN	Well developed, well nourished	WNL	Within normal limits
WPW	Wolf-Parkinson-White		

-X-

X-fer	Transfer	X-prt	Transport
--------------	----------	--------------	-----------

-Y-

y/o	Years old		
------------	-----------	--	--

Approved Abbreviations

-Symbols-			
α	Alpha	β	Beta
@	At	?	Questionable, possible
♀	Female	♂	Male
1°	First degree	2°	Second degree
3°	Third degree	x	Times
Δ	Delta (change)	+	Positive
-	Negative	=	Equal
≠	Not equal to	≈	Approximately
↓	Decreased / below / lower	↑	Elevated / increased / upper
→	Move/went to	↔	Between
#	Number		

Decisions regarding patient destination should be made in the following order, AGE appropriate and: Trauma ACTIVATION, ***if not then*** Condition listed below (closest designated facility) ***if not then*** Patient and/or family preference ***if not then*** Closest facility listed.

Comprehensive List of Approved Transport Facilities

University Medical Center at Brackenridge	Dell Children's Medical Center	Heart Hospital of Austin	North Austin Medical Center
Round Rock Hospital	Seton Medical Center Austin	Seton Northwest Medical Center	Seton Southwest Medical Center
South Austin Hospital	St. David's Medical Center	Westlake Medical Center	Austin Women's Hospital
University Medical Campus. Round Rock, S & W	Seton Medical Center Williamson	Cedar Park Regional Medical Center	Seton Medical Center Hays
St. David's Bee Cave (FSED)			

SINGLE TRAUMA PATIENT IN THE UNIT

Trauma ACTIVATION ≥15 yrs **OR** <15 yrs (**With OB or Cardiac Arrest**) closest Adult Level 1 or 2 Trauma Center: UMC Brackenridge, Round Rock Hospital or Seton Medical Center Williamson.

Trauma ACTIVATION <15 yrs Dell Children's Medical Center (**EXCEPT – OB**) unless a prolonged transport would potentially compromise the patient, then closest Adult Level 1 or 2 Trauma Center for immediate stabilization, **then on to Dell Children's Medical Center.**

MULTIPLE TRAUMA PATIENTS IN THE SAME UNIT

Guiding principle of trauma transportation destination decision with multiple patients in the unit: The most severely injured patient determines the destination unless a prolonged transport would potentially compromise either patient, then closest Level 1 or 2 Trauma Center.

- **STEMI ALERT with 12 Lead Transmission (when available)** ≥ 18 yrs All Hospitals **EXCEPT:** Seton Northwest Medical Center, Seton Southwest Medical Center, Dell Children's Medical Center, Cedar Park Regional Medical Center, Austin Women's Hospital and St. David's Bee Cave (FSED).
- **STEMI ALERT with 12 Lead Transmission (when available)** < 18 yrs Dell Children's Medical Center (**EXCEPT – OB**)
- **Stroke ALERT Level 1** ≥18 yrs UMC Brackenridge Hospital, Seton Medical Center Austin, and St. David's Medical Center
- **Stroke ALERT** < 18 yrs Dell Children's Medical Center (**EXCEPT – OB**)
- **Resuscitation ALERT** ≥ 18 yrs UMC Brackenridge Hospital, Round Rock Hospital, South Austin Hospital, Seton Medical Center Austin, St. David's Medical Center, Seton Medical Center Williamson, Heart Hospital of Austin, North Austin Medical Center, Seton Medical Center Hays
- **Resuscitation ALERT** < 18 yrs Dell Children's Medical Center (**EXCEPT - OB**)
- **Basic Receiving Facility** ≥ 18 yrs (**Alpha, Bravo, Charlie–non OB**) All Hospitals **EXCEPT:** Dell Children's Medical Center and Austin Women's Hospital
- **Basic Receiving Facility** < 18 yrs (**Alpha, Bravo, Charlie–non OB**) All Hospitals **EXCEPT:** Austin Women's Center



- **Comprehensive / Critical Care Facility** ≥18 yrs (**Delta & Echo – non trauma/non OB**)
All Hospitals **EXCEPT**: Seton Southwest Medical Center, Westlake Medical Center, University Medical Campus RR, Dell Children’s Medical Center, Cedar Park Regional Medical Center, Austin Women’s Hospital and St. David’s Bee Cave (FSED).
- **Comprehensive / Critical Care Facility** <18 yrs (**Delta & Echo – non trauma/non OB**)
Dell Children’s Medical Center
- **OB ECHO Patients** All Ages, UMC Brackenridge
- **OB Delta Patients** All Ages, All Hospitals **EXCEPT**: Dell Children’s Medical Center, Heart Hospital of Austin, Westlake Medical Center, Seton Southwest Medical Center, University Medical Campus RR, Cedar Park Regional Medical Center and St. David’s Bee Cave (FSED).
- **OB Pre-Registered and/or OB Alpha, Bravo, Charlie, Patients** All Ages, All Hospitals **EXCEPT**: Dell Children’s Medical Center, Heart Hospital of Austin, Westlake Medical Center and St. David’s Bee Cave (FSED).
- **Diving Barotraumas (HBO)** All Ages, St. David’s Medical Center
- **Sexual Assault** ≥18 yrs St. David’s Medical Center and St. David’s Round Medical Center
- **Sexual Assault** <18 yrs Dell Children’s Medical Center (**EXCEPT – OB or Menses has begun or Male ≥ 12 yrs old – these go to St. David’s Medical Center or St. David’s Round Rock Medical Center**)
- **FSED Additional conditions: NO Open Fractures and NO Psychiatric patients regardless of classification (Alpha, Bravo, Charlie).**

The “ALERT” status declaration is made to Communications and is for their assistance (as needed) in determining the most appropriate transport destination (based on time, distance and facility level/type). Communications will provide an “ALERT” notification to the selected Hospital. Then, communications will advise and facilitate the most expeditious mode of Transport (Ground or Air).

Infection Prevention

Adherence to infection Prevention principles is the responsibility of each Provider. All EMS Providers must be aware of well-known infectious agents (Hepatitis B, influenza, etc.), as well as emerging new pathogens (Avian Flu, SARS, etc.) that present challenges to medicine and risks to Providers. A personal commitment to employing basic infection Prevention measures on every single incident will provide the simplest and best protection against infectious diseases. Make it a habit!

Basic Protection Guidelines and Immunizations

The infection "triad" requires a portal of entry, an adequate amount of the infectious agent, and a susceptible host in order for a person to actually become infected. Through the engineering of safer equipment and the use of Personal Protective Equipment (PPE), we can prevent portals of entry and reduce the amount of materials to which you may be exposed.

Although it sounds simplistic and obvious, individuals that are well nourished, rested, and physically fit have immune systems that are more responsive and better prepared to mount an effective fight against invading pathogens. Taking care of ourselves decreases our long-term morbidity and allows us to recover more quickly should we become infected.

In any health care environment, Providers can expect to be routinely exposed to infectious agents. Immunizations are an extremely important weapon against infection from many of the more common agents. Keeping current on appropriate immunizations protects you, protects patients from becoming infected by you, and decreases overall disease transmission (this is a concept in public health known as herd immunity). As always, you should consult with your regular physician regarding your health care and immunization status. For healthcare workers, the currently available recommended immunizations (or documented immunity) include:

- Hepatitis B
- Measles
- Mumps
- Rubella
- Varicella
- Tetanus
- Diphtheria
- Pertussis
- Influenza (Pandemic & seasonal)
- Hepatitis A

Attention to ongoing hand washing, especially during the cold and flu season, is very important. Contact with contaminated surfaces provides a ready way for you to become infected and for you to infect others. Hands should be washed after each patient contact, the removal of gloves, and after cleaning all equipment. Waterless, alcohol-based hand cleaners are an acceptable alternative to soap and water provided there is no gross organic material present. To be effective, hand washing with soap and water needs to be performed for a minimum of twenty (20) seconds, using a vigorous rubbing together of all surfaces of lathered hands followed by thorough rinsing under a stream of water. If soap and water are not available at the scene, a waterless hand wash/wipe should be used before boarding the vehicle. Upon return to the station, all Providers should wash their hands with soap and water.

Additionally, it is important to conduct a self-check of your skin (particularly hands and exposed surfaces) prior to any potential patient contact. Identify scrapes, wounds, or other non-intact

Infection Prevention Exposure Management

surfaces and cover all open and scabbed wounds with bandages. The integrity of any bandages should be monitored during your shift to ensure the continuation of their protection.

Personal Protective Equipment (PPE)

PPE is designed to stop the transmission chain of an infectious agent by preventing potentially infectious microorganisms from contaminating a Provider's skin, mucous membrane, or clothing, and subsequently being transmitted to others. While PPE reduces the risk, it does not completely eliminate the possibility of infection, and is only effective if chosen and used correctly.

Remember, PPE should always be readily available, not just carried in the vehicle for those "surprise" circumstances where the possibility of exposure exists.

There are instances that the selection of appropriate PPE should be obvious and regarded by all Providers as standard practice. These include:

- Anytime patient contact is made, gloves are to be worn.
- During any type of airway management procedure, or other situation that fluid splash contact with the Provider's face is a possibility, the protection of mucous membrane is crucial. Effective mucous membrane protection may be afforded by use of the combination eye shield and mask apparatus, or N95 mask in conjunction with department issued or approved eyewear (goggles).
- Whenever the possibility exists that a patient's bodily fluids could be splashed onto a Provider, gowns should be utilized.

There are times when the selection of proper PPE, especially respiratory protection, is not so obvious and must be made based on how a disease is spread. In these situations, the difficulty in determining the appropriate level of protection is that a truly informed decision usually can't be made until a patient assessment is completed and/or a history is obtained. By then, it's too late! For that reason, a patient exhibiting any of the following signs or symptoms should be a signal to Providers, that in addition to gloves and, possibly a gown, some level of respiratory protection is required:

- Productive cough (with or without blood)
- Fever and chills with coughing
- Night sweats
- Dramatic (>10%) unexplained weight loss
- Fatigue (in the presence of other symptoms)
- Hemoptysis (coughing up blood)
- Nuchal rigidity (stiff neck)
- Chest and upper torso rash

In determining the type of respiratory protection needed, remember that only the N95 mask will afford protection against disease spread via airborne particles (i.e., tuberculosis), while the combination eye shield and mask apparatus is appropriate protection against disease spread through larger droplets (i.e., meningitis). In either case, protection is only afforded if the mask is worn properly.

- For a patient exhibiting signs and/or symptoms of a disease spread via airborne particles, the N95 mask should be donned prior to entering an enclosed area that the patient may have contaminated
- When caring for a patient with signs and symptoms of a disease spread through larger droplets, the N95 mask or combination eye shield and mask should be donned as soon as possible, and worn anytime the Provider is within six (6) feet of the patient.

Infection Prevention Exposure Management

- When airborne or droplet precautions are appropriate, the additional step of placing a non-rebreather mask with supplemental oxygen on the patient should be employed. This will limit the amount of aerosolized agent emitted.
- Provide surgical masks to all patients with symptoms of a respiratory illness who can tolerate its placement. Provide instructions on the proper use and disposal of masks.
- For patients who cannot wear a surgical mask in addition to any medical treatment being provided, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling these materials.
- Continue to use droplet precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond standard precautions.
- When in doubt, maximal rather than minimal PPE should be selected.

Sharps Hazards

- The greatest risk for an occupational exposure to blood occurs with the use of needles and other sharp utensils. The most common occupational blood exposure occurs when needles are recapped. Needles that have contact with human tissue should not be recapped, re-sheathed, bent, broken, or separated from disposable syringes.
- Used needles and other sharps shall be disposed of in approved sharps containers.
- Providers should ensure that no sharp is used in a manner inconsistent with its intended purpose or attempt to circumvent the safety features of the device.
- See Crime Scene Preservation (in Procedures Section) regarding used sharps at a potential crime scene.

Cleaning and Disinfection of Equipment and Work Areas

Remember how important it is to keep all medical equipment clean and free from infectious agents. The essential part of cleaning and disinfecting equipment is ensuring the removal of all accumulated organic material. Failure to remove organic material provides a continuing breeding ground for organisms. After the removal of the organic material, disinfecting can take place.

Be thorough with your cleaning and consider using your PPE eyewear if you need to do heavy cleaning that may result in splashing. Remember to clean any surface that your gloved hand may have contacted. After applying your disinfectant, permit the equipment to air dry. Wiping dry the wet disinfected surface will negate the effects of the agent and render it useless. Upon completion of the cleaning, make sure you wash your hands.

Exposure Follow-up

The purpose of PPE, and always using sound infection Prevention practices, is to reduce or eliminate the potential for infection. On occasion, a Provider is exposed to blood, bodily fluids, or airborne particles, and appropriate action must be taken. Many of these actions are time-dependent so it's important to initiate the reporting and follow up process as soon as possible. Besides adherence to sound infection Prevention practices, the most important thing you can do to ensure your health and well-being is to educate yourself. Become knowledgeable about infectious diseases, and the exposure reporting and follow-up process for your organization. Knowledge of the process specific to your organization ensures the right people are notified in a timely manner should post-exposure testing, follow-up, and documentation be required. Following are general guidelines to be followed should you experience, or suspect that you have experienced, an exposure to blood or other infectious material:

Infection Prevention Exposure Management

- Withdraw from patient care as soon as it is appropriate. This is usually at the completion of care but may need to occur sooner in some cases.
- Take self-care steps and cleanse the wound (or irrigate the membranes) with the appropriate solution immediately after any exposure to a patient's bodily fluids. Don't attempt to "milk" any needle stick injuries. This does not appear to be useful in removing source patient material.

Exposures require immediate intervention. Report any suspected exposure to communicable diseases to the appropriate designated individual in your department as quickly as possible. Questions and consultation regarding post exposure actions should be immediately directed to the Infection Preventionist through Austin/Travis County EMS Communications. Consultation may reveal that medical evaluation of the exposure, testing, follow-up, and/or additional documentation is necessary. In the case of a blood exposure due to needle stick (or other sharps), spray to mucous membrane, or patient blood contacting non-intact skin, the Provider should immediately travel, or be transported to, the closest appropriate facility for evaluation.

Interfacility Medical Staffing Requirements

1. The following medications and procedures are approved for ALS transfer:
 - Digibind
 - Mannitol
 - Etomidate
 - Lorazepam
 - Procainamide
 - Norepinephrine
 - Potassium supplements
 - Insulin or Insulin/D50 infusions
 - Steroids (mineral and glucocorticoid)
 - Patient Controlled Analgesic (PCA) pumps
 - GP IIb/IIIa Inhibitors (ReoPro, Integrilin, Aggrastat)
 - H1 blockers (benadryl, promethazine) and
 - Fentanyl Citrate
 - Ketamine
 - Antibiotics
 - Pralidoxime
 - Phenobarbital
 - Heparin (all forms)
 - Phenytoin/Fosphenytoin
 - Multivitamin preparations for infusion
 - Narcotics (Demerol, Dilaudid, Toradal)
 - Percutaneous Endoscopic Gastrostomy (PEG)
 - Beta Blockers (atenolol, Metoprolol, propranolol, esmolol)
 - H2 blockers (Tagamet, Zantac, Pepcid, Axid)
2. The following medications and/or devices require hospital or clinical staff for transport:
 - Diprivan
 - Arterial lines
 - Nitroprusside infusion
 - Intra-aortic balloon pump (IABP)
 - Central venous pressure (CVP) monitoring
 - Amrinone
 - Prostaglandin E1
 - Fibrinolytic therapy via infusion
 - Ventricular assist device (LVAD/ RVAD)
 - Pulmonary artery (PA) monitoring (Swan-Ganz catheter)
 - Blood, plasma, albumin, hetastarch, or dextran infusions
 - Post coronary angiography with insertion sheath still in place
 - Three or more infusion pumps in simultaneous use on any one patient
 - Infusion of paralytic agents unless intubated and receiving mechanical ventilation
 - ICP monitoring (intraventricular catheter, subarachnoid screw, epidural transducer)
 - Any other medication for hemodynamic stabilization or as an antiarrhythmic not listed as an approved medication above.
3. Any medication or device not on this list, or not included in the Clinical Operating Guidelines, will require an RN for transport.
 - Contact the EMS Communications Supervisor for consult with the On-Duty Medical Director.

Scope

All Clinical Providers credentialed to practice within the Austin/Travis County EMS System

Purpose

The Provider Clinical Performance Review Process provides a mechanism for the Medical Director to more fully and directly review significant clinical performance concerns in order to identify potential clinical performance improvements. This process also meets the requirements of the Texas Medical Board rules (TAC Title 22, Part 9, Chapter 197). Specifically, the Texas Medical Board requires the Medical Director to “direct an effective system audit and quality assurance program” and to “develop and implement a comprehensive mechanism for the management of patient care incidents”.

Background Information

At times, preliminary event review findings indicate the possibility of serious adverse actions or omissions on the part of an individual provider(s). In rare cases, such clinical concerns have the potential to result in significant action including a suspension or revocation of a Provider’s System Credentialing privileges. Although suspension of clinical credentials may occur quickly, revocation of clinical credentials will generally occur only after an OMD Clinical Performance Review. However, the Medical Director is ultimately responsible for the providers who practice under his medical license and thus always has the authority to revoke the System Credentialing privileges of any individual provider within the System without utilizing the OMD Clinical Performance Review process.

Nothing in this document should be interpreted to limit the authority of the Medical Director to perform as required by Texas laws and regulations, including but not limited to the authority to suspend an individual provider from medical care duties pending review and evaluation or to revoke System Clinical Credentials.

Definitions

OMD Clinical Performance Review – A formalized process initiated by the Office of the Medical Director intended to review the Clinical Event Review findings and root causes associated with a significant clinical incident.

Clinical Event Review – A formalized process initiated by a System Organization or the Office of the Medical Director following the identification of possible clinical event intended to review the circumstances, causes and remedial actions as applicable. [Refer to the OMD PI Plan Section titled “Clinical Event Review Process”]

Indications

An OMD Clinical Performance Review may be requested by the Medical Director or his designee at any time. However, such reviews are generally reserved for instances in which a Clinical Event Review’s findings suggest a significant clinical performance concern or a pattern of clinical performance concerns involving a provider(s). Examples of cases likely to indicate the need for an OMD Clinical Performance Review include but are not limited to:

1. A Clinical Event Review finding one of the following may have occurred
 - a. Falsification of any clinical documentation
 - b. Knowingly providing false information during a clinical review
 - c. Intentionally withholding care from a patient
 - d. Intentionally harming a patient
 - e. Providing care while impaired by drugs or alcohol



Provider Clinical Performance Review Process

- f. Failure to remediate and/or participate in a required education or clinical review
2. A clinical event in which actual harm to a patient appears to have occurred due to a provider's actions or omissions
3. Any clinical event with a high likelihood of resulting in an extended suspension or a revocation of a provider's System Credentialing privileges as determined by the Organization's Clinical Event Review process or the OMD.

Performance Review Group Membership

The OMD Clinical Performance Review group consists of members of the OMD Clinical Quality Committee and is expanded to include the following as members of the Committee while conducting the assigned Performance Review:

- One or Two providers having similar (as close as possible) characteristics as the provider being reviewed (selected by and from the same Organization as the provider being reviewed)
 - System Clinical Credential level
 - Organizational Rank
 - Organizational Tenure
- One Clinical Quality Improvement/Performance Management staff member; A Clinical Education staff may be selected instead when the Organization's Clinical QI/PM staff member is not available (Selected by and from the same Organization as the provider being reviewed)
- One Clinical Quality Improvement/Performance Management staff member from the Office of the Medical Director
- Two OMD Clinical Quality Committee Physicians selected by the Medical Director

A minimum of one similar provider is required. However, two similar providers are preferred. In the event the Organization is unable to provide at least one similar provider, the Medical Director may select an additional review member from the OMD or another System Organization.

Provider Clinical Performance Review Process

With the exception of the persons outlined above, no others are permitted to observe or actively participate in the OMD Clinical Performance Review group except as requested by the Medical Director. This exclusion applies to labor organization representatives, Human Resources representatives and Organization Management. The primary reason for this practice is to strictly comply with the Health and Safety Code rules regarding confidentiality of the records.

The provider being reviewed may choose to defer having colleagues from his/her Organization participate in the review. Though this practice is discouraged, the provider may request such a review by submitting the request in writing to the Medical Director. In such cases the review will continue but without the provider's colleagues from his Organization.

Rarely, clinical events involve performance concerns of providers from multiple System Organizations. Generally, Clinical Performance Reviews will be conducted separately for providers within each Organization. However, the Organizations and the Medical Director may agree to combine Review Group membership for such reviews. In all cases, individual Review decisions are made for each provider being reviewed regardless of the provider's Organizational affiliation.

Conflict of Interest

When an OMD Clinical Performance Review is requested, the provider(s) being reviewed will be asked to identify any persons within his/her organization who 1) have the potential to be selected to the Review Group as described in the Performance Review Group Membership section and 2) have a potential conflict of interest with regard to the provider(s). Conflict of interest may occur when the review group members are in a position to potentially exploit their membership for personal or other motivations unrelated to the purpose of the OMD Clinical Performance Review.

The simple matter of expressing a potential conflict of interest does not indicate any wrongdoing on the part of the review group members or the providers being review. It simply means the potential for bias or the perception of bias is present and identified. Examples of potential conflicts of interest for a Review Group Member include but are not limited to:

- A person who is likely to personally benefit from a specific outcome of the review
- A person has a past or present family interest or relationship with the provider(s) being reviewed (e.g. ex-spouse or significant other, uncle of the provider being reviewed)
- A person who has an employment or business relationship outside the provider's current Organization (e.g. is co-owner of a construction business with the provider being reviewed, works for the provider being reviewed)
- A person who has in the past openly expressed interest in reprisal against the provider being reviewed (e.g. a colleague who has filed a lawsuit in the past against the provider being reviewed)

The provider's Organization will select Review Group members who do not have a potential or real conflict of interest with regard to the provider being reviewed. An objective review of the provider's performance is the intent.

Confidentiality

For quality improvement efforts to be successful, providers and their Organizations must be secure in the fact that open discussions regarding less than optimal performance will remain confidential. For this reason, the Texas Health and Safety Code section 773.095 specifically addresses confidentiality of clinical review, evaluation and improvement documents. Section 773.095 states:

“the proceedings and records of organized committees of hospitals, medical societies, emergency medical services providers, emergency medical services and trauma care systems, or first responder organizations relating to the review, evaluation, or improvement of an emergency medical services provider, a first responder organization, an emergency medical services and trauma care system, or emergency medical services personnel are confidential and not subject to disclosure by court subpoena or otherwise.”

In order to maintain confidentiality of Committee records, the Committee must ensure it uses these records and protects these records ONLY in the course of its designated committee functions and within specific procedural methods. On the other hand, the Texas Health and Safety Code section 773.095 goes on to state

“this section does not apply to records made or maintained in the regular course of business by an emergency medical services provider, a first responder organization, or emergency medical services personnel.”

In addition, the Texas Health and Safety Code section 773.095 provides a committee member with immunity from damages for an action taken or a recommendation made "within the scope of" a quality review committee if the committee member "acts without malice and in the reasonable belief that the action or recommendation" is warranted by the facts.

The OMD Clinical Quality Committee and OMD Clinical Performance Review Group members will maintain the confidentiality of Committee records and proceedings and follow the procedures required to meet the intent of the Texas Health and Safety Code section 773.095. Clinical Performance Review Group members may discuss the proceedings and document contents with other members of the Review Group and members of the OMD Clinical Quality Committee. Disclosing such confidential information to any other person or Organization may result in a loss of the confidentiality privilege afforded by the Health and Safety Code.

Roles & Responsibilities

Office of the Medical Director

- 1) Determine the need for and request scheduling of an OMD Clinical Performance Review
- 2) Coordinate scheduling of the Clinical Performance Review
- 3) Identify and schedule the OMD staff required for the Review
- 4) Communicate the Review progress with the provider(s) being reviewed (after initial notification by the Organization Performance Improvement staff)
- 5) Maintain records of Clinical Performance Reviews
- 6) Update this procedure as needed
- 7) Maintain confidentiality of review proceedings

Provider Clinical Performance Review Process

Organization Performance Improvement Staff of the Provider Being Reviewed

- 1) Assist the OMD with scheduling of the Clinical Performance Review as needed
- 2) Identify Review Group members from the Organization
- 3) Notify the provider(s) being reviewed
- 4) Ensure the provider(s) being reviewed and Review Group members from the Organization are able to attend the Review during the time period(s) required
- 5) Provide input for improvement of this procedure as needed
- 6) Maintain confidentiality of review proceedings

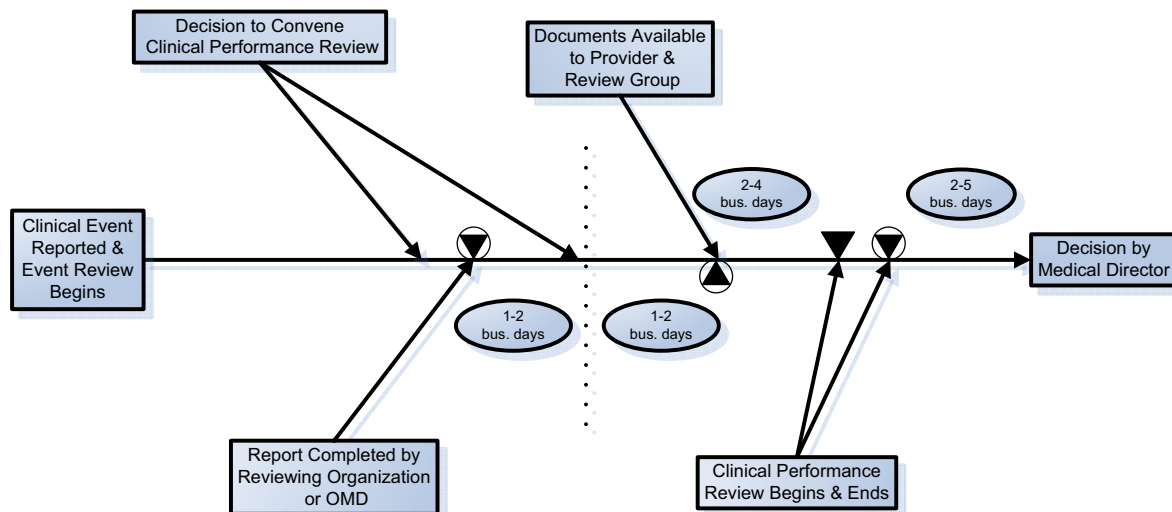
Provider Being Reviewed

- 1) Participate fully, openly and honestly in all Review proceedings
- 2) Utilize the provided time to review all pertinent documents to be utilized in the Review process
- 3) Maintain confidentiality of review proceedings

Estimated Timelines

Once a decision is made to convene an OMD Clinical Performance Review, all pertinent clinical performance documentation will be assembled. While every effort will be made to review clinical events quickly, the focus must remain on ensuring the review is complete, accurate and objective. Reviews must remain focused on identifying causes for the clinical performance concern and on defining actions for sustained improvement.

The following is an estimated timeline for the elements leading up to and following an OMD Clinical Performance Review.



NOTE: This diagram is intended to provide estimated sequencing and time frames associated with the Clinical Performance Review Process. Actual times will vary depending on a variety of circumstances.

Estimated Timelines (continued)

In summary, the estimated timelines for specific events leading up to and following the Performance Review are:

- Once the Reviewing Organization has completed its Clinical Event Review Report, the report will be provided to the OMD within 1-2 business days.
- When the OMD receives all required documentation, it will assume the lead role in the Clinical Performance Review Process.
- When the OMD has received all required documentation, it will have the documents available for review by the provider(s) being reviewed and to the Review Group members within 1-2 business days from receipt.
- The OMD will schedule the performance review no sooner than 3 business days following the availability of the documents for review by the Provider(s) and the Review Group.
- The Provider(s) will have a minimum of 2 business days to review all documents provided to the Review Group. Generally, no more than 4 business days will be available for review of the documents.
- Once the Clinical Performance Review is completed, the Medical Director through the OMD Clinical Quality Committee will reach a decision within 2 – 5 business days.

Outcome / Resolution / Appeal

Upon completion of the OMD Clinical Performance Review, the review group members will provide recommendations to the Medical Director regarding the provider's performance. Upon completion of the review, further discussions regarding the outcome of the review will be limited to the OMD Clinical Quality Committee. The Committee along with the Medical Director will determine whether the provider may be remediated while ensuring future patient safety. In some cases, the Medical Director may choose to revoke the Austin/Travis County EMS System Credentialing privileges of the provider.

In most cases, providers subject to a Clinical Performance Review will be suspended from practice within the Austin/Travis County EMS System prior to a decision by the Medical Director. This is generally done to ensure safe and effective care is provided to patients who would otherwise be seen by the provider being reviewed. Suspension from practice does not necessarily imply wrongdoing and does not indicate the decision to be rendered by the Medical Director.

The decision by the Medical Director based on the OMD Clinical Quality Committee recommendations may result in:

- No action resulting in a return to practice for the provider
- Change in the credential level for the provider
- Extended Suspension from practice as part of a remediation plan
- Revocation of the provider's credential to practice

Once a decision is made following the OMD Clinical Performance Review, the provider may appeal the decision directly to the Medical Director. No other appeals related to clinical performance are available. The Medical Director's decision regarding the appeal is final. The Medical Director ultimately determines the course of action in accordance with the requirements of the Texas Medical Board Rules Chapter 197.



Provider Clinical Performance Review Process

Note: The OMD Clinical Performance Review is separate from any reviews or actions completed by the Organization of the Provider being reviewed. The outcome, resolution and actions addressed by the Provider's Organization from a clinical perspective must be submitted to the OMD Clinical Quality Committee to maintain confidentiality of the records. When such clinical reviews or actions are performed separately from the OMD Clinical Quality Committee or when the reviews or actions involve non-clinical improvement activities, the confidentiality privilege may no longer be applicable.

Documentation & Recordkeeping

All records of the OMD Clinical Performance Review are maintained by the Office of the Medical Director as part of the OMD Clinical Quality Committee's records. The final Review document will be provided in an Original form to the following persons:

- Provider(s) being reviewed
- Performance/Quality Improvement designee of the provider's Organization
- OMD Clinical Quality Committee Records

This same group of persons may review the Clinical Performance Review proceeding records by contacting the OMD during standard business hours. Access to these records is limited to the provider(s) being reviewed, the provider's Organization Performance/Quality Improvement staff and the OMD Clinical Quality Committee members.

Patient Transport Condition Classification System

1. Once a patient has been assessed they should be assigned a transport code in the "Alpha, Bravo, Charlie, Delta or Echo" coding system based on acuity as determined by the transport medic
2. Trauma patients will be further categorized according to the Trauma Categorization Criteria
3. During a Mass Casualty Incident (MCI), patients should be categorized according to a "Triage" coding system.
4. Patient Transport Condition Classification System Patient transport condition classification is based on the magnitude of abnormal physiology or the potential for clinical deterioration. Specific interventions are not the sole determinate of abnormal physiology.

ALPHA A patient condition or circumstance that appears to require little or no medical evaluation or treatment. An example would be a minor being transported to DCMC because no parental consent for refusal is available. MCI designation- "Green" / "Minimal"

BRAVO A patient condition or circumstance that requires minimal acute treatment or further evaluation. An example would be a patient involved in a low speed MVC complaining of neck pain, and neurologically intact. MCI designation- "Green" / "Minimal"

CHARLIE A patient condition or circumstance that requires moderate acute treatment or stabilization and further evaluation. An example would be a patient with a moderate asthmatic exacerbation with a slightly decreased O2 saturation requiring nebulized beta agonists. MCI designation- "Yellow" / "Delayed"

DELTA A patient condition or circumstance that requires immediate acute treatment and stabilization and further evaluation. An example would be a hypotensive patient with ECG evidence of a STEMI. MCI designation- "Red" / "Immediate"

ECHO A patient condition or circumstance that requires immediate resuscitation and life sustaining measures. An example would be any patient with resuscitative efforts in progress. MCI designation- "Black" / "Expectant"

Suspected Child Abuse – Recognition and Reporting

Children suffer several types of abuse. All are harmful to their physical and emotional development and all require intervention. Under the Child Abuse Prevention and Treatment Act (CAPTA), child abuse and neglect means, at a minimum, “Any recent act, or failure to act, on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm.” By Texas State law, all healthcare providers are obligated to report cases of suspected child abuse or neglect to either the local law enforcement agency or the Texas Department of Family and Protective Services (TDFPS).

State of Texas Definitions of Abuse and Neglect

- Abuse includes any of the following acts or omissions by a person:
 - Mental or emotional injury to a child that results in an observable and material impairment in the child’s growth, development, or psychological well being;
 - Causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child’s growth, development, or psychological well being;
 - Physical injury which results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury which is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;
 - Failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;
 - Sexual conduct harmful to a child’s mental, emotional, or physical welfare;
 - Compelling or encouraging the child to engage in sexual conduct as defined by Section 43.01, Penal Code;
 - Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film or depiction of the child is obscene or pornographic, as defined by the Penal Code;
 - The current use by a person of a controlled substance, as defined by the Health and Safety Code, in a manner or to the extent that the use results in physical, mental, or emotional injury to the child or
 - Causing, expressly permitting, or encouraging a child to use a controlled substance.
- Neglect includes any of the following acts or omissions by a person:
 - The leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child;
 - Placing a child in, or failing to remove a child from, a situation that a reasonable person would realize requires judgment or actions beyond the child’s level of maturity, physical condition, or mental abilities and that results in bodily injury or substantial risk of immediate harm to the child
 - Failure to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or

Suspected Child Abuse and Reporting

bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child;

- The failure to provide a child with food, clothing, or shelter necessary to sustain life or health of the child, excluding failure caused primarily by financial inability unless relief services have been offered and refused; or,
- Placing a child in, or failure to remove a child from, a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child; or,
- The failure by the person responsible for the child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away.

Who Must Report / Circumstances

- Any person;
 - When they have cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect;
 - Professionals, including teachers, nurses, doctors, day-care employees, juvenile probation officers, juvenile detention or correctional officers, and employees of a clinic or health care facility that provides reproductive services.
 - If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected or that a child is a victim of an offense under Section 21.11, Penal Code.

Privileged Communications/Confidentiality of Records:

- The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, and an employee of a clinic or health care facility that provides reproductive services.

When Child Abuse or Neglect is Suspected:

- Anyone having cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect **MUST** report the case immediately to a state or local law enforcement agency or the Texas Department of Family and Protective Services (TDFPS).
- Current law requires that professionals such as teachers, doctors, nurses, or child daycare workers must make a verbal report within 48 hours. Failure to report suspected child abuse or neglect is a misdemeanor punishable by imprisonment of up to 180 days and/or a fine of up to \$2000.

EMS reporting of suspected child abuse can be accomplished by only one of two methods

- Reporting it directly to law enforcement (not hospital security) either on scene or at the hospital

OR

- Directly contacting the 24 hour TDFPS Family Violence Hotline at 1-800- 252-5400
 - The report of child abuse or neglect is confidential and immune from civil or criminal liability as long as the report was made "in good faith" and "without malice"
 - "In good faith" means that the person making the report took reasonable steps to learn facts that were readily available and at hand.

Suspected Child Abuse and Reporting

- “Without malice” means that the person did not intend to injure or violate the rights of another person.
- Provided the report was made “in good faith” and “without malice” the Provider will be immune from liability if asked to participate in any judicial proceedings that may result from the report.

Patient or Scene Presentation:

- The patient may present with patterned burns or injuries suggesting intentional infliction
 - Injuries in various stages of healing (old bruises, etc.)
 - Injuries scattered over multiple areas of the body
 - Fractures or injuries inconsistent with stated cause of injury
 - The patient, parent, or caregiver responding inappropriately to the situation
 - Malnutrition or extreme lack of cleanliness of the patient or environment may indicate neglect
 - Signs of increased intracranial pressure without a readily explainable cause (fever, head trauma, etc.)

Procedures for Dealing with Suspected Abuse Patients:

- Stabilize and treat all injuries accordingly
- Immediately request law enforcement assistance
- Do not initiate a report to law enforcement or social services in front of the patient, parent, or caregiver
- If sexual abuse is suspected, discourage the patient from washing
- If patient, parent, or caregivers are hostile, immediately request law enforcement assistance
- Do not confront or become hostile to the parent or caregiver.
- Document
 - Verbatim (in quotation marks), all statements by the patient, the parent, or caregiver, including statements made about the manner of the injuries.
 - Document any abnormal behavior of the patient, parent, or caregiver.
 - Document the condition of the environment and other residents present.
 - Document in the PCR who received the report of suspected abuse or neglect
 - If reporting is done after PCR completion, an addendum should be written and attached with reporting date, time, who reported to, etc. This will serve to protect the Provider.
- Once a determination of abuse or suspected abuse has been made, notify the appropriate EMS Commander or Designated Medical Officer to provide support for the completion of reporting regulations and processes

To ensure consistency in the assessment and treatment of patients that may be suffering circulatory system problems, the following definitions will apply:

Tachycardia

Resting heart rate greater than 100 bpm in adults

Bradycardia

Resting heart rate less than 60 bpm in adults

A child's heart rate should be evaluated based on age and condition. The heart rate of an anxious, sick, or injured child should be rapid. A heart rate less than 60 bpm coupled with signs of poor perfusion in children <8 years of age is an ominous sign.

Hypertension

Consistent resting blood pressure greater than or equal to 140/90 mmHg in adults

Hypotension

Consistent resting blood pressure (less than) < 90/60 mmHg (or Systolic BP < 90mmHg) in adults with associated signs and symptoms of hypoperfusion.

The goal in treating patients suffering from non-compressible bleeding is to maintain a systolic BP of 70 mmHg. This is referred to as permissive hypotension.

Trauma Activation Criteria: "Traumatic injury with signs of shock". The need to rapidly make a determination should be based on signs of hypoperfusion as evidenced by:

- Skin color and condition, **and**;
- Pulse rate and location, **and**;
- Capillary refill, **and**;
- Blood pressure

The blood pressure ATCEMS System will use to validate a "Trauma Activation" decision in an Adult will be a systolic blood pressure of < 90 mmHg.

BP of < 70mmHg + (age in years x 2), with associated signs and symptoms is considered hypotensive in a child.

Hyperglycemic

Blood Glucose level of > 300 mg/dl with signs of Hypoperfusion.

Hypoglycemic

Blood Glucose level of < 50 mg/dl with signs of Altered Mental Status.