



Clinical Standards

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Standard:

Provide direction on managing patients and circumstances that are outside the protocols.

Purpose:

Give direction for providers who encounter complicated, unusual, and atypical patient encounters and establish an orderly method by which clinical issues can be rapidly addressed.

Application:

1. Clinical encounters requiring use of this protocol may be divided into two types:
 - Those whose clinical situation is covered by existing protocol but who are presenting a clinical/administrative challenge (e.g., clarification of a COG, patient destination, other healthcare provider issues, etc.) and require non-medical control guidance or
 - Those whose clinical situation is not covered by existing protocol (e.g., modification of drug dosage, patient medication not addressed in protocol or unfamiliar to a provider, termination of resuscitation not covered in current policy) and thus require medical control orders via on-line medical consultation (OLMC).
2. Patients (b) requiring OLMC shall contact medical control as described in steps 4 and 5 below. The provider requesting OLMC must be at the scene with the patient.
3. The first call for operational/administrative issues related to an individual patient or patients will be placed to an organization's designated clinical supervisory personnel (e.g., DMO, FMO, etc.). The call should be placed via a recorded line through EMS Communications. If the clinical supervisory personnel are not available the call should be directed to the On-Call Medical Director via EMS Communications on a recorded line.
4. If OLMC consultation is required the request should be via a physician at the intended receiving hospital (radio or recorded telephone line through EMS Communications). Please note that only physicians at receiving hospitals can provide medical direction; other staff, including nurses, may not provide online medical direction.
5. In the PCR, the name of the individual providing OLMC or administrative direction will be documented in the narrative section.

Cancellation or Alteration of Response

Standard:

Establish direction for cancelling or altering an initial response to a request for service.

Purpose:

To give the providers in the ATCEMS System guidance on when they may be able to alter or cancel an initial response based on patient or scene presentation.

Application:

1. Resources will be initially dispatched to a 9-1-1 request for service based on the currently approved Medical Priority Dispatch (MPD) standards.
2. After assessing the patient(s) and making a determination of needed resources any on-scene Credentialed Provider may modify or cancel the response mode of any other System Provider not already on-scene.
3. If cancelled, responders may, at their discretion, reduce their response to non lights and sirens ("Code 1") and continue to the scene in order to provide other assistance deemed appropriate by their organization or department. This does not apply to responses for responsibilities other than patient care (scene safety, fluids, etc).

Standard:

Assessment of a child abused based upon the following principles:

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

Purpose:

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) hotline 800-252-5400.

Application:

1. Stabilize and treat all injuries.
2. Immediately request law enforcement assistance.
3. Do not initiate a report to law enforcement or social services in front of the patient, parent, or caregiver.
4. If sexual abuse is suspected, discourage the patient from washing.
5. If patient, parent, or caregivers are hostile, or refuse access/transport protect your safety and immediately request law enforcement assistance if not already requested.
6. Do not confront or become hostile to the parent or caregiver.
7. Document:
 - In their own words (in quotation marks) all statements by the patient, the parent, or caregiver, including statements made about the manner of the injuries
 - Any abnormal behavior of the patient, parent, or caregiver
 - The condition of the environment and other residents present
 - 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
8. Healthcare Providers are required to immediately report any suspicious findings to the Texas Department of Family and Protective Services (TDFPS) hot line 800-252-5400. This phone is answered 24 hours everyday. This should occur as soon as reasonably possible at the hospital after patient transfer is completed. Providers may need to request a **brief** “out of service time” for this process to be completed. Other than the phone interview, there are no other immediate written documentation reporting requirements by the State.
9. When the patient is transported the hospital; the RN/MD receiving report should be advised of the conditions/situation the patient was found in. Law Enforcement may also be notified if available. Notification of Law Enforcement does meet the “minimum requirement” of the State. However, notification of Hospital Staff only does not meet the State reporting requirements for abuse of people < 18 years old. For people ≥18 years old Refer to CS – 12.

Standard:

When clinically related concerns meeting the indicated criteria are identified, each System Organization's Performance/Quality Improvement staff will perform a systematic evaluation of the actions and omitted actions associated with the specific event or situation to identify opportunities for improvement. A clinical event review does not require actual harm or a negative patient outcome to have occurred.

Purpose:

To establish a standardized process for each System Organization and the Office of the Medical Director to review clinical concerns and/or reports of suboptimal clinical performance with the primary objective focused on the identification of individual and system improvements to clinical care.

Application:

1. Each System Organization as well as the OMD will foster an environment that encourages reporting of clinical concerns and errors including self reporting
2. At a minimum, a clinical event review will be conducted when Level 1 or 2 events are identified as defined in the Clinical Event Review Process document. (This document and process can be found on the OMD Website www.atcomd.org document OMDR – 06.
3. Reporting of Level 1 or 2 events will be provided to the On-Call Medical Director within the prescribed time intervals. Level 3 events will be provided to the OMD within the prescribed time intervals.
4. Each Organization's Performance/Quality Improvement staff will conduct an initial review to:
 - a. gather pertinent facts, documentation and data
 - b. analyze the facts, data and related information
 - c. identify the cause(s) of the less than optimal performance
 - d. draft a plan for clinical improvement for review by the Medical Director
5. A report of the above findings will be drafted and submitted to the Office of the Medical Director within the prescribed time frame based on the level of the event (Level 1, Level 2 or Level 3)
6. Each Organization will maintain copies of the Clinical Event Review report for future review by authorized persons only.
7. The OMD will store electronic and/or paper records of the Clinical Event Review reports submitted to the OMD by each Organization.
8. All aspects of the Clinical Event Review including the proceedings, recordings and documents are considered confidential under the Texas Health and Safety Code Section 773.095.
9. All persons involved in the Review follow all requirements for confidentiality as described in the Clinical Performance Review Process document.
10. Each Organization will ensure its identified performance/quality improvement staff is appropriately trained in the current methods of performance review and analysis.
11. The OMD will provide professional development to System performance/quality improvement staff on the topics of performance review and analysis.
12. Each System Organization and Individual Provider will fully participate in the Clinical Event Review process as requested by the Office of the Medical Director.
13. For Level 1 and 2 events, the information, data, findings and causation will be reviewed by the Medical Director prior to implementation of the plan for clinical improvement where identified.

Standard:

To establish guidelines for conducting patient care on a potential crime scene.

Purpose:

When prehospital care or resuscitation efforts are no longer appropriate it is every Provider's responsibility to assist law enforcement by preserving evidence at potential crime scene. Any scene involving a patient that is pulseless and apneic is to be considered a crime scene and treated accordingly. In such situations Provider's should also maintain a heightened awareness for the presence of weapons.

Application:**General principles of crime scene management:**

1. The first arriving Credentialed Provider on-scene must make patient access to determine whether resuscitative efforts are indicated or not. If law enforcement prevents entry, additional responding units should be reduced to "Code 1" response. All law enforcement refusal of access to patients by Providers will be retrospectively reviewed with law enforcement.
2. Weapons should not be handled by a Provider unless necessary to ensure a safe patient care environment. If weapons must be handled, the Provider must wear gloves, clearly document the items original and new location, and inform on-scene Law Enforcement.
3. Never use anything (phones, sink, bathroom, towels, sheets, blankets, pillows, etc.) from an incident scene.
4. Victims of suspected assault should be strongly discouraged against "cleaning up," washing or showering prior to arrival of Law Enforcement or transport.
5. Providers should not touch anything in the crime scene unless required for patient care activities. Patient demographic information should be obtained from law enforcement when possible.
6. Any ligature(s) involved should be left as intact as possible and should be cut rather than untied. All cuts made should be in an area well away from any knots.
7. Containers of any substance which may have been ingested by the patient/victim should be left in the position found unless needed for ongoing patient care. If the container must be touched, use gloved hands and limit handling to a minimum in order to preserve any fingerprints that may be present.
8. Disposable items used during resuscitation efforts are to be left in place on the body. Sharps used during the resuscitation should be stored in an appropriate container and taken away by EMS personnel. Any extraneous trash should be taken away as well.
9. Intravenous/IO lines, airways and all other disposable equipment used, that are successfully placed, are to remain in place on the body.
10. Pronouncement should be made in accordance with the standards outlined in the Criteria for Death or Withholding Resuscitation/Discontinuation of Resuscitation Standards. The existence of a possible crime scene should not influence the decision to initiate resuscitative efforts.
11. Providers may cover a body with a clean sheet or sterile drape, if requested to do so by Law Enforcement. All efforts should be made to protect the dignity of the patient and block the public view of the body.
12. Once a pronouncement time is obtained the body falls under the jurisdiction of the Medical Examiner. It may not be touched or altered in any way without authorization from the Medical Examiner's Office.
13. It is acceptable to share Patient Care information with appropriate on-scene law enforcement if the patient has been pronounced dead.

Crime Scene

Crime scene management where no resuscitation is initiated:

1. Any Responder, who is not properly Credentialed to seek pronouncements of an obvious Dead on Scene (DOS), should immediately leave the area without touching anything via the path of entry.
2. When pronouncement of death is required, only one properly Credentialed Provider should make entry to the area.

Crime scene management with unsuccessful resuscitation:

1. Once resuscitation efforts have ceased and a pronouncement has been obtained Providers should immediately vacate the area.
2. The Medical Examiner must be able to differentiate between punctures originating from resuscitation efforts and those present prior to arrival. All unsuccessful IV/IO or pleural decompression attempts should be marked on the body by circling with a marker or pen.

Crime scene management with patient transport:

1. Clothing, jewelry or other objects removed from the patient should be left on-scene. Clearly document any items left and inform on-scene Law Enforcement of the items original and current locations.
2. When cutting clothing for the purpose of assessment and/or treatment avoid cutting through existing defects in the clothing (tears, entry or exit points) whenever possible.
3. If the patient has been placed on a sheet, notify the receiving facility that the sheet and all personal effects may be considered evidence.
 - If law enforcement is not on-scene prior to transport, the first response agency is to remain on scene, out of the crime scene perimeter, until arrival of law enforcement. An effort should be made to keep all individuals out of the area.

Criteria for Death or Withholding Resuscitation

Standard:

Define the parameters in which providers in the ATCEMS System may withhold resuscitative efforts.

Purpose:

CPR and ALS treatment are to be withheld only if the patient is obviously dead per criteria below or a valid **Out-of-Hospital Do Not Resuscitate Form** (OOH-DNR) and/or **OOH-DNR ID device**. The form and device may be from any (US) state. (see separate DNR policy)

Application:

1. Resuscitation efforts should not be initiated or continued by a ATCEMS System provider if one or more of the following is present:
 - Rigor mortis and/or dependent lividity;
 - Decomposition;
 - Decapitation;
 - Incineration;
 - Obviously mortal wounds (severe trauma with obvious signs of organ destruction)
 - Patient submersion greater than 20 minutes from arrival of first Public Safety entity until the patient is in a position for effective resuscitative efforts to begin
 - Fetal death with a fetus < 20 weeks by best age determination available at scene. (Is considered products of conception and does not require time of death)
2. If resuscitation efforts have been initiated or continued by a system provider discontinuation is at the discretion of the paramedic provider.

Document in the PCR the specific indications for withholding resuscitation. Fetal death < 20 weeks may be documented on mothers PCR if ≥ 20 weeks create separate PCR

Note:

- **If you are unsure whether the patient meets the above criteria, resuscitate**

Standard:

To establish guidelines for who meets the criteria to be considered a patient in the ATCEMS System.

Purpose:

The definition of a patient is any human being that:

- Has a complaint suggestive of potential illness or injury
- Requests evaluation for potential illness or injury
- Has obvious evidence of illness or injury
- Has experienced an acute event that could reasonably lead to illness or injury
- Is in a circumstance or situation that could reasonably lead to illness or injury

All individuals meeting any of the above criteria are considered “patients” in the ATCEMS System. These criteria are intended to be considered in the broadest sense. The determination of an individual’s status as a patient requires the input of both the individual and the Provider as well as an assessment of the circumstances that led to the 9-1-1 call. If there are any questions or doubts, the individual should be considered a patient.

Application:

1. Anyone that fits the definition of a patient must be properly evaluated by a System credentialed provider and appropriate treatment and transportation offered. (If a patient wishes to refuse offered treatment and/or transport Against Medical Advice (AMA) refer to Refusal of Treatment or Transportation Standard and the Determination of Capacity Standard).
2. Anyone that does not fit the definition of a patient as defined above does not require an evaluation or completion of a Patient Care Record. If there is any doubt, an individual should be deemed a patient and appropriate evaluation should be provided and documented in the PCR.
3. If an individual meets the definition of a patient the following apply:
 - **The definition of an adult is a person who is 18 years of age or older**
 - Adults have the right to consent to or refuse medical treatment
 - **The definition of a minor is:**
 - A person under the age of 18 who is not and has never been married or who has not had the disabilities of minority (emancipation) removed for general purposes by a court
 - *Generally, minors can neither consent to, nor refuse, medical treatment. Some minors however, are considered to be emancipated and have the rights of consent/refusal afforded an adult*
 - A minor is considered emancipated if he or she has obtained a court order of emancipation from a Texas court. Minors may petition the court for emancipation if he is:
 - *(i) A resident of Texas; (ii) 17 years of age or at least 16 years of age and living separate from his parents, managing conservator or guardian; (iii) Is self-supporting and managing his own financial affairs*
 - In certain situations, a minor may consent to medical treatment without involvement of a parent or legal guardian. A minor may consent to treatment if the minor:
 - Is on active duty with the US armed services;

Definition of a Patient

- Is 16 years or older residing separately from his parents or guardian and is managing his own financial affairs (regardless of the source of income);
 - Consents to diagnosis and treatment of any infectious/communicable disease with a reporting requirement;
 - Is unmarried and pregnant and consents to care related to the pregnancy, other than abortion;
 - Consents to examination and treatment relating to drug or alcohol dependency;
 - Is unmarried and has custody of their biological child, they may consent to treatment for the child
- **The protocol definition of a pediatric patient is:**
 - For the purpose of determining transport destination, any patient younger than 18 years of age unless expressly stated in another protocol, standard or procedure. (eg Trauma Transport Guidelines where it is defined as age <15 years)
 - For the purpose of selecting appropriate treatment protocol, any patient < 37 kg or who can be measured using a Broslow-Luten tape

Discontinuation of Prehospital Resuscitation

Standard:

Unsuccessful cardiopulmonary resuscitation (CPR) and other advanced life support (ALS) interventions may be discontinued prior to transport when this standard is followed.

Purpose:

The purpose of this standard is to allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate ALS therapy.

Application:

1. Any System Credentialed Provider, in the following circumstances, may discontinue resuscitation efforts without OLMC:
 - Resuscitation efforts were inappropriately initiated when criteria outlined in the Criteria for Death/Withholding Resuscitation Standard were present
 - A valid Out of Hospital Do Not Resuscitate Form (OOH-DNR) and/or OOH-DNR ID device was discovered after resuscitative efforts have been initiated. The form and device may be from any (US) State (Original or Copy) as defined in the DNR Standard
2. In addition to the previously stated criteria a Paramedic Credentialed Provider, in the following circumstances, may discontinue resuscitation efforts without OLMC:
 - If the patient suffers a traumatic injury meeting the following criteria:
 - The patient is pulseless and apneic on arrival of the first provider on scene **AND**
 - Lacks respiratory effort after basic airway maneuvers **AND**
 - Lacks organized electrical activity on ECG with a rate > 40.
3. In the case of suspected medical cause of arrest all of the following criteria must be met:
 - Patient must be at least 18 years of age **OR** the family of a minor is agreeable;
 - Cause of arrest is NOT due to suspected hypothermia;
 - Adequate CPR has been administered;
 - Airway has been successfully managed with verification of device placement. Acceptable management techniques include endotracheal intubation, blind insertion airway device (King) or cricothyrotomy;
 - IV/IO access has been achieved;
 - Rhythm-appropriate medications and defibrillations have been administered according to protocol;
 - Persistent (>20 min) Asystole or agonal rhythm is present and no reversible causes are identified;
 - Failure to establish spontaneous circulation (palpable pulse) at any point in the arrest;
 - Failure to establish persistently recurring or refractory ventricular fibrillation/tachycardia or any continued neurological activity (eye opening, or motor response) after appropriate BLS and ALS resuscitation efforts over 20 minutes;
 - All Paramedic Credentialed providers on scene agree with decision to cease efforts.
 - If all of the above are not met and the provider feels it is appropriate to discontinue resuscitative efforts contact an on call System Medical Director.
4. When an on call System Medical Director is involved in the decision to terminate; resuscitative efforts must be continued while:
 - the family is counseled on the patients unchanging condition and impending discontinuation of efforts;
 - requesting a pronouncement from an on call System Medical Director.
5. If termination of efforts is anticipated Victim Services, when available, should be contacted as early as possible
6. Document all patient care and any interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS patient care report (PCR)

DNR Advanced Directives

Standard:

In the event any provider of the EMS System is presented with a completed Out of Hospital Do Not Resuscitate (OOH-DNR) form and/or OOH-DNR ID device, the provider shall withhold CPR and the listed therapies in the event of cardiac arrest. The form and device may be from any (US) State. Refer to DSHS Rule 157.25.

Exceptions:

- A patient that is known to be pregnant.
- If there are any indications of unnatural or suspicious circumstances.

The provider shall begin resuscitation efforts until such time as a physician directs otherwise.

Purpose:

- To honor the terminal wishes of the patient and to prevent the initiation of unwanted resuscitation.

Application:

1. When confronted with a cardiac arrest patient, the following conditions must be present in order to honor the DNR request and withhold CPR and ALS therapy:
 - Out-of-Hospital Do Not Resuscitate (OOH-DNR) – or – OOH-DNR ID device; (Original or Copy)
 - Valid Out-Of-Hospital Do Not Resuscitate Written Order (Original or Copy) or Device from any (US) State;
 - A licensed physician on scene or in contact by telephone orders that no resuscitation efforts are to take place
2. A DNR request may be overridden by:
 - The patient or person who executed the order destroying or directing someone in their presence to destroy the form and/or remove the identification device
 - The patient or person who executed the order telling the EMS Providers or attending physician that it is his/her intent to revoke the order
 - The attending physician or physician's designee, if present at the time of revocation, recording in the patient's medical record the time, date and place of the revocation and enters "VOID" on each page of the OOH-DNR
3. In the event there is a question regarding whether to honor or not honor an OOH-DNR or Advanced Directive, contact an on call System Medical Director.
4. An advanced directive does not imply that a patient refused supportive or palliative care.

Documentation of Patient Care Report

Standard:

Establish the minimum documentation requirements for every patient contact.

Purpose:

To provide consistent and accurate documentation of the events of a patient encounter, the A/TCEMS System Medical Director is responsible for designating the minimum data required for patient care reporting. The following is the minimum requirements for documentation on all patient encounters.

Application:

- For every patient contact, the following documentation requirements apply and must:
 1. Be truthful, accurate, objective, pertinent, legible, and complete with appropriate spelling, abbreviations and grammar.
 2. Use only approved medical abbreviations per “Approved Medical Abbreviations”.
 3. Reflect the patient’s chief complaint and a complete history or sequence of events that led to their current request or need for care.
 4. Contain a detailed assessment of the nature of the patient’s complaints and the rationale for that assessment.
 5. Reflect the initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment and significant changes important to patient care.
 6. Reflect ongoing monitoring of abnormal findings.
 7. Summarize all assessments, interventions and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events.
 8. For drug administrations, include the dosage, route, administration time, and response.
 9. List all treatments in chronological order. Response to treatments should also be listed
 10. For patients with extremity injury, note neurovascular status before and after immobilization.
 11. For patients with spinal immobilization, document motor function before/after spinal immobilization.
 12. For IV administration, document the catheter size, site, number of attempts, type of fluid, and flow rate.
 13. Include a lead II strip for all patients placed on the cardiac monitor. Any 12-leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, pacing attempts, etc. should be attached.
 14. Document clearly any requested orders, whether approved or denied.
 15. Document any waste of narcotics including the quantity wasted, where wasted, and name of the person who witnessed the waste.
 16. Include an explanation for why an indicated and appropriate assessment, intervention, or action prescribed by the Clinical Operating Guidelines did **NOT** occur.
 17. Clearly describe the circumstances and findings associated with any complex call or out-of-the ordinary situations.
 18. Be available in an acceptable time period after the patient encounter.
 19. Remain confidential and be shared only with legally acceptable entities.
 20. For a birth or stillborn/non-viable fetus document the time of delivery. In cases of a fetus that is without signs of life where no resuscitation attempt is made documentation should include the reasons why resuscitation was withheld. In cases of products of conception (<20 weeks) documentation may be included on the Mother’s PCR.
 21. Once the PCR is completed, original document will not be modified for any reason. Any changes required to correct a documentation error or for clarification shall be recorded in an addendum.
 22. In the case of an interfacility transfer, documentation must include any medications administered or discontinued during transfer.

Documentation Vital Signs

Standard:

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

Purpose:

To insure that evaluation of every patient's volume, cardiovascular and mental status is documented with a complete set of vital signs.

Application:

1. It is expected that vital signs will be taken manually initially with possible subsequent vital signs obtained mechanically as long as they correlate with the manual vital signs. If there is a discrepancy, manual vital signs will be continued. Initial vital signs may be deferred until transport in severe trauma when other treatments and packaging may take priority and vital signs may interfere with the timely execution of these priorities.
2. An initial complete set of vital signs includes:
 - Pulse rate
 - Systolic AND diastolic blood pressure
 - Respiratory rate
 - Pain / severity (when appropriate to patient complaint)
 - GCS for Injured Patients
3. When no ILS or above treatment is provided, palpated blood pressures are acceptable for REPEAT vital signs.
4. Based on patient condition and complaint, vital signs may also include:
 - Pulse Oximetry
 - Temperature
 - End Tidal CO₂
 - Mental Status (GCS)
5. If the patient refuses this evaluation, document the refusal in the PCR in accordance with the Refusal of Treatment or Transportation Standard.
6. When any components of vital signs were obtained using the cardiac monitor, the data should be exported electronically to the patient care report. Where values are inconsistent with manually obtained values, values may be appropriately edited to reflect the manually obtained values.
7. Document situations that preclude the evaluation of a complete set of vital signs.
8. Record the time vital signs were obtained.
9. Any abnormal vital sign should be repeated and monitored closely.

Domestic Violence (≥ 18 years old) (Partner and/or Elder Abuse) Recognition and Reporting

Standard:

Domestic violence is physical, sexual, or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship. Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of a caregiver, spouse, neighbor, or adult child of the patient. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality health care, and preventing further abuse. For people < 18 years old Refer to CS – 03.

Purpose:

Assessment of an abuse case is based upon the following principles:

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

Application:

1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Healthcare Providers are required to immediately report any suspicious findings to the Texas Department of Family and Protective Services (TDFPS) hot line 800-252-5400. This phone is answered 24 hours everyday. This should occur as soon as reasonably possible after leaving the scene (if patient refuses) or at the hospital after patient transfer is completed. Providers may need to request a **brief** “out of service time” for this process to be completed. Other than the phone interview, there are no other immediate written documentation reporting requirements by the State.
5. If the patient is transported to the hospital; the RN/MD receiving report should be advised of the conditions/situation the patient was found in. Law Enforcement may also be notified if available. However, notification of Hospital Staff or Law Enforcement does not meet the State reporting requirements for domestic violence/abuse for people ≥ 18 years old.

Standard:

- This standard establishes a uniform level of response for the EMS System and provide for the safest and most appropriate level of response to the patient(s)

Purpose:

- EMS Units and First Responders will be dispatched in accordance to the standards developed by the Medical Director and the Emergency Medical Dispatch (MPD) Protocols
- EMS Units and First Responders will respond Code 1 or Code 3 in accordance to MPD standards. As more information from EMS Communications or on scene medical responders becomes available, the response may be upgraded to Code 3 or downgraded to Code 1

Application:

1. EMS Units and First Responders dispatched for Code 1 response, will not upgrade to a Code 3 response unless:
 - The EMS Communications personnel determine that the patient's condition has changed and upgrades the incident to a Code 3 response
 - Public Safety personnel on-scene requests a Code 3 response
2. EMS Units and First Responders may be diverted from a lower priority incident (e.g., Priority 3, 4 or 5) to a higher priority incident (e.g., Priority 1 or 2) based on MPD Protocol, if the diversion provides a significant time savings.
3. The EMS unit or First Responder may divert their response if they come upon what appears to be a higher priority incident (e.g., en route to a Priority 3, 4 or 5 incident and comes upon an MVC with high potential for patients in need of trauma activation).
4. EMS Units and First Responders may by-pass what appears to be a lower priority incident and continue to the originally assigned incident. EMS Communications should be notified so that another EMS resource may be assigned to the lower priority incident.

Standard:

This standard establishes the conditions under which a System hospital may go on diversion and the process by which this should be implemented and discontinued.

Purpose:

- The ATCEMS System, with few exceptions, employs a no diversion policy for the transport destination of EMS patients
- This standard was developed in cooperation with the hospital networks, the medical community and the Travis County Medical Society ED/EMS committee

Application:

1. All hospitals are to remain open to EMS patients at all times except in the conditions described herein or in extraordinary circumstances with approval of the Medical Director.
2. Black-Internal Disaster:
 - If a hospital experiences an “Internal Disaster” such as Fire, Utility Failure or other significant infrastructure failure they may close to EMS transports (and all other services)
 - If a hospital with a specialized designation such as a “Stroke Center” experiences failure of critical equipment needed to meet that requirement (i.e., CT Scanner) they may close to EMS transports for that particular patient category
 - Hospitals which need to close due to Internal Disaster as described above will contact ATCEMS Emergency Communications Supervisor at 512-978-0410. They will advise the supervisor of the Internal Disaster and/or the critical equipment failure that has led to the closure
3. Black-Trauma Priority:
 - Brackenridge Hospital, utilizing their internal process to assess their trauma capacity, may close to Charlie, Delta, and Echo category medical patients
 - This does not include any patients meeting Trauma Activation criteria or any Bravo or Alpha category medical patients
 - This diversion status is limited to two hours and expires automatically unless an extension is requested
 - The Brackenridge charge nurse or their designee should contact the ATCEMS Emergency Communications Supervisor as indicated above. The Communications Supervisor should confirm the name and title of the person making the request. The hospital's compliance with their internal process is assumed and does not require validation or confirmation by the Communications Supervisor
4. Any attempt to divert patients due to reasons other than those listed above should result in notification of the on-call Division Commander and the on-call Medical Director.
5. In each case listed above Transport units, Commanders, Medical Director(s) and other individuals will be notified of the change in hospital status via AWACS page to the “EMS-Hospital Closure” group indicating that Hospital XX has an Internal Disaster and/or Trauma Priority and is diverting the corresponding EMS traffic until further notice. The page will indicate the affected hospital, the reason for the diversion (Internal Disaster/Trauma Priority) and that the facility is on diversion until further notice.
6. EMS Transport units should honor the request of the affected hospital by diverting patients to another appropriate open facility. The patient should be informed of the reason the hospital is diverting EMS patients and in the absence of a time critical or unstable patient condition the EMS provider(s) should recommend that a patient be transported to another network hospital where possible. When a time critical or unstable patient condition exists the recommendation should be transport to the closest

Hospital Diversion

appropriate facility that is not on diversion. If the patient refuses the recommended destination the EMS unit should transport the patient to a facility (not on diversion) of their choosing.

7. If a patient insists on being transported to a facility on diversion providers should explain the reason for the diversion status and that transport to that facility may result in significant delays in their care, worsening of their condition or even death. Providers may use any means at their disposal to convince the patient of the need to go to an alternate facility. This includes, but is not limited to, contacting a supervisor or on line medical control at the diversion facility. If a patient insists on transport to that facility and the only alternative is refusal of transport the EMS provider(s) should have the patient sign a refusal acknowledging the explained risks of transport to that facility and transport the patient to their destination of choice. If that hospital is unable to care for the patient due to a lack of equipment or expertise (e.g. STEMI to non-PCI facility, Stroke to facility without CT capabilities, etc) the EMS providers should advise their Supervisor of the situation and upon arrival at the destination remain immediately available for transfer of the patient. The length of this availability is to be determined in consultation with the EMS Supervisor. The provider should thoroughly document their description of the risks and their efforts to convince the patient to go elsewhere.
8. If a hospital has closed to all patient traffic including walk-ins due to catastrophic loss of capabilities or potential threat to the safety of both providers and patients the hospital is no longer considered an approved receiving hospital until the condition is removed. Patients should be informed that the hospital is closed and that they will be denied access to the facility. The patient should be transported to another appropriate facility in accordance with #6 above. If a patient still wishes to refuse transport they should be informed of the risks and a refusal obtained in accordance with the Refusal of Treatment/Transportation Standard.

Identification Badges

Standard:

Badges are the property of the Office of the Medical Director and are valid only if they are issued and maintained as designated by the Medical Director and Clinical Standards. Badges will not be modified by any provider or organization. It is the responsibility of System Provider Organizations to immediately collect the badges of those individuals whose Credentials have been revoked, or who are no longer associated with the organization. Collected badges will be returned to the Office of the Medical Director.

Purpose:

Due to the variety of providers with different levels of training an ID badge system is required to ensure that everyone on scene knows the System-credential capabilities of each Provider.

Application:

1. Proper identification of System Providers is required by the Texas Department of State Health Services (TDSHS).
2. System identification badges serve as the primary identifier for System Credentialed individuals as well as his/her Credential level.
3. These badges are not intended for use as organization or department identification.
4. Proper identification of Providers will facilitate the exchange of patient information within the guidelines established by Health Insurance Portability and Accountability Act (HIPAA).
5. Badges should be visibly worn by any responder providing any level of patient care. The exception would be when circumstances require the responder to utilize personal protective outerwear (i.e. bunker gear, rain gear, etc.).
6. Badges are valid throughout the System and are not limited to specific venues or defined response areas.
7. The ATCOMD ID badges include:
 - Provider's Picture
 - Name
 - Credential Level
 - TDSHS Certification or Licensure Level
 - TDSHS Certification or Licensure number
 - Color coding denoting the appropriate credential level
8. Below is the color coding used to aid in identifying System Credential Level:

White	Responder with no System Medical Credentials
Yellow	System Responder
Blue	EMT-Basic
Green	EMT-I
Red	Paramedic
Purple	Physician

Candidates that are transitioning to a higher credential level will wear the color badge for the desired level of credential with the words "CANDIDATE" within the color coding and above the OMD LOGO

9. A system responder that is currently system credentialed, but without a badge is, at that point, functioning as a First Aid Provider. In cases where an individual is recognized and known to be a currently credentialed provider in the System, the provider in charge of patient care may, at their discretion, allow the individual to participate in patient care. The lead transport medic and the provider in question are responsible for assuring

Identification Badges

badge compliance, but all Providers on scene are charged with pointing out any on-scene discrepancies.

10. A Provider within the Austin / Travis County EMS System who performs a procedure they are not credentialed to perform is functioning outside the scope of his/her practice. The Provider performing the procedure in question and the provider in charge of the scene should both immediately report the occurrence using your Organization's defined Clinical Error Reporting Process. *Failure to do so may be considered a component of falsification of documentation and may result in action against the providers credential and/or State Certification/License.* This does not apply to candidates in an approved training program operating under the supervision of their training officer.

Standard:

Texas law provides a responsible alternative to mothers who might otherwise abandon or harm a newborn child. It states that a parent may leave an unharmed infant, up to 60 days old, at any hospital, fire station or EMS station with “no questions asked.”

Sec.262.302 of the Texas Family Code, states...(a) A designated emergency infant care provider shall, without a court order, take possession of a child who appears to be 60 days old or younger if the child is voluntarily delivered to the provider by the child's parent and the parent did not express an intent to return for the child. (b) A designated emergency infant care provider who takes possession of a child under this section has no legal duty to detain or pursue the parent and may not do so unless the child appears to have been abused or neglected. The designated emergency infant care provider has no legal duty to ascertain the parent's identity and the parent may remain anonymous. However, the parent may be given a form for voluntary disclosure of the child's medical facts and history. (c) A designated emergency infant care provider who takes possession of a child under this section shall perform any act necessary to protect the physical health or safety of the child. The designated emergency infant care provider is not liable for damages related to the provider's taking possession of, examining, or treating the child, except for damages related to the provider's negligence.

Purpose:

To provide:

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

Application:

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

Standard:

Establish a process for guidance on Emergent Critical-Care, Hospital-to-Hospital transfers (ETRAN).

Purpose:

The transport of a patient who requires Advanced Life Support care during their transport from one medical facility to another. These patients often present on multiple medications and infusion pumps and may have medical devices in use which are unfamiliar to EMS personnel.

Application:

1. The transporting paramedic should ensure that all appropriate documentation accompanies the patient. Known STEMI patients are an exception to this rule. An MOT must be obtained (exceptions noted in CS – 19) but all other records may be faxed to the receiving facility if not presented at time of transfer.
2. While in transit to the new facility, all appropriate standing orders shall remain in place.
3. If the patient deteriorates, the transferring facility should be notified via radio or cellular phone. Additional orders if needed should be obtained from the receiving physician or facility whenever possible.
4. For any medication not included in the A/TCEMS System Clinical Operating Guidelines, specific orders must be provided by the sending facility.
5. The attending EMS crew is responsible for ensuring that they are familiar with all medications, pumps, or devices prior to departure. Medication or equipment questions should be discussed with the transferring nurse or physician prior to transport.
6. When transporting hospital staff, both the transport crew and accompanying staff are responsible for management of the patient.
7. All EMS rendered treatments must comply with the A/TCEMS System Clinical Operating Guidelines and/or instructions from the transporting or receiving physician.
8. An A/TCEMS patient care record will be completed in accordance with the Documentation of the Patient Care Report Standard.
9. All medications/procedures approved by the A/TCEMS System Clinical Operating Guidelines are approved for ALS transfer regardless of the method of administration.
10. The following items are required equipment for all transfers.
 - Cardiac monitor/defibrillator
 - Combo kit with oxygen
 - Obstetrics kit (OB/GYN transfers only)
11. All patients that fall within the intent of this Standard should, at a minimum receive:
 - Continuous ECG and oxygen saturation monitoring
 - Non-invasive hemodynamic monitoring (auscultated blood pressure, palpated pulse rate)

Memorandum of Transfer (MOT)

Standard:

To establish the expectations that ATCEMS transporting crews will review Memorandum of Transfers (MOT) in order to transfer the patient to the appropriate receiving facility as ordered in the MOT.

Purpose:

A Memorandum of Transfer (MOT) is a medical order written for the transfer of care of a patient between one hospital/facility to another hospital. The transport providers will honor the MOT unless there is a change in patient condition that necessitates transport to a closer facility for the purpose of stabilization.

Application:

1. Ensure that there is an MOT for every patient that is being transferred from one hospital to another that it includes the signature of the sending physician, the name of a receiving physician and a destination that is an approved transport destination as outlined in the COG's. If the transport providers perceive a conflict with the existing ATCEMS destination policy and the indicated destination this must be clarified with the sending physician or his designee before transport is initiated.
2. Review the MOT to ensure the intended destination is listed on the MOT. If it is not indicated or there is a change in destination this must be modified by the sending facility prior to transport. The transport providers shall not modify or document on the MOT.
3. The patient is to be transported to the intended destination unless there is a change in the patient status that can not be managed through existing ATCEMS treatment protocols or through contact with the sending/receiving physician. In such cases the provider may divert to a closer appropriate facility for immediate stabilization. The reasons for diversion should be thoroughly documented in the PCR.
4. Treat the patient in accordance with the COG's or medical orders provided by the transferring physician. Providers must ensure that the orders from the transferring physician are within their defined scope of practice according to the COG's.
5. A patient with present mental capacity who has not had this capacity removed by physician or court order and who is not in custody retains the rights of consent and refusal outlined in the Refusal of Treatment/Transport Standard. If the patient wishes to refuse care or alter the prescribed destination this should be discussed with the sending physician.
6. A copy of the MOT should be made and placed in envelope to be turned into EMS HQ for inclusion with the patient's medical record.

Exception (s) to MOT Requirement FSED:

- Transfers from St David's Bee Cave to St David's South Austin Medical Center
- Transfers from St David's Pflugerville to St David's North Austin Medical Center

Minimal Equipment Patient Side

Standard:

To establish a minimum list of equipment that will be taken to the patient's side on every call.

Purpose:

ATCEMS System providers are often faced with patient conditions that require immediate intervention in order to decrease morbidity or prevent mortality. Time dependent interventions are those that must be performed immediately or within seconds/minutes to be effective.

Application:

ATCEMS System providers will ensure that the following equipment will be immediately available for use at the patient's side:

Required System Responder and EMT-B Equipment:	
Appropriate PPE***	Stethoscope
Defibrillator (AED or Manual)	B/P cuffs
BVM with appropriate masks	Suction
O2 + delivery devices (incl. CPAP)	OPA / NPA
ITD	King LT airway (EMT-B only)
Epi Pen (Adult & Pedi) (EMT-B only)	Albuterol with nebulizer kit (EMT-B only)
Glucometer & test strips	Oral glucose
Tape	4X4
Kerlix	
Required ILS & ALS Equipment (In addition to equipment listed above):	
Saline lock equipment	Epi 1:1000 and IM supplies (Paramedic)
D50 (IV)	Mucosal Atomization Device
Surgical Cricothyrotomy kit (Paramedic)	Needles for thoracostomy (Paramedic)
Laryngoscope & blades for FBAO	Magill forceps for FBAO
Naloxone (IN, IM, IV)	

The above interventions are most commonly associated with the following clinical conditions:

- Obstructed or compromised airway
- Ineffective ventilation
- Ineffective circulation
- Removal from impending, active or ongoing physical harm

****Be observant for of the level of Disease Isolation Precautions in effect, if any, for the patient situation. Should there be no immediate need for equipment to intervene to decrease morbidity or prevent mortality, stage the equipment outside the potentially contaminated environment for immediate access if the patient condition changes.*

On-scene Authority Patient Care

Standard:

Establish the clinical hierarchy of authority for on-scene patient care.

Purpose:

Credentialed Providers within the ATCEMS System are responsible for providing patient care in accordance with the prescribed protocols, standards and procedures. However there may be times when providers disagree about the care being delivered. Patient safety is the responsibility of every provider and any concerns should be immediately brought to the attention of other caregivers at the scene. In ANY disagreement regarding circumstances relating to patient care a professional demeanor and focus on the best interest of the patient is paramount. In order to maintain an orderly scene and allow rapid resolution of conflict a hierarchy of clinical responsibility must be established.

Application:

1. In the event of conflicting approaches to providing patient care, extraction, or transport, it is the responsibility of the on-scene Credentialed Providers to reach consensus as to the most appropriate care for the patient(s). In the event of unresolved conflict, the Senior Credentialed Provider on-scene has final authority and responsibility for decisions regarding patient care. If there is a conflict involving a supervised provider (Cadet/Student) the assigned training officer has authority (at their level of Credential) and should be consulted.
2. Seniority of Credentials (in ascending order) is:
 - Administrative Provider
 - System Responder
 - Emergency Medical Technician — Basic
 - Emergency Medical Technician — Intermediate
 - Paramedic First Responder
 - Paramedic Transporting Unit
 - Clinical Specialist Paramedic on Transporting Unit
 - On-scene Physician (In accordance with the Physician on Scene Standard)
 - On-Line Medical Consultation Physician
 - EMS System Medical Director or designee
3. All significant or unresolved conflicts regarding on-scene management of patients should be reported via the appropriate chain of command and will be retrospectively reviewed in accordance to each organization's Event Review Process.
4. If any provider, regardless of credential, feels the conflict negatively impacted patient care the incident should be reported to the Office of the Medical Director as soon as practical without causing an additional impediment to care.

Patients with Special Healthcare Needs

Standard:

This standard is established to provide quality patient care and EMS services to patients with special health care needs. It is also important for the EMS providers to understand the need to communicate with the patients, family and caregivers regarding health care needs and devices that EMS may not have experience with.

Purpose

Medical technology, changes in the health care industry, and increased home health capabilities have created a special population of patients that interface with the EMS system. It is important for EMS to understand and provide quality care to patients with special health care needs.

Application:

1. Emergencies involving special needs patients may involve equipment (e.g. LVAD or vagus nerve stimulation device, etc.) that is unfamiliar to the provider. To familiarize themselves with the equipment providers may:
 - ask the family, caregiver or patient for any documentation or specific information regarding the condition and/or device;
 - utilize Just in Time Training aides/information regarding devices where available;
 - contact the patient's primary care physician or OLMC for assistance with specific conditions or devices or for advice regarding appropriate treatment and/or transport specific to the patients condition.
2. Transportation will be to the hospital appropriate for the specific condition of the patient. In some cases this may involve bypassing the closest facility for a more distant yet more medically appropriate destination.

Standard:

The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. All care should be provided within the rules and regulations of the Texas Medical Board of the State of Texas.

Purpose:

This standard is established to identify a chain of command for System providers when dealing with physicians on scene and to assure the patient receives the maximum benefit of appropriate physician resources.

Application:

The TMB has specific rules pertaining to the authority of a physician to order specific patient care interventions on the scene of a medical call. There are two different types of situations regarding on-scene physicians. One is when the patient's own physician is on-scene ("**Patient's Personal Physician**"). The other is when a physician that does not have an established relationship with the patient is on-scene ("**Intervener Physician**").

1. Physician On-Scene/General Guidelines:

- The Credentialed Provider on-scene is responsible for management of the patient(s) and acts as the agent of the Medical Director or OLMC
- In order to participate in care, the patient's personal physician or intervener must present a valid Texas Medical Board License (all physicians are issued a wallet card) or be recognized as a physician by the Provider

2. Patient's Personal Physician On-Scene:

- If the patient's personal physician is present and assumes care, the Credentialed Provider should defer to the orders of the patient's personal physician if the directed practice is within the scope and training of the credentialed provider
- The patient's personal physician must document his or her interventions and/or orders on the EMS Patient Care Record
- OLMC should be notified of the participation of the patient's personal physician either from the scene or on arrival at the emergency department
 - *If there is a disagreement between the patient's personal physician and the System COGs, the physician shall be placed in direct communication with OLMC at the receiving facility. If the patient's personal physician and the on-line physician disagree on treatment, the patient's personal physician must either continue to provide direct patient care and accompany the patient to the hospital, or must defer all remaining care to the on-line physician*

3. Intervener Physician On-Scene:

- If an intervener physician is present at the scene, has been satisfactorily identified as a licensed physician and has expressed willingness to assume responsibility for care of the patient, OLMC should be contacted. The on-line physician has the option to:
 - manage the case exclusively
 - work with the intervener physician
 - allow the intervener physician to assume complete responsibility for the patient
 - *If there is a disagreement between the intervener physician and OLMC, the Provider will take direction from the on-line physician and place the intervener physician in contact with the on-line physician*
- The intervener physician must document his or her interventions and/or orders on the EMS Patient Care Record

Physician on Scene

- The decision of the intervener physician not to accompany the patient to the hospital shall be made with the approval of the on-line physician
- Medical orders are not accepted by any non-physician health care providers unless specifically approved by OLMC

Standard:

To establish a standardized process for the Medical Director to conduct a thorough review of significant clinical performance concerns to identify potential improvements including revocation of a Provider's System Credentialing privileges. (formerly known as a Peer Review).

Purpose:

The Medical Director will convene a Clinical Performance Review when he believes sufficient information exists to warrant a more thorough and complete review prior to making decisions regarding a Provider's Credentialing privileges. The Office of the Medical Director will conduct the Clinical Performance Review as described in the Clinical Performance Review Process. (www.atcomd.org document OMDR - 06) All Clinical Performance Reviews will be conducted in a fair, objective, respectful, confidential and patient focused manner.

Application:

1. The Medical Director determines the need for a Clinical Performance Review.
2. The membership of the Clinical Performance Review team will meet requirements intended to ensure a fair and objective review.
3. Conflicts of interest will be managed by the OMD to ensure a fair and objective review.
4. All aspects of the review including the proceedings, recordings and documents are considered confidential under the Texas Health and Safety Code Section 773.095.
5. All persons involved in the Review follow all requirements for confidentiality as described in the Clinical Performance Review Process document.
6. Each System Organization and Individual Provider will fully participate in the Clinical Performance Review as requested by the Medical Director. Failure to do so may result in the suspension or permanent revocation of a providers credentials by the Medical Director.
7. The Clinical Performance Review will be conducted in an expedient manner without compromising the focus on performance improvement and a thorough review.
8. The final recommendation of the Clinical Performance Review Team is considered by the Medical Director in determining the next course of action.
9. Once a course of action is made by the Medical Director, a provider may appeal the decision directly to the Medical Director. No other appeals are available with regard to the status of System Credentialing privileges.
10. The Office of the Medical Director will maintain the original Clinical Performance Review records.
11. The credential status of all providers practicing under the license of the Medical Director is at the discretion of the Medical Director.

Standard:

Define credentialing and the credential levels of providers within the ATCEMS System.

Definitions:

Certification or Licensure: an individual who is certified or licensed by a regulatory body as minimally proficient to perform emergency prehospital care at a particular level that is defined by a regulatory body (e.g., ECA, EMT-B, EMT-I, EMT-P or LP).

Credential to Practice: a process that is defined by the Medical Director that requires a certified or licensed individual to demonstrate competency to practice at a specified level of prehospital care. The credential to practice does not necessarily match the individual's certification or license.

Purpose:

Every Provider that delivers medical care within the ATCEMS System must be "Credentialed to Practice" in addition to holding a current State of Texas Certification or Licensure. All Credentialed Providers within the ATCEMS System are allowed to provide care under the delegated authority of the Medical Director in accordance with the rules of the Texas Department of State Health Services and the Texas Medical Board. Credentialing is the final approval by the System Medical Director that ensures an individual's competency to care for patients as part of the Emergency Medical Services System. An individual is "Credentialed to Practice" when he or she successfully meets and maintains the defined Credentialing requirements. The levels of Credentialing are:

- Administrative Provider
- Emergency Medical Dispatch (EMD)
- System Responder
- Emergency Medical Technician - Basic (EMT-B)
- Emergency Medical Technician - Intermediate (EMT-I)
- Emergency Medical Technician - Paramedic (EMT-P)

Credentialing Requirements (OMDR – 09) defines what is required to obtain and maintain credentials to practice within the ATCEMS System and can be found at www.atcomd.org

Authorized Skills by Credential Level (OMDR – 3) defines the interventions available to credentialed providers and can be found at www.atcomd.org

Standard:

Define qualifications in specialty areas that may include additional maintenance requirements or training.

Purpose:

Establish qualifications for ATCEMS System providers with specialized training, protocols or skills. These provider qualifications may have minimum credential levels, competencies, and/or other requirements which must be completed or maintained in addition to any requirements associated with a provider's System Credential. Qualifications are created and granted by the Medical Director independent of System Credentials and may be awarded, suspended or revoked independent of or in conjunction with any action against a providers credentials. Below are the current qualifications approved by the Office of the Medical Director. These qualifications or any additional qualifications created by the Office of the Medical Director may be modified or removed based on the needs of the EMS System and at the discretion of the Medical Director.:

- **System Educator (SED)**
- **Performance Management/Improvement (PMI)**
- **System Credentialing Preceptor (SCP)**
- **Community Resource Paramedic Provider (CPP)**
- **Special Operations – Tactical Medic (TAC)**
- **Immunization (IMM)**
- **Special Operations – HAZMAT Medic (HAZ)**

For a list of requirements for each of the qualifications (OMDR – 02) see the OMD Website at: www.atcomd.org

Refusal of Treatment and/or Transport

Standard:

To establish guidelines for Providers when addressing issues of consent or for patients who wish to refuse the treatment and/or transportation offered.

Purpose:

Adult patients with present mental capacity retain the right to refuse care and/or transport against medical advice.

Definitions:

Informed Consent

In Texas the general rule of law is that before a person may receive medical treatment they must give informed consent for that treatment. Without consent the medical treatment is unlawful. This is true regardless of whether the person receiving the treatment is a minor or has reached the age of majority (18 years of age).

Informed consent is based on an individual's appreciation and understanding of the facts, implications and future consequences of an action. In order to provide informed consent or refusal a patient must have adequate reasoning faculties(capacity) and be provided with information (risks/benefits) relevant to the decision making process. They should also be aware of the options available to them if they choose not to accept evaluation and/or treatment.

Implied Consent

In potentially life-threatening emergency situations where a patient is unable to give informed consent the law presumes that the patient would give consent if able. In potentially life-threatening emergency situations, consent for emergency care is implied if the individual is:

- Unable to communicate because of an injury, accident, illness, or unconsciousness and suffering from what reasonably appears to be a life-threatening injury or illness

OR

- Suffering from impaired present mental capacity

OR

A minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian is not present

Substituted (Surrogate) Consent

In some circumstances an individual with legal standing may give consent for a patient when the patient does not have the ability to do so because they are a minor, incarcerated or have been determined by courts to be legally incompetent. Parents or guardians are entitled to provide permission because they have the legal responsibility, and in the absence of abuse or neglect, are assumed to act in the best interests of the child. The best way to think about this is not to view the minor as "refusing" treatment, but simply to ask: Has someone **who is legally competent to do so** given consent to treat this minor? Without this consent, medical treatment cannot begin.

Refusal of Treatment and/or Transport

The following person(s) may consent to, or refuse, the evaluation, treatment, and/or transportation of a minor:

- Parent
- Grandparent
- Adult (> 18) sibling
- Adult (> 18) aunt or uncle
- Educational institution in which the child is enrolled that has received written authorization to consent/refuse from a person having the right to consent/refuse.
- Adult who has actual care, control, and possession of the child **and** has written authorization to consent/refuse from a person with the power to consent /refuse (i.e., daycare camps, soccer moms, carpools, etc.)
- Adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court
- A court having jurisdiction over a lawsuit affecting the parent-child relationship of which the child is the subject
- A peace officer who has lawfully taken custody of minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.
- A managing or possessory conservator or guardian.

Application:

1. All patients refusing treatment and/or transport must :
 - Be at least 18 years of age or an Emancipated Minor;
 - Be able to demonstrate present mental capacity in accordance with the Determination of Capacity Procedure.
 - NOT have been declared legally incompetent by a court of law. (If a patient has been declared legally incompetent, his/her court appointed guardian has the right to consent to, or refuse, evaluation, treatment, and/or transportation for the patient.)
 - NOT be suicidal or homicidal. (A law enforcement officer may arrest a patient who threatens or attempts suicide under Texas Health and Safety Code Section 573.001. The statute also covers other mentally ill patients and a similar statute allows an arrest for chemical dependency. Only a law enforcement officer can make these arrests.)
2. Patients meeting the above criteria who demonstrate present mental capacity retain the right to refuse any or all treatment and/or transportation. All patients should be encouraged to seek care. Additional resources may be employed including but not limited to involving the patients physician, additional providers such as a Commander, DMO, or On-line Medical Control.
3. Under no circumstances will ATCEMS System providers refuse or deny treatment or EMS transportation to any patient (or legal patient representative) who requests medical assistance from the provider or agency. The initiation of treatment should not be dependent on the patient's willingness to accept transport. (e.g. Hypoglycemia, Asthma, etc.) This does not include the administration of narcotic pain medications or sedative agents.
4. ATCEMS System providers shall not discourage any patient (or legal patient representative) from seeking medical care from a physician or from accepting EMS transport to a hospital.

Refusal of Treatment and/or Transport

5. When a patient with present mental capacity wishes to refuse care:
 - The patient will be instructed that the evaluation and/or treatment is incomplete due to the limitations of the pre-hospital care environment;
 - The providers will attempt to identify any patient perceived obstacles to treatment/transport and make reasonable efforts to address these obstacles. This includes but is not limited to the offer of transportation without treatment, or the offer of transportation to a facility not recommended by protocol. These should be offered only for the purpose of facilitating additional evaluation and/or treatment which would otherwise be refused.
 - The provider will inform the patient of the risks of refusal and benefits of treatment/transport in accordance with their presenting complaint. It should be explained that the risks described are not comprehensive due to the diagnostic limitations of the pre-hospital environment and that their refusal may result in worsening of their condition, serious disability or death.
 - The patient will be advised that they should seek immediate medical care at an Emergency Department or with their own physician and that they may call 911 again at any time if they wish to be transported to the hospital or if their condition changes or worsens.

Documentation:

1. The provider must document facts sufficient to demonstrate the patient's present mental capacity and understanding of his/her condition and the consequences of refusing treatment and/or transport to include those mentioned above.
2. If a patient wishes to refuse assessment, treatment and/or transport, have the patient sign the AMA form relating to the refusal of specific assessment, treatment, destination recommendation, or transport and have a third party witness the signature.
3. If the patient refuses to sign the refusal form, the provider will document the circumstances under which the patient refused to sign.

Safe Transport Pediatric Patients

Standard:

To provide a safe method of transporting pediatric patients within an ambulance and protect the EMS system and personnel from potential harm and liability associated with the transportation of pediatric patients.

Purpose:

Without special considerations children are at risk of injury when transported by EMS. EMS must provide appropriate stabilization and protection to pediatric patients during EMS transport.

Application:

1. Drive cautiously at safe speeds observing traffic laws unless patient condition requires emergent transport in accordance with operational standards on emergency response/transport.
2. Tightly secure all monitoring devices and other equipment.
3. Ensure that all pediatric patient less than 40 lbs are restrained with an approved child restraint device secured as per manufacturer's instructions if not secured by other means as part of patient care.
4. Do not transport the pediatric patient who meets trauma activation criteria in a child seat that was involved in the collision.
5. Ensure that all EMS personnel use the available restraint systems during transport when not otherwise engaged in patient care activities.
6. Transport adults and children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible.
7. Do not allow parents, caregivers, or other passengers to be unrestrained during transport.
8. Do not hold or allow the parents or caregivers to hold the patient during transport.
9. For patients with medical conditions that may be aggravated by stress, make every attempt to optimize safety when comforting the child.

Suspension or Revocation of Credential to Practice

Standard:

To identify potential circumstances that may lead to a provider's credential to practice being suspended or revoked.

Purpose:

In the ATCEMS System, a provider's ability to practice medicine is based on the Medical Director's authorization. Individuals and agencies that are part of the EMS System must always focus on providing appropriate clinical care. Accountability for actions taken lies with individual providers and agencies. The ATCEMS System strives to be an error-friendly system that will focus on a non-disciplinary approach to support and re-educate members of the System. However, circumstances may arise that require a change in Credential status, such as suspension or revocation.

Application:

1. In the ATCEMS System, a provider's credential to practice may be temporarily suspended, if in the opinion of the Medical Director, the providers actions pose a threat to the safety of current or future patients of the System. The providers credential may be permanently revoked, if substantiated through a process of appropriate investigation and review, for any of the following actions:
 - Falsification of a patient care document
 - Intentionally withholding care from a patient
 - Intentionally harming a patient
 - Providing care while impaired by alcohol or drugs
 - Failure to remediate and/or participate in required education and/or review
2. Additionally, there may be other circumstances that result in suspension or revocation of System Credentials. These may include, but are not limited to, the following:

Lapse, Loss, or Suspension of TDSHS Certification or Licensure

In the event that a Provider's TDSHS Certification/Licensure is allowed to lapse, the following process will apply:

- Unless confirmation of renewal, extension or upgrade can be verified and documented on the TDSHS website, the Provider's Credentials to Practice will be suspended. System Credentialing badges must not be worn.
- The suspension will remain in effect for no more than three (3) months from date of TDSHS certification/licensure expiration. Based on extenuating circumstances, documented in writing, and forwarded to the Medical Director for consideration, extensions may be granted.
- Without documented proof of renewal or upgrade or extension granted by the Medical Director, the Provider's Credentials will be revoked at the conclusion of the 3 month suspension period. The Provider's System Credentialing Badges must be returned to the Office of the Medical Director.
- Should a Provider renew or upgrade their TDSHS certification/licensure following revocation of Credentials, he/she will be required to complete the current Initial Credentialing Requirements for their level of Practice.

Suspension or Revocation of Credential to Practice

3. Separation from All System Registered Responder Organizations

In order for a Provider to be Credentialed in the System, he/she must be associated with a Registered System Organization. The following outlines the process for Providers who leave or disassociate from a Registered System Organization:

- A Provider is required to immediately notify the Office of the Medical Director when he/she is no longer affiliated with a Registered System Organization. When it is determined that a Provider is not associated with a System Organization, his/her Credentials will be suspended for a period of 30 days. System Credentialing badges must not be worn. During this period, the Provider may affiliate with another System Organization without being required to Recredential. The 30 day timeframe may be extended upon written request to the Medical Director.
- ILS and ALS Credentialed Providers must continue affiliation with an Organization designated as a “Tier 2 Organization” by the Office of the Medical Director to maintain ILS or ALS Credentials.
- After 30 days without affiliation (unless an extension is granted) with a System Organization, a Provider’s Credentials will be revoked.
- Should a Provider affiliate with a System Organization following revocation of Credentials, he/she will be required, to complete the current Initial Credentialing Requirements for their level of practice. New badges will be issued at that time.

4. Activity That May Pose a Threat to Public Health

- Criminal or Regulatory activity that may pose a threat to public health, or other circumstances as deemed appropriate, will be reviewed by the Office of the Medical Director.
- Individual providers and their respective Organizations are responsible to report any arrests of the provider involving alcohol, drugs or a felony directly to the OMD on or before the 1st business day after the arrest is made. Failure to do so may result in immediate suspension. Reporting the event to the TDSHS is the responsibility of the individual provider and must occur in accordance to specified Rules, with the appropriate form (s) and within the prescribed timelines.
- Except for those situations and processes specifically addressed, the process for suspending or revocation of Credentials will be determined by the Office of the Medical Director’s *Clinical Performance Review Process*.

5. Action Taken By TDSHS

- Any action taken (administrative review, suspension, revocation, etc.) by the TDSHS must be reported and documentation forwarded to the Office of the Medical Director. Failure to do so may result in suspension/revocation of Credentials.
- In all events concerning these issues, the Chief Officer, Director, or Program Manager of the Responder’s Organization will be advised. If deemed appropriate, the leadership of other organizations within the System and/or TDSHS may be notified.

6. The credential status of all providers practicing under the license of the Medical Director is at the discretion of the Medical Director.

Standard:

Define the design of the system and how the organizations integrate to form one System of Care.

Purpose:

The ATCEMS System is comprised of multiple agencies that include a diverse group of healthcare professionals including Communications Specialists, First Responders, Transport Providers, Hospital Networks (including specialty receiving centers) and Physicians with varying specialties in the community. Together, this “System” provides the basis for seamless delivery of care to acutely ill or injured patients in our community.

Application:

The ATCEMS System maximizes the opportunity to deliver appropriate care to patients as defined by the Protocols, Procedures and Standards established by the OMD (Collectively the Clinical Operating Guidelines). The goal of these documents is to provide safe consistent and sophisticated care to the citizens and visitors of the City of Austin and Travis County.

Medical Direction for all EMS Providers and First Responders flows from the EMS System Medical Director to each Texas Department of State Health Services (DSHS) Licensed System Organization, via Provider and First Responder Organization Agreements. In order for Medical Direction to flow from the Licensed Organization to the System Credentialed Providers or First Responders; they must respond and provide patient care with the approval of their Licensed Organization (s) within the State of Texas only.

Should they provide COG level patient care at preplanned events not approved by their System Licensed Organization and/or outside the State of Texas; System Medical Direction does not apply. This provision does not preclude Providers and First Responders from “stopping to render aid”.

1. All medical care within the EMS System should be provided according to the current Clinical Operating Guidelines.
2. All individuals providing medical care as part of the EMS System will be Credentialed according to the Credentialing requirements of the EMS System.
3. Specific medical care in the system will be delivered by appropriately Credentialed AND (if applicable) Qualified individuals within the environment specified in the COGs.
4. Individuals holding current Qualifications may deliver specialty care as defined by the COGs when appropriate equipment and conditions exist.
5. All individuals providing medical care as part of the EMS System will be currently certified or licensed by the Texas Department of State Health Services or the Texas Medical Board.
6. All organizations providing medical care as part of the EMS System will comply with Texas Department of State Health Services requirements for Provider or First Responder Organization Licensure.
7. All 9-1-1 requests for care will be managed by EMS Communications according to the requirements of the currently adopted Medical Priority Dispatch System. This includes call triage, pre-arrival instructions and response determinants.
8. All Tier 2 First Response Organizations will be capable of delivering, at a minimum, Basic Life Support care (BLS) as defined by the OMD.

System Design

9. Appropriately Credentialed and equipped individuals may provide First Response Intermediate Life Support (ILS) or Advanced Life Support (ALS) level of care according to the COGs.
10. First Response ILS and/or ALS level of care is supplemental to the System minimum requirements.
11. All System First Response Organizations must maintain the BLS supplies identified on the Minimal Equipment List. If a System Registered Organization chooses to equip an ILS or ALS Credentialed Provider, the equipment must be supplied and maintained according to the appropriate Minimal Equipment List for that level of care.
12. The ground transport component of the EMS System (ATCEMS Department) will be capable of delivering ALS level care according to the Clinical Operating Guidelines when appropriate for the patient's condition.
13. Standby and on-site Special Event Providers Minimal Equipment will be determined based on the need of the specific event.
14. Treatment of **patients** with "Non-prescriptive" medications that are not specifically included in the COG **or** not approved by specific OLMC is considered practicing outside the scope of practice and the provider's scope of care.
15. During unusual or extreme conditions or circumstances, the above criteria may be modified by the Medical Director to best meet the needs of the patients of the EMS System.
16. The use of Equipment or Supplies not approved by the System Medical Director during patient care is prohibited. Approved items are specified per the Equipment Lists for each System Organization Tier and Credentialing Level. Refer to OMDR 1, OMDR 4, OMDR 5, and OMDR 12.

Transport Destination Decision

Standard:

Define how a transport destination decision is reached taking into consideration the specialized care needs of specific conditions and the needs and preferences of our patients.

Purpose

Patients treated by the ATCEMS System may have complex clinical conditions that require care at facilities with specialized capabilities or expertise in treating these conditions. In the absence of the need for specialized care patients may want to be transported to facilities based on their personal preference or the location of their physician and records. Whenever possible the providers of the ATCEMS System will provide transport to a prescribed medical facility or their preference as a patient.

Application:

1. The following assumes the patient or the patient's guardian (in the case of a minor) has decision making capacity in accordance with the Refusal of Treatment/Transportation Standard and the Determination of Capacity Procedure. In the absence of decision making capacity or in cases where consent is implied the patient should be transported to the closest appropriate facility. If a patient wishes to refuse treatment/transport but has been determined to lack the capacity to do so providers should consult their supervisor and OLMC in accordance with the Refusal of Treatment/Transportation Standard.
2. When a patient presents with a clinical condition requiring specialized care the transporting providers will transport the patient to the closest facility that offers the specialized care for that patient's condition. (STEMI, Stroke, Trauma, Resuscitation Center, Pediatric care, etc).
3. If a patient refuses to go to the recommended facility transport providers will explain the benefit of transport to the recommended facility and the risk of transport to another facility. If the patient still refuses transport to the recommended facility transport providers will recommend transport to the next closest appropriate facility for their condition.
4. If a patient continues to refuse transport to the alternative specialty care facility or requests transport to a facility that lacks the ability to care for the patient condition the transport provider will make every effort to explain the need for the specialty care facility. These efforts may include but are not limited to contacting the patient's physician, a supervisor, on-call Medical Director or OLMC at the facility the patient wishes to be transported to.
5. If after the efforts described above the patient continues to request transport to a facility not recommended for the patient's condition the transport providers will transport the patient to the facility of the patients choosing. They should notify their supervisor and the receiving facility of their transport. On arrival at the facility the crew should consult with the attending physician to determine if the patient will be transferred. If such a transfer is imminent the provider should contact their supervisor and remain immediately available to transfer the patient after the required screening examination by the receiving facility. The duration of this availability is to be determined by the supervisor based on the patient's condition and the anticipated time to transfer.

Transport Destination Decision

6. If a patient does not have a condition that requires transport to a specialized facility as prescribed by protocol the providers will transport the patient to an approved system facility of the patient's choosing. When a patient requests transport to a facility other than an approved system facility the transport decision should be made in consultation with a supervisor. If in the provider's opinion the patient's condition warrants transport to a closer facility for rapid stabilization the need for this destination should be explained to the patient and every effort made to deliver the patient to the closest appropriate facility. These efforts may include but are not limited to contacting a supervisor or OLMC. If the patient continues to refuse the recommended destination the patient will be advised of the associated risks and transported to the destination of their choosing.
7. If the patient has an MOT or if transport has been arranged by another healthcare provider the transport provider should transport the patient to the destination indicated by the MOT or sending healthcare provider in accordance with the MOT Standard.
8. If the patient does not have a condition that requires specialty care as prescribed by protocol and does not have an expressed preference the transport provider may transport the patient to the closest appropriate facility.
9. In the event multiple patients from the same event are to be transported in one unit the patient with higher acuity determines the transport destination. Where the need for different facilities can be anticipated reasonable efforts should be made to split the patients at the scene as long as doing so does not place either patient in danger.
10. Any refusal of treatment or recommended transport destination should be performed and documented in accordance with the Refusal of Treatment/Transport Standard and Determination of Capacity Procedure.

Transfer of Care to Provider of Lesser Credentials

Standard:

To define circumstances and establish a process for transferring patient care from a higher credentialed provider to one of lesser credentials.

Purpose:

Providers may be presented with multiple patients, limited resources, or patient conditions requiring early rapid transport in order to maximize potential outcome (for example one critically injured patient and multiple non-injured occupants in a motor-vehicle collision). These situations may require that patients be left in the care of a lesser credentialed provider. The ultimate decision of whether or not to initiate transport of a critically ill or injured patient while awaiting additional resources rests with the on-scene Provider with the most advanced level of system Credentials as defined in Authority for Patient Care.

Application:

When transferring care to a provider of lesser credentials the following applies:

1. Leaving patients on-scene should not be a routine procedure. It is to be considered only when a patient requires immediate transport in order to maximize potential outcome.
2. The transport Provider may transfer patient care to a Provider of lesser Credentialing when transfer of established care is **not** beyond the scope and/or training of the Provider(s) assuming care (i.e., an intubated patient may not be left with a System Responder level provider or EMTB Credentialed Provider).
3. All patients should be accounted for, assessed and triaged, and appropriate additional resources requested prior to transport of the critically injured patient.
4. No patient requiring immediate advanced stabilization (i.e., pleural decompression, intubation, defibrillation etc.) is to be left on-scene awaiting additional resources unless an appropriately credentialed and equipped Provider is present and able to perform such care.
5. Mass and Multi-casualty incident transport decisions will be made by the on-scene command structure.

STEMI Alert Criteria

In order to more consistently assess and apply the notification for a STEMI Alert the following criteria have been developed in conjunction with Mission Lifeline.

A STEMI Alert should be called when a patient is currently **“symptomatic”** for an Acute Coronary Syndrome (ACS) event **AND** a new or presumably new ST elevation ≥ 1 mm in two anatomically contiguous leads **AND** does not have exclusion criterion listed below in the ACS Consultation section.

The STEMI Alert notification should 1st be “declared” to Communications via radio or phone. Then as soon as possible transmit a 12 lead ECG. Whenever possible the patients name should accompany the 12 lead ECG.

The transport Hospital should be notified of the STEMI Alert as soon as practical by Communications and the Alert must be included in the Transport radio report to the Hospital with the patient condition information.

If < 18 yrs old and not OB, transport to Dell Children's Medical Center.

ACS Consult Criteria

The Provider should not declare a STEMI Alert and should consult with the anticipated receiving Hospital prior to transport. And, transmit a 12 lead ECG with “ACS Consult – Facility Name” in the patient ID field.

- Patients that are currently **“asymptomatic”** for an ACS event however, have ECG readings consistent with the above STEMI Alert Criteria.

OR

- Patients who are **“symptomatic”** for ACS and have evidence of Isolated V1 and V2 elevation only, LBBB, LVH, Early Repolarization, Ventricular/Ventricular Paced, Diffuse ST Elevation, or Non-Specific ST Changes or other type “Abnormal” ECG findings including poor quality ECG tracing.

The declaration of the Alert or use of the ACS Consult option should be based upon the patient's current condition and the Provider's judgment.

Stroke Alert Criterion

This criterion is for patients exhibiting current signs and symptoms of a Stroke as evidenced by using the “Cincinnati Prehospital Stroke Scale” (CPSS) Clinical Procedures CP - 14.

If the patient’s current presentation and history are suggestive of stroke (≤ 8 hours), early notification (**STROKE ALERT**) and rapid transport to a designated Stroke Center Appendix A – 02 is warranted. The “ALERT” status declaration is made to Communications for their assistance (as needed) in determining the most appropriate transport destination (based on time and distance), notification of the selected Hospital and the most expeditious mode of Transport (Ground or Air).

Patient’s that are **without a current** Stroke presentation (s) and have a history suggestive of a T.I.A. (≤ 8 hours); are to be transported to a Stroke Center for an evaluation.

These T. I. A. patients’ are **not** considered Stroke Alert Patients.