METROCREST MEDICAL SERVICES

POLICIES & PROCEDURES

INDEX

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

DEVELOPMENT AND AUTHORITY

POLICY CODE:	**2009-001**	**APPROVED BY**
REPLACES:	2000-001	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To assign responsibility, accountability, and authority for establishing and enforcing Medical Control policies.

POLICY:
It is the responsibility of Metrocrest Medical Services (MMS) to develop and enforce policies and procedures relating to the patient care activities of all personnel within the MMS Medical Control System. These policies and procedures are binding on the employees of the MMS Medical Control System (MMS MCS), all prehospital care organizations for which MMS provides medical control, the individual EMS personnel within these organizations, and the administration/management of these organizations.

PROCEDURE:
1. A policy may be authored by any person in the MMS MCS, the MMS Medical Director, or the MCS Manager.

2. The policy, if not authored by the MCS Manager, will be reviewed and may be revised by the MCS Manager.

3. The policy will be reviewed by the Managers Committee, who may make recommendations for additional revisions.

4. The policy is then reviewed and may be revised by the Medical Director.

5. The policy is then reviewed by the local Associate Medical Director (if applicable) who may make recommendations for additional revisions.

6. The policy will be distributed and enacted as described in "Distribution and Enactment Policy" policy #2009-002.

METROCREST MEDICAL SERVICES
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DISTRIBUTION AND ENACTMENT

POLICY CODE:	**2009-002**	**APPROVED BY**
REPLACES:	2000-002	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure the timely and effective distribution of new Medical Control policies and the proper notification of affected personnel.

POLICY:
It shall be the responsibility of the MCS Manager to distribute new Medical Control policies as described in the below procedure.

Once received by the Managers Committee representative of the EMS provider(s) and approved by the Medical Director, the policy shall be in force on the date indicated on the policy as the "Effective Date".

PROCEDURE:

1. The MCS Manager will first distribute the policy to those MMS personnel who are affected by the policy, to always include the Medical Directors, Associate Medical Directors, Medical Control Officers (MCO's) and Field Training Officers (FTO's).

2. The MCS Manager will then distribute the policy to the EMS provider agencies no less than 45 days prior to the “Effective Date” of the policies. The MCS Manager may delegate this task to an MCO but retains the responsibility.

   The individuals holding the following offices or positions within each provider agency shall be the recipients of a copy of all policies:
   A. The Chief Officer (Chief, Owner, Executive Director, etc.).
   B. The EMS operations director, coordinator, or officer.
   C. The provider's Manager Committee representative.

3. The provider service's administration shall be responsible to ensure that all EMS personnel have a copy of the policy for review, in each station or facility before the “Effective Date” listed on the policies. MMS will provide orientation to the policy at the service's regular CE.

METROCREST MEDICAL SERVICES
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MANDATORY TRANSPORTS

POLICY CODE:	**2009-003**	**APPROVED BY**
REPLACES:	2000-003	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure the appropriate response to a request for EMS evaluation, treatment, and/or transport.

POLICY:
When the following signs, symptoms, or situations are encountered by MMS EMS personnel, they will be regarded as mandatory transports. EMS personnel will *actively encourage* the patient to accept EMS treatment and transport. While the patient is still legally entitled to refuse EMS transport, EMS personnel may not deny transport, discourage EMS transport, or encourage a refusal of EMS transport by the patient. Additionally if any patient in the mandatory transport category does refuse transport, On-line Medical Control must be contacted, in accordance with Policy 2009-017.

1. Anytime one or more of the EMS personnel of the responding crew believes transport is indicated.
2. Cardiorespiratory:
   a. Shortness of breath.
      EXCEPTION: Hyperventilation that improves within 10 minutes of intervention by EMS.
   b. Chest pain or other symptom suspicious of cardiac ischemia, regardless of medical history.
   c. Hypertension with diastolic pressure of 110 mm Hg or higher, regardless of symptoms.
3. Abdominal:
   a. Abdominal pain with any of the following:
      orthostasis (systolic drop of 10 mm Hg or pulse rate increase of 10/min.)
      guarding
      rigidity
      hematemesis
      melena
      temperature of greater than 99.5 degrees
      history of abdominal surgery within 3 months
      jaundice

b. Female of child-bearing potential with abdominal pain of unknown etiology.
c. All abdominal pain if alternative means of transport is not available within 30 minutes.

4. Overdose or Poisoning:
   a. All overdoses, intentional or accidental unless Medical Control directs otherwise.
   b. All poisonings, unless Medical Control directs otherwise.
5. Neurological:
   a. Altered mentation.
   b. Seizures with no past history.
   c. Neurological deficit such as paresthesias, paralysis, dysphasia, etc.
6. Pregnancy:
   a. Any complaint or abnormal finding related to a known or suspected pregnancy.
7. Age:
   a. Any minor for whom legal guardians cannot be located within 10 minutes.
   b. Any person 65 years or older who presents with an acute medical or surgical problem.
8. Trauma: A patient involved in an injury-producing or potentially injury-producing incident with one of the following:
   a. Hypotension WITH evidence of hypoperfusion (tachycardia, pallor, diaphoresis, altered mentation, prolonged capillary, etc.).
   b. Evidence of compensated hypotension, such as normal systolic with tachycardia or other signs of hypoperfusion (see above).
   c. Significant injury mechanism with bradycardia.
   d. Penetration injury to the head, neck, abdomen or chest.
   e. Significant, persistent dyspnea and/or respiratory rate <10 or >29
   f. Persistent altered mentation or GCS <14 or Pediatric Trauma Score of < 8
   g. Motor vehicle collision resulting in:
      Death of another occupant in vehicle
      Ejection of patient
      Passenger compartment intrusion >12 inches
   h. Fall greater than 20 feet or 3 times the patient's height.
   i. Following fractures:
      Two or more proximal long bones (humerus or femur)
      Flail chest
      Pelvic fracture
      Open or depressed skull fracture
   j. Paralysis
9. Abuse
   a. ALL persons that the EMS personnel have reason to suspect may be victims of abuse. This includes patients of any age (infant through geriatric).

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ADVANCED MEDICAL PROCEDURES

POLICY CODE:	**2009-004**	**APPROVED BY**
REPLACES:	2000-004	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure the appropriate equipment is available and training and credentialing is provided for personnel performing advanced medical procedures, which are not be included in the protocols for the MMS MCS system as a whole (e.g. RSI).

POLICY:
All services under the Metrocrest Medical Services Medical Control system shall obtain written authorization from MMS to implement the use of advanced medical procedures or agency specific protocols in the prehospital setting.

The Medical Control System (MCS) Manager, the Associate Medical Director, and the Medical Director shall be responsible for reviewing and approving such requests.

The provider service shall be responsible for meeting the requirements of the equipment as required by the Medical Director and training of personnel as specified in the procedure as set out in this policy.

PROCEDURE:

1. The provider service shall submit a written request to initiate the implementation of advanced medical procedures. This request shall be addressed to the MCS Manager.

2. The MCS Manager, the local Associate Medical Director, (if applicable) and the Medical Directors shall review the request based upon the service's capabilities (in terms of equipment, personnel, and level of care). The MCS Manager will obtain from the service any and all information needed to fully evaluate the request.

3. If approved, the service shall arrange to provide the approved MMS course for its personnel in the specific advanced medical procedure. The course may be presented in lieu of a monthly CE or as an extra class for the agency.

4. The agency may institute the use of an advanced medical procedure once a minimum of **75%** of it's paramedic level personnel complete the course and pass the written exam with a score of **80%** or greater.

5. Individual personnel who have not completed the course once the agency has implemented an advanced medical procedure are not authorized to perform the procedure until they have completed training and authorization for the procedure. Medical Control authorization to perform an advanced medical procedure is extended on an individual basis.

6. Once an agency has implemented an advanced medical procedure, the agency has the responsibility to ensure that authorized personnel and the required equipment are available for all emergency responses.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

RECEIVING FACILITY CONTACT PROCEDURES

POLICY CODE:	**2009-005**	**APPROVED BY**
REPLACES:	2000-005	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure and provide proper reporting and continuity of patient care through communicated verbal patient report to a receiving facility.

POLICY:
MMS MCS personnel will adhere to the procedures outlined below when contacting a facility to which they are transporting a patient. If On-Line Medical Control consultation is needed, MMS MCS personnel must refer to Policy 2009-007 to obtain On-Line Medical Control patient care treatment orders.

While communicating with a receiving facility, maintain patient confidentiality as prescribed by HIPAA regulations.

PROCEDURE:
NOTIFICATION OF RECEIVING FACILITY
Whether receiving facility contact is being made by radio or telephone, the same basic procedures shall apply.

1. The EMS unit will identify themselves by service, unit, and EMT or paramedic. They may ask about the quality of their transmission signal.
2. Advise the receiving facility that you are calling in a report for a patient being transported to that facility.
3. Give a concise report to the receiving facility that consists of the general patient condition/chief complaint, the therapies you have implemented, and your ETA to that facility.
4. If the EMS unit has contacted an On-Line Medical Control site for patient care treatment orders, advise the receiving facility of the specific orders received and implemented.
5. If the receiving facility staff has further questions regarding the patient, provide that information to them.

UNSOLICITED ORDERS FROM A RECEIVING FACILITY (NOT A MEDICAL CONTROL SITE)
In the event that a physician at a receiving facility that is not a MMS MCS On-Line Medical Control site communicates patient care orders to a MMS MCS unit that is transporting a patient, the following procedures should be followed and documented:
IF the therapy is within the scope of the MMS Patient Care Protocols and would be a standing order in the MMS Patient Care Protocols:

1. Perform the suggested therapy if in the MMS MCS personnel's judgment the therapy provides the best course of patient treatment.

2. MMS MCS personnel may, but are not required to, contact an On-Line Medical Control physician to discuss and confirm the therapy requested by the physician at the receiving facility.

IF the therapy is not in the scope of the MMS Patient Care Protocols, or if the therapy is one that requires On-Line Medical Control approval in the MMS Patient Care Protocols:

1. Confirm the order with the physician, and advise them that you must first contact a MMS MCS On-Line Medical Control physician before you can implement the patient care therapy.
2. Contact MMS MCS On-Line Medical Control and request from the physician permission to implement the suggested therapy.
3. MMS MCS personnel will follow the direction of the On-Line Medical Control physician regarding the requested therapies.

DIVERSIONS/HOSPITAL CAPABILITY ACCOMODATIONS

In the event that when contacting a receiving facility they advise they are on divert, or are otherwise not capable of providing for the anticipated needs of the patient:

1. If possible, the patient and/or family should be advised that the original receiving facility is not available, and consulted regarding an alternative facility.
2. If patient/family is not able to or available to make a decision, MMS MCS personnel should transport the patient to the next closest appropriate facility for the patient's condition.
3. If possible, advise the original receiving facility of the new destination so that they may advise arriving family members of the change in destination.
4. Documentation should include the name of the original receiving facility, the reason that they were not able to receive the patient, and if possible, the name of the individual who was contacted at the original receiving facility.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

ON-LINE MEDICAL CONTROL SITE ASSIGNMENTS

POLICY CODE:	**2009-006**	**APPROVED BY**
REPLACES:	2000-006	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To designate those personnel who are authorized by the Metrocrest Medical Services Medical Control System (MMS MCS) to provide on-line medical control to MMS EMS units.

To assign responsibility for the provision of on-line medical control for MMS EMS units among the designated MMS Medical Control Sites.

POLICY:

The following facility is authorized to act as On-line Medical Control sites for the Metrocrest Medical Services Medical Control System:

Baylor Medical Center at Carrollton

The on-duty attending ED physician at this site is authorized to provide On-line Medical Control to MMS EMS units as needed.

MMS EMS may enter into agreement with other hospitals for them to function as On-Line Medical Control sites, and this policy will be updated with that occurrence. Agencies will be assigned a primary On-Line Medical Control site if there is more than one OLMC hospital. Site assignments are subject to change, as system needs require, and will be designated by operational memorandum from the Medical Control System Manager.

EMS personnel will not contact a receiving facility for the purpose of consulting an ED physician unless the facility is designated as an On-Line Medical Control site.

METROCREST MEDICAL SERVICES
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ON-LINE MEDICAL CONTROL CONTACT

POLICY CODE:	**2009-007**	**APPROVED BY**
REPLACES:	2000-007	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To establish the responsibility, format, and procedure for MMS EMS units to contact Medical Control for on-line medical direction.

POLICY:
MMS EMS provider services have the responsibility to ensure:

1) That **all** on-line medical control contact is made on a designated and approved phone line or radio channel.
2) That MMS Medical Control is notified of any and all problems with on-line medical control.
3) That MMS procedures and policies concerning the use of on-line medical control are followed by all personnel at all times.
4) That all EMS units are equipped with two independent methods of contacting on-line medical control. The two methods must be of such a nature that a failure of one will not disable the other.
5) The **primary** means of contacting on-line medical control will be via cellular phone. In the event of failure of the cellular phone, the **secondary** means of contact will be via a designated radio channel.

PROCEDURE:
TRANSMITTING PATIENT REPORTS
Whether On-line Medical Control contact is being made by radio or telephone, the same basic procedures shall apply.

1. Once the site personnel answer the phone or radio. They should identify the facility and give their name.
2. You will then identify yourself by service, unit, and EMT or paramedic name.
3. If you so desire, this is the correct time (prior to your report) to ask On-line Medical Control about the quality or clarity of your transmission.
4. You will then provide the patient report, utilizing the following format:
   a) "We are *on the scene* or *enroute to* (destination facility name).
   b) "With an *emergent* or *non-emergent* patient".

   Patient condition is as follows:

Emergent:	Critical patient, CPR, or with life threatening illness/injury.
Non-Emergent:	Non-critical patient.

c) **IF YOU ARE IN NEED OF ON-LINE MEDICAL CONTROL**, indicate so at this point by saying:
"I need to speak with an Physician for orders".
"I need to speak with an Physician for information".

If the physician is not immediately available for direct communication, then the facility personnel have been directed to:

a) Record the patient information given by the EMS unit, including what interventions have been done and the requested orders.
b) Communicate this information directly to the physician.
c) Relay the physician's orders to the EMS unit, identifying the ordering physician by name and insuring that it is clear to the EMS unit that the orders are from the physician.

5. If any orders are given, *REPEAT THE ORDER* for verification.
6. Be certain you understand what, if any, *follow up* is expected of you with On-line Medical Control (i.e., repeat medication if no relief, etc.).
7. Verify the *On-line Medical Control Physician's name.*
8. If needed, request that the On-Line Medical Control staff contact the receiving hospital with a patient report and ETA. EMS unit should contact receiving hospital if possible especially if On-Line Medical Control staff indicates they are not able to make this report.

MEDICAL CONTROL RADIO/PHONE TESTS

EMS units may test or check the radios or phones used to contact on-line medical control, as they deem necessary. After the on-line medical control source has identified themselves in the usual manner, the EMS unit will ID itself and ask how the MC source is receiving the transmission.

INTERFACE WITH QUALITY IMPROVEMENT

The MMS Quality Improvement (QI) program has among its responsibilities the evaluation and improvement of on-line medical control procedures and activities. The MMS MCS is also responsible for evaluating and improving all aspects of patient care provided by MMS field personnel.

If MMS EMS personnel have a question or concern regarding the activities of personnel providing on-line medical control, they are instructed to bring this to the attention of their Medical Control Officer or the MCS Director. This can be done by contacting MMS or the Medical Control Officer assigned to that service directly or by completing one of the "Request for QI Investigation" forms found in your station QI manual. This form should then be forwarded to the MMS office. The Medical Control Officer has the responsibility to investigate all such requested incidents and provide feedback to the requesting entity.

If On-line Medical Control site personnel or receiving ED personnel have a question or concern about any aspect of the MMS Medical Control system or the field personnel within the system, they are encouraged to bring it to the attention of MMS.

THERAPY DENIAL

Should the Medical Control Officer or On-line Medical Control Physician deny a *reasonable or appropriate* therapy requested by MMS EMS personnel, the EMS personnel may document this denial on one of the "Therapy Denial" forms found in the Medical Control manual. Upon completing the form, the EMS personnel will forward the form to MMS. The MCS Director and the Medical Director have the responsibility to investigate all such incidents and provide feedback to the involved EMS personnel and to the On-line Medical Control physician if so requested.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

ON-LINE MEDICAL CONTROL CONTACT FAILURE

POLICY CODE:	**2009-008**	**APPROVED BY**
REPLACES:	2000-008	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure that proper patient care will be performed in the event of a communications failure preventing an EMS unit from contacting on-line medical control.

To ensure that the service's management and the MMS MCS are notified of the problem in a timely manner *(within 24 hours of the incident).*

POLICY:
In the event of a communications failure MMS EMS personnel are required to follow the procedure outlined in this policy.

A communications failure is defined as:

> Inability to make contact with the designated On-line Medical Control site via the **primary or secondary** means of communications in two (2) attempts.

Contact is defined as radio or phone communication with quality of transmission adequate to successfully communicate the information appropriate for the patient's medical need.

The appropriate service supervisor/manager (or designee) shall have the responsibility of notifying the service's Medical Control Officer (MCO) within 24 hours of the event.

If the problem is with the EMS unit's equipment, procedure, or personnel, the service's management shall have the responsibility to rectify the situation and notify the MCO of the status of the problem.

PROCEDURE:
In the event that an EMS unit is unable to make On-Line Medical Control site contact with their primary or secondary means of communications due to a problem at the facility or on the EMS unit's part, the attending EMS personnel shall: “treat as per protocol,” meaning the entire protocol, including the treatments below the Medical Contact line, will be standing orders. Examples of failures would include inoperable cell phone, radio system disruption, physician at Medical Control site is unavailable for consultation, call disconnected, or busy signals.

1. Attempt ***twice*** to contact on-line medical control using the primary or secondary means of communication.

2. If this should fail or any problems are encountered with the primary or secondary means of communication, treat the patient as per protocol.

3. Try to ensure that the receiving facility is notified of the units impending arrival.

4. Notify their supervisor as per their service policy as soon as possible.

5. Provide to their supervisor, by the end of their shift, a written incident report detailing the nature of the communication failure and what therapies were provided that were beyond the standing orders in the MMS protocols.

The service supervisor/manager (or designee) shall have the responsibility of providing written notification of the nature of the failure, copies of all patient care documentation, and incident reports from the EMS personnel to the MCO within 24 hours of the event.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

DOCUMENTATION REQUIREMENTS

POLICY CODE:	**2009-009**	**APPROVED BY**
REPLACES:	2000-009	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure that documentation is generated on all EMS incidents in the MMS system.

To ensure that MMS receives or has electronic access to copies of all pertinent patient documentation generated in the MMS Medical Control System.

To ensure those persons who walk into EMS stations for assistance are cared for properly and if appropriate defined as a "walk-in" patient.

POLICY:
The provider service shall have the responsibility for ensuring that all EMS incidents to which a unit from that service is dispatched are documented. This includes all incidents where a patient is treated and/or transported by the responding agency. Also included are incidents where the responding transport unit is canceled by the on-scene first-responder unit. Patients who refuses any aspect of EMS service, patients have left the scene, false calls, the patient is referred to another unit or service for transport, adult patients who "walk-in" to make contact with EMS personnel (even for routine v/s checks), and "no patient" calls, must be documented appropriately.

The provider service shall have the responsibility for ensuring that MMS receives a legible copy or electronic access to all patient charts generated by the service. The patient chart copy may be in the form of a paper copy, electronic media, or via access to the agencies network. The charts must include copies of any refusal forms completed and of ECG strips generated. The charts for each month must be turned in to MMS by the 10th business day of the following month. All CAAS accredited services will provide all charting documentation within 10 days of document date.

PROCEDURE:

With the exception of "walk-in" contacts, all patient contacts must be documented on a patient chart (as pre-approved by MMS). The chart must contain the minimum operations and demographic information required by the service's administration. The patient charts will include information set for within the MMS QI Programs, "Standard for Documentation". In addition, the chart must always include:

Date of incident.

Times, including call received by dispatch, call dispatched, unit responding, unit canceled, unit on scene, patient contact time (may be estimated if not collected by dispatch system), arrival time of transporting entity, departure time of transporting entity, time of arrival at receiving facility, and time unit clear of scene.

Incident number.

Location of incident, as reported by dispatcher.

Unit designation that answered call.

Unit designation and service of transporting entity.

Personnel names and MMS medical control identification numbers that were on responding unit(s).

Statement of dispatch nature.

Statement of reason for cancellation.

Assessment of findings upon arrival of unit.

In addition, the chart must include any other applicable components as defined in the "Standards for Documentation" as issued by MMS.

Persons who "walk-in" (come to an EMS station or approach EMS personnel who are not on a call) for EMS assessment and/or treatment must have documentation completed as follows:

1. All "walk-ins" under the age of 13 must have a complete assessment and patient chart.

2. The EMS personnel MUST directly ask an adult who presents to EMS with a request for a vital signs assessment if the individual is experiencing any symptoms or complications at this time.
   a. If the adult patient indicates that he or she is having any sign or symptom of a medical problem, then the individual must be treated as a patient and have a complete patient chart generated as stated above.
   b. If the patient denies any medical problem, or symptoms, the vital signs (v/s) are above or below the thresholds given in this policy, the individual must be treated as a patient and have a complete patient chart generated as stated above.
   c. If the individual denies any medical complication or symptoms, AND the vital signs are within the parameters in this document, then the documentation of the contact may be accomplished as follows:

      - A log which includes the patient's name, the date and time of contact, why the patient wanted the v/s measured, and what the v/s were.

ACCEPTABLE V/S PARAMETERS FOR DOCUMENTATION OF PUBLIC CONTACT AS A V/S CHECK ONLY:

Adults: (Pediatric patients require a full chart/refusal documentation)

Respiratory rates:	12-24
Pulse:	60-120
Blood pressure:	Systolic 90-180, Diastolic 50-100

In addition to these numeric parameters, the vital signs must be clinically acceptable for the person. Example; a systolic BP of 92 mm Hg is not clinically acceptable on a 100 kg 50 year old male patient, and would require a complete patient chart. For this patient a systolic pressure of 92 mm Hg would be considered low and require further evaluation.

METROCREST MEDICAL SERVICES
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ON-LINE MEDICAL CONTROL RECORDINGS

POLICY CODE:	**2009-010**	**APPROVED BY**
REPLACES:	2000-010	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure the proper recording of on-line medical control contacts within the MMS system for QI purposes.

To assign responsibility for purchase, maintenance, storage, and review of medical control recordings.

POLICY:
Contact with on-line medical control via cellular phone by an MMS EMS unit will be recorded on digital media.

MMS On-line Medical Control Sites have the responsibility of:

1. Ensuring that the designated phone and recording device are functioning properly.
2. Ensuring the digital media is kept for at least 30 days.
3. Ensuring that digital media is changed as necessary.

MMS has the responsibility of:
1. Providing all equipment necessary for recording.
2. Retrieving the digital media from the medical control site.
3. Preparing the digital media for re-use at the medical control site.

Once the digital media is recorded upon with MMS EMS unit traffic, the device is under the jurisdiction of the Metrocrest Medical Services Medical Control System. MMS is authorized to retain and copy the content as needed.

METROCREST MEDICAL SERVICES
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CORRECTIVE ACTION

POLICY CODE:	**2009-011**	**APPROVED BY**
REPLACES:	2000-011	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To establish authority for taking corrective actions on EMS personnel within the MMS Medical Control System.

To establish the sequence of steps to be taken in the event of improper activities or deficient performance by an individual within the MMS Medical Control System.

POLICY:
Metrocrest Medical Services has the authority:

- To require specific education or training of EMS personnel within its Medical Control System, both on an individual and system-wide basis.
- To impose restrictions, suspensions, or revocations of the privilege of practicing in the system upon individual EMS personnel of any certification level or upon services within its system.
- To evaluate the performance of the personnel and services within its system in all aspects of patient care and patient care oriented operations.
- To establish binding standards for all patient care oriented activities.

PROCEDURE:
IDENTIFICATION OF NEED FOR ACTION

1. The need for some form of corrective action, either with an individual, a service, or the system as a whole, will be determined through chart evaluations, field evaluations, a patient or patient family complaint, a request for investigation (from any source), skills testing, didactic examinations, or any other evaluation tool utilized within the Metrocrest Medical Control system.
2. The MCS Manager, or his designee, is responsible for articulating the specific problem and/or need for action in a written document.
3. This document shall include:
    a. a descriptive synopsis of the problem or need
    b. an action plan for rectifying the problem or meeting the need
    c. assignment of responsibility for completing the actions

4. A copy of this document shall be given to the:
   Medical Director of MMS
   Associate Medical Director, if applicable
   Medical Control System (MCS) Manager of MMS
   Medical Control Officer (MCO) responsible for the involved agency
   EMS operations supervisor of the service or agency
   Line personnel addressed by the document

MINOR INFRACTIONS OR SUBSTANDARD PERFORMANCE

Once the need identification process indicates either a minor infraction or a trend of minor substandard performance, the following procedure will be utilized.

"Minor" is defined for this purpose as having a low probability of threat to patient care or to the operations of the Medical Control System.
Minor infractions or substandard performance may include, but are not limited to, such things as:

- A trend of poor chart evaluation, MC contact complaints, or field evaluation scores and/or minor protocol violations (which are clearly not a threat to the patient)
- Failure to comply with policies and procedures (if the failure is not a threat to the patient or the System).
- Disrespectful demeanor toward medical control personnel
- By-pass of on-line MC
- Failure to participate in the QI program

1. The MCO shall notify the EMS operations supervisor of the service of the infraction.
2. The MCO (and the EMS operations supervisor of the service, if s/he wishes) shall meet with the individual and provide feedback as to the nature of the substandard performance.
3. The MCO shall specify the desired performance, and discuss the means to reach this goal with the individual.
4. The MCO shall document the meeting and submit this documentation to the MCS Manager.
5. The repeat occurrence of a minor infraction, for which an individual has received formal remediation within the past year, will be considered a moderate infraction.

MODERATE INFRACTIONS OR SUBSTANDARD PERFORMANCE

Once the need identification process indicates either a moderate infraction or a trend of moderate substandard performance, the following procedure will be utilized.

"Moderate" is defined for this purpose as having a probability of threat to patient care or to the operations of the Medical Control system, although not apparently immediate or severe.
It also includes three (3) or more minor infractions or performance deficiencies within one (1) year after an individual has initially received counseling (as described above) for the previous minor incidents. Moderate infractions or performance deficiencies may include, but are not limited to, such things as:

- Protocol violations (which did not result in harm to the patient, but could have)
- Failure to comply with policies and procedures (which did not result in harm to the patient or System, but could have). An example would be practicing with a lapsed TDSHS certification.

1. The MCO shall notify the EMS operations supervisor of the service of the infraction.
2. The MCO (and the EMS operations supervisor of the service, if s/he wishes) shall meet with the individual and provide feedback as to the nature of the substandard performance.
3. The MCO shall specify the desired performance changes, and discuss the means to reach this goal with the individual. Both the specific desired performance changes and a specific date for their measurement will be written as a letter by the MCO to the involved EMS personnel prior to the meeting.

4. The document shall also include a statement of the actions to be taken in the event of failure to meet the performance change goals and those to be taken in the event of a repeat infraction or performance deficiency.
5. The repeat occurrence of a moderate infraction, for which an individual has received formal remediation (i.e., verbal, written exam, and/or practical exam) within the past year, will be considered a major infraction. The involved EMS personnel shall sign a copy of this document indicating that they received the counseling and that they understand both the requirements and the consequences (listed in number 6 below) of not meeting the requirements.
6. *Repeat* incidents of moderate infractions or performance deficiencies by an individual previously counseled for such shall result in:
    a. Steps 1 - 5 above.
    b. Formal placement on probation of Medical Control authorization
    c. Specific remedial instruction as deemed appropriate by the MCO and approved by the MCS Manager and Associate Medical Director, (if applicable), which may include but is not limited to:
        - Individual training and evaluation by an MCO or FTO.
        - Mandatory attendance at a designated CE offering, including satisfactory completion of any testing associated with the CE offering.
    d. Written notice of the terms of probation, including the above instruction, the standards to be met, and consequences of not meeting the criteria.
7. More than three (3) incidents of moderate infractions or performance deficiencies by any single individual within one (1) year of initial counseling for a moderate infraction (or the equivalent) shall be considered a major infraction or substandard performance.

MAJOR INFRACTIONS OR SUBSTANDARD PERFORMANCE

Once an investigation process indicates either a major infraction or a trend of major substandard performance, the following procedure will be utilized.

"Major" is defined for this purpose as having an immediate probable or established threat to patient care or to the operations of the Medical Control System.
It also includes three (3) or more moderate infractions within one (1) year after an individual has initially received formal counseling (as described above) for the previous moderate infractions. Major infractions or substandard performance includes, but is not limited to:

- Protocol violation which results in harm to a patient
- Failure to comply with a policy or procedures which results in harm to a patient or represents a serious risk to the Medical Control System
- Falsification of records
- Knowingly providing misleading or false information to a representative of the MMS Medical Control System
- Failure to report a major infraction or below standard performance by any other person in the MMS MC System.

1. The MCO shall notify the EMS service operations supervisor of the service of the infraction.
2. The MCO shall notify the MCS Manager, Associate Medical Director if applicable, and Medical Director immediately upon recognition of a major infraction or performance deficiency.
3. The MCS Manager, or his designee, shall have the responsibility of investigating, or having investigated the incident as soon as possible. This investigation shall include, at a minimum:
    A. An interview with the EMS personnel directly involved and with any on-line medical control personnel involved, and any other individuals involved, if applicable.
    B. An evaluation of the patient chart.
    C. An evaluation of any other applicable documentation (incident reports, etc.)
    D. An evaluation of the medical control contact. (if available)
    E. A review of the applicable laws and regulations, as well as all applicable MMS protocols, policies, and procedures.

4. Once such investigation confirms a major infraction or performance deficiency, the MCS Manager shall immediately notify the Associate Medical Director (if applicable), and the Medical Director of the situation.
5. The MCS Manager, Associate Medical Director (if applicable), and the Medical Director shall have the option of redefining the incident as minor or moderate as they deem appropriate, within the constraints of this policy.
6. If the Associate Medical Director and the Medical Director agree that this represents a major incident or performance deficiency, the MCS Manager shall enact an immediate suspension of the individual's medical control authorization.
7. The MCS Manager shall then have the responsibility of notifying the involved EMS service operations supervisor, of the immediate suspension of the individual's medical control authorization.
8. The MCS Manager or his designee shall then have the responsibility, along with any official representatives of the service provider who wish to participate, of notifying the individual that his/her medical control authorization is suspended.
9. The MCS Manager or his designee will review the incident with the Managers Committee as soon as possible. The Managers Committee shall review the findings of the Medical Director and MCS Manager, and make the final determination of the proposed course of action that will be taken by MMS in regards to this individual. The course of action to be taken in this case may include, but are not limited to:
    a. Permanent revocation of Medical Control authorization
    b. Re-assignment of Medical Control authorization at a lesser certification level (i.e., from Paramedic to EMT-Basic level)
    c. Medical Control probation coupled with remedial training/education, as outlined under "Moderate infractions"
10. The MCS Manager shall have the responsibility of notifying the involved service's administration and the individual provider of the decision. The MCS Manager or MCO shall also notify the individual of his/her options for appeal (as per the Appeals policy) at this time.
11. The MCS Manager shall have the responsibility of ensuring that the prescribed action plan is successfully completed.
12. The MCS Manager shall have the responsibility of documenting the process.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

APPEAL POLICY

POLICY CODE:	**2009-012**	**APPROVED BY**
REPLACES:	2000-012	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To provide EMS personnel within the MMS Medical Control System (MCS) with a method to appeal any findings, evaluations, and actions rendered by the MCS.

POLICY:
MMS MCS will provide for a procedure by which EMS personnel acting within the MMS Medical Control System may request a review and revision of any findings, evaluations, and actions by MMS MCS personnel.
MMS MCS must reply, in writing whenever possible, to any such request made within the constraints of this procedure.

PROCEDURE:
FOR QI EVALUATION FINDINGS
1. Should an individual EMS provider disagree with an assessment in one of their chart evaluations, field evaluations, or other QI tools utilized by MMS MCS, and wish to have that evaluation reviewed and revised, the provider may document the request for review in a written request to MMS. Included with the written request should be a copy of the QI tool evaluation and the findings in dispute.
2. The request and documents will be submitted to the service's assigned Medical Control Officer (MCO).
3. The MCO shall review the provider's request and comments.
4. The MCO may revise the QI finding, as he/she deems appropriate.
5. The MCO will then return a copy of the documentation to the provider who requested the review. The MCO will include comments as to what, if any, revisions were made and why they were, or were not, made. This portion of the review must be completed within 10 business days of the day it is received by the MCO.
6. The revised evaluation will be retained in the MCS files as the permanent record of the evaluation.
7. If the provider still disagrees with the revised evaluation and wishes to appeal, the provider shall submit the copy of the revised documentation to the MCS Manager with a written request for review.
8. The MCS Manager shall review the provider's request, comments, and the evaluation.
9. The MCS Manager may revise the evaluation, as he/she deems appropriate.
10. The MCS Manager will then return a copy of the documentation to the provider who requested the review. The MCS Manager will include comments as to what, if any, revisions were made and

why they were or were not made. This portion of the review must be completed within 10 business days of the day it is received by the MCS Manager.

11. The revised evaluation will be retained in the MCS files as the permanent record of the evaluation.
12. If the provider still disagrees with the revised evaluation and wishes to appeal, the provider shall submit the copy of the revised documentation to the Medical Director with a written request for review.
13. The Medical Director shall review the provider's request, comments, and the evaluation. The review and revision process shall be completed as noted above for the MCS Manager.
14. If the provider still disagrees with the revised evaluation and wishes to appeal, the provider shall notify the MCS Manager that s/he wishes to appeal the evaluation to the Managers Committee. The MCS Manager shall arrange a meeting of the Managers Committee as soon as possible.
15. The Managers Committee shall review the provider's request, comments, and the evaluation. The committee may interview the FTO or MCO who performed the evaluation. The provider may address the committee directly as well if s/he wishes. The ruling of the ***Managers Committee will be final.***

FOR CORRECTIVE ACTIONS

1. Should an EMS provider, the provider's supervisor, or an administrator of the provider's EMS agency disagree with a corrective action taken with the provider by the MMS QI program and wish to appeal that action, the provider, the provider's supervisor, or an administrator of the provider's EMS agency shall notify the MCO responsible for that service that they wish to appeal the action.
2. The MCO shall forward the request to the MCS Manager within 3 business days of its receipt.
3. The MCS Manager shall review the request, the incident and documentation, and the actions taken. The MCS Manager shall render a decision as to what, if any, revisions to the action are appropriate. The MCS Manager may ***not*** revise any actions taken directly by the Managers Committee. The MCS Manager shall then return the documentation to the provider, including written discussion of what, if any, revisions were made and why they were or were not made. This component of the review must be completed within 10 calendar days of the date the request is received by the MCS Manager.
4. If the provider still disagrees with the actions and wishes further appeal, the provider shall notify the MCO that s/he wishes to appeal the MCS Manager’s decision.
5. The MCO shall notify the MCS Manager of the request within 3 business days of receipt. The MCS Manager shall forward the appropriate documentation to the Medical Director within 3 days of receipt.
6. The Medical Director shall review the request, the incident and documentation, and the actions taken. The Medical Director shall render a decision as to what, if any, revisions to the action are appropriate. The Medical Director may ***not*** revise any actions taken directly by the Managers Committee. The Medical Director shall then return the documentation to the provider, including written discussion of what, if any, revisions were made and why they were or were not made. This component of the review must be completed within 10 business days of the date the request is received by the Medical Director.
7. If the provider still disagrees with the actions and wishes further appeal, the provider shall notify the MCO that s/he wishes to appeal the Medical Director’s decision.
8. The MCO shall notify the MCS Manager of the request within 3 business days of receipt. The MCS Manager shall arrange a meeting of the regional Managers Committee as soon as possible. The MCS Manager will forward all appropriate documentation to the committee members as soon as possible for their review prior to the meeting.
9. The Managers Committee shall review the request, the incident and documentation, and the actions taken. The committee, by voice vote, shall determine what, if any, revisions are to be made to the action. The determination of the ***Managers Committee is final.***
10. The MCS Manager will then return a copy of the documentation to the provider who requested the review. The MCS Manager will include comments as to what, if any, revisions were made and why they were or were not made. This portion of the review must be completed within 10 business days after the Managers Committee renders its decision.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

PATIENT REFERRAL

POLICY CODE:	**2009-013**	**APPROVED BY**
REPLACES:	2000-013	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To provide EMS services within the MMS system with the option of referring transport responsibility of a patient in the out-of-hospital setting to another ambulance unit or service.

To ensure that such referrals are done in a legally and medically acceptable manner.

POLICY:
All EMS units in the MMS Medical Control System shall adhere to the following procedure when electing to utilize a transport referral.

Patients who may be referred to another unit or agency for transport are those who are medically stable and who will not suffer any adverse consequences from the delay in transport caused by the referral.

Patients appropriate for transport referral include, but are not limited to, stable patients with non-life or limb threatening illnesses or injuries who are *requesting transport to a facility outside the responding agency's normal transport area*.

This policy *does not* include those situations in which EMS personnel elect to utilize a helicopter ambulance to evacuate a patient, a mass casualty incident, or where patient transport is referred to another unit or agency due to the inability of the referring unit to provide transport (mutual aid/automatic aid).

Each provider service that wishes to refer patient transports is responsible for establishing the necessary agreements with other ambulance service providers and maintaining a current list of those services which are available to provide transport in that area on a referral basis.

Patients **MUST** be referred to an ambulance unit medically capable of managing the patient's injury or illness and of maintaining any therapies initiated prior to their arrival.

PROCEDURE:
1. Determine that the patient's medical status is appropriate for transport referral. This determination shall be based upon, at a minimum, a complete primary and secondary survey, assessment of all appropriate vital signs and diagnostic parameters (ECG, blood glucose determination, etc.), a complete history of the current illness/injury, and a complete previous medical history.
2. If the patient requests transport to a facility outside the agency’s normal transport area, the agency will inform the patient that they will call another ambulance to transport him/her to that hospital. Inform the patient that this will result in a delay in his/her transport. If the patient agrees, continue

with this procedure. If the patient does not wish for you to refer transport, you will then do one of the following:

a. Offer to transport the patient to a facility within the normal transport area,
b. IF PERMITTED TO DO SO BY YOUR SERVICE'S OWN POLICIES AND PROCEDURES, transport the patient to the facility that the patient is requesting, OR
c. Execute a complete and legal patient refusal, and allow the patient to proceed to the facility of his/her choice via private means.

3. If the patient agrees to the referral, contact the transport entity and have them dispatch an ambulance to the location. Inform the transport entity of the level of care required for the patient (basic, intermediate, or paramedic). Secure an ETA from the transport entity.
4. While awaiting the arrival of the transport ambulance:
    a. Complete the patient chart, including all demographic information and appropriate clinical/assessment information (vital signs, history, assessment findings, medications, etc.).
    b. Complete a patient refusal form, indicating that the patient is declining transport by ambulance. Have the patient (or patient representative) sign the refusal. Indicate on the patient chart and the refusal form that this patient is being referred to another ambulance for transport, and what ambulance service that is.
5. Upon completion of **all** the above steps, your unit may become available for dispatch to emergency calls. However, ***THE RESPONDING EMS UNIT SHALL REMAIN ON THE SCENE AND IN DIRECT PATIENT CONTACT UNTIL RELIEVED BY THE REFERRAL UNIT UNLESS ABSOLUTELY NEEDED FOR AN EMERGENCY CALL.*** If dispatched to another call prior to the arrival of the transporting unit, the EMS crew will leave a copy of the completed chart on the scene for the transporting unit. The responding EMS unit ***may not*** return to service if any advanced life support therapies have been initiated prior to the arrival of the transporting unit.
6. Upon arrival of the transporting ambulance, the attending EMS personnel shall:
    a. Provide the attendant of the referral unit a complete face-to-face patient report.
    b. Have the attendant of the referral unit sign the patient chart as having received the patient. Provide the attendant a copy (generally, the "hospital" copy) of the chart, if possible.
    c. Assist the referral unit with management and/or loading of the patient as needed.
7. Once the patient is in the care of the referral unit, the original responding unit may clear the scene.
8. The patient chart must include, at a minimum:
    a. Complete demographics and patient information as required by the provider service.
    b. All information required for a patient refusal, as dictated in the MMS Standards for Documentation and Patient Refusal policy.
    c. A statement indicating that the patient desired to be transported to a facility outside the normal transport area of the service, what facility that was, and why the patient desired transport to that facility.
    d. That the patient agreed to the referral.
    e. The agency and unit designation of the transporting entity

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

RESPONSIBILITY TO PROVIDE APPROPRIATE LEVEL OF CARE

POLICY CODE:	**2009-014**	**APPROVED BY**
REPLACES:	2000-014	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure that all patients entering the MMS Medical Control System (MMS MCS) receive the appropriate level of care as soon as it can be provided to them.

To assign responsibility for making the determination of the required level of care and the responsibility for securing the appropriate level of care for the patient.

POLICY:
Patients are considered to have entered the MMS Medical Control System once a provider service in the MMS MCS receives a call to respond to the patient or scene, as stated in the Texas State Board of Medical Examiners EMS Rule 197.5 (b).

Upon receiving a call for service, it shall be the responsibility of the dispatcher of the EMS units to correctly assess the medical needs of the patient and assign the appropriate unit(s) to respond and to assign the appropriate response mode for the unit(s).

All dispatchers who receive calls for medical assistance shall be trained in obtaining correct patient information via phone and using that information to make response determinations. Each EMS agency in the MMS MCS must have a process that has been approved by the MMS Medical Director for receiving and dispatching calls for medical assistance and/or transport. If MPDS (Medical Priority Dispatch System) or other call screening tools are used, they must be reviewed by an approved by the Medical Director.

The ultimate responsibility for decisions and actions taken in regards to the level of care provided and adherence to this policy shall rest with the administration/management of the provider service.

Upon arrival at the scene, it shall be the responsibility of the attending EMS personnel to determine the appropriate level of prehospital care needed by the patient(s). Should the patient(s) need out-of-hospital care at a level other than that which the attending EMS personnel are authorized to provide, it is the responsibility of the attending EMS personnel to make the appropriate level of care available to the patient(s) as soon as possible.

Should the responding EMS crew consist of providers capable of more than one level of prehospital care, it shall be the responsibility of the provider authorized at the highest level of care (subsequently referred to as the "Primary Attendant") to make the determination of the level of out-of-hospital care needed by the

patient. Should the Primary Attendant determine that the patient may be properly cared for by a provider authorized at a *lower* level than that of the Primary Attendant, they may allow a lower authorized attendant to assume patient care activities. The Primary Attendant retains ***responsibility*** for all aspects of the care of that patient, regardless of who is actually providing the care. The Primary Attendant is responsible for ensuring that the provider performing patient care under his/her supervision is capable of managing the patient and is providing care within the MMS standards. The Primary Attendant may delegate any activity that the provider is capable and/or authorized to perform, including attending the patient during transport and completing the patient chart.

PROCEDURE:

DISPATCH

1. When a dispatcher receives a call for medical assistance, he/she will use the provider service's MMS approved procedure to determine the correct response.
    a. Immediately dispatch closest unit and unit with highest available level of care (if not same as closest unit).
    b. **IF AVAILABLE** (through pre-arranged agreements), contact appropriate outside service and request a response of a unit with the capabilities to provide the required level of care. The assisting unit can respond directly to the scene behind the service's unit(s), or meet the service's unit in transit with the patient via an "ALS intercept." In any case, the assisting unit should only be used **IF** it can initiate the appropriate level of care sooner than having the service's original unit(s) directly transport the patient rapidly to a local ED.
    c. The use of an outside (assisting) unit in this setting will be considered a transport referral. Such an incident requires documentation as dictated in the "Transport Referral" policy (2009-013).

FIELD OPERATIONS

1. If, upon arrival at the patient's location, the attending EMS personnel are faced with a patient whose pre-hospital medical requirements exceed what the EMS crew is authorized/equipped to provide, the EMS crew shall respond (as specifically dictated in the provider agency's policies) by:
    a. The on-scene EMS personnel will immediately notify dispatch, the appropriate service supervisor, or administrator (as specified by the service's internal policies) that they have contact with a patient requiring advanced care.
    b. **IF AVAILABLE** (through pre-arranged agreements), contact appropriate outside service and request a response of a unit with the capabilities to provide the required level of care. The assisting unit can respond directly to the scene behind the service's unit(s), or meet the service's unit in transit with the patient via an "ALS intercept". In any case, the assisting unit should only be used **IF** it can initiate the appropriate level of care sooner than having the service's original unit(s) directly transport the patient rapidly to a local ED.
    c. The use of an outside (assisting) unit in this setting will be considered a transport referral. Such an incident requires documentation as dictated in the "Transport Referral" policy (2009-013).

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

CONTROLLED SUBSTANCES

POLICY CODE:	**2009-015**	**APPROVED BY**
REPLACES:	2000-015	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure that the MMS MCS agencies can obtain the Schedule II and IV medications necessary to comply with the MMS Patient Care Protocols for Therapy.

To ensure that all controlled substances, specifically Schedule II and IV medications used in the MMS system are accounted for legally.

POLICY:
MMS will provide each agency with the physician authorization documents necessary to obtain the Schedule II and IV medications specified in the MMS Patient Care Protocols for Therapy. Each agency will then use these documents to obtain the medications from a vendor of their choice.

It is the responsibility of the provider agency to secure and to track all of the controlled substances in its possession. This includes controlled substances in the EMS units and in the supply safe. This tracking may be accomplished with either the MMS provided documents (or approved substitutes) or via approved electronic data management system. Agencies using the MMS paper documents must have on board an MMS approved Narcotics Accountability Form and a minimum of 6 MMS approved Narcotic Use Forms. Controlled substances inventory logs must be available for viewing by any officer of the MMS MCS upon request.

It is the responsibility of the provider agency to see that the controlled substance inventory is correctly completed *each day* by the personnel responsible for that unit.

Controlled substances past their expiration date may not be used for patient care and must be disposed of in an approved manner.

PROCEDURE:
IF NARCOTIC IS USED
1. The paramedic who administered the medication is responsible for completing documentation of the controlled substance use. Documentation, either written or electronic, should include: the date and time that the medication was administered, the run number that it was used on, the patient's name who received the medication, how much medication was administered (and wasted), and the physician's or MCO's name who ordered the medication. If the medication was given on standing order, the paramedic will enter the phrase "standing order" under "ordering physician".

2. If the entire volume of medication was not administered to the patient, the remainder of the medication **MUST** be wasted. The paramedic will have someone (preferably a healthcare provider at the receiving facility) witness him/her waste the medication. The witness will sign the Narcotic Use Form under "witness" or indicate such on the electronic record.

IF A NARCOTIC IS LOST OR DESTROYED

1. The paramedic will notify the appropriate supervisor within the service, as required by the service.
2. The paramedic or supervisor will notify the Medical Control Officer responsible for that service.
3. The paramedic will complete a Narcotic Use Form, or complete an entry in the electronic data management system, indicating "0" medication administered and the full amount wasted. Write "broken" or "lost" under "Patient name".
4. The paramedic will complete an incident form (as indicated by the service), documenting the events surrounding the loss or breakage of the medication.
5. The paramedic will have any witnesses to the loss or breakage sign both the Narcotic Use Form and the incident form.
6. The agency supervisor will forward the incident report to MMS and follow departmental requirements for follow-up testing and investigation. Findings from any follow-up investigations will be forwarded to MMS when they become available.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

MEDICAL CONTROL INSPECTIONS

POLICY CODE:	**2009-016**	**APPROVED BY**
REPLACES:	2000-016	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To provide MMS Medical Control with a quality assurance/improvement tool to confirm compliance with equipment, supply, and medication requirements as established in the medical protocols.

POLICY:
MMS has the authority to inspect any unit within the MMS MC system.

Any MMS Field Training Officer, Medical Control Officer, Medical Control System administrator, or Medical Director may conduct a unit inspection.

MMS may inspect a unit at any time, with or without previous notification of the crew or service administration.

The inspection of a unit by MMS may **not** interfere with that unit's ability to provide emergency medical response to its assigned district. The inspection of a unit by MMS may **not** take place while that unit is enroute to a call, on the location of a call, or has a patient on board.

The service's administration or management must be notified by the inspecting MMS officer as soon as possible that an inspection is taking place, either immediately prior to the inspection, during the inspection, or no later than 1 hour after the inspection. Each provider service's administration shall designate the individuals authorized by them to receive this notification from the inspecting officer.

If the inspection reveals any major infractions of either TDSHS rules or MMS policies which are a significant threat to patient welfare, such as a lack of critical patient care equipment, supplies, or medications, the inspecting officer shall notify the service's administrative representative that the unit is out of compliance with the equipment/supply requirements. The inspecting officer shall inform the service's administrative representative at what level, if any, the unit remains authorized to operate at. The unit may **not** be dispatched on any calls which might require a level of care for which it is no longer authorized to operate at until the shortfall is corrected and the inspecting officer approves the unit for service at that level.

If the inspection reveals other infractions that do not represent a significant threat to patient welfare, such as incorrect stock levels or unapproved substitutions of materials, the inspecting officer shall document the findings, and notify the service's administrative representative of the shortfalls by 1700 hours that day.

PROCEDURE:

1. Upon locating a unit to be inspected, the inspecting officer shall identify him/herself to the crew and notify the crew that they and their unit are about to be inspected for compliance to MMS MCS policies.
2. The inspecting officer shall then notify the service's administration representative that an inspection of one of their units is about to occur, if possible to do so in a timely manner. If not, the inspecting officer **must** notify the service's administration representative within 1 hour of the completion of the inspection.
3. The inspecting officer shall inspect the unit and components, using the appropriate protocol equipment/supply list as the template.
4. If the inspecting officer encounters any major infractions of either TDSHS requirements or MMS policies, the inspecting officer shall:
   a. Notify the service's administration/management that the unit is out of service, what the specific reason is, and what must be done in order to place the unit back in service.
   b. Notify the crew that they are out of service until further notice, and explain the specific infraction(s) involved.

   Examples of major infractions include, but are not limited to, the following:

   Any missing equipment, supplies, or medications that would render the unit unable to complete a protocol.

   A malfunctioning piece of equipment, which would render the unit unable to complete a protocol or which, is a direct threat to patient safety.

5. The service's administration/management shall then have the responsibility of rectifying the shortfall. The service's administration/management shall then notify MMS that the problem has been corrected.
6. Should the inspecting officer note any discrepancies or shortfalls, which are not major infractions, such as inadequate stock levels or unapproved equipment/supply substitutions, the inspecting officer shall document these findings and notify the service's administration/management by 1700 hrs the same day. A follow up inspection may be undertaken within 10 business days to ensure compliance.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

PATIENT CONSENT AND REFUSAL

POLICY CODE:	**2009-017**	**APPROVED BY**
REPLACES:	2000-017	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To establish what constitutes a "patient" in the MMS Medical Control System. To provide EMS personnel with clear rules for managing situations in which a patient (or a patient's representative) is declining or refusing care or transportation by EMS. To establish how a patient's refusal of treatment and/or transport must be documented.

POLICY:
All instances in which a patient (or a patient's representative) refuses or declines any aspect of EMS contact, assessment, care, or transport shall have documentation completed as directed in the following procedure as in the "Documentation Requirements" policy 2009-009.

All EMS and on-line medical control personnel shall adhere to the procedures outlined in this document.

DEFINITIONS:

Legal Competency – the legal ability to perform a legally recognized act or function, such as consenting to or refusing medical care. Persons are declared incompetent by the courts, and will have a guardian appointed for their decision making.
Mental Capacity – the present ability to understand and appreciate the nature and consequences of one's condition to form a rational treatment decision. Factors that affect mental capacity include intoxication, head injury, hypoxia,
Minor – any person under the age of 18
Emancipated Minor – any person under the age of 18 who for legal purposes is considered an adult
Guardian – a minor or an adult legally declared incompetent will have a guardian to make consent and refusal decisions on their behalf. The incompetent adult's guardian will have a Durable Power of Attorney for Health Care that allows them to make medical decisions for the patient.
A guardian for a minor may include:

- Parent or Grandparent
- Adult sibling, aunt or uncle
- School staff that has written authorization to consent/refuse from a person having the right to consent/refuse.
- Adult who has actual possession of the child and has written authorization to consent/refuse from a person having the right to consent/refuse (i.e., daycare, Scout leader, carpools, etc.).
- Adult who has possession of a child under the jurisdiction of a juvenile court (i.e., foster parent).
- A court having jurisdiction over a suit 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 (an individual appointed by the court, usually during divorce proceedings, to have custody of a minor, to make decisions for the minor and to make a home for the minor).

PROCEDURE:

"NO PATIENT" OR "NO SICK OR INJURED"

In order for an EMS unit to clear with "no patient" or "no sick or injured", the following criteria must be met:

1. The patient must have left the scene prior to EMS arrival, **OR**
2. The call itself must have been false (no such incident) **OR**
3. The people or person in question:
   a. must deny ANY physical complaint to the EMS personnel's direct questioning **AND**
   b. The EMS personnel must not be able to visualize ANY injury or evidence of injury or illness **AND**
   c. The people or person must appear competent and capable to make such an assessment of themselves

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy (2009-009).
2. EMS shall clearly document that the above criteria were present.

EMS DENIAL

Is defined as a situation in which the EMS personnel do not offer EMS transport to a patient or deny treatment or EMS transport to a patient who has requested it.
EMS may NOT deny transport to ANY patient within the Metrocrest Medical Control System.

ADULT PATIENTS:

- **Adult Patient who does not wish EMS Assessment, Treatment, and/or Transport:**

Assessment and Interventions

1. The patient MUST demonstrate to EMS that he/she knows:
   a. His/her own name
   b. Where he/she is
   c. What day of the week it is OR what month and year it is

   If the patient is unable to correctly answer these questions, the patient's refusal MUST be rejected, and appropriate care and transportation by EMS must be imposed (See next section regarding patient who is not fully oriented)
2. If the patient is adequately oriented, the EMS provider shall obtain all of the following assessment components, which the patient allows:
   a. A complete primary surveys, defined in protocol definitions
   b. A complete secondary survey, as defined in protocol definitions
   c. All pertinent diagnostic tests, such as blood glucose level, ECG, etc.
   d. A complete history of the current injury/illness
   e. A complete previous medical history
   f. A list of the patient's medications and medical allergies
   g. All pertinent demographic information: address, DOB, social security number, etc.

   If the patient refuses any assessment component or intervention after satisfactorily establishing that his/her mental status is adequate to refuse (step #1), the EMS providers

shall comply with the patient's request unless directed otherwise by on-line medical control or law enforcement.

3. EMS shall offer treatment and transportation to the patient.
4. EMS shall inform the patient of the possible consequences of the apparent injury/illness if further medical care is not sought.
5. EMS shall provide the patient with instructions as to what further actions should be taken, to always include:
    a. Any immediate care or management for the injury/illness
    b. To call EMS back if any further problems develop or condition persists
    c. To be evaluated by a physician as soon as possible
    d. A repeat of the potential consequences of refusing EMS treatment/transport

    These instructions should also be provided to a family member or friend who will be with the patient after EMS departs.

IF *EMS Disagrees with the Patient's Decision to Refuse Treatment or Transport, the Patient is Included in a "Mandatory Transport" Category, EMS Notes Evidence of Alcohol or Drug Intoxication, Head Injury, or Any Other Factor Which Would Affect the Patient's Ability to Make a Valid Informed Decision; In addition to the above (steps 1-5) EMS should:*

i. EMS shall enlist the assistance of the patient's family or friends in convincing the patient to accept EMS treatment/transport.
ii. If the patient still refuses, the EMS providers shall enlist the assistance of law enforcement in encouraging or requiring the patient to allow appropriate and needed assessment or interventions.
iii. If law enforcement is not available, is unsuccessful in convincing the patient to allow further assessment or treatment, or does not wish to require the patient to comply, **EMS shall contact on-line medical control**. EMS shall provide on-line medical control with a complete patient report and inform on-line medical control that the patient is refusing. The medical control physician may elect to communicate with the patient (or family/friends) directly, and may elect to provide additional direction to the EMS personnel.

IF *EMS Notes Evidence That the Patient May Be a Threat to Himself or Others (i.e., the Patient Verbalizes a Suicide Threat); In addition to the above (steps 1-5) EMS should:*

i. EMS providers shall enlist the assistance of law enforcement in encouraging or requiring the patient to allow appropriate and needed assessment or interventions. **It is the primary responsibility of law enforcement to make the determination whether the patient is a threat to himself or others and whether the situation requires the patient to be placed under protective custody.**
ii. If law enforcement does not wish to require the patient to comply, **EMS shall contact on-line medical control**. EMS shall provide on-line medical control with a complete patient report and inform on-line medical control that the patient is refusing and that law enforcement is declining to place the patient under custody. On-line medical control may elect to communicate with the patient (or family/friends) and/or law enforcement directly, and may elect to provide additional direction to the EMS personnel.
iii. If there is any evidence that the patient may have any medical problem (took medications, cut self, etc.), then the patient, if transported, MUST be transported by EMS. The transport may NOT be referred to any other entity, including law enforcement, unless law enforcement orders otherwise.
iv. If the patient accepts assessment and treatment but refuses transport by EMS, the EMS providers must consult with on-line medical control prior to accepting the patient's refusal, regardless of the apparent lack of any significant medical problems.

IF *the Patient is in the Custody of Law Enforcement; In addition to the above (steps 1-5) EMS should:*

i. EMS shall inquire from the ranking law enforcement officer present whether the officer wishes EMS to accept the refusal or impose assessment, treatment, and/or transport on the patient. Law enforcement shall be responsible ultimately for making the decision to allow the patient to refuse or requiring the patient to accept care.

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy (2009-009).
2. EMS shall document all assessment information: especially the patient's mental status and any evidence leading EMS to suspect intoxication, head injury, or other factors affecting the patient's ability to make a valid informed decision, or evidence indicating that the patient was a threat to himself or others.
3. EMS shall document that the patient was offered treatment and/or transport by EMS and that the patient refused offers(s) of treatment and/or transport.
4. EMS will document the role family/friends played in encouraging the patient to accept treatment/transport, and any interaction with law enforcement regarding the patient's consent or refusal.
5. If the patient may be a threat to himself or others, EMS shall document that the law enforcement personnel were advised of the possible consequences of not taking the patient into custody and allowing EMS treatment and transport. The ranking law enforcement officer on the scene also must sign the patient chart, indicating that he/she received the instructions and advice of the EMS personnel. If the officer refuses to sign, then EMS shall document this on the chart.
6. If medical control was contacted, the name of medical control site and physician should be included. EMS will also document any instructions or interaction from on-line medical control.
7. EMS shall document what instructions were given to the patient, and that the patient acknowledged the instructions. EMS shall also document if the instructions were given to others as well (family, friends, law enforcement), and who received the instructions.
8. The patient shall sign the refusal form and shall sign for the receipt of EMS follow-up instructions. If the patient refuses to sign the refusal form, EMS shall have a minimum of two witnesses sign the refusal indicating that the patient did refuse treatment/transport and refused to sign the form. If possible, these witnesses should not be drawn from the EMS, Fire, or Police personnel on the scene.

- **Adult Patient who is Awake, Not fully oriented; Does Not Wish EMS Treatment and/or Transport:**

Assessment and Interventions

1. Once the EMS provider establishes that the patient is disoriented, any and all attempts by the patient to refuse any appropriate aspect of assessment and treatment must be rejected by the EMS provider.
2. The EMS provider is authorized and required to use the minimal reasonable force necessary to impose appropriate assessment and treatment modalities, and to effect transport of the patient. The EMS provider shall utilize safe physical restraints as needed. The physical restraints must not inflict any harm on the patient, worsen pre-existing injuries or conditions, or be utilized in a punitive or unnecessary fashion. The EMS provider shall enlist the assistance of law enforcement personnel as appropriate in utilizing force and restraints.
3. In all disoriented patients, the EMS provider may not refer transport of the patient to any other entity, including law enforcement. Regardless of the

presence or absence of any medical findings, the disoriented patient must be transported by EMS and must receive all assessment components and interventions as dictated by the appropriate MMS medical protocol. EMS personnel should not endanger themselves in the course of treatment and/or transport of the patient.

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy.
2. EMS shall document all assessment information: especially the patient's mental status.
3. EMS shall document exactly what, if any, force or restraint was utilized to affect treatment and transport of the patient, and who ordered the imposed care upon the patient (on-line medical control vs. law enforcement).
4. EMS shall document what role law enforcement and on-line medical control played in the imposition of treatment and transport on the patient.

ADULT PATIENTS, INCOMPETENT

Incompetent adult patient is defined as any adult patient who does not have the legal competency to make his or her own decisions regarding medical care. These patients will typically have a guardian to make health care decisions on their behalf. This may include but is not limited to:

Mentally ill patients
Patients with an organic brain deficit, such as Alzheimer's disease

- **IF *the Patient's Guardian is Present and Can Provide Proof of Guardianship (Durable Power of Attorney for Health Care).***

  Assessment and Interventions

  1. The patient himself may not refuse any assessment, treatment, or transportation by EMS. Consent for or refusal of EMS services must be obtained from the patient's guardian.
  2. The patient's guardian MUST demonstrate to EMS that the guardian knows:
     a. His/her own name
     b. Where he/she is
     c. What day of the week it is OR what month and year it is

     If the guardian is unable to correctly answer these questions, any refusal of care MUST be rejected, and appropriate care and transportation by EMS must be imposed.
  3. If the guardian is adequately oriented, the EMS provider shall obtain all of the following assessment components on the patient which the guardian allows:
     a. A complete primary survey
     b. A complete secondary survey
     c. All pertinent diagnostic tests, such as blood glucose level, ECG, etc.
     d. A complete history of the current injury/illness
     e. A complete previous medical history
     f. A list of the patient's medications, medical allergies, and private physicians' names
     g. All pertinent demographic information: address, DOB, social security number, etc.

     If the guardian refuses any assessment component or intervention after satisfactorily establishing that his/her mental status is adequate to refuse (step #1), the EMS providers shall comply with the guardian's request unless directed otherwise by on-line medical control or law enforcement.
  3. EMS shall offer treatment and transportation of the patient to the guardian.
  4. EMS shall inform the guardian of the possible consequences of the apparent injury/illness if further medical care is not sought.

5. EMS shall provide the guardian with instructions as to what further actions should be taken, to always include at least:
    a. Any immediate care or management for the injury/illness
    b. To call EMS back if any further problems
    c. The patient is to be seen by a physician as soon as possible.

IF *Patient's Guardian is Present, But Cannot Provide Proof of Guardianship (Durable Power of Attorney).*

i. On-Line Medical Control MUST be consulted prior to accepting the guardian's refusal.

IF *the Patient's Guardian is Not Present.*

i. If the patient's medical problem is urgent, then EMS shall initiate assessment, treatment, and transport immediately. Contact with the patient's guardian shall become the responsibility of the receiving hospital or law enforcement.

ii. If the patient's medical problem is not urgent, EMS should attempt to contact the patient's guardian by phone if possible. If the patient's guardian is not contacted within 10 minutes, EMS shall initiate treatment and transport.

iii. If the patient's guardian is contacted by telephone and, after receiving a report on the patient's assessment and recommendations from the EMS personnel, wishes to refuse further treatment and/or transport, EMS shall contact on-line medical control. On-line medical control may elect to:
    a. Allow EMS to accept the refusal by telephone.
    b. Allow EMS to await the guardian's arrival at the scene, if the delay will not endanger the patient nor endanger the community by keeping the EMS unit out of service for an extended period of time.
    c. Reject the guardian's refusal and order EMS to provide appropriate treatment and transportation.

iv. A minimum of two EMS personnel (or one EMS personnel and one other witness, not related to the patient) must directly hear the patient's guardian:
    a. Identify himself
    b. Identify the patient
    c. Identify himself as the guardian of the patient
    d. Decline the offer of EMS treatment and/or transport.

<u>Documentation</u>

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy.
2. EMS shall document all assessment information: especially what specific state makes the patient unable to consent on his/her own and the guardian's mental status.
3. EMS shall document what proof was offered as to the guardian's identification as the patient's legal guardian.
4. EMS shall document that the guardian was offered treatment and/or transport for the patient by EMS.
5. EMS shall document that the guardian refused the offer(s).
6. Chart must also reflect if on-line medical control was contacted and what the orders were from on-line medical control.
7. EMS shall document what instructions were given to the guardian, and that the guardian acknowledged the instructions.
8. The guardian shall sign the refusal form. If the guardian refuses to sign the refusal form, EMS shall have a minimum of two witnesses sign the refusal indicating that the guardian did refuse treatment/transport and refused to sign the form.
9. If the refusal is being accepted via telephone, then the refusal form shall reflect the guardian's name and the fact that the guardian was contacted by phone and refused. A minimum of two EMS personnel shall sign the refusal form witnessing the phone refusal.

MINOR PATIENT, "EMANCIPATED"

An "emancipated" minor is defined as a person of minor age (17 years or less) who is legally empowered to make his or her own medical decisions as an adult. Refusal of care by patients in this category will be handled as in the Adult section above. This category of patients includes:

- Any person living apart from his/her legal guardians and who is not financially supported by his/her guardians
- Is on active duty with the U.S. Military
- Is consenting to the diagnosis and treatment of a communicable disease that is required by law or rule to be reported to a local health officer or the Texas Department of State Health Services
- Is consenting to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use
- Is unmarried and pregnant and consenting to evaluation and/or treatment related to the pregnancy
- Is unmarried, is the parent of a child, and has actual custody of the child, consenting to evaluation and/or treatment of the child.

A pregnant minor must have adult consent unless she fits within one of the previously mentioned exceptions.

MINOR PATIENT

- ***Minor Patient's guardian is refusing EMS assessment, treatment, and/or transport:***

  Assessment and Interventions

  1. The patient himself may not refuse any assessment, treatment, or transportation by EMS. Consent for or refusal of EMS services must be obtained from the patient's guardian.
  2. The patient's guardian MUST demonstrate to EMS that the guardian knows:
     a. His/her own name
     b. Where he/she is
     c. What day of the week it is OR what month and year it is

     If the guardian is unable to correctly answer these questions, any refusal of care MUST be rejected, and appropriate care and transportation by EMS must be imposed.
  3. If the guardian is adequately oriented, the EMS provider shall obtain all of the following assessment components on the patient which the guardian allows:
     a. A complete primary and secondary survey
     b. All pertinent diagnostic tests, such as blood glucose level, ECG, etc.
     c. A complete history of the current injury/illness
     d. A complete previous medical history
     e. A list of the patient's medications, medical allergies, and private physicians' names
     f. All pertinent demographic information: address, DOB, social security number, etc.

     If the guardian refuses any assessment component or intervention after satisfactorily establishing that his/her mental status is adequate to refuse (step #1), the EMS providers shall comply with the guardian's request unless directed otherwise by medical control or law enforcement.
  4. EMS shall offer treatment and transportation of the patient to the guardian.
  5. EMS shall inform the guardian of the possible consequences of the apparent injury/illness if further medical care is not sought.
  6. EMS shall provide the guardian with instructions as to what further actions should be taken, to always include at least:
     a. Any immediate care or management for the injury/illness
     b. To call EMS back if any further problems
     c. To be seen by a physician as soon as possible

IF *EMS disagrees with the guardian's decision to refuse transport of the patient or the patient is included in a "Mandatory Transport" category:*

i. EMS shall enlist the assistance of the guardian's family or friends in convincing the guardian to accept EMS treatment/transport.

ii. If the guardian still refuses, EMS shall **contact on-line medical control**. EMS shall provide on-line medical control with a complete patient report and inform on-line medical control that the guardian is refusing. On-line medical control may elect to communicate with the guardian (or family/friends) directly, and may elect to provide additional direction to the EMS personnel.

IF *EMS suspects abuse or neglect of the patient:*

i. It shall be the primary responsibility of law enforcement to determine if sufficient evidence exists to necessitate taking the child into protective custody and imposing medical care against the guardian's wishes.

ii. If law enforcement does not wish to require the guardian to accept EMS transport of the patient or take the child into custody, EMS shall **contact on-line medical control**. EMS shall provide on-line medical control with a complete patient report and inform on-line medical control that the patient's guardian is refusing, that EMS suspects abuse/neglect, and that law enforcement is declining to place the patient under protective custody. On-line medical control may elect to communicate with the guardian (or family/friends) and/or law enforcement directly, and may elect to provide additional direction to the EMS personnel.

iii. If there is any evidence that the patient may have any medical problem, then the patient, if transported, MUST be transported by EMS. The transport may NOT be referred to any other entity, including law enforcement.

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy.
2. EMS shall document all assessment information: especially the guardian's mental status.
3. EMS shall document that the guardian was offered treatment and/or transport for the patient by EMS.
4. EMS shall document that the guardian refused the offer(s).
5. EMS will document if the assistance of family/friends was enlisted, what role law enforcement played, and that medical control was contacted. EMS will also document any instructions or interaction from law enforcement and/or on-line medical control.
6. In cases of suspected abuse/neglect, EMS shall document that the law enforcement personnel were advised of the possible consequences of not taking the patient into custody and allowing EMS treatment and transport. The ranking law enforcement officer on the scene also should sign the patient chart, indicating that he/she received the instructions and advice of the EMS personnel.
5. EMS shall document what instructions were given to the guardian, and that the guardian acknowledged the instructions.

The guardian shall sign the refusal form. If the guardian refuses to sign the refusal form, EMS shall have a minimum of two witnesses sign the refusal indicating that the guardian did refuse treatment/transport and refused to sign the form.

- ***Minor Patient, Patient's Guardian is Not Present***

Assessment and Interventions

1. The patient himself may not refuse any assessment, treatment, or transportation by EMS. Consent for or refusal of EMS services must be obtained from the patient's guardian.
2. If the patient's medical problem is urgent, then EMS shall initiate assessment, treatment, and transport immediately. Contact with the patient's guardian shall become the responsibility of the receiving hospital or law enforcement.

3. If the patient's medical problem is not urgent, EMS should attempt to contact the patient's guardian by phone if possible. If the patient's guardian is not contacted within 10 minutes, EMS shall initiate treatment and transport.
4. If the patient's guardian is contacted by telephone (EMS must be reasonably certain of the identification of the individual as the guardian and the orientation/mental status of the guardian) and, after receiving a report on the patient's assessment and recommendations from the EMS personnel, wishes to refuse further treatment and/or transport, EMS shall contact on-line medical control. On-line medical control may elect to:
   a. Allow EMS to accept the refusal by telephone.
   b. Allow EMS to await the guardian's arrival at the scene, if the delay will not endanger the patient nor endanger the community by keeping the EMS unit out of service for an extended period of time.
   c. Reject the guardian's refusal and order EMS to provide appropriate treatment and transportation.
5. A minimum of two EMS personnel (or one EMS personnel and one law enforcement officer) must directly hear the patient's guardian:
   a. Identify himself
   b. Identify the patient
   c. Identify himself as the guardian of the patient
   d. Decline the offer of EMS treatment and/or transport.

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy.
2. EMS shall document all assessment information: especially the guardian's mental status.
3. EMS shall document that the guardian was contacted and was offered treatment and/or transport for the patient by EMS.
4. EMS shall document that the guardian refused the offer(s).
5. EMS shall document what instructions were given to the guardian, and that the guardian acknowledged the instructions.
6. Chart must also reflect that on-line medical control was contacted and what the orders were from on-line medical control.
7. If the refusal is being accepted via telephone, then the refusal form shall reflect the guardian's name and the fact that the guardian was contacted by phone and refused. A minimum of two EMS personnel shall sign the refusal form witnessing the phone refusal.

- ***Minor Patient, Patient's Guardian is Not Present or unable to be located in 10 minutes, and Patient Has No Injury/Illness.***

Assessment and Interventions

1. EMS shall thoroughly assess the patient to be certain that the patient has no medical problem or injury.
2. Should the patient have any medical problem or injury, the minor will be treated as outlined in the preceding section.
3. If after an assessment EMS determines that the minor has no medical problem or injury, EMS shall attempt to make contact with the minor's guardian via telephone.
4. If EMS can make contact with the guardian, within 10 minutes, then EMS will transport the minor to the appropriate medical facility.
5. If the guardian is unavailable, EMS may release the minor to the custody of law enforcement if law enforcement agrees to take responsibility for the minor.
6. EMS may only release the minor to:
   a. The guardian directly.
   b. An adult designated by the guardian.
   c. A law enforcement officer

Documentation

1. EMS shall document all demographic and operational information as outlined in the "Documentation Requirements" policy.
2. EMS shall document all assessment information: clearly indicating that the minor had no medical problem or injury.
3. EMS shall document that the guardian was contacted and that the minor was subsequently released to the guardian or to another adult designated by the guardian

   OR

   That EMS was unable to make contact with the guardian and that the minor was released to law enforcement.

   OR

   That EMS was unable to release minor to law enforcement and minor was transported to medical facility.
4. The individual taking custody of the minor from EMS shall sign the patient's chart indicating that they are taking responsibility for the minor. The EMS personnel shall document the name and relationship of the person.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

MEDICAL CONTROL AUTHORIZATION

POLICY CODE:	**2009-018**	**APPROVED BY**
REPLACES:	2000-018A-F	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure that the Metrocrest Medical Services Medical Control System (MMS MCS) is in compliance with Texas State Board of Medical Examiners rule number 197.

To ensure that all personnel providing out of hospital care in the MMS MCS are approved and credentialed to do so by MMS.

To establish the specific requirements to obtain MMS approval to provide care.

To establish responsibilities for completing the necessary requirements to obtain Medical Control authorization.

POLICY:
No individual may provide out-of-hospital care to a patient within the MMS MCS without approval by MMS.

MMS must approve each individual's level of care, and may authorize an individual to function at a level other than that individual's state certification or authorization.

It is the responsibility of MMS to establish and enforce appropriate procedures for the issuance of authorization to provide out of hospital care in the MMS MCS.

It is the responsibility of the administration/management of the provider services within the MMS MCS to ensure that all personnel within their organization adhere to these procedures.

PROCEDURE:

To Obtain Initial MCS Authorization:

1. *Prior to allowing the employee to function in a patient care delivery role,* the provider agency shall notify MMS of the individual's hire and provide MMS with the following information:
   - The individual's name, date of birth, address, social security number, and home phone number (Completed Personnel Data Form)
   - A copy of the individual's current Texas Department of State Health Services (TDSHS) EMS certification. The copy must legibly show the recipient's name, certification number, and expiration date.
   - For paramedics, a copy of the individual's American Heart Association Advanced Cardiac Life Support (ACLS) course completion certificate. The copy must legibly show the recipient's name and the date the course was completed.
   - The above three items may be faxed or emailed to MMS to initiate the authorization process.
2. MMS or the agency will then issue the appropriate medical control number. After a review of the documents, MMS will approve a specific level of care authorization for the individual. The issuance of this number and level of care authorization shall constitute authorization to function in the MMS MCS at the specified level.
3. Authorization levels within the MMS MCS include:
   a. First Responder
   b. Emergency Care Attendant
   c. Emergency Medical Technician – Basic
   d. Advanced Emergency Medical Technician – Basic
   e. Emergency Medical Technician – Intermediate
   f. Limited Paramedic
   g. Paramedic
   h. Advanced Paramedic

   All interventions and procedures approved for each level of authorization are specified in the MMS Patient Care Protocols for Therapy.
4. New personnel entering the system will be assigned to either First Responder authorization level (personnel presenting ECA, EMT-B, EMT-I certification), or Limited Paramedic authorization (personnel presenting EMT-P or Licensed Paramedic credentials).
5. Personnel will remain at this authorization level until they have successfully completed the MMS New Employee Training and Testing Course (NETTC). All personnel entering the system must complete NETTC within 120 days of hire, or at the next available NETTC if one is not offered within 120 days of their hire date.

The specific requirements to obtain MCS authorization at the individual's TDSHS certification level:

The individual must:

- Be currently certified by TDSHS, unless seeking authorization as First Responder
- Attend NETTC at all required class times
- Pass the written exam on MCS Policies and Procedures, with at least an 80%
- Pass the written exam on the patient care protocols for their authorization level with at least an 80%
- Successfully complete skills exams for each specialty skill for their authorization level
- Paramedics must have successfully completed an American Heart Association ACLS course within the past two (2) years or successfully complete one within 180 days of their activation date.

Unsuccessful completion of the orientation is defined as failure of any of the testing components (skills, MCS Policies, or Protocols). In the event of a failure, the provider must retake the failed component within ten business days. Should the individual fail the component a second time, she/he must attend a retraining session (provided by MMS) on the component within ten business days of the second failure. The individual must then retake the component within ten business days of the retraining session. Should she/he fail the component a third time, the following action will be taken:

- Paramedic and EMT-I: Reassignment to the level of EMT-Basic.
- EMT-B, ECA, First Responder: Suspension of Medical Control authorization to function in the MMS MCS.

The individual must then attend the next scheduled MMS New Employee Training and Testing Course (NETTC) and must retake all of the testing incorporated into the course. The individual will be provided the same opportunities to retest any failed components as described above. Authorization to function in the MMS MCS will remain restricted as described in this section until all of the testing components are completed successfully.

***To Maintain MCS Authorization**:*

1. All personnel must successfully complete 66% of all MMS MCS continuing education (CE) offerings. One half of these (a total of 33% of the offerings) may be completed via a "distributive CE" packet. Not all CE classes will be available via distributive CE, depending if MMS deems that method is appropriate for the subject matter. The individual must pass the post-test for the CE module with at least an 80% to receive credit for the make-up. The remaining CE requirement must be completed by attending the CE and passing the post-test with at least an 80%. This parameter will be evaluated at six (6) month intervals.
2. All personnel must participate as directed by their service and/or MMS in the Quality Improvement program.
3. All personnel must maintain current appropriate TDSHS certifications.
4. Paramedic personnel must successfully complete ACLS training every two (2) years. This will be provided through MMS CE modules on a biennial basis. Personnel who do not complete ACLS though the provided CE modules must complete the course by other means and send MMS a copy of their ACLS card within 30 days of the expiration date on their ACLS card.
5. All personnel must successfully pass a skills exam on all MMS MCS skills for that level every two (2) years.
6. Paramedics who serve in an administrative role only are exempt from items 1, 2, 4, and 5 above. However, these paramedics are only authorized to perform at the LIMITED Paramedic level, and are not permitted to attend a patient during transport without a fully authorized paramedic (Paramedic, or ADVANCED Paramedic) also in direct attendance with the patient.

Inactive Status:

Personnel who cannot or do not wish to comply with the MMS requirements to maintain active medical control authorization may elect to go on ***inactive*** status with the MMS MCS. Personnel on inactive status may ***not*** function in the MMS MCS in any patient care or dispatch role. They may continue to display certification patches. In order to re-enter the MMS MCS as an active provider, the individual shall:

- Notify the MCO for their EMS agency of their desire to become active
- Comply with all applicable components of the procedure for obtaining medical control authorization as directed by the MCO
- Comply with an individualized program of re-orientation to the MMS MCS as specified by their MCO

***Re-activation of Medical Control Authorization**:*

1. An Individual leaves the MMS MCS in "good standing" For the purposes of this policy, "good standing" is defined as leaving the MMS MCS while the individual's medical control authorization was not revoked, suspended, or downgraded; and while the individual was not on medical control probation, under disciplinary action, or receiving remediation, (as defined in the "Corrective Action" policy 2009-011.

   An individual who wishes to re-activate their medical control authorization with MMS in this situation shall successfully complete the following requirements prior to receiving full, active authorization:

   - Comply with all applicable components of the procedure for obtaining medical control authorization as directed by the MCO
   - Comply with an individualized program of re-orientation to the MMS MCS as specified by their MCO

2. An Individual leaves the MMS MCS under investigation, downgrading, probation, disciplinary action, or remediation
   a. The medical control authorization status (suspended, downgraded, etc) may be immediately reinstated as a "First Responder" on a temporary basis
   b. The assigned MCO shall re-evaluate the situation and render a decision regarding the individual's medical control authorization status within ten business days of the individual's re-activation with the MMS MCS. The MCO shall specify, in writing, the following issues:
      - The individual's exact, current medical control authorization status
      - The performance objectives and time lines to be met to affect a change in the individual's medical control status
      - What goals (if any) have been established for the individual's future medial control authorization status and performance

      This document shall be forwarded to the involved individual, the appropriate supervisor(s) within the individual's service, the MCS Manager, the Associate Medical Director (if applicable), and the Medical Director
   c. Should the individual disagree with any aspect of this decision, s/he may appeal as prescribed in the "Appeals Process" policy.
3. Individual leaves MMS MCS due to a revocation of their authorization
   a. The individual (or his/her representative) shall notify the MCO of the desire to re-activate their medical control authorization.
   b. At the next regular meeting, the appropriate Managers Committee shall consider the individual's request as an appeal of the revocation. The Managers Committee, at its discretion, may review whatever materials and information it deems necessary to render a decision.
   c. Should the Managers Committee elect to allow the individual to re-enter the MMS MCS, the Managers Committee must specify:
      - The individual's exact, current medical control authorization status
      - The performance objectives and time lines to be met to affect a change in the individual's medical control status
      - What goals (if any) have been established for the individual's future medical control authorization status and performance

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

ALLIED HEALTH CARE PROVIDERS ACCOMPANYING EMS UNITS

POLICY CODE:	**2009-019**	**APPROVED BY**
REPLACES:	2000-019	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure compliance with the rules of the Texas State Board of Medical Examiners (TSBME), the Texas State Board of Nurse Examiners (TSBNE), and the Texas Department of State Health Services (TDSHS).

POLICY:
Allied health care providers are defined for the purpose of this policy as personnel trained, certified, or licensed to provide health care *other than physicians.*

Allied health care providers are authorized to assist and/or accompany EMS units functioning within the MMS MCS at the request of the attending EMS personnel, the transferring physician, or the on-line medical control physician.

In accordance with the rules of TSBME, TSBNE, and TDSHS, allied health care providers may assist and/or accompany EMS personnel during the ambulance transport of a patient for the purposes of:

1. Providing additional personnel to allow the efficient and effective provision of care to critically ill or injured patients.
2. Monitoring and managing equipment, adjuncts, or medications which are not included as approved therapies for EMS personnel in the MMS MCS.

The attending paramedic, along with the on-line medical control physician, is ultimately responsible for the management of the patient while in the care of the MMS MCS.

Either the protocols or the on-line medical control physician must authorize all treatments and therapies. Orders from the transferring physician concerning care to be rendered during transport may not be followed unless they either comply with MMS MCS standing orders or are approved by the on-line medical control physician.

Allied health care personnel may not independently treat patients while those patients are in the care of the EMS system. They may assist the EMS personnel with care at the request or direction of either the EMS personnel or the on-line medical control physician.

The presence of an allied health care provider does not exempt the EMS unit from proper staffing requirements, as outlined in the "Appropriate Level of Care" policy.

METROCREST MEDICAL SERVICES
MEDICAL CONTROL POLICY

PHYSICIAN INTERACTION ON-SCENE

POLICY CODE:	**2009-020**	**APPROVED BY**
REPLACES:	2000-020	MCS Manager: Chris Cothes
EFFECTIVE DATE:	01/01/10	Medical Director: Suresh Chavda

Manager Committee approval date: 11/18/09

PURPOSE:
To ensure compliance with the Texas State Board of Medical Examiners (TSBME) rule 197.5d-m.

POLICY:
The request for dispatch of an advanced life support unit from the MMS MCS establishes a patient-physician relationship between the patient and the Medical Director of the MMS MCS.

Unless the patient's personal physician is physically present at and accepts complete responsibility for the medical incident, the patient-physician relationship established between the MMS Medical Director and the patient via the activation of the EMS system is exclusive of any other physician.

The EMS personnel authorized by the MMS Medical Director are responsible for the medical management of the patient and are acting as the agent of the Medical Director.

PROCEDURE:
IF *The Patient's Private Physician Is Present:*
A Private physician is defined as a physician licensed by the Texas State Board of Medical Examiners who does have a previous physician-patient relationship with this patient.

If the private physician wishes to direct the care of the patient once EMS arrives, the EMS personnel shall:

1. Notify the on-line medical control physician as soon as possible.
   Accept the orders of the private physician **so long as they do not conflict with MMS protocols.**
   A. Should the private physician's orders conflict with protocol, the EMS personnel must immediately contact the on-line medical control physician for direction. The on-line medical control physician may authorize the EMS personnel to accept the private physician's orders or may choose to communicate directly with the private physician. In any case, the EMS personnel shall follow the directions of the on-line medical control physician.
   B. If the on-line medical control and private physicians cannot agree, the private physician must either:
      i. Personally provide direct care to the patient throughout the out of hospital phase (including accompanying the patient during transport) **OR**
      ii. Defer all further interventions to the EMS crew and the on-line medical control physician.
2. The private physician shall sign the EMS patient chart indicating that s/he provided orders to the EMS crew.

***IF** An "Intervening Physician" is Present:* "Intervening physician" is defined as a physician licensed by the Texas State Board of Medical Examiners who *does not* have a previous physician-patient relationship and wishes to direct the out of hospital care of the patient.

1. The EMS personnel shall ask the physician to produce a copy of her/his medical license. If the physician is unable to do so or the EMS personnel are unable to confirm the validity of the document, the physician's assistance shall be politely declined and the EMS personnel shall continue to treat the patient as per protocol.
2. If the physician does identify her/himself to the satisfaction of the EMS personnel, the EMS personnel will ask the physician whether she/he is accepting responsibility for the medical incident and will agree to accompany the patient to the hospital. If the physician does not agree to this, she/he may assist the EMS crew but may **not** direct any aspect of the care.
3. If the physician agrees to accept responsibility for the incident and accompany the patient to the hospital, the on-line medical control physician shall be contacted as soon as possible.
   A. Any urgent care will not be delayed or interrupted to make on-line MC contact
   B. The directions of the Intervening physician may not be accepted until on-line MC contact is made and the on-line physician approves the participation of the Intervening physician
4. The on-line MC physician shall be ultimately responsible for the management of the patient.
   A. The on-line MC physician may authorize the EMS personnel to accept the direction of the Intervening physician or may order the EMS personnel to follow the protocol or his/her orders only.
   B. In the event of a disagreement between the Intervening and the MC physician, the EMS personnel will follow the orders of the MC physician.
   Should the on-line MC physician authorize the EMS personnel to follow the direction of the intervening physician, the EMS personnel may not provide any care that is in conflict with MMS protocol.
5. Should the intervening physician provide or direct care, the Intervening physician shall accompany the patient to the hospital unless expressly relieved of this duty by the on-line MC physician.
   A. All orders from the intervening physician shall be repeated to the on-line MC physician.
   B. The intervening physician shall provide the attending EMS personnel with her/his name, address, and license number. The intervening physician shall sign the EMS patient chart indicating that she/he directed or provided care.