Transport Decision Process

Standard:

To establish guidelines for all System Credentialed participants and providers when provider level of transporting provider.

Purpose:

To define patients that cannot be transferred to a provider other than a credentialed ≥ PL5.

Application:
For the purpose of this standard, a ≥ PL5 refers to an ATCEMS credentialed ≥ PL5 with no current restrictions on their credential to practice.

All providers on scene are expected to participate in patient care. Both providers are responsible for conducting an initial evaluation to determine a chief complaint, level of distress and initial treatment plan. Stable patients not in need of ≥ PL5 level care may be attended by another provider. The Lead Transport ≥ PL5 is responsible for making the decision for which patients can be safely transported by a provider with lower credentials.

The care of the following patients cannot be transferred to a lower level of credential:

1. Any patient who requires additional or ongoing medications, intervention and/or monitoring beyond the scope of the system credential provider as defined by the clinical operating guidelines.
2. Any patient that receives medications beyond the scope of practice of the system credential provider.
3. Postictal seizure patients who have not returned to baseline mental status.
4. Any patient with the following:
    a. Trauma Alert (steps 1 and/or 2) listed in the Trauma General COG
    b. Stroke Alert
    c. STEMI Alert
    d. Syncope
5. Any patient for which the transporting providers do not agree can be safely transported without a ≥ PL5 attending in the back of the ambulance.
6. Any "High Risk" patient as defined above must be assessed by a ≥ PL5.

Exceptions to the above listed items:

1. Patients listed as "High Risk" may be transported by a ≥ PL2 if the ≥ PL5 provider completes an assessment and the patient does not require any care and monitoring beyond the scope of practice of the ≥ PL2 provider.
2. Patients who received a single dose of IN narcotic for the purpose of pain control in a traumatic injury not involving the patient's head, chest, or abdomen.
3. Patients who have a syncopal episode who are < 50 years of age, have a normal blood sugar, and a normal ECG.
4. Monitor IV saline lock.
5. Monitor administered PO route medications.
6. Any hypoglycemic patient that returns to a baseline mental status after treatment.
7. A ≥ PL2 transport provider may call and obtain a Termination of Resuscitation (TOR) on behalf of a ≥ PL5 transport provider post ≥ PL5 assessment for patients that meet the criteria for death or withholding resuscitation.
    a. Patients who fall under the Discontinuation of Prehospital Resuscitation, the decision for TOR must be discussed between the ≥ PL5 and OLMC.

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Any “High Risk” patient as defined above must be assessed by a ≥ PL5 provider or responder. Except if a ≥ PL5 provider or responder has not been dispatched to the scene and the primary complaint is ambulatory dysfunction/ lift assist only then there must be an offer for a ≥ PL5 evaluation. If the patient refuses a ≥ PL5 evaluation, then OLMC must be contacted and after consulting with OLMC the ≥ PL1 provider may complete the refusal based on OLMC direction.

Even when a ≥ PL5 provider or responder completes a full evaluation, consultation with OLMC is recommended for “High Risk” refusals.

The ePCR should reflect the decision-making process to determine which provider attends to the patient. As with all documentation, both providers are responsible for the content of the ePCR.