policies, training, and scope of practice as recognized by HFD.

F. Each occurrence of communication failure will be considered a breakdown in system operations and will be reviewed to determine if the occurrence was due to equipment failure or member non-compliance with department policy, procedure or guidelines.

6.04 Confidential Patient Information

A. It is the responsibility of all HFD personnel, particularly those members who have direct contact with patient information, to ensure that patient information is kept confidential. Texas law prohibits the disclosure of any patient information to unauthorized individuals or entities.

B. Texas Health and Safety Code, Chapter 773, Emergency Medical Services, Subchapter D. Confidential Communications (773.091): Records of the identity, evaluation, or treatment of a patient by EMS personnel or by a physician providing medical supervision that are created by EMS personnel or physician or maintained by an EMS provider are confidential and privileged and may not be disclosed with the following exceptions:

1. Medical or law enforcement personnel, EMS personnel, the physician providing medical supervision, or EMS provider determines that there is a probability of imminent physical danger to any person or if there is a probability of immediate or emotional injury to the patient;
2. Governmental agencies if the disclosure is required or authorized by law;
3. Qualified persons to the extent necessary for management audits, financial audits, program evaluations, system improvements, or research, except that any report of the research, audit, or evaluation may not directly or indirectly identify a patient;
4. Any person who bears a written consent of the patient or other persons authorized to act on the patient's behalf for the release of confidential information as provided by Section 773.093;
5. The department for data collection or complaint investigation;
6. Other EMS personnel, other physicians, and other personnel under the direction of a physician who are participating in the diagnosis, evaluation, or treatment of the patient;
7. Individuals, corporations and/or governmental agencies involved in the payment or collection of fees for emergency medical services rendered by EMS personnel.

C. Any other request for patient information shall be directed to the HFD Records Section. They are the official custodians of records for HFD.

6.05 Controlled Substances Accountability

A. In order to carry and administer controlled substances (i.e. narcotics), members are required to comply with the Federal Government's daily accountability regulations for Schedule II drugs.

B. At the beginning of each shift, the Controlled Substances Accountability Form shall be completed according to the current Controlled Substances Accountability Guideline.

C. When there is a change in the in-charge paramedic, the Controlled Substances Accountability Form shall be completed according to the current Controlled Substances Accountability Guideline.

6.06 Documentation

A. Documentation provides a record of what you did or did not do while additionally serving as a Medical Record and a Legal Document.

B. Each unit involved in direct patient care shall complete the appropriate record. For quality assurance and other purposes, other EMS professionals, physicians, nurses, insurance companies, Medicare/Medicaid personnel and the legal community frequently examine these records. They are also used in court cases, grand rounds at the hospitals and reviewed by the Texas Department of State Health Services and the local media.

C. When EMS responds to a request for service and finds individuals not meeting the definition of a patient (*Ref. Def. 3.28*), the record should be appropriately coded.

D. S.O.A.P.: **S**ubjective data, **O**bjective data, **A**ssessment, **P**lan

E. **S**ubjective Data: *What you were told by . . .*

1. Patient, family, bystanders, witnesses, police officers, other HFD members. Start with the patient's Chief Complaint(s) (CC).
2. The patient's history:
   a. History of the Present Illness (HPI). Each Chief Complaint has a HPI to be pursued. For each CC the HPI will consist of determining:
      •Onset of the symptom •Duration of the symptom
      •Frequency of the symptom •Character of the symptom
      •Intensity of the symptom •Associated symptoms and Aggravating / Alleviating factors
   b. The past medical history of the patient (SAMPLE)
      •**S**igns / Symptoms
      •**A**llergies
      •**M**edications
      •**P**ast illnesses
      •**L**ast meal, Last Menstrual Cycle
      •**E**vents leading up to this event

F. **O**bjective Data: *What you saw . . . What you found (Mechanism of Injury)...*

1. On your approach, at the scene, where the patient was found, the patient's position.
2. Your PHYSICAL findings from the primary survey, the secondary survey, vital signs and diagnostics (glucose levels, ECG tracings, SpO_2 levels and end-tidal CO_2).
3. Physical Exam (CHAMPION)
   •**C**ardiac (Heart Sounds, Pulses)
   •**H**EENT
   •**A**bdomen
   •**M**ental Status
   •**P**ulmonary (Breath Sounds, Work of Breathing)
   •**I**ntegumentary (Skin)
   •**O**ther (Vital Signs, Diagnostics)
   •**N**euro (Strength, Sensation)

G. **A**ssessment: Based on the data collected, document the assessment of the patient's problem and which plan/guideline you are going to follow.

H. **P**lan: All interventions performed: C-collar / spinal immobilization, AED, CPR, intubation, I.V. therapy, medications, evaluation of the therapies performed and on-going monitoring noting changes in the patient's status including notations on the patient's condition on arrival at the ED.

I. Responsibility

1. When members hold the same EMS credentialing status, members are <u>equally responsible</u> for complete and accurate documentation of the record.
2. In situations where one member is credentialed by the Medical Director's Office at a higher level, that member is responsible for the complete and accurate documentation of the record.
3. The highest ranking member on the apparatus is responsible for signing the patient care record and ensuring it is completed and posted.

J. In ALL cases, the patient care record will be provided to the hospital prior to the unit leaving the hospital property. Patient care records are still to be completed and provided to the hospital during periods of resource management.

K. For all dispatched EMS incidents (FE dispatch code), and all Fire incidents (FF dispatch code) in which an Ambulance, Medic, Squad or EMS Supervisor is dispatched, an EMS patient care record shall be completed.

1. All units shall utilize the laptop electronic patient care record (ePCR), ensuring that it

contains:

a. Dispatch information including accurate location address.
b. Correct shift, apparatus and all personnel with appropriate crew level and role.
c. Identifying patient information including insurance information on transports.
d. A chief complaint, a physical exam and a working assessment.
e. A narrative detailing the specifics of the patient's presentation, care, decision making processes, and proper documentation of patient refusals if applicable.
f. Documentation of vital signs, medications and procedures in their appropriate sections. **It is not acceptable for vitals, medications and interventions to be listed only in the narrative section.**
g. The 12-lead ECG shall be downloaded into the patient record if performed.
h. The appropriate Incident Disposition for the incident.
i. The signatures from all required HFD personel and, as indicated, the patient, witness, law enforcement or hospital representative.
j. The Telemetry Number from Base Station and the Hospital Medical Record number when a patient is transported.
k. The name of the receiving hospital for all patient transports.

2. Any unit without a laptop computer to complete the ePCR shall utilize the ePCR software on a station computer to complete the record according to the requirements stated (*6.06 K.1.*)

L. All members are to fully document and describe the events of their dispatched incident, even when a patient (*Ref. 3.28*) was not found. An explanation for why an individual for whom EMS was requested is not 'a patient' is required.

6.07 Emergency Transfers (One Emergency Dept. to Another)

A. In all cases when dispatched to a hospital Emergency Department, HFD members should contact their immediate EMS Supervisor to apprise him/her of the situation.
B. The EMS Supervisor is to review the case to ensure the use of public safety resources is appropriate. If there is any question or doubt, contact the on-line physician via the base station.
C. Given approval from the EMS Supervisor, paramedics should be able to transfer patients as long as the patient care is within their scope of practice. If the patient is in need of a medication that is not currently on the approved drug list or is on a mechanical device that is not used by the Houston Fire Department, then a nurse or physician familiar with such medications/devices needs to accompany the patient during the transfer.

6.08 Equipment and Actions on Each Run

A. Bring all basic equipment (see "D.R.O.P.S." below) in close proximity to the patient.
B. Basic equipment ("D.R.O.P.S.") includes: **D**efibrillator (LifePak, A.E.D., etc.), **R**adio, **O**xygen and airway equipment, **P**rimary Medical Kit and **S**uction.
C. The defibrillator and/or the suction may be left in the ambulance at a motor vehicle incident scene, only if it remains in close proximity and there is no prior evidence or communication of possible need for these devices.
D. Consider special circumstances in which additional equipment should be immediately carried (such as stretcher/backboard into a high-rise or a C-collar and other packaging devices in an entrapment case).
E. ALS units must take all appropriate ALS equipment onto the transporting BLS unit.
F. Upon arrival to the dispatched address, the HFD apparatus will attempt to locate the person(s) for which 911 was activated.
G. The HFD apparatus will determine if this/these individual(s) meet the definition of a 'patient' as per 3.28.