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.

H. A complete history and physical exam will be conducted on every patient, unless specifically refused by the patient. Document in the patient care record any intended action that the patient refuses.
I. A brief description of why persons for whom 911 was activated do not meet the definition of a patient is required.

6.09 Family-Centered Care

A. Family-centered care is a systematic approach to building collaborative relationships between health care professionals and families that uses those relationships to assist in providing quality EMS care and promoting overall community health and safety.
B. It acknowledges and uses the family's knowledge of their family member's condition and their skills in communicating with and caring for their family member. It emphasizes the importance of keeping family members informed about their loved one's condition, prognosis, and treatment.
C. Prehospital family-centered care encourages family presence during procedures and embraces family-centered care principles during on-scene treatment, transport, and transition of care to in-hospital health care providers.
D. The goal of family-centered care is to achieve the best possible outcome for children, and all other patients, through a mutually beneficial collaboration of health care professionals and family members. Families desire to be kept informed, to have their questions answered and to participate in their loved one's care. They generally object to processes that make them feel helpless, uninformed or uninvolved. Patients generally want to feel assured that they are receiving the care and treatment they need and desire to be comforted and supported by their families during care. Meeting the family's needs can help reduce patient and family anxiety.
E. Guideline
    1. Identify a team member to interact with family members on each call. Let the family know who that person is, and when that person changes. Make eye contact when speaking. Identify yourself by name, and ask patients and family members how they would like to be addressed. Use courtesy titles (Mr. Mrs. etc.) and avoid slang terms.
    2. Communication should be consistent and constant throughout the incident. Explain equipment and procedures in clear, factual terms (what you're doing and why you are doing it), avoiding jargon and technical terms. Be aware of individual differences in ability to understand, but do not assume that family members cannot understand explanations. Watch for verbal and non-verbal cues from families about the amount of information they want and whether they understand what you are telling them. Know that it is acceptable to say "I don't know", but follow that answer with "we will do everything we can to reach the best possible outcome for your child."
    3. Acknowledge feelings, offer support (how can I help you?) and express empathy when appropriate. Allay guilt by calling attention to something the family has done right. Maintain a calm professional demeanor; avoid matching emotional responses from family members. Avoid confrontations with other health care providers in the presence of patients or family members.
    4. Provide family members with options whenever possible. Helping families to restore a sense of control can decrease patient and family member anxiety and combativeness.
    5. Allow a family member to accompany the patient in the ambulance when possible. Allow a family member to remain with the patient during transport (seat-belted securely) if possible.
    6. Use the family as a source of assistance to patient care by providing information (pertinent history, normal level of consciousness, special developmental concerns, dominant hand, best known IV site, etc.) and comfort (hold the patient's hand, reassuring the patient, singing a favorite song, comforting the patient during procedures, etc.).
F. Family Presence and Participation During Transfer of Care