than the officer in charge, that member will be in charge of patient care and the documentation of the EMS record.

b. The officer in charge of the EMS apparatus still bears the ultimate responsibility to ensure the EMS record is completed in a timely manner.

B. ALS Unit Crew Responsibilities:

1. In HFD, the Fire Fighter paramedic (FFP) will be considered to have the primary duty of delivering patient care on the emergency scene.
2. The Engineer/Operator paramedic (EOP), either acting or assigned, is in charge of the ALS unit and carries the over-all responsibility for delivery of appropriate care to the patient. The EOP will assist the FFP in providing patient care as needed throughout the incident.
3. Should circumstances dictate, the EOP will assume full responsibility for patient care and will remain with the patient at the scene and during transport in order to ensure the continuity of patient care. In these cases, the EOP must notify the EMS Supervisor as soon as possible of the situation.
4. In the event the FFP believes the EOP is inappropriately directing patient care, the FFP must notify the EMS Supervisor as soon as possible of the situation.
5. The FFP is responsible for the complete and accurate documentation of EMS records including the patient care record and documentation of patient refusals. The EOP shall review the patient care record.
6. Both the EOP and the FFP will be held equally responsible for patient management and record documentation as outlined by the Texas Department of State Health Services.
7. Generally speaking, the first arriving paramedic will be in charge of patient care until such time as a higher ranking paramedic assumes patient care or until transfer of care for the purposes of patient transport is appropriate.
8. The EMS Apparatus Paramedic is responsible for immediate patient care until the arrival of the Medic or Squad Paramedic. The EMS Apparatus Paramedic will assist the Medic or Squad Paramedic in providing patient care as needed throughout the incident.
9. Should circumstances dictate, the EMS Apparatus Paramedic will assume full responsibility for patient care and will remain with the patient at the scene and during transport in order to ensure the continuity of patient care. In these cases, the EMS Apparatus Paramedic must notify the EMS Supervisor as soon as possible of the situation.

6.22 Termination of Resuscitation

A. Background

1. Termination of ALS efforts in the out-of-hospital setting will apply to patients who experience a non-traumatic cardiac arrest and meet the specific criteria indicating futility for further resuscitative efforts.
2. This policy is intended to be applied to situations involving patients who may have had poor quality of life factors or whose death was anticipated. The policy may, under appropriate circumstances, also be applied to situations involving patients whose death was unexpected.

B. Inclusion Criteria:

The decision is based on the following criteria:

1. Patient must have had a presumed primary medical arrest.
2. Patient must be successfully intubated or successfully ventilated with an alternative airway device, have IV or IO access and have standard advanced life support (ALS) measures applied throughout the resuscitation effort.
3. On-scene advanced resuscitation efforts by paramedics will be sustained for at least 20 minutes regardless of previous CPR time and the arrest interval. In other words, patients should receive 20 minutes of ALS intervention/medication not counting the time for basic CPR/defibrillation

provided by BLS prior to paramedic arrival.

4. Persistent asystole or agonal rhythm (PEA < 20) is present and no reversible causes are identified during the resuscitation effort.

C. Exclusion Criteria:

Resuscitation efforts will not be terminated in patients found in open public places or who meet the following exclusion criteria:

1. The patient whose medical arrest may be associated with hypothermia or cold water submersion injury.
2. The patient who has persistent ventricular fibrillation (VF) or ventricular tachycardia (VT) or normal appearing, well organized complexes without pulses (QRS rate > 60/min.).
3. The patient who demonstrates any neurological signs (i.e., spontaneous opening of the eyes or spontaneous movements).
4. The patient who has a cardiac arrest after being in the care of HFD personnel.
5. Patients with a Ventricular Assist Device.

D. Operating Procedure:

1. If a patient remains unresponsive to ALS resuscitation measures and meets all of the inclusion criteria and none of the exclusion criteria, field termination shall be pursued.
2. In all cases, the paramedic in charge of the resuscitation will notify an EMS Supervisor of every opportunity to terminate resuscitative efforts. EMS Supervisors will make every effort to respond to the scene of a potential on-scene termination of resuscitative efforts.
3. The EMS Supervisor or paramedic in-charge of the case shall discuss the situation in its entirety with the Base Station physician. The Base Station physician may then give permission to terminate the resuscitation.
4. During resuscitation, EMS personnel (and preferably an EMS Supervisor) will apprise the family of the progress of resuscitative efforts. The EMS Supervisor will advise them of the on-line medical direction and the directives to terminate efforts.
5. The family, or relevant bystanders, shall be approached and notified that all resuscitative efforts have failed to restore a pulse and that transport of the patient to the hospital is not going to change the patient's ultimate outcome. Because of this, HFD will stop resuscitative efforts and HFD will turn scene management over to HPD.
6. HFD shall not transport patients who meet criteria for Termination of Resuscitation unless a) the resuscitation takes place in a public setting or b) HFD member's personal safety may be endangered by non-transport of the patient or c) the family strenuously objects.
7. EMS personnel shall actively engage the family and answer their questions as appropriate. The on-call physician will be available to directly converse with the family if the family or the bystanders wishes to do so.
8. Upon approval to terminate the resuscitation effort, tie off and knot any established intravenous lines (close to the IV/IO site) and remove the IV fluid bag and remaining tubing. The IV/IO catheters and the endotracheal tube (or alternative airway) will remain in place.
9. Contact the dispatcher for notification of the Medical Examiner and HPD.
10. At all times, HFD members will be attentive to the social and psychological support needs of the "survivors" (i.e., family, friends, witnesses) and provide support as needed (*Ref. 6.01 #1 Rule : Holder Rule and 6.09 Family Centered Care*).
11. If there is no suspicion of any criminal activity, the body may be moved by HFD personnel only to place the body in a bed (to minimize family members' discomfort with the event).

E. Documentation:

1. Information surrounding the events of the resuscitative efforts and the time of death will be properly recorded on the Patient Care record in the comments section in addition to a detailed description of the resuscitation attempt.

F. If at any time during a respiratory or cardiac arrest resuscitation a valid DNR form, advanced directive, or verbal order from the patient's physician is produced (*Ref. 6.17 Out-of-Hospital DNR Orders*), all resuscitative efforts should be stopped and termination of resuscitative efforts should be documented.

6.23 Voluntary Self Reporting of Medical Errors

A. Purpose
   1. To establish and maintain a system in which certain types of medical errors are viewed as sentinel events to be taken advantage of in order to improve the overall quality of patient care, while at the same time ensuring the safety of the public.

B. Definitions
   1. Error – an act that deviates from what is correct. For the purposes of this policy, correct action is defined by HFD policy and procedures referenced III-01 7.00 through and including 9.06.
   2. Neglect – to fail to care or give proper attention to; to fail to do as through oversight or carelessness.

C. Procedure
   1. Self Reported Errors
      a. When a member recognizes they have committed a medical error, that member has twenty-four on-duty hours to report the error to an EMS Supervisor.
      b. The officer to whom the medical error has been reported will document the report on a Medical Error Reporting Form found in the HFD Forms list.
      c. The officer will perform and complete an investigation to include interviewing of other members, witnesses or examination of equipment, or any other such investigation as necessary to determine the nature, severity and circumstances of the reported error.
      d. The officer will also document action taken by the officer in response to the report. The officer may choose from the following options:
         1) Document analysis of the perceived error and provide positive reinforcement to the member for bringing the opportunity for improvement to the supervisor's attention.
         2) Provide immediate counseling and document such counseling on a Medical Error Reporting Form.
         3) Provide immediate counseling as above and recommend further remediation through the Medical Director's Office.
         4) Remove the member from patient care duties pending review by the Medical Director's Office.
      e. Members who self-report medical errors will not be subjected to formal investigation by the Medical Director's Office.
   2. Unacceptable Errors
      a. Most reported medical errors will be considered to be opportunities for system improvement by the Office of the Medical Director.
      b. Certain errors will be considered unquestionably unacceptable behavior on the part of the member and remediation will not be offered. While many of these errors are also addressed in other areas of fire department policy, the following offenses will be considered grounds for immediate revocation of paramedic and/or EMT patient care privileges:
         1) Willfully inflicting harm of any kind on a patient.
         2) Willful neglect of a patient.
         3) Willful disregard for patient care policies and procedures.
         4) Untruthfulness with the Medical Director, his or her designee, or an officer of the department with regard to patient care, documentation, or error reporting.
         5) Failure to remediate or repeatedly committing the same or similar errors in spite of