If a BLS-only transport occurs in this situation, the reasons shall be clearly documented in the patient care record.

F. BLS Unit Transport of Critically Injured Patients

1. When a BLS unit is first on the scene with a "critically injured" trauma patient, BLS personnel shall quickly immobilize (if required), provide BLS support, and rapidly transport the patient directly to a Trauma Center (*Ref. 6.12 D. Hospital Destination Decisions for Trauma Patients and 9.05 Approved Hospitals and Hospitals With Specialized Facilities*).
2. **The patient's chances for survival following a serious traumatic injury are directly related to the amount of time required to get the patient to the appropriate trauma center**. A BLS unit is dispatched to a serious traumatic incident to rapidly transport the patient to a Trauma Center.
3. BLS units are **NOT** to delay transport awaiting the arrival of a paramedic. Immediate BLS transport to a Trauma Center is appropriate and provides the patient the greatest chance of survival. For example, in a situation where the patient has suffered an airway injury, paramedics may be able to provide an advanced airway intervention. Unless an appropriate rendezvous point can be established between the BLS and ALS, provide direct, immediate, and rapid transport of the patient to a Trauma Center. If the BLS unit transports the patient, that unit must continue to provide all of the following, as indicated:
    a. Basic airway management.
    b. Basic respiratory support with supplemental oxygen.
    c. Spinal immobilization (including C-spine precautions) as indicated.
    d. Basic circulatory support, including hemorrhage control and CPR as needed.
4. If at any time there is a question as to whether a patient is a candidate for rapid BLS transport, notify the responding ALS unit to report the patient's condition and request transport instructions. If no ALS unit has been dispatched, proceed with rapid transport to the closest appropriate trauma center. OEC may be contacted to arrange a rendezvous with an ALS unit provided that such action does not delay a patient's arrival to the trauma center.

6.21 Riding in Charge

A. BLS Unit Crew Responsibilities:

1. BLS Ambulance
    a. In HFD, the Fire Fighter EMT (FFE) will be considered to have the primary duty of delivering patient care on the emergency scene.
    b. The Engineer/Operator EMT (EOE), either acting or assigned, is in charge of the BLS unit and carries the over-all responsibility for delivery of appropriate care to the patient. The EOE will assist the FFE in providing patient care as needed throughout the incident.
    c. Should circumstances dictate, the EOE 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. The EOE must notify the EMS Supervisor as soon as possible of the situation.
    d. In the event the FFE believes the EOE is inappropriately directing patient care, the FFE must notify the EMS Supervisor as soon as possible of the situation.
    e. The FFE is responsible for the complete and accurate documentation of EMS records including the patient care record and documentation of patient refusals. The EOE shall review the patient care record.
    f. Both the EOE and the FFE will be held equally responsible for patient management <u>and</u> record documentation as outlined by the Texas Department of State Health Services.
2. BLS EMS Apparatus
    a. Any time a member of an EMS apparatus company holds a higher EMS credentialing level

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