

City of Winter Park Fire-Rescue Standard Operating Guideline

300.02

**Title: Emergency Medical Services
Patient Care Report**

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Purpose: This procedure is designed to provide a standard for the completion of EMS Patient Care Reports in compliance with the State of Florida Statutes and Federal HIPAA Compliance laws. It is intended to give the information needed to produce a concise, complete and well-documented Patient Care Report.

Scope: This procedure is to be followed by all employees working under the Medical Director and Standing Orders with whom the Department is currently contracted. Authority to deviate from this Department guideline rests with EMS Supervisors or their designee.

General: All Fire Rescue Personnel shall know how to fully document an emergency medical incident using the provided software program available on the station and/or MDT computers. The responsibility for the completion of the report shall be placed upon the individual in charge of primary patient care or their designee.

A patient shall be identified as any person for whom a Fire Department unit was dispatched to provide care for.

Computer generated reports shall be completed for all incidents where Fire Department personnel arrive at the scene and perform a patient exam and/or provide care to a patient. This will include all AUTO ACCIDENTS. Incidents involving patients with no apparent medical problem, i.e. persons found sleeping will be documented on a Fire Department Refusal Form and a computer generated EMS report will be completed under the PUBLIC ASSIST section.

Any time a person refuses exam, treatment and transport, an EMS REFUSAL FORM must be completed. All DRY RUNS must be entered in the computer under "Disposition of Call". An Auto Accident that has NO INJURIES qualifies as a "DRY RUN".

If Fire Department units are canceled prior to arrival at the scene, the responding unit must continue to the scene and obtain signatures for the REFUSAL FORM, unless the Fire Department unit is canceled by another Emergency Medical Unit.

NOTE: EACH EMS INCIDENT SHALL HAVE AN "EMS" COMPUTER REPORT OR FIRE DEPARTMENT REFUSAL FORM COMPLETED BY THE PARAMEDIC OR EMT.

THE REPORT SHALL BE COMPLETED BEFORE THE DUTY DAY IS COMPLETED FOR THE PARTICULAR SHIFT INVOLVED. NO INCIDENT REPORTS SHALL BE LEFT TO COMPLETE DURING THE NEXT DUTY DAY.

300.02.01. Patient Care Report:

When completing the Patient Care Report, the following documents shall be used as references:

Winter Park Fire - Rescue / Abbreviated EMS Report
Winter Park EMS Standing Orders, or the current Standing Orders generated by the Medical Office with whom the Department has a contract.

300.02.02. Patient Care Worksheet / Winter Park Fire - Rescue / Abbreviated EMS Report:

The Winter Park Fire - Rescue / Abbreviated EMS Report is designed to allow personnel to record pertinent patient information while on the scene and to aid in the completion of the complete patient care record upon return to the station.

The original (WHITE COPY) of the worksheet will be forwarded to the EMS Supervisor for report review and billing purposes.

A Winter Park Fire - Rescue / Abbreviated EMS Report will be completed for each patient assessed by Fire Department personnel.

300.02.03. ECG Information:

Any ECG generated as a result of patient assessment shall be mounted on the Fire Department issued mounting paper. At no time shall an ECG strip be simply stapled to the back of a run report.

All mounted ECG paper shall have all appropriate patient information completed on the form.

3-lead ECG shall have 6 seconds of strip mounted at the "LEAD 2" position on the mounting paper.

12 Lead ECGs shall have at least one clear QRS complex mounted in each appropriate position on paper.

Code Summaries shall be mounted in six-second strips on the mounting paper. Use additional pages if necessary.

300.02.04. Reporting Responsibility:

The Company Officer shall insure that all EMS reports are completed in a timely manner, ensure that all ECG strips are attached to the ECG mounting paper as described in this SOG.

If a discrepancy is found by the Company Officer, the report will be returned to the writer of the report for any corrections.

The EMS Supervisor or their designee will also review all EMS reports for completeness and for quality assurance.

If a report is found to have errors in the alarm or biographical areas, note of the error will be kept by the EMS Supervisor. A consistent pattern of errors will result in remedial education for the employee involved.

If a major problem with the quality of care or a deviation from protocol occurs without proper documentation, a Quality Improvement Review (QIR) form will be forwarded to the report writer through the chain-of-command. A copy of the EMS report will be attached to the QIR form with all problem areas described.

Each officer in the chain-of-command must initial receipt of the form as it is passed. The report writer shall respond in writing to the problems as listed on the QIR form.

The completed QIR form shall be forwarded to the EMS Supervisor through the chain-of-command with each officer initialing the comments before forwarding it through.

The QIR form must be completed and returned to the EMS Supervisor within (7) seven calendar days from the issue date, unless the writer is on leave from the Department.

All reports with major errors or discrepancies will be forwarded to the current Medical Director with whom the Department has a contract.

300.02.05. Final Narrative:

Any information relevant to a call that is not available as a menu choice should be included in the final narrative. Unusual scene observations, pertinent patient or witness comments should be recorded.