



# *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 patient care report form (PCR). 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.

A written PCR 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 and incidents involving patients with no apparent medical problem. If a member of the fire department examines an individual with the intent of determining whether or not the individual has an injury or illness this is a patient and a record shall be documented on the PCR as a patient refusal. A signature shall be collect on the PCR documenting the patients understanding to the fact that they are refusing treatment, transport or both.

THE PCR 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.

A PCR CONTAINS INFORMATION PROTECTED UNDER THE HEALTH INFORMATION PORTABILITY AND PRIVACY ACT (HIPPA). THIS INFORMATION IS BE PROTECTED BY THE AUTHOR AT ALL TIMES. NO PCR SHALL BE LEFT OUT IN COMMON AREAS OF THE FIRE STATION AWAITING COMPLETION AND NO PCR SHALL BE KEPT IN A PERSONEL LOCKER.

**300.02.01. Patient Care Report:**

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

The blue field notes section of the PCR. 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. Field notes section of the PCR**

The field notes section is designed to allow personnel to record pertinent patient information while on the scene and to aid in the completion of the complete PCR upon hospital arrival. This allows the author to write a concise PCR on a stable work surface with improved penmanship.

**300.02.03. ECG Information:**

Any ECG generated as a result of patient assessment shall be mounted on the Fire Department issued mounting paper and a copy made. At no time shall an ECG strip be simply stapled to the back of a run report. The optical scanner used to store the PCR will not aspect any ECG tracing in its original form.

All mounted and copied ECG paper shall have all appropriate patient information and identification 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 concise and complete and all ECG strips are attached and copied to the mounting paper prior to shift change 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 choice in the bubble menu should be included in the final narrative. Unusual scene observations, pertinent patient or witness comments should be recorded. Consider the narrative section of the PCR your chance to tell a short story of what you did and what you saw. This will be your only chance for officially recording your actions and treatments prior to report submission.



A handwritten signature in black ink, appearing to read 'James E. White', is written over a horizontal line.

James E. White  
Chief of Department