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|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 1 OF 12 |
| | | Title: Procedure, Run Documentation | | |

| Revision History: | | | | |
|-------------------|------------------------|---------------|--------------|-----------------|
| Rev. | Description of change: | Initiated By: | Approved By: | Effective Date: |
| - | Initial Release | S.Weigold | R.Bubeymre | 05/22/05 |

1.0 PURPOSE

The purpose of the Run Documentation Procedure is to provide proper instruction in the selection of and use of department run documentation forms.

2.0 SCOPE

2.1 APPLICABILITY

This policy applies to all members of the St. Clair Twp. – New Miami Life Squad regardless of rank or seniority.

2.2 RESPONSIBILITY

The Chief shall make Administrative Appointments as needed based on the guidelines set forth in this policy.

3.0 DEFINITION OF TERMS


No special terms are required by this policy

4.0 REFERENCE DOCUMENTS

OPS-F-016 - Form, Run Report, Numbered
 OPS-F-017 - Form, Run Report, Unnumbered
 OPS-F-013 - Form, Continuation Sheet
 OPS-F-019 - Form, Refusal Checklist
 OPS-F-020 - Form, Refusal Information Form
 OPS-F-001 - Form, Controlled Substance Use
 OPS-F-008 - Form, Death Scene Report
 OPS-F-021 - Form, Rehab Log

5.0 EQUIPMENT USED

No equipment is required for compliance with this policy

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 2 OF 12 |
| | | Title: Procedure, Run Documentation | | |

6.0 SAFETY CONSIDERATIONS

There are no special safety considerations for compliance with this policy.

7.0 SPECIAL REQUIREMENTS

There are no special requirements for compliance with this policy.

8.0 POLICY

8.1 General Considerations

Members are reminded that all run documentation forms are legal documents, reflect the quality of the service we provide to the community, and are admissible in court as evidence. As such, members should strive for accurate, professional and complete documentation. When in doubt, document it. Remember the rule of thumb: “If it’s not in the report, it didn’t happen!”. In addition, members should remember that a blank line or space on any form suggests that the space was overlooked or forgotten. Thus, members are strongly encouraged to mark any non-applicable spaces with N/A or some other appropriate designation to indicate that the space was considered, but unnecessary.


8.2 Run Report, Numbered

The Numbered Run Report OPS-F-016 is the primary form used to document all runs made by the St. Clair Twp – New Miami Life Squad. One and only one Numbered Run Report will be used for each squad for each call. There are no exceptions. Circumstances requiring multiple squads or care for multiple patients will use one Numbered Run Report per squad and document the remainder of patients using Unnumbered Run Reports (see section 8.3). Some of the report sections will not apply in the event that no patient care is given. These sections should be marked as such.

8.2.1 Dispatch Information

Upon dispatch, a Numbered Run Report will be initiated. A crew member will record the following:

- ? Date
- ? Dispatch location, preferably with an address
- ? The nature of the call
- ? If the call is mutual aid, for what department

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 3 OF 12 |
| | | Title: Procedure, Run Documentation | | |

? Time of call (see section 8.2.5)

8.2.2 Page Number

The Numbered Run Report does not provide a designated space for a page number. In the event that a continuation form is required for a complete narrative (see section 8.4) the page number will be recorded in the report margin near the run number in the format “page x of y” where “x” indicates the current page number and “y” indicates the total number of pages. Note that for the Numbered Run Report, the page number should always be “page 1 of y”.

8.2.3 Patient Number

The Patient Number is generally determined at the conclusion of the evolution after all patients have been treated and transported. The number of patients is documented in the “Patient x of y” fashion. Only one patient for each squad is documented on a Numbered Run Report. Refer to section 8.3 for more information. Use extra care not to confuse patient number with page number (8.2.2). On calls where no patient care is given, the patient number does not apply.


8.2.4 Patient Information and Race

Patient information should be documented as completely as possible, especially in the case of unresponsive or altered LOC patients, as this information will likely be used by other agencies (such as the ED) as well. Chief Complaint information should be completed by the treating attendant only, but all other patient information may be completed by any crew member provided care is used to ensure correct entries.

8.2.5 Run Times

Whenever possible the crew should ensure that all run times are recorded accurately as the run progresses. In the event a time is missed due to heavy or garbled radio traffic or an especially hectic transport, the dispatch center may be contacted to provide missing times, but this should be considered a privilege and a last resort. This section may be completed by any crew member.

8.2.6 Safety Equipment

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 4 OF 12 |
| | | Title: Procedure, Run Documentation | | |

The Safety Equipment check boxes are used to indicate what if any equipment the *patient* used prior to the injury or event necessitating an EMS call. This section may be completed by any crew member.

8.2.7 Factors Affecting Delivery of Care

Any factors affecting delivery of care should be marked here. In the event of delayed access due to trains or other situations, the time of the delay should be documented if possible either in minutes, or in the form of time delayed/time cleared. This section may be completed by any crew member.

8.2.8 Physical Findings

The physical findings section should only be completed by the treating attendant. This section gives a general indication of the patient's condition *on arrival*. Changes to the patient's physical findings during the course of care should be documented in the narrative.

8.2.9 Incident Site


The incident site box should be marked that indicates where the emergency occurred, not necessarily where the patient was found. This section may be completed by any crew member.

8.2.10 Pupils, Breath Sounds

The treating attendant should indicate the results of these assessments. Note that multiple boxes may be checked in the pupils section. For example, most patients' pupils are both equal *and* reactive.

8.2.11 History

Medical history may be documented by any crew member, but care should be taken to ensure that the history is both accurate and complete. Members with lesser training should be wary of conditions that sound similar but vary slightly in spelling and dramatically in meaning. For example Hypokalemia and Hyperkalemia sound and are spelled very similar, but mean entirely different problems. When in doubt, allow the treating attendant to complete the medical history.

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 5 OF 12 |
| | | Title: Procedure, Run Documentation | | |

8.2.12 Medications/Allergies

Using care to document the correct spellings and dosages, any crew member may document the medications and allergies. Care should be taken to ensure that the treating attendant is aware of any medications and allergies.

8.2.13 Primary Injury Description

The treating attendant should select the most appropriate classification for the primary injury.

8.2.14 Vital Signs

Vital signs will be assessed by the treating attendant or other designated crew member, but may be documented by any crew member provided correct and clear documentation is used. Note that whenever possible, multiple sets of vital signs should be obtained in order to illustrate any trend in vital signs changes. Vital signs taken beyond the number provided for should be documented in the narrative by the treating attendant.

8.2.15 GCS


The Glasgow Coma Score (GCS) will be documented by the treating attendant. As with vital signs, multiple assessments of GCS should be obtained and documented in order to illustrate trends in GCS changes. GCS assessments beyond the number provided for should be documented in the narrative by the treating attendant.

8.2.16 Procedures/Medications

The procedures and medications section may be completed by any crew member, but only under the direction of the member actually completing the procedure. In order to ensure correct documentation of procedures conducted and medications administered, it is strongly suggested that this section be completed by the treating attendant.

8.2.17 Treatment Given

The treating attendant shall select the appropriate boxes in the Treatment Given section, and complete any supporting information required.

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 6 OF 12 |
| | | Title: Procedure, Run Documentation | | |

8.2.18 Pt. Assessment

The Patient Assessment section is intended for the treating attendant to provide a narrative of the events of the run. An organized method to this narrative should be used, and the treating attendant should use extra care to ensure the completeness of the information.

8.2.19 Destination and Determination

The patient transport destination and the method for determining the destination will be indicated by the most appropriate selection. This section may be completed by any crew member.

8.2.20 Crew Members

All crew members should review the run report for completeness and accuracy, and then sign on the appropriate lines. Once completed, the report will then be presented to a nurse (preferably the one receiving the patient) for a signature.

8.2.21 HIPPA/Billing Certification

The patient or a designated representative should sign indicating permission to bill and receipt of the HIPPA form.


8.2.22 Report Submission

Once the run report is completed, the pink copy of the report (along with the pink copy of any Continuation Sheets) is to be submitted to the ED (if possible or applicable) and the remainder of the copies are to be submitted to the department.

8.3 Run Report, Unnumbered

The Unnumbered Run Report OPS-F-017 is a companion form to the numbered run report. It is to be used in the following cases:

- ? In the event the Numbered Run Report becomes damaged or contaminated
- ? When multiple patients are treated by the same squad on the same incident.

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 7 OF 12 |
| | | Title: Procedure, Run Documentation | | |

When a single squad treats multiple patients from the same incident, such as in the case of a multi occupant car crash with minor injuries, the first patient is documented on the standard Numbered Run Report (see section 8.2). The remaining patients are documented using the Unnumbered Run Report. This run report is then given the same number as the original numbered report and a tally of the number of patients is taken. The number of patients is then documented on each report in the fashion “patient x of y” (see section 8.2.3).

If a patient is treated by one squad and documented on an Unnumbered Report, and then later transferred to another squad, the Unnumbered Report should be completed and reflect the transfer of care in the narrative. The new squad will then document patient care on a report consistent with sections 8.2 and 8.3.


If a Numbered Run Report becomes damaged or contaminated, an Unnumbered Run Report should be given the same number, and used in place of the damaged or contaminated report. In the margin at the bottom of the report the treating attendant should record the fate of the original report. If possible, the damaged Numbered Run Report should be submitted with the replacement copy. Contaminated reports should be destroyed and disposed of in a fashion appropriate for the type of contamination and in a method that will ensure that protected health information is not released.

With the exception of page numbers and patient numbers, Unnumbered run reports may be completed by following the instructions in section 8.2.

8.4 Continuation Sheet

The Continuation Sheet OPS-F-013 is a simple form used to allow the treating attendant more space to write the narrative for a given run. One or more Continuation Sheets may be used as needed to provide for long narratives.

1. Enter the patient’s name (if applicable) to the top of the form
2. Enter the run number
3. Enter the page number using the “page x of y” format
4. Enter the squad number
5. Enter additional narrative as needed
6. Ensure that all members signing the Run Report also sign all Continuation Sheets
7. On the top of the Numbered Run Report enter “page 1 of y” where “y” indicates the total number of pages of the report. As an example, a report with one continuation page would be labeled “page 1 of 2” and “page 2 of 2”.

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 8 OF 12 |
| | | Title: Procedure, Run Documentation | | |

8. The pink copy of the Continuation Sheet should be submitted to the ED with the Run Report as applicable (see section 8.2)

Use care NOT to enter the page numbers on the lines reserved for indicating the number of patients (refer to section 8.2).


8.5 Refusal Checklist

The Refusal Checklist OPS-F-019 is one of several forms that should be completed in the event that a patient wishes to make an informed refusal of care. This form is intended to aid the treating attendant in making a determination as to whether all of the informed refusal requirements have been met. Once completed, the yellow copy of the checklist should be provided to the patient.

1. Complete an appropriate assessment of the patient and indicate the following:
 - a. Alcohol or drug ingestion
 - b. Altered level of consciousness
 - c. Head injury
 - d. Level of orientation.

Obviously, patients with an altered level of consciousness (not completed oriented) are potentially not capable of making an informed refusal and thus should not be allowed to do so. Oriented patients with head injuries or alcohol or drug consumption need to be handled on a case by case basis. Contact medical control as needed.

2. Determine if medical control should be contacted. If so, note how contacted, the name of the physician and his orders. If not, indicate "Not Contacted" on the "other" line.
3. Determine what advise will be given to the patient:
 - a. Medical treatment or evaluation needed? (Generally yes)
 - b. Ambulance transport needed? (case by case basis)
 - c. Further harm may result without medical care? (Generally yes)
 - d. Non ambulance transport may be hazardous? (case by case basis. If yes, medical control should probably be contacted)
 - e. Patient provided with refusal advice sheet? (ALWAYS yes)
 - f. Patient would not accept refusal advice sheet? (generally no)
4. Note any additional comments pertaining to patient care. Information that may be helpful to the patient's physician is appropriate. Some examples include:
 - a. Mechanism of injury if appropriate (example 2 car MVA)
 - b. Vital Signs

| | | | | |
|---|---|--|-------------|--------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 9 OF 12 |
| | | Title: Procedure, Run Documentation | | |

5. The treating attendant should sign the form and provide the date and time. If a department officer is present (and not the treating attendant) he should also sign the form.

The original (white copy) of this form should be submitted with the other run documentation.

8.6 Refusal Information Form

The Refusal Information Form OPS-F-020 is one of several forms that should be completed in the event that a patient wishes to make an informed refusal of care. This form is intended to aid the patient in making an informed refusal. Once completed, the yellow copy of the checklist should be provided to the patient.


1. The treating attendant should enter "St. Clair Twp – New Miami Life Squad" in the blank below item 5.
2. If medical control was consulted prior to allowing the informed refusal, check the box in item 5.
3. Identify who will be signing the form, and indicate by circling the correct title below the signature line.
4. Print the patient's name
5. The treating attendant should sign the form and print his name below the signature.
6. Enter the report number
7. Have the patient sign on the signature line.
8. Obtain a witness signature. Print the witness name below the witness signature.
9. Enter the date.
10. Provide the yellow copy of the form to the patient.

The original (white copy) of this form should be submitted with the other run documentation.

8.7 Controlled Substance Usage

The Controlled Substance Usage Form OPS-F-001 is used by Paramedics and Intermediate EMTs to document the use of controlled substances (narcotics) during the course of patient care. The treating attendant should:

1. Document the date, run number and squad number
2. Document the patient's name
3. Document the Receiving Hospital

| | | | | |
|---|---|--|-------------|---------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 10 OF 12 |
| | | Title: Procedure, Run Documentation | | |


4. Document the telemetry base (medical control hospital) if applicable.
5. Document the telemetry (medical control) doctor's name if applicable. Spell carefully. If not applicable write "per protocol"
6. Clearly document any and all orders received if applicable. If not applicable write "per protocol"
7. Document the narcotic bag seal number, drug lot number and drug expiration date.
8. Indicate the type of medication administered and the amount.
9. Sign on the "administered by" line
10. Have a member witnessing the administration sign on the witness line.
11. Indicate the amount disposed of
12. Sign on the "disposed by" line.
13. Ensure the disposal is witnessed, and have the witness sign on the witness line.

This form should be submitted with the other run documentation.

8.8 Death Scene Report

The Death Scene Report Form OPS-F-008 (also referred to as the Death Scene Information Form) is used to document details of a run where the patient was found to be DOA. This form or a copy of it may eventually be provided to the Coroner's office, and if so, would be a contributing factor to a determination of cause of death and to the decision to perform an autopsy. As such, members should take care to ensure that the form is completed correctly.

1. Document time of call/time of dispatch, run number and date
2. Document patient's name, address, social security number, age and date of birth.
3. Document patient's physician and phone number.
4. Document patient's past medical history to the extent known
5. Document patient's medications and dosages.
6. Document patient's last medical visit if known
7. Document patient's occupation.
8. Document the name, address and phone number of the person who first found the patient.
9. Document the name, address and phone number of the patient's next of kin.
10. Clearly document any signs of violence either to the patient, or at the scene.
11. Indicate who the deceased was released to: (example: funeral home, coroner)
12. Each crew member will sign the form and provide his ID number

| | | | | |
|---|---|--|-------------|---------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 11 OF 12 |
| | | Title: Procedure, Run Documentation | | |


The form should be submitted with the other run documentation unless it is requested on scene by the Coroner.

8.9 Rehab Log

On scene rehab should be considered at any time there is an extended fire department evolution, especially if fire suppression or unusual working conditions (such as high heat) are encountered. The final determination on the necessity of rehab lay with the Fire Officer in Charge, but the EMS Officer in Charge or Crew Leader should suggest it if necessary. An “optional” rehab may also be established in the event that the Fire Officer in Charge does not establish it, but one or more firefighters report for rehab anyway. Any time rehab operations take place the operation will be documented on OPS-F-021 Emergency Incident Rehabilitation Log form.

1. At the establishment of rehab operations, the EMS Officer in Charge will note the following at the top of the log:
 - a. Date
 - b. Location of incident
 - c. Type of incident
 - d. Weather conditions
 - e. Incident Commander
 - f. Rehab Sector Officer (EMS Officer in Charge or Crew Leader)
2. The page number will be noted in the form “page x of y” where “x” is the current page number and “y” is the number of pages. Obviously the number of pages should be determined at the end of rehab operations.
3. EMS staff will then complete an entry for each person reporting for rehab. This entry will include:
 - a. Name
 - b. Rehab entry time
 - c. Length of time working and/or number of SCBA bottles used.
 - d. Two sets of vitals. The first just after arrival, and the second, prior to departure.
 - e. Any complaints and or a description of the person’s condition
 - f. Any actions taken or comments (example: restricted work for extended period due to excessively elevated BP)
 - g. If the person is transported to a hospital, and if so, which one.
 - h. Rehab exit time.

A repeat visit to rehab by any person requires a new entry in the log.

| | | | | |
|---|---|--|-------------|---------------------|
|  | St. Clair Twp. New Miami Life Squad | Document No.: ADM-P-004 | Revision: - | Pg. 12 OF 12 |
| | | Title: Procedure, Run Documentation | | |

9.0 DOCUMENTATION

Non-compliance with this policy will be documented as needed using the standard department complaint procedure.