



PURPOSE

The purpose of this policy is to establish benchmarks and standards for documentation of patient encounters.

POLICY

EMS reporting software is used to formally document all patient encounters, regardless of whether the patient is transported.

All required fields in the reporting software must be accurately completed. Any other fields that are considered pertinent to the medical incident must also be completed. Vital signs shall be documented for each patient encounter. At least two sets of vital signs are required if patient care is ≥ 15 minutes in duration, and the patient is transported. Any patient transported in emergent mode shall have vital signs documented a minimum of every 10 minutes.

Narrative Requirements

The narrative should serve as an opportunity for the healthcare provider (HCP) to further explain and document treatment information on a transported or non-transported patient. Narratives should include observations, interventions, assessment of the patient, and other pertinent information for the patient record. The chronological format will be utilized as the standard format for all narratives. The format is as described below:

- Dispatched To: A brief description of the initial dispatch.
- Upon Arrival: Describe the incident scene.
- Chief Complaint: Quote the patient's chief complaint.
- Primary Assessment: Your first impression, patient's level of consciousness, airway, breathing, circulation, history of present illness, past medical history, and life-threatening conditions.
- Secondary/ Focused Assessment: Information that pertains to a detailed physical exam, or a focused assessment, pertinent negatives, cardiac rhythm interpretation, 12 lead interpretation, lung sounds, and CBG (capillary blood glucose).
- Treatments: All treatments that were provided to the patient.
- Ongoing Assessment: The patient's response to treatments, medications or additional assessments that were performed.
- Transport: Mode of transport, any alerts transmitted, destination and the name of the individual that patient care was transferred to.
- Notes: Any additional information that needs to be documented.
- A release of liability must be completed for any patient who originally had a complaint of injury or illness.

Approved

Fire Chief

1 of 1