Rogers Fire Department Standard Operating Procedures

Policy Title:	EMS Documentation		
Policy Number:	203	**Volume:**	Field Operations
Approved By:	Tom Jenkins	**Last Updated:**	March 2019
CFAI Reference:	5G.4, 5G.6	**CAAS Reference:**	201.03.02, 202.05.01
Revision Summary:	Created – October 2010 Formatted – May 2012 Clarification Update – August 2012 Updated – July 2016 (Vital Signs) Updated – November 2017 (RMS Program) Revised – March 2019		

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 Paramedic 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 patients 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

- 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.

The following serve as additional required information in the narrative:

- Advanced airway placement must be confirmed by a minimum of three methods including waveform capnography.
- If a patient with injury refuses treatment the paramedic shall document findings as you would for any other patient adhering to the criteria above and Northwest Arkansas Regional Medical Protocols. It is imperative that the narrative includes information about the paramedic's recommendation to be treated and/or transported.
- A release of liability must be completed for any patient who originally had a complaint of injury or illness.