PURPOSE:

To establish minimum documentation requirements so that each run report accurately reflects a patient's assessment, history, and the emergency medical care given to that patient.

POLICY:

Every run report will contain the following information:

1. **General Information**: Name of the provider, responding unit, call number, crew members' last names, call date, reason for call, location, destination, first responding units, monitoring MD/medical control operator, receiving RN/MD signature, patient (or parent/guardian) signature if treatment or transportation is refused.
2. **Patient Information**: Patient name, address, age, birth date, sex, and personal physician
3. **Times**: Initial call, enroute, at scene, leave scene, and at destination.
4. **Chief Complaint**: Ideally in the patient's own words, what is their primary complaint? If the patient has none, write "none". If patient cannot give one, describe what the major problem appears to be, such as "unresponsive" or "cardiac arrest."
5. **History of Present Illness**: What events led up to the request for assistance? When did symptoms begin? What was the patient doing when they began? Has anything the patient taken or done changed the complaint? If pain, describe severity, location, type, and radiation. Have there been any previous episodes? Has there been any loss of consciousness? If pregnant, include pregnancy number and due date. Use direct quotes when documenting drug or alcohol use.

   (or)

   History of Present Injury: What events led up to the request for assistance? What is the mechanism of injury? When did it occur? Include information on speed, accident type, vehicle damage, ejection, entrapment or loss of consciousness. Was safety equipment such as seatbelts, helmets, air bags, or car seats used? Attach photo if available.
6. **Past Medical History**: List pertinent history, especially heart and lung disease, diabetes, stroke, seizures, recent surgeries, psychological problems, communicable diseases, and DNR/DNI status.
7. **Allergies**: List allergies; especially drug, and food or insect if pertinent to call.
8. **Medications**: Document all current medications and when last taken, if pertinent. *If patient denies any of the above, write "none" or if unknown, write "unknown".* It is permissible to document "see list" if the list of medications is attached to the chart and contains a patient identifier.
9. **Physical Exam**: How was the patient found (positioning/obvious distress)? What was initial level of consciousness (AVPU)? Was patient oriented to person, place, and time? Document assessment of airway, breathing (dyspnea, lung sounds, JVD, 02 sats), and circulation (pulses, skin color/temp, bleeding, capillary refill). Document findings of head-to-toe exam, including wounds, deformity, tenderness, edema, pupils, incontinence, and CMS findings before and after treatment. Include pertinent negatives. Include Glasgow Coma Scale (GCS). If chart is not on form, then document: GCS=12 (E-3, V-4, M-5). If newborn, include one and five-minute APGARs.
10. **Treatment**: Document all treatment administered. The following treatments/assessments have specific documentation requirements:

    A Oxygen: liter flow and route. Example: "NRB mask at 15 lpm".

B. I.V.: time, fluid type and size, needle gauge, location, drip rate, amount infused. Example: "16:04 - IV 500 cc NS, 18 g. to ® antecubital, 250 cc fluid challenge, then TKO".

C. ECG -3 and 12 lead (ALS): rhythm interpretation, rate, ectopy, and injury patterns. Example: "ECG - sinus tach at 120/min w/ 1-2 unifocal PVCs/min. with inferior injury". Attach ECG sample to run report and leave with patient in ER. ECG -3 and 12 lead (BLS): attach strip only, do not interpret rhythms.

D. Medications: time, name, dosage, route, initials of person who administered, and SO (standing order) or VO (verbal order). Example: "15:48 - lidocaine 75 mg IV SO

E. Advanced airway: type, size, and evaluation. Example: "Intubated with Combitube, ventilated through #1 port, good bilateral chest rise/lung sounds, absent stomach sounds, passed NG tube through port #2 with release of stomach air". Confirm and document airway placement before entering ED.

F. Defibrillation: time and joules. Example: "18:10 - Defib at 200 J."

G. MAST: time and sections inflated. Example: "4:26 – MAST applied, both legs inflated".

H. For signs/symptoms suggestive of stroke, complete the Cincinnati Prehospital Stroke Scale and document the findings and time of onset on the run sheet.

11. **Response/Transport**: How did the patient respond to any treatment given? Were there any changes in the patient's condition enroute? How was the patient transported to the hospital (routinely or red lights and siren [RLS], and whether stretcher was used)?

12. **Vital signs**: One complete set of vital signs every 15 minutes on each patient, including time, BP, pulse, respirations, and O2 sats. More are required if patient is unstable (every. 5 min.), or receives medication or treatment that indicates the need to reassess more frequently. Most patients should have two complete sets of vital signs obtained on them before arrival to the hospital unless patient contact is < 10 min. If unable to obtain, document why.

13. **Rationale for allowing the patient to be transported BLS, if first evaluated by ALS.**

14. **Impression**: What is the provider's impression of what is wrong with the patient?

15. **Signatures**: Each run report must be signed by the person who wrote it. An EMT or paramedic may write BLS run reports. A Paramedic or Intermediate must write ALS run reports. If the patient is transported, the receiving RN or MD must sign the form. If the patient refuses treatment or transport, they must sign a refusal statement. Document any instructions given to the patient. If patient is a minor, a parent or guardian must sign the form. If the patient refuses treatment/transport and also refuses to sign, then write "refused" in the box and have someone who witnessed the refusal co-sign the form.

SPECIAL NOTES:

1. All information obtained during the course of patient care delivery is confidential.
2. A run report must be filled out each time an EMS provider offers or provides service to a patient. The only exception to this is a mass casualty incident.
3. Complete one run report for each patient; e.g. mothers and newborns must each have separate run reports.
4. In severe trauma, where scene times are delayed longer than 10 minutes, document reasons for extended scene times, i.e. extrication or unsecured scene.
5. All reports should be written in black or typed/printed.

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Reviewed:
Revised:

6. Correct errors by drawing one line through the incorrect item and initialing by it. Example: "Administered 4 mg ~~morphine~~TG Narcan IV push."
7. Any suspicious situation regarding child/elder neglect/abuse must be reported, according to Wisconsin State Law, to a licensed peace officer or child protection officer.