

LEON COUNTY E.M.S.

Standard Operating Guideline

Title: Patient Care Reports
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Pages: 2

I. PURPOSE:

To maintain an accurate record of medical care given by LCEMS personnel in compliance with standard medical records practices.

II. GUIDELINE:

EMS patient care reports are to be completed on all patients whom LCEMS assesses, treats and / or transports. The patient care record in all instances will accurately describe the services provided to the patient, any and all pertinent scene information, an accurate and complete patient assessment and accurate and complete treatments. All sections of the ambulance run report must be completed in as much detail as possible. Intentional falsification of patient care records is a serious violation of LCEMS policy and will result in disciplinary action up to, and including, termination.

III. PROCEDURE:

1. Patient care reports or ambulance run reports are to be completed as soon as possible after the incident. This assures completeness and accuracy. At no time shall patient information, notes or reports be removed from LCEMS or taken home for completion. All run reports must be completed by the end of the shift.
2. It is the responsibility of the crew member who cared for the patient to complete the patient care record. The other crew member shall review the patient care record for completeness and accuracy. If a dispute arises concerning the content of the report each crew member will provide the Shift Supervisor a written report detailing the dispute. These disputes will be forwarded to the Education / IQM Manager for final resolution.
3. As per the HIPAA policies in place, all LCEMS employees will safe guard all patient information and protected health information. If a LCEMS employee finds unsecured patient information or PHI, that employee will immediately secure the information and then provide it to the Shift Supervisor.
4. The patient's name and incident number will be entered into the LifePak for all patients who are placed on the cardiac monitor. A copy of the patient's cardiac

- rhythm records shall be left at the receiving facility.
5. LifePak – Crews will upload the EKG code summary from the LikePak to their electronic patient care report during or immediately after each call.
 6. For patients who are transported. A completed Ambulance Run Report is to be left at the following locations as soon as practical after patient delivery to that institution:
 - A. TMH - Bixler Emergency Center: Leave a completed copy and any ECG with the Facilitator located in the area of the Bixler Emergency Center that the patient was delivered to. The ECG, when left with the Ambulance Run Report, must have the patient's name documented on it.
 - B. Capital Regional Medical Center - Emergency Department: Leave the completed copy of the Ambulance Run Report with the Emergency Department registration staff. When an ECG procedure is performed, leave a copy of the ECG (with the patient's name documented on it) with the Emergency Department registration staff.
 - C. Any VA Hospital - Leave a completed copy of the Ambulance Run Report at the "Travel Officer's" office (must have beginning and ending odometer readings).
 - D. All Other Hospitals - Leave a copy of the completed Ambulance Run Report with the facility.
 7. End of Shift Procedure.
 - A. Electronic reports – all electronic patient care records will be exported in the patient care computer system as soon as possible after the completion of the report. Crews will make sure that all reports are exported prior to the end of their shift..
 - B. Paperwork – any hard paper created concerning patients will be placed in the locked box located in the crew's computer room at the logistics area. Be sure that the patient's name and incident number are on each piece of paper. Notes containing patient information that are being discarded will be shredded.