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## DOCUMENTATION/RECORD KEEPING

**PURPOSE:** To provide a template for the standardized expectations on EMSIRS utilization, documentation procedures, and how the forms should be disseminated.

### I. EMS Services and EMS Personnel Responsibilities

- a. Emergency Medical Services Incident Reporting System (EMSIRS) run forms or an authorized equivalent will be used to document each time an authorized EMS unit responds to and/or participates in an incident or when advanced life support is provided on any patient.
- b. EMSIRS run forms or an authorized equivalent will be routinely completed at the time of patient delivery to the receiving facility.
  - i. In the event that an EMSIRS or authorized equivalent cannot be completed prior to the EMS unit's dispatch to another call, the run form will be completed and delivered as soon as possible after that call, within that working shift.

### II. Procedure

- a. Run forms should be completed in accordance with South Central Connecticut CMED EMSIRS Coding Guidelines and the NHSHP policy.
- b. ALS Documentation should include the following
  - i. An ECG rhythm strip should be obtained and attached to the run form on all patients who are cardiac monitored. It should include the patient's name, date, time of recording, and pertinent medical information (i.e. "with chest pain" or "after atropine")
  - ii. Intravenous access should be documented on the run form including the time, size catheter, location, fluid hung, rate of fluid, attempts made and success or not.
  - iii. All medications should be documented with drug, dose, route, time, reactions, and effects.
  - iv. Intubation documentation will include time, route (oral/nasal), attempts, success, tube size, depth of tube at lips, confirmation of placement by more than one method, adjuncts used (suction), and complications.
  - v. All skills/procedures will be documented by noting indication, time, process, complications, and effects.



- vi. Documentation of medical control will include standing orders or on-line medical control, time, route (phone/CMED), physician name, orders requested, approved or denied.

### **III. Forms**

- a. Hospital Copy
  - i. The hospital copy of the run form will be left with the Emergency Department Staff (or designee) in the patient area to which the patient is triaged. Every effort should be made to complete the form and leave a copy in the patient care area prior to departing the ED.
  - ii. Ambulatory patients who will await registration without going to a specific patient care area will have their hospital copy left with the triage nurse or designee.
- b. Data Processing Copy
  - i. The data processing copy of the run form will be left in the locked box provided for this purpose in designated EMS write-up area of each hospital.
- c. Service Copy
  - i. The service copy will be taken by the EMS crew and handled in accordance with their EMS services policy.