

Documentation of Patient Care

Section 1 North Central Connecticut EMS Council Guidelines

Documentation of assessments and patient care shall be done on all patients evaluated including, but not limited to: emergency, transfer, patient refusals and stand by circumstances.

Documentation of patient care shall be done immediately upon completion of patient care, and/or transfer of care, and after restocking necessary equipment and drugs. The only exceptions to this practice are personal safety issues.

A patient care record shall be left at the receiving health care facility. Every effort shall be made to be certain that the nurse and/or physician responsible for care receive the record.

In the event of delay causing the provider to be geographically distanced from the receiving facility, you may fax your report to that facility immediately following the call.

Quality assurance reports/records shall be submitted to the sponsor hospital in keeping with prescribed standards.

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Section 11 Manchester Memorial Hospital EMS Policy on Documentation

Run forms should be signed by the on-line physician in cases when ALS procedures and/or drugs have been administered.

It is understood that in rare instances such as natural disasters, and for compelling service issues, documentation may not be completed immediately after a call. In the event a particular situation delays completion of documentation, the EMS/Trauma Coordinator shall be notified of the reason for the delay.

Failure to adhere to documentation standards is considered to be just cause for disciplinary action up to and including withdrawal of medical authorization from the individual and/or the service.